Exploring the potential of classroom learning for adults with mental health problems: perceptions of transformation and well-being

By

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Acknowledgement of authorship

‘I, Denise Buchanan confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.’

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Abstract

In the United Kingdom, although one in four adults reported experiencing mental health difficulties in one year, only a quarter of them received treatment for their condition BMA (2017). Moreover, this group of adults have been underrepresented in fulltime employment and education. This thesis argues that facilitating Further Education (FE) opportunities for adults with mental health problems, may assist in promoting their well-being and a pathway towards a different future.

A narrative study was carried out involving 15 adults with mental health problems, who were attending classes in an FE College. Specifically, participants were asked during extensive one-to-one interviews, about their recent experiences of classroom learning and their narratives were analysed in relation to well-being and transformative learning theory. Participants reported numerous benefits arising from their learning which they felt had positively influenced their sense of well-being and which for some, included transformative changes.

This thesis makes an original contribution to knowledge as it highlights that for adults with mental health problems, formal learning does have the potential to contribute positively to their lives. Furthermore, it suggests that unless certain wider societal factors are sufficiently addressed, the potential for these benefits to be fully realised, will be severely hindered. The thesis also extends the theory of transformative learning theory and highlights the value of bridging the divide between health and education when working with adults with mental health problems. Straddling these two disciplines in this study, has led to new understandings in relation to the best way to support adults with mental health problems in an FE setting. It has additionally led to identifying how best to interview vulnerable learners in a meaningful, safe and ethical way within an educational setting. The implications for policy and practice because of this work are outlined.

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List of Abbreviations

ASs	Advanced Subsidiary level exams
BAME	Black, Asian and Minority Ethnic Communities
ESA	Employment Support Allowance
FE	Further Education
GCSEs	General Certificate of Secondary Education
MHF	Mental Health Foundation
MHAs	Mental Health Advisers
NHS	National Health Service
OTs	Occupational Therapists
PGCE	Post Graduate Certificate of Education
SES	Socio- economic Status
UK	United Kingdom

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Chapter 1 Introduction

In this chapter I introduce the topic of this thesis and how it evolved and discuss my personal and professional reasons for carrying out the study. I outline the nature of mental health problems, their causes, impact and support for people with such problems. Against this background I outline the aims of this research, focusing on the links between learning, well-being and transformation. Additionally, I describe the difficulty I experienced in attempting to bridge the divide between the fields of health and education yet note the importance of doing so. Finally, I outline the structure of this thesis.

1.1 The emergence of the thesis

My interest in mental health problems first arose when I was studying for my undergraduate psychology degree at University of London between 1979 and 1982 and had to study a unit referred to as abnormal psychology; I found it to be a fascinating subject given that it spanned the affective, cognitive, social and biological aspects of psychology. Following this, I trained as a nurse between 1983 and 1985 and it was during this time I was shocked to hear of the prevalence of mental health problems as the tutor predicted that approximately one quarter of our nursing cohort would personally experience such difficulties in the future. I had not realised the prevalence of mental health problems would be so high, particularly among a group of educated people. Consequently, I did not imagine then, that 15 years later I personally would suffer with mental health difficulties, the most traumatic experience of my life, and which led to me being unable to work for five years. At the point at which this happened, I was working in a Further Education (FE) college as following my nursing training, I had been persuaded to teach on the FE courses which required trained nurses to deliver them.

Nonetheless, despite becoming so unwell with my own mental health problems, during my extended period of recovery, I learnt invaluable things about mental health, which neither my psychology degree nor nursing training could have taught me, despite the excellent teaching I had experienced on both courses. Such lived experience changed how I viewed

mental health problems as I came to realise that mental health exists on a continuum and that anyone could potentially experience mental health problems, at any stage in life. Additionally, I realised that a variety of factors may combine, encompassing the cognitive, medical, emotional, social, environmental and behavioural domains, to lead one to experience mental health problems. Such insights came to me through a mixture of reading around the subject as well as undergoing therapy, and critically reflecting on how I had become so unwell and how I could recover from my illness. These new understandings led me to move away from a deficit focussed bio medical model in which certain behaviours and dispositions were categorised as being abnormal, to moving towards a positively focussed recovery model. Years later, I came to see this shift echoed in the positive psychology movement which involved identifying the strategies a person could implement in order to keep mentally healthy and recover well from setbacks, which has the potential to lead to 'post traumatic growth' (Seligman, 2011, p. 5).

On returning to teaching, I had little idea that my lived experiences of mental health problems would help to inform my teaching. I was asked to teach cookery skills, a subject I had never taught before, to a group of adults with mental health problems and it was then that I discovered to my surprise, that I enjoyed teaching this practical subject as well as this cohort of students. The cookery class was called a discrete class, as although it took place in a mainstream college, the provision was only open to people with mental health problems who had been referred from the local mental health unit. This course had been set up to provide a non-threatening environment in which these vulnerable adults could re-engage with formal learning in a non-clinical setting with the aim of bridging the gap between the healthcare system and education or training. For the purposes of this thesis, vulnerable refers to a person 'in need of special care, support, or protection because of age, disability, or risk of abuse or neglect' (Oxford Dictionary, 2017). Furthermore, formal learning refers to that which takes places in 'educational or training institutions' and which leads to nationally recognised qualifications (Learning and Work Institute, 2017, p. 6).

Within this discrete class, extra support was provided by two Occupational Therapists (OTs) and the hope was that as the skills and confidence levels of the students grew, they would consider progressing onto other mainstream classes within the college, which did and still does happen.

It was whilst I was teaching this class that I began to study for my Post Graduate Certificate of Education (2007) and it was during this course that my love of academic learning was re-ignited, which led me to my present place of study for a Master's degree (2009) and a doctorate (2012). However, it was during the Master's degree that I first became interested in carrying out research in relation to adults with mental health problems. Previously I had had many students speak to me of how greatly they felt they were benefiting from attending the cookery class, but it was only when I began my MA research module that I discovered that little research had been carried out among this group of learners in non-clinical settings. Subsequently, my first piece of research among this group of students looked at the possible barriers to learning that might hinder them from engaging in formal learning (Buchanan, 2014). Although this exploratory study did identify some of the barriers to participation that these students experienced, the main discovery that emerged, was the great extent to which my participants perceived they had benefited from their learning: it was this finding that determined the direction of this work.

Due to my postgraduate studies, I realise now that I had come to view my own recovery from mental health problems differently. First, I came to see how in my case, returning to formal learning, initially in the form of a typing course followed by a computer one, were small but significant steps in my recovery trajectory. It was the stimulation, structure and commitment that these courses offered, that strengthened my confidence that I was gradually becoming mentally well enough to consider returning to paid work. Also, I came to see that although I felt I had exercised a lot of agency in the progress of what I called my 'recovery journey', the reality was that I was only able to do so because of other factors. These included being able to access good health care, which I had the education to know how to do, as well as the fact that I was socially and economically secure in my home life, which

enabled me to take as much time as I needed, to recover. Only since engaging in my doctoral studies did I come to understand that these optimum conditions are sadly not available to everyone who experiences mental health problems. Yet, through my own experiences and research work, I became convinced that if adults with mental health problems were helped to engage with and benefit from formal learning, it could play a significant and positive role in their recovery trajectories.

In the following sections I will outline the prevalence and impact of mental health problems, how formal learning may play a positive role in the lives of this group of people as well as outlining the theory of 'transformative learning' which will be addressed through this work. Finally, issues related to how this work aim to bridge the divide between health and education will be outlined.

1.2 The prevalence and impact of mental health problems

Looking further into the issue of mental health, revealed that 23% of the UK population every year are affected by mental health problems, and that the impact of such problems are multiple, at personal, societal and economic levels (MHF, 2015). However, despite the high prevalence of mental health problems and its ramifications for individuals and society as a whole, mental health does not have the same funding allocation as physical ill health does, as only 11% of the NHS budget in the UK is allocated to this area (BMA, 2017). The BMA (2017, p. 4) concluded that 'Historically, mental health has been chronically underfunded as it has not had the same level of political prioritisation as physical health care'. Consequently, there is an imbalance between the scale of mental health problems and the relative lack of investment and provision for this group of people, which reflects a lack of parity of esteem concerning mental and physical problems respectively. For instance, in terms of treatment, whereas 90% of people with diabetes will be receiving the necessary treatment (Layard and Clark, 2014), three out of four people with a mental health problem in England will receive little or no treatment for their condition, (BMA, 2017). Layard and Clark (2014, p. 4) define receiving treatment as being when a person has the opportunity to be treated with 'modern psychological therapy and drugs', when appropriate.

Similarly, in terms of research funding, mental health only receives 5.5.% of the UK research budget as opposed to 19.6% for cancer research (MQ Landscape Analysis, 2015).

Another important disparity that exists is how mental health problems are distributed throughout society, as there is a greater incidence of people with mental health problems from certain ethnic groups, as well as among those who are economically disadvantaged. Public campaigns (e.g. Time-to-change, 2013) commonly quote that one in four people experience mental health problems each year in the UK which is factually accurate (McManus *et al.*, 2009) but as Rogers and Pilgrim (2002) argued, such messages may be misleading. This is because they give the impression that is it 'one in any four', (ibid. p.7) and thus suggests a randomness that does not exist. Rather, the MHF (2015, p. 57) reported that people who were 'socioeconomically disadvantaged were 2-3 times more likely to develop mental health problems' and that they would find it more difficult to recover well than those who had a higher standard of living. This unequal distribution reflects the health inequalities that exist in the UK generally as identified by Marmot (2010), who found that people who have a lower level of socio-economic status (SES) will experience more years of ill health and die at an earlier age than those who have a higher level of SES. Due to these disparities in health and well-being, the MHF (2015, p. 59) argued that 'health inequalities or inequities are systematic differences and are socially produced in health between social groups, that are avoidable and therefore unjust'.

1.3 How formal learning can enhance well-being

Previous educational research highlighted that formal[1] adult learning could have educational, vocational and economic value for some people, and could help the well-being of the individuals as well as their families and their communities (Duncan, 2015; Feinstein *et al.*, 2008). However, much less research has been carried out in relation to how learning can contribute positively to the lives of adults with mental health problems. Consequently,

[1] This term will be defined in section 3.2

given the multiple disadvantages that can accompany mental health problems, this work set out to discover how, having the opportunity to engage in formal learning, could enhance the well-being of this group of people to help improve their quality of life generally. This would tie in with the recommendations outlined by Marmot (2010) in his review of the health inequalities that exist in the UK , that more adult learning courses should be made available so as to help disadvantaged adults to have opportunities to improve their educational and employability skills, which in turn may help their health and well-being. For the purposes of this thesis the definition of well-being by Seligman (2011) was adopted, which proposed that well-being incorporated five elements: positive emotion; engagement; meaning; positive relationships; and accomplishment or achievement. Additionally, I wanted to contribute to the limited body of knowledge that currently exists surrounding how people with mental health problems engage in a FE college, in order to establish how involvement in formal learning can best be achieved.

1.3.1 The role of transformative learning theory

Another aim in this study was to investigate if learning could affect the lives of the individuals in a deeply embedded and permanent way that is a transformative way. During my teaching career and in my exploratory study, many students had spoken of feeling that their recent learning had transformed them and a recent research project has documented similar testimonies from a large number of mature students (Duckworth and Smith, 2017a). Consequently, this study set out to discover if what the students were talking about, was at the level of transformation proposed by Mezirow (1990, p. 92) in his theory of transformative learning. This is a process that he believed happened when:

> we transform problematic frames of reference (mindsets, habits of mind, meaning perspectives) – sets of assumption and expectation – to make them (*the frames of reference*) more inclusive, discriminating, open, reflective and emotionally able to change.

Mezirow proposed this theory after carrying out research in 1978, among mature women who had returned to formal learning and reported that it had significantly changed their lives. Through returning to learning as an adult, Mezirow suggested that the adults began to question their previously held beliefs and replace them with beliefs that were more inclusive. He believed that this could happen if they were in an environment that encouraged critical dialogue with others and critical reflection, both which he thought had the potential to lead them to changing how they viewed the world and their position within it. That is, Mezirow felt that such transformative changes, particularly in their sense of identity, had the potential to influence their future actions. This theory provided the theoretical framework in which to situate this research, as it was specifically a theory of adult learning, which was well documented and researched. Finally, the hope was that this current work could serve to extend the theorisation of transformative learning in relation to students with mental health problems.

1.4 Bridging the divide

Before embarking on the thesis, one recurring issue that arose early in the research process was how best to bridge the divide between two separate disciplines: health and education. Straddling the divide between education and health was essential in this work, particularly as I could only access participants via the National Health Service (NHS) mental health department. In addition, it was important since my own academic, professional training and subjective experiences encompassed both domains, possibly reflecting a breadth of experience that is unusual among academics. Consequently, this work aimed to bridge these different domains, with the hope that it would extend the relevance of the research carried out. As Pearson (2016, p. 313) suggested, interdisciplinary science is considered desirable, 'because scientists…have recognised that solutions to many important problems can come only from research that bridges traditional boundaries between disciplines'. I would echo that desire in relation to educational research.

Ethical issues

One early challenge that arose from working in two domains was in relation to gaining ethical approval; initially it did not seem appropriate for me to seek NHS approval given that I was interviewing my participants in college, about their college experiences. However, it transpired that I was required to by the Occupational Therapy department, as they were responsible for referring patients onto the discrete course which I taught and from which I hoped to recruit participants. This led to a lengthy process of dialogue with health professionals, which was difficult to manoeuvre, as I was no longer part of the medical system professionally. However, this was an important part of the process as my exploratory study had highlighted the need to be prepared for the ethical dilemmas that may arise, when interviewing adults with mental health problems in a non-clinical setting. The study had raised the question of whether it would be possible at all to investigate such vulnerable people in an educational context in a meaningful, ethical and safe way.

Choice of literature and the nature of knowledge

Another challenge that arose was which sources of academic work I should use. When I focussed on the health research it mainly involved research concerning the mental health staff and their learning rather than the people who had mental health problems, although it was unclear why this was so. On the other hand, when I focussed on the educational side, much of the research concerned those with special educational needs such as autism or students with physical disabilities. Of those that did involve people with mental health problems, they tended to involve people with mild to moderate mental health problems,[2] such as those who might attend a self-referred community learning group, as opposed to those with moderate to severe mental health problems, as in my study.

Part of my challenge regarded the nature of the material I was sourcing, as although there was much relevant literature in relation to mental health

[2] Please see Appendix 2 for details regarding definitions of mild/ moderate and severe mental health problems.

problems within the biomedical literature, I was reluctant to place myself fully in this field. This was because within the biomedical field, there can be a tendency to view people in terms of their mental health diagnosis. In contrast, as a teacher I deliberately do not ask about the diagnostic labels my students have been given, to avoid prejudging them. Alongside this, I would argue that biomedical research privileges the tacit ontological and epistemological assumptions 'that there is an observable social reality that exists and can be measured by the researcher using scientific methods' (Burke and Jackson, 2007, p. 27). Therefore, from an epistemological angle, the health field tends to privilege studies that are viewed by clinicians and scientists as 'proving' facts as they appear to produce outcomes in a valid and reliable way. However, most of these studies are quantitative by design, undergirded by an approach of positivism and rely heavily on Randomised Controlled trials, which are presently regarded as the 'gold standard for comparison' in the health field (Layard and Clark, 2014, p. 117). I would argue that such an approach does not allow for an acceptance that reality can be viewed in different ways and that there are alternatives to how one can view disability outside of the biomedical field such as from within the social model of disability (see James and Talbot-Strettle, 2009). Additionally, Burke and Jackson (2007, p. 26) postulated that from a feminist perspective, one could argue that such reliance on positivist research privileges 'masculinised, white, racialised and Westernised ways of knowing' and implies that such information is neutral and value-free, even though in reality it is often gendered and always politicised. In contrast, in educational studies, the nature of research tends to be more inclusive and to encompass an array of ontologies and epistemologies, as it incorporates a greater range of methodologies such as those relying on qualitative data. Yet, I could not discount the important sources of work that exist in the health field regarding the prevalence and processes of mental health problems, as they reflect the dominant discourse both medically and politically. If my work was to be considered credible in the health field as well as in the field of education, I needed to include such data sources despite being sceptical at times regarding the claims they made regarding 'proving' stated facts.

Choice of language

Finally, a challenge existed in my choice of language as I wrote up the thesis: what was the best way to reconcile the different languages used by health researchers and educational researchers? Although there is a commonality in themes between domains, they each have their own language. For instance, it is common in health to talk about mental illness as opposed to the more inclusive term, mental health problems or difficulties and so for me, the question was whether psychology, health, education or sociology should take precedence. In the end, given my belief that bridging the divide between different domains would strengthen the nature of the research among adults with mental health problems, I attempted a hybrid. This thesis therefore represents my unique attempt to synthesise and bridge the divide between contrasting subject domains.

1.5 Aims of the research

The aims of this research were to identify the wider societal context for adults with mental health problems as well as to discover if and how adult learning could influence their sense of well-being. In doing so, I aimed to examine the links between learning, well-being and transformation. This was specifically to counteract a research gap that exists in relation to how adults with enduring mental health problems can be helped to benefit from Further Education in the UK. Moreover, my aims were that, by strongly focusing on the learning of adults with mental health problems, this would serve to change them from being viewed primarily as patients, to being viewed primarily as learners, by the consumers of my final research presentations as well as the participants themselves. Then, additionally, in drawing together work in education and health, I aimed to illustrate how one can build a bridge between these two aspects of their lives.

I also aimed that such knowledge could enhance the capacity of those who work in education and health, to improve the social, educational and vocational opportunities of this vulnerable group of students. This was particularly important as adult mental health problems are often combined

with economic disadvantage, low confidence levels and a lack of resources and opportunities. Another aim was that this work would extend the limited body of knowledge available concerning how this group of learners can be safely and ethically interviewed for research purposes, in a non-clinical educational setting. In turn, new understandings may contribute towards widening participation in FE colleges, among adults with mental health problems, as well as to help bridge the divide between research in health and research in education. Such understandings could thereby contribute to increasing the levels of social participation among this disempowered group of learners. This may then lead to them experiencing changes in their sense of agency, educational and employability skills and their status in society, all of which Marmot (2010) proposed is essential for improved health. Finally, the hope is that such new understandings may contribute to society being able to find ways to lessen the health inequalities that exist in the UK today, which the MHF (2015, p. 59) argued, 'are avoidable and therefore unjust'.

Considering these aims, the research questions were:

1. What is the wider societal context for adults with mental health problems returning to formal learning?

2. Considering the relationship between wider societal factors and mental health, what are the perceptions of adults with mental health problems regarding the influence of classroom learning on their well-being?

3. In what ways can their experiences and perceptions be understood with reference to Mezirow's theory of transformative learning?

4. In terms of bridging the divide between the fields of health and education, what can be learnt regarding how to interview vulnerable adults in a meaningful, safe and ethical way within an educational setting?

1.6 The structure of the thesis

Concerning the structure of this work, chapter two will explore the wider societal context in terms of mental health problems in the UK as well as considering why there exists an unequal distribution of mental health

problems in society. These will help to answer research question one. Chapter three will look at the topic of learning and well-being whilst chapter four will consider the possibility that for some people, learning may lead to them experiencing transformation. These will serve to answer research questions two and three. Chapter five will outline the methodological approach adopted for this work as well as the methods employed throughout the research and if and how it was possible to interview vulnerable participants safely; this will serve to answer research question four. Chapters six, seven and eight will contain the findings and analysis for the three groups involved. Chapter nine will attempt to synthesize the findings from all three groups to identify any commonalties and differences that emerged from the narratives of the three groups. A discussion of these findings will take place in chapter 10 and finally, chapter 11 will outline the conclusion and recommendations resulting from this research.

Chapter 2 The wider societal context for adults with mental health problems

Introduction

This chapter will seek to answer the first research question in relation to what the wider societal context is for adults with mental health problems returning to formal learning. To achieve this, the chapter will give an overview of what mental health problems are and how they can affect the lives of adults in the UK, as well as looking at some of the wider societal issues that may be impacting their lives adversely. First, after defining what mental health problems are, the chapter will cover issues relating to the nature, prevalence, impact of mental health difficulties and the current treatment options available. Second, the chapter will seek to address the controversial issue concerning the possible causes of mental health problems. In doing so, the chapter will explore how and why there is an unequal distribution of mental health problems throughout the UK as well as how this imbalance appears to reflect the social gradient that exists in terms of health generally. The chapter will further examine how, despite suitable employment being shown to be good for physical and mental health, such inequalities affect the employment prospects for adults with mental health problems. The chapter concludes by arguing that given the disadvantages that these adults experience, attention should be paid as to how they may be encouraged to engage in formal learning, as it may provide a potential means by which their sense of well-being and health can be positively affected.

For the sake of simplicity, all statistical quotes in this chapter, unless otherwise specified will be taken from the Mental Health Foundation report (MHF, 2015), which is a charity that is funded by donations and grants. However, one caveat is necessary: such statistics may appear to be definite, but the reality is that they should be viewed with some caution as they are dependent on time, place and measurement techniques. Added to this, it is difficult to access comprehensive figures as the exclusions vary in that for example, some figures will include people who experience eating disorders or dementia and other figures will not. Equally some figures will be based on

measurements over one year, and others over only one week. So, although these facts are included, reflecting the current dominant discourse regarding mental health problems, they will be used on the understanding that they are contestable.

2.1 Defining mental health problems

The issue concerning how one defines mental health problems is a contentious one and often reflects how one understands the concept of mental illness. From a medical point of view, the definition of mental illness according to the American Diagnostic and Statistical Manual V (DSM-5, 2013) is: 'a syndrome characterised by clinically significant disturbance in an individual's cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological or developmental processes underlying mental functioning' (p20). Previously, in psychology it was traditionally referred to as abnormal psychology: abnormal because the behaviour was considered as deviating from the norms of society. This perspective is now seen as being inappropriate as what society regards as normal behaviour has been seen to change over time and place (Nolen-Hoeksema, 2014).

Given the contentious nature of these labels and for the purposes of this work, the inclusive term mental health problems or mental health difficulties will be used to cover a range of diagnosable mental illnesses, including personality disorders (Department of Health, 2011). These are terms favoured by mental health charities such as Mind and were confirmed by the participants in this study as reflecting their preference. However it is important to note that the term mental health problems in this thesis, will not include physical disabilities although 46% of people with a mental health problem will also have a long-term physical health difficulty (The King's Fund, 2012). Neither will it include dementia or developmental problems such as autism. Lastly, it will not encompass learning disabilities, although 54% of people with learning disabilities have been found to have a mental health problem (MHF, 2015).

2.2 The nature and prevalence of mental health problems

Mental health problems may present at any time during a person's life from birth to old age. While many people will make a good and full recovery, for some people, living within the constraints of their illness can, with adequate medical and social support, enable them to function well in society and work. For others, they may have longer periods when they will have relapses requiring hospitalisation and so may struggle to maintain a steady job or live independently, thus generalisations regarding mental health problems can be difficult to make (MHF, 2015).

Mental health problems can broadly be categorised into common and severe, of which the former includes problems such as anxiety, depression and panic. The latter includes problems which cause a person to perceive or interpret things differently from others around them, possibly including hallucinations or delusions (NHS, 2016). Yet one must recognise that these diagnostic categories are themselves socially constructed and thus contested by some people. Pilgrim (2013) argued that psychiatric labelling was inherently flawed given that two people could be given the same diagnosis without an overlap in their symptoms and even in this study, many of the participants testified to being given different diagnoses throughout their lives. Due to this Pilgrim argued that there are multiple inconsistencies involved in psychiatric classifications such as in terms of construct validity, inter-rater reliability and predictive validity to name but a few.

On a global level, the World Health Organisation (WHO) estimated that 450 million people suffer from mental health problems, and a recent review identified mental health as being one of the main cause of the overall burden of disease in the world. The burden of disease is measured by combining the number of years lost to the disease and the number of years lived with disability due to the disease (Public Health England, 2016). Depression was found to be the leading condition in terms of mental health problems and these depression rates tend to double after major disasters and wars (WHO, 2013). The two tables below, outline the percentage of people aged 16 years

and above, reported to live with these diagnoses in England 2014, taken from the Adult Psychiatric Mobility Survey[3].

Table 1: The prevalence of common mental health problems (MHF, 2016, p. 17)

Generalised Anxiety Disorder	5.9%
Depression	3.3%
Phobias	2.4%
Obsessive Compulsive Disorder	1.3%
Panic disorder	0.6%
Common Mental Disorder Not Otherwise Specified	7.8%

Table 2: The prevalence of severe mental health problems (MHF, 2016, pp. 18-20)

Psychotic mental health conditions	0.5%
Bipolar disorder	2.0%
Autism spectrum disorder	0.8%
Personality disorder	13.7%
Attention deficient hyperactivity	9.7%

Although this study will centre on adults 18 – 65 years old it is important to note that there are a high number of children and young people who

[3] These tables are a guide to the relative distribution of mental health problems. Please consult reference if more clarification is needed.

experience a range of problems mentally as well. Layard and Clark (2014) estimated that approximately one in ten children will have serious mental health problems diagnosed in one year in the UK. Over half of all mental health problems begin before the age of 14 and 75% (excluding dementia) develop by the age of 18 (Department of Health and Public Health England, 2016). Yet treatment is often postcode dependent with a number of adolescents having to wait on average for between 13 -140 days to be placed in a suitable facility, which in some cases will be hundreds of miles away from their homes (The Children's Society, 2015). In relation to older people, an increase in an ageing population affects the rate of general mental health problems; estimates are that one in five people (over 50 years) experience depression possibly due to loneliness, declining physical health and poverty, although 85% do not receive treatment for it.

It is difficult to know if mental health problems are generally rising in the UK, although a rise, for example has been noted in FE settings. Recently, staff from 85% of FE colleges reported that they believed there to have been an increase in the number of students with disclosed mental health problems in the past three years (Association of Colleges, 2017a). Added to this, in the period of 2015 -2016, 74% of FE colleges had to refer students who were experiencing a mental health crisis whilst in college, to casualty (Association of Colleges, 2017b). Similarly, in terms of adults with mental health problems in universities, there has been a dramatic increase in the number of students disclosing mental health problems within the last 10 years (Thorley, 2017).

2.3 The impact of mental health problems

Despite it being difficult to find a consensus regarding the causes of mental health problems, much consensus does exist regarding how negatively such problems can impact the lives of the individuals involved, their families and society. At a personal level, it has been found that the mental pain resulting from mental health problems, 'is extremely difficult to adapt to – much more so than physical illness except for unremitting pain' (Layard and Clark, 2014, p. 5). Additionally, those with mental health problems will have a greater number of physical problems with a poorer prognosis. For instance, if a

person who has anxiety or depression has a heart attack, they are twice as likely to die compared to someone who does not have these problems (ibid.) Reasons for this disadvantage are thought to be due to a combination of factors: diagnostic overshadowing, where people's concerns about their physical health problems are dismissed as being part of their mental health problems; being less likely to access good physical care or physical health checks combined with GPs being less likely to raise issues of lifestyle with them; the side effects of their medication contributing to obesity and other problems such as smoking and finally, self-medication through drugs and alcohol. Yet paradoxically it is more difficult for people with mental health problems to access public health interventions such as Smoking Cessation (Department of Health and Public Health England, 2016). This may account for their lower life expectancies and a disproportionate number of avoidable deaths. Figures show that out of the 100,000 avoidable deaths recorded in England, one third of them involved people with mental health difficulties (Rethink, 2013). Although suicide is not a mental health problem, it is linked to mental health problems and during 2003-2013, 18,220 people with mental health problems took their own life in the UK.

At a societal level, isolation is a problem among those who experience mental health problems and when it affects people of working age, it can lead to unemployment which may increase isolation. This isolation can further be compounded by the stigma of experiencing mental health problems, a stigma which is not commonly associated with physical disabilities. Yet such stigma has been in existence for many years. For instance, Haggett (2015) when interviewing GPs about mental health problems in men in the post-war era found that a number of doctors admitted to having written 'LMF' in their medical notes, when presented with a male patient reporting symptoms akin to mental health problems. This abbreviation referred to a 'lack of moral fibre' which Haggett (2015, p. 45) attributed to being 'a hangover from associations of weakness, assigned to soldiers with war neuroses during the Second World War'. Fortunately nowadays this stigma is being challenged publicly by a number of mental health charity campaigns such as Heads Together (2017) and Time-to-change (2014). Yet much work remains to be

done, and despite several high profile people discussing their own mental health difficulties in the media, ignorance, fear and prejudice still persist in society today. For example, there is a common misconception fuelled by the media, that mental health problems are associated with violent behaviour. Consequently, although there is only a 3%-5% risk of people with mental health problems being involved in violent encounters, in 2011 in the UK, 14% of newspaper articles made this association. The real situation is that people with mental health problems are more likely to be victims of crime rather than perpetrators; in a 2013 survey it was found that 45% of people with mental health problems had suffered in this way (MHF, 2015). Finally, at an economic level in Britain, the estimated cost of poor mental health to the government is between £24 and £27 billion and to the economy, between £74 and £99 billion per year (Stevenson and Farmer, 2017, p. 5). This large economic impact is due to lost taxes, welfare benefits and care costs. Furthermore, the economic effects are also great at the level of the individual and their families, given the likelihood that a person will be unable to work to their full capacity at times.

Having looked at the impact of mental health problems at a variety of levels, an overview of the main mental health treatment options and preventative strategies in relation to mental health will be briefly outlined.

2.4 Mental health treatment options

There is a long and fascinating history in the UK concerning how society cares for people with more severe mental health problems. Two major changes happened in the 20th century which led to a shift in how to care for people with mental health problems. The first change involved the introduction of psychiatric medications around the 1950s when an antihistamine chlorpromazine was found to help treat schizophrenia and tricyclic antidepressants to treat depression and anxiety (Layard and Clark, 2014). The second change was the closing of institutional facilities in the 1980s to support people to live independently within local communities. Nowadays crisis care takes the form of hospitalisation, respite in a crisis house or similar, or daily visits from a Crisis Resolution Home Treatment

team, although this does not happen as frequently as it is intended to. The policy framework in the UK that exists to care for people with more severe mental health problems, centres around the Mental Health Act (2007). This provides the main guidelines covering admission, treatment, aftercare and discharge and includes how to differentiate between voluntary or informal patients and those who are formally admitted as patients to hospital. Formal patients refer to those who have been compulsorily detained or 'sectioned' by approved mental health professionals under section 2 or 3 and detention under section 2 can last for 28 days and section 3 for up to 6 months for treatment to be carried out, although this can be extended. In all cases the Act specifies how many doctors must be involved in approving these detentions and treatments and outside of hospital, legalisation may extend to a Compulsory Treatment Order being given to ensure treatment is carried out at home. Ideally, patients should have mental health advocates attending medical consultations with them to help them understand and implement their rights, but the law does not stipulate such a presence and consequently many people do not have this support.

Despite these changes in care in the last century, there are many people with mental health problems in the UK who are not able to access the necessary treatment. The most common treatments offered centre around medication and talking therapies, the latter of which Layard and Clark (2014) report are particularly helpful for depression and anxiety conditions (e.g. Cognitive Behaviour Therapy (CBT); mindfulness) which are relatively inexpensive. In terms of CBT treatment Layard and Clark (2014, p. 8) argue that although 'around 50% of people treated with CBT for depression or anxiety conditions recover during treatment', only one third of people who require it are actually receiving it. Layard and Clark (2014) further argue that the advantages of funding effective treatment such as CBT outweigh the cost of it given that such treatment may enable the patients to improve in their well-being and so become less reliant on the healthcare system. Comparing this to the availability of treatment for a physical illness, they maintain this is a shocking injustice revealing a lack of parity of esteem as in contrast to adults with mental health problems, 90% of people with diabetes will be receiving the

necessary treatment for their condition. Additionally, mental health problems account for 28% of the total burden of disease in contrast to 16% for heart disease and cancer, only 1% of the public health budget is allocated to mental health problems (MHF, 2016, p. 88). Finally, in terms of research only the equivalent of £10 is spent per person with mental health problems as opposed to an estimated spending of £1571 per person who has cancer. In light of this discrepancy the 'Five Year Forward View for Mental Health' (Mental Health Taskforce, 2016) has set out a strategy to move towards greater parity over the next five years in order to progress towards diminishing this discrepancy.

2.4.1 Health Promotion

Given the large number of people with mental health problems, there have been increasing attempts to implement preventative mental health strategies. One such popular campaign has been to promote 'Five steps to mental well-being': Connect/ Be Active/Keep Learning/ Give to others/Take notice (NHS Choices, 2016). Added to this, there is an increasing drive to include mental health promotion in schools and in community by focusing on well-being, as a means to build resilience (Layard 2013). However, despite these preventative strategies, the one area that remains perpetually in dispute is what causes mental health problems in the first place; this issue will now be explored in detail.

2.5 Reported causes of mental health problems

The reasons why certain people develop mental health problems and others do not, even when exposed to similar circumstances, is a contested subject in the field of medicine, psychology, sociology and other disciplines. Moreover, although this is a vast area for discussion beyond the confines of this thesis, it is however worth noting that certain academics have even questioned whether mental illness exists at all or whether it is in fact a product of social and political constructions (e.g. Goffman (1959); Scheff (1966) and Foucault (1976)). Some people view mental health problems as being mainly biologically caused and some as being mainly due to

psychosocial issues. One suggested biological cause is that there is an inherited genetic component; for instance Torrey, Taylor and Bracha (1994) found there to be a concordance rate in terms of schizophrenia of 28% for identical twins and only 6% for non-identical twins which suggests a high heritability component. Nonetheless this cannot explain fully the causes of mental health problems, given the fact that some identical twins, despite experiencing similar environments, do not necessarily both develop a mental health problem.

In relation to possible psychosocial causes, it is generally accepted that mental health problems can be triggered by a variety of difficult life events such as early deprivation and abuse, inadequate parenting style, bereavement, severe or long-term stress or unemployment. Furthermore, for groups of people who are in a minority, there can be a higher level of mental health problems, as for instance, people who identify as lesbian, gay, bisexual and/or transgender are more likely to experience poor mental health (MHF, 2015). Another area is in relation to gender as women are diagnosed more frequently with mental health problems. Although some of this may be reflective of a greater female willingness to disclose their mental health problems, some feminist writers (e.g. Chesler, 1972) maintain that it is related to being the result of a patriarchal society. Feminist writers argue that in such a society, women who fail to conform to stereotypical female roles are in danger of more easily being labelled as mentally ill, even among psychiatrists. Yet there is indisputable evidence that mental health problems are particularly high among women, especially among those who have experienced extreme abuse and violence, either as children or as adults. Such adults have been found to be 'more likely to face other adverse circumstances in their lives such as a poor mental and physical health' as well as other factors such as disability, poverty and homelessness (Agenda, 2016, p. 1), reflecting the interplay between a variety of sociocultural factors.

One of the most controversial areas surrounding the issues of unequal distribution that has been debated for many years is that of ethnicity. Formerly it was found that there were higher rates of diagnosis in certain

ethnic groups, particularly for psychotic disorders among people of Black, Asian and Minority Ethnic communities (BAME) (Harrison, 1997). In 2003 it was reported that people of BAME origin were 'less likely to have their mental health problems detected by their General Practitioners (GPs) and more likely to have other problems incorrectly described as mental health problems' (MHF, 2015, p. 42). Subsequently in 2008, a study stated that among Black Caribbean and Black African groups, the possibility of experiencing psychotic episodes was double that of white British adults even after controlling for socio-economic status (SES). Additionally, NIACE (2011) reported that people from BAME communities, accounted for 48% of the claims for the former incapacity benefit, due to mental health problems. More recently, it was found that men of African Caribbean ethnic origin were twice as likely to be detained in low secure units than white British origin men and have to stay for twice the length of time, reflecting a failure to 'ensure equal access to earlier intervention and crisis care services' (NHS, 2014, p. 31). Additionally, Time-to-change (2014) identified there to be cases of dual discrimination as perceived by BAME adults. These centred on two areas: 73% reported discrimination due to their race and 93%, due to their mental health difficulties, including 49% reporting discrimination from mental health staff. However, as Rogers and Pilgrim (2002) warned, there can be an unsubstantiated propensity to conflate race with socio-economic status. Consequently, it is hard to discern whether these are causes or patterns and so the debates regarding the aetiology of mental health problems remain much contested.

Additionally, it has been argued that social disadvantage can be another cause as there are a higher proportion of people who are diagnosed with mental health problems and are in the lower socio-economic groups (Allen *et al.*, 2014). Socio-economic status (SES) is a term that reflects a person or a group's position within the hierarchy of society, reflecting access to leisure time, material goods , power etc. (Oakes and Rossi, 2003). This issue will now be examined in detail as it is particularly of relevance to the cohort of participants who took part in this study.

2.5.1 Health inequalities

Despite the figure that one in four people in Britain will experience mental health problems in any one year, Rogers and Pilgrim (2002, p. 7) point out, that it is 'not any one in four'. Rather, they purport that this message of randomness is misleading as it obscures the 'social patterning' involved (ibid.). This is because there is much evidence to show that there are certain groups of people who are more vulnerable to mental health problems, which reflects the overall health inequalities that exist today in many countries. Before looking at this in relation to people with mental health problems, it is necessary to first look at the topic of the general health inequalities that exist in Britain today, as this will provide the backdrop to exploring how unevenly mental health problems are distributed in society.

2.5.2 The social gradient in health

During the 1970s it was believed that the people who were working at a senior level in their jobs, due to the psychological pressures that managers were under, would have a higher mortality rate than those below with fewer responsibilities (Friedman, 1974). However studies of the mortality rates of 17,000 civil servants in Whitehall, UK between 1978 and 1984 (Marmot, 1984) revealed that the men at the bottom of the work hierarchy had four times higher mortality rates than those at the top. The Whitehall studies attributed these findings to the observation that those who were working in higher status jobs, had more control over their work lives and this contributed to their lower levels of stress. It was this perceived locus of control that was found to be important for health alongside one's status in society and level of social participation which Marmot (2004) called the Status Syndrome. This linkage of social position with health is referred to as the social gradient in health (Marmot, 2015) and predicts that the more economically disadvantaged a person is, the less healthy they will be. However, Scambler (2012) criticised Marmot's Status Syndrome by pointing out that causal economic structures have not been addressed. Rather, he accused Marmot and others of emphasizing too greatly that it was the interpersonal and psychological effects of the stress of being subordinate and being devoid of a

perceived internal locus of control that were detrimental to health. It was this stance that failed to mention the part that political structures and their everyday material effects play, e.g. poor housing and diet. Additionally, Alderson (2013) criticised a report concerning poor health service provision for people with mental health problems (LSE, 2012), saying that it too failed to mention the causes of ill health or the role of social structures, thereby ignoring social contexts. However, these shortcomings have since been counteracted in the report by Marmot (2010) as it specifically set out to suggest ways in which the 'causes of the causes' (Marmot, 2015, p. 45) could be tackled.

The social gradient is additionally apparent when looking at disparities in life expectancy around the world. On a global level, the WHO (2016) reported a difference in average life expectancies between Japan (83.7 years) and Sierra Leone at (50.1) years, revealing a gap of 23.6 years between these countries. One could argue that the discrepancy in life expectancies between Japan and Sierra Leone is purely reflective of the disparities in Gross Domestic Product (GDP) levels between the two countries. Yet even within the UK where there is a high level of GDP and access to free health care, a social gradient exists. In 2011, the gap in life expectancy between people in the richest social class group and those in the poorest was seven years was larger than in the 1970s (DoH, 2011). Added to this, disparities exist in how much of one's life a person spends free of disability or ill health. These findings illustrate starkly the health inequalities that still exist in the UK as reinforced by the MHF (2015, p. 59) who alleged that 'health inequalities or inequities are systematic differences and are socially produced in health between social groups, that are avoidable and therefore unjust'.

2.5.3 The social gradient in relation to mental health problems

Although Layard and Clark (2014) maintain that the association between mental health problems and social class is less certain than is generally proposed, particularly as such problems can 'push one down the occupational ladder' (p.105), there is much evidence to support the claim that mental health problems are unequally distributed through society. For

instance, at an international level, a 2013 systematic review found that the socio-economically disadvantaged were twice or three times more likely to develop mental health problems. In Britain, people with mental health problems are also more likely to have poorer physical health; be homeless; live in impoverished areas, have fewer educational qualifications and have less secure employment. Added to this, the people who are more disadvantaged economically in society, will have poorer mental health outcomes once they become mentally unwell, than those in the middle and higher income brackets. Another major contributing factor to mental health problems is that of debt as unsecured debt is associated with depression. In 2008, it was reported in England and Wales that mental health problems rose as a person's level of debt did, even when allowing for socio-demographic variables. The Children's Society (2016) estimated that if children lived in a household which had a problem with debt, they were five times more likely to experience lower levels of well-being than children who did not live in such an environment. Educationally, there is also a disadvantage as there is a greater prevalence of mental health problems for people with lower educational attainment, particularly as many who develop such problems whilst teenagers will have been less able to complete their schooling. Therefore, the Marmot report (2010) included the recommendation that there should be an investment in helping disadvantaged groups to gain employability and educational skills, which may contribute to improvements in their SES and well-being. Subsequently, the next section will discuss the issue surrounding how the social gradient affects employment opportunities for the general population and how it specifically affects those with mental health problems.

2.5.4 Employment issues and the social gradient

One of the ways which may enable a person to improve their social position in society and level of well-being is through employment, which has been found generally to have a positive effect on health (Marmot, 2010; Sainsbury Centre for Mental Health, 2009). However, this is not a straightforward matter despite most people agreeing that good and appropriate work is

beneficial for a person. Not only does work provide an income but it also keeps a person occupied which helps their perceived levels of self-esteem, autonomy and health. Autonomy, for the purposes of this thesis will adopt the definition used by Marmot (2004, p. 2) as it includes why he sees it as being important: 'Autonomy – how much control you have over your life – and the opportunities you have for full social engagement and participation are crucial for health, well-being and longevity'.

Yet being employed in a stressful job can have the opposite effect, as evidenced by the statistic that 1 in 6.8 people are reported to experience mental health problems in the workplace (Lelliott *et al.*, 2008). Added to that, 300,000 adults with long term mental health problems, as reported by Stevenson and Farmer (2017), will lose their jobs each year. Moreover, for those who are at the bottom of the social hierarchy, as Marmot (2015) points out, although actually in a job, they can still be disadvantaged due to poor working conditions. These poor working conditions are a 'toxic cocktail' (ibid. p179) of which the ingredients are: shift work; high demand and low control; social isolation; imbalance between effort and rewards; organisational injustice and job insecurity. These factors, which compound poor health and feelings of disempowerment, serve as a reminder of why Marmot (1984) discovered that it was the men at the bottom of the work hierarchy that had four times higher mortality rates than those at the top. Equally, they serve as a reminder that although employment is generally considered to be better for one's health overall, it is a complicated matter as once in work, there are other issues that will need to be addressed for employment to enhance a person's life, rather than deplete it. For instance, being employed does not necessarily guarantee an adequate standard of living, as MacInnes (2013) found that over 50% of the 13 million people in UK living in poverty were from a working family.

Just as being in a job with poor working conditions is detrimental to one's health, so too is being unemployed. Clark *et al.* (2018, p. 61) state that unemployed people lose not just income but also 'something even more precious – a sense of contributing, of belonging and of being wanted'.

Marmot (2015, p. 189) cited a study spanning 1999-2005 of 30,000 people from former communist countries in Eastern Europe and found that the 'risk of dying in men and women who were unemployed… was more than double that in the employed people'. In 2008 it was found that unemployed people in Great Britain were between four and ten times more likely to develop anxiety and depression. Unemployment has been found to lead to a range of social problems which include debt, isolation and the development of further mental health problems, even for those who were initially unemployed due to other health difficulties. (MHFE, 2011). So, being in a job with adverse working conditions or being unemployed can both be detrimental to a person's health, in contrast to being in a job with reasonable working conditions, which is optimal for health. In light of this, the proposals made by Marmot (2010) to improve the employability and educational skills of unemployed people are much needed. Nevertheless, attempting to similarly enhance the life opportunities of unemployed people who already have mental health problems, invariably poses more challenges. This will be the topic of the next section.

2.5.5 Employment issues for people with mental health problems

The rate of unemployment is great among people with mental health problems as over one third of those who experience mild to moderate problems and two thirds of those with severe problems are unemployed (OECD, 2014). Added to that, 300,000 adults with long term mental health problems, as reported by Stevenson and Farmer (2017) will lose their jobs each year. These high numbers are reflected in the fact that almost half of the recipients of Employment Support Allowance (ESA) are receiving it primarily for mental health problems (Mind, 2014, p. 3). In terms of the welfare support available for those who are unemployed, there have been significant shifts in policy during recent years which have significantly impacted people with mental health problems in an adverse way. Black (2011, p. 7) carried out a review concerning long term absenteeism due to health problems and concluded that the 'longer someone is off sick or out of work, the harder it is to get back to work and worklessness comes at great

personal and financial cost'. To this end the ESA replaced Incapacity benefits in 2008, with the aim of encouraging people who were previously registered as being too unwell to work, to now be actively seeking employment rather than remaining on welfare benefits for prolonged periods. However, these changes in ESA eligibility and a reduction in the amount available for people with long term mental health problems, combined with a threat of benefit sanctions, served to put people with mental health problems who were already vulnerable, under further, chronic stress. Additionally, the 'Disability Living Allowance', which enabled people with long term health conditions to have financial aid for daily living costs, was replaced by the Personal Independence Payment (PIP). This change made accessing financial aid more difficult, particularly as the Work Capability Assessment (WCA) was introduced. However this assessment has been found by Marks, Cowan and Maclean (2017) to be causing harm on multiple levels for people with mental health problems. They argued that it was discriminatory for people with mental health problems as the assessments were carried out by healthcare assessors who were not qualified to assess mental health conditions. This led in many circumstances, to a further decline in a candidate's mental health condition and in some cases leading to thoughts of suicide. This lack of recognition of these discriminatory and detrimental practices resonates with Lewis *et al.* (2016, p. 21) who argued, that such a change in emphasis regarding support for people with mental health problems, reflected a neoliberal agenda as:

> One of the key aims of broader economic policy is to decrease the so-called 'burden' of state welfare and to encourage (or coerce) people away from long-term use of public services, off disability and sickness benefits and back into paid employment.

The fact is that for people with mental health problems who are deemed capable of working, re-entering the workplace or entering it for the first time needs careful consideration as they may have little confidence, few qualifications and long gaps in their curriculum vitae. Yet the longer they are out of employment, the more isolated they may become, not just socially but also in terms of employability skills, which is most apparent in the context of information technology. As digital technologies are ever changing and

evolving, those who have not had the opportunity or incentive to keep abreast with these progressions will increasingly become socially isolated; this is evidenced already among older people as the predominant means of information given even by utility companies, is via the internet which many cannot access. Applying this to students with mental health problems one could argue that education may help to avoid another double jeopardy occurring in their lives. This is not only that they are too unwell to work but they are unable to keep pace with the digital technological developments in society which are rapidly changing. By not being in a work environment where people are propelled into having to adapt and update their digital skills regularly, or by not having the economic resources or capabilities to own the latest modern technology, they are at risk of becoming increasingly socially isolated. Farooq *et al.* (2015) spoke of how this lack of access for this group leads to them falling even further behind than other people in society and decreases their levels of social participation as their voices are not present in the many public forums because they tend to be digitally driven.

A lack of employability and technological skills, alongside the possibility of relapses in their mental health problems and surrounding fears associated with disclosure despite anti-discriminatory legislation, makes entering a competitive workplace environment a potentially stressful event for people with mental health problems. When is it best to disclose to a potential employer: during an interview or when beginning the job, or not at all? Furthermore, people with mental health problems will need to be given support to navigate all parts of the employment process including the financial elements, due to the possible shortfall of money as the transition from receiving welfare benefits to employment occurs. Presently the best evidence for supporting re-entry into employment is the Individual Placement and Support scheme in which high support is given in order to help people make these difficult transitions (Centre for Mental Health, 2017). Yet it must also be acknowledged that for some people with severe and enduring mental health problems, entering paid employment may be too great a strain for them and positively detrimental to their mental health. However, remaining unemployed and spending time in voluntary work or community classes is no

longer an option for many, because of the benefit changes. Due to this Marks, Maclean and Cowan (2017) further argued that the underlying premise, that if a person is capable of taking part in voluntary work, they are capable of paid employment, is fundamentally flawed. Rather, they maintain that ‘For some people with severe and enduring mental health conditions, voluntary work may be as "good as it gets"’ (ibid. p.1).

It would seem from the above that people with mental health difficulties are suffering from a triple jeopardy. Not only have they mental health problems to cope with, but this will often be accompanied by a low SES and a lack of opportunities or the capabilities to improve their employability skills. Consequently, it is a vicious circle as the possibility of people with mental health difficulties being able ever to improve their levels of health and well-being through being healthily occupied such as in a job, may remain severely limited. It is this vicious circle that will in turn limit their chances of improving their mental and physical health as well as their economic prospects. Additionally, it will prevent the possibility of them being able to improve their status in society, their levels of social participation and perceived locus of control through employment, all which Marmot (2004) saw as being key elements in improving a person’s level of health and well-being. Considering this triple jeopardy, the role that education can potentially play in improving such a person’s life, for those who are currently unemployed alongside those for whom employment is not a viable option, will be explored throughout the thesis.

Summary

This chapter sought to answer the first research question in relation to the wider societal context for adults with mental health problems. First, the chapter contained a brief overview of the nature, prevalence and impact of mental health problems in the UK as well as some of the current legislation and treatment approaches that are dominant within the healthcare system. Second, the chapter discussed how the unequal distribution of mental health problems are reflective of the general health inequalities that exist in the UK today. Further, it showed how these inequalities are reflected in employment

issues and the potential role that employment could play in trying to help rectify this inequality was explored, in relation to the general population and in relation to people with mental health problems. As it was acknowledged that for some people with mental health problems, employment may not yet be a feasible option, attention will now be paid in the next chapter to the positive role that education can potentially play for people with mental health problems.

Chapter 3 Well-being and learning

Introduction

In chapter two, the nature, prevalence, impact and treatment options for adults with mental health problems were outlined. Also, the wider societal context in which adults with mental health problems in the UK live was explored to answer research question one. Evidence was cited that showed mental health problems are not evenly distributed throughout society and that people of a lower socio-economic status (SES) can experience on average more years of ill health and die at a younger age (Marmot, 2015). Added to that, not only are such people more likely to be diagnosed with mental health problems, but they will find it more difficult to improve their levels of well-being and quality of life than those who have a higher standard of living. However, it was illustrated how employment, with reasonable working conditions, could play a positive role in improving a person's level of well-being. Nevertheless, as a significant number of people with mental health problems are not in paid employment, the issue will now be explored as to how education may be able to play a significant additional or alternative role in helping their well-being. Specifically, this chapter will look at what the wider benefits of formal learning may be for people with or without mental health difficulties and how this may positively influence their well-being. This chapter will also define two key terms that permeate this work: well-being and learning, as well as briefly outlining the evolution of Further Education (FE).

3.1 Defining Well-being

Increasingly the term *well-being* is being used in relation to positive mental health reflecting the understanding nowadays that there is 'No health without mental health' (Department of Health, 2011). However, as well-being is a shifting cultural construct and a 'much contested term' (Lewis *et al.*, 2016, p. 5), finding a universal definition is problematic. This is particularly so as it is an umbrella term spanning a variety of areas ranging from mental well-being to economic well-being. Yet it is appropriate to include it in this thesis given that it is increasingly being used in both the fields of health and education as

well as in the media generally. Part of the difficulty in reaching a consensus as to what constitutes well-being reflects two historical philosophical approaches which are attributed to being originally proposed by the Greek philosophers Aristippus (Hedonia) and Aristotle (Eudaimonia) (Encyclopedia Britannia, 2017). The former proposed that to experience a happy or fulfilled life, a person must do everything possible to maximize pleasure and minimize pain. In contrast, the eudaimonic approach proposed that a good life was not just being about a 'mental state, a positive feeling or a cognitive appraisal of satisfaction, but rather a way of living' (Ryan, Huta and Deci, 2008, p. 143). Specifically this approach did not focus on happiness per se but rather on the process of what contributed to living well, seeking to uncover which conditions facilitated it or diminished it (Deci and Ryan, 2008). These historically different approaches are reflected in the variety of definitions that consequently exist in the literature today and why consensus is not easily reached, as in addition to these philosophical debates, the term well-being has come to be used to promote certain political agendas since 1997 in the UK (Coleman, 2009).

The current emphasis on well-being reflects a change in approach about mental health that took place during the 1990s in the field of psychology as alluded to in the introduction. Prior to this, psychology focussed on what could go wrong with a person's mental health by focusing on mental illness or 'abnormal psychology' (as it was referred to 30 years ago). However, a change of emphasis emerged, of which Seligman was one of the main protagonists, when psychologists discovered a positive link between optimism and a strong immune system (Kamen-Siegel *et al.*, 1991). This work led to not only looking at the factors common to people who maintained good levels of mental health but also to working out ways in which one could improve one's mental health using strategies devised in this field. Essentially this involved moving from a deficit model of mental health to a positive one and led to much work on how to define this improved positive focus on mental health or 'happiness'. Although the happiness movement began in North America, it has since expanded to the UK and been embraced by the economist Prof Layard. Layard (2006, p. 233) argued that we 'should monitor

the development of happiness in our countries as closely as we monitor the development of income' and so develop ways in which governments can strive to increase this. Layard defined happiness as 'feeling good – enjoying life and wanting the feeling to be maintained' (ibid. p.12). However, despite Seligman calling his initial theory relating to this subject 'Authentic Happiness', he moved away from using the word happiness. One of the reasons was because he felt that happiness was too subjective a measure, lacking objective components. He came to view happiness as being a 'thing', whereas he felt that 'well-being' was a construct, 'which in turn has measurable elements, each a real thing, each contributing to well-being, but none defining well-being' (Seligman, 2011, pp. 14-15). Considering the interest by professionals from a variety of fields, psychology, medicine, education and economics to name but a few, different means have now been devised as to how well-being can be measured or monitored. Consequently, prior to defining well-being, as it will be used in this thesis, the different research approaches currently dominant will be outlined.

3.1.1 Research approaches

For the researchers or clinicians who believe that well-being can be measured, many quantitative questionnaires have been devised which usually involve 'cataloguing positive and negative emotions' (Layard, 2016, p. 5) as well as the absence of pain. One example of the type of questions used is, 'Overall, how satisfied are you with your life nowadays?' to which a person will answer using a scale of 0 (not all all) and 10 (completely) (What Works Well, 2017, p. 5). Other popular measures in current use particularly in clinical settings, include the 20 item PANAS scale; the 54 Satisfaction with Life Scale and the Warwick-Edinburgh Mental Well-being Scale (Tennant *et al.*, 2007, p. 1), the latter of which is particularly focussed on positive questions. Alongside this, there are dedicated centres which carry out research in order to inform government policy, such as at the Well-Being Institute at Cambridge University (see for example, Huppert, 2009). Besides quantitative measurements, methods such as semi structured interviews, self-report and ethnography are used by researchers to collect

qualitative data (e.g. Candy *et al.*, 2015; White, 2015). A similar approach was adopted for this study in the form of narrative interviews, to avoid limiting the responses of the participants and so move well beyond 'measuring' well-being. Rather, recognising that well-being itself is a disputed construct and not reflective of everyday conversational speech, in encouraging participants to speak of the personal experiences that they deemed to be significant to them, I did not use the word well-being. This deliberate omission was to avoid manipulating their responses into a predetermined framework based only on a 'common sense' understanding which was not the only sense that I wished to explore.

3.1.2 Reconciling well-being definitions

Reaching agreement on how best to define well-being fluctuates greatly among varied domains despite certain overlaps. One overlap appears to be that most definitions begin with the presupposition that certain social and material needs are already being met in a person's life prior to considering their sense of well-being. As White (2011, p. 27) said: 'If personal fulfilment is to have any place in our life at all, we all have social and material needs that must be satisfied for it to be possible'. So, no matter how divergent well-being definitions may be, there is this implicit precondition for well-being, regarding social and material needs already being met. Yet one could argue that unless fundamental needs such as adequate housing and money are food are being met, the well-being of such a person will always be compromised. This idea is reminiscent of the hierarchy of needs theory of Maslow (1954, 1970) as he surmised that for students to reach their full potential in their learning, most of their social and material needs must firstly be met. The order of these needs from the bottom upwards, were their physiological needs (hunger and thirst etc.); safety needs (security and protection etc.); social needs such as belongingness, love; esteem needs (self-esteem and reputation etc.); cognitive needs (knowledge and insight etc.); aesthetic needs (beauty and harmony etc.) and finally at the top of the hierarchy, self-actualisation (reaching one's full potential). The underlying premise of this theory does resonate with the above premise of White (2011). However,

Maslow's theory has been criticised for lacking scientific rigour, being culturally biased and as epitomising the idealism of the American middle class dream in the 1950s (Hoffman, 1994). Also, Illeris (2007, p. 90) points out that in reality this hierarchy contains a 'doubtful order'. Nonetheless, Diener and Tay (2011) did find evidence when carrying out work among a diverse range of countries and cultures in the world, that gave credence to Maslow's theory. Although the authors did find that people tried to have their basic and safety needs met before other ones, the order in which they were fulfilled did not strongly affect their well-being. Rather, Diener and Tay (2011) concluded that people living in impoverished nations with only a little control over whether their basic needs were met, could still achieve 'a measure of well-being though social relationships and other psychological needs over which they have more control' (p.364).

Returning to the issue concerning how best to define well-being, even the main mental health charities, which influence much of public and academic debate regarding research in this area, choose to adopt different definitions. For instance, Mind (2017) adopt the approach of the World Health Organisation saying that 'Mental health is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community' (WHO, 2014). However, the Mental Health Foundation (MHF, 2015) adopt the definition by the New Economics Foundation (2012) which appears to focus more on the subjective evaluation a person makes regarding their level of well-being as it proposes that 'Well-being can be understood as how people feel and how they function, both on a personal and a social level, and how they evaluate their lives as a whole'. Both definitions appear to be reflecting the eudaimonic approach as they are concentrating on the process and the components that may contribute to well-being. In the field of psychology, Diener and Chan (2011, p. 1), defined well-being as referring to 'people's evaluations of their lives, which can be judgments such as life satisfaction, evaluations based on feelings, including moods and emotions'. In the field of education there are a number of differing opinions as to how best to define well-being, of which a

comprehensive outline has been made by Spratt (2017). The choice for this study was to adopt that of Seligman (2011), which originated from his earlier theory of Authentic Happiness (Seligman, 2002) and various studies investigating the possible components involved in well-being (e.g. Schueller and Seligman, 2010). Seligman (2011) incorporated five elements into his theory of well-being that he suggested contributed to well-being: positive emotion; engagement; meaning; and positive relationships and accomplishment or achievement (PERMA), reflecting both the hedonic and eudaimonic approaches. It is an appropriate choice for this study, given its emphasis on the process of living well and the plural elements that lead to this; this plurality resonates with the multiplicity of factors that may impact the well-being of the participants in this study, some of which may or may not be related to their mental health problems. Another reason for adopting Seligman's view of well-being was because it contained both objective and subjective aspects, enabling a person to reflect not just on how they feel today (subjective) but also to reflect on the objective factors, such as engagement and accomplishment, that may be influencing their well-being. In fact such a mixed approach is favoured by many others (e.g. De Ruyter, 2015; Lewis *et al.*, 2016) and a mixed approach reflects a belief that 'mental health is not simply the opposite of mental illness. It is possible for someone to have a mental disorder and high levels of well-being. It is also possible for someone to have low levels of well-being without having a mental disorder' (DoH, 2014, p. 1). This would appear to support the maxim that although well-being and mental health problems may interrelate, they are not opposite ends of the same axis as a person may have significant symptoms such as hearing voices but view themselves as having a good level of well-being.

The five tenets of Seligman's' approach to well-being were:

1. **Positive emotions:** These refer to those aspects a person feels are pleasurable about their lives in the present moment such as rapture, comfort and ecstasy as well as love, joy, pride, hope and enjoyment (Shaver *et al.*, 2001). Yet Seligman pointed out that positive emotions are a subjective state and so dependent on how one feels at the time of asking. Consequently, they are not the goal of the whole theory, but

merely one of the factors contributing to well-being. Yet to rely on these answers solely would be inadequate given that a person's mood can fluctuate throughout one day. For example, for introverts, who are 'less cheery than extraverts'(Seligman, 2011, p. 14), their answers may not reflect their true sense of well-being, although they may have more engagement and meaning in their lives than the more cheerful respondents.

2. **Engagement:** This refers to when a person is involved in activities that give them a sense of 'flow'. The concept of flow was developed by Csikszentmihalyi (1997) who proposed that it referred to activities in which a person is fully engaged and loses their sense of time due to their absorption in a task. For such flow to take place, this task needs to contain a set of explicit goals (such as when playing chess or a musical instrument) but to be neither too easy nor too complex. The prediction is that this will be a retrospective enjoyment and that the more experiences of engagement or flow that a person has, the better their well-being will be (Schueller and Seligman, 2010).

3. **Positive Relationships**: Seligman saw such relationships as being a crucial element to a person's well-being as he argued that our most enjoyable, life enhancing experiences tend to involve other people. Additionally, Seligman identified that this promotes well-being as it is only in relation to others that we can give, or be kind, as 'doing a kindness produces the single most reliable momentary increase in well-being of any exercise' (Seligman, 2011, p. 20).

4. **Meaning**: This refers to a person believing that they belong to and serve something bigger than themselves such as religion or an ideology and although it is partly subjective, it is not solely so. Rather, it can be measured and defined independent of all the other components involved in well-being such as positive emotion, as it involves an objective assessment of how a person perceives that they have met their goals and their significance to them. Seligman (2002, p.

254) suggested that ‘meaning allows one to transcend oneself’ which leads to the person believing their life is purposeful, noteworthy and comprehensible (Steger, 2009).

5. **Accomplishment (or achievement)**: this refers to feelings that one has achieved or accomplished something, which may lead to a recognised qualification or can be pursued for its own sake. This may refer to ‘accomplishment in its momentary form and the ‘achieving life’, a life dedicated to accomplishment for the sake of accomplishment, in its extended form’ (Seligman, 2011, p. 19). This will include activities that people choose to spend their time doing for its own sake, which often includes the component of perseverance but happens in the absence of coercion (Kern *et al.*, 2015). This differs from ‘meaning’ given that it may involve engaging in an activity, such as playing bridge, which does not serve a higher purpose outside of personal enjoyment and challenge.

Seligman maintained that well-being is a combination of all these five elements: feeling positive emotionally, as well as experiencing a sense of engagement, meaning, good relationships and accomplishment.

Having outlined which definition of well-being was adopted for the purposes of this study, it is important to identify how this might fit in with the third research question regarding transformative learning theory by Mezirow (1991). In his theory, Mezirow did not focus on well-being per se, most probably because his theory was originally formulated prior to the growth in positive psychology. However, he did say that when transformative learning happens, it will for that person affect among other things, their sense of ‘contentment and emotional well-being, and their performance’ (ibid. p.xiii). So the implication throughout his work is that if an adult learner does undergo a transformative journey, it will have impacted their well-being positively. This study set out to discover whether the participants did appear to have undergone the stages of transformative learning as outlined by Mezirow, and how this had influenced their overall sense of well-being. Attention will now

be paid in relation to how learning will be defined for the purposes of this thesis.

3.2 Defining learning

Just as reaching a consensus on how one defines well-being is a challenge, so too is defining *learning*, particularly as it is often interchanged with *education*. The word education can mean many things according to the context in which it is used and so for the purposes of this thesis it will be understood as ‘knowledge acquired through study, experienced or being taught’ (Oxford Dictionary, 2017).

As this thesis concentrates mainly on learning in the context of an educational institution, the term learning will now be explored more fully as it too is a much-contested term. For instance, in psychology, the behaviourist approach focuses on learning happening when certain behaviours are rewarded and strengthened by repeated success, resulting in observable changes in behaviour (e.g.Pavlov, 1927; Skinner, 1974). In contrast, the cognitive school focuses on the mental processes that happen during learning, proposing that learning happens when one understands what one is learning and by making sense and constructing one’s own meaning usually out of prior learning, experience and instructional materials (e.g. Piaget, 1952 (1936)). Finally, the humanistic school focuses on learning happening when the emotional needs of learners are met and they are able to pursue their own interests and talents in order to develop them in a unique way (e.g. Maslow, 1954, 1970; Rogers, 1967). Nonetheless, whichever approach one favours, it must be emphasized that learning encompasses much more than what is learnt in a classroom setting. Rather, as Schuller and Desjardins (2007, p. 2) suggested, it is both ‘lifewide’ (i.e. it occurs in multiple contexts such as at work, at home and in our social lives) and ‘lifelong’ (from cradle to grave)’. Alongside this, it should be acknowledged that although we speak of someone having learnt, one cannot be certain that a person has learnt; rather the only certainty is that they have been in a learning environment. However, in the context of this thesis the focus will be on the learning that students

perceive to have taken place whilst attending classes in a FE college. Consequently the terms formal or classroom learning will be used throughout, referring to learning which takes place in an educational institution. This is distinguishable from non-formal learning, which refers to learning as a result of attending community based courses that may or may not lead to qualifications. Finally, formal and non-formal learning differ from informal learning as it refers to any learning that happens 'through the media, online, reading or participating in a club or society' (Learning and Work Institute, 2017, p. 6).

A further complication when defining the term learning is the current usage of the term lifelong learning. Aspin *et al.* (2012, p. lii) defined this as being made up of three sometimes conflicting elements: 'education for a more highly skilled workforce; personal developmental leading to a more rewarding life; and the creation of a stronger and more inclusive society'. Yet this too is a controversial term as Duckworth (2014) argued, that educating for life is not truly about seeking the best for the student, but can be reflective of a neo liberal stance which is part of a political agenda where jobs for life have been replaced by lifelong learning. This change in emphasis reflects government policy concerns over 'competitiveness, innovation and growth' (Field, 2012, p. 894) and pushes people to constantly upskill, in order to compete with the ever changing knowledge economy in a globalised setting. It is this focus based on a neo-liberal ideology that Duckworth (2014) argued is detrimental to students from deprived areas, as it implies that success is a result of choosing to improve oneself, rather than an acknowledgement that success often reflects privilege rather than talent. In this context students are expected to 'succeed against the odds and if they do not, the fault is their own rather than being down to the structural inequalities many encounter at each step of the learning journey (and indeed life)' (ibid. p.17).

Given the array of definitions of learning and the inability to find a universal definition that would suit every academic, for the purposes of this work the definition by Mezirow (1991, p. 12) will be used. This definition is that:

> Learning may be understood as the process of using a prior interpretation to construe a new or a revised interpretation of the meaning of one's experience in order to guide future action.

Although this is cognitively oriented, it does form the basis of Mezirow's theory of transformative learning (chapter four) and applies specifically to adult learning.

3.3 The educational context for adult learning

Prior to addressing some of the evidence regarding the wider benefits of adult learning, a brief outline will be given to explain the context of adult learning provision in England. Further Education (FE) is an umbrella term covering a variety of post 14 educational provisions and this term will be used throughout the thesis as referring to any adult learning that occurs within a structured setting. This is because the particular college in which this research took place, provided both formal and non-formal learning courses and classed itself as a Further Education provider at the time of writing, hence the adoption of this term.

According to Hodgson (2015, p. 3) in England 2015, there were 235 FE providers alongside over 1000 other providers in venues such as prisons, armed forces training and community learning providers, among others. This range of providers may partly account for the difficulty in assembling statistical information in relation to FE as well as the difficulty in generalising about it, except to say that it is concerned with vocational and academic education and training for students of 14 years and upwards.

3.3.1 A brief history of Further Education in England

It was in the 1900s that FE colleges were first recognised as being part of the education service and commonly referred to as 'The Tech.' where technical and commercial training for local industries was mainly taught. Students usually attended in the evening voluntarily to gain accreditation but from 1945, employers began to release workers to train during the day. Alongside

this, the need arose among people who felt they had received inadequate education whilst at school (mainly working class people) to study on academic courses which were equivalent to today's GCSE's and Advanced level exams, a provision which expanded into offering degree courses, accredited by universities (Hodgson, 2015). Additionally, from the 1970s onwards, FE colleges began to provide help for the growing number of NEETs (young people who are not in education, employment or training), in a bid to improve their employability potential. Alongside these courses, adult education classes, referred to as Adult and Community Learning (ACL) or commonly known as 'evening classes', were offered for example in history of art or computing.

The changing political landscape of Further Education

Further Education has been at the mercy of multiple interventions from government (e.g. Foster, 2005; Kennedy, 1997; Leitch, 2006; Lingfield, 2012; Wolf, 2011). Additionally, FE has suffered from a low profile politically relative to schools, arguably because the courses they offer are not those that politicians themselves would consider for their own children (Hodgson, 2015). Underpinning these multiple interventions has been a neoliberalist agenda in England which has influenced the direction that the UK government in relation to education generally, including FE (Duckworth, 2014; Duckworth and Smith, 2018a; Lewis *et al.*, 2016; Smith, 2015). Consequently, in the 1990s the UK government came to impose 'strict rules of surveillance, financial accountability and productivity onto institutions such as universities, that were ill suited to them' (Harvey, 2007, p. 61). Major shifts in educational policymaking came into force due to this, which affected all educational institutions, including FE colleges as they were have been pushed towards a culture of marketization, competition and globalisation, for example, as evidenced in the PISA tables (OECD, 2018).

Another major change that occurred in FE education specifically was when incorporation took place. This happened with the passing of the Further and Higher Education Act (1992) as colleges were removed from local authority

control and regarded as autonomous organisations who were positioned as ‘free standing, legal entities, with responsibility for their employees work contracts’ (Smith, 2015, p. 19). Incorporation was essentially based on a neoliberal business model, hence a new model of leadership emerged as the principals became company directors, with the emphasis being on accountability. This was accompanied by a new focus on standards and assessment, with the FE teacher becoming the agent who would deliver the skills required by the local industry. Such a change in emphasis meant that colleges not only had to increase their productivity in terms of students and courses, in competition with other colleges, but also that they had to manage their own corporations (Smith, 2005). Hodgson (2015, p. 170) concluded that incorporation gave colleges, ‘the freedom to fail but not the freedom to succeed’.

The ramifications of incorporation were multiple, not least in causing a substantial decrease in the FE workforce and undermining the legitimacy of the teaching unions; this affected teachers, students and the type of courses on offer. In terms of the teachers, it led to a diminution in their autonomy and agency which diluted their professionalism. Additionally it put them under pressure in terms of adhering to a prescribed annual funding cycle, ‘with its reductive and continually changing incentive and disincentives’ leading to a tendency to ‘objectify students’ (Duckworth and Smith, 2018b). In terms of the students, this objectification introduced a transactional element between teachers and students as now students became viewed as consumers, with teachers being under pressure to improve their success rates in terms of their recruitment and retention data. Duckworth and Smith (2018a, p. 2) argued that a narrowing of the curriculum occurred as the courses privileged were focussed on producing a flexible, adaptable and ‘skilled’ workforce, in order to make countries competitive in a globalised economy. This course of action led to instrumentalising students as it operationalised education and was reinforced by the government offering colleges ‘perverse incentives…which encouraged the bundling of qualifications for ‘profit maximisation’ (Wolf, 2011, p. 120). Duckworth and Smith (2018b) summarised these major changes in FE as imposing the ‘triple lock’ of

objectification on FE colleges due to: 1)'the international discourse around skills and globalisation'; 2) the academic/vocational divide in relation to academic versus vocational courses and 3) the pressure for teachers to 'recruit and retain each student as a source of funding for the college'.

Needless to say, the privileging of such vocational courses impacted adult and community learning courses. A study by BIS (2013, p. 7) found that 60% of learners were studying on ACL courses for 'non-economic' reasons' including wanting to learn something new or due to having a personal interest in a course. However due to the focus on qualifications for employment in the last 20 years, funding for ACL has greatly diminished and so enrolment figures fell from 3,480,000 to 1,500,00 in ten years (Hodgson, 2015, p. 58) and adult enrolments in FE declined even further when these students were required to take out loans in order to fund their studies.

Arguably, the increasing rise in neoliberalism is reflected in which courses the government prioritised, which one would surmise explains why ACL has not been seen as being important enough to invest in. This may also help to explain why there is a gap in policy (see 3.3.2) in relation to learners for instance, with mental health problems, as the potential for some of them to be economically productive is much less than for other students. How far this attitude appears to deviate from the holistic purposes of education as suggested by Reiss and White (2013), who proposed that the primary purpose of education is to enable a person to flourish (see 3.5).

3.3.2 Diversity within Further Education

In England alone there are currently 2.7 million students in FE contexts compared with 2.28 million students in 2015-2016 studying in higher education institutions in the UK (Universities UK, 2015-2016). One of the striking differences between what FE colleges can offer and what schools and universities offer is the diversity of provision in terms of courses and the student body. In terms of courses, this diversity spans a multiplicity of levels ranging from the most basic courses such as entry level 1 and 2 in English

and numeracy skills, to undergraduate and postgraduate courses. Additionally, these span vocational courses; language courses for non-English speakers; apprenticeships; and basic living skills for people with learning difficulties and community courses.

In terms of the student body, much diversity is reflected in FE colleges as they have a more ethnically mixed cohort with a much greater age span (from 14 years to elderly) than universities have. Also, FE includes a higher proportion of students who live locally; for undergraduates studying in an FE college, they will live within a radius of 17 miles from home in contrast to a radius of 52 miles on average for university students (2016/2017). This includes a greater number of students who are economically disadvantaged compared to any other educational provision (Hodgson, 2015, p. 27; 50) and may account for why two thirds of FE students work for ten hours or more per week which is proportionally greater than for their school counterparts (ibid. p.52). Alongside this, there are a high proportion of FE students who have disclosed experiencing mental health problems (NUS, 2015), yet this prevalence is not reflected in current FE policies; this will be the topic of the next section.

Mental health problems and Further Education

Both the Tomlinson report (1996) and the Kennedy (1997) report found that there were relatively few students with mental health problems engaging successfully in FE. However, although the reports proposed ways in which colleges could widen participation among this under represented group and support them in doing so, the Association of Colleges (2017a) found in 2017 that this was still not happening. For instance, they found that only 40% of colleges had full time mental health advisers or counsellors. This lack of provision was verified also by an NUS (2017, p. 4) report which refers to there being a 'huge gulf in both dialogue and policy' in relation to FE.

This gap was evident too in the 'Five Year Forward View for Mental Health'(NHS England, 2016). In this report, a myriad of recommendations were proposed regarding education and mental health issues, one of which was to ensure that all education staff received mental health first aid training.

Nonetheless, this recommendation did not include FE staff. It would seem that the policies that do exist in relation to mental health and education are either centred mainly on children and young people. Two prominent policies were Future in Mind (NHS England, 2015a) and Local Transformation Plans for Children and Young People's Mental Health and Wellbeing (NHS England, 2015b), yet neither of these reports mention FE, although the latter does mention colleges. Admittedly, such policies may have an impact on younger FE students, but they will not impact the more mature FE students with mental health problems.

The only recent reports that do include FE are the green paper (GOV.UK, 2017) and a report by the Learning and Work Institute (2017). The former recommends that schools and colleges have mental health support teams working in them and a mental health lead among the staff. The latter, that governments should 'embrace the demonstrable value of adult learning' as it contributes to 'maintaining health, wellbeing and independence' in relation to their educational aims (Learning and Work Institute, 2017, pp. 28,30). However, as yet these plans have not led to policy changes affecting FE. Rather, the most recent research carried out in relation to FE appears to be that of the Association of Colleges (see section 2.2 and 3.5.2) and the NUS (2017). The NUS report made 17 recommendations for colleges and policy makers. Among these recommendations were proposals that: every college have a mental health policy; all staff to have mental health awareness training; a stronger partnership with NHS mental health services is forged and that there is greater support financially for such students.

Given the paucity of policy relating to FE and mental health issues, the hope is that the findings and recommendations emerging from this study, will help build upon the work by the Association of Colleges and the NUS, as they campaign towards educational mental health policies including adult students in FE specifically.

The moral purpose and potential of Further Education

Not only is more legalisation needed in relation to FE and mental health, but more financial resources too as the reality is that the funding for adult education is very low. Keep (2014) predicted that between 2010 and 2018, it will have experienced an estimated 43% reduction in funding. Additionally, London Economics (2015) found that funding for an adult non apprentice learner was 15% below that for an undergraduate at university. Yet, this is despite the fact that FE has gained a worthy 'reputation for open access, social inclusion and 'second chance' provision'(Gleeson et al., 2015, p. 81), which in turn contributes to the great moral purpose of FE, it helps to counteract social injustice and disadvantage. The importance of this cannot be underestimated as recognised by Sharp (2011, p. 3) who noted that, 'Reaching out to hard-to-reach groups…not only leads to a steady supply of learners for higher levels qualification-based study, but supports colleges' wider role in promoting well-being and cohesion of their communities'. There is much evidence that FE does play an essential role in the lives of many people who have struggled with formal learning the past, as evidenced by Duckworth and Smith (2017a). They gathered evidence that FE can have a significant transformative impact not only on an individual, but also on their immediate and extended families as well as their communities.
This issue regarding the transformative potential of FE will be further explored below as the evidence for the wider benefits of learning is presented. Prior to that however, it is important to acknowledge that not all people experience formal learning in a positive way.

3.4 The negative aspects of learning

Considering the emphasis most societies put on formal learning, it is generally assumed that such learning is beneficial, but the reality is that this is not the case for everyone, particularly those who are outliers, non-conformists or socially disadvantaged. Consequently, it would be remiss in this thesis to advocate the benefits of education without acknowledging the dis-benefits for some people, as much work has been carried out on the negative effects of learning which may occur in formal settings (e.g. Ball,

Bowe and Gewirtz, 1996; Bourdieu, 1998; Bowles and Gintis, 1976; Reay, 2006). In fact, Francis and Mills (2012, p. 251) argued that schools can cause a variety of damage such as:

> the reproduction of social inequality via schooling and the psychological injury and practices of harassment and exclusion this involves for pupils; institutional structures of discipline and surveillance; brutalisation of young people.

This idea of school reproducing social inequality was previously postulated by Bourdieu; this will now be outlined briefly in relation to his general arguments regarding social class and inequalities.

Bourdieu's positioning

Bourdieu purported that schools played an unfortunate but significant role in replicating the class structure within society, not only because of the differences that existed between pupils in terms of their family's economic capital, but also in terms of other forms of capital, namely cultural capital. Bourdieu's concept of capital was connected with his theoretical ideas in relation to class, as he argued that economic, cultural and social capital all had a relationship to class. Proposing that cultural capital was made up of a variety of forms e.g. educational qualifications or an appreciation of art, literature and classical music, he argued that although this capital was not necessarily dependent on wealth, it enabled the higher classes to differentiate themselves from people of lower classes (Bourdieu, 1984). Such differences allowed those who were high in cultural capital, combined with their social capital (consisting of social networks) and symbolic capital (see below), to maintain their dominant position in society. Symbolic capital referred to having a reputation of being a competent, honourable and respectable person which was 'easily converted into political positions', and through which the dominant classes could reproduce their power in society (Bourdieu, 1984, p. 291). Bourdieu maintained that as economic, cultural and social capital become socially effective, their ownership was legitimized through the mediation of symbolic capital.

Bourdieu further argued that just as differences in economic capital within a society could create social division, so could the other forms of capital. He believed that these interdependent capitals contributed to creating the habitus from which a person grew up i.e. their subjective perceptions of how they viewed the world and how they developed their tastes and preferences in life. As Reay (2004, p. 434) stated, 'a person's individual history is constitutive of habitus, but also is the whole collective history of family and class to which they belong'. Although there have been criticisms of the concept of habitus as being too deterministic (e.g. Jenkins, 1992), Bourdieu argued that it was because of a person's habitus, that those who lacked the cultural capital of the higher classes, were more likely to suffer from symbolic violence in the field of education; this in turn reproduced the class structure in society. Bourdieu referred to the field, as being the place where individuals, institutions or other agents compete for power such as in the family, the workplace or an educational establishment. Consequently, it is within such fields that those who are least advantaged in terms of cultural capital can be most adversely affected as the symbolic power of the advantaged, can serve to violate them. For instance, in the field of education, the symbolic power of middle class parents is evidenced in their 'monopolising scarce educational resources' within the state education system in order to privilege their own children (Reay, 2017, p. 165), at the expense of the poorer children.

Bourdieu proposed that symbolic violence takes place in schools in relation to working class children. Symbolic violence is a non-physical, unrecognised violence in which the dominant class affirms that their culture and lifestyle is superior and something which all should aspire to. As such, the school reinforces middle class discourses which the teacher then legitimises, and which results in the school reproducing the class differences of society. This happens as the working class families are made to feel deficient as they do not 'speak the same language' (ibid. p.70) as the teachers and do not understand the rules of the game. In contrast, the cultural capital of the middle class families enables the children to take to a school environment as a 'fish to water' (Bourdieu and Wacquant, 1992, p. 127).

In the context of adult learning, the testimonies of the adults who enrol on FE courses suggest they may have unwittingly experienced symbolic violence themselves as they often recount tales of their schooling in which they were labelled inferior and lacking in ability (Duckworth and Smith, 2017b). Added to that, many of these adults will assign personal blame to their previous academic failure which supports Bourdieu's hypothesis, that the symbolic violence is such a part of the fabric of the education system, it has gone unrecognised by both the oppressed and the oppressors. Yet in some cases there are also tales of resistance, in which they have deliberately played truant, or compliance in which they have deliberately remained silent and refused to participate in class, whilst giving the appearance of complying, when they were not (ibid.). At a political level, it may be symbolic violence that explains why politicians have always privileged schooling and universities in terms of policies and funding, at the expense of FE. Presumably this is because FE colleges are not the places that the dominant classes, which includes politicians, would send their own children to (Hodgson, 2015).

Nonetheless, despite the harm that education can cause in peoples' lives, there is much evidence that returning to learning as an adult can yield innumerable benefits which now will be outlined.

3.5 The benefits of learning

Before discussing the issues surrounding the benefits that learning can bring, it is worth defining what the word 'benefit' means. Originating from the Latin 'bene facere', the word was taken to mean 'to do good'. However now it is used in common speech in many ways. It can either be used as a noun (a gain or advantage) or a verb (to bring advantage to something). For the purposes of this work the definition will be as that of a noun: 'an advantage or profit gained from something' (Oxford Dictionary, 2017).

In industrial societies such as the UK, education and learning have been promoted as being particularly beneficial in terms of accessing employment opportunities. To this end, much work has been carried out in this area (see

Field, 2012), yet Wolf (2002, p. 254) argued that the links 'between education and the economy are more tenuous and complex than most people suppose, and that our beliefs about "education for *(economic)* growth" have produced a series of misguided policies'. In contrast, this thesis would argue that a holistic view of learning and education should be taken, such as that by Reiss and White (2013, p. 4) who proposed that the aim of school education should be to equip every child 'to lead a life that is personally flourishing and to help others to do so'. By extension, I would argue that these aims can be applied to learning with adults and that learning can be beneficial in many ways beyond solely economic and vocational ones.

3.5.1 Evidence that formal learning can enhance the well-being of adults

To identify the ways in which learning can be beneficial for a person's well-being, beyond economic and vocational benefits, 'The Centre for Research on the Wider Benefits of Learning' ran multiple projects exploring this topic. With regard to what the wider benefits of learning actually referred to, Feinstein *et al.* (2008, p. 9) said it referred to 'the quality of life of individuals, their families and communities'. Schuller *et al.* (2004) defined these benefits as being first at a personal level, referring to non-economic benefits which were not necessarily associated with a rise in productivity or extra earnings. Second, he defined these as referring to benefits that could be identified as above the level of the individual (extending to the family, community and society). However, he did so whilst acknowledging that the term benefit is itself 'inherently value-laden' (p7), given that it is a contestable, often subjective measure. Schuller also noted that the definition of learning which he worked with in this context was first, that which occurred among those who had left compulsory settings, whilst he acknowledged that one's schooling invariably will have impacted one's subsequent learning. Second, he noted that the benefits referred to below, concerned learning generally as it covered both taught and non-taught learning; the former referred to any learning that was a result of being taught in a class or training course and the latter to learning in a non-formal way such as teaching oneself or being supervised in a job. Within

these parameters, Schuller (2004) concluded that taking part in learning activities did have value even when a person was elderly and purported that 'huge costs are incurred when learning is absent' (p192) in terms of how it affects health, family and communities. Yet, he additionally recognised that even when benefits were perceived in positive terms by students, dis-benefits could co-exist; learning could 'dispel certainties and accentuate feelings of insecurity' (p8) as well as cause isolation in some cases from former family or friends. Additionally, as alluded to above, he recognised that taking part in classroom learning could inadvertently reinforce inequalities of power and social stratification and as such inequalities may not necessarily be redressed through an increased opportunity to learn.

Despite these dis-benefits Schuller *et al.* (2004) concluded that not only could learning have a transformative effect but it could also have a sustaining influence, even though the latter may be less visible and involve a time lag between learning and implementation. First, he maintained that learning could have a sustaining effect in terms of the prevention of negative consequences. Second, that learning could help to build up a person's resilience in order to develop good coping strategies when problems invariably arise during his or her life. In this way Hammond (ibid. p79) further argued that adult learning could have a sustaining therapeutic effect: not because it 'tackles ill-health directly, but because it helps individuals to deal with its consequences' in building up their physical and psychological health. Considering these factors, Schuller contended that the sustaining effects of learning should have political importance in terms of reinforcing the value of investing in adult learning.

In order to bring together current evidence on this topic, the work by Feinstein (2008), Field (2012) and the Department for Business, Innovation and Skills (BIS (2012)) will be mainly considered as they each provide summaries of the work carried out. In all cases qualitative and quantitative research was reviewed. One caveat to acknowledge is that such research will have involved those learners who have remained on courses and not necessarily those who left the courses prematurely.

In the case of the BIS (2012) review and update of research relating to how beneficial learning can be for a person's well-being, their findings were based on those of the British Household Panel Survey which is a national survey conducted each year involving 10,000 adults. Questions included those relating to formal learning (that led to a qualification) and informal learning (that did not lead to a qualification such as a craft class). BIS (2012) criticised the results from several qualitative studies reviewed, accusing these of having overstated the extent to which learning can enhance well-being. However, it could be argued that such criticisms may in part be reflective of this being a government funded organisation whose interests would not be well served by finding that the benefits of learning do extend well beyond economic and vocational ones. Since 2010 there has been more emphasis on employment and skills and an 'increased focus on encouraging employability through adult learning' with a linking to welfare benefits (Lewis *et al.*, 2016, p. 25). Lewis (2014) argued that this has been at the expense of significantly fewer opportunities being afforded to adults to engage in learning which has non-economic benefits such as in Adult and Community learning (ACL)**.** Additionally, BIS argued that asking learners about outcomes in qualitative research, did not say anything meaningful about the causal effects of adult learning, as well as the fact that these studies often involved small sample sizes. Furthermore, they felt these to be biased as they relied on recalling past events and recommended that natural field experiments involving randomised interventions be carried out. A number of these criticisms were similarly outlined by Field (2012) as he noted the prevalence of small sample sizes and the reliance on self-reports of past events and experiences and recommended there should be more longitudinal studies carried out adding to existing ones. Yet despite these criticisms, BIS and Field noted that there was enough concordance between the qualitative and quantitative results in supporting evidence that learning can positively influence a person's well-being.

At a societal level, Feinstein *et al.* (2008) found that attending adult education classes increased civic participation (such as increasing voting). BIS reported a greater involvement in voluntary work (following formal learning

only) and an increase in trade union membership, although they argued that overall the impact on civic participation levels was less pronounced than the personal benefits that were identified. Feinstein reported that as learning in class was found to give access to a wider diversity of people, which promoted social cohesion and reduced racism, he concluded that adult learning could yield benefits for communities, society and individuals. Although some may dispute these aspects as being of less tangible than academic or economic benefit, their inclusion echoes the importance that Putnam (2000) put on social participation. He argued that social participation contributed to social capital which he defined as the 'connections among individuals – social networks and norms of reciprocity and trustworthiness that arise from them' (p19). Having traced a decline in social participation in USA, he proposed that this even affected the health of the nation's people adversely. In contrast there is evidence that being involved in community groups can aid one's mental and physical health (Creech A. *et al.*, 2013; Pearce *et al.*, 2016)**.**

At an interpersonal level, learning was found to increase social interaction which cannot be underestimated in terms of promoting an increase in personal well-being. The BIS reported that this could even affect family life; they found there to be rise in the probability that once a mother had been involved in further education, the chances of their children choosing to confide in them about serious matters, would be greater. Jenkins and Mostafa (2013) reported evidence that among the over 50s, there was strong evidence that informal learning increased levels of well-being; some evidence that obtaining qualifications led to a higher level of personal well-being but no evidence that formal education or a training course did. Feinstein *et al.* (2008) reported an increase in people's abilities to make informed decisions about behaviours that would influence their happiness and health, due to both formal and informal learning opportunities.

At the personal level, BIS found there was a reduction in the number of GP visits and increased satisfaction with one's physical health after engaging in adult learning activities. They concluded that the greatest benefits were in the

domain of physical health, mental health and job-related outcomes. Feinstein reported that such wider benefits were more pronounced for educationally disadvantaged adults as they reported even higher levels of healthy living (such as giving up smoking and exercising more). In terms of well-being, the BIS reported increased levels in a person's life satisfaction and happiness; increased self-confidence and higher feelings of self-worth alongside a reduction in self-reported depression; a greater desire to find a better job and improved financial expectations (especially after informal learning). Shifts in attitudes were also found. Given that shifts in the attitudes of adults tend to be very small, as 'attitudes and behaviour in adult life are entrenched' (Field, 2012, p. 893), this was a noteworthy finding. Overall Field concluded that there is 'highly significant' evidence, that adult learning can impact the lives of adults positively (ibid. p.892).

Although Ecclestone and Hayes (2008) argue in the context of schooling that such 'soft' outcomes are increasingly being promoted at the expense of subject knowledge being taught, for the adults involved in this study I would argue that these are essential ingredients to consider. For instance, Duncan (2015), found that when the biographical interviews of adults who took part in non-formal learning were analysed, there was evidence of a ripple effect in terms of the variety of benefits that the adults perceived to have experienced. It transpired that the learners did not just speak of one or two benefits but 'rather spoke of several benefits together' (ibid. p.39), such as an increased sense of agency and of fulfilment, to which Duncan referred to as 'bundles of benefits' (ibid.). This echoed an earlier assertion by Duncan (2013) that a 'positive cycle' can occur for the adult learner: as their confidence levels rise through their new learning, this encourages them to try something else and again their confidence rises, leading to them undertaking further new opportunities. More recently, such benefits have been re-affirmed by Duckworth and Smith (2017a) in a nationwide study investigating how FE can transform the lives of adults. Interim findings report that although many adult learners bring 'significant barriers, including negative prior experiences of education and experiences of symbolic and physical violence', their

narratives tell of gains in terms of achievement, empowerment and 'reclaiming' positive identities (ibid. p.6).

3.5.2 Evidence that formal learning can enhance the well-being of adults with mental health problems

From the above one can see the variety of evidence illustrating that adult learning can enhance well-being. The question will now be considered as to whether this is also the case for those who have mental health problems. Before looking at some of the work relating to this area, it is worth acknowledging that although there appears to be a rise in students disclosing mental health problems (chapter two), there is still a lack of provision within many FE colleges, in terms of supporting such learners. For instance, a survey of 105 colleges in England by the Association of Colleges (2017a) found that only 40% of colleges had full time mental health advisers or counsellors. Additionally, only 41% had joint provision with their local health authority and 48% reported no relationship with the local clinical commissioning groups, which is extremely low given that, as this study will later show, providing support that straddles health and education is vitally important in this context. Added to that, the survey found that only 46% carried out mental health awareness training for all staff, yet the need for such training had been identified previously by Morrison, Clift and Stosz (2010). They reported in their survey of 33 FE colleges, that the staff felt ill equipped to support learners with mental health problems. They also found that staff believed that a discrete provision to support vulnerable students with mental health problems, such as the cookery class in this study, 'could be seen as discriminatory' (ibid. p82). This belief was despite other evidence that the authors had found, which suggested that a discrete course could provide a 'stepping stone' onto a mainstream course for such learners (ibid.).

Relatively little work has been carried out in identifying the ways in which formal learning can benefit the well-being of adults with mental health problems. However, in an effort to collate some of the work that does exist, the findings from three substantial studies will be considered: work by James

and Talbot-Strettle (2009); Lewis (2014); and Fernando, King and Loney (2014). These have been chosen because each of these studies span a range of settings. The first study involved interviews with staff and students from 35 FE learning providers in the UK; the second involved learners who attended targeted mental health ACL classes in the UK and the third was set in a hospital based educational provision in Canada involving both participants who were inpatients and outpatients. In all cases they reported there to be strong evidence to support the idea that engaging in adult learning yielded wider benefits beyond economic and vocational ones for adults with mental health problems. This was alongside an acknowledgement that certain barriers to learning needed to be overcome to access this learning fully, such as the negative side effects of their medication, social isolation, not having a stable residence and lack of family support among other factors. Equally some people experienced dis-benefits from being involved in adult learning such as struggling with the transition into mainstream classes and the extra pressure such courses put on them.

Considering this, certain prerequisites were identified as necessary for adults to benefit from their learning opportunities from these three studies. Some of these included the students: experiencing what they perceived to be good teaching and learning; being able to get help quickly when experiencing difficulties and when absent, having teachers contact them as it showed they were valued. Additionally, students appreciated the provision of shorter taster courses which could act as a bridge in a familiar environment and being given help to return if they did leave prematurely. Moreover, James and Talbot-Strettle (2009) found that it was essential that there was a partnership between the college and the health and social care provision, as the main causes for students leaving prematurely were found to be not because of their mental health problems, but the lack of support they received in college. In all cases these studies reported there to be many benefits from attending college and led one participant to say that they would turn up to the classes even if they ‘won the lottery’ (James and Talbot-Strettle, 2009, p. 51).

At a societal level some of the benefits reported were increased involvement in collective action and political life as well as increased social participation (particularly for older participants) due to attending classes. At an interpersonal level students spoke of finding: their levels of confidence increasing as a result of being part of the class; enjoying positive social interactions; developing an increased ability to speak out and also for some, to speak out publicly in order to stand up to violence and abuse (particularly for the females); and feeling less isolated in their mental health problems. At a personal level, there was evidence of learning enhancing well-being in a variety of ways. These included: finding learning fun; increased levels of self-determination; gaining a sense of personal responsibility; feeling hopeful generally; experiencing hope to progress and 'the acceptance of being a normal person' and finally, some reported positive changes in their identities. (Fernando, King and Loney, 2014, p. 23).

It could be argued, in light of these studies, that being involved in formal learning is of vital importance, as a way of enabling this underprivileged group to live well in society. James and Talbot-Strettle (2009) concluded that it was essential to put their findings into practice, to help lower social isolation, exclusion and discrimination, which can lead to withdrawal and a vicious circle of negative assumptions about what people cannot do. To help avoid this vicious circle, they stated it was of paramount importance for work to be extended in enabling access to education for this group of students, proposing that there needed to be a partnership between the health and social care providers and the learning providers. Only then could a virtuous circle be created in which learners take responsibility for their own learning, facilitated by the 'provision of appropriate and on-going support and good teaching which enables people to turn up and succeed in their learning and also to overcome many of the disabling effects of social exclusion, social isolation and discrimination'(p51). This echoes the aims of this current work.

Summary

This chapter defined how the terms well-being and learning would be used in this thesis. This was followed by exploring how formal learning has been

found to enhance the well-being of adults, including those with mental health problems. Although formal learning can also cause difficulties, it was found that these may be outweighed by the wider benefits to learning beyond economic and vocational benefits. These wider benefits it was argued, have the potential to positively influence the well-being for adults with mental health problems at a personal level, as well as positively affecting their families, communities and society too. Additionally, such benefits may further help to diminish the amount of social isolation, exclusion and discrimination that many adults with mental health difficulties encounter, as well as play a role in counteracting the social gradient in health which reflects inequities in the UK generally. Finally, as some people have reported their adult learning experiences have been transformative, the possibility that this could be the case for adults with mental health problems too will be explored further in the next chapter.

Chapter 4 The transformative potential of learning

Introduction

The earlier chapters outlined the wider societal context for adults with mental health problems, as well as how they are reflective of the health inequalities that exist in the UK. Additionally, they outlined how such inequalities lower opportunities for a person with mental health problems to improve their chances of moving into employment or further education. It was recognised that although both employment and formal learning can cause difficulties at times, the absence of them is often detrimental to one's health. Therefore, it was proposed that for adults with mental health problems who are presently unable to work, facilitating opportunities for them to engage in learning may in turn, positively influence their sense of well-being. By extension, this may also influence their health generally, in ways which may radiate to their families, communities and the society in which they live. Now the focus will be on whether such learning can be understood as being transformative, in the way that Mezirow (2000) proposed.

4.1 The development of transformative learning theory

Mezirow (1990) proposed the transformative learning theory after studying the effects of returning to learning for adult women. Essentially it was a theory to account for how adults 'changed the way they interpreted their world', leading to transformation that goes beyond mere 'change' as it leads to a 'paradigmatic shift' (Taylor, 2008, p. 5). However before looking at the genesis and outworking of this theory it is worth reiterating how Mezirow (1991, p. 12) defined learning itself:

> Learning may be understood as the process of using a prior interpretation to construe a new or a revised interpretation of the meaning of one's experience in order to guide future action.

Transformative learning theory was prompted by many studies that found it was not so much what a person experienced in life that was important, but rather 'how they interpret and explain what happens to them that determines their actions, their hopes, their contentment and emotional well-being, and

their performance' (Mezirow, 1991, p. xiii). The theory grew out of the cognitive movement in psychology and psychotherapy and its emergence was influenced by the work of Rogers (1967), Habermas (1984),Gould (1978) and Freire (2000). In the case of Rogers, it was his work in psychotherapy in which he developed the idea of the potential for significant learning to take place in an adult's life that particularly influenced Mezirow. This was an idea that had previously had been alluded to by Freud in 1930s when he spoke of 'catharsis'. Rogers (1967, p. 280) purported that significant learning was more than an 'accumulation of facts' but rather was 'learning which makes a difference – in the individual's behaviour, in the course of action (she) he chooses in the future, in (her) his attitudes and in (her) his personality'. To achieve such significant learning in psychotherapy there were certain conditions that needed to be met, two of which will be referred to here. First, that for the client to begin the process in the first place, they needed to have been facing a serious and meaningful problem, which so far, they had been unable to reconcile. It was this that led to their present desire to learn about themselves, despite being apprehensive at what may be uncovered in the process. Second, that the relationship with the therapist was, among other things, one of acceptance, empathy and unconditional positive regard, a relationship which demanded 'no personal gratification' for the therapist (ibid. p283).

As this approach was developed by Rogers in client-centred therapy, Rogers then sought to transpose it into education. He proposed that the approach in therapy in which the focus had been shifted from being counsellor centred to client-centred, could work in the classroom too. He purported that by changing classroom learning to become student centred as opposed to teacher centred, an opportunity would be afforded in which the students would benefit from having the chance to guide themselves and take responsibility for their own learning. To achieve this, there needed to be an atmosphere of acceptance, respect, and understanding that was free from threat; this was the only circumstance that genuinely facilitated learning as it led to a person becoming relaxed enough to experience 'a change in the organisation of self' according to (Rogers, 1951, p. 390). Consequently, he

proposed that deep learning could not be achieved if it was subjected to assessment as he stated: 'the testing of the student's achievements in order to see if (she) he meets some criterion held by the teacher, is directly contrary to the implications of therapy for significant learning' (Rogers, 1967, p. 290). This type of significant learning, transcended a solely intellectual exercise as it became an experience that was 'personally meaningful' (Rogers, 1951, p. 427) and contributed to the person's self-development. However, although Mezirow was greatly influenced by the work of Rogers, Mezirow's theory did also differ from that of Rogers in several ways. For instance, Rogers referred to the psychological core of self, encompassing cognitive, social and emotional aspects as part of a 'broader psychological and theoretical conception of the person' (Illeris, 2015, p. 332). In contrast Mezirow placed more emphasis on which learning processes were involved and which individual meaning perspectives or frames of reference were altered, and less on the social and emotional side.

Just as Rogers' work influenced Mezirow's work with its focus on the internal aspects of learning including the importance of the relationship with the therapist or teacher, the work of Freire (2000) influenced Mezirow regarding the external emancipatory potential of learning. Having worked among economically disadvantaged adults in Brazil, Freire (2000) came to believe that there was a culture of silence among such disempowered groups. He attributed this to the economic, social and political domination and paternalism they had encountered and been oppressed by. Working in education Freire (2000) came to believe that such oppressed people were capable of 'looking critically at the world in a dialogical encounter with others', if the right 'tools' were provided (p.32). This opportunity could happen if the education available sought to be emancipatory, no longer relying on the old model of a paternalistic relationship between a teacher and student. It was this he believed that could lead the students to develop a new awareness of themselves combined with a sense of dignity and hope. Freire saw this process of transforming learning as being both potentially emancipatory and humanising, and one in which the student had the opportunity to develop 'conscientization'. This concept of a critical conscience referred to developing

an in-depth understanding of their world, alongside an awareness of the co-existence of social and political contradictions within that world. Additionally, it involved students becoming aware of 'their capacity to transform that reality through action upon it' (Freire, 1970, p. 27). As part of this process, Freire emphasized the need for education to include reflection and critical dialogue with others as part of an attempt to avoid the 'banking concept of education' (ibid. p72). In this style of education, the 'educated' teacher is said to fill the student, (who may remain passive throughout this process), with the knowledge the teacher deems to be important for the student to know. By doing this, Freire argued that this limited the students' creative powers and only served to support the interests of the oppressors, 'who care neither to have the world revealed nor to see it transformed' (p73); this teacher-dominated process did not aid transformative learning, he argued. Mezirow was influenced by Freire's idea that a group can play a significant role in perspective transformation and this transformation involved becoming critically aware of how and why our presuppositions have come to constrain 'the way we perceive, understand and feel about our world' (Mezirow, 1990, p. 14). Mezirow proposed that this could happen either individually following psychotherapy, or collectively, as Freire proposed. However, although Freire (1970) was a critical theorist, Mezirow was not as politically orientated as him, despite proposing that transformative learning could lead to empowerment and emancipation.

4.2 The theory of transformative learning

Mezirow (2009) came to view adult learning as being transformative when it reached the point of causing a significant change in a person's life. Believing that this process was initiated often following a life crisis, Mezirow postulated that it could occur in a sudden way or in a cumulative way, where one's insights were progressively changing. He argued that the interpretations and the opinions that adequately helped adults to understand the world when they were children, may become inadequate for them later in life particularly as they encounter difficult life events. Three ways in which transformative learning may change a person's thinking and be evidenced, will now be outlined. These

are that there will be: a change in a person's frames of reference; a change in a person's way of viewing the world; and a change in a person's sense of self.

A change in a persons' frames of reference

Mezirow (1990, p.92) purported that the first step in the transformative process was to become aware of ones' own taken for granted assumptions (our 'frames of reference' or 'meaning perspectives'), or 'way of knowing' (Kegan, 2009, p. 44). It is these assumptions that Mezirow proposed a person used to filter how they dealt with the world and which led to a tendency to discount any ideas that did not fit in with their frames of reference. This in turn provided the context for meaning-making. Consequently, Mezirow (1990, p. 92) suggested that for significant changes to occur during adult learning, the process must entail either consciously or unconsciously, that:

> we transform problematic frames of reference (mindsets, habits of mind, meaning perspectives) – sets of assumption and expectation – to make them (*the frames of reference*) more inclusive, discriminating, open, reflective and emotionally able to change.

Mezirow proposed that such significant changes could happen in one of four ways: 'by elaborating existing frames of reference; by learning new frames of reference; by transforming points of view, or by transforming habits of mind' (Mezirow and Associates, 2000, p. 19).

These habits of mind were contained in one's frame of reference and were habitual ways in which a person thinks, usually as a result of their family and cultural upbringing. An example of a habit of mind changing, might be that of an adult female learner who rushed home after class to cook the dinner for her husband, whilst her colleagues stayed to continue their discussions. Part of her transformation may have been to have critically reflected on this contrast, which led to a transformation in her habit of mind in relation to her role as a wife.

Mezirow further argued that it is these habits of mind that led to expressions of specific points of view, which reflected deeply held assumptions. For example, a person may have an ethnocentric habit of mind which leads them to view

anyone who is outside of their own group and who displays characteristics that are different from their own, as being inferior (Mezirow, 2009). A positive personal encounter with someone from this group may serve to counteract this existing point of view, but this may not necessarily challenge the person sufficiently to change their long held ethnocentric habit of mind, in relation to other groups of people. Yet, Mezirow (1997, p. 5) proposed that if changes in these ways of thinking did happen, it would lead a person to develop 'autonomous thinking'.

A change in a person's way of viewing the world

This transformative change towards autonomous thinking, Kegan (2009) illuminated further by proposing that transformative learning was not merely about adding to existing forms of knowledge, by acquiring more information or a behavioural change. Rather it was about experiencing an epistemological change in a person's frame of reference. This means that 'trans-*form*-ative learning puts the form itself at risk of change' making the process of change not about '*what* we know but changes in *how* we know' (ibid.p.42). Kegan argued that essentially this involves moving from beyond acquiring more facts (which would be within a pre-existing frame of mind) to developing the capacity for abstract thinking as one begins to ask questions about the facts and the creation of the facts themselves. This involves 'reconstructing the very frame' which leads to 'our knowing', and so enables this frame to become 'more complex, more expansive' in other words: 'We change our epistemologies'. (ibid. p.45). Mezirow proposed that such advanced changes in a person's thinking were more likely to occur after the age of 30 and there does appear to be evidence that such perspective transformation can be a lasting and irrevocable process (Courtenay, Merriam and Reeves, 1998).

A change in a person's sense of self

Another way that Mezirow proposed that transformative learning would be evidenced is by the person experiencing a change in their self-concept or sense of self. This idea was reinforced by Illeris (2014, p. 40), who suggested that 'the concept of transformative learning comprises all learning that implies change in the identity of the learner'. Part of this change is due to the person

now re-interpreting both their present and past experiences, in light of their new ways of seeing the world. This is because they now have the ability to 'look critically at their beliefs and behaviours, not only as these appear at the moment but in the context of their history' (Mezirow, 1991, p. 197). It is such thinking that can become emancipatory and empowering as the adult reaches an awareness of why they experience life as they do. Yet Mezirow acknowledged that being able to acquire this degree of autonomous thinking, will always be 'limited by social, historical, and cultural conditions' (Mezirow and Associates, 2000, p. 27). Nevertheless within these constraints, this new awareness or critical stance, will lead to a 're-integration into one's life context on the basis of conditions dictated by a new perspective' (Mezirow, 1991, p. 193). This means that any transformation must include acting on these new insights, even if being able to do so is delayed, due to one's present circumstances.

The role of critical reflection and discourse

In order to enable such significant shifts to take place, Mezirow (1990) proposed that the adult learner would have engaged in both critical reflection and critical discourse with others. Mezirow (1990, p. xvi) defined critical reflection as the 'assessment of the validity of the presuppositions of one's meaning perspective and examination of their sources and consequence'. This went beyond introspection as it would not be enough to only become aware of something, but rather it must involve critique: the questioning of one's prior assumptions as well as the assumptions that other people may hold.

Equally essential was that of critical dialectical discourse (referred to as critical discourse or discussion in this thesis) which Mezirow (2003, p. 59) defined as 'dialogue involving the assessment or beliefs, feelings and values'. He proposed that this would involve a discussion taking place with 'either implicit or explicit claims regarding the justifications or validity of what it said, implied or presupposed' (Mezirow, 1991, p. 66). It is through this rational discourse with other adults, which is free from coercion that there could be 'validation of our transformative insights' (Mezirow, 2009, p. 94).

This could then lead to a person becoming liberated from 'reified forms of thought that are no longer dependable' (Mezirow and Associates, 2000, p. 27).

Altogether, ten recognised steps were proposed in the original theory: 'a disorienting dilemma; self- examination with feelings of fear, anger, guilt or shame; a critical assessment of assumptions; recognition that one's discontent and the process of transformation are shared; exploration of options for new roles, relationships and action; planning a course of action; acquiring knowledge and skills for implementing one's plan; provisional trying of new roles; building competence and self-confidence in new roles and relationships; a reintegration into one's life on the basis of conditions, dictated by one's new perspectives' (Mezirow, 2009, p. 94)

In summary, Mezirow (2001) proposed that if transformative learning took place in a person's life, it would have involved changes in a person's frames of reference, way of viewing the world and in their sense of self. These changes would have been achieved by engaging in critical reflection and discussions with others who do not necessarily share the same beliefs and becoming prepared to critique one's old experiences in light of new understandings. It is these changes which he believed would determine for the person, 'their actions, their hopes, their contentment and emotional well-being, and their performance'(Mezirow, 1991, p. p.xiii).

Transformative teaching and learning theory

Some recent learning theories have postulated that transformative teaching should be included in theories of transformative learning, arguing that it is an essential component in the process. Slavich and Zimbardo (2012, p. 576) defined transformative teaching as being when the teacher has 'the expressed or unexpressed goal to increase students' mastery of key course concepts while transforming theory learning-related attitudes, values, beliefs, and skills'. Therefore, in extending Mezirow's work on transformative learning, Slavich and Zimbardo argued that in order to foster such learning, certain attributes of how the teacher teaches, must be included. For instance, that the teacher needs to act as a facilitator who focuses on learner centred

activities in order to encourage a learner towards becoming an autonomous thinker, an approach that would be dependent on a dynamic relationship developing between the teacher and student. This would constitute a collaborative and active relationship, with the teacher acting only as an intellectual coach, in order to positively drive forward the students' own development and attitude to learning. Among other things, this would involve a shared vision for the course, provision of modelling and mastery experience and ample opportunities for pre-reflection (before beginning an assignment) and reflection.

Building on this idea of transformative teaching being a key component in any transformative learning, Duckworth and Smith (2018a, p. 5) defined Transformative Teaching and Learning (TTL) as describing 'an interactive, interdependent and dynamic relationship between students and other students, and students and teachers'. Recently they gathered evidence to support their theory of TTL in a project involving over 30 UK colleges, in which students, their families, teachers and employers were interviewed. Their findings indicated that understanding the context that learners came from was a vital component in TTL and so it was essential to understand their backgrounds as well as to relate the curricula to their biographies (Duckworth and Smith, 2018b). This emphasis defers from Mezirow's, as he focussed on the individual learner in the classroom and not the context from which they came.

Extending the premise proposed by Slavich and Zimbardo, Duckworth and Smith (2018b) maintained that there needed to be an egalitarian relationship in the classroom between the teacher and the student. Such a relationship resonated with that of Mezirow (1997) who argued that this would help to facilitate critical dialogue in the classroom. It was this egalitarian environment, in which there was a co-construction of knowledge, that Duckworth and Smith (2018b) proposed encouraged the learner to take responsibility for their own learning. However, they did acknowledge that such a proposal would challenge 'teachers theoretical understanding of what constitutes effective practice' (Duckworth and Smith, 2018b).

Despite these recent theoretical developments, for the purposes of this work, the theory of transformative learning (Mezirow, 1991) will be used as the theoretical framework. However, it must be acknowledged that transformative learning theory does have other limitations despite its longevity, which will be the topic of the next section.

4.3 Limitations of transformative learning theory

While transformative learning theory has much strength as an explanatory framework to understand the potential of education and well-being, there are four main criticisms that warrant attention. These limitations are:

1. That transformation is dependent on a person already possessing a high level of cognitive functioning and education in order to engage intellectually with the process of change.

2. That the theory is North American in its orientation.

3. That unless the transformative process has involved a deconstruction of power issues, the changes will be inadequate.

4. That the theory underplays the role of emotion.

In terms of the first two limitations, Howie and Bagnall (2013, p. 820) suggested that the ability to engage in rational discourse and critical reflection was dependent on a high level of cognitive functioning, which led to 'a circular causality dilemma, in which it is futile to argue whether one event comes before another'. Added to this, Lange (2015, p. 623) cited evidence that much of the research concerning transformative learning has been criticised for being 'North American' in its orientation given that research concerning the theory had been carried out among highly educated North American students. For instance, Mezirow (2009) set up a doctoral programme specifically to facilitate and find evidence to support the theory in that context. To my knowledge it would seem that Mezirow (2003, p. 60) did not directly address how the theory might work outside of such educated contexts although he did acknowledge that 'Hungry, desperate, homeless,

sick, destitute and intimidated people obviously cannot participate fully and freely in discourse', and urged adult educators to be committed to 'economic, cultural and social action initiatives'. However, a study among economically disadvantaged adults, who were not highly educated was carried out in relation to transformative learning by Hyland-Russell and Syrnyk (2015). They concluded that transformative learning was an appropriate model for this cohort too as some of the findings identified among the students, included there being 'significant shifts in their frames of reference as they moved from spaces of exclusion to inhabit a community of learning' (ibid. p515). Yet the authors surmised that despite such evidence, it could be problematic to put their new thinking into practise due to significant systemic and institutional barriers in terms of money and familial opposition that inhibited their progression. Although this study suggested that the transformative learning model can work outside of middle class educated people, it did highlight that structural difficulties in society may inhibit the outworking of the transformations in an economically disadvantaged person's life.

In terms of whether the theory is applicable outside of a North American context, Lange (2015) explored whether people from minority groups immigrating to Canada, experienced transformative learning. She found that this model did significantly contribute to making sense of how they came to settle into a new country and proposed that it could be applied transculturally as she observed that there were three significant stages that such people underwent. First that they experienced a disorienting dilemma involving feelings of anger and shame as they wondered how they would ever fit in due to the huge culture shock they faced on arrival. This was coupled with an increasing awareness that they did not understand the implicit and explicit vast cultural disparities between their host country and their new one. Second, that gradually through exposure, constant readjustment and dialogue with others, they began to learn how to juggle their multiple identities and taken-for-granted assumptions. However, Lange purported that transformation did not occur until they reached the third stage: a stage of integration. This occurred when they became mentors to enable other

immigrants to settle in, suggesting that the effects of transformation may radiate beyond the confines of the individual's life, who experienced them.

The third criticism that transformative learning is inadequate unless it involves a deconstruction of power issues has been argued in light of the theory itself focusing mainly on transformation at the individual cognitive level. This was highlighted as Brookfield (1991, p. 97) stated:

> I believe that the persons concerned must engage in some sort of power analysis of the situation or context in which the learning is happening. They must try to identify the assumptions they hold dear that are actually destroying their sense of well-being and serving the interests of others; that is, hegemonic assumptions.

With regard to this criticism, when interviewing rural Canadian women about their personal experiences of depression, Cameron (2016, p. 115) said that they did speak of their 'transformed perspectives on power' as a result of experiencing transformative learning as they re-evaluated and re-adjusted their lives in light of their experiences of depression. For some women, this involved moving from complying with the medical treatment on offer, particularly in relation to taking psychiatric medication, to trying to deconstruct the 'fundamental roots of depression like poverty, colonialism, sexism … and other forms of oppression' (ibid. p.115). As this study did not involve formal classroom learning, it suggested additionally that transformative learning is a transferable model that can be applied outside of the context of a classroom.

While the last criticism dealt with external forces, the criticism regarding the underdevelopment of the role of emotion in transformative learning refers to an internal issue. Mezirow (2009) readily admitted that this aspect was downplayed, although he had included emotion in his proposal that transformation will lead to one becoming reflective and 'emotionally able to change'. (Mezirow and Associates, 2000, p. 21). Rather he tended to place more emphasis on transformative learning, being 'essentially a metacognitive process of reassessing reasons supporting our problematic meaning perspectives' (Mezirow, 2009, p. 96). However, Illeris (2015) pointed out that the emotional component should not be overlooked as any change in understandings and attitudes is usually motivated by both new

cognitive insights as well as powerful emotional ones. To this end, it may be helpful to accept the definition by O'Sullivan (2003, p. 327) who suggested that transformative learning involved 'experiencing a deep, structural shift in the basic premises of thought, feelings, and actions'.

Despite a myriad of limitations that have been suggested in relation to transformative learning, the theory has been further developed in a variety of dissimilar contexts suggesting it is transferable and potentially significant. For instance, in relation to neurobiology, there has been work carried out suggesting that the structure of the brain actually changes during transformation (Janik, 2007) and in a different domain, that spirituality and culture can play a role in transformation (Brooks, 2000; Tisdell, 2003). Consequently, it is an appropriate choice as a theoretical framework in which to situate this research given that it is an established theory of adult learning which has attracted much research and discussion in the academic world. Added to that, this present work sought to add to the existing body of knowledge regarding transformative learning theory, in relation to adults with mental health difficulties.

Summary and research questions

Given the multiple disadvantages that adults with mental health problems may experience personally, socially and economically, this thesis has argued that engaging in formal learning cay be one means by which these adults may experience an enhanced sense of well-being. As some of the evidence presented in chapter three showed that attending adult learning classes could be transformative for some adults, this chapter explored the theory of transformative Learning. Having identified the genesis of this theory, what it entails and how it is regarded in the academic literature, four main limitations relating to this theory were also outlined and addressed. Using this theory as the main theoretical framework, one of the aims in this thesis is to understand whether, in the context of adults of mental health difficulties, the theory of transformative learning can illuminate the process through which these adults benefit from their return to formal learning.

As the first research question regarding the wider societal context for adults with mental health problems was answered in chapter two, the fieldwork that was carried out to answer the remaining three research questions will be explained in chapters five, six, seven and eight. These research questions are:

2. Considering the relationship between wider societal factors and mental health, what are the perceptions of adults with mental health problems regarding the influence of classroom learning on their well-being?

3. In what ways can their experiences and perceptions be understood with reference to Mezirow's theory of transformative learning?

4. In terms of bridging the divide between the fields of health and education, what can be learnt regarding how to interview vulnerable adults in a meaningful, safe and ethical way within an educational setting?

Chapter 5 Methodology and methods

Introduction

This chapter comprises three sections. The first section outlines the choice of methodological approach underpinning this study, which involved adopting a narrative approach. The second section outlines the methods utilised in terms of: the literature review; the research design; the sampling method for the three groups of participants; data collection; and analysis. The final section outlines the ethical issues that had to be considered throughout both the interviews and class observations as well as the thesis-writing.

5.1 Methodology

5.1.1 The nature of social reality

It could be argued that there is a multiplicity of factors that permeate decisions as to the nature of social reality. Due to this complexity, Burrell and Morgan (1979) suggested that there were certain assumptions that needed to be made explicit by a social scientist prior to embarking on research, as it is these that will influence their choice of methods. The first assumption that needs to be made explicit is in relation to ontology, which concerns 'the nature of social phenomena and the beliefs that researchers hold about the nature of social reality' (Denscombe, 2010, p. 118). However, although this is a complex issue there are two basic positions that operate within this much contested field. These are, at one end of the spectrum, the belief that there is a real world that is independent of our perceptions and experiences of it (positivism) and at the other end of the spectrum, the belief that social reality is the product of people's consciousness and created by people's agency (constructivism). Consequently, Burrell and Morgan proposed first, that it is important for researchers to be explicit about what they believe at an ontological level and the assumptions they are making: where does the researcher position themselves in the debate regarding the nature of social reality? For the purposes of this work I have chosen to position myself in constructivism, regarding the social world as being constructed by the human

mind through a person's perceptions, which may be reinforced as they interact with other people (Denscombe, 2010). Such an ontological position accepts that there are multiple realities as opposed to a single reality, as social reality 'is constantly being produced and reproduced; something that exists only as long as people persist in creating it through their everyday actions, words and beliefs' (ibid. p.119). By extension, this stance accepts that the nature of these social worlds may differ between various groups and cultures; another illustration that there are multiple realities instead of only one. Consequently, according to constructivists, any attempt to give a 'definitive account of social phenomena…is misguided and impossible' (ibid.) and so researchers should concentrate on finding out and describing how people construct their social realities.

The second assumption that researchers need to be explicit about is in relation to epistemology which concerns how humans create their knowledge about the social world (ibid.). What does the researcher believe about the nature of knowledge and how it can be constructed? In addition, how can it be communicated to others? In social research, if one views knowledge as objective and tangible, then the researcher would choose to make observations in a similar way as a natural scientist would. This would involve adopting a positivist approach, which seeks to uncover the variables that commonly and consistently cause the effects observed. In contrast, if one views knowledge as being subjective, unique and personal, requiring the researcher to be involved with their participant, an anti-positivist or subjective approach would be appropriate (Cohen, Manion and Morrison, 2011). In this case, the role of the social scientist would be to understand how different people interpret the world in which they live and to help them to construct the subjective meanings they give to their actions and choices. From an epistemological angle, in this study I adopted the concept of interpretivism, which is when the researcher recognises the need for people to interpret reality and for the researcher to interpret their interpretations. Consequently, this paradigm maintains that reality is 'the product of individual consciousness' which is 'created by one's own mind' (Cohen, Manion and Morrison, 2011, p. 5), and so the role of the an educational researcher is to

insert themselves into the ‘continual process of meaning construction in order to understand it’ (Scott and Morrison, 2006, p. 131).

5.1.2 Interpretivism

Interpretivism is ‘an umbrella term for a range of approaches that reject some of the basic premises of positivism’ (Denscombe, 2010, p. 121). In this work, I adopted the perspective outlined by Denscombe (2010) as he used the term interpretivism in its broadest philosophical sense, characterised as an alternative to positivism. Such a position adheres that ‘social reality is subjective’ and that ‘humans react to the knowledge that they are being studied’ and so their behaviour will change due to being involved in the research (p.121-122). Accepting such a stance implies an acknowledgement that objective knowledge in relation to social reality is never possible, as any knowledge will be influenced by the participants’ awareness that they are being studied and influenced by the researcher’s values and experiences. Denscombe (2010, p. 123) recognised this subjectivity as he wrote that ‘social research cannot explain things in terms of grand theories’ as knowledge can never be objective. Rather it would appear that research is an activity of meaning-making, as the researcher uses the perspectives of the participants to construct an understanding of the ‘phenomenon of interest’ (Merriam and Kim, 2012, p. 58). Given that these meanings can be varied and multiple, I was as a researcher looking for the complexity of views and relying as much as possible on the participants’ views of the situation being studied as well as interpretations derived from class observations and informal discussions with the Mental Health Advisors.

However, interpretivism, as with all epistemological approaches does have several limitations. Denscombe (2010) outlined three such limitations concerning:

1. The issue of relativism: given the absence of objective truth, the researcher’s account may be viewed as being so subjective that

another researcher would not necessarily explain the phenomenon in the same way.

2. The degree of uncertainty inherent in such an approach: in the quest to discover how people construct their social world there may be 'contradictions and internal inconsistencies arising as part of the explanations that interpretivists produce' (ibid. p.123), leading to more incomplete and open-ended explanations which will not be respected by positivists.
3. The lack of apparent rigour, given the absence of statistical measurement that is commonly regarded as being an objective reflection of reality.

Despite these limitations, Denscombe (2010) argued that it is possible to carry out a credible interpretivist study by ensuring that a systematic approach is taken which is rigorous. Such rigour can be manifest in the: appropriateness of sampling methods; quality of the data collection; transparency of analysis and in the clarity of explaining how the data has been used, to reach the conclusion identified. To achieve this, reflexivity will be essential, as outlined below.

Recognising interpretivism was not an easy decision for me, given that my original training was in experimental psychology which had led me to view social reality as being possible to access via the lens of positivism. Yet my later experience of working in education and nursing led me to question such a stance as providing an adequate means of accessing social reality, particularly as I was aiming for insights into the personal perspectives of my participants rather than for a measurement of observable features. Consequently, this involved me choosing to collect qualitative data as I saw this as being the only trustworthy way to do so in a study such as this one. Also, it was deemed to be the best way to access the participants' experiences in this study as Hollway and Jefferson (2000, p. 3), argued 'if we want to do justice to the complexity of our subjects, an interpretative approach is unavoidable'. Only by collecting qualitative data could I credibly access the narratives of my participants to ensure that '"thick" description'

(Geertz, 1973, p. 6) was made possible and reductionism avoided. Although such a choice could be potentially time consuming and involve a limited sample size (Alderson, 2013), I believed it would be the best means by which to explore and understand the experiences narrated by a carefully selected group of participants. This approach was crucial to my research questions which aimed for understanding rather than prediction and also resonated with using the narrative approach in this work. I would suggest that I was a 'co-producer' of the data, as the results came from an interaction between the researcher and researched (Mason, 1996, p. 36); a reminder of the co-constructed nature of narrative interviews (Riessman, 1993).

5.1.3 The narrative approach

For the purposes of this research, a narrative approach was chosen. Creswell (2013) states that a narrative approach encompasses different types of narratives such as a biographical study or auto ethnography, life history or oral history. Although they may vary in detail, they all essentially are attempting to capture 'an account or story' (Scott and Morrison, 2006, p. 159), and collect stories from individuals about their 'lived and told experiences', which may shed light on their identities (Creswell, 2013, p. 71). Such an approach has become increasingly popular in the sociology of health research (e.g.Charmaz, 2002) and education (e.g.Cortazzi, 1991), hence the choice for this study.

According to Denscombe (2014, p. 291) a narrative will be told for a specific purpose; will contain a plot line linking the past to the present and will involve people. Riessman (1993, pp. 8,31) pointed out that 'We cannot give voice, but we do hear voices that we record and interpret' and so such narratives are 'co-constructed'. Overall narratives can often lead to highly personal information being shared but although they can provide important insights into the minds of both the story teller and researcher, it should be acknowledged that they are essentially incomplete as 'what remains unsaid or unwritten may be as important as what is said or written' (Scott and Morrison, 2006, p. 162). Riessman (2008, p.6) suggested that such narratives in human sciences can involve several overlapping elements:

‘stories told by research participants (which are themselves interpretive); interpretive accounts developed by an investigator based on interviews and fieldwork observation (a story about stories), and even the narrative which the reader constructs after engaging with the participant’s and investigator’s narratives’. Added to these multiple layers, it may be difficult to decide whether what the interviewee narrates is fact or fiction or whether there is an unconscious tendency in analysis for the interviewer to present the narrative as a ‘Hollywood plot’ as though everything works out well in the end (Clandinin and Connelly, 2000, p. 81). This relates to the issue of validity. Riessman (2008) proposed, that there are two levels contained in narrative accounts in relation to validity: the validity of the narrative told by the participant and the validity of the analysis by the researcher. These issues add a layer of complexity to narrative research that the empirical scientist may never address.

Elliott (2005, p. 3) spoke of a narrative as ‘organising a sequence of events into a whole so that the significance of each event can be understood through its relation to that whole’. Elliott suggested that they contain three key elements: they are chronological (as opposed to descriptive), meaningful and social in that they are produced for a specific audience in a specific context. These elements lead to a narrative; a narrative which tells of a sequence of events that are relevant for both the narrator and their audience. Additionally, Elliot maintained that narratives contain two important aspects: experience and temporality. In terms of experience, narrative interviews can give a person the space in which their years of experience can ‘be ‘compressed’ into one account’ (Scott and Morrison, 2006, p. 161). Also, as Elliott (2005, p. 4) suggested, it ‘provides a form of communication in which an individual can externalise his or her feelings and indicate which of those experiences are most significant’. Clandinin and Connelly (2000, p. 2) maintained that speaking about such experiences enabled there to be ‘continuity, namely the notion that experiences grow out of other experiences, and experiences lead to further experiences’; this had been emphasized earlier by Dewey (1938). So, narratives involve a process of moving back and forth simultaneously between the personal and the social and thinking about the past, present and future:

‘inward and outward, backward and forward’ (Clandinin and Connelly, 2000, p. 50).

In terms of temporality, Clandinin and Connelly (2000, p. 29) maintained that, ‘We take for granted that locating things in time is the way to think about them. Any event, or thing, has a past, a present as it appears to us, and an implied future’. Consequently, they pointed out that all experience is temporal and that all aspects of people’s lives are on a continuum: ‘what we may be able to say now about a person or school or some other is given meaning in terms of the larger context and this meaning will change as time passes’ (ibid. p.19). I would argue that both experience and temporality were central to the narrative accounts in this study.

The benefits of taking a narrative approach evolved from previous exploratory research (Buchanan, 2014) as it became apparent how much the participants wanted to tell me their stories as opposed to merely answering my questions. Additionally, such an approach fitted with the decision to apply the theory of transformative learning to this research; Merriam and Kim (2012, p. 63) maintain that, ‘Narrative analysis is particularly well suited for the study of transformative learning because it allows people to convey their personal experience of this type of learning through stories’, and in doing so, can capture the ‘multidimensionality of transformative learning. People’s stories are rich resources for accessing the depth of this type of learning’ (ibid. p.68). Furthermore, Dein (2016) proposed that the actual process of narration can in itself cause hopefulness among the participants.

However, it needs to be acknowledged that the form of inquiry adopted for this study was not typical of what one normally regards a narrative study. For instance, narrative studies will often focus on only one or two individuals and so the participants will be encouraged to tell their life story over many hours, with few questions being asked by the interviewer. For example, in a longitudinal study which looked at the experiences of girls from different social classes growing up, the narrative interviews, which were based on a checklist of open-ended questions, lasted two to three hours (Walkerdine, Lucey and Melody, 2001). However allowing for such lengthy interviews was not feasible

for this study due to the number of participants and researchers involved, and other considerations which are outlined below:

1. My previous research had identified that some participants were extremely limited in their answers and so it would not have been possible to ask them to narrate without using questions in order to prompt them.
2. There were time limits on how long I could interview them (under one hour) as set by the gatekeepers, in order not to tire or overtax these vulnerable participants.
3. A stipulation of the NHS ethical approval granted was that participants would not be directly asked to give their clinical histories, which was also a reason the term 'life history' was not adopted.
4. Due to the possibility that some participants may have severe mental health problems it was crucial that I did not encourage them to speak too long about their painful and at times, traumatic histories, in case these such reflections triggered distress or mental deterioration.

Due to these considerations I used a shortened form of narrative interviewing which comprised of using open ended questions as prompts, alongside allowing the participants to narrate more freely when they so wished, within the aforementioned ethical constraints. This resulted in most cases of a 'second order narrative' (Elliot 2005) being formed, in which I constructed the narrative from the different answers told by the participant (as seen in the pen portraits).

5.1.4 Reflexivity in narrative research

Given the complexities involved in narrative research, reflexivity was an essential component in the adoption of such an approach. Reflexivity is the 'process by which the researcher comes to understand how they are positioned in relation to the knowledge they are producing' (Scott and Morrison, 2006, pp. 201-202). However, it should be noted that this term can be interchanged with critical reflection as discussed by Malthouse, Roffey-Barentsen and Watts (2014). Consequently, for the purposes of this thesis,

reflexivity and critical reflection will both be used. This is because reflexivity is often used in narrative research and critical reflection is the term Mezirow uses in his theory of transformative learning. Mezirow (1990, p. xvi), defined critical reflection as the 'assessment of the validity of the presuppositions of one's meaning perspective and examination of their sources and consequence'.

Being reflexive in narrative research acknowledges that the researcher 'can never stand outside the social world he or she is studying' as any viewpoint 'will be contaminated by contact with that social world (Denscombe, 2003, p. 300). Consequently it is important that the researcher aims to present a trustworthy account of what was said by the interviewee, whilst recognising their own part in the narrative that emerges. Silverman (2010, p. 47) explained that: 'The assembly of narratives in interviews…is always a two-way process. Therefore, we must treat the interviewer's questions not as (possibly distorted) gateways to the authentic account but as part of the process through which a narrative is collectively assembled'. This premise was extended by Clandinin and Connelly (2000, pp. 60,61) who said that we 'meet ourselves in the past, the present, and the future' and so 'we are not merely objective inquirers…..on the contrary we are complicit in the world we study'. Reflexivity will be discussed later on in relation to the data collection process.

5.2 Methods

5.2.1 Methods for the literature review

A literature review was conducted involving two main steps: literature searching and analysis of the literature.

Literature search: this involved identifying relevant academic texts as well as college and government policies and reports, which focussed on mental health issues in the UK mainly. Additionally, it involved several text books about learning theories and mental health. An online search for relevant literature was conducted using the following databases BEI, ERIC, AEI, DERA and IOE Eprints. Each online database was searched using the following key terms: mental health difficulties; mental health problems; mental illness; mentally ill; abnormal psychology and, additionally all the above words, in conjunction with education. I also followed up references contained in articles to identify other relevant texts. Searches for grey reports and documents were undertaken using Google Scholar as well as through websites with a mental health focus such as the Mental Health Foundation, Mind and Rethink. Alongside this, any suggestions that were made by the stakeholders with whom I met were followed up.

b. Literature analysis: in terms of the quality of the literature used, peer reviewed articles, books, studies, and reports formed the main body of literature analysed. Attention was paid to the methods used in research studies and studies were excluded if their design was not explicitly outlined and if they employed methods that were deemed inadequate to support the conclusions drawn. Documents about the overarching research questions were classified and analysed to identify key, relevant issues. Finally, chapter two was checked for accuracy by one of the stakeholders I had previously interviewed, who worked for the mental health charity Mind.

5.2.2 The research design and methods for the fieldwork

A narrative approach was taken as outlined in 5.1.3, as the exploratory study had shown that one to one ‘interview conversations’ (Goodson and Sikes, 2001, p. 27) would be the best way to enable the voices of these vulnerable

participants to be heard. Interviews were carried out and class observations were made (see 5.3), in order to supplement the data from the interviews. Byrne (2012, p. 209) suggested that in contrast to questionnaires, using qualitative interviews is 'particularly useful as a research method for accessing individuals' attitudes and values – things that cannot necessarily be observed or accommodated in a formal questionnaire. Open ended and flexible questions…(*are*) more open to hearing respondents' views 'in their own words', which allows for a more complex analysis'. Wengraf (2001, p. 5) argued that using such interviews are 'high – preparation, high risk, high gain and high analysis operations' but a belief that this was the only way to hear the participants in their own words outweighed the disadvantages.

The focus in the interviews was to encourage the participants' narratives to emerge freely but some questions (see 5.3) were prepared, with the aim that these would act as prompts. This format allowed me the opportunity to determine when it was appropriate to probe for exploration of suppressed views, amplification and clarification. Added to that, it enabled me to broach sensitive issues such as how the participants viewed themselves because of their mental health problems and for them to focus on some elements more than others, if they so wished. Byrne (2012) suggested that achieving the right balance in this respect requires skill by the researcher and so who carries out an interview and how they do so, can influence the progress of the interview and may lead to vastly contrasting results. In this case, as it involved vulnerable participants, this was particularly important. Sagan (2008, p. 97), who also interviewed adults with mental health problems, suggested that the aim throughout the interview process was for the participants to experience 'maximum psychological comfort'. I surmised that this was achieved as participants did speak at length about sensitive issues.

5.2.3 Sampling

Rationale for the selection of the college

There were three reasons for carrying out this study in a specific Further Education (FE) college. The first reason was because the work with students with mental health problems in this college had been recognised as being outstanding, having gained the Queen's Anniversary Award. This is a biennial award recognising world class excellence and achievement in further and higher education in the UK. Also, the college was selected because the college won a Beacon Award and TES 2016 in recognition of its outstanding and transforming contribution in the field of working with students with mental health problems, which has led to significant social change[4]. Selecting this college provided the opportunity to identify how, in a setting in which there is recognised outstanding provision for those with mental health problems, one may be able to discover how the actual learning affected the lives and well-being of these students, as opposed to inadequate mental health provision. The second reason was because it afforded me the opportunity to explore how education may be influencing students in both non-accredited courses and accredited courses. The former does not include assessments whereas the latter does. The third reason was because I was able to gain access to participants in this college due to teaching the discrete cookery class there. This was a class which ran in conjunction with Occupational Therapists (OTs) and the college Mental Health Advisers (MHAs).

The setting

This college is situated in an inner London borough[5]. Ten years ago, this area had been known for its high levels of crime; high levels of people with physical and mental health problems and high levels of welfare benefit claimants. However, the demographics changed as the area became regarded as a culturally desirable place to live which has attracted more educated, employed people. Consequently, although the proportion of people who received welfare benefits in 2006 was 21.3%, in 2016 this figure was

[4] Full details omitted to preserve anonymity

[5] See Appendix one for more details

13.9% which compares favourably with the rest of Britain (12.0%). However, these changes were not necessarily reflected within the college as in 2016-2017, 60.8% of students were unemployed and 3.2% of students had disclosed mental health problems (up from 2.2% in 2013-2014). In relation to ethnicity, the number of people in this borough of Black, Asian and Minority Ethnic origin communities (BAME) was 45.3% in 2016 whilst in the college it was 76.6% of students (2016-2017).

Part of the college setting included the Mental Health Advisers and as they played an important part in facilitating this piece of research, the nature of their jobs will now be outlined in detail.

The role of the Mental Health Advisers (MHAs)

The MHAs straddled both the field of health and education as although they were based in the college four days a week, they spent the fifth day in the hospital trying to encourage inpatients to enrol onto courses. The posts of the MHAs were set up in 1997 as a gap was identified in moving people successfully from the healthcare system into education, training or employment. Although there are MHAs working in other colleges, the MHAs in this college were unique as they were not dependent on college funding but were employed full time by the local Health Trust. Their role involved advising and supporting the students as they moved from their hospital-based care into education, as well as whilst they were in the college. However, another essential component of their job was writing and delivering training for teachers on how best to work with students with mental health problems and supporting them accordingly. For instance, if a student became unwell or was hospitalised whist attending college, the MHAs communicated with their teacher during this period to ensure that the student did not lose their place on the course or fall behind with assignments.

My working relationship with the OTs and MHAs was crucial in enabling this research to take place as not only did I need approval from the OT department to interview students in the discrete class, but I also needed to obtain ethical approval from the NHS. Because of this, I was then able to have the MHAs acting as gatekeepers for this study. Oliver (2003; p.39)

describes a gatekeeper as being the 'person who controls access to where it is hoped to carry out research'. As will become apparent later, their role as gatekeepers turned out to be crucial to the success of this study, not least because they also advised me on the research design and process, before and during data collection.

Selecting and recruiting student participants from different levels of classes

The selection process was purposive in terms of the college, the classes and the participants, all of whom had diagnosed health problems. Participants were selected from three different types of classes as outlined in Table Three.

Table Three Summary of how the sample was chosen

Discrete course	Students on a cookery course that was open only to people referred via the local mental health unit, so all the students in this class had mental health problems.
Mainstream courses	Students who had independently enrolled onto a college mainstream course and chosen to disclose their mental health problems to the college.
Former-students	Former students (regardless of whether they completed their courses or not), who had been registered as having mental health problems.

This selection process was chosen in order to reflect the range of students with mental health problems who were at different stages in terms of their recovery, which was echoed in the level of the courses they chose to enrol onto. For instance, the discrete course which I taught, represented a less confident group of adults which is why the class included high levels of support (two Occupational Therapists and a teacher). The mainstream group represented a more confident group as these students were in classes

alongside members of the public. Finally, the inclusion of the former-students group was to afford the students the opportunity to reflect on their past experiences of learning within college and how they felt that these experiences had influenced their lives longer term.

5.2.4 Participants in the discrete group

The discrete class had been set up to bridge the gap between attending hospital-based classes and classes in college and was restricted to only ten students. The purpose of this discrete provision was to offer a first step back into education for these students, with the hope that their skills, desire to learn and confidence levels would be built up, so they could choose to progress onto other courses. One could argue that the power differentials in the relationship between the participants from this group and me as their teacher might have interfered with the study, but the advantages outweighed the potential drawbacks. These participants were classed as vulnerable, so our prior relationship helped both in terms of recruitment and knowing how best to interview them.

5.2.5 Participants in the mainstream group

This group was made up of students who had enrolled onto any of the other college mainstream courses such as B.Tech or A' levels or Hospitality and Catering, all of which involved external assessments. Many of these students would have initiated their enrolment themselves onto courses that were open to the general public.

5.2.6 Participants in the former-students group

This group was made up of students who had mental health problems but had left the college within the last few years. This included two students who had been unable to complete their courses.

Although I was in the unique position of both teaching these students and having help from the MHAs, recruitment was still a challenge. This was due to the restrictions imposed by the Data Protection Act (1998), which meant that I was only able to access present and past students who had contact

with the MHAs, as I had no direct access to their data. Consequently, aside from the students in the class that I taught, recruiting students for the two other groups was dependent on them having a prior relationship with the MHAs. Also, recruitment was challenging due to the restrictions imposed by the ethics committee, which will be outlined later.

In all cases the intention was to interview between five and ten students from each group, but I was only able to recruit five per group. This was the maximum who were willing to participate despite more being invited to do so. In terms of recruiting students for the mainstream group, I was offered more potential participants who were on Advanced (A') level courses but had to refuse them as they were below 18 years old and so were excluded from my study.

The demographic features of the student participants

No differentiation was made regarding the types of mental health problems the participants experienced and the participants were given the option to self-disclose about their mental health problems or not: all chose to do so. Six participants said they had been told they were experiencing depression; six reported schizophrenia; one reported schizo-affective disorder; one reported psychosis and one reported borderline personality disorder. Definitions of these diagnoses are in Appendix Two.

One possible limitation of the recruitment process was that the participants may not have been fully representative of the whole population of adult learners with mental health problems studying in this college. This was because they were students who already had contact with the MHAs and a good relationship with them. However, given the ethical restrictions imposed on whom I recruited, this was unavoidable as it would have been difficult to recruit any past students, had they not already had a positive prior relationship with the MHAs.

In relation to the levels of the courses that the participants were on, no differentiation was made, except for the five who were in my cookery class. One participant (Orla) was enrolled on two courses simultaneously. Orla wanted to remain in the discrete class for another term whilst she settled into

a higher-level catering course. Four participants were all on catering courses (excluding my cookery group) and the other courses represented were: Initial Teacher Training (two); A' levels (two); B.Tech (one); Bookkeeping (one). Although this was not planned, the classes provided a cross section of the range of courses, available in FE as they ranged from foundation level to level four (Appendix Three). No differentiation was made in terms of gender (eight males and seven females took part) or ethnicity or age (except for being over 18 years old), details of which can be seen in Appendix Three. The most common highest level of qualifications prior to joining their present course, as shown in Appendix Three, was level two (the level of education a school child in the UK is expected to reach by age 16). However, I had no means by which to authenticate these figures as some of the participants had been educated overseas and were unsure of the equivalence of their qualifications in terms of the UK education system.

5.3 Data collection

Prior to beginning data collection, I met with stakeholders to learn what they felt were the wider societal factors that may affect the lives of adults with mental health problems and to gather information about which services were currently available for this group of adults. This included meeting with NHS staff: the head Occupational Therapist of the local mental health unit and the head of the local mental health day rehabilitation centre. Within the college this included meeting with the Deputy Principal and the Mental Health Advisers. Finally, I met with a senior staff member within the mental health charity Mind. All these meetings provided invaluable material which greatly influenced the direction of the literature reviewed, the design of the study and the research questions. Data collection then happened in two stages. The first involved interviews with all the participants and the second, involved observing some of the participants in one of their classes.

The previous exploratory study which I had carried out in my discrete class served as a pilot for the design of this work. Three issues that arose from this study directly informed the design of the present study. These were that:

1. Although narrative interviews would be the most appropriate way to find out about the participants' lives, there would need to be some questions planned as some of the participants found it difficult to talk about themselves without prompting.
2. During the process of narrating their stories, there would a strong possibility that the participants may become upset or distressed. Due to this, the MHAs agreed to act as the gatekeepers in this research and also to be available to talk with any participants who became upset during their interviews, if the participants wished it.
3. A good rapport with the participants would need to be established very quickly during the interviews with those participants who did not already know me, due to the possibility of the sensitivity of the personal narratives that may emerge. Due to this, it was arranged that the MHAs would introduce me personally to the participants when they arrived and that I would begin each interview by gathering basic

demographic material. This would serve as an icebreaker, given that all the participants would be familiar with having to divulge such information in formal settings, as well as give me the chance to help them relax as I chatted informally with them whilst carrying out this task.

Stage one: the narrative interviews

Prior to the interviews, all participants were sent an information sheet (Appendix Five) which outlined the purpose of the research, what it would entail and how the findings would be disseminated. Participants were able to read this beforehand and ask questions verbally prior to signing the consent form in my presence (Appendix Five). At the end of the data collection period, all participants were sent thank you letters. The interviews with the participants took place on two occasions lasting on average 45-50 minutes; there was a three-month gap between the two interviews. All the interviews were audio recorded using software that was password protected and conducted on college premises in a soundproof room, adjacent to the office of the MHAs which most of the participants were familiar with.

The interview questions

All of the first interviews began with asking basic demographic information (Appendix Three). The process of devising questions to ask during the rest of the interview was informed by my previous exploratory study, teaching experience, theoretical framework, literature review and from talking with the MHAs, stakeholders, my own students and my university supervisors. The provisional list of potential questions was then discussed and further developed with the MHAs, in order to ensure that the questions could encourage the participants to talk freely about their experiences in college in a non-threatening way, within the constraints imposed by the NHS ethical approval that had been awarded.

The possible interview questions that were planned for the two rounds of interviews can be seen in Appendix Six. Brannen (2013, p. 5) suggests that the actual questions ‘can act as hooks upon which people choose to hang

their stories' in narrative research and so the questions were planned with a view to being loosely adhered to, to allow the participants to speak freely about what was important to them. Questions generally included those concerning how they came to begin their courses at college, which invariably meant that they discussed their mental health problems, as well as their lives outside of college and how they managed financially and socially. This then led onto questions regarding their actual experiences in the classroom and which teaching strategies have helped or hindered their learning; what they valued and hoped to achieve; whether and how they perceived their engagement in education to have influenced their achievements; barriers they had encountered; and the influence, positive or negative, of learning on their lives in general as well as on their mental health and well-being, although the latter word was not directly used. Invariably these questions were informed by the conceptual framework of transformative learning and so some questions were asked in relation to how they felt their learning had changed them intellectually, socially or emotionally. The questions in the second interviews included some questions that had been originally planned to be asked at this stage such as those relating to teaching and learning preferences. However, the second interview also contained questions that had arisen from the first round of interviews and so were influenced by the material that had been gathered, transcribed and analysed from them. For instance, an awareness emerged during the first interviews, that education was helping them in different ways from how they perceived that their healthcare provision helped them. Another example was that during the first interviews the participants spoke often about how helpful the MHAs had been and so this was then included in the second set of interviews in order to explore why this was so. Additionally, for those who had been observed in class, questions were asked in the second interviews relating to what had emerged from the class observations. However, the above list does not represent what each participant was actually asked due to the narrative nature of the interviews. Rather, they summarise the range of questions that arose during the interviews.

Reflexivity and power relations in this research setting

Reflexivity or critical reflection was an important aspect for me throughout this work and so a reflective diary was written throughout the whole of the data collection and analysis process. Although my reflections on the power differentials inherent in this study will be mentioned at relevant points throughout the thesis, it needs to be acknowledged that such an awareness undergirded my approach during the whole process, which was particularly important, given that I had multiple roles in the research. These roles included me being: the teacher of five of the participants; a teacher and authority figure to all the participants; a former nurse; a researcher; an insider given my past mental health problems; and an observer. Consequently, I was aware that this would invariably affect the power differentials in the research on many fronts. For instance, for the five of the participants whom I taught, I was aware that this may have led to them feeling coerced into taking part and possibly inhibited their levels of honesty if they did not want to disclose certain things or appear to be criticising me as their teacher. For the others, it was that as I was a teacher and authority figure, they might have felt obliged to respond in certain ways to my questioning.

Another reason why such reflexivity was important was because the work involved vulnerable participants and so I was mindful of the adage that 'in conducting research it is important not to add to the disempowerment of already disempowered groups' (Cohen, Manion and Morrison, 2011, p. 175). However, as will be illustrated below, given that nearly all the participants reported afterwards that they had enjoyed and benefited from taking part in the research interviews, I believe that I managed these power differentials well.

Reflexivity in the interview process

During the interviews there was an ever-present tension as to whether I was pushing the participants too much in my questioning, interjecting too frequently or subjectively biasing the results by asking questions in such a way that they confirmed what I was hoping to hear. Yet at the same time, I

deliberately tried not to be a detached neutral interviewer as this would have been inappropriate for this research and it would have severely limited what the participants said, had I not engaged in dialogue with them. Byrne (2012, p. 213) argued that instead of striving for neutrality, 'the interviewing process involves acknowledging that the researcher approaches the research from a specific position and this affects the approach taken, the questions asked, and the analysis produced.' To me, I believed that striving for detachment and not giving something back during the process would have been detrimental to the participants, which the feminist researcher Oakley (1981, p. 30) strongly argued, would be 'morally indefensible'. Oakley (1981) advocated that there must be some reciprocity within an interview in which there must be 'a relationship of mutual trust' (p56), which is what I strived for. Consequently, although I had not planned to disclose my own mental health history during the interviews, as I did not want to distract the participants, on a few occasions, I found myself doing so. Doing this did serve to equalise the power dynamics that are normally present between a researcher and participants although I was simultaneously mindful that it should not be used exploitatively to gather even more revealing material. At times, I also mentioned to some participants who appeared nervous, that I had been a nurse which seemed to relax them, but I did wonder if I did that in a manipulative way in the hope that they would be even more candid.

I was constantly aware that I needed to achieve a fine balance between talking enough to help the participant relax, and not talking too much that I dominated the interview. Equally, I was aware that I should allow silences to be left uninterrupted at times. Charmaz (2002, p. 303) suggested that silences may be either 'intended or imposed'. In this research this was not always easy to achieve. I was aware that a number of my participants were very nervous and so I was often tempted to 'fill' silences in order to avoid them feeling more awkward and unforthcoming. Yet I reflected that in terms of my very nervous participants, particularly those with whom I had had no prior relationship, it was vital that I did spend some time 'chatting' with them during the first ten minutes of the interview. This helped to lessen their nervousness and build a partial rapport with them which was especially

important, given that I was hoping they would speak to me about personal matters. Building this partial rapport proved to be invaluable as in some interviews the participants became upset (further discussed in the ethics section). However, the fact that all the participants returned for the second interview and in many cases, even contacted me asking when we could next meet, suggested that a good rapport had been established. When I asked them after the second interview, of their feelings about having been involved and whether it caused them any distress, and they said, 'no'. They said they had enjoyed talking to me because I worked at the college and had been recommended by the MHAs whom they said they greatly respected. The only exception was Gordon who told me that he had found some of our discussions upsetting due the memories they elicited, although he said that he did not need to talk to the MHAs afterwards about this.

At the beginning of the second interviews I summarised what I believed the participant had told me in their first interview, to check I had understood what they had meant and modifying it when necessary. In some ways this also served to empower the participants as they were directing me to the most salient features of their lives although I ultimately made the choice as to what to include in the findings and what to leave out. Additionally there was an awareness that during the three month gap between the two interviews, not only had the participants changed, but I as a researcher had too (Geertz, 1995). This was the case as having listened, transcribed and initially analysed the first interviews, my thinking had changed as I processed the narratives of the participants. Also, I was mindful in my listening and questioning that I as the narrator was influenced by the possible or imagined future audiences I would be presenting the narrative to (Bernstein, 1997).

One issue that arose was that the participants disclosed much more personal and upsetting information than I had fully anticipated, such as when Santosh disclosed about being raped and Reuben, George and Simon about their recent suicidal thoughts. Although I was pleased to be accessing such interesting material, it caused a dilemma for me in having to cope with them being upset and being careful not to cause them harm by allowing them to continue, as well as feeling pleased to be gathering such interesting stories.

Dickson-Swift *et al.* (2007, p. 343) suggested that a researcher can 'feel simultaneously excited and guilty by the data gathered', reflecting the conflicted position a researcher can find themselves in when interviewing vulnerable participants; I too felt this conflict.

On some occasions I was aware of feeling awkward when I heard something that I did not agree with or found offensive such as racist or sexist remarks, as well as negative information about other staff members. Byrne (2012) notes that there is no single appropriate response to these occurrences, but they require one to weigh up the need ethically to maintain a good relationship with the participants without causing offense or intruding. In one interview a participant (Orla) severely criticised an OT who assisted me in class and as I listened to the recording afterwards, I heard myself defending the OT in question. On reflection I think I should not have intervened and imposed my judgement of the situation onto the participant nor to have let my prior relationship with the participant and prior knowledge contaminate the research interview. Fortunately, Orla did not seem to take offence and continued speaking openly for the rest of the interview, but it did highlight one of the limitations of interviewing my own students and the challenges due to the power dynamics involved.

The strengths and limitations of using narrative interviews

Reflecting on the chosen design used in this study, I would affirm that adopting a narrative approach was an appropriate one**,** concurring with the proposition by Merriam and Kim (2012) that a narrative approach suits the theoretical framework of transformative learning. This is because participants did use the opportunity to convey their learning experiences through stories as they tried to make sense of their lives. These narratives led to many powerful personal stories being told, which spanned not only a huge range of aspects of their lives generally but also details of their past and present difficulties in relation to their mental health problems, their experiences in the classroom and for many, their disadvantaged living conditions too. In relation to the length of the interviews and the number conducted, although it may have been advantageous for me to have spent more time in the interviews,

the participants and I were both tired by the end of each one. Also, asking them to have attended a third interview may have been excessive and have led to some drop-out. In the case of the validity of the narrative told by the participant, over all I would argue that the truthfulness of what the participants were telling me in the interviews was upheld as their narratives resonated with my informal conversations with the Mental Health Advisers (MHAs), as well the class observations which I undertook for five of the participants.

Stage two: Observations in class

The intention was to carry out observations in class 'to gather "live" data from naturally occurring social situations' to gain first-hand accounts, supplement the interview data and provide rich description (Cohen, Manion and Morrison, 2011, p. 456). My aim was to see how the participants acted in a class setting with the hope that this would complement and elucidate the information the participants had given me in their first interviews as well as help to inform what I needed to ask them in their second interviews. As there can sometimes be a mismatch between what a participant says and what is going on, these observations were a useful way of watching how they engaged with their teachers, the other students and their academic subjects in order to help contextualise what they had told me in their first interviews.

The only group eligible to be observed were the mainstream group, as I taught the discrete group and the former-students group were no longer attending classes. Consideration was given regarding videotaping my own teaching sessions with the discrete group but from experience I have found that these particularly vulnerable students did not like the idea of being videotaped. Although the plan was to observe one class for each of the five participants in the mainstream group, one participant (Daisy) did not want me to observe her class as she did not want the teacher to know about her mental health problems. Consequently, only four participants were observed in their classes and consent was obtained from both the students in these classes and their teachers (Appendix Five).

In planning for these observations, I chose to undergo non participant observations despite being aware that inevitably my presence would have an influence on the participant. I planned to observe but not interfere with the lesson itself although this was not always easy (see below in the Sociology class). In each case I remained for the whole of the class and sat where I could easily view my participant and the teacher but also where I would be least intrusive in the class.

I took field notes throughout, one example of which is in Appendix Seven and aimed to observe both the verbal and nonverbal behaviour of the participant. During these observations, I attempted to watch systemically and note any interactions that the student had with their teacher, the other students and the assigned tasks, looking for irregularities that occurred in their behaviour and when and how they focussed on the set tasks. For instance, I observed that in the case of June, during most of the whole class teaching elements, she chose to work on her own work as opposed to what the teacher was currently teaching. Prompts included looking for verification of any of the points raised in the first interviews; noting how engaged the participant was with their class work during independent, paired and group learning tasks; noting their words, exclamations, movement, body language and facial expressions. Additionally, whether their behaviour displayed any signs of boredom, curiosity or lack of understanding; any dialogue the participant had with their teacher and similarly with their colleagues; any encounters that triggered a particular reaction form the participant; how the teacher responded to the participant's questions and the participant's level of involvement; how well they coped with any difficulties that arose within this setting. Lastly, I noted how the other people in the room responded to the participant generally.

There were limitations to what I was able to take notice of and record such as only being able to record accurately what was in front of my eyes as I struggled to write my observations down quickly, whilst trying not to miss what was going on elsewhere in the classroom. Nonetheless within the constraints of such limitations I found it to be very worthwhile, especially as it reinforced what had been said in the first interviews as well as giving me a

wider perspective of the context in which participants were learning. With regard to the material gathered during my observations in the classroom, I endeavoured to give a trustworthy record of what I had observed. This endeavour was in recognition that these were subjective interpretations, dependent on recording the encounters I perceived as being noteworthy.

Reflexivity in relation to the class observations

One common criticism regarding unstructured observations is that they are prone to bias in terms of the fact that it is subjective; it is the observer who decides what is worth recording. Considering this, a reflective diary was written up immediately after each observation. As a teacher I found it very difficult to be an observer who did not affect the dynamics in the classroom. In most cases I was able to remain in the background except in the catering class as it took place in a working kitchen and lasted five hours. However, I deliberately spent time with each member of the class to minimise the chances of the students guessing I was there to focus mainly on Danny. However, it was difficult to be inconspicuous in the Sociology class (June's class) where the teacher chose to introduce me and ask me to explain why I was there and what my research was about. Although I did comply with this request, I did so in a guarded way as I did not want to identify the student I was there to observe. Another unexpected problem that arose in this class was that the Sociology teacher began to talk to me about the participant I was observing, which would have exposed June as being the focus of my research interest. I had to politely explain again to the teacher that it was important that June was not identified in this way.

A critical incident refers to an event occurring 'which can reveal an extremely important insight into a person or situation' (Cohen, Manion and Morrison, 2011, p. 464) and one such incident did occur, whilst I was observing Charlie in his bookkeeping class. The class observation took place one week before the students would be sitting a summative external exam, and so Charlie was answering a mock exam paper in this class. Unfortunately, he was told at the end of the class by the teacher that he had obtained a very low mark which

would constitute a ‘fail’ in the forthcoming exam. On hearing this news, Charlie was visibly upset and so due to his upset I felt that I could not leave the class immediately after it finished, as I had planned. Consequently, I waited for him and chatted to him as we walked out of college, seeking to reassure him regarding his forthcoming revision to allay his obvious distress and disappointment. Should I have done this as an observer? Perhaps not, but my concern for the well-being of the vulnerable participant outweighed research protocol, I believed. This was strengthened by a realisation that possibly the research process itself had impacted him negatively as being seen to fail in front of me, may have added to his embarrassment and distress. This strengthens the argument by Oakley (1981) that there must be reciprocity in a research setting. By the time we parted he was calm and in his next interview he told me he had been fine after he left me and that what I had advised him had been helpful.

The strengths and limitations of carrying out observations

The class observations were invaluable in expanding my understanding of the context in which these participants were learning, helping to give a fuller picture of how they operated within the classroom and interacted with their teachers and other students. Additionally, the observations gave me information that I could not pick up from the interviews alone: listening to the stories of Danny and June, I surmised that the negative experiences which they encountered in college were extremely detrimental to their learning. Yet when observing them in class and from my informal conversations with the MHAs, I came to realise that the student services, registry departments and certain teachers had given these two students an enhanced level of support that other students would not have been given. This led me to reflect that had I only interviewed June and Danny, I would have concluded that most of their experience of being in college had been negative whereas this was not the whole story. This reinforced how useful it was to have included class observations to collect data. However, I was aware that observing only one class per participant due to time constraints was a limitation, as one observation may not have been representative of how they engaged in all their other classes, with different teachers and students.

5.4 Data Analysis

The process of analysis began with the transcription process when I transcribed 25 of the 30 scripts; five were transcribed professionally due to time constraints. During this process I kept a diary of emerging ideas which I used when carrying out thematic analysis on each script. I did consider returning these transcripts to the participants as this has been argued to be one way in which one can ensure the trustworthiness of what a researcher has transcribed. Riessman (1993, p. 197) suggested that, 'The credibility of an investigator's representation is strengthened if it is recognisable to participants', but this was not possible for this study although the matter was discussed with the gatekeepers. We concluded that as six months had lapsed since the interviews and as we could not know the current mental state of the participants, some of whom were no longer attending the college, it was deemed as ethically dangerous to subject them to reading what they had said before, in case it triggered a negative memory or emotional reaction.

Analysing the transcripts

My aim throughout the process of analysis was to identify the 'themes' told by a participant (Riessman, 2008). This process began after the first interviews, prior to the second round of interviews. This was an iterative process as even when writing the final chapters of this thesis, I still went back to some of the recordings to check certain aspects. The first thing I did was immerse myself in the interview scripts. This involved not only reading each individual script a number of times but also listening again to certain parts of the recordings. Such immersion influenced some of what I chose to look out for in the observations and what to include in the second round of interviews. Analysis then continued in greater depth after completing all the interviews and observations. The process followed three main stages as outlined by King and Horrocks (2010, p. 153): first, I developed 'descriptive coding' as I read all the transcripts a few times each, highlighting relevant comments and material as well as defining descriptive codes. Second, I worked on

clustering these codes in order to develop ‘interpretive codes’ (ibid.), in relation my research questions and underpinning theoretical perspective by looking for any material that related to the questions I had devised as well as any other material, before beginning to write interpretative codes onto the scripts as they emerged (see Appendix eight for an example of one annotated script).

I analysed only one group of participants at a time in order to immerse myself firstly with individual participants before attempting to identify themes for the group. From this individual level of analysis I was then able to write a brief narrative summary in the form of a pen portrait for each participant, which helped to clarify my thinking of what seemed to be emerging for each individual. Following this I devised two tables of codes that appeared to occur: one table contained the answers to the generic interview questions that some people had been asked, although this differed from person to person as it was not a structured interview; the other table contained the initial codes that had arisen spontaneously (Appendix Eight). Having made up the tables I devised one mind map per person to move away from a linear process of analysis and try to collate the codes into themes (Appendix Eight). Following this, I devised a mind map for a whole group. This process of assembling codes enabled me to move onto the third stage, that of developing ‘overarching themes’ (King and Horrocks, 2010, p. 153). This process of identifying themes was replicated for all the three groups leading to a comparison at the end of all the mind maps, from which prevalent sub and main themes emerged. Having reached a consensus on the four emerging main themes, I cut and pasted each relevant quotation into the separate themes before writing up one chapter per group for the themes.

Incorporating the observational data

For those who had been observed in class, I combined the field notes with the interview transcripts. This enabled me to continue noting possible codes and emerging themes, in a similar way to how I had worked with the other interview transcripts. Again, this informed some of my questions for the second interviews for these students. For example, I had been surprised to

observe in class that Prem, who I knew from her first interview to be a conscientious learner, had failed to complete the set homework, alongside her colleagues. Consequently, I asked her about this issue in the second interview and her answer then provided material that contributed to the theme of the 'negative aspects of learning' (7.4) for the mainstream group. Equally for Danny, during the observation I thought that his teacher was supportive at times, despite what Danny had said in his first interview; we discussed this in his second interview. Additionally, Danny had spoken in his first interview of the frustration he felt when his peers were less motivated than he was in class; the observations confirmed this to be true and contributed to one of the main themes (7,4). Overall, the observational data served to expand on the first interviews and help to elucidate what the participants had previously said.

Given that this analysis took place in relation to a narrative approach, an effort was made to retain the stories that the participants were creating themselves, whilst trying to keep the sequencing of it too as well as being mindful of the prior theories that guided the study. Additionally, I was aware of the co-constructed element of my attempt to analyse and interpret these narratives. Finally, at different points during this process, I discussed some of the scripts with my supervisors as well as analysing them in a group setting with other PhD students, to establish some agreement on my interpretations.

In terms of trustworthiness, I ensured that I was explicit and transparent in detailing the steps in the analyses process. From an ethical stance, I strove to avoid manipulating the data to fit into any preconceived ideas of what I hoped to find or to misrepresent the narratives. Consequently, I believe that my results presented a fair picture of what I had interpreted from the participants' accounts; this concurred with Hammersley (2002, p. 19) who argued that 'knowledge claims are valid if they accurately represent the relevant facts of the matter'.

5.5 Ethical issues

This section discusses the ethical aspects of this research in detail given that the participants who were interviewed were classed as vulnerable adults in the BERA (2011) guidelines Nos. 16-21. The other participants were the teachers and students in the classes in which I carried out observations. According to Oliver (2003, p. 35) vulnerable participants are those 'who may not have the required degree of understanding (for whatever reason) to give their informed consent to participation in research'. Consequently, consideration was paid to ensure they did not adversely suffer because of taking part. To protect the vulnerable participants, the inclusion and exclusion criteria were agreed with the NHS staff (the Head OT and MHAs). The inclusion criteria stipulated that I could only interview students on the discrete course who had attended for at least one term and that all participation was voluntary with no coercion involved. The exclusion criteria was that I could not include current inpatients; anyone who became mentally unwell and was admitted to hospital during the research period; anyone who mentally declined during the research period; anyone that the MHAs and I decided did not have the capacity to give fully informed consent in line with the Mental Capacity Act (2005). Lastly, I could not involve any students who came to the college via the forensics route (ex-offenders) as this would have required different ethical approval. The ethics application process was time consuming due to having to communicate with two different institutions; this is outlined in Appendix Four alongside the necessary ethical approval from the NHS Ethics Subcommittee**.** As I had taught adult students with mental health difficulties for several years, alongside my professional training, and the fact I had already carried out a study among such students, I was confident that I had the resources to cope should any unforeseen difficulties arise, despite my dual role as teacher and researcher. I already had an up to date Disclosure and Barring Service Certificate and perceived no risk to myself as a researcher given my professional experience.

The MHAs agreed to act as gatekeepers, which served to strengthen the safeguarding of the participants as well as to help me with any ethical or

disclosure matters that may have arisen unexpectedly during data collection. Oliver (2003) suggested that when interviewing vulnerable groups, ethical decision making should be a gradual process, judging the effects of the research incrementally, as one cannot always anticipate what areas of difficulty may arise. Being able to collaborate with the MHAs at different points during the data collection proved to be invaluable. One example was when Gordon arrived for his second interview and said that he felt unwell physically and depressed in mood, but still wanted to carry out the interview. Following consultation with the MHAs, the interview did take place and Gordon reported no ill effects afterwards.

The social utility of the research

It was important to weigh up the potential social benefits of carrying out the research relative to the personal cost of doing so for the participant (Cohen, Manion and Morrison, 2011). Given that the study involved an underrepresented group of students, I would argue that the potential benefits of carrying out this piece of research did outweigh the potential costs. Although interviewing can at times seem to be an intrusion of privacy, it was the best way to enable the actual voices of this group of students to be heard, and so the social utility of the research made this potential intrusion worthwhile. Oliver (2003, p. 35) suggested that the research process can enable participants to have an 'enhanced sense of their own worth', not least because it can enable the participant to articulate and reflect on some complex issues which may help them to clarify their own thinking. After the interviews had finished nearly all the participants said they had enjoyed being involved and that for most of them it was helpful to reflect on these issues.

Informed consent

The underpinning values of informed consent derive from the value of one's right to freedom and self-determination and so when participants are asked to be involved in research that may in some way limit their freedom, they must be asked to agree to this limitation. In order to achieve this informed consent however, Frankfort - Nachmias and Nachmias (1997) suggest that four elements must be present: competency, full information, comprehension

and voluntarism, all of which guided my study. Competency was a concern in relation to these vulnerable participants, as it could be suggested that some of them were not mentally competent or capable of fully comprehending the study and thus not capable of making an informed choice. I would challenge such a suggestion as undermining the abilities of my participants, and as (Oliver, 2003) pointed out, it is both condescending and constitutes direct discrimination (Equality Act, 2010 Section 13). However, it was an important issue to consider as part of the ethics approval process and so it was agreed that the MHAs and I would not ask any participants to take part who we all deemed did not have the capacity to give fully informed consent in line with the Mental Capacity Act (2005).

Regarding full information and comprehension, the information sheet was explicit and simple (Appendix Five) and posted to participants beforehand to give them time to read it and ask for any clarification verbally before they signed the consent form. This comprehension was essential as informed consent must also include informed refusal, so participants needed to fully understand that they had the right to withdraw from the interview at any point, with no pressure being imposed on them to continue. Here the ethical issue was of promise-keeping (Oliver, 2003): that I would keep to the promises I made concerning them being able to withdraw at any stage of the process, even if it was disappointing for me when they did. This right to withdraw was particularly important in the case of this research study as in my previous study, one of the participants became very upset during an interview which led to my offer to terminate it, which the participant declined. The fact is that allowing such upset is not permissible when involving vulnerable participants, as BERA (2011) specifically stated that researchers 'must desist immediately from any actions, ensuing from the research process, that cause emotional or other harm' (No.18). Provision for this occurrence was made in the consent form which included a clause saying that if they became upset the interview could be stopped and the MHAs would be available for them to talk to (Appendix Five). During their first interviews, two participants did begin to cry (Santosh and Orla) and although I asked them both if they wished to stop the

interviews, they declined to do so; fortunately, no negative consequences were reported by the participants afterwards.

An awareness of the possibility of the participants feeling coerced into taking part, due to the power differentials involved, led me to stress to them that they were under no compulsion to take part as it was purely voluntary to do so. Additionally, as a way of thanking the participants for taking part in the research a £10 voucher was given after completion of the second interview. Although some may see this as bribery, I would argue that it was as remuneration for their participation and could be argued as being a way of equalising the power differentials: 'our money for their time' (Hollway and Jefferson, 2000, p. 84).

Confidentiality

Confidentiality was promised as participants are entitled to privacy, akin to other human rights. An explicit statement was made to the participants about who would have access to the material and how it would be retained, as part of gaining informed consent. This included the clause that if a participant became distressed during an interview, the MHAs would be informed. Omitting this clause would have contravened a promise of confidentiality. Another important aspect was to ensure that I did not tell other college staff of a participant's specific mental health diagnosis unless the participant had given me permission to do so. Also, I was conscious that as some of the participants were also my current students whose relationship with me continued beyond the research itself, I needed to ensure that I did not refer in class to anything they had told me within the research setting; to do so would have been breaking my promise of confidentiality.

Anonymity

Another area of consideration was that of ensuring anonymity as this is the cornerstone of any research study. To achieve this, students were told that they would be given aliases reflecting their gender and ethnic origin in written documentation; it was hoped that this helped them to feel they could speak freely, with no fear of redress from the institution. However, one caveat is that this anonymity may enable the participants to feel liberated and

uninhibited and so it was necessary to caution them that they should attempt to be as balanced and objective as they can. Additionally, fictional names were given in the written texts to any of the individuals who were mentioned by the participants in order to protect those people too. Finally this anonymity was also applied to the institutions involved in order to ensure no one was identifiable or traceable. (Data Protection Act for Social Research, 2005). I did not offer the full set of results to be made available on completion of the thesis although I promised to send a short summary to the two participants who requested them. However, since carrying out the work I decided that I would invite all the participants to attend a follow-up session during which I would feedback about my findings.

Ethical considerations in relation to other teachers and students

During the class observations, the need to give informed consent, alongside a promise of anonymity and confidentiality applied equally to the teachers as well as all of the students present and so both groups signed consent forms (Appendix five). Students were told, in order to avoid identifying my participants as being the focus of my observations, that I was looking at ways in which education can support well-being and no one questioned this. Reassurance was given concerning confidentiality and that I would not be reporting anything back to their teacher.

Although there was less of a risk of the teachers feeling coerced into taking part, there was a possibility that my presence would have been construed as being threatening and I was mindful of the fact that I would be continuing to be working alongside some of these teachers and so did not want to jeopardise that relationship. To minimise this, I explained what my role would be in the classroom: not as a fellow teacher observing a lesson to assess standards, but as a researcher who solely wanted to observe the interactions between my student participant and the class. The teachers seemed to enjoy my presence in their classes and all kindly offered me additional help if needed in the future. Although I was aware that ethical dilemmas may have arisen had I observed poor teaching or the mistreating of a student, fortuitously I did not witness anything I was uneasy about.

The teachers were fully informed as to the true nature of the observation although I deliberately did not discuss with the teacher the nature of the mental health problems difficulty that their observed student had. However, as I had to protect my participant from the rest of the class knowing they had a mental health problem and that I already knew them, a small measure of deception was necessary with the other students. This was justified ethically to protect my vulnerable participant from being identified.

Secure storage of data

In line with the NHS ethical restrictions a voice recorder with password protection was used and 25/30 interviews were transcribed by myself on a personal PC. This was password protected and backed up on a password protected USB stick locked away with the other data. Five interviews were transcribed by a reputable transcription company in a manner which protected the anonymity of the participants.

I was the only person with access to the data and after completion of the PhD and associated journal articles, hard copies will be securely disposed of using a cross cutter shredder. The data will also be cleared digitally using a data clearing software such as 'Secure Ease' in line with NHS requirements for the electronic files. The consent forms and data were stored at home in a lockable filing cabinet to which only I had access.

Ethical considerations during the interviews and observations

Aside from the aforementioned ethical considerations outlined above, I was also aware of the need to conduct the data collection itself in an ethical manner. During the interviews, as outlined earlier (page 105), I was mindful of ensuring that I did not cause any harm to the vulnerable participants (BERA, 2011, p. No. 18). Consequently support from the gatekeepers was made available to the participants.

Nevertheless, another ethical consideration emerged once the interviews began: the importance of opening and closing the interviews in an ethical manner. As discussed earlier (page 107), I realised that I needed to open the interviews in a way that could quickly help towards building a partial rapport

with the participants, especially for the many I had no prior relationship with. To achieve this I called upon my previous nursing training regarding the best way to conduct interviews with vulnerable patients. This included aiming to begin the conversation in a non-threatening way, as well as reiterating safeguarding issues and displaying my pastoral concern for their wellbeing. This easing into the interview helped to lessen their nervousness given their possible fears and ignorance regarding how the interview may proceed.

In addition to this I realised that closing the interview was equally as important and so I deliberately told the participants five minutes before the end of their interviews that it would be finishing soon and by changing the conversation to more neutral generic topics. Given that many participants had revealed personal, upsetting events, I needed to prepare them for leaving the interview in an emotionally safe way. This helped me to achieve 'a relationship of mutual trust' (Oakley, 1981, p. 56) as it became clear that it would have been ethically irresponsible to have not done so.

However, in addition to employing these 'opening and closing' skills when interviewing, it was found that these were also necessary during one of the observations when a critical incident happened with Charlie (see page 111). In order to ethically ensure that he was safe when leaving the class in which he became distressed, I deliberately waited for him afterwards. I then employed the aforementioned pastoral skills by giving him the opportunity to talk about the class, if he so wished to. Before we parted, I used my pedagogical skills as a teacher to help him plan how best to revise for the forthcoming exam. Again, this appeared to contribute to him recovering emotionally from this upsetting incident before he left the college, which he confirmed to be the case when asked in his second interview. Using both my nursing and pedagogical skills illuminated how important it is for researchers to consider how to safely open and close their encounters with vulnerable participants, in order to ensure that no harm is experienced by the participants as a result of the research process.

Summary

This chapter has outlined three important aspects of the research. The first aspect was in relation to the methodological approach adopted to carry out this study. The second aspect related to the methods that were employed and the third aspect referred to the ethical aspects of this work, which were particularly important given that all the participants were classed as vulnerable adults. The next three chapters will outline the findings from all three groups.

Chapter 6 Findings: discrete group participants

Introduction

This section sets out the findings from an analysis of the interviews with participants attending the discrete course. These attended the cookery course I taught, alongside the support of two Occupational Therapists (OTs). This course was only open to people with mental health problems who had been invited to join by the mental health team.

The quotations throughout the next three chapters are intentionally extensive as I resisted the temptation to summarise the narratives of the participants, instead of letting the reader hear their actual voices. This was because the study was set up in order to enable this often-unheard group of adults, tell of their personal experiences of learning and so my desire is that the reader is left with the participants' own words, as opposed to mine. Also, it is worth noting that some participants spoke much more than others e.g. in groups two and three, which is why a variation will be seen in the length of the quotations.

First, pen portraits will give brief background information on the five participants who were interviewed and second the three main themes that emerged from this group will be explained. These are: the negative impact of their mental health problems; the pre-requisites for learning and how learning helped their sense of well-being.

6.1 Pen portraits for the discrete group

Orla

Orla[6] was a white Irish woman who was approximately aged 60 and lived with her husband and one of her four grown up children. Orla had been working full time in a care home when she became severely depressed two to three years ago; this had led to a very low mood as well as shaking and trembling badly. Orla spent six months on a psychiatric ward due to this but was now, she said, keeping mentally well.

Although Orla said that she had enjoyed school, she had had to leave at 16 for economic reasons and so worked as a waitress in a hotel. Since then, whilst bringing up her family, she had worked in care, looking after mainly elderly people which she enjoyed, given her original aspiration to train as a nurse. At the time of the interviews Orla had completed one term on the discrete foundation class but was also already, simultaneously attending a level two course (same level as GCSE exams). This was in Hospitality and Catering, a two-year course, requiring a three day a week commitment. Orla hoped that on completion of level two she would be able to get a job cooking in a school or similar.

[6] All names of participants and staff have been changed to protect anonymity

Colin

Colin, a 41-year-old West Indian man, lived alone in supported accommodation near his foster parents whom he visited weekly. He said they were supportive and that he and his brother had been fostered by them when Colin was seven. Colin said that eight years ago he had been admitted to an acute psychiatric ward and sectioned, although he had no recollection of feeling unwell. There he remained as an inpatient for eight months and was given a diagnosis of paranoid schizophrenia. He reported that his mental health was now good.

On leaving school Colin had been trained in cabinet making but had not worked since his mental health difficulty emerged. He loved designing, entering design competitions and making objects; his latest project was an electric harp. He said he liked to structure his week by attending various classes or groups such as badminton or dance or cookery. The extreme fatigue and shaky hands that his psychiatric medications caused, prohibited him from working with the machinery that his training used. In its place he intended to continue with different courses and working on his own design projects.

Louise

Louise was a 50-year-old Caribbean lady who came over to UK aged 44. She married but her husband (now deceased) became violent and so she ran away and lived on the streets for four years, hiding from him. She had a grown-up son in America who was unaware of her living conditions. Although Louise was no longer homeless and now lived in supported accommodation, due to problems with her immigration status (her husband, she said, had destroyed all her identification papers) she was refused welfare benefits. Subsequently she relied on £10 a week widow's pension and shopping vouchers from the mental health unit. She regularly used the local Food Bank[7]. Louise's period of homelessness ended when she tried to commit suicide on two occasions. It was then she was admitted into psychiatric care and given a diagnosis of paranoid schizophrenia. This involved problems with auditory hallucinations causing much anguish and numerous relapses.

Prior to Louise escaping her domestic violence situation, she worked with children with special needs in a school, which she loved. She left this job as her husband tried to find her there after she had left him. She was now eager to learn and was involved in English and Maths classes and groups such as knitting, gardening, swimming and badminton. In addition to this she was a volunteer helper at a local hospice. Louise longed to be able to get back working with vulnerable children or vulnerable adults.

[7] This is a place where people in need can be supplied with basic provisions and non-perishable items, donated by the public.

Egren

Egren, a 54-year-old West African woman lived with her older third husband who had multiple medical, physical and mental difficulties. They lived in supported accommodation which was intended for single occupancy only. Her fourth daughter was12 years old and lived with one of her older sisters in Africa which Egren was happy about as when she was hospitalised, her daughter had had to go into foster care in England on a few occasions. Egren first became mentally unwell following the death of her father; she was sectioned and remained in hospital for three months. She had frequent relapses requiring differing periods of hospitalisation and she believed she had been given a diagnosis of depression although at times this shifted to paranoid schizophrenia.

Egren had worked as a domestic assistant and looked after disabled children in their homes. Having enjoyed school, which she had to leave early due to being married whilst still a pupil, she was keen to learn and had been on a few FE courses when well enough. She had volunteered to join the cookery class after hearing it mentioned whilst in hospital. Employment was not an option for Egren as she said that her doctor said she was too fragile mentally to work. Consequently, she spent her time caring for her disabled husband and now hoped to enrol on another course after completing cookery.

Joan

Joan was a 49-year-old woman who grew up in England and whose mother was Chinese and father (now deceased) was Jamaican. Although she now lived in supported accommodation alone, she had formerly lived with her fiancé, who was 37 years older than her, for 15 years before he died. Joan said that she had a strong family network and that she and her mother attended their local church regularly, which Joan said was a great source of comfort for her. Joan had had a 'couple of breakdowns' beginning when she was 28/29, although she was not sectioned until after her fiancé died. She said that she had been diagnosed with schizo-affective disorder which included experiencing hallucinations but had not been admitted to hospital for 12 years. She was currently on a high dose of medication as she had been experiencing a higher incidence of auditory hallucinations which had led to a recent relapse.

Joan had studied languages at university at both undergraduate and Master's level however she had no desire to do any more academic study as she felt it would not aid her chances of employment**.** Aside from the cookery class Joan also went to an art group, a computer course and a group at the mental health charity Mind. Joan was hoping to improve her computer skills to get some employment although she was unsure if she could mentally cope with working. She also wanted to attend a patisserie class.

6.2 The negative effects of the participants' mental health problems

The sub themes in this section were of their traumatic memories of being in hospital; the fragility of their mental health and concerns of relapsing; the presence and intrusiveness of auditory hallucinations; the side effects of their medications affecting their lives and learning; shame, stigma and disclosure issues and courage and perseverance.

Traumatic memories of hospital

A common theme that participants raised when they explained why they joined the class, were recollections of trauma associated with being hospitalised. As Orla recounted when asked why coming to class had helped her so much:

> Because I was in hospital for the best part of six months and the only time out was when I would go home at the weekend. Don't forget it was New Year's Eve in the hospital *(she begins to cry at the memory).*

Colin's reference to hospital was summed up by the word 'punishment' which he then refined to:

> Well, it was not really punishment. I don't know how to explain it but I was interviewed by a doctor who thought that I was slightly unwell, so he asked me to stay and that was the beginning of it all. It was just a lonely time for me.

Louise spoke of her time in hospital in both a positive and a negative light. Positively, going into hospital for Louise was a relief as she had been living on the streets for four years:

> But when I ended up in the hospital I find now that it's better 'cos that's how I got the accommodation. I came off the street when I was in hospital. I had a good bed, clean water, I had a shower. But you were being pumped up with medications and your head is heavy.

Egren also said that hospital had been helpful most of the time but she still had painful memories:

> Because the environment of hospital for me is not a good memory. It's like, what will happen after the group, am I going back to the

> ward or going to a meeting? I saw other patients who were very seriously ill…and I used to think of when I leave the hospital. 'Where will I go'? Because I was homeless.

Finally Joan recalled her first admission and her mother's desperate attempts to try to help as best she could:

> My mum was very worried. I remember her coming into hospital with crucifixes and hanging one around my neck. We tended to think it was more Satan getting at you as well as being just an illness.

These traumatic memories caused a number of participants to become upset whilst they were recalling them which was in stark contrast to when they later spoke with excitement about how they were benefiting from coming to college.

The fragility of mental health and concerns of relapsing

A frequent issue that emerged from accounts of Louise, Egren and Joan was how fragile and unpredictable their mental health was at certain times and during the academic year, three of this group had relapses. Egren, spoke of relapse indicators for her as being:

> Egren: I start not sleeping and getting upset and thinking of dying.
>
> Interviewer: Do you mean committing suicide?
>
> Egren: Yes, I feel like I just want to die. Life is boring. What I realise now is that anytime I want to do a bit more, push a bit, I have a relapse.

Joan also spoke of relapses, which she said she could spot: 'I can tell because the voices will get worse' and although her relapses did not always lead to a hospital admission, they often resulted in an increased dosage of her anti-psychotic drugs.

The presence and intrusiveness of auditory hallucinations

For Louise and Joan auditory hallucinations, or' voices' as they referred to them, were an ever-present difficulty particularly as they were intrusive, persecutory and hard to control. In both cases the voices interrupted their sleep, adding to their tiredness levels and in Louise's case they also

interrupted her work in class. If in class she was working alongside someone, she would imagine they were reprimanding her and saying negative things. She had developed strategies to try to counteract this:

> Louise: And I have to speak out. Sometimes I use my headphones. Someone would think I'm listening to the radio or something and then I will speak out something positive.
>
> Interviewer: And when you are in class would you hear those voices sometimes?
>
> Louise: Only sometimes if I'm struggling with anything as they say, 'I told you, you can't do it'. The voices are telling you should you sit down or stand up so you are not in control.

Joan also spoke of being unable to control the voices currently:

> I've also been hearing a lot of voices giving me some racist abuse unfortunately, saying 'black' and 'nigger'. And I was thinking that any time I hear the voices that say 'black', I keep thinking, 'cos my mum is Chinese and I like to look Chinese so I keep trying to make the focus on 'I'm more Chinese'.

These extracts give a flavour of the daily battles that people with severe and enduring mental health problems have to overcome in order to function each day.

Side effects of medication impacting life and learning

The negative side effects of medication were mentioned by all participants at some point as they commented on the drowsiness that such medications caused during the day, especially when in class. As Colin described:

> Yea it seems a bit weird on the medication. It makes you want to sleep extra and you feel like a bit of a big baby.

Despite this, they all recognised how important the medications were, as Louise related how she had tried to come off them of her own volition but had deteriorated and had to go back onto them. Additionally, Louise and Joan spoke of striking the balance of needing the medications to subdue the voices that kept them awake at night yet having to live with the consequences. Colin mentioned the hand tremors that he experienced, which

meant he could not work as a cabinet maker. Finally, Egren spoke of the delicate balance between the good and bad elements of medication:

> The medication tries to keep my moods stable. And you do the medication and at night you feel like you are drunk and in the morning you still wake up tired. When I started taking the medication, that's when it became a bit difficult because, going to school, learning and drinking medication is hard.

Such responses highlight the ambivalent relationship that the participants had with their medication: gratitude for the diminishing of negative symptoms, alongside frustration with the drowsiness that they also bring.

Shame, stigma and disclosure issues

The theme of the shame felt due to the stigma attached to mental illness was mentioned several times although Orla felt that due to the media exposure of celebrities talking about their mental health problems, there was less stigma attached to it nowadays. Yet, she was certain that she did not want her mental health problems disclosed to either her teachers or classmates on the higher-level course as she felt they 'did not need to know'. Colin was not concerned about the issue of disclosure, but Louise did feel shame in relation to her diagnosis. This was particularly in light of not wanting to bring dishonour on her son who was doing well in his job in America, as she said:

> Louise: And I don't want to bring shame on him, with my shame. So, I just thought about ending it.
>
> Interviewer: Do you think there is still a stigma in society or ignorance?
>
> Louise: Ignorance, it is something that can happen not just to certain people, but to anyone. Today everything is fine and tomorrow you have a breakdown.

However, although Louise felt ashamed it did not prevent her from disclosing her mental health problems to her teachers as she said:

> Louise: The teacher knows about my background, but the students don't.
>
> Interviewer: Has it been helpful that the teacher knows?
>
> Louise: Yes, it's been helpful 'cos they include you in everything.

Joan did feel the pain of the stigma acutely, in association with her experiencing hallucinations:

> Joan: Well I haven't actually told them *(her family*) that I'm hearing voices as I'm a bit ashamed due to the stigma. I just tell them nervous breakdown.
>
> Interviewer: Why do you think you feel ashamed about hearing the voices?
>
> Joan: Because, I think people might not like me or think I might become a bit violent but I'm peace loving, I'm not violent at all but sometimes the voices tell you to do something, ''cos a lot of schizophrenics might hear voices to kick someone or something. And they go and do it, they listen to the voice, but not me. And I'm especially worried about getting a job. What am I going to say to an employer, because it does make a difference?

From these extracts one is given a glimpse of the fears relating to disclosure that all the participants in this group experienced, except Colin.

Courage and perseverance

One overarching theme that permeated interviews was how much courage and perseverance these participants displayed in overcoming their difficulties. Orla displayed tenacity in her determination not to make 'hospital your second home' and continuing at college even when she had an operation on her fingers. Louise spoke often of how coming to class always involved a fight mentally to counteract the negative voices which were trying to persuade her not to go:

> Interviewer: So when you are tempted to turn back are the voices saying, 'Why are you even going'?
>
> Louise: Yes, and you open the door and it's like you are being dragged back and I fight and I fight and I do the exercise, of speaking out (*to the voices*). Like today as I run out to come here I left the sheet behind (*participant information sheet that I had given her to read*). All I heard was 'You see, that will show that you are not really even interested'. But whatever college or sessions I go to, by the end of it I am loving it. I realise there must be something there for me to do because it's not hard to kill yourself; it's very easy and if you made two (*suicide)* attempts and you are still here then there must be a reason.

This persevering attitude of working hard to overcome such difficulties was also present in Egren's interview as she said: 'I try not to let myself down; I try to be strong'. This was despite the ever-present possibility of relapse. For Joan, the evidence of how courageous she was in trying to overcome the difficulties that her illness caused was apparent as she said:

> I'm slowly building up my life. I can't tell you how difficult it has been to build up my life, and I've been building up my life slowly.

For Joan, her deepest disappointment was the lack of cure there was for mental health problems:

> If it were a bladder problem, it can be cured, but I would walk the length of Britain if I could find a cure. I mean they've given me medication and I appreciate (*that*), because I've got two degrees, and it's the best doctors can do but they haven't found a cure, a total cure. Hopefully they will one day, so that the voices can be eliminated completely.

This last comment was particularly pertinent given the paucity of money available for mental health research, in comparison to that for physical health (see chapter two).

6.3 The pre-requisites for learning

What became apparent throughout the interviews was that there seemed to be certain underlying needs that were required to be met before the participants were in a place to engage fully in learning. These subthemes were: the need for shelter, money and food; the need to feel safe in the classroom; the need to feel well enough to learn; the need for graduated progression; the need for a positive relationship with the teacher and the need to have teaching and learning strategies that aided learning

The need for shelter, money and food

A number mentioned that at the points when their struggles with basic living issues relating to shelter, money and food were dominating their lives, it was difficult to engage fully in learning, time wise and mentally. For instance, both Louise and Egren spoke of having periods of homelessness, which in Louise's case extended to four years of living on the streets or hiding in garden sheds, night buses and churches; she said that she could not have been in education at those points.

Having enough money to live on was a problem for several participants. Both Louise and Egren were currently not eligible for welfare support because of issues related to their immigration status. Consequently, Egren attended numerous appointments, which meant she was unable to commit to a more demanding course time wise as she said:

> At the moment yes, because I have a lot of appointments: benefit and housing. Yea, nearly every week I have appointments. So many.

However, by the second interview when she had these issues sorted out, she said she would consider a class with a bigger commitment time wise.

Louise's money struggles spanned a long-time period which had affected her ability to attend as many classes as she would have liked. She was determined to still come to the class even though she had many absences due to her mental health problems and trying to sort these issues out. However, one added benefit of attending the cookery class was that it

provided her with a hot meal each week and food to take home afterwards as eating healthily was a problem:

> I've been waiting for months to get Employment Support Allowance (ESA) and a freedom pass for the bus. I get £40 month for a widow's pension. Food wise, it's hard to get fresh stuff as it canned and tinned at the Food Bank.

In Joan's case it was the threat of the welfare benefit changes that was worrying her greatly and impacting her possible commitment to education; she feared that her ESA would be removed as the benefits agency would re-assess her and tell her that she must be self-supporting in a job. Given her precarious mental health and not having been in the job market for many years, this was causing her much anxiety which seemed to be leading her to become depressed:

> I haven't worked for so long and I'm really worried, because I don't know the financial future. So, it's really getting depressing and my motivation is suffering.

The need to feel safe in the classroom

When asked about whether they would need to feel physically safe in order to learn, a number recalled feeling unsafe when other patients were 'out of control' in the psychiatric ward they had been on. Colin said about the classroom environment, 'It's not wild or anything' and later said that he needed to feel safe 'from staff and other pupils as well.' Emotionally they all mentioned needing to feel safe with the other students and Louise explicitly referred to her worries before starting any classes, about not feeling safe in the class, as she had worried:

> What they're going to say or are they going to look at me funny or they going to be laughing or talking about me? Really, 'cos there are people who are always talking and stuff. So I thought maybe they were coming to judge me and just look at me. Because if that happened, I couldn't concentrate and it would give space for the negatives *(thoughts)* coming in as well, which I'm trying to keep out.

Joan thought that part of feeling safe included feeling she could cope with demands of the course as she recalled:

> Yeah, I think I've always felt safe in all of my classes. There was just one class I went to at another college, and that was web design and that was completely out of my depth and emotionally I felt a bit, I couldn't cope with that.

This fear had been echoed by Orla who said that prior to stepping onto the higher-level cookery course she had been thinking:

> I just kept thinking, you know, will I be able to cope with it? And so far, it's been very good.

The need to feel safe in the classroom appeared to be a particularly important theme in this group, possibly because they emerged as being the least confident group in the study.

The need to feel well enough to learn

All spoke of the need to be well enough to learn as they said that when they were acutely ill they would not have been able to concentrate on learning or commit to a regular class. For example, Joan reminisced of a time when she had been asked to specifically join a cookery class:

> I remember when I was sectioned about 13 years ago, they offered some cookery at the hospital, you know, just rehab and I was very wary. But I went on it, but I was very scared they were trying to take my freedom away from me. But now? That was because I was ill, I was seeing things differently, but now it's just totally different, you know, doing the cooking.

This idea of needing to be able to progress at a pace that is suited to them echoes the next subtheme.

The need for graduated progression

What emerged from several people was how important they viewed the opportunity to gradually progress at their own speed in terms of the level of the course they attended. Simon (former-students group) referred to such progression as a 'stepping stone' and so this was a phrase I too used in the interviews. Orla said that coming to this class was the first thing she had attended since spending six difficult months in hospital and although it was in many ways too easy a course for her, it still had played an important role as it was 'testing the water'. She went on:

> Orla: But honestly going back to your cookery course, it has set a goal for me (*as)* it helped me come out of myself but there was no challenge in your class in terms of learning for me. You were doing your job as it's a foundation course – but that is the one that really helped me.
>
> Interviewer: You needed the stepping stone?
>
> Orla: Yes, and anyone who says something different is wrong.

I asked Egren specifically if she could have gone onto a higher-level course instead of this foundation course and she replied 'no' because:

> Egren: I'd be scared to, because I'd be scared to relax because it would be a bit too much for me, 'cos I know what, I usually go through in a week. Starting from Monday to Sunday, I know how things are like, sometimes down, down, down, down. So, my GP advised me to start but if I found it was difficult I could leave.
>
> Interviewer: So not to put yourself under any stress? But coming to this class isn't a stress?
>
> Egren: No, it's okay.

This highlighted how, regardless of their past achievements academically, it was important to offer a class such as this one that was of a lower level and less demanding than courses involving assessments. This course seemed to help them rebuild their confidence whilst also allowing them the space to cope mentally when they were having a particularly difficult week.

Louise also spoke of how significant it was, to be coming to a basic class that she could cope with:

> To be given a second chance, for me I am really happy for this opportunity to have a second chance. And to know that I can actually achieve something with the second chance…I'm able to achieve something which I didn't dream of really being able to do. Because, while you're ill you never thought you could be better at something or to do something, but learning gives me a sense of purpose that I can actually do something.

The need for a positive relationship with the teacher

Even though Orla found the discrete class too easy and quickly moved onto the higher level one, when asked how essential it was to have a positive relationship with ones' teacher, she said, 'Very important. You did a lot for me

while I was there for a year. You did'. Louise said it was important for her 'because they *(the teachers)* need to know where I'm struggling' and said she had felt comforted when she joined the class and realised:

> That you (*the teacher*) talked to, you socialised. You talked to us and come down to the level that we need to understand, but you explain it very well.

Egren also spoke warmly of how she felt in the cookery class: 'I like the environment; I like the people; I like you'. In contrast she spoke of past negative experiences and their impact:

> Because if I don't trust the teacher I will be very frustrated when I'm in the class, and that will make me feel uncomfortable.

Overall every participant spoke of the importance of having a positive relationship with their teacher.

The need to have teaching and learning strategies that aided learning

Teaching styles

Most students spoke of certain classroom practices that helped them to learn. When asked about which communication style they found the most helpful, Orla and Louise both spoke of appreciating a teacher explaining a topic well by 'breaking it down'. Louise had had an experience where rapid 'teacher talk' dominated the class and led to her having to leave that class, as she explained: 'I couldn't follow 'cos it was moving really fast'. Joining an equivalent class with a different teacher enabled her to successfully complete the course because 'this teacher broke everything down; didn't go too fast and would keep asking time and again if we understood'. Similarly Egren found listening to lecturing difficult, when it was delivered as a monologue, given the drowsy effect of her medications. On a few occasions with one such teacher she fell asleep in class:

> Egren: The problem I had was that the teacher was always telling me, 'You are sleeping, stand up, go and wash your face'.
>
> Interviewer: Did the teacher realise this was possibly due to your medications?

> Egren: Yeah, I told her, but it was like every time she forgot about it.

All participants said that they found the teacher demonstrating helpful, which was particularly relevant to the cookery class they were in. Colin, who when asked if he preferred a demonstration or the teacher mainly talking said: 'I think the two combined makes things a lot smoother'. Additionally, Louise and Orla spoke of how useful it was if the teacher made themselves available to explain things individually to them if needed, as Orla said:

> We had *(teacher's name)* for Maths and she was very, very good. She explained it so well and if you wanted to stay back she would listen to you afterwards.

Working in groups

Regarding working with other students, although most found this helpful and were happy to do this, for Louise it had been problematic at points due to her 'voices'. When asked what she found so difficult about working with someone else she said:

> Louise: 'Cos it's not the person really but you think it is them telling you something but they're not there.
>
> Interviewer: So, you think they are telling you off? Or that you are hearing things that they are not actually saying?
>
> Louise: Yes, both those things. I think it's the person. I was worried about making mistakes and someone eventually laughing at the mistakes I make. I couldn't come close to other people because I'm always thinking they are judging me.

The importance of positive feedback

When asked about what kind of feedback from the teacher was most useful, a number said that the being told they were competent was encouraging, particularly when learning a new skill, as Joan felt. Egren said:

> Yeah, it makes me feel happy, makes me trust myself – so I think oh, so I'm doing better, I'm doing well. It's encouraging me to try harder.

Louise echoed this and spoke of an instance when she genuinely wanted to leave a class as she felt she was unable to keep up. On speaking to her

teacher about this he encouraged her to stay by pointing out she was ‘actually away ahead of most of the students’ and this boost ensured she stayed and completed the course. However, Orla pointed out that encouragement was only helpful for her if it was realistic and proportional: ‘Sometimes you need a bit of praise, but not patting on the shoulder every minute.’

6.4 How learning helped a sense of well-being

There were many aspects to how the participants felt their learning had helped their sense of well-being, of which the subthemes were: the enjoyment and benefits of learning; staying well; challenge and structure; acquiring new capabilities extending into home life; increased motivation, confidence and pride in achievement; hope and progression; a positive sense of self; changes in participants' thinking and perspectives and the social benefits of learning.

The enjoyment and benefits of learning

The most prominent sentiment expressed about their college experiences was how much they all enjoyed the class and how therapeutic they felt it to be. Although Colin told of his initial intention: "I told the OT, I'll go there once, but if it's not for me I won't attend again', this did not happen. Now he was able to state: 'I do enjoy it and it's not just enjoyment as it's creating something'. The enjoyment of creating something was echoed by Joan who chose to compare it to a more academic course she had previously undertaken. She spoke of how in contrast, she was benefiting from being on a vocational course:

> I find it very therapeutic, cooking. After having gone to university, especially the M.A., which didn't get me a job really because it was very academic, not vocational, it's nice to go away and be creative. The meal looks so difficult but you get halfway through and you realise, 'Oh, it's coming together'. I couldn't believe that I made it myself and it tastes like a meal you could buy in a restaurant, instead of microwaved one.

Egren spoke of how much she enjoyed coming and the positive effect she felt it was having on her thinking and her mood:

> It's changed me, like I think very positive now than before. Before it was like, lots of negative in my thoughts. Because even though sometimes on one of the mornings I feel down, when it comes time to come to the class, I feel like more encouraged.

The positive value of the class in terms of helping to counteract negative thoughts was mentioned by Louise too, in contrast to the painful memories

she had of her abusive ex-husband, who used to pour the food over her if he did not like her cooking. Also, that the distraction of doing something creative and absorbing helped free her mind from the troublesome voices:

> Louise: It takes my mind from all the worry; the worry of thinking what's going to happen to you – you're not going anywhere.
>
> Interviewer: So, do you think that coming to a class directly affects how much you are listening to the voices for those few hours?
>
> Louise: Yes, it does.

During the first stage of interviews the participants seemed to suggest that education was able to provide something different to what the hospital could provide, and so specific questions were asked about this in the second interview. For instance, Orla felt that although she had gone to the groups organised at the hospital, they were not comparable to the classes she attended in college as she said:

> In college you are definitely learning. Those coffee groups (*in the hospital*) are only gossip.

Colin agreed with this sentiment and felt strongly that medical care was not enough as he personally wanted to 'Get away from the mental health thing' by being in a college environment.

Egren valued the fact that although she had cooked in hospital with the OTs, in college she was cooking more independently and learning specific skills as she mentioned: 'I'm learning how to hold a knife, for the rice: how to keep it safe, yeah.' When Joan was asked what education offered that the hospital did not she said:

> Lifelong learning really. You can always maintain your sense of wonder and sense of learning something new, be open to new experiences. It keeps my mind intellectually stimulated.

Louise was equally adamant about education offering something that was different from the hospital provision as she said:

> Louise: It's a different thing 'cos at the college there are able bodied and disabled, inclusion. In the hospital I'm being treated as

> if I'm heavily sedated or I'm still sick. To be in college and all the classes I think I'm being treated as normal.
>
> Interviewer: And how does that feel?
>
> Louise: In hospital you are all pumped up with medications – your head is heavy, your body, but when I'm out there 'cos training I feel 'normal'. Group therapy? You are still being treated like a patient.

Staying well

Not only did the participants say how much they enjoyed the class but also that they felt that coming to classes contributed to helping them stay well mentally. Orla felt that her attendance 'probably has made me stronger, with the depression'. Louise spoke of how her head had felt whilst recovering in hospital, in contrast to now:

> You don't want to do anything – it's so nice just to lie around because you are so heavy with the meds – lethargic – your head is just like it is all over the place. But the classes have helped me a great deal.

This sentiment of how much the classes helped was echoed by Joan who described them as helping 'an enormous amount' and spoke of having a relapse during a six week break from classes. She felt, as did her doctor, that not having classes to attend contributed to a recent relapse:

> I think my psychiatrist said that because of the long break, the long Christmas break, I wasn't involved in the activities and so that's why it happened.

Challenge and structure

Another theme that emerged was how much they appreciated the challenge of learning. Orla felt very clearly that coming to this foundation course set a goal to aim for, which led her quickly onto a more challenging course which she loved. Louise echoed this sentiment as she said: 'I have a sense of purpose…that I can actually do something. It builds me up'.

Several participants mentioned that the structure that attending classes gave to their lives, was invaluable. When Colin was asked if he agreed with this, he answered: 'Of course, yes. It's something to do, if I can explain it like that',

and went on to say that if he could not come to this class he would definitely seek out another one. Egren felt that the class punctuated her week positively as she said:

> For one day a week, few hours a week of the cooking. Yeah, because even when I finish today I still look at the calendar and know yeah, next one is there. I'm in the class then, or not.

For Joan it was the focus that the class gave to her day that helped her, which was lacking at home as she said: 'If I was just ambling along from day to day, maybe watching television, you can lose focus'. This reference to the alternative of not having a structure in one's day was echoed by Orla who likened the discipline of coming to college to the discipline one needs in coping with depression:

> In some ways it's a bit like the depression – you have got to get on with it. You know the easiest thing for me to do today would have been to go to bed, with it rainy outside. But I knew I had made a commitment.

Louise appeared to thrive on the structure the class provided, even in the face of negative voices encouraging her not to attend:

> I look forward to going to the class; I prepare from the night before 'cos it helps me to want to get up and go, and I'm excited to get there. I will hear stuff along the way, things that comes up behind you but I speak my positive stuff against the negative ones (*voices*) I'm hearing, and it helps me to get there.

Acquiring new capabilities extending into home life

Orla spoke of how much she was benefiting from the fact that not only was she studying cooking, but now also her literacy and numeracy skills were being improved and she was additionally trying to find a course to improve her computer skills. For Colin, although he admitted that as yet, he had not begun to cook for himself much at home, he still felt he was acquiring useful skills: 'Basically it's taught me how to cook for myself, things I just take for granted and buy'. In contrast, Egren was trying to implement these new skills into home life and had been pleasantly surprised at her ability to do so as she said: 'I used to eat some of this food but I didn't know how to cook it, and now I find it so easy'.

For Louise learning at college was expanding her mind in many ways even in terms of her vocabulary and the fact she had access to the college library, as she said:

> Louise: I'm learning new words every day. I read a lot of books and I try to help myself by trying to use the words.
>
> Interviewer: Would you have done that before you began these classes?
>
> Louise: No, I don't read very well but I love it.

Joan felt that the cooking skills she was learning were definitely impacting her home life

> The class is really helping me in being a housewife as I didn't do much cookery before. I only had a microwave. Now I've bought a lot of things like a rolling pin and grater and potato masher and apple corer.

These responses reinforce the wider benefits of adult learning, as outlined in chapter three, which extend beyond purely academic and vocational achievements.

Increased motivation, confidence and pride in achievement

The high levels of motivation that Orla exhibited were evidenced by the fact she was simultaneously attending two courses, as well as wanting to add on a computer course. She attributed part of this motivation to the fact that coming onto the discrete course had helped her to 'come out of myself'. She said, this had increased her confidence as she discovered that she was well enough to commit to something regularly. She also spoke of how her mental illness had dented her confidence for a while and how learning was playing an important role in her recovery: 'Nine times out of ten, medication can only do a certain amount a lot of it you just have to do for yourself'.

Louise's motivation levels equally were already high before coming to class as she had multiple groups that she attended during the week including knitting, swimming and badminton.

> I started doing the activities and if I'm well and I do the activities, it helps because some days you don't want to come out at all…it builds my confidence to know that I am really learning, actually showing that I'm learning. It's helped me to believe I can believe in myself.

This rise in confidence was often cited in relation to the pride they felt in their achievements. For Orla and Louise some of these achievements involved summative assessments as Louise said:

> When I see the achievements, whenever voices come I would always look at the stuff that I have *(certificates)* or just write something and read it out to myself…nothing positive has ever happened before.

Egren also had been motivated prior to coming as she had responded immediately when asked whilst in hospital if she would be interested in joining and was thrilled to do so. She spoke of how low her motivation levels were before coming to the class as:

> Not (*being*) able to do something, not able to, no motivation. But now I have motivation…The benefits for me are that I am learning cooking for things I didn't know before. Maybe after the citizenship test that I'm doing, another motivation will come in the future, where I'll like maybe, to go back to cooking. Maybe chef, yeah.

Joan, insisted that the cookery class had increased her motivation greatly at home:

> So, the cookery's helpful because it's simple. I've always wanted to do a class, a more simple class, not so academic. You take those skills with you and go home and be a good housewife and be a good home organiser.

This led to her requesting homework each week involving cooking a new dish after which she would bring in photographs to show the class.

Although one could argue that most of these participants were already motivated, hence their willingness to join the class, their narratives suggested that their motivation and confidence levels had increased due to the involvement in the course. This then inspired them to consider taking part in other activities as well.

Hope and progression

Linked to the pride in their achievements, hope and the possibility of progressing onto something more was often referred to. For Orla, coming to college had opened unforeseen possibilities as her hope now was to complete her year level two course and then get a job as a cook. Louise similarly felt this hope as she said that she wanted to continue onto more courses, with a view to working with vulnerable adults or children. However, this was not necessarily the trajectory the others were aspiring to. Colin explained that his medications would mitigate against him working in cabinet making for which he was trained. Rather, his hope was to continue with his design work at home and: 'Once this course is finished I will join another course and just continue doing courses'.

Egren felt that her main hope was to stay strong *(mentally)* and to enrol on the citizenship course mentioned earlier. She spoke of how grateful she was for the opportunity that coming to college had given her as she said:

> So I think the staff are doing very well organising some sort of activities to make you come in back to the society, and feel happy. When I came to this course it was once a week, and now they offer me to do something more if I can, so that is like they are still supporting me.

For Joan, during the first interview she was hoping that she could attend a computer course to get a secretarial job and then buy a house for her and her mother to live in. Sadly, by the second interview her hope was overshadowed by fear and anxiety due to the government changes regarding her welfare benefits. Consequently, she worried about how she would cope given that her medication had to be increased due to the 'voices' becoming more intrusive.

A positive sense of self

One theme that emerged from the participants speaking of how therapeutic they found the class, was that for Louise, Egren and Joan, it had led to a change in how they saw themselves. Louise spoke often of not having seen herself as a 'normal person' since she first become mentally unwell and in the first interview she said, 'I used to be a good person before'. When I asked her to explain this she said:

> Meaning I used to have a job, care for people. I used to take care of others and to find myself (*now*) in a place with other people taking care of me, I just thought that that was the abnormal bit of it. So, I had a job, I had a life, I had a home and all these things. And I was training people so I thought maybe that's when I was someone and, becoming a patient, I just thought I was nobody.

Yet through coming to college she was beginning to see a change in working towards the goal of becoming once again, a 'normal person' which gave her a renewed sense of dignity:

> Louise: I try to act as normal people do - that's what I am working on. Getting my life back, and a better one than the one I had before. I'm 100% different now. I have a right to be here, I don't have to hide.
>
> Interviewer: What is a normal person?
>
> Louise: A normal person goes around every day, goes to work, has a family, have children maybe, have a life, and I hope that one day I will have that again. A life I'll enjoy this time.
>
> Interviewer: So, do you not see yourself as a normal person?
>
> Louise: No, because I am led to believe that because of my breakdown and all that, you are not like anyone else but when I go to college or any form of training, I don't feel that way. It's different.

Just as Louise saw herself as changing from not feeling like a normal person to feeling like one, Egren too spoke of changing how she saw herself. Egren said that now she thought of herself proudly as a student and when I asked how she would have described herself before, she said:

> Egren: Unemployed, learning difficulty, not able to do something.

> Interviewer: So, what's changed?
>
> Egren: It changed like I think very positive now than before. Before it was like lots of negative in my thoughts, yeah.

Joan's shift in how she saw herself was more complex as she frequently mentioned that coming to the cookery class had enabled her to see herself now as a 'housewife' which she was happy about. What became apparent as the participants spoke about the shifts in how they saw themselves, was that these were diminishing their previous feelings of shame due to their mental health problems. Rather, learning appeared to be positively contributing to increasing feelings of dignity.

Changes in participants' thinking and perspectives

During the interviews Orla, Louise and Egren mentioned ways in which they felt education was changing their thinking. Some of these themes emerged around becoming more adaptable and reflective. Orla spoke frequently about this matter, which may have been due to her attending a higher level, more demanding course as well as the foundation one. She talked of becoming more adaptable and recognised this as being an issue for her as she said:

> But it's very hard you know. Both me and my husband are similar in many ways – we stay in the same job for years upon years; we have a ritual of our own and nobody dare break it.

Now she felt this was changing:

> For example, on a Friday when my husband may have the day off for blood tests, we'll go out for the day and before I would say, we're going here and we're going there and now I think to myself, 'Let him choose'. One of my worst faults - I don't like to be told what to do; I'm ashamed to say it but that's just it. Well, we all have our faults and now I'm thinking about trying to identify them and think, 'Let's try and improve in this'.

Louise and Egren also felt they had become more adaptable in relation to other people. This had caused Egren to become reflective about what her capabilities were, as she said: Because I see all the persons who are even less able to cope than me'. Louise spoke too when asked if she felt these learning experiences were changing her said:

> It has transformed me I must say…what I have received inside is totally different from even when I was at school. Education opened a lot of space for more stuff. It's like it's not enough, I just want to get more stuff. It's like it's not enough, I just want to get more.

Another theme that emerged from the first interviews as they spoke about their illnesses was how little control they seemed to have over their lives, summed up by Colin as he said:

> I try my best *(to keep well)* myself. It's just working with others 'cos that sort of situation where I have to trust doctors, but half of my life is in the trust of other people, which is not a very good position to be in.

Consequently, in the second interview they were asked how much control or autonomy they felt they had in their lives since joining the course. As this was an abstract concept, only a few directly answered it. Although Louise felt that education was changing her profoundly, in answer to whether she felt she was flourishing, she replied: 'I'm trying to'. She felt that she only had about 70% control in her life due to her precarious mental health problems and lack of money. However, despite not feeling fully autonomous Louise went on to say, that she saw herself as a different person now:

> Just coming to class and just being accepted tells me I am normal…Here I'm allowed to cook on my own. I'm allowed to cook on my own at home but still someone will call you to find out if everything it okay *(the OT telephones Louise at home when she cooks, in order to check on her safety).*

For Egren also, she felt that she did not have 100% autonomy as she said:

> The voices are telling you should you sit down or should you have a shower today? So, you are not in control, but I have more autonomy now that I came to the college as a student.

It appeared that for many of the participants, they felt that their thinking was changing in terms of them becoming more adaptable or accommodating in relation to other people and reflecting about themselves. However, such changes had not yet led to significantly difference in their perceived levels of autonomy, due to their other factors outside of their control.

Social benefits of learning

All participants spoke frequently about how they had benefited socially from attending the class. Orla said that she had made many friends through her courses as she said: 'Yea a good crowd – all of them are nice'. Also that she had benefited from having to work in a group as it had challenged her former attitude of preferring to do things her own way. Louise equally felt pleased with being part of the class as she said:

> Just to come and see people smiling with you and talking to you, that's enough for me. No, you don't understand - that is a lot, that's a lot. I like the interaction with the group as well. I don't know if you notice but I sometimes go over to G and D to talk to them? You feel included; it feels good as I feel like I belong.

Although she expressed how her voices could be intrusive when working with someone, it did not detract from how she enjoyed the social side. This sentiment was echoed by Colin, Egren and Joan. Egren's words were: 'I found all the students very nice; very understanding; all good' and said she loved making 'new friends' there. For Joan, the socialising reminded her of a happy time in her life when she had first been to university as she recalled:

> Yes, it's nice to come to the class and to the college. And socially it's nice as well as it reminds me of my time at university – I was very happy there.

What contributed to this social enjoyment was the fact that all the students engaged in a common task, cooking and eating a meal together in which they helped each other if help was needed.

Summary

This chapter reported the findings from the discrete group and the main themes that emerged. These themes were: how their mental health problems negatively impacted their lives and learning; how there were certain pre-requisites that needed to be in place in order for them to be able to engage fully with their classes; and finally, the many ways in which the participants felt that their learning had helped their sense of well-being. The following chapter will now discuss the findings that emerged from the mainstream group.

Chapter 7 Findings: mainstream group participants

Introduction

This section sets out the findings for the mainstream group. This group was made up of participants who had enrolled onto a college course and disclosed to the college that they had mental health problems. Consequently, they were all known by the Mental Health Advisors (MHAs) but unknown to me before the interviews. Throughout the next two chapters the MHAs will be referred to as Kevin and Sarah (names changed).

The mainstream group differed in several ways from the discrete one as the courses on which these participants were enrolled involved summative assessments and were open to the public. These courses were more demanding time wise (approximately three days a week), aside from Charlie's course in bookkeeping which involved one three-hour class, once a week for one term. The data collected differed too as although it included two interviews for each participant and for four of the participants, they were also observed in one of their classes. Daisy was not observed in class as she did not wish to disclose her mental health problems to any of her teachers. The group fell into two distinct clusters as three were studying on vocational courses and two were studying for Advanced Subsidiary (AS) levels. The latter two were much younger than the first three and their interviews took place before and after their AS exams.

In this chapter, five pen portraits will give brief background information on the participants who were interviewed, followed by the four main themes that emerged. These themes were: the negative impact of their mental health problems; the pre-requisites for learning; the negative aspects of learning and how learning helped their sense of well-being.

7.1 Pen portraits for the mainstream group

Prem

Prem was a 22 year old Caucasian student who lived with her mum and two sisters, with whom she got on well. Money, she said, was very tight for the whole household, (also manifest by the fact she never had any credit on her phone to contact me when we were meeting for the interviews). Prem had paid work approximately 12 hours a week which she found demanding and tiring at times. At home her mother, who had depressive periods, had a difficulty with hoarding and due to lack of space, her mother had to sleep in the lounge. Prem reported that she had suffered from depression from the age of 11, for which she now took medication although by the second interview she had chosen to bring herself off it. Prem had attempted to commit suicide on three occasions which had led to casualty visits, but no hospital stays. In addition to her depression she believed she had a social anxiety disorder

Prem had changed schools locally on a few occasions but finally left during her AS levels due to her depression. After a period as an apprentice gardener, she had returned to education to study for three AS levels (English, Classical Civilisation and History). Her future hope was to go to university to read Classical Studies with a view to becoming a writer of historical fiction.

June

June was a 19-year-old Caribbean student, an only child who lived with her parents whom she said she got on well with. Her family had many financial pressures due to debt and she could not return my 'phone calls as she had no available credit. Her father had been unemployed for a number of years and her mother had recently qualified as a teacher. Due to this, June said it was imperative she had a job: she worked 10 hours a week as a receptionist. June spoke very fast and stammered often. Whilst sitting her AS level exams she became extremely anxious and depressed which she attributed to the stress of the exams although she also thought she had suffered on and off with depression since she was five. When she joined the college to re-sit her AS levels, she had not planned to disclose her mental health problems, but did so when she began to feel her symptoms returning.

Although June said she had dyslexia, her time at school had been happy and she felt she flourished there due to the support of her teachers. The first time she studied for her AS levels she was unable to complete them due to feeling depressed and anxious and so spent her next academic year studying photography. She had now recommenced her AS levels studying History, English and Sociology but had discontinued with History earlier in the academic year. June wanted to go to university to study Sociology and Politics and to become a researcher.

Danny

Danny was a 50-year-old mixed race man who had suffered much abuse and neglect as a child which had led to him being taken into foster care at the age of 11. He spoke warmly of his foster family whom he was in regular contact with. Danny was divorced and the father of four grown up sons with whom he had some contact. Danny was diagnosed with having a borderline personality disorder and had made many attempts to kill himself. Although he had spent 12 years in and out of hospital for long admissions, he had not been re-admitted during the last five years. Danny reported having variable moods which were difficult to predict and manage, leading on one occasion to him initiating a physical fight during class.

Danny had found school very difficult as he said he had 'lots of issues' and subsequently left with no qualifications. He was now completing his first ever qualification: NVQ Diploma in Professional Cookery Level 2. By the second interview Danny had completed his course and was about to begin working as a chef in a pub.

Charlie

Charlie was a 50-year-old mixed race man who lived on his own in supported accommodation but was part of a family with five siblings, whom he said he was close to. His father, who was from Nigeria, was now dead but his Indian mother was still alive, and he visited her every day. Charlie spoke extremely fast and was difficult to understand. Charlie said he had been diagnosed as having paranoid schizophrenia when he first became ill in 1985 (30 years ago) as well as anxiety and depression recently. After 15 years of between five to ten hospital admissions, he had not been in hospital for 15 years, although he still reported problems with delusional thoughts. Aside from his mental health problems, he had Type one diabetes and dyslexia.

Charlie had loved school and had wanted to become a solicitor or pilot when young; he worked for ten years in various unpaid placements which he said he found too stressful to continue. Since attending college as an adult he had acquired several level two and three qualifications and was always enrolled on short courses. He filled the rest of his time working as a volunteer football coach as well as peer mentor for others with mental health problems. His future hopes included wanting to train as a professional football coach and carry on with his education including a degree if possible.

Daisy

Daisy was a 42-year-old woman whose father was West Indian and mother Caucasian; she lived alone in supported accommodation. Although Daisy had three children aged 9/13/22 years old, she had no contact with any of them as they were all adopted at various points. Daisy was in contact with both her parents but had been brought up by her father who had been married five times. Daisy said that she had become mentally unwell at the age of 28 when her oldest child was six and living at home with her. She attributed her first 'nervous breakdown' as being caused by taking cocaine regularly and becoming depressed after splitting up with her partner. Daisy said she was initially diagnosed as having schizo-affective disorder which changed to schizophrenia. From that point on she had many admissions into five different institutions, including secure units; her longest admission was for two and a half years. She was on regular medication for her condition.

Daisy's time at school was problematic and she left with no qualifications. Presently she was studying for NVQ Diploma in Professional Cookery Level two, having completed level one which was the first qualification she had ever gained. Daisy never mentioned if she had ever been employed but had worked as a volunteer mental health advocate. Daisy hoped to finish the second year of her course and work as a chef.

7.2 The negative effects of the participants' mental health problems

The sub themes in this section were how their mental health problems affected their lives and learning; how the side effects of their medication impacted their lives and learning; shame, stigma and disclosure issues and the courage and perseverance they displayed amidst their difficulties.

How their mental health problems affected participants' daily lives and learning

What became clear for each of these participants was that although they were now able to continue with their respective courses, their mental health problems had and still did at points, impact their lives negatively. Both Prem and June (AS students) spoke of having 'dropped out' of past courses due to their mental health problems and also of still having days when they felt unwell mentally. Prem spoke of when she had prematurely left her last school due to 'depression and stuff' but even after she began at this college, she still experienced times when she was emotionally fragile which affected her ability to learn. Recalling one such instance, she said:

> I remember coming in here one day and I didn't know why, but I was just crying and I just didn't want to be at college at all. It was an overwhelming sense of depression and loneliness and stuff.

June also had time out from studying after her first attempt at AS levels, which is when she felt that her mental health problems came to the fore as she said:

> Then I started my A2s and everything started to fall apart. I wouldn't go to exams and I was feeling absolutely terrible and spent weeks just crying because it was just too much. I went to the doctor and then I told him and I got diagnosed.

Although Danny said he was much stronger mentally than he had been for many years, his mental health problems did still impede his ability to study at times. Frequently, he had traumatic dreams and mood swings, the latter of which he felt caused him to have good and bad days:

> I really have bad dreams like I want to kill somebody, that I'm fighting something. Sometimes you can never forget certain things for the rest of your life, like the abuse and neglect. When I feel like

> down, I feel like I don't want to come in. It's hard on a bad day as even in English and Maths when you are trying to focus on something and then everyone's messing around or things are going wrong, it's hard.

For Charlie, although his mental health problems had led to multiple admissions to hospital in the past, he claimed that he had now recovered. However he still experienced panic attacks and feelings of being scared, as he said:

> Recently I was a bit scared about being in groups as I was into people knowing my thoughts, and they control me with their thoughts…I thought they knew my thoughts and they were taking the mick out of me.

In the case of Daisy, she was feeling well mentally at the time of the interviews but the impact of her mental health problems was still prevalent in relation to the fear of being stigmatised by other students.

Side effects of medication impacting life and learning

In this group all the participants, excluding June, were on regular medication for their mental health problems. The first thing Prem mentioned in relation to her medication was how much she needed it to manage her life:

> Yea I take medication every day and if I don't, it will start to build up over the days where I start to feel more depressed. I get so anxious, but I can concentrate more when I'm not on antidepressants.

However, the issue mentioned by all the participants who were taking medications was how the side effects of feeling fatigued did impact their class work many times. For instance, Charlie mentioned that on Saturdays and Sundays he could sleep all day due to the medications, which highlighted how great the challenge of being alert enough to study during weekdays could be, as he said:

> Well, it's just tiring in the morning. I'm sleepy in the morning. I wake up, go to college and you think you've got the whole day to get through.

Shame, stigma and disclosure issues

It transpired that for Daisy, her mental health problems were impacting her now in relation to her feeling fearful of her past being disclosed to others. Daisy had spent 15 years in and out of psychiatric units for long periods of time which led to all of her children being taken into fulltime care against her wishes. The issues surrounding how and why this happened were still painful for her as she explained in some detail how these events had unfolded:

> We went to the hospital and I had a caesarean (*for my daughter*)…and then the police came and they took her from the hospital. With my next child, I gave birth to him in Africa but when I returned to the UK, a social worker said, 'Oh you're not having none of those children in our country. We'll give him back to you but we're just going to foster him for a bit' and so then I ran off with him and rented a room in (*named place).*

Due to these traumatic events, Daisy feared people at college knowing this History, including her teachers. When she was asked why she did not want anyone in college to know, she said:

> Because it's personal, private and people might start judging you and might start taking the micky out of me. I don't like sharing that I've got mental health problems…The girls were asking me, 'Have you got mental health problems?' And I said, 'No, I've got special needs'.

This issue concerning disclosure was shared also by Prem, June and Danny as they all felt they did not want the other students to know and June said that she did not disclose her mental health problems during enrolment as she 'didn't want that kind of stigma'.

Danny, when asked if he had told his new employer said: 'No, he don't know nothing about it' and admitted later that he felt 'there's still a stigma about mental health'. Conversely, Charlie felt it was easier for him if people did know about his mental health problems and so he would disclose to the other students when he joined a new class. However, despite fear of disclosure being an issue generally, all the participants, excluding Daisy, were happy for me to observe them in class although this involved disclosing their mental health problems to the teacher of that class.

Courage and perseverance

Much courage and tenacity was displayed among this group as they had to cope with not only their mental health problems, but challenging home circumstances too. Prem spoke in a pragmatic way about how she had to work long hours in paid work on top of trying to study, mentioning how her life at home was not comfortable either:

> My mum's a hoarder, and the electric broke two years ago in the upstairs, so I've been living with candlelight for like two years. I don't really mind, I quite like it, it's scenic. But then quite recently the hot water broke, so I just have to take kettles upstairs every time I need a bath. It takes so long.

For June, her courage was noticeable as she struggled to keep combining paid work due her family's financial challenges, with studying. This was whilst at the same time, coping with the anxiety she experienced during her exams, given her negative memories of past episodes:

> The other night I remembered I had a break down in the exam season and that I couldn't get out of bed sometimes and I was crying a lot, but I did sit the exam this time.

For Danny who struggled daily with unpredictable mood swings, it was the courage he displayed to face people who did not understand what he was going through mentally that was noticeable:

> It's hard when people look at you and you look alright, but they don't know what you go through on a daily basis. And what it does to you sometimes and you don't want to embarrass yourself, you know. But I had to keep going (*on the course*) 'cos with no formal qualifications whatsoever, every job I went for was a struggle.

Charlie spoke a number of times of the effort he had to put into coping in his interactions with other students:

> I've got to be strong. Then I worry others might provoke me…it goes through my mind the whole process of it all. They might be intimidating, and they make me feel unwelcome.

Daisy's courage was evident, too as although she spoke of the shame and stigma she felt regarding her mental health problems, she courageously persevered to finish her course.

7.3 The pre-requisites for learning

During the interviews there seemed to be certain underlying needs that were required to be met before the participants were in a place to engage fully in learning. The subthemes in this theme were: the need for shelter, money and food; the need to feel safe in the classroom; the need to feel well enough to learn; the need for graduated progression; the need for help from the Mental Health Advisers; the need for a positive relationship with the teacher and the need to have teaching and learning strategies that aided learning.

The need for shelter, money and food

All the students had secure accommodation and an adequate amount of food but one issue that was commonly mentioned was the pressure of not having enough money to live on. In the case of the two AS level students (June and Prem) whose families were unable to support them financially, the pressure to have paid work greatly impacted their available study time.

As Prem outlined:

> I had a job in a café nearby, but I could feel my anxiety build up so much that the next day, I didn't even want to go again, but I had to because I needed the money. I'm dreading September when I know I have to find a way to fix work schedules around college schedules and because of the zero hours *(contracts*). I can start at like seven at night or something, and work until two. Yeah, it's just not ideal, but it's life.

June's family also were unable to help her financially and so it was a constant pressure for her as she said:

> June: I'm always in debt. I've been in debt since I was like little.
>
> Interviewer: And you don't rely on your parents at all?
>
> June: Well no, my mum she's just got a new job, but she's in a lot of debt. I think that's why I failed my last year. Oh my God, (*paid*) work plays a massive impact and you have to do it because you have to eat.

For Danny, although he had managed to cope financially whilst studying he was now scared about how he would cope making the transition into employment as he said:

> I'm so relieved it is weekly pay (*in his new job*) as there's a big gap money wise between the benefits stopping. The first month is going to be tough financially and it will be bloody hard having to pay for gas and electric and buy food.

For Charlie, money became a great worry for him in the context of changes to his welfare benefits, which he did not understand. He said:

> But Kevin (MHA) has told me that the government have changed the policy and now you would have to pay money for your course and I'm poor. I get benefits and they're going to stop the benefits now. A new organisation is doing it. PIP?

Daisy spoke of her struggle to cope with having to furnish her new flat after living in a hostel for years, as she recounted.

> Daisy: I've got my own flat now and I've just bought carpet and chairs, so I have not had much money as I've got to buy furniture. So, I've been buying a bag of potatoes for £1 in Turkish shops. I've been buying bags of potatoes and cooking chips and egg - fried egg and beans.
>
> Interviewer: Do you find that your benefits cover what you need?
>
> Daisy: No, it doesn't, I need more. I've had to use the Food Bank twice.

All five of the participants spoke often about how they struggled with being able to afford to eat and live adequately.

The need to feel safe in the classroom

Although Daisy did not mention this matter, all the other participants did. Both Prem and June spoke of needing to feel emotionally comfortable with their teachers to work well in their classes as June said:

> You need to like your teacher in order to like, feel safe. You need to feel like, you're wanted.

Although Prem and June were not in the same classes and did not know each other, they had the same History and English teachers. In both cases they contrasted how safe they felt in the English classes with how uneasy they felt in their History classes, as Prem explained: 'Because the teacher and I have had past arguments, so I feel anxious in class'.

Danny agreed that he did need to feel safe in his classes. However, this issue was complex about Danny feeling safe with other students, given that he instigated a physical fight with another student during a class on one occasion. He explained:

> It was due to a misunderstanding with one of the other students. It was a stressful day anyway and he said the wrong thing, and so things exploded, and I saw red and picked a fight.

Finally, Charlie said that if he did not feel safe he would become scared and have paranoid thoughts.

The need to feel well enough to learn

The fact that Prem and June both had to leave their earlier studies due to being mentally unwell showed how they felt they needed to be well enough to engage in learning. Prem said:

> I don't think I would have been able to be in an environment (*like college*) with so many people when I was ill.

In the case of Danny, he said that he was only able to cope with being in class now, due to having spent many years receiving intensive psychotherapy, which he felt helped him to feel much stronger mentally. When Charlie was asked if he could have begun studying straight after his period in hospital he answered:

> No, it would have been difficult. It would have been too stressful…You need some period of time to recover. When your mind is more stable. It takes me a long time to adjust as well to new situations.

This sentiment of needing to be well enough to learn was reinforced by Daisy:

> Interviewer: When you came out of the ward four years ago, if the MHAs had asked you to join a course in college what would you have said?
>
> Daisy: Probably no, because I just wasn't well enough. I wouldn't have done it, no. I was depressed and all I wanted to do is eat and sleep, eat and sleep.

It appeared from the narratives that although these participants still experienced a varying degree of mental health problems and were able to function reasonably well, they did feel that when they had been acutely unwell, they would not have been able to engage fully with their learning.

The need for graduated progression

One theme that emerged was the importance of needing 'stepping stones', a gradual progressive introduction to increasingly challenging courses. In the mainstream group these emerged as being of particular significance for the three mature participants who had spent much time previously in hospital, had no prior qualifications and were on vocational courses. The two AS level students did not mention the need for such steps.

This step by step approach was alluded to by Danny when asked:

> Interviewer: Is this the first college course you have studied on?
>
> Danny: Yes, in my life! I suppose I've been out of hospital for the last 10 years, then in the community and I went to the rehab. (*rehabilitation*) centre and I did catering there. They encouraged me to come here. I always loved cooking but never got a certificate to prove it.

In the case of Charlie, he also thought these steps were needed:

> Interviewer: Do you feel that it is important you can do the first level and then the next level, like stepping stones?
>
> Charlie: Yes, like a ladder as I go up, and up and up.

Lastly Daisy agreed when asked:

> Interviewer: Would you have had the confidence to go straight from hospital onto a college course?
>
> Daisy: No, the rehabilitation centre was an important stepping stone.

The narratives from all the participants reinforced the value of students being able to progress in a graduated way in line with their well-being and perceived capacity.

The need for help from the Mental Health Advisers (MHAs)

In the first round of interviews for the mainstream and former-students groups, a frequent theme that occurred was the crucial role the students felt that the MHAs (Kevin and Sarah) played, in enabling them to cope within college. Due to this, questions were asked in the second interviews concerning how the support from the MHAs differed from that of the teachers.

Although Prem felt positive about the level of support she received in college generally, when asked specifically about why the MHAs were so valued by all of these participants she answered:

> Prem: They just help you have someone to talk to, that's completely a separate entity from everyone else.
>
> Interviewer: Can you not do that with your teacher?
>
> Prem: They (*the MHAs*) understand more I suppose, because mental health awareness is not really very good to be honest.

In June's case, when asked to explain the role the MHAs played, she explained:

> They give you a safe place to talk, because I think with teachers they're always in a rush and they always have things to do, but Kevin and Sarah were like, they're there for you and your personal needs. But the actual environment of the college has been abysmal.

Danny was adamant that if he had not had this targeted support he would not have completed his course as he explained:

> Danny: Communication between teachers and college is very bad. The MHAs pushed for my support and it's very good now. Without Kevin and Sarah, I don't think the college would survive with keeping people with mental health problems.
>
> Interviewer: Tell me what Kevin and Sarah do that's so different.
>
> Danny: They understand more; take time to listen; tell you the positive side about yourself. When I wanted to leave the course, they encouraged me to stay. But I'm going to miss the MHAs as they've been good support and there's no support once I leave college. I ain't got nobody, so it's going to be hard.

Charlie was also passionate about how key the MHAs were and described them as 'backup', and continued:

> Charlie: (*They*) make me feel comfortable with myself and they understand me, and they give me a lot of time and patience.
>
> Interviewer: Do they have more time than the teacher?
>
> Charlie: I feel more comfortable. They speak at my level.

Finally, the MHAs played a significant role in Daisy's time in college also, particularly as she had chosen not to disclose her mental health problems to anyone else at college. She described in detail how she perceived their help as she said:

> Daisy: They are there; they listen to you if you've got any problems or just having a nice chat with them, they are very supportive.
>
> Interviewer: How are they different from what your teacher does?
>
> Daisy: Because your teacher doesn't really know that you've got mental health problems.

Undoubtedly the support that the MHAs offered was perceived as being key for all the participants in how they managed at college.

The need for a positive relationship with the teacher

All the participants mentioned at some point those teachers with whom they had a positive relationship. In the case of Daisy, when asked about her relationship with her teachers she replied:

> I think I get on well with teachers. They listen to me and I can hear what they are saying when they're giving directions out on the course, about what you've got to do.

Prem was full of admiration for two of her teachers, John and Kim. She spoke on many occasions about John as she described him as:

> He's wicked, he's the best teacher ever as he really brings this subject alive. I've never had such respect for a teacher than I have for John. And the (*cultural)* trips he organises (*abroad)* are amazing.

When June was asked about this matter, she emphatically said, 'The teacher – student relationship is the most important thing'. In her first interview she

was very critical of her Sociology teacher, who she accused of getting June to teach other students too often, as June was re-sitting the AS course. This issue appeared to have been dealt with satisfactorily as by the second interview, June was able to recognise the positives of their relationship as she said:

> Yes, I think she's a good teacher. She's very, very accommodating to me. So, I can't really be that upset (*about the initial problem*). She was really sensitive to me in the end.

This was evidenced in the class observation as the teacher was seen to be most accommodating of June's preference to work on her own during the lesson. For Danny, it was a complex issue to unravel as he did not have many positive things to say about his teachers except the English teacher who was 'Absolutely brilliant, so I always did the homework for her'. This complexity continued with Charlie who spoke positively about his teacher in the first interview but had altered his opinion of the teacher by the second interview, when he spoke negatively of him. However, this was probably because by the end of the course when Charlie was observed in class, he was struggling to cope with the academic workload. Although I perceived that the teacher was trying to help him, this was not Charlie's perception.

Teaching and learning strategies that aided learning

Teaching styles

When asked for any teaching styles that suited participants, June answered:

> I think what's important for teachers is breaking it down, like asking people who don't understand because obviously they can explain that.

The benefit of a teacher demonstrating skills or techniques was mentioned frequently by Charlie, Daisy and Danny, although at times Danny felt that it could lead to confusion as he said:

> And if they demonstrate three or four things in one go, I'm thinking that's too much for my head. It feels like it gets overwhelming and I want to explode.

When asked which teaching techniques Prem found to be helpful, she said,

> Prem: Storytelling is a good one. John does a lot of that, and I think to get a class engaged in a story, that's really, that works for me. And he writes out what we are going to be doing in the lesson. He manages to get it all done and have some more time for an extra activity.
>
> Interviewer: And can you think of situations in a classroom where you're not actually learning?
>
> Prem: Yes, I think if someone just stands there and talks and isn't interactive with the students then…If they just talk and talk and talk and you just have to sit there and listen.

Both these sentiments were echoed by June who additionally mentioned that it was important that the topic being taught was relevant to her. This had not been the case in her History class as she said:

> He'll *(the History teacher*) just be talking and it's like well, how does this help us? And he would go off at so many tangents and it was constant.

Danny said that he could not learn when a teacher lectured and was not interactive, as he said:

> The Maths teacher this year was crap so I didn't learn my Maths. He's sitting there and he's talking for about 30 or 40 minutes and then by the time he gives you work, it's time to come out of the class.

Both Charlie and Danny mentioned that sometimes the speed and volume of information a teacher was giving them caused them problems whereas Daisy spoke of benefiting from the one to one help that her teachers gave her when she needed it.

Working in groups

When Prem was asked how she enjoyed group work, she said:

> Prem: It's kind of frustrating, but at the same time if they're (*the other students*) not going to do it well, then I'd rather they just don't bother. I would be happy to just do it all on my own.
>
> Interviewer: So do you think if you'd been in a class with equally motivated people, do you think you would've been inclined to want to do the group work more with them?

> Prem: Yeah I think so, because with other people who are on the same level as you can exchange ideas, and then develop your own ways of thinking.

Notably, when Prem and June were observed in their classes, both chose to work on their own and when June was asked to explain why, she said that group work was only helpful if the other students were as motivated as she was. Additionally, she said that group work could be unprofitable, as in the following case:

> The History teacher would talk for like ages. It's like a good hour. Nobody listens, and nobody knows what he's talking about, and then he'll be like, 'Well do group work', and he wouldn't explain what we were to do.

It would seem that both Prem and June felt group work to be useful if first, it was set up well by the teacher and second, if the group was made up of students with similar levels of motivation as themselves. When Charlie was asked about group work, he mentioned again that the speed of the work was too fast for him, so he could not keep up with the rest of the group.

The importance of feedback

As Prem was studying for AS levels which are high stakes exams, grades were very important to her. Consequently, when asked about how valuable receiving feedback from the teacher was to her, she saw it in terms of grades as shown below:

> Interviewer: Does it help you that you know the teachers feel you are doing well?
>
> Prem: Yes, it makes me feel better. I get my worksheets back and I've got As but when I get Cs and stuff it makes me feel demotivated. And then I just don't want to revise anymore.

Both June and Daisy did value getting positive feedback from their teachers, particularly as in Daisy's case it encouraged her to persevere when she was struggling, as the teacher would say: 'Come on, you can do it, I know you are good with money'. This contrasted with Danny as shown in the following extract, who said that even when a teacher praised his work, he could not believe them and when asked why he answered:

> I think it's because as a child I was always pushed away and got neglected and then when someone says something nice you're thinking, 'Shit, someone's being nice to me; is this normal?'

However, during his class observation, it appeared to me that Danny did appreciate the positive feedback given to him by the teacher and the other students as he did not discount their praise and his mood seemed brighter following it.

Finally, Charlie, in the context of feedback recalled his experience of hearing that he had failed his mock exam as he recounted: 'My teacher had a go at me'. I had been observing him in that lesson and this was not how I perceived that the teacher had spoken to him. His upset at failing the exam, appeared to colour how he interpreted what the teacher said to him and is a reminder of the negative aspects of learning in relation to assessment, which will be covered in the next theme.

7.4 Negative aspects of learning

Although this group spoke about numerous positive aspects of their educational experiences, there were many negative aspects expressed by all except Daisy, possibly because the catering course she was on did not involve high stakes exams. The subthemes within this theme were: the disorganised college structure; poor teaching; the pressure of assessments and the lack of motivated peers.

Disorganised college structure

This was a prominent issue for June and Danny as they both needed extra learning support in class, which the college did not organise in a timely manner. June had found the process of securing support in class and exams for her dyslexia extremely stressful as she said:

> I think the reason I'm struggling is because I have no support, and it's not that just I have no support, it's that I deserve support. My teachers didn't even know I was dyslexic until I told them, which was coming up to mocks time in January and February.

For Danny this was a big issue as seen by the answer to the first question in the first interview:

> Interviewer: And how are you enjoying the course?
>
> Danny: Yea, it's okay but there's not enough support for people who have got mental health issues. But Kevin (MHA) and I have got a big meeting next week discussing my actual support sometime. And it took Sarah (MHA) and me a year to fight for one to one support in my English. The communication and that at college is bad all over. They lost (*my*) coursework and that teacher won't admit it. So, you know what, I'd thought about doing year three but I'm not. I can't wait to get out. There is not enough support for people who have been through mental health, and in the kitchens, there's just no continuity (*with the staff*).

Poor teaching

The negative impact of having a teacher whom a student perceived to be of a poor standard was great, although in the case of Daisy, she had no experience of this in college.

The problems that Prem was encountering with her History teacher became apparent within the first five minutes of her first interview as she said;

> I have a problem with my History teacher, we don't get along. I just can't stand people shouting at me and like he has a tendency to shout and point his finger at people and like I argue back to him. I think it has a lot to do with his method of teaching. He takes long pauses and it's really hard to follow. Like I'm having to run study sessions for all of us History students, to try and like get a grasp on the topic 'cos obviously there's so much content that we need to know. I know at university you do study groups, but you shouldn't have to do it at college.

Similar issues with the same teacher were echoed by June, even though neither of these students had met. In June's case this led to her giving up the course prematurely.

> Interviewer: When did you decide to give up the History AS level?
>
> June: When we got out first new teacher and I didn't like his teaching style, ''cos all he would do was just talk. He didn't do anything, and I can't learn like that. There was no rapport. I went to my form tutor and she said you have just got to stick with it. So I went to the Sarah (*MHA*) and she said, 'No, you are not doing that' and I dropped History.

Initially, June also had a problem with her Sociology teacher although this was apparently resolved by the time of the interviews, as she explained:

> It's very stressful because I study a lot at home and have done it (*the AS course*) before, the teacher put pressure on me to teach the class and stuff. Some of the students have noticed that and said, 'You're basically the teacher', which is a bit overwhelming at times. But just the pressure of that got to me and I had to contact Sarah and get counselling.

This was confirmed during the class observation as June was asked to explain several things to her peers. She did this clearly and the other students and her teacher appeared to be appreciative of her input.

In Danny's case, his complaints regarding poor teaching were related to the teachers' lack of understanding in relation to teaching students with mental health problems, compounded by a high turnover of staff who did not know about his mental health difficulty. However, I did remind him that when I observed him in class the teacher suggested, on a few occasions when Danny was becoming visibly tense, that he have a five-minute break which was not offered to other students. Danny then

conceded: ‘Yes, that guy was very understanding as if he saw me getting a bit red or angry, he was quite lenient. I’ll give him credit there’.

In Charlie’s case, although he was initially happy with his teacher’s skills, as the course progressed, and the pressure mounted due to the summative exam, his view changed. In the second interview he said:

> Sometimes a bit boring if there’s a lot of waffle. I lose my focus. The book keeping was too rushed as there was too much information and too little time. I’ve had a hard course before but he’s not my cup of tea and it wasn’t the best way for me to learn. It was parrot fashion.

The pressure of assessments

Inevitably the students felt the pressure at times due to exams and coursework deadlines as shown by how upset Charlie became when he was told that he had failed his mock exam (see 5.3). However, Prem and Daisy both spoke of ‘enjoying’ the challenge of the assessments. In contrast, June found the whole assessment process stressful particularly when she did not feel that the teachers had covered the syllabus thoroughly enough. This was further compounded by her dyslexia, alongside bad memories of her first AS levels as she explained:

> Interviewer: So, you were crying a lot around this period of exams?
>
> June: Yeah, because obviously the last ASs because they were like, I spent a lot of time just cramming in all the information I could and the night of my Sociology exam I worked until like twelve and I got up at four.

Fortunately, Danny did not have to cope with such high stakes exams but he still found completing his coursework a struggle as he said:

> It got a bit crazy towards the end of April and May, I think it was because of coursework and it just got to my head and then I picked myself up. I thought, ‘You know what? I’ve got my flat; I’ve got to keep that going’.

Lack of motivated peers

In Prem's class there was a high level of absenteeism the day I observed her class, despite the AS exams happening in a few weeks' time. Added to this none of the students, including Prem had completed the set homework. As this was the basis for the lesson, the teacher had to restructure the whole plan in order to accommodate this non-completion. Prem was asked about this in her second interview to which she replied:

> Prem: Towards the end of the year I just – because hardly anyone ever does homework, so I started to get a bit slack with it as well.
>
> Interviewer: Do you think it did affect you, being surrounded by people who were not as motivated?
>
> Prem: Yes, and I think they get annoyed at me sometimes because I'm so enthusiastic about Classics. Like, I've seen one girl roll her eyes a couple of times, but I've just learnt to shrug it off.

A similar disparity in motivation and progress was evident between June and her fellow students as she said:

> The students aren't doing the work. A lot of my classmates don't like the way the teacher teaches. They don't understand it, like at all. So there's like a communication barrier. So obviously she's (*the teacher*) trying to, but she tries and gets frustrated and the students can't communicate their ideas properly. So there's miscommunication there and I think because I get it and I think because they just get the way I explain things; I kind of break it down for them.

For Danny the issue was also the disparity in motivation between himself and the much younger learners in particular, which did affect his concentration and tested his patience at times, as he explained:

> It's a very difficult thing because when I started there I was 48 and I had no formal qualifications. Sometimes I look around and in class, and I don't understand something that is basic, and the youngsters will look at you and say, 'Well he's thick'. In the Maths and English it can be a few younger ones and if they tend to mess around, it can put on a strain on your head and you feel like telling them to, 'Fuck off' but you're trying to concentrate and can't.

It was noticeable that Charlie and Daisy did not mention any tensions between themselves and their fellow students yet Prem, June and Danny did,

many times. Part of this disparity may have been because Prem, June and Danny were older than their fellow students. Also, these three were all highly motivated in their learning as they had overcome a variety of obstacles relating to their mental health problems and finance, to attend college and so they may have felt more frustrated when their learning was hampered by others.

7.5 How learning helped a sense of well-being

There were many aspects to how the participants felt their learning had helped their sense of well-being, of which the subthemes were: the enjoyment and benefits of learning; staying well; challenge and structure; acquiring new capabilities extending into home life; increased motivation, confidence and pride in achievement; hope and progression; a positive sense of self; changes in participants' thinking and perspectives and the social benefits of learning.

The enjoyment and benefits of learning

From her first interview, Prem indicated that she was thoroughly enjoying learning, as she said:

> I think throughout this year, finding a passion for Classics has just changed me quite a lot to be honest. Just to have a proper active interest in something; like just to do things that you're really interested in. I love that academic community. I love like, History and Classics and anything to do with human thought.

Although, in contrast to Prem, June spent quite a bit of time outlining the difficulties she had with the college itself, she did also convey that she loved learning, as shown below:

> People think that learning is just for academics and it's not. If you're interested in something find out about it and then you learn that way and there's no pressure and you flourish that way. I think that's so important.

Although Danny articulated multiple difficulties that he had encountered in the college, he did say that he found learning to be therapeutic:

> I love learning and I love doing the cooking. English was always a good class: that was therapeutic, and I was learning. It's not all negative about college. It's helped me a lot.

Both Danny and Charlie agreed with this sentiment when Charlie was asked if learning was therapeutic, he said: 'Always. It's great, even if stressful with the exams…Education's really good for me'.

Finally, another component of the benefits of learning that emerged from the interviews for all the groups was an awareness that education was helping them in different ways from how their healthcare provision helped them. In light of this emerging in the first interviews, specific questions around this issue were asked in the second. As shown earlier, Prem felt that she was thriving from being part of the academic community and so when she was asked if being in class was different from when she had therapy, she replied: 'Just the pursuit of knowledge, for me, is a kind of therapy'. However, this question was answered differently by June, who believed that: 'I'd much rather go to therapy. What's helped me more is counselling'. Nonetheless she also agreed that although therapy was helpful, it was important to be learning and gaining qualifications as 'You have to, because you can't really get anywhere otherwise'.

Danny also was positive about his therapy as he said: 'Well, the psychotherapy was the best thing ever done for me'. However, he later spoke of his amazing progression from being an unqualified and unemployed middle-aged man a few years ago, to now being able to say: 'I'm doing something productive to get a qualification - and a job', neither of which he said therapy could have offered him.

In contrast to Danny, Daisy was very clear that college was giving her more than what could be offered by the health system as she said it enabled to gain a certificate as well as 'It's stretching me for work'.

Staying well

When the participants were asked if and how learning had affected their mental health, Prem answered:

> Prem: Yeah, I've been good you know, steady. Just to have a proper active interest in something is good. Compared to this time last year when I was in a dead-end job, which wasn't really stimulating at all.
>
> Interviewer: Was that the gardening?
>
> Prem: Yeah. I think just coming back into education and having something to look forward to, is a help. Like when I'm here it almost feels like I barely have a mental health problem.

June spoke of how she felt mentally stronger as she compared it to how she had felt at the beginning of the academic year:

> It was like months and months of just awfulness and I think that it was pure depression but I'm better at coping with it now that I'm in college.

By the time of Danny's second interview he already had a job as a chef lined up and so was positive when asked:

> Interviewer: Do you think that learning has helped you to keep well?
>
> Danny: Yes, and I asked to go and see my doctor about going back to work. I think it's that time to cut medication down a bit but he might not give me that straight away. Amazingly, five years ago I was on one to one (*suicide)* watch.

For Charlie he likened being able to study on courses to replacing work:

> Through work there's expectations…So instead of working I'm studying as a replacement for a job. I'm actually helping myself get better by doing courses.

Daisy spoke of how beneficial she felt learning to be in the context of her history of spending numerous periods in hospital, although she had not been an inpatient for four years. There were now plans for her to lower her medication too:

> My psychiatrist said that he wants to take me off one of my medications. He said, 'Things are going swimmingly well with you'. And my social workers and my new psychiatrist, they are going to help get me off my Home office section 37/41, so I'm going to see my solicitor today[8].

Overall every participant in this group spoke positively of how they felt they had benefited from their recent learning, despite facing certain negative experiences as well.

[8] *Section 37/41 is a restriction order given when a patient is deemed to be a risk to the public due to their mental health problems.*

Challenge and structure

All the participants spoke of education positively providing both challenge and structure to their lives. When Prem was asked about this, she said: 'I like the challenge. Education gives me goals'.

Although June did not like the stress that the exams put on her as mentioned earlier, she did like being intellectually challenged. Several times she spoke of how challenging the work was particularly in AS English which she had not studied before, as she said:

> I love the subjects I do. I love English and learning about ellipsis and literature, and my vocabulary has widened. It's the nerves that come with exams, 'cos I love my subjects, I do 'cos if I didn't, I wouldn't have kept going. Sociology? I get Sociology, but English I found it really difficult and I don't want to fail.

Although June did not mention the importance of the structure that education provided, for Danny, Charlie and Daisy, all of whom had had periods of being severely mentally unwell, it was a particularly important matter. When Danny was asked whether structure and challenge was helpful he answered:

> Yes, a proper structure. If I wasn't here I would be sitting indoors doing nothing. I would get up early, but I go back to bed about 10 or 11 o clock am or 1 pm.

Danny's passion for learning was affirmed by his teacher during the observation as he said Danny was 'like a sponge' in relation to his desire to learn.

Daisy also spoke at length of how her course both structured and challenged her life as she said:

> Daisy: I'm quite shocked that I manage to get up every morning – early.
>
> Interviewer: What difference has going to college made to you?
>
> Daisy: It gives you responsibility. Getting up early every morning, showering, getting ready for college, washing my uniforms, making sure they are clean and doing all my homework that I'm supposed to. I like to be out and about doing something really positive.

These testimonies highlight the importance of the structure and challenge that learning can provide, particularly for those students who have faced past periods in their lives of being unwell and under occupied.

Acquiring new capabilities extending into home life

The development and application of new skills beyond the specific subject they were studying was particularly noticeable with Danny and Daisy who were on cookery courses as it transpired that they both had low literacy and numeracy skills when they commenced their courses. Danny reflected:

> Danny: I've achieved a lot (*in college*).
>
> Interviewer: So, you have definitely learnt more cookery. Do you think your Maths and English is improving even though it's a struggle?
>
> Danny: My English has got a lot better. Maths is still a big struggle.

Similarly, Daisy's reflection was:

> Yeah, I've learned a lot since I've been in college. Things that I never knew before and I've learned a lot and not just about cookery, Maths and English - I was terrible at it. Since I've been here, I've learned so much.

Increased motivation, confidence and pride in achievement

Obviously, the motivation and confidence levels of all the participants were reasonably high prior to them joining their respective courses otherwise they would not have chosen to be in classes that involved assessments. However most did cite examples of feelings of improvement in these areas. For Prem, her motivation levels had soared due to finding a new passion for Classics and further evidenced by her desire to run study groups to help her fellow History students**.** Additionally, her interest in politics had grown and recently she spoke publicly at the Houses of Parliament and at an education festival held at a famous public school. When asked what this entailed, she said:

> I'm ambassador, so I just talk about stuff that we've been doing politically and socially, in college and around college.

Prem appeared to speak with pride about these achievements.

In contrast to Prem, June felt that her motivation and confidence levels were already reasonably high regardless of being at college, evidenced by her perseverance in the face of many obstacles in relation to her dyslexia support. Nonetheless she did seem to be proud of the fact that her Sociology teacher felt she was very capable as she had asked her to teach her peers so much, even though it had become another source of pressure.

Danny equally was highly motivated as shown by his perseverance, despite the disorganisation within the college. However, in terms of confidence there was a progression as he said:

> Having come to college and been encouraged by the MHAs, that's helped. The last two years, it's brought a lot of confidence back.

He spoke of how the manager of the rehabilitation centre he formerly attended, recently referred to him as being a role model to other clients, as he had told Danny: 'You was in a bad state and look at you now – the others see that you have gone to college and a lot want to go as well now'. Additionally during the class observation, he was clearly proud of his achievements as he had photographs taken of himself holding all the dishes he had cooked that day.

In the case of Charlie, who was motivated already as he enrolled each year onto a different course, he showed great pride with regard to all the qualifications he had accrued over the years and did feel that education had helped his confidence levels. He said:

> I am making progress and becoming more confident. I can do things for myself. I'm an independent person. I've got character. I've suffered from depression but I'm recovering.

However, it did seem that temporarily, his difficult experience in book keeping had dented his confidence as he was now reticent to commit to another course.

Daisy's rise in motivation, confidence and pride in achievement was fully apparent in both interviews and she brought in all her certificates to show to me and spoke of laminating them. She then contrasted this newfound confidence with her memories of school when she tended to be isolated due

to her shyness, as she said: 'Yes I'm enjoying the group that I am in. I enjoy the tests that we have. I got 100%in one of my tests and then I got 98% in another'.

The increases alluded to here in relation to the pride, motivation and confidence that learning can lead to, cannot be underestimated for people who have been so adversely affected by their mental health problems in the past.

Hope and progression

Prem spoke often of how she now felt hopeful about her future plans in contrast to her previous apprenticeship in gardening as she said:

> With the gardening, there was just no future in it. But I can't wait to go to university when I can surround myself with that even more learning. I love like, History and Classics and anything to do with them…I have found something I really want to do.

For June too, she had hope and a clear route in terms of what she was aiming to progress onto in the future as shown here:

> Future hopes? To get my A2s. To go to a really good university that I really like and I really enjoy, and then to be happy. To have a job that I really like. To want to go into work every day. I now want to be a researcher in social issues as I want to do Sociology and Politics at university. My kinda goal in life is to try and get representation in the media so it's not just about skinny white people all the time.

Given that Danny was much older than Prem and June it was significant to hear how far his hope had moved from his first interview to his second as evidenced in these extracts:

> Interviewer: Did you ever imagine you'd be doing these courses?
>
> Danny: No, I always imagine I'd be working in a dead-end job or working too hard seven days a week to make ends meet. I've been off work for years now. I was in hospital for years and I can't imagine going back to full time work.

However, by the second interview when he already secured a fulltime job, his hopes for the future were much more ambitious:

> I want to stay in the catering game and work as much as I possibly can. And after I've passed this year, my future is to settle down with a wife, buy my house and become second or third chef in command.

Daisy was on the same course as Danny and she too had hopes to complete her second year and get a job in catering as she said:

> I like being at college and I'd like to be able to come back next year. And college gives me a chance to get a job when I leave college and like to get a job in a hotel, as the cook.

It was noticeable that although Daisy never mentioned having worked in paid employment before, she mentioned on three occasions how her course was 'preparing' her for work.

Finally, although Charlie did sound positive about his hope to become a qualified international football coach, it was difficult to determine how realistic these hopes were as he spoke about his previous difficulties of being in work:

> I did work for 10 years (*unpaid*), but it was too stressful 'cos you know how it is, it's all computerised. It's just like that (*he clicks his fingers*) it happens in seconds. And if you make a mess, they say, 'We'll get somebody else'.

Although it could be argued that some of these aspirations were unrealistically high e.g. Charlie, as he imagined becoming a professional coach and Danny becoming a homeowner in his 50s, they did appear to give them much hope. Conversely, it appeared that although the aspirations of Prem and June were realistic intellectually, it may be more difficult financially for them to reach their goals, given their economic and social circumstances. Yet the sense of hope that such aspirations gave was in stark contrast to the hopelessness that many spoke of having experienced when they had been inpatients on the mental health wards.

A positive sense of self

The idea that they had acquired a more positive sense of self was one which I specifically asked all participants about as they spoke of how they felt their learning was changing them. The only person who did not

feel this to be so was Charlie who when asked said, 'No, I'm the same person apart from the tablets'.

When Prem was asked if she saw herself differently since being at college, she answered:

> Yeah completely, completely, but now I've got much better things to look forward to. A passion for Classics has just changed me quite a lot to be honest. I feel like such a different person now.

For June, she said: 'I have changed as a person' which she felt was partly due to the teacher asking her to explain things to the other students in the class and seeing that they benefited from her help and also due to her studies in Sociology which were changing her politically she felt. This contrasted with the sense of failure she had experienced when she failed her AS levels two years before.

Danny also agreed that his view of himself had changed since learning at college, as he now felt he was a competent chef, as he said:

> Danny: I'm getting slightly more confident and I'm trying to change the way I am and who I am. When I've got confidence, I can say to myself, 'Yea I'm good at doing that'. Trying to get it into my head saying that 'I'm good at being a chef. I'm good at being a baker'. It's hard because as a child I was knocked back so many times and it's always at the back of your head and you've got to deal with it yourself.
>
> Interviewer: Does it help to say, 'I'm a student'? What did you say before?
>
> Danny: I wasn't working.

In Daisy's case she spoke of how at school she had been very shy and that this now had changed, as she said:

> Daisy: Yeh, it's (*being college*) made me more outgoing. And more, I feel responsible, like I'm doing something positive here. You feel posh because you've got a role in society. You are a student and you know that it's going to prepare you for work as well: its responsibility.
>
> Interviewer: Before you came to college, how would you have described yourself then?

Daisy: That I'm a mental health patient.

The changes in how these participants saw themselves, should not be underestimated in terms of how they felt that they now had a role in society, in contrast to how they felt when they were patients in psychiatric units.

Changes in participants' thinking and perspectives

Participants were asked about was whether they felt they had changed in their thinking and perspectives as a result of learning. Prem did feel that she had changed in many ways as she mentioned becoming more adaptable, particularly in relation to working with the younger students and their different attitudes to learning. About intellectual issues she was asked: 'So do you think then that learning and all that comes with it has really changed you?' to which she replied:

> Yeah, 100% as you are constantly changing the way you're thinking, I think. The more you know, it can just make everything else seem different. I do try to reflect on intellectual stuff. Like if I'm reading, I like to sit back and think about what I've just read, so I can remember it and sometimes it can give me a new perspective.

June thought her ability to adapt had changed as she said:

> June: I've learnt to deal with the people that I wouldn't normally have to deal with and like their opinions and I have to learn how to, because there's this girl in my English class gets on my nerves. Like she's great, but I have to talk to her and understand her points of view and work through that.
>
> Interviewer: Do you think you're getting better at that?
>
> June: Definitely. I think in some situations you have to just adapt and I think that's what I did.

Danny did not feel that his thinking significantly was changing as he felt it was 'Just adding to what I already knew' but he did concede that he had become more adaptable with the other students and reflective about his work. Charlie did not feel his thinking had changed significantly during his present course. In contrast Daisy spoke positively about becoming more

adaptable as well more knowledgeable, as she said: 'I'm more accepting and I enjoy meeting new people as well'.

A few times issues relating to a change in their perceived levels of autonomy emerged, such as when June spoke of her powerlessness over organising her learning support, as she explained:

> The college controlled the access to support, because I didn't get my dyslexic report. So, you do feel really helpless I think, but now I have control of my own life and I feel much better.

She also spoke of feeling more autonomous in the second interview, as now she could control her timetable by not having to attend early morning classes, given that she preferred to study later in the evening.

By the time of Danny's second interview when he was about to start a job, he said that he felt that he did have more autonomy, except in terms of finance as he was anticipating a shortfall as he transitioned into work.

When asked, Charlie compared his level of autonomy to when he was hospitalised as he said:

> I've got freedom now compared to when I was in hospital. My life has changed for the better.

Finally, Daisy was asked: 'Do you feel you are free to make choices about your life?' she replied:

> Daisy: Yes, sometimes friends try to give me advice to do things, but if it's good advice I do take it on board and follow a good advice.
>
> Interviewer: And do you think you've got better at working out what's good advice and bad advice through all your learning?
>
> Daisy: Yes, I do.

Overall it appeared in this group that only Prem and June had experienced changes at a deeper intellectual level. Rather, the more common changes were that participants perceived their levels of autonomy to have increased in some ways and that they perceived themselves as having become more tolerant and adaptable in relation to other students, whose opinions differed from their own.

Social benefits of learning

Although Prem and June did not know each other, they both were similar in terms of their interactions socially with the other students in their respective classes. Possibly because they were both older than their fellow students and different from them in terms of motivation and ability, they did not get very involved socially with them. Neither seemed particularly bothered about benefiting friendship wise in college, possibly because of the age difference and the fact that they felt their significant friendship groups were outside. Yet they did get on well with their colleagues and were often asked by them to assist them in their studies, which they did. However, there were other social benefits for them in terms of being given the experience of teaching their peers and opportunities to speak publicly in the college and beyond.

For Danny in contrast, there were obvious social benefits from being involved in learning, despite the frustrations he encountered as well. He spoke about having made good friends within the class who had recently taken him out to celebrate his birthday, to some of whom he had disclosed his mental health problems.

When Daisy was asked what she felt were the social benefits of attending a course, she said:

> We get to meet new people and we have a laugh. And then sometimes if I can't do something (*in class*), I'll get help from the other students, so we work as a team.

This working as part of team and a sense of belonging was echoed by Danny but not by Charlie as he was in a class with only four other women for whom English was not their first language. Yet when asked about the general positives in college, for him socially, he said:

> To meet new people and meet my friends. To make good friends and I like mixing with nice people like you guys'.

These social benefits are significant as often people with mental health problems can become socially isolated due to a myriad of reasons. In contrast, taking part in classes enabled these participants to feel part of a small community.

Summary

This chapter reported the findings from the mainstream group and the main themes that emerged which were: how their mental health problems negatively impacted their lives and learning; how there were certain pre-requisites that needed to be in place in order for them to be able to engage fully with their classes; the negative aspects of learning and finally, the many ways in which the participants felt that their learning had helped their sense of well-being. The following chapter will now discuss the findings that emerged from the former-students' group.

Chapter 8 Findings: former-student participants

Introduction

This chapter contains the findings for the former-students, the third group which was made up of five participants who had previously attended college but had now left. All these participants were known by the Mental Health Advisors (MHAs), Kevin and Sarah who recruited them all, aside from Simon who was recruited by me as he had been in my class four years earlier.

All participants were interviewed but not observed in class as they were no longer attending college. The length of the courses they studied ranged from one to two years and the length of time since the participants had left college spanned from two terms to five years. Three of the learners had experiences of not being able to complete their courses at times and so this provided an opportunity to hear from a group of people normally unavailable for interviewing due to the difficulty of tracing them for ethical and practical reasons.

In this chapter, pen portraits will provide brief background information on the five participants, followed by how this group described their experiences in terms of the main themes that emerged from all 15 participants. These main themes were: the negative impact of their mental health problems; the pre-requisites for learning; the negative aspects of learning and how learning helped their sense of well-being.

8.1 Pen portraits for former-students group

Gordon

Gordon, a 57-year-old Caribbean man, lived on his own in supported accommodation. After being married for 34 years, he had recently had an acrimonious divorce and there was currently much disagreement concerning whether the marital home which his wife lived in should be sold. Gordon had four grown up children. He said that for the last 13 years, he had mental health problems due to clinical depression, a difficulty that he had in common with his sister, mother and daughter. On a number of occasions, he had attempted to commit suicide and spoke of feeling suicidal recently; for safeguarding purposes this was reported to the MHAs. As he frequently failed to take his medication, he said he felt very low and was re-admitted to hospital intermittently. As Gordon said he was feeling more depressed by the time of his second interview, the MHA and I discussed with him whether we should continue. Gordon decided to proceed and said he was glad he had done so afterwards.

Gordon had loved school and had worked consistently since leaving until he became mentally unwell. He had had many jobs in the past ranging from being a church pastor to running his own successful IT consultancy company. Whilst in hospital it was suggested by the MHA that he study for a diploma in teaching adults, to teach computer skills. Due to his mental health problems, on the first two attempts to study this course, he was unable to finish it but did so on his third attempt, 10 years after he had initially begun. He said he was unable to make any future plans at this stage until he had sorted out his housing issues.

Nelson

Nelson, a 50-year-old man, was born in Nigeria and came from a family of five children. Although his parents and younger siblings moved to the UK, he and his brother were sent to school in Nigeria. Later he moved to North America and got married, although this marriage, which had included violent episodes, ended in an acrimonious divorce. During the time he lived in North America, Nelson began to feel mentally unwell with stress induced auditory hallucinations which were later diagnosed as being part of paranoid schizophrenia. When Nelson moved to the UK, he was homeless initially. This homelessness ended when he was admitted into the local mental health unit where he remained for three months and although he still took medication for his condition, he felt well mentally.

Nelson was highly educated with a degree in engineering after which he had trained as an airline pilot although he was unable to complete this training due to his mental health problems. Whilst recovering in hospital he was encouraged to return to education and it was suggested he studied on a short teacher training course for teaching adults. Simultaneously he was training every day to become a personal bodyguard which he chose not to complete. By the time of his second interview he had applied for two adult teaching jobs in a mental health charity. Nelson hoped to find work in this field although he was open to other job opportunities too.

Santosh

Santosh, a 40-year-old woman, was born in India having been brought to England for an arranged marriage which lasted for six years. During her marriage she was emotionally and physically abused by her husband, resulting in a miscarriage on one occasion. She intimated that he had raped her. Santosh escaped from this marriage by finding a live-in hotel job but ended up homeless for a period before moving into a hostel from which she eventually was rehoused. She lived now in a flat with her two-year-old son, whose father was her current partner. Santosh said that she had been diagnosed with clinical depression which at times led to extreme insomnia. She had tried to commit suicide three times and it was after one attempt that she was sectioned and spent six months in hospital. Although Santosh had been on antidepressants for many years, she was no longer on any medication.

Prior to her hospitalisation she had worked as a waitress in a hotel. Since completing her Hospitality and Catering level two course she had worked as a chef in a school and at the time of the first interview had a trial at a prestigious restaurant. She was offered this job. Santosh now wished to progress in her new job to become a sous or head chef and eventually start her own restaurant business.

Simon

Simon, a 52-year-old Caucasian man, had multiple congenital difficulties which meant he was unable to move unaided with either crutches or a wheelchair and was currently awaiting a gastric bypass operation as he was now clinically obese.

Simon had grown up with his parents who recently had divorced, as well as his three siblings one of whom had died. He was on good terms with his family although it had been a struggle to stay so, as his father had sexually abused his sister and his brother had recently been in prison due to paedophilia. Simon had been married for 33 years until a few weeks before the first interview, when his wife unexpectedly left him. Simon had a strong Christian faith and was very involved in his church where he sang in the choir. He was diagnosed with clinical depression five years earlier when his sister suddenly died. He was on regular antidepressant medication. Simon had recently tried to harm himself with a knife which led to two hospital admissions and in his second interview he spoke of feeling suicidal which was reported to the MHAs.

Simon attended a special school for physically disabled children which he had loved. He then had joined the discrete cookery class as an adult, during which time his place was kept open for him as he spent one year in hospital due to his physical difficulties. He returned and successfully completed the course before progressing onto the Hospitality and Catering level two course. However, he was unable to complete it as he was re-admitted to hospital again for nine months, due to his physical disabilities. Simon was very keen to return to education once his physical care was organised at home as his wife had formerly been his live-in carer.

Reuben

Reuben, a 20-year-old Asian man, lived on his own, having grown up in a family with much older brothers and sisters. He usually saw his parents once a week. Reuben first became mentally unwell during his GCSEs, although prior to that he had become addicted to computers and would be using one for 24 hours a day when able to do so. His illness also manifested itself by him becoming violent at home and then at school. He had then spent a compulsory six-month-period in a psychiatric hospital for teenagers before moving into supported accommodation. Reuben said he had been diagnosed with having a personality disorder/ psychosis which involved him hearing multiple voices, including frequent intrusive thoughts about killing himself and injuring others. In the first interview Reuben spoke much about how he was periodically contemplating committing suicide; this was reported to the MHAs.

Although Reuben enjoyed school, he left with only one qualification. He then attended the college and studied on a Travel and Tourism course. Although he enjoyed the first and second years, he did not complete the third year and had not been on a course or in work since then. Reuben hoped to begin an Access to University course at a different FE college.

8.2 The negative effects of the participants' mental health problems

The sub themes in this section were how their mental health problems impacted their lives and learning; how the side effects of their medication impacted their lives and learning; shame, stigma and disclosure issues and the courage and perseverance they displayed amidst their difficulties.

How their mental health problems affected participants' daily lives and impacted their learning

Gordon spoke a lot about his past and present depressed moods which he felt affected many areas of his life negatively, as he said:

> Gordon: My problem is staying in. I will stay in bed for hours and hours and days and days and sometimes I will just start really crying and crying and if you asked me why I would have no idea and I really plummet and I get very depressed and nothing, nothing, nothing happens…On one of those occasions I tried to kill myself, I remember, I had a suicide attempt and it was the course at college, and everything.
>
> Interviewer: Have you had any suicidal episodes recently?
>
> Gordon: Just casual thoughts of it. If I go anywhere that's like a high building or railway track or something I think what would it be like to jump. And then it comes to me, it's got to work 'cos I remember the last time I tried to commit suicide it didn't work. At other times I have these negative voices sometimes – 'You shouldn't be here, you're not as good as them'. I would always think lowly of myself.

One impact of Gordon's mental health problems was that he had frequently been absent due to relapses in his mental health which had led to him dropping out of two different PGCE courses before completing and passing on his third attempt.

Nelson, when asked how he felt his mental health was whilst he was studying said:

> Something I learnt from my doctor was that with this illness you never get completely healed or well. So I would say I was in a more 'containable' situation.

For Santosh, her mental health problems had impacted her life dramatically leading her to attempting suicide on a number of occasions and feeling extremely anxious as she said:

> Santosh: I got some problem with my ex-husband because there was abuse from him, domestic violence and I ran away. I tried to commit suicide three times; at that time I can't even think about anything else; I just want to die because I had enough.
>
> Interviewer: But after you had been in hospital, how did you feel?
>
> Santosh: I was very, very anxious even I couldn't take my tablet. The people (*community psychiatric team*) used to come twice a day to make sure I did. They tried to take me out and I can't go – all the time I'm in my room.

As Santosh recalled these painful memories during the interview, she cried but chose to continue being interviewed.

Simon was an interesting case as when I had taught him before, he had loved returning to study, had progressed onto a higher course and reported great improvements in his mental health problems. Sadly, both courses had been interrupted due to having to be hospitalised for long periods as he had needed surgery for his physical difficulties.

> Interviewer: And did going into hospital affect your mental health problems?
>
> Simon: It did because I wanted to be in college. I didn't want to have an operation… I wanted to be in college and complete something that was for me. Even though I was ill I thought 'I want to go back' but I couldn't go back as I'd missed eight or nine weeks and the course have moved on so much that I couldn't. I got low again.

By the time I rang him to ask if he was interested in participating in the study, he said he had just been discharged from being an inpatient on the psychiatric ward, after feeling suicidal and trying to harm himself when his wife unexpectedly left him.

Reuben spoke in detail of how he battled daily with auditory hallucinations and how these struggles had led him at different points to consider leaving his studies, which he eventually did:

Interviewer: When you were actually studying how you do think your mental health condition affected your workload? Let's think about your concentration?

Reuben: It was 50:50 'cos I'm listening to the teacher but once my mind is looking out the window and distracted, that's when I get very loud aggressive voices (*auditory hallucinations*). And the voices are escalating things in your mind and any problem gets bigger and bigger and you just can't really control what they tell you, what they order you to do. I always fear the day that someday I will do something violent; that's one of my biggest fears.

Interviewer: Let's talk then if you don't mind about why you decided not to complete the third year? What happened between September and December when you retuned after the summer, that made you want to leave?

Reuben: I think it was one day and I was actually in the computer room and I was just doing my work and my voices started talking to me and I was responding to them but very over the top. And then this girl (*in my class*) who was sitting next to me, started like calling me names and it was bad names and it was stuff I'd never heard before and the worst part was when she told other people about it. And over the next couple of days I thought I had never really heard those sort of criticisms from people so I didn't know what to do. It was either react in a very dangerous way or leave. And I think to a certain extent, I think I did the kinda right thing.

This extract shows how dominating and dangerous Reuben's hallucinations were and how the class's reaction to his mental health problems directly caused him to leave the course prematurely. In this group, all except Nelson spoke of past suicide attempts which was a reminder how acutely unwell they had been at points and contrasts starkly with how well Santosh and Nelson now were mentally which they partly attributed to their experiences at college.

Side effects of medication impacting life and learning

Nelson and Simon both spoke of the negative impact of their medications on their body weight. In contrast, Gordon's difficulties revolved around his dislike of having to take such medications. Due to this ambivalent relationship with them, he often chose not to take them which he said then led to him to become dangerously depressed as was the case at the time of his second interview. In contrast, Reuben did feel he needed his medications for his

daily battle with auditory hallucinations but was upset about how they interacted with each other:

> It's difficult to shut down (*mentally*), particularly on a strong dose of medications. I've been on about seven different medicines. You've got one medicine that puts you to sleep. One medicine that doesn't make you focus. They all have their negatives and positives and you can't really not pick out the ones you want and the ones you don't...a bit tricky.

Santosh was the only participant who was no longer taking any medication but for the others there were varying degrees of how their medications could negatively impact their lives, whilst at the same time help them.

Shame, stigma and disclosure issues

Three of the participants, referred to situations in which they felt there was a stigma, which at times impacted them negatively in college. Santosh said that she had dreaded people knowing about her mental health problems during her first year in college, but this had changed as her confidence grew:

> Interviewer: So when you were in the class did you tell your class mates that you'd had problems with depression when you started at college?
>
> Santosh: No, as I was hiding my problems from everyone. And then in an English class, the teacher was reading someone's story and they talk about rape and all this and that really upset me. Everybody was looking because I can't stop crying (*she's crying at this point and I ask if she wants to stop which she refuses*). It was because with my past I didn't want anyone to look at me differently, as it's not my fault. I don't want them to abuse me, or come and rape me or something.
>
> Interviewer: Did the teachers know you had mental health problems?
>
> Santosh: Yes, they did know because I came via the MHAs, but they just treated me like a normal person and when I needed help or was upset or something, they help me but they never make me feel different.

Just as Reuben related previously how he had experienced ridicule form other students about his mental health, Gordon also spoke of experiencing this too. As Gordon said:

> I had an experience on one occasion in my teacher training class where people were making fun of mental health students and it just immobilised me. Like, a part of me wanted to say, 'Hold on, I've got mental health problems', but part of me was scared to, as they might make fun of me.

Additionally, Reuben spoke of how difficult it was for him that his teachers knew of his mental health problems, and that the way they tried to accommodate his needs sensitively, annoyed him. This outlined the complex nature of disclosure:

> At first it was a bit annoying because they would always be by my side making sure I was doing fine. I mean they weren't treating me badly, but they were treating me in a way that was too different from the young people. So, like when any students were late, the teacher would have a go at them but when I turned up late the teacher would just say I hope you're fine and tell me to sit down... Maybe the main thing is the teacher just finding out what suits you.

In contrast Nelson felt it to be a benefit to disclose his mental health problems:

> I was never really ashamed of my mental health problems personally. Also, as a student being mentally ill I would make that known to the teacher and that helps so that if I don't understand something I will feel free to say so.

These reflections show how fear of disclosure and the associated stigma was understandable given the mocking comments that Reuben and Gordon experienced, whilst at the same time revealing that not every participant felt the same about these issues.

Courage and perseverance

Gordon spoke often of struggling to face the world each day when all he really wanted to do was to stay in bed. In this light, agreeing to begin his teacher training a third time, took much courage. Likewise, Nelson who formerly had had a high status job (airline pilot), demonstrated courage not only by returning to learning but also by being prepared to disclose his

mental health problems to the class. Equally his perseverance was made evident when he spoke of studying extensively if required, as he said: ‘Every day I worked until 12 or 2am; at least I would not go to bed until 1 or 2am’. The courage of Santosh too was evident when she outlined the extreme fear she had felt when she attended college during her first year. Her tenacity to continue even when her insomnia was severe was impressive:

> Sometimes I don’t sleep all night and still have nightmares and I couldn’t use the tablet all the time. But it’s still much better than it was, and sometimes I start 7am (*work*) and finish 11 o clock at night.

In the case of Simon, it was noteworthy that despite a challenging combination of multiple physical disabilities, mental health problems and demanding socio-economic circumstances, he still strove to be positive:

> The doctor swopped some of my tablets around yesterday ‘cos he said, ‘You are not coping.’ and I said, ‘Yea I’m fine’. He said, ‘No, I’m a doctor, I know. You are always like that. Even though you are in pain, you’ve always got a smile’.

Finally, Reuben seemed to be devoid of self-pity despite speaking of how unbearable his life could be given the daily experience of multiple intrusive auditory hallucinations, as he said:

> Interviewer: I would say that people with mental health problems are very strong. Would you agree with that?
>
> Reuben: I guess it’s according to the definition of what strong would be. Because there will come a time when someone like me won’t want to be living with this illness. And there may come a time when I may be thinking of doing something I shouldn’t, and that day would turn up. But I just try to be positive and that.

The narratives reflected much courage as the students persevered in their studies despite experiencing numerous setbacks in their lives.

8.3 The pre-requisites for learning

As the participants in all the groups spoke about their challenging home circumstances, it became apparent that there seemed to be certain underlying needs that were required to be met before the participants were in a place to engage fully in learning. The subthemes in this theme were: the need for shelter, money and food; the need to feel safe in the classroom; the need to feel well enough to learn; the need for graduated progression; the need for help from the Mental Health Advisers; the need for a positive relationship with the teacher and the need to have teaching and learning strategies that aided learning.

The need for shelter, money and food

One theme that recurred with all participants in the former-students group was that they felt they were unable to engage well with education if their social and material needs in terms of money, food, shelter and safety were not adequately met. This was highlighted by the fact that both Gordon and Simon, when asked about their hopes in terms of education, said they were unable to pursue their educational goals at present due to their current difficulties at home.

Nelson, when asked about money, mentioned that he had had to rely on the Food Bank a few times:

> As a mentally ill patient, especially when you come out of the hospital, the drugs you are being given have so many bad side effects, so if you want to be healthy on those drugs, you are looking at a ridiculous amount of money to eat properly.

Nelson also had had difficulties financially shown by that fact that although his initial hope had been to retrain in business and economics in order to set up his own business, this was impossible due to the cost involved. Even studying for his short teacher training course had cost £500, which was a barrier for him that was only eventually overcome due to the help of the MHAs.

In the case of Santosh, although she was now earning and economically stable, she had never forgotten what it was like financially when she was unwell as she recounted:

> One time I tried to sell my watch at a bus stop as I was desperate. The woman in the end gave me £10 and told me to pass it on to someone in need when I could.

When it was time to give Santosh her £10 voucher for participating in this study she refused it due to being employed. She asked for it to be donated anonymously to another participant that I perceived to be struggling financially, which I did. However, she did say that she was disappointed that she did not have enough money to progress onto the level three chef training course which would further have enhanced her career opportunities. Fortunately, neither Simon nor Reuben were presently struggling financially although they had to be very prudent with their spending.

In relation to accommodation, Gordon, Nelson and Reuben were all living in supported accommodation but both Nelson and Santosh had spent some time living on the streets due to being homeless. Nelson's reflections on this difficult time were revealing in relation to mental ill health:

> Nelson: I actually was homeless so that compounded the situation with my mental illness as it's one thing to be mentally ill and it's another thing altogether to be homeless.
>
> Interviewer: Do you think that impacted your mental health problems?
>
> Nelson: Well, I would say from my experiences, homelessness would actually create more of a difficult situation to someone with mental illness. Even if you're not mentally ill, if you become homeless that definitely trigger mental illness and all sorts of things could come out of that and it could lead to drugs.

Santosh also spoke of when she was homeless, which although was for only a few days and nights, remained a painful memory:

> I had to sleep in the park – really cold in December and I was so scared. Then somebody said, 'Come to this homeless shelter'. So, they put me in a hostel and that would make me more worse. That hostel, if I was still there, I would definitely be dead because it was so horrible. The doctor pushed for me to go into another hostel.

All five participants spoke of the different ways in which any difficulty in their living circumstances in relation to money, shelter and food, greatly limited their ability to engage in learning.

The need to feel safe in the classroom

When Gordon was asked whether he felt it was important to feel safe in the classroom, he answered:

> Gordon: Yea absolutely.
>
> Interviewer: Is that feeling safe with the students or the teacher?
>
> Gordon: Both 'cos it will affect you. It will affect your confidence. For example, if the teacher says, 'Divide yourselves into groups', you're worried 'They might laugh at me'.

Similarly when Nelson was asked if safety was important, he replied: 'Yes, there must be emotional support or else the student wouldn't learn anything'. Santosh when asked the same question answered:

> It's totally important. At the beginning I felt really unsure and unsafe with everybody. I only relax and learn once I felt safe in the classroom.

This echoed what Simon also said:

> Simon: Yeah (*safety is*) definitely important as if you feel comfortable around the other students and the teacher, then you will understand what you are doing better.
>
> Interviewer: If you didn't feel safe, would you have been able to learn well?
>
> Simon: Well, I would get panicky and suicidal 'cos I cannot control the situation and I couldn't learn because I'd be watching out for other things that are going to happen. So, you are not taking in what's being taught.

Lastly when Reuben was asked the same question said:

> Absolutely, I think no one should be living with intimidation or fear because you can't operate or come to college if you have those type of things inside of your mind, you don't feel you're learning.

In total all these participants believed that unless they felt emotionally and physically safe in their classrooms, it would hinder them being relaxed enough to engage fully in their classes.

The need to feel well enough to learn

In this group, only Gordon and Santosh spoke of the need to feel well enough mentally, to engage in formal learning. Gordon explained:

> If I'm feeling really bad about something, it's going in one ear (*what he is hearing in class*) and out the other, so I can't learn. But it's like Maslow's hierarchy of needs, the emotional part needs to be sorted out at the base. I mean, if I'm not feeling well emotionally; if my house is going to be repossessed while I'm in class, then hello, I'm not going to be able to think about quadratic equations.

Equally Santosh said that at first, she could not learn because of her fears:

> At first, I was so nervous to meet people. I can't talk with people as I thought they would laugh at me, but this did get better, but I don't think you can learn if you are very, very ill.

The need for graduated progression

One theme that emerged as important was needing stepping stones, a gradual progressive introduction to increasingly challenging courses. Although Gordon did not mention this topic, Nelson and Santosh both agreed that coming to study was the first step to becoming re-integrated into society after long periods of hospitalisation. This was echoed by Reuben who said: 'College was like the first step to getting back as after hospital I went straight to college'.

Similarly, Simon was emphatic that the stepping stones were essential for him as it represented a 'step up' from the hospital classes. Without these graduated steps he felt he would have 'freaked out' if he had suddenly been enrolled onto a higher-level course.

The need for help from the Mental Health Advisers (MHAs)

All the participants spoke highly of the support from the MHAs (Kevin and Sarah) apart from Simon who had had little contact with them.

Gordon, was most grateful for all the help he had received from the MHAs, as he said:

> I wouldn't even have started the course without the service the MHAs provide. You need someone who understands people from the mental health side of things. Before when I relapsed, Kevin helped me get back in, but I still failed but this time he's been there too to help me 'cos there were times when I did plummet. And things would happen, but Kevin was really encouraging and approachable. He puts time aside to see me he guides me; there's no end to his willingness just to help me.

Nelson was equally vocal about how key the MHAs were to his ability to study when asked:

> Interviewer: Why did you say that the MHAs have been invaluable?
>
> Nelson: Kevin is experienced in mental health. He actually goes to Ground Zero given that he comes into the actual wards - the recovery section. The whole issue is, after the hospital, where do you go from there? With Kevin he is able to manipulate the situation as he understands the process of being sick, recovery and leaving the hospital. So, he is concentrating on 'after hospital' which is so valuable. Yes, that transitional period is very dangerous, but Kevin literally took me to the induction and introduced me to the teachers and told them I would need assistance. It was such a good backup support system and the facilities were there as well. I had opportunities with the computers as I don't have one at home.

Santosh also recalled how she felt she would not have been able to complete her course in college, had she not had their support, especially as they were able to give her time personal help in sorting out any problems she encountered in college. Finally, for Reuben, he similarly had experienced Kevin spending a lot of time helping him:

> Reuben: It was the crucial element to have Kevin. I would not have survived for a week otherwise. The MHAs have an understanding about mental health. The teachers who teach you, it's just a lucky guess. They probably see mental health on television and assume that's what you're like.
>
> Interviewer: Was Kevin a good person to act as a go between you and the teachers?
>
> Reuben: Well, I always said to him, 'I'm not coming back. I just want to stop', but he managed to convince me and talk to the

> teachers about me, in a way that the next morning when I approached the classroom, it was like nothing just happened. So, I met up with Kevin regularly and got these things off my mind a bit and I managed to concentrate and relax and just do my work.

The need for a positive relationship with the teacher

Nearly all the students spoke of the need to have a positive relationship with their teachers. Gordon spoke a number of times of how supportive his teacher, Una had been. Embarrassed about having failed to complete his course twice before, he spoke of how if Kevin and Una had not pushed him a third time, he would never have re-enrolled on the course. Then near the end of this third attempt, he almost did not complete the course again:

> This time I stopped coming. I got depressed, I got dishevelled and everything. I spoke to Kevin about it and eventually I had to speak to Una as well. I said I'm not sure if I want to continue, if I want to finish. She encouraged me to and to cut a long story short, they helped me through that.

Both Simon and Nelson also spoke of how much backup the teachers provided for them and similarly Santosh was positive, when asked how her relationship had been with her teachers:

> It was hard at first but in my second year I was like bullying my teacher. I got jokey with some and they helped me out a lot. By then I could talk to them.

In contrast, Reuben's relationships with his teachers were more problematic than those of the other participants, mainly due to issues surrounding disclosure, as he said:

> There were times with teachers, I had a bit of complications with and sometimes I got the sense that the teachers were a little bit intimidated by me. They always thought I was going to do something bad once they turned their back.

Such complexities highlighted how it can be difficult for teachers who may have little experience of working with students with mental health problems, to know how best to interact with them.

Teaching and learning strategies that aided learning

Teaching styles

Most participants were asked which teaching methods helped them learn and some answered this more directly than others. Both Nelson and Santosh said that they appreciated a variety of methods such as the teacher demonstrating a skill or lecturing, as well as one to one help when needed. In Simon's case he spoke of benefiting greatly from the teacher who was:

> Checking and understanding, if you didn't get it and saying, 'Well, we will go through it again' and demonstrating.

When Reuben was asked which teaching techniques would enable him to learn best, he replied:

> Reuben: Yea, the teacher would set examples and references and that kinda helped me a lot.
>
> Interviewer: If that teacher was lecturing and not asking questions would you learn well with that?
>
> Reuben: It depends what the teacher is talking about…if the teacher is talking about a subject I am truly enticed by, then I really focus but if not, my brain would switch off.

Working in groups

Although Gordon had mentioned being anxious about being laughed at when working in a group, he also said that it could be effective at other points:

> It could be effective when I allowed myself to open up to the group work. Yes, there was always different takes and different avenues and perspectives you could learn, 'cos on your own you just have your ideas. And so it certainly enriches the experience.

Both Simon and Nelson had enjoyed group work as Nelson said that the 'peer learning was awesome'. However, this was more problematic for Santosh and Reuben who both said that when they was less confident in their first year of college they had found it difficult, although in their second year they enjoyed it as they had grown in confidence by then.

The importance of feedback

As Gordon claimed to have little confidence in his abilities, the issue of feedback from the teacher was complex for him:

> Interviewer: Do you think it makes a difference if the teacher is affirmative to you, saying that you can do it, even when you lack confidence?
>
> Gordon: I'm not sure. Sometimes in a class it is helpful, because I always think I'm not good enough for it. But then I feel the teacher is only saying it and she doesn't really mean it.

In Nelson's case he spoke of benefiting from specific feedback: 'It helped me when I knew what the teacher wanted so I could regroup in the way I asked the questions and delivered the programme'.

Santosh, who described herself as lacking confidence when she first arrived at college was emphatic about how the teacher giving her positive feedback helped her:

> Santosh: It was really, really important. Once I rang up the teacher and said I was not coming back and he refused to let me and he persuaded me to stay by saying I was capable of finishing the course. The teachers really did encourage me to keep going as they seemed to believe in me. Every time I was on level one, they always mixed me with level three. And I feel like, 'Why are they doing that'?
>
> Interviewer: They were pushing you on?
>
> Santosh: Yes, and when I would say 'No', they would say, 'You can do it'.

For Simon being told by the teacher that he was doing well was 'a big pick up'.

> They would say to me, 'Right you CAN do that'. So, it's like the trust as well and confidence that they were giving me.

This was not as straightforward for Reuben:

> Interviewer: So, does it make a difference when a teacher tells you explicitly that you are doing really well?
>
> Reuben: It would have made a difference. It would have given me encouragement, but no one has actually sat down and said you

are doing extremely well because if they did that to me they would have to do it to everyone.

These examples illustrate how valuable encouraging feedback is for under confident adults, when they return to education.

8.4 Negative aspects of learning

For this group, the only negative aspect of learning that emerged related to the sense of failure that participants felt due to being unable to complete the courses they were previously on.

A sense of failure due to non-completion

In the case of Gordon, Simon and Reuben they mentioned a few times how difficult they found being unable to complete their courses and the sense of failure that this radiated. Although Gordon did manage to complete his course on the third attempt, he still used the word failure on seven occasions throughout the interviews.

> Interviewer: But surely you didn't fail as you just weren't able to complete the course because you were ill?
>
> Gordon: I call it a failure. You know what sticks in my mind? Outside the college I was standing in an alley nearby and the teacher was coming along and in a short conversation she said, 'Sorry, Gordon you've failed' or 'You've not passed', somewhere along those lines.

Although Simon's non-completion was due to his physical difficulties as opposed to his mental ones, it still caused negative feelings:

> Simon: I had to leave the course because of the operation I had. I felt a failure then, an absolute failure.
>
> Interviewer: When you look back, what do you regret about being unable to finish it?
>
> Simon: That I haven't got the qualifications and experience of learning and the friends that I made. I wanted to get to the point I got a qualification and be able to say: 'This is what I've done. I've got this. I've achieved this.'

Reuben equally viewed his leaving with a sense of failure as he referred to it as 'dropping out' as opposed to finishing. Later, after he had related what had led to his non-completion he was asked:

> Interviewer: So, it wasn't the actual work at level three which was the difficulty but the experience with the other pupils?
>
> Reuben: Yea.

Interviewer: Well, maybe that shows how immature they were?

Reuben: Yea and it shows how immature I was to leave.

Interviewer: So, do you still regret dropping out?

Reuben: That's a maybe because I wanted to finish but I couldn't be in a classroom environment with people who just don't understand me. But I do regret it a bit.

This sense of failure and regret is a reminder of the negative consequences that can exist when engaging in learning.

8.5 How learning helped a sense of well-being

There were many aspects to how the participants felt their learning had helped their sense of well-being, of which the subthemes are: the enjoyment and benefits of learning; staying well; challenge and structure; acquiring new capabilities extending into home life; increased motivation, confidence and pride in achievement; hope and progression; a positive sense of self; changes in participants' thinking and perspectives and the social benefits of learning.

The enjoyment and benefits of learning

Although Gordon was mentally fragile at the time of the second interview he was very positive about how much education could positively affect a person. The following exchange illustrates this:

> Interviewer: Do you think education can help people with mental health problems?
>
> Gordon: Absolutely, unquestionably. When you see a person learn, you can see their self-esteem grow as they engage. And then there's the actual learning part itself, when they actually do grasp a concept and they do learn and their mind is enlightened. On all different fronts, it's a boon.
>
> Interviewer: Looking back would you say that education was giving you something that health care couldn't provide? *(Leading question based on what has emerged during the first round of interviews*)
>
> Gordon: Yes, I would say so. I feel it's innate, a desire to learn, to grow or to expand. And you are learning how to deal with people, how to respond, how to react. But there were times when I didn't feel too bad and I felt that I kinda belonged.

When Nelson was asked how he had benefited from his recent training he answered:

> Nelson: First it opens different doors. It gives you the opportunity to do something different from what you are used to and it helps you 100% both mentally and physically. It was an exciting and challenging time and I even enjoyed my teaching observations. When you educate somebody, you are opening doors for other people to be educated.

Interviewer: So, do you think that college can offer something more than the health system can in terms of learning?

Nelson: Yes, but it is more than that because firstly, you are mixing with others and secondly, you're being taught. Lastly there's an element of responsibility that comes into it.

Santosh, Simon and Reuben all spoke of changing in significant ways through learning. Santosh was most enthusiastic about how she felt she had personally benefited from being in class as she said:

Sitting in hospital and in the hostel made me feel worse, so learning does help you become better. I don't think anyone improves in that hospital ward. It was awful. Everybody watching you and because I was sectioned I literally could go nowhere alone. I was as fearful and timid as a mouse. Now I'm assertive and have self-respect.

When Simon was in the discrete cookery course he had spoken of how helpful it had been for him and so questions were asked about that experience:

Interviewer: If I remember correctly, when you were on my course you said you were changing in so many ways?

Simon: Big time, big time, being changed into a better person. Yeah, I absolutely loved your course. But the course gave me a reason to get out of bed, you know and showed me where I needed to get to.

Interviewer: And what about the higher course that you started?

Simon: I enjoyed it a lot too because it covered all aspects in catering, everything from the dietician to buying food as a manager – all the calculations. The side that I liked was the healthy side about the dietician, healthy eating, nutritionist, which was the way I was going to go when I finished.

Despite Reuben being unable to complete his last course he still could remember about the good parts of his time at college:

Reuben: Before I went to college I'm just going to sit around doing nothing my whole life. Going to college was like the first ever step that pushed me and I'm quite confident that even when I leave this college I'm going to start in another college. I have the confidence in me to do it.

> Interviewer: Do you think education can meet a need that the health system can't meet?
>
> Reuben: Absolutely yes. Education is a foundation of everyone's minds and so it helps people regulate their mind and helps them get along.
>
> Interviewer: When you were on the course you enjoyed, in any way would you say it was therapeutic or more about learning?
>
> Reuben: I'd say it was more about learning.

These responses show how classroom learning benefited these participants in differing ways, as well as offering something beyond what the healthcare system was able to offer.

Staying well

As the participants were so positive about how they had benefited from being in class, even those who were unable to complete their courses, it was likely that we would discuss whether they felt it had helped them to stay well mentally. Unfortunately, Gordon was unable to say that it had in his case but Nelson did say that learning had helped him to stay well. This was also the case for both Simon and Santosh, as Santosh said:

> Since I left college I never stopped! I got the school job which was fantastic and in 2010 I stopped taking pills. I used to take 60g of depression tablets but after 2010 I've got my full-time job (as a café supervisor) in a school. I haven't been in hospital since my time at college. I would say that it did help hugely to keep me well.

Simon recalled being well during the period he was attending class even though he was mentally unwell now: 'When I was coming to college I was doing really well mentally'.

Although Reuben's situation was more complex, he thought he had benefited mentally from his time in college as he said that he felt the auditory hallucinations (voices) had lessened during that period:

> College was the one place that helped me kinda get through a day. There are days I'm not really having good days as I'm not keeping my brain occupied now and my main focus is just on my mental health.

As all the participants in this group had enduring mental health problems, the finding that learning had helped to keep them well mentally, aside from Gordon, is very significant.

Challenge and structure

When Gordon was asked about the ways in which college had helped him organise his day he answered:

> It helped to have to engage and meet with people and get out of the house. My problem was staying in as I would stay in and stay in bed for hours and hours and days and days. College gave you something to come out to, somewhere TO go, people TO meet. There was a pressure to try and complete stuff, assignments and so on. I didn't have a structure prior to it at all as there isn't that structure of eating and washing etc. And so to introduce it into one's life, such a regime is a paradigm shift.

Nelson also felt positive about the structure studying could provide, as he said:

> It is very vital because you are coming from one situation (*being in hospital)* which is total dependency. There you are being housed, fed and then you're being taken from that to a whole new world, transitioning to become independent. The whole way you have been taken care of has been ripped away and when you come into the real world you are like, 'What happened'? This is what means that they can go back easily into that state again. And when you're out of work and there's nothing to do, you are mainly at home, doing other things that you are supposed to do at home, but when you have something to do outside of your home, it kind of energises you. You have something to look forward to and achieve that day. You need to do your homework, you need to get to the class on time; there are the rules and regulations of the classroom. And the rules and regulations of the institution which helps shape and model you to get you back into society.

For Simon, as he was no longer studying or in work, he reflected on how he thrived on having the structure and challenge imposed on him and when asked why, he said:

> Simon: 'Cos I had something to get up for. Even though it was college it was like a job. I've got to be there for 9 o clock so I'll definitely be there at a quarter to nine.
>
> Interviewer: And what was it like when you didn't have that structure?

Simon: Horrible. You're just sitting back doing absolutely nothing.

For Reuben, education had a similarly positive effect on the structure of his life:

> Reuben: Well I'd been in the hospital for mental health reasons and when I got discharged from the hospital I was pretty much doing nothing. It was a pretty dangerous way I was going, so my doctors recommended that I got into some sort of education.
>
> Interviewer: And did you enjoy that structure?
>
> Reuben: I did, you know it was pretty good for me 'cos then I'm used to working five days a week and it's better than sitting at home doing nothing.

These positive comments, in relation to how classroom learning can provide a valuable challenge and structure in the lives of these adults are illuminating. This is because this group of former-students could give a retrospective perspective that contrasted greatly with how unstructured their days were now, in the case of Gordon, Reuben and Simon.

Acquiring new capabilities extending into home life

Although neither Gordon nor Nelson felt that they had acquired new skills that had extended into their home lives, Santosh, Simon and Reuben did suggest that this had happened to them. As Santosh's native language was Hindi, on beginning at college she was unable to write in English and college helped her to learn essential language and literacy skills.

> Like when I was writing I didn't want anyone to see me. I get so nervous, you know like, why are they looking at me? Maybe I'm doing something wrong, and that's all gone now. But it was not just about English and Maths that I learnt but also about nutrition. Before the course I ate crisps and chocolate all the time and then I learnt what to eat and how to cook.

Simon, although he presently was classed as clinically obese, did feel that his learning had impacted what he intended to eat at home:

> Your course was an eye opener for me. You know, instead of having a hamburger, have a cheese salad. Don't eat chips – forget about chips. Frying pans are a 'No' and it was good because you had to go to other classes as well, like Maths and English classes.

In the case of Reuben, he seemed to have developed a thirst for knowledge since his attending college:

> Reuben: There was always something the teacher taught which I didn't know…so that's when I would have to switch on and pay attention.
>
> Interviewer: So, would you say that some of the teaching did expand your thinking?
>
> Reuben: Yea 'cos after me going to college I do go to the libraries to pick up books on subjects that were way beyond what I have ever read before, on philosophy. I didn't choose philosophy, it was whatever book was on the shelf I just grabbed it; it wasn't organised, just whatever caught my eye. I do try to learn new stuff there every day.

These quotations illustrate the expansive potential that engaging in learning can have on a person's life.

Increased motivation, confidence and pride in achievement

When asked if his confidence levels had improved since attending college, Nelson said he was '100%' certain that returning to college had helped to increase his motivation and confidence levels and continued:

> Nelson: There was no confidence when you're mentally ill and being under the psychiatrist and under drugs as well, I was just hopeless.
>
> Interviewer: And when did your confidence start to be rebuilt?
>
> Nelson: As soon as the treatment kicked in: therapy, meeting with the mental health team, having the opportunity to go outside of the hospital and being able to socialise. And coming to college, all of that kind of like, stimulates the mind and stimulates your way of doing things and mentally you are being rejuvenated.

This positive soaring of motivation and confidence was also echoed by Santosh who spoke of having previously visited the college to enrol, and turning back home without doing so, due to her extreme lack of confidence. She said:

> Santosh: No, I came to this college two or three times before. I would come down and be outside and I see so many people, I just thought 'Wow, I can't do it'.
>
> Interviewer: So, when you then did enrol, did you meet the MHAs here?
>
> Santosh: Yes, my home care team just dropped me to meet Sarah (MHA) and so I couldn't even go back as I was too nervous to go on my own back. So, I was stuck as I can't go in, and I can't go out. The teacher asked me to fill form and I was so nervous because so many people there. The first time in class you know I can't get up and say, 'Yes, I know the answer', 'cos I was so nervous.

Simon spoke with much pride of some of the skills he had learnt whilst in college as shown in the following excerpt:

> The best compliment I had was by someone at church who came up to me and said, 'I heard you made the carrot cake; it's the moistest, tastiest one I have ever had'.

Finally, Reuben did believe that his time at college had helped with both his motivation and confidence levels as he said:

> Before I went to college I'm just going to sit around doing nothing my whole life. I have the confidence in me to do it now and, like when I was in secondary school, if I had a problem with a subject I would not have had the confidence to go up and just ask the teacher. But in college I think it showed me how kinda to talk to the teachers.

Such reflections suggested that for most participants, classroom learning made significant differences to their confidence levels as well as their sense of pride and motivation.

Hope and progression

The fact that three participants from this group were unable to complete their courses at points affected how they responded to questioning about how education have given them hope. Although Gordon said he felt too low in his second interview to say anything about being hopeful, Nelson felt that coming to college had given him much hope as he said:

> In terms of opportunities, this was another opportunity; that was another door opened that I could just go into. Currently I would

> love to go into teaching as it's my first priority or anything else that comes my way. So, I'm not rigid to one path and I'm working with Kevin and Sarah about it, helping me build a future.

Santosh spoke often of how coming to college had opened up many positive doors for her:

> After college, I got the school job which was fantastic but then left to have my baby. I love cooking because it's not only my job, it's my passion now, and I want to do something better. I want to get sous chef or head. That's why I'm applying for this new job. I'm going for a trial next Monday and then after that we'll see.

Although Simon had the disappointment of not completing his last course he spoke of coming back to college with hope:

> Yea, I would love to come back on a cookery course. And then I would like to work, I would love to work. And I think that is what I'm missing.

Reuben spoke of the hope he had to begin studying again at a different college and seemed to suggest that coming into education had opened up possibilities to him that previously he had been unaware of:

> Reuben: I didn't have any ambitions before college 'cos I wasn't around people who had ambitions. I just let life take its natural course and that's just how it went.
>
> Interviewer: Do you think it would have made a difference if you had had people around you who had ambitions?
>
> Reuben: Absolutely yes. If I was around people who had high expectations in life maybe my life would have taken a different type of turn you know.

The optimisms expressed here by Santosh and Nelson served to stress how learning can offer much hope for adult students particularly in relation to progressing onto other courses or jobs.

A positive sense of self

In the second interviews, questions were asked about whether the participants had changed how they came to view themselves in relation to the world. This was because there were suggestions of such changes having taken place in the first set of interviews. Gordon, during his first interview,

mentioned a few times that he did not see himself as being a 'normal person' and so he was asked to explain what he meant by this in his second interview:

> Gordon: Normal people, who don't have their inhibitions. They don't have their baggage…they go about life enjoying life! They've got places to go, people to meet. Life is going on.
>
> Interviewer: But did you feel that how you saw yourself changed for you in any way, during the time you were studying here?
>
> Gordon: Yes, yes.
>
> Interviewer: You saw yourself as…?
>
> Gordon: Someone who is in a class. There were times I thought 'I don't belong' and others when I thought I was doing okay, but there was a fluctuation. This person going to college isn't the same person lying down in bed, not doing anything.
>
> Interviewer: Has this changed again since you finished college and have not been working?
>
> Gordon: Yes, although I don't know if that's a good thing or bad thing or right thing or wrong thing.

Santosh was passionate about the changes that had taken place in the way she saw herself as seen in the following extract:

> Interviewer: Do you see yourself differently as a result of becoming a student and learning new things?
>
> Santosh: Definitely. My friends are amazed – and my family in India who say I am very, very different. I have gained so much confidence and now I am not intimidated by friends who are lawyers or doctors. What I have to say to them is as valuable as what they have to say to me. I now can hold my head up high and stick up for myself. I know who I am now. I know I am worth it. I have self-respect now.

For Simon, although his physical ill health had interfered repeatedly with him completing his courses, he was still able to recall how he felt his identity had changed for the better during his time in college:

> Interviewer: So, do you think you saw yourself differently when you became a student?
>
> Simon: Yeah, it did because you are heading towards a goal and at the end of the course, you've achieved your goal.

> Interviewer: You seemed to almost have gained a new sense of who you were?
>
> Simon: Yeah, because it was like 'I can do this.'

Although Reuben and Nelson did not feel that they had changed in how they saw themselves whilst attending classes, this was an important issue for the other participants.

Changes in participants' thinking and perspectives

During the second interviews, questions were specifically asked about how their thinking may have been changed through learning, as it was a common theme percolating through the first interviews. When asked of any changes in his thinking, Gordon replied:

> Gordon: Yes, my critical analysis skills were sharpened. On the course itself I had to learn about different aspects of teacher training and lifelong learning, but I did not go home and think I've changed my perspectives on life.
>
> Interviewer: Did you feel you were adding to what you had already known or were you being changed intellectually?
>
> Gordon: Certainly, a bit of both as sometimes we have to unlearn. Sometimes we have learnt something that might be a bit flawed or has to be revised or changed in some way. But there is addition as well as going onto the next step, like in Bloom's taxonomy knowledge, comprehension, analysis, evaluation etc. Sometimes I genuinely thought, 'Yea this is really not above me. I know what I've got to do. I can go home and delineate this and extrapolate that'.

Nelson did suggest that he had changed his thinking in significant ways in relation to learning how to teach:

> Interviewer: Have you ever had moments when you have thought 'I am completely restructuring'?
>
> Nelson: Yes, I always have moments like that. What I did in the classroom and what the teacher helped me do, because I knew what the teacher wanted, helped me regroup the way I asked the questions and delivered the programme (*as a teacher)*.

Equally Santosh felt she had changed her thinking on a number of fronts:

> Interviewer: Do you think your perspectives were broadened by being in a class?
>
> Santosh: Definitely. I learnt not to just argue needlessly when I did not agree with someone but to say, 'This is what I think' and why but I can accept you think differently. We can agree to disagree. It helped me to learn how to weigh up evidence. I do think things through a lot. Not so much politically but I learnt so much about other people and how to deal with them.

For Simon too:

> I am more understanding of people with mental health problems. Someone might push into a queue and I think, 'Okay'. I still go 'Be careful I'm disabled', but I don't rant and rave. Your course was an eye opener for me. Watching other people with learning difficulties, that couldn't understand what you were saying was an eye opener.

In Reuben's case there were different changes:

> Interviewer: In your two good years at college, did you think that learning was beginning to change the way you were thinking or was it not significant enough?
>
> Reuben: I did learn a lot of things going to college. It taught me how to learn and it taught me how to learn individually by myself so I didn't have to be in groups of people to learn you know. I could do it isolated by myself so that's one thing it really did teach you.

Finally, participants were asked if they perceived their levels of autonomy to have changed since returning to education. Whilst both Nelson and Santosh did feel that they had autonomy in their lives, such as being able to apply for jobs, the other three participants who were all struggling emotionally at present, did not feel that they had autonomy at present. When asked, Gordon said: 'No I haven't got any freedom – it's like being caged or bound or imprisoned'. Similarly, Simon said: 'I've got no control in my life at present'. Reuben said that he was trying to be proactive about looking after himself despite the problems with his auditory hallucinations and not attending college or working: 'Yea, I always keep moving – I do the groceries, I do exercise and I do interact with family members. But I don't have a social life and that's the only downside to it'.

It appeared from this group that although some participants felt that learning had helped them to be more adaptable and understanding of other people and their views, few of them have undergone deep changes intellectually, except possibly Reuben who now read books on a variety of subjects to expand his mind. However, in terms of autonomy, Gordon, Reuben and Simon, who had all reported recent suicidal thoughts, did not perceive any long lasting, positive changes in their levels of autonomy.

Social benefits of learning

All the participants from this group aside from Gordon, spoke of the social aspect of learning being a benefit. In contrast, Gordon said that he had struggled to 'fit in' the class.

Nelson said that he had enjoyed mixing with the other students and said that the socialisation that comes from attending college 'makes all the difference'. Santosh also was positive although she mentioned too the challenges that being in a class with others could bring:

> When I come here and speak with my people, my classmates, everybody is different. We had a few arguments because we're different, but I learned to mix with other people.

Simon thrived on the social interactions that college enabled him to have as he said:

> I felt great (*in class*) 'cos there was a mixture of all ages and it was like a community as everyone helped everyone and even though you were supposed to do your own thing you helped each other. That was really important. You're all here to learn the same things, that's what I liked, and you know you're not competing against each other. It's like this is what we have all got to do so let's help each other.

This issue was more complicated for Reuben due to his bad experiences of being ridiculed by some other students. Yet he was able to reflect on some positive social interactions as he said when asked about positive aspects of college life he said:

> Reuben: I met friends and I socialised. But now, my doctors are a bit disapproving of my lack of social life ‘cos they’re always telling me I need to go out and engage with people.
>
> Interviewer: So, your lack of socialising, is that out of choice or not knowing where to go?
>
> Reuben: I know where to go, I just can’t connect with people. I just lost hope. I lost touch with reality. I just gave up with people, you know. I think maybe when I’m in college again, I want to do something about it ‘cos I’m going to be in an environment where I’m going to be with these guys 24/7, so I’m going have to put in a genuine 100% to do what I have to do to work with these guys.

Reuben’s current loneliness, which his doctors were worried about, emphasized how learning did seem to have benefits socially. The level of social interactions that both Simon and Reuben had encountered in college appeared to be in stark contrast to the amount of time they now appeared to be spending on their own.

Summary

This chapter reported the findings from the former-students group who all spoke clearly about how beneficial their time in college had been even though there were some negative experiences for Gordon and Reuben. Notably, Gordon, Simon and Reuben all spoke of their recent thoughts regarding suicide. Although this may be viewed as conjectural, one wonders if this high incidence was partly because none of them were currently involved in attending classes or working. This contrasted with when they were attending classes, which they felt had helped them to stay well mentally.

The next chapter will now bring the findings from all the three groups together.

Chapter 9 A synthesis of key issues across all three groups

Introduction

The last three chapters presented the main findings from all the groups and the four main themes which emerged. These themes were: the negative impact of their mental health problems; the pre-requisites for learning; the negative aspects of learning and how learning helped their sense of well-being. This chapter now synthesises these findings to identify commonalities and differences that emerged from the narratives.

9.1 Commonalities and differences

There were many commonalities in the themes from the three groups, despite participants within the groups differing in terms of their diagnoses, levels and length of time in adult education. However, there were differences too, particularly in relation to the negative features associated with education and so this theme was absent for the discrete group, who were supported at a very high level by the extra staff involved in the classes. Rather it was most common for the mainstream group who were presently studying on accredited courses and so the negatives were both salient and had the highest consequences. For the former-students group, their contribution to this theme centred on the disappointment they felt when they were unable to complete their courses.

Although it was striking to see how emotionally fragile the participants in the discrete group were, it was a surprise to discover how fragile mentally some of former-students also were, as three spoke of having had recent suicidal thoughts. Interviewing participants who had left college turned out to be enlightening as it was striking how vividly they could remember from that period. These vivid memories, both negative and positive, did suggest that their time in college had significantly influenced their lives in some way, even for those students who were unable to complete courses. Even though in all cases their non-completion was related to health problems or experiencing discrimination, they all seemed to feel personal blame which the reader may

ascertain was as a result of symbolic violence (Bourdieu, 1998); this was an observation that could benefit from further probing in future research.

9.2 The negative effects of the participants' mental health problems

Some of the commonalities for this theme included the fact that most participants (13/15) recounted traumatic memories of being acutely unwell and in hospital, as well as nine mentioning past suicide attempts though there may have been more who had such incidents in the past. Additionally, most participants struggled with the negative side effects of their medications impacting their daily lives, whilst simultaneously recognising their usefulness. The fear of relapsing was most prevalent among the discrete group, but participants from all groups spoke of how their mental health problems led to frequent absences and in some cases caused them to leave courses altogether. There was concordance across all groups of how their mental health problems could adversely impact their learning in the classroom due to a lack of sleep as a result of their mental turmoil. This also included how their concentration levels could be affected if they felt low in mood on certain days or found that their auditory hallucinations (voices) were troublesome. About the stigma associated with mental health problems and the shame they felt, this was common among all groups with a few individual exceptions and was usually accompanied for many by a fear of disclosure among their fellow students and in some cases, their teachers too. In Reuben's case (former student), it was surprising to hear how complicated the issue regarding disclosure could be. Ironically, he had teachers who had been informed about how to deal with students with mental health problems, but their attempts to make reasonable adjustments to accommodate his needs led Reuben to feel uncomfortable in front of his peers about being given special treatment.

9.3 The pre-requisites for learning

The necessity for their social and material needs to be adequately met

All groups demonstrated that when their social and material needs regarding having somewhere safe to live, having enough money to live on and buy food were in jeopardy, their ability to concentrate on their education was greatly inhibited. The effects of poverty heavily permeated each group and it was striking that nearly all participants had no families who could provide any financial support. Also, it was notable that only three participants owned a computer which meant that most were unable to do their assignments at home; neither did they own smartphones (which may function as a computer) but had only the most basic mobile phones which few ever had enough credit on to return my calls. For those who had spent some time homeless (six participants) and living on the streets, they recalled that this had meant that trying to find shelter was all consuming mentally, as well as possibly making their mental health problems worse. In the discrete group, for those who were not eligible for welfare support, finding enough money to live on was a never-ending preoccupation and in all groups, there was a fear concerning the government's recent changes in welfare support. Participants feared the prospect of their support being withdrawn suddenly and them being forced to find employment despite being very fragile mentally or experiencing severe side effects from their medication that would have interfered with their capacity to work. Yet, there was a prevailing desire among all groups to be well enough to be in employment. In the mainstream group both AS level students had to have at least ten hours of paid work to survive which invariably impacted their study time. Equally difficult financially was coping with transitions in life, even when they were positive transitions: Danny moving into employment, Daisy having to furnish her new flat when she left her hostel. Finally, given their poverty, it was not possible for a number of them to progress onto the higher-level courses they now were qualified for, given that they had little disposable income after paying for their essential living costs.

Participants from all groups spoke of needing to feel safe and secure in the classroom with their teacher and other students. Although I had expected this from the discrete group, it was illuminating to hear that even the potentially most confident participants in the mainstream group felt this to be essential. Many spoke of how they felt that education had helped their mental health to improve, and said that at the stage when they were acutely ill, they would not have been able to fully engage in learning.

The necessity for targeted help in college

The need to have a positive relationship with their teachers emerged as being a key aid to learning. The attributes they valued included: someone they felt emotionally safe with whom they could trust; someone who listened; someone who made time for them despite being busy; someone who was patient with them when they had not completed their work; someone who understood their mental health problems and was accommodating regarding their fluctuating levels of fatigue. It emerged that a teacher who could relate to the student and encourage their sense of competence, appeared to add to a student's level of perceived autonomy and helped to motivate them. When these factors were present, students spoke of how such a teacher had the potential to inspire and challenge them and it was clear that students thrived in classes where most of these elements were present together. Conversely it was clear that when this was absent, it hampered a student's progress as evidenced by those who spoke of how stressful they found this to be.

Yet it became apparent that good teaching and learning strategies such as making explicit the plan for each lesson, interactive lessons and making clear the guidelines for group work, in themselves would never be enough for students with mental health problems to partake in FE. What emerged from their narratives was that they felt the role of the Mental Health Advisers (MHA) was as key to their progress as the teachers were. However, as the discrete group had had little contact with the MHAs, this was not mentioned in their interviews. All of the nine students who had contact with the MHAs said their help was invaluable and in many cases, they would not have remained on their courses without their support. The key elements that the

MHAs provided were : a thorough understanding of mental health problems which was superior to that of even well-informed teachers; providing a degree of support which reflected the students level of need and educational desires as opposed to their diagnosis; a gradual lessening of support as students became more independent; exuding confidence and care in working with such students, unlike some of the teachers who appeared fearful of them; liaising with and educating the teachers when needed; enabling students to progress in a graduated manner academically, at a pace tailored to their needs and intervening when a student was experiencing difficulties as a result of the disorganisation within the college system or substandard teaching. Other distinguishing characteristics were: spending more time with students than the teachers could in individual appointments; keeping in contact during relapses and crucially co-ordinating with the teachers throughout this period as well as facilitating a return to the classroom; knowing how to access other learning and welfare support within the college system; showing care over an extended period of time (unlike the teaching staff who might change each year); making time to persuade students not to leave prematurely whilst working out ways to improve the issues causing them to want to leave. Finally, it emerged that their support was of paramount importance when the students faced transitions either into new courses or jobs as their vulnerabilities were heightened at this time. Having help from the MHAs who were part of a multidisciplinary team, straddling both health and education, was crucial as this complementary approach provided wraparound care for the recovery journey from the hospital to college and beyond.

Teaching strategies in the classroom identified as being particularly effective

In relation to teaching styles, all participants appreciated a variety of methods, such as the teacher demonstrating new skills or techniques, whether it was practical in the case of catering or involved the teacher showing how to work through examples on the board. They also liked being told the outline for each lesson and having step by step instructions when relevant, particularly in relation to group work. A teacher delivering a lecture was only acceptable under certain conditions: they did not speak for too long;

it was relevant; it was broken up by interactive questioning and group work; it was not too fast; it included checked students' understanding before progressing onto the next stage; it did not contain too much information for them to process mentally. Overall, interaction seemed to be the key and participants liked it when the teacher used interactive stories and questions. Finally, participants spoke of valuing well prepared lessons and being told at the beginning what the plan for the lesson was, as well as being given extension tasks when applicable.

When the subject of working in groups arose, some participants were mainly happy to work in groups although for the less confident participants this could be problematic as they feared being ridiculed either due to their mental health problems or lack of knowledge. Also, group work put additional stress on those who were troubled by auditory hallucinations (six participants), as they were not sure whether the voices they heard belonged to their co-workers or were delusional. Overall, all participants agreed that group work could work well, although there were certain conditions that needed to be met to do so. At its best, group work enabled peer learning and increased participation levels. At its worst, it could feel like wasted time if two conditions were not met: first, that the teacher had outlined what exactly the group was going to do and why; secondly, that the group was made up of students who were similar in terms of their motivation and attempted to work at a similar speed.

Feedback was an important component in enabling participants to learn effectively as they said that they found it most helpful when the feedback was specific, realistic and proportional and that this could move them on in their thinking. Also, it helped when the teacher showed that they believed in the student's level of competence.

9.4 Negative aspects of learning

It was notable that this theme emerged from the mainstream and former-students groups, but not group the discrete group. This may have been because the discrete group was protected from the wider negative aspects of college life as they were given individualised care from the staff. However, it

might also have been because they were less confident than the other groups or because they did not want to criticise me as their teacher.

The disorganisation within the college was a great source of stress for a few students who needed extra learning support, as this support was not accessed as quickly as it should have been. Also, for some students they had experienced many staffing problems; on many occasions, teachers did not turn up and crucially, this was not communicated to the students beforehand. Poor teaching, including lecturing irrelevantly and for too long, combined with showing no interest in the student personally, was also a source of stress and demotivating. This particularly affected the two AS students who were sitting high stakes exams. For Danny, one negative aspect was the feeling that his teachers were unable to cope with his unpredictable mood swings which he felt were due to his mental health problems. Equally, assessments did cause pressure for the mainstream group participants who had work deadlines to make. In June's case the pressure led to her being diagnosed with anxiety and depression, but it did not stop her continuing in her studies after she ensured she had support in place to help her cope more easily. For Charlie, he felt it was the speed at which the syllabus had to be covered that caused him to feel stressed and believed that had he had more time, he would have managed to pass the exam. However, assessments were not a negative for everyone as some spoke of enjoying them and finding them exciting and challenging.

For Prem, June and Danny, the lack of motivated peers posed problems; possibly this was heightened by these participants being older and having high levels of motivation, particularly given the financial sacrifices they had made to return to studying. Finally, a fear of failure in assessments was prevalent in the mainstream group and in the former-students group, there was a sense of failure due to not being able to complete their courses.

9.5 How learning helped a sense of well-being

There was total concordance in this theme between all the groups and so only a few features will now be highlighted. A number mentioned that they

found learning to be therapeutic at times, not in a clinical sense but in a creative sense. They felt this was due to the level of concentration that learning demanded, which in turn led to absorption and was helpfully distracting from their preoccupying worries. Additionally, almost all of the participants felt that being in education had led to an improvement in their mental health which helped them to regulate their minds; in some cases, this had enabled them to contemplate lowering their medications (Danny; Daisy) or to discontinue them (Prem; Santosh). Although they agreed that they would have found it too difficult to learn when they were acutely ill, once they were beginning to improve, they felt that the learning helped their recovery and to stay mentally well in many cases, although this was less pronounced among the more fragile students. However, it was notable that this improvement in their mental health was not reported as present for the three former-students (George, Reuben and Simon) who were currently not in education or training and who were undoubtedly the most fragile mentally during the interviews. Although they had equally felt that their time in class had helped them mentally, as they were no longer in it, they felt the lack; was it a coincidence that these three all disclosed recent suicidal thoughts during their interviews?

Finally, two corollary benefits were that first, when learning one subject, they also learnt about related topics (e.g. healthy eating) which impacted on their lives generally. Second, a major by-product of attending college was the opportunity it provided in enabling these students to improve their essential literacy, computer and numeracy skills.

The benefits of being in college as opposed to a health care setting

Many of the participants spoke of how they felt that college was able to offer them something which their healthcare provision could not. This was evident in how they spoke of being in hospital, where they felt that at points they had been passive recipients of treatment (Nelson: 'total dependency'). In contrast, in college they appeared to see themselves as being in active, agentic roles. Previously their aim had been to 'get their lives back' whereas in college, they appeared to have moved beyond that, providing the opportunity to move forward towards new openings and possibilities different

from their former lives. This change in role was potentially empowering and transformative, particularly as they reported their levels of autonomy being increased in some cases. Another contrast was that of the discomfort that they recalled whilst in hospital; although attending college could be stretching, challenging and stressful at times, they felt it to be a more positive discomfort which was worth tolerating in order to achieve their goals in completion. Conversely, the disappointment that the few people who were unable to complete their courses felt, highlighted how key this was.

The intellectual stimulation of attending classes in college was a frequent theme that differed from the classes they had taken in the health unit. This was not a negative reflection on the hospital provision but rather that college classes were qualitatively different because they were intellectually more demanding, and in many cases ignited a new passionate thirst for knowledge. Additionally, participants spoke of how gaining qualifications validated their competencies, giving them the currency, they needed to apply for jobs. Not only did this give them a sense of pride but also it prepared them for work and as Nelson said, helped to 'shape' them back into society.

The sense of flow mentioned earlier seemed to help shift the focus away from their illnesses, something that was less achievable in a healthcare setting. However, such benefits of absorption and distraction were dependent on the college provision running smoothly, although it could often be inadequate. It was a source of stress and they felt that they would have been unable to navigate these obstacles if the MHAs were not available to help their lack of self-direction.

The positive structure provided by attending classes was frequently mentioned and yet many participants did have structure in their week due to having to attend various medical or welfare appointments. Such appointments did not necessarily follow a regular pattern or involve seeing the same member of staff each time. Could this, combined with the possibility of a negative outcome, account for why none of the participants mentioned the structure such appointments gave them, in a positive light? In contrast, attending college, which they chose to do, involved a certain level of

predictability as the class was at the same time each week, in the same place with the same teacher and had a similar outcome each week.

Another contrast mentioned was an appreciation of the focus, whilst in college, no longer being on their diagnostic labels in comparison to healthcare settings which could be diagnosis dominant. In college few people knew of their diagnosis which they appreciated, and this was a reminder of the importance for educational institutions continuing to emphasize learning. All the students spoke of college being able to offer something intrinsically distinct from what a healthcare setting could offer, which they appreciated and benefited from.

The opportunity to mix with a greater variety of people who significantly they had not met via the healthcare system was referred to many times. Even though there were benefits of being with people who have similar mental health problems for the discrete group, the other groups preferred to mix with 'normal people' as they called them. They felt this helped to enable them to feel more normal themselves, even though at times it raised uncomfortable questions surrounding how much they should disclose and their fears concerning stigma. From this, one can see that the students felt that college was able to offer something intrinsically different and important from the healthcare system.

Hope and a positive sense of self

Another prevailing benefit that emerged throughout the study was that of hope, particularly for those who were currently on college courses. These hopes included the possibility of progressing onto higher level course as well as hoping to progress into a job, in which they could be productive, and which offered prospects. The participants spoke of having increased ambitions for their lives which were not present before; for example, Louise referred to having a 'second chance'. This increase in hope and ambition impacted how they viewed themselves in terms of how they saw themselves as people and in society. A number spoke of having struggled to see themselves positively when they were patients. It appeared that they felt they had progressed from formerly inhabiting a sick role as a patient with mental

health problems, a role which was socially stigmatising and isolating, to now inhabiting the positive role of a student, who had a future and belonged. This included seeing themselves as someone who now had a role in society as opposed to a patient who had no role in society. Consequently, they viewed themselves as people who had something to contribute both in conversations with others as well as to society and potential employers. This included no longer being intimidated by well educated people (Santosh) and feeling proud to be referred to as a role model for other people with mental health problems (Danny). A number referred to this change in how they saw themselves, as helping them to feel like a 'normal person' who they thought of as someone who had autonomy and a sense of purpose in their lives, which in turn seemed to increase their sense of dignity. With these changes came a spark of agency, so that although at times they felt powerless over inadequate college provision, they had enough self-efficacy to know they deserved better treatment and seek ways in which to improve it.

Summary

This chapter brought together the findings from the three different groups, to identify the many overlaps that existed between them as well as the differences. To do this, each of the main themes were considered in turn. These themes were: the negative impact of their mental health problems; the pre-requisites for learning; the negative aspects of learning and how learning helped their sense of well-being.

The next chapter will seek to discuss the implications of these findings in relation to past study in this field as well as how the findings did answer the four research questions. The chapter will conclude with a critical reflection on my role as the researcher.

Chapter 10 Discussion

Introduction

The main aim of this study was to explore how engaging in formal classroom learning, for adults with mental health problems, could influence their sense of well-being as well as for some, lead to a sense of transformation. More specifically, the four research questions which this thesis set out to answer were:

1. What is the wider societal context for adults with mental health problems returning to formal learning?

2. Considering the relationship between wider societal factors and mental health, what are the perceptions of adults with mental health problems regarding the influence of classroom learning on their well-being?

3. In what ways can their experiences and perceptions be understood with reference to Mezirow's theory of transformative learning?

4. In terms of bridging the divide between the fields of health and education, what can be learnt regarding how to interview vulnerable adults in a meaningful, safe and ethical way within an educational setting?

This chapter will discuss the findings from this study in terms of how they answer the four research questions. First, it will summarise what was identified in chapter two regarding the wider societal context for adults with mental health problems. Second, it will consider the perceptions of the adults in this study in relation to previous work in this area, as well as reflect on if and how this corresponds with the theory of well-being by Seligman (2011). Third, the chapter will reflect on whether the narratives in this study did shed further light on transformative learning theory, as well as exploring if there is a relationship between well-being and transformation. Fourth, the chapter will explore the value of bridging the divide to discover safe ways in which to interview vulnerable adults in an educational setting. Finally, the chapter will finish with a critical reflection in relation to myself as a researcher.

10.1 The wider societal context for adults with mental health difficulties

As was outlined in the initial chapters, looking at the wider societal context for adults with mental health problems, revealed that such problems are ubiquitous at a national and global level which adversely affects not only those who experience it, but society generally. Part of this is due to the fact that there is an unequal distribution that exists in society in relation to mental health problem. There is a higher proportion of people who are diagnosed with such difficulties, among those who are socially and materially disadvantaged, reflecting the social gradient in health generally (Marmot, 2015) and as Bourdieu (1984) would argue, because they lack not only economic capital but also social, cultural and symbolic capital. This unequal distribution is reflected in the multiple disadvantages which people with mental health problems encounter ranging from poorer physical health, lower life expectancy, lower educational attainment, lower employment opportunities and social exclusion accompanied by a lack of opportunities to improve their socio-economic status (SES) and well-being generally. As there is evidence that education can benefit the well-being of adults, including those with mental health problems, this study set out to identify the ways in which this may be able to happen.

10.2 Learning and well-being

Attention will now be paid to the second research question which asked what the perceptions of adults with mental health problems were regarding the influence of classroom learning on their well-being. First, the present findings will be considered considering previous work in this area. Second, there will be a reflection on if and how these findings resonate with the theory of well-being proposed by Seligman (2011).

10.2.1 Past studies and current findings

In terms of the evidence that learning can influence the well-being of adults, there was much overlap with the work that has been carried out in this area (e.g.BIS, 2012; Feinstein *et al.*, 2008; James and Talbot-Strettle, 2009). This

past work will now be looked at alongside the findings of this study, at personal, interpersonal and societal levels. With regard to the personal benefits, this study agreed with the previous evidence that learning could lead to improved self confidence, self efficacy or 'bundles of benefits' (Duncan, 2015, p. 39). Equally that there was an increase in their sense of agency as well as a sense of hope which included the desire to progress onto other courses, employment or voluntary work. There was also concordance that learning could impove their well-being and that such improvement in well-being involved a change in their sense of self. At an interpersonal level the findings found that the opportunities afforded by learning included being able to mix with a wider diversity of people, outside of their usual social interactions which in turn helped some people to experience a change in their attitudes concerning a range of topics. Also, participants spoke of how their learning had affected their wider families positively and that as their confidence levels increased, so too did their ability to speak in group situations .

Such progress affected the participants at a societal level too as there were increased levels of social participation for many or social capital (Bourdieu, 1984); they spoke of having experienced a sense of belonging, which in some cases led to less isolation. However, in terms of it leading to a change in their levels of civic participation or involvement in voluntary work which were reported by Feinstein *et al.* (2008) and BIS (2012), no one in this current study mentioned such information, although there was evidence that their recent learning had inspired both Prem and June to become more politcally involved. Equally, no one mentioned whether they had lowered their number of visits to their GPs or that their levels of physical activity had increased, as reported by BIS (2012).

At the level of interaction with the college itself, there was overlap particularly with the findings of James and Talbot-Strettle (2009) and Fernando, King and Loney (2014). In terms of the positive aspects regarding interacting with college, this study echoed the need for: good teaching and learning (James and Talbot-Strettle, 2009; Lewis *et al.*, 2016); targeted support from staff in

order to enable adults to complete their courses and a partnership between the health and social care providers and the college (James and Talbot-Strettle, 2009). Also these findings re-emphasized the need for a discrete provision to be made available as well as opportunities for graduated progression onto higher level courses or a 'stepping stone' (Morrison, Clift and Stosz, 2010, p. 82). With regard to the negative aspects of attending college, there was also concordance in relation to the side effects of their medicines impacting their learning negatively, as well as the pressure of assessments. Contrariwise, this study did not find evidence concerning the difficulties of not having family support or transitioning onto mainstream course as James and Talbot-Strettle (2009) had found.

On the whole, the findings of this current study did correspond in multiple ways with earlier research both in relation to the benefits of learning for adults generally, as well as those with mental health problems, but it also extended it too. For instance, this work provided a detailed outline of the pre-requisities which emerged as being crucial to enable these adults to benefit from being in college, such as needing to have a safe place to live and enough money to live on, alongside being well enough to engage in formal learning. Additionally, this study illuminated the value of learning within a college setting as opposed to a clinical one as it highlighted not only how important the roles of the Mental Health Advisers (MHAs) were, but the exact nature of what they were able to provide and how that differed from what teaching staff could provide. Insight was also given into the overlaps and contrasts that existed between participants from the three different groups. For example, the need to have a good relationship with their teacher was common to all, which was seen as an essential component in the theory of transformative teaching and learning (Duckworth and Smith, 2018b), but only the mainstream group had much to say about the negative aspects of coming to college. Equally, it was only those in the former-students group who spoke of experiencing a sense of failure and regret about being unable to complete their courses as well as highlighting the fact that good support from the staff was not always enough to prevent a person from having to leave prematurely (e.g. Reuben; Simon). Furthermore, as the study was able

to include participants who had not completed their courses, who are normally difficult to access, it provided some support for the propostion that learning can have not only a tranformative effect but also a sustaining one, (Schuller *et al.*, 2004). For instance, even though former student participants had left college many months before, they were able to recall the benefits they had experienced during their time in college. Overall, the current findings did accord with many of the previous ones cited in chapter three as well as adding to the evidence showing that learning can be beneficial for adults with mental health problems, in a myriad of ways.

10.2.2 Insights into learning and the theory of well-being

Having now reviewed how the findings corresponded to previous research in the field, attention will be paid to the specific and detailed insights it provided regarding how learning contributed to the well-being of the adults with mental health problems. Seligman (2011) proposed that five elements contributed to well-being (positive emotions; engagement; positive relationships; meaning; achievement), and so each of these will be addressed in turn.

1. Positive emotion*:* This refers to those aspects a person feels are pleasurable about their lives in the present moment. In this work, as participants spoke of the benefits they had experienced from learning, many positive emotions were expressed. These included feelings of surprise at how much they were enjoying learning as well as how pleased they felt to be achieving something valuable. Additionally, they expressed experiencing joy and delight in relation to the knowledge they thought that they were gaining and the other ways in which they felt they had benefited. Such benefits led to feelings of hope, as well as affection and fondness for both certain students and staff. Almost all the participants suggested that learning contributed positively to their well-being although this was retrospective for the participants who had left college. As Louise contrasted her current situation with how she felt prior to attending college, she said: ‘nothing positive has ever happened before’. Furthermore, these positive emotions were reflected in how animated the participants were about wanting to take part in the interactions as well as their attitudes during the actual interviews.

However, it is worth noting that such positive emotions contrasted greatly with the various negative emotions that the participants had also expressed such as anger, disappointment, frustration and shame, which were contained in three of the themes that emerged from the narratives. The first was when they spoke of the negative impact of their mental health problems such as the possibility of relapses and the side effects of their medications (e.g. Colin and Charlie, who both described how drowsy their medications caused them to feel). The second was when they spoke of how they had been unable to benefit from learning when they did not have enough money to live on or a stable residence to live in (e.g. Egren, who had been unable to access welfare benefits yet and Nelson, who had spent time living on the streets). The third was when they spoke of the negative aspects of learning such as the pressure of assessments (e.g. June) and a sense of failure when unable to complete their courses (e.g. Simon and Reuben). Although these negative emotions could not be completely eradicated by benefiting from learning, particularly in relation to their economic situations, it did emerge that learning could play a significant positive role. The positive emotions that learning elicited appeared to lessen some of the impact of these difficult issues and their current mental health problems, particularly as it gave them hope for their futures.

2.Engagement: This refers to when a person becomes so absorbed in a task that they lose their sense of time ('flow'), which happens when a task is sufficiently challenging in order to promote engagement but is neither too easy or too challenging (Csikszentmihalyi, 1997). The narratives suggested that such engagement played an important role in aiding the well-being of the participants, as many times their recollections suggested that they experienced a sense of absorption, although they did not use that word themselves. Furthermore, Louise and Reuben felt that experiencing such engagement in learning helped to lessen their auditory hallucinations, which were ordinarily negative, preoccupying and distracting. Another aspect that emerged was how much the participants valued the engagement that came because of the structure that learning provided, in terms of regular classes and assignments. This contrasted with some of their days at home, spent

lying in bed and watching television for extended periods (e.g. Joan who described her non-college days as spent ‘ambling around and watching television’; Danny who described going back to bed at 10am).

3. Positive Relationships: Seligman (2011) saw positive relationships as being a crucial element contributing to a person’s well-being and this claim did appear to be justified in this study as multiple references were made to the other people the participants encountered whilst learning. Even though some of these interactions were problematic, such as studying alongside students who lacked motivation as in the case of June, Prem and Danny, the benefits of the positive relationships they forged whilst learning seemed generally to outweigh the challenges. However, the important role that positive relationships played was not restricted to involving only their fellow students but also to the staff they interacted with: the Mental Health Advisers (MHAs), the Occupational Therapists (OTs) and the teachers. The support, help and kindnesses they experienced from these different groups were commented on as positively influencing their well-being and, in the case of Gordon who struggled with his classmates, the positive relationship with the MHAs and teachers provided some compensation for this lack. Even Danny, who at times tended to focus on the negative aspects of college life, when he frequently referred to the disorganised college and poor teaching, did express immense gratitude for the help and support he had received from the MHAs and some of his teachers.

The importance of the contribution that positive relationships can make to well-being was demonstrated when it was absent. When positive relationships were absent, as in the case of Prem and June with their History teacher or in the cases of Reuben and Gordon with their fellow students by whom they sometimes felt ridiculed, it became a source of stress and frustration. In June’s account a poor relationship with her History teacher led to her leaving the course and in Reuben’s case, mistreatment by the other students led to him leaving college completely. This lack of positive relationships led to them feeling emotionally unsafe in the classroom, the ramifications of which were that their concentration levels and enjoyment of the classes were lessened. Similarly, at an intellectual level, positive

relationships were key in providing an atmosphere of safety and acceptance among students, which helped to facilitate critical discussions to take place within their classes.

Finally, Seligman proposed that one of the reasons that positive relationships played a key role in a person's well-being was because they presented opportunities in which a person could show kindness to another. Again, this was apparent here; for example, Danny was seen whilst being observed in class to willingly give help to the students who were struggling with their work. Equally, Santosh who chose to donate the £10 voucher that was given to her for participating in the study to a student that I perceived to be struggling financially, even more than she was.

4. Meaning: This refers to a person feeling they belong to and are involved with something that has a beneficial purpose such as religion or politics. This leads to a person feeling that what they are doing is valuable and worthwhile and, in this research, many participants spoke of how they felt that learning had helped them to find a new sense of purpose in their lives. This was most evident in the plans they were now making concerning their futures, which consequently appeared to increase their well-being. For some, their purpose was to finish their present course well; for others it involved longer-term plans such as progressing onto a job, another course or voluntary work, in order to help other people.

The significance of feeling that they now had acquired a new meaning or purpose in their lives cannot be underestimated given how all the participants had experienced mental health problems, some at a very severe level. Their narratives suggested that this new meaning was both empowering and life enhancing: for example, Danny and Santosh as they established their catering careers and Louise who referred to being able to return to learning as having a 'second chance'. It appeared that part of the route that led to discovering new purpose and meaning in their lives was through undergoing major changes in their thinking and perspectives which will be explored later, in the context of transformative learning theory.

5. Accomplishment or achievement: This refers to experiencing the feeling that one has achieved competence in certain areas, which may lead to a recognised qualification or vocation, or for its own sake. For some participants, this sense of achievement came from being able to commit to a weekly obligation as well as to learn new skills within a group context, which was a major achievement for some of the participants who spoke of previously living unstructured and chaotic lives. This led to feelings of pride in managing to complete courses and persevere through the difficulties that the participants had encountered along the way. It also highlighted the need to be assigned to the right level of course; without this they floundered, lost confidence and experienced stress such as when Joan spoke of enrolling onto a computer course which was too difficult for her. Contrariwise, when someone was assigned to an appropriate course such as in the case of Orla, the discovery of unexpected levels of competence led to an upward trajectory of incremental progression. The pride that the participants expressed in relation to what they felt they had achieved did appear to contribute to a positive change in their identities and sense of well-being.

However, it must be noted that learning could also have a negative influence on the well-being of these participants. When they had negative experiences in college such as facing inadequate teaching or a disorganised college system, their well-being was impacted negatively (e.g. June and Danny), which in turn exacerbated the pressure of high stakes exams (e.g. June and Prem). Equally, when participants did not achieve as they had wished to, it could have a negative effect on their well-being as in the cases of Reuben and Simon who experienced a sense of failure due to their non-completion. Additionally, when a person did not have their most fundamental social and material needs being met before and during their time in college, then their chances of experiencing an improvement in their well-being as result of their learning were severely hampered.

Overall, I would affirm that the findings suggested that the five elements proposed by Seligman that contribute to a person's well-being, did provide a useful tool to analyse the participants' experiences of well-being. Many participants spoke of having experienced numerous positive emotions and

relationships and for some, fewer relapses in their mental health since attending college.

10.3 Continuities and transformations

The next step to consider (in relation to the third research question), is if and how the participants in this study experienced transformative learning. To recap, Mezirow (2009) postulated that if a person came to see themselves in relation to the world in a different way, this could lead to them experiencing transformative learning, as:

> we transform problematic frames of reference (mindsets, habits of mind, meaning perspectives) – sets of assumption and expectation – to make them (*the frames of reference*) more inclusive, discriminating, open, reflective and emotionally able to change.

Mezirow (2009) proposed that if transformation was to occur, it could involve a notable change in a number of ways. Three changes will now be discussed in relation to the findings. These will be: a change in a person's frames of reference; a change in a person's way of viewing the world; and a change in a person's sense of self. Although these will be addressed separately, they may be related to one another.

A change in a persons' frames of reference

In terms of changing their frames of reference, it appeared that for some participants this was manifest by them becoming more questioning and accommodating concerning their previously held assumptions and those of others. This seemed to be the case for Simon, Egren, Santosh, Daisy, June, Prem, Louise, Danny and Orla. They all spoke of feeling that they had become more open to the views of others and of becoming more adaptable and accommodating in this respect. For example, Orla spoke of becoming more flexible both inside and outside of class which she thought was a breakthrough for her. She spoke of how learning had led her to review her

'faults' so that she now aimed to 'identify them and think; let's try and improve in this'. Danny, also believed this to be so for him and given his past tendency to become angry in class at points and even initiate a physical fight on one occasion, this was a significant step forward.

A change in a person's way of viewing the world

The second change that appeared to have occurred was at a deeper level which Mezirow suggested would include looking critically at their previous beliefs in the context of their history, leading to a change in their 'way of knowing' or a change in their epistemology (Kegan, 2009, p. 44). This appeared to be so for only three participants, Prem, June and Reuben. For instance, Reuben spoke of now actively seeking out new reading material in subjects such as philosophy, which he had never considered reading before attending college. June and Prem spoke of experiencing intellectual changes which appeared to hint at the idea of critical conscientization (Freire, 1970): they implied a belief that they had the capacity to play a part in transforming the world around them, as evidenced by their political activism. This intellectual change appeared to fit in with the limitation that was pointed out by Brookfield (1991), that transformative learning should involve a deconstruction of power issues. This suggests that Brookfield was correct in highlighting this limitation in Mezirow's theory (see 4.3), although in reality, this was not apparent in the testimonies of the other students in this study. Finally, there was a suggestion from Reuben that such shifts in thinking could have a long-lasting effect, as although this study took place over a relatively brief period, it was notable that he did report such changes in his thinking, despite leaving his course one year ago.

Nonetheless, although the narratives of only three participants intimated this deep level of learning, the narratives of the other participants did imply that they also had benefited greatly from their learning at college. Danny expressed a great passion for his subject ('I love learning'), but in terms of his

learning experience overall, he said it was: ‘Just adding to what I already knew and bringing back the confidence that I lost’. This sentiment was echoed by Colin, Gordon, Charlie, Orla, Nelson and Joan, who all implied that although they had learnt much during their classes it was not necessarily at this level of intellectual change. Possibly one of the reasons why some people experienced deep changes and others did not, could have been attributed to the level of the course they undertook as Prem, June and Reuben were all on higher level courses that involved demanding external assessments. This finding suggests that the limitation proposed by Howie and Bagnall (2013, p. 820) (see 4.3), that a person must already have a high enough level of cognitive functioning in the first place in order engage in such intellectual discourse (‘circular causality’) may be partially true. Although a number of participants experienced transformative learning in some areas, only Reuben, Prem and June appeared to undergo deep intellectual, epistemological changes.

A change in a person’s sense of self

Mezirow postulated that if a person came to view themselves differently in relation to the world, it could lead to transformative learning. This appeared to happen among the participants in this research such as Louise, Egren, Prem, June, Danny, Daisy, Santosh, Simon. For instance, Louise said: ‘I’m 100% different now’, which was an astonishing claim as she was still living without adequate financial support, yet she had new aspirations regarding her future hopes. Another example of a significant change in how she viewed herself was that of Daisy, who proudly spoke of moving from seeing herself as ‘a mental health patient’ to someone who now had ‘a role in society’ and significantly was no longer regarded as a ‘threat’ to society. Yet another was of Danny, who spoke with amazement that he had moved from previously identifying himself as an unqualified, unemployed, mental health patient to now seeing himself as a trained chef who had become a ‘role model’ to other people with mental health problems. The significance of this shift that Danny and others experienced cannot be underestimated in terms

of its value to such vulnerable participants, particularly as they felt that these were shifts that they would not have been able to make, whilst only engaging with their healthcare provision. Such changes in their sense of self were also significant, as several of these participants were unable to return to their former means of employment (e.g. Louise and Egren). Consequently, this affected how they re-imagined their futures, such as in the cases of Santosh and Danny who now wanted to progress up the catering career ladder.

Having considered some of the partial transformations that appeared to have happened for the participants above, it is important to consider those that did not seem to experience transformative learning**.** In all the other cases, although the narratives of Nelson, Gordon, Joan, Colin and Charlie did not suggest such significant changes, they did all identify that they had benefited greatly from their studies. In the case of Gordon and Nelson**,** they spoke of having acquired greater subject knowledge, but did not feel that this learning had changed their thinking at an intellectual level. Possibly, this was because they were older men who previously had worked in intellectually demanding jobs. Another such person was Colin; the reality was that although his well-being was positively affected by being in class, it did not lead to more permanent transformative changes in his thinking and life. Similarly, Charlie who loved attending classes generally, did not feel that he was being changed, possibly because he found it to be too short and the external assessments too difficult. Joan emerged as an outlier. Her narrative did show how she felt that being in class had led her to develop a new passion for cookery and helped her sense of well-being. This had a ripple effect on how it was affecting her home routines practically. However, intellectually she did not appear to have undergone such significant changes that one could attribute to transformative learning, possibly because she was already highly educated. This suggested that she appeared to represent a borderline case of experiencing transformative learning although it may also suggest that being transformed in this way is not an absolute state but may represent a grey area for some people. In conclusion, for those who did seem to have experienced transformative learning, there appeared to be variations about the nature, breadth and depth of it (e.g. Reuben changed intellectually: Daisy

changed in her sense of self), although for Prem and June, all three components had changed. Conversely, although all participants in the study did benefit from their learning, they did not necessarily experience transformative learning. Attention will now be turned to consider if critical discourse and reflection played an important role in the process of transformation.

10.3.1 The role of critical discourse and reflection in facilitating transformative learning

Mezirow (2003, p. 59) proposed that critical discourse or discussion was important in facilitating transformative learning as it could lead to 'the assessment of beliefs, feelings and values' for a student. Critical discussion did appear to provide the means through which the thinking of the participants in this study was challenged, in three ways. The first related to them being able to listen to and consider different points of view. The second was a realisation that it was valid for people to hold different points of view and third, that there was an understanding that their own and other views were dependent in part to contextual factors. Additionally, such discussions appeared to help participants contextualise their own problems as they came to understand that others encountered obstacles in life, both similar and different to their own. For instance, as Egren and Simon spoke of how they now realised that some people experienced even greater health problems than they did. One important factor that appeared to help facilitate this dialogue was feeling physically and emotionally safe in the classroom, in which these discussions took place. This included feeling safe with the teacher and the other students and such a setting seemed to provide the context in which participants' new sense of self were formed which led to them feeling more empowered. Could it be that although they arrived at college feeling powerless (*my word*), their powerlessness dissipated through these discussions as they began to talk with others and as they came to see themselves as being on a more equal footing

with them? This in turn gave them the confidence to have the right to voice their opinions, be listened to as well as be respected, and this seemed to contribute to the change in how they viewed themselves in relation to the world (e.g. Louise, Egren and Simon). Consequently, the narratives suggested that the major emphasis on critical discussion in Mezirow's theory resonated with this study. Mezirow additionally proposed that the path to such changed thinking would involve critical reflection and aside from Charlie and Colin, many spoke of finding themselves regularly engaging in this, which was evidenced throughout the interviews. This was particularly in relation to an increase in their ability to consider the points of view of other people more respectfully (Orla; Louise; Egren; Prem; June; Danny).

In conclusion, the findings suggested that many of the participants had experienced some degree of transformative learning. However, there are two caveats to consider in relation to this discussion. The first caveat is that the process of identifying who appeared to have experienced transformative learning and who had not, turned out to be more problematic than anticipated. Trying to distinguish if and how a person had experienced transformative learning did seem to be dependent on interpretation as at times it appeared to be too abstract a concept to identify. Although certain components, such as a change in their sense of self taking place seemed to be less abstract, identifying whether significant intellectual changes had occurred were not always so obvious. Despite that, there was some evidence that transformative learning could lead to tangible consequences as illustrated by Santosh and Danny, who attributed their progression into jobs, to the transformations they had undergone whilst learning**.** One may however view the conclusions that I reached regarding whether or not a person had experienced transformation as interpretation on my part; possibly only the reader can decide whether they also interpret this to be so from the narratives outlined in this thesis.

The second caveat is that it may be that the time lapse was too short to determine such transformations, given how Schuller *et al.* (2004) spoke of the sustaining effects of learning. Consequently, it may be that the long-term effects of their recent learning may as yet, not be fully understood until much later on in the lives of these participants.

10.3.2 The limitations of transformative learning theory

Although the narratives of the participants in this study did suggest that for some of them, they had experienced degrees of transformative learning, it is important to revisit the limitations of the theory that were outlined in chapter four (4.3).

The first two limitations were in relation to 'circular causality' (Howie and Bagnall, 2013, p. 280) and the need for a deconstruction of power dynamics to happen if transformative learning is to occur were addressed in the previous section (10.3). Consequently, two of the other limitations referred to in chapter four will be considered in light of this research. These two relate to the role of emotion being underplayed in Mezirow's theory (Illeris, 2015) and whether the theory reflects a North American bias (Lange, 2015). The first limitation with regard to emotion was upheld in this study because the narratives revealed that the significant changes the participants alluded to, encompassed a large emotional component. This was most visible during the interviews as they spoke passionately, some with tears, about how much they felt they had progressed in their lives due to their recent learning experiences.

The remaining limitation, that the theory is only appropriate for highly educated North Americans will be reconsidered in light of this current work. Hyland-Russell and Syrnyk (2015) and Lange (2015) argued that despite these limitations, they found that the theory could be applied to other ethnic and social class situations. This current work would concur with this as the process of transformative learning was found to be applicable among many of these vulnerable and economically disadvantaged students. However Hyland-Russell and Syrnyk (2015) additionally found that even if there was

evidence of a transformation for these learners, significant institutional barriers prevented further progression. This too was echoed in the findings: although many participants did undergo elements of transformation, the difficulties they experienced in terms of the effects of poverty, which in turn exacerbated their mental health problems, meant that it was not always possible to participate in the learning opportunities on offer, or to the level they would wish. Despite the enthusiasm of Louise and Egren, they could not progress very far on their transformative journeys until the 'pre-requisites for learning' (*my term*), were in place. This was also the case, though to a lesser degree, for those who were living on low incomes, as progression onto higher level courses was found to be prohibitive due to funding and loss of income. For instance, in the case of Santosh who would have liked to have continued in education to maximise her learning and vocational potential, she was unable to do so due to such financial limitations. This is a reminder of how much wider societal factors impacted the lives of these participants which is something that the theory of transformative teaching and learning privileges more than Mezirow did (Duckworth and Smith, 2018b).

Equally, when participants did not feel safe emotionally or supported in the classroom either in relation to their teacher or the other students, it was noticeable that in their vulnerability they were less likely to navigate the myriad of unforeseen difficulties that they encountered in the college. Yet there was evidence from some participants, such as Prem, that despite her home circumstances remaining difficult, they were able to experience transformative learning which they attributed to the help they received from the teachers and the MHAs. Nonetheless, overall the findings suggested that although it would not be necessary (or possible) for adequate living conditions to be fully satisfied, a certain level of material and social stability was needed for a person to be able to concentrate on their learning. The findings suggested that overcoming such inadequacies to be able to fully participate in learning was found to be achievable only if they received targeted help from both the MHAs and the teachers.

Considering this, I would suggest that the need to consider the material and social conditions from which a learner comes and which they are currently

experiencing whilst learning is not made explicit enough in the theory transformative learning. Rather, the theory appears to begin with the assumption (like several the well-being theories), that adequate living conditions are already in place, prior to beginning the learning process. This may be because most of the research that Mezirow carried out took place among North American middle-class people. As a result, one could assume that their material and social conditions were already adequate, prior to embarking on adult learning, although admittedly, Mezirow (2003, p. 60) did acknowledge that one cannot partake fully in critical discourse, if one is, 'Hungry, desperate, homeless, sick, destitute and intimidated'.

In this research, the adverse effects of the difficult living circumstances experienced by participants were found to permeate their narratives frequently. Consequently, such difficulties impacted not only their ability at times to concentrate fully on their present learning but also to progress further educationally should they wish to. Due to this, it could be argued that Mezirow's theory would benefit from including the need for explicit attention to be paid to these aspects as only then will it be potentially appropriate for adults who are often socially excluded. Not only could this recognition help these previously marginalised adults to experience transformative learning and become more empowered as a result, but it could contribute to improvements in their SES, health and well-being. This would further advance the recommendation by Marmot (2015) that providing educational and employability skills for disadvantaged adults is paramount in seeking to find ways in which to counteract the health gap that currently exists in the UK between the rich and the poor (see chapter two). Yet unless learning theories such as Mezirow's point out the importance of considering these issues, adult learners and particularly those with mental health problems will not be able to benefit from such opportunities.

Having discussed both well-being and transformative learning considering the findings in this study, there will now be an exploration to see if and how these two concepts are linked.

10.3.3 Well-being and transformative learning

The remaining question to be answered is the nature of the relationship, if any, between well-being and transformative learning. In considering this question, two aspects emerged: first, that a person's well-being may be positively influenced by their learning, yet not involve transformative learning and second, that a person may undergo transformative learning, yet still experience a fluctuating level of well-being.

In the first case, that a person's well-being may be positively influenced by their learning, yet not involve transformative learning, this was illustrated in the narratives of Gordon, Nelson, Charlie, Colin and Joan. For example, Joan who was already highly educated before joining the cookery class said that although she did not feel her recent experiences had changed her intellectually, her well-being had improved because of attending the cookery class. Rather, she felt that her learning had changed how she lived at a practical level, and this helped to keep her intellectually stimulated which in turn she felt helped to keep her well. A similar story emerged from the narratives of Colin, Charlie, Nelson and Gordon who, despite an acclaimed absence of transformation, felt that their well-being had been positively impacted through learning. As Charlie said: 'I'm actually helping myself get better by doing courses' and so he did not appear to be adversely affected by not having achieved the deep intellectual changes that can occur in transformative learning.

In the second case, that one could experience elements of transformative learning and yet still experience a fluctuating level of well-being afterwards, was illustrated in the cases of Louise, Egren, Reuben and Simon. For instance, Reuben suggested that he had changed intellectually whilst he was attending college, and that during that period the number of auditory hallucinations he experienced had decreased. Sadly, since he was no longer involved in formal learning, his hallucinations had once again increased. Similarly, Simon felt that when at college, his sense of self has significantly changed and during that period his depressive symptoms had lessened but his depressive symptoms had returned since leaving college, despite his

transformative experiences. In both these cases, despite their well-being being improved during the period when they appeared to be experiencing transformative learning, by the time of the interviews, both were experiencing recurring suicidal thoughts. This suggested that although transformative learning can have an enduring effect, this does not guarantee a sustained sense of well-being, as there are other factors that may impinge on their lives, such as their health and challenging social and material circumstances.

It would appear from the narratives of the participants in this study, that although well-being and transformative learning may be linked at times, they can also be separate entities as they relate to different aspects of a person's life. For instance, the components that Seligman argues that make up well-being (PERMA) are: positive emotion, engagement, relationships, meaning and achievement. Although some of these will overlap with transformative learning such as the importance of positive relationships and accomplishment, well-being does not seem to be at the deep level of change that Mezirow proposed. For example, although meaning is included in Seligman's theory, it does not equate to the level of change in how one makes meaning as in transformative learning theory, where deeply held beliefs are challenged and restructured, possibly leading to ideological changes in one's thinking. Reasonably, it could be argued that well-being appears to represent a more fluid, context dependent concept which is prone to fluctuations. For instance, at any one time, if one of the components of PERMA change such as a relationship breakup, it may significantly adversely affect a person's overall well-being, despite the other four components being present. Or it may be that in this circumstance, the other aspects of PERMA, such as meaning, and engagement are able to compensate for this lack. Either way, it may be that a person's well-being can be prone to changes and so it appears to represent a capricious concept. In contrast, transformative learning perhaps represents a more irreversible and enduring construct as it leads to changed perspectives that cannot be unlearnt. Yet although such new insights can be positive, they do not necessarily always enhance a person's well-being. It could be that reaching a new understanding ideologically about the world and one's place in it serves to open a person's

eyes to the structural barriers in society that exist. This newly acquired knowledge can possibly have a detrimental effect on a person's well-being due to the realisation that it is not possible to overcome such structural barriers. Similarly, the narratives in this work suggested that even when transformative learning takes place, it cannot completely compensate for the challenging circumstances that these participants often had to face. Whether their difficult environments were a result of their mental health problems or the impact of the wider societal context in which they lived, the ramifications of their disadvantaged social and material conditions caused them multiple challenges on a regular basis. In conclusion, although adult formal learning may possibly lead to transformative learning, it is not possible to privilege this concept over that of well-being, even though a person's sense of well-being may fluctuate according to changing circumstances.

10.4 Health and education: building bridges, crossing boundaries

The fourth and final research question will now be considered as it sought to uncover what, in terms of bridging the divide between health and education, can be learnt in relation to interviewing vulnerable safely in an educational setting. As anticipated, new understandings were gained through this study in terms of the importance of bridging the divide between health and education in relation to carrying out research among vulnerable participants. Furthermore, much insight was gained from adopting a narrative approach throughout, although this did inadvertently lead to a few ethical and methodological issues during the interviews. Despite having had experience in interviewing vulnerable participants before, I had not anticipated the number of ethical issues that would arise, particularly concerning having to deal with participants disclosing recent suicidal feelings. This led me to question whether non-medically-informed educational researchers would have the skills to interview such vulnerable participants, given that although I had trained as a nurse, I still found these revelations to be disturbing. Would educational researchers be equipped to cope with such disclosures, as well as to exit such interviews in a safe way, for both the people involved? This relates to whether the researcher can conduct the interview in a way that

does not cause harm to the participant. For instance, some interviewees (e.g. Santosh, Orla and George), became distressed during their interviews, yet they chose to continue being interviewed. Could this choice have caused significant further harm to them? Although one may argue that upsetting reminiscences are not necessarily harmful and may even be therapeutic or cathartic to a participant, this is not the purpose of the research interview (Lowes and Paul, 2006). Alongside this, in relation to vulnerable participants, the BERA (no. 18) guideline stipulates that the researcher 'must desist immediately from any actions, ensuing from the research process, that cause emotional or other harm'; could it be that I as a researcher was exploitatively allowing them to continue, for my own gain, to gather interesting material? Equally, in allowing them to continue being interviewed, might such remembrances have triggered a decline in the mental health of the interviewee, either immediately or afterwards, neither of which the researcher would be trained to deal with? Fortunately, in the context of this study the safeguards which had been put in place beforehand, involving the MHAs as gatekeepers, worked well. However, this work did highlight how essential the support from the gatekeepers was in this case, given their expertise in dealing with such vulnerable participants and a reminder of the importance of a cross disciplinary team being involved.

Considering this, I would surmise that the need to acquire ethical approval from the NHS was crucial alongside the support from the gatekeepers, in carrying out work among vulnerable participants in a non-clinical setting. In my own research, not only did this ensure the work was carried out in relation to the ethical guidelines of BERA (2011), but it also served to ensure that the actual process of hearing the voices of this group of people, did not cause them further harm, as well as a protection for me as the researcher, in terms of my own mental health.

10.5 Critical reflections as a researcher

In terms of the need to be critically reflective during the interviews, observations, and analysis and writing, I did endeavour to be as transparent as possible. I was aware that during these steps, there was still a difference

between what I believed the participant to have said and what they might have meant. Equally, although I tried during the interviews to let participants speak freely, the direction of the dialogue was affected not just by what they said, but also the decisions I made along the way regarding which lines of conversation to pursue and which to close. This serves as a reminder of the epistemological complexities of research, as well as the fact that I too, alongside the participants, had inserted myself into the narratives that were told, as well as the observations I made in class.

Although I had experience teaching and interviewing adults with mental health problems, I was surprised at the depth of honesty with which they spoke. This confirmed how the social benefit of this research outweighed the potential intrusiveness of the work. Added to that, many participants said how much they had appreciated the opportunity to tell their stories. Another unforeseen surprise was that listening to the candid reports of the mental health problems which my participants had experienced triggered painful personal memories of my own past mental health problems. These reactions I discussed afterwards both with the MHAs and my supervisors which I found to be helpful. Experiencing these triggers served as a reminder that a researcher can never be an objective observer; rather, we 'meet ourselves in the past, the present, and the future' (Clandinin and Connelly, 2000, p. 60). Indeed, all the data was refracted through the lens of someone who was an insider in terms of mental health problems. I found however, that rather than this prejudicing my analysis, it helped with my level of understanding and empathy. Additionally, I did feel that the few times when I chose to disclose my mental history to a participant, it was an advantage and not a hindrance to the work in terms of trying to be reciprocal (Oakley, 1981). Overall, despite some of these surprises, the journey that I first embarked on did follow the path I had hoped it would follow, providing invaluable insights in relation to the value of learning for adults with mental health problems, including myself.

On a personal note, outside of the above surprises, there were two more. As I listened to the stories of the participants, I came to reflect that I had in fact

been on a parallel journey with them. One parallel was that during my PhD I experienced a major personal trauma within my family; learning was one variable that significantly helped my well-being during this period, mirroring some of the stories the participants had told. Another parallel was a realisation that I too had experienced transformative learning, as my thinking throughout the PhD process was challenged and stretched in ways I could never have anticipated, leading to my inhabiting a new identity. Never when I embarked on this journey could I have foreseen the impact it would have on my own life; a true testament to the power of adult learning.

Summary

This chapter considered how the findings helped to answer the four research questions in relation to: the wider societal context in which adults with mental health problems live and the bearing this context may have on their lives; the ways in which these current findings corresponded with previous ones; how the participants perceived their learning to have influenced their well-being and whether one could establish that these changes constituted a transformative experience. Additionally, the chapter examined the ways in which bridging the divide between health and education enabled lessons to be learnt in relation safe ways to carry out educational research among vulnerable adults. The chapter concluded with reflections on my own role as the researcher in this study. The next chapter will conclude the thesis as well as discussing the implications arising from this research.

Chapter 11 Conclusion and implications

Introduction

In this thesis it has been argued that, for adults with mental health problems, being involved in formal learning has the potential to influence their sense of well-being and lives. In answering the four research questions, this study has shown that although learning has the potential to positively influence the lives of these adults, most of the narratives suggested that it can only do so when certain societal factors are adequately in place. Added to that, learning can only be of help to adults when a certain level of support is provided in order for them to manage attending college, which in this study related to the Mental Health Advisers and the teachers,

Some of the factors identified in the narratives, were evidenced in the five components of well-being proposed by Seligman (2011) (PERMA). These were manifest as they spoke of multiple positive emotions; the enjoyment of feeling engaged and absorbed in their learning; experiencing positive relationships because of participating socially in class, including feeling that they belonged; enjoying having a new sense of purpose and meaning in their lives and finally, being proud of their accomplishments and enjoying their achievements. Additionally, the narratives of nine of the participants suggested that they had experienced some degree of transformative learning particularly in terms of how they saw themselves differently in relation to the world, as well as how they had learnt to be more able to accept diverse perspectives. Three participants appeared to experience major changes intellectually. Additionally, it was noted how participants felt that they could only benefit from this learning experience when their health care worked in tandem with education; in addition, it emerged that learning in the college environment facilitated opportunities which were unobtainable within a health care setting.

Conversely, alongside these positive features, the study identified that there could be negative aspects to formal learning, such as when they experienced poor teaching; a disorganised college system; and feelings of failure when

they were unable to complete their courses. Significantly, the findings suggested that unless certain pre-requisites were met prior to and during learning, then most participants felt that they were not able to benefit fully from their college involvement. These pre-requisites included being well enough to learn; having at least several basic material and social conditions met in terms of accommodation and finance, as well as feeling safe in the classroom. Consequently, the thesis concluded that despite learning being potentially transformative, unless the negative effects of poverty were dealt with, such external factors could hinder some of the participants from progressing in ways they valued and to which they aspired. Although it would be naïve to imagine that learning can be panacea for the many difficulties these students experienced, particularly relating to the effects of poverty and structural and institutional barriers, this study highlighted the potential benefit that learning can offer to such a vulnerable and disadvantaged group of adults.

11.1 Contribution to knowledge

I would like to suggest that this study has made an original contribution to knowledge in the following four ways:

An enhanced understanding of the wider societal factors that may hinder the well-being of adults with mental health problems

Although there was an awareness before commencing the research interviews, that this the study would involve many participants who were socially and economically disadvantaged, it was not anticipated that this issue would dominate the narratives as much as it did. It was found that unless certain social and material needs were met (which I termed 'pre-requisites for learning'), the potential to benefit from their learning experiences was severely hampered. Not only did this idea help to identify how fundamentally important it is to consider the wider societal context in which these participants lived, but it also served to strengthen the link (made in chapter two) between this work and work in the field of health by Marmot (2015). Marmot (2015) identified that adults who are socially and

economically disadvantaged are more likely to experience poorer health and have a lower life expectancy than those who are more socially and economically advantaged. Considering this premise, I would argue that this current work supported Marmot's argument. Specifically, this work highlighted with vivid detail that for disadvantaged groups of adults, although formal learning did have the potential to improve their lives and well-being in a myriad of ways, unless certain wider societal factors were sufficiently addressed, the potential for these benefits to be fully realised was severely hindered.

A new understanding of the perception of adults with mental health problems, regarding the influence of classroom learning on their well-being

Through carrying out this study I was able to generate new understandings regarding how adults with mental health problems experience and can benefit from learning in a college setting. This served to counteract the research gap that currently exists in the UK in terms of how adults with enduring mental health problems can benefit from further education.

The work did contain certain original features, one of which was using extensive one to one interviews that allowed these adults with mental health problems, to express themselves freely. Another was to observe participants with moderate to severe mental health problems in class, within a non-clinical setting. Furthermore, it was original in carrying out a study which straddled a health and educational provision, in which the focus came to be on the research participants as individual learners, in addition to them being patients. Also, it was unique in its design as it involved participants from three distinct groups. By comparing the discrete, mainstream and former-students groups, it was possible to identify the common and diverse challenges that participants experienced. In turn, this reinforced the importance of providing 'stepping stones' for these participants as they benefited most from their learning when they were able to progress in graduated ways onto increasingly demanding courses, at their own pace. Such features were positively informed by my own unique positioning in the field, given that I

worked as a teacher who taught students with mental health difficulties but also had a nursing background, as well as (to an extent at least), having had my own experiences of mental health problems.

Furthermore, in terms of the work being carried out in relation to well-being, this study served to substantiate the theory of well-being proposed by Seligman (2011). It was found that the five elements (positive emotion, engagement, relationships, meaning and achievement) suggested by Seligman as constitute well-being, did encapsulate the myriad of tangible benefits from learning, and reported by many of the participants in this study.

An advanced understanding of how transformative learning theory can be applied to adults with mental health problems

From a theoretical angle the work contributed to the existing body of knowledge regarding transformative learning theory (Mezirow, 1991), specifically in relation to people with mental health difficulties and students who were socially and economically disadvantaged. It was suggested that as result of this work, transformative learning theory may benefit from further emphasis being placed on the need for educators to consider the material and social conditions in which students are living, as included in the theory transformative teaching and learning (Duckworth and Smith, 2018b), otherwise this will be a barrier to adults being able to experience transformative learning. Consequently, it would be worthwhile carrying out further research in relation to this theory, among groups similar in profile to those in this study. Such work could explore how the theory can be improved to accommodate students who have a low level of socio-economic status (SES), as well as trying to discover how long lasting their transformations were, given their fragile living conditions.

A better understanding of the importance of bridging the divide between health and education

As hoped, this study demonstrated the expediency of bridging the divide between health and education, both in terms of practice and research; and being able to carry out this work in a college which already had excellent

mental health care provision in place, served to illuminate the effectiveness of such a partnership. This partnership emerged as being essential as it provided care from hospital into college and beyond and showed that unless there was pastoral and practical support from the MHAs, such vulnerable students were less likely to be able to complete their courses and progress further. Consequently, the need for there to be a two-tiered level of support emerged as being vital: academic and caring support from the teachers who were educated by the MHAs as to how best to work with adults with mental health problems. Alongside this, pastoral and practical support from the MHAs was needed, as they ensured that students had regular one to one meetings with them and help in navigating the practical complexities of attending college. When this support was in place, it was found that learning in a college environment could offer these students something that was different and intrinsically more life affirming than what could be offered to them within a healthcare setting, at this stage in their recovery. This was not to say that the educational provision was superior to the health provision but rather that the two needed to run in parallel if such vulnerable students are to be helped. Further, it outlined some of the teaching and learning strategies that worked well for this group of students. For example, teachers having to be mindful of how stressful group work can be for vulnerable learners, particularly for those who experience auditory hallucinations. These discoveries could only be made visible when students were receiving the right level of pastoral help from the MHAs and these complementarities showed the value of bridging the divide between health and education for both the students and the staff.

An improved understanding of how best to carry out research among adults with mental health problems within a college setting, in a meaningful, ethical and safe way.

This study added to the knowledge base in relation to conducting research among participants with mental health problems in a meaningful way by adopting a narrative approach. Such an approach provided a unique opportunity to gather a range of perspectives from the participants, as they

spoke freely about their past and present experiences, as well as their lives inside and outside of college. Many participants commented that they had appreciated the opportunity to talk about their life histories in the interviews, as normally they only spoke about the medical aspects of their lives in meetings with healthcare professionals, which were presumably limited time wise.

The work also added to the knowledge base of how to carry out this research among vulnerable adults in an ethical and safe way within a college setting, as many ethical dilemmas arose during the process. Even obtaining ethical approval to interview these participants was found to be initially problematic as it involved straddling both the fields of health and education; such difficulties may help to explain why little educational research has been carried out in the past in a non-clinical setting, among people with moderate to severe mental health problems. This previous lack therefore adds to the importance and originality of this study. The work specifically highlighted the importance of involving experienced gatekeepers who had clinical expertise, as not only did this minimise the chances of the participants experiencing harm during the research interviews, but also helped to resolve certain ethical dilemmas that occurred during data collection. For instance, when George arrived at his second interview saying he felt extremely depressed, the MHA and I had to discuss whether the interview should take place. Likewise, this work underlined how the gatekeepers could provide support for me as the researcher, as I did find some of the interviews distressing and emotionally challenging, for example when Gordon, Simon and Reuben disclosed their recent suicidal thoughts. Such occurrences re-emphasized the need for the researcher, when working with vulnerable participants, to be perpetually critically reflective during the duration of both the data collection and analysis stages. Also, the study illuminated the need for researchers in such a setting to have an awareness of the importance of being able to 'open and close' interviews with vulnerable participants in an ethically safe way. Finally, it showed how an approach which spanned health and education was of paramount importance in this research context, not just in terms of caring for the people with mental health problems in an educational setting but also

in terms of facilitating and conducting research across the different domains. Consequently, it was found to be possible to carry out such work in a meaningful, ethical and safe way but only when these safeguards were put in place prior to commencing the work.

11.2 Implications arising from the research

The implications that have emerged from this work which I would like to draw attention to are outlined in three main areas: in relation to policy; practice; and research.

In terms of implications for policy, I would suggest that a new way of commissioning education and mental health services should be introduced as this study highlighted and reinforced the importance of bridging the divide between health and education. This would involve the two domains working as one, to maximise the close links between mental well-being and education, as not only are they intrinsically linked but as argued in this study, education can positively affect one's mental health. Such a change could shift the focus in terms of mental health from being either that of prevention or treatment, to attempting to address both aspects concurrently through health and education. This could strengthen and expand the work being carried out by other organisations such as the Association of Colleges as they seek to highlight the importance of considering how best to support adult learners with mental health problems, given that most of the current increased focus on mental well-being and education, is in relation to schools and universities rather than FE.

Such a change in focus and emphasis could lead to a much-needed increase in the employment of college-based MHAs, who span both health and education, as well as providing more adult and community learning courses. Given the many benefits that opportunities for learning can produce for adults with mental health problems, potentially at the personal, interpersonal and societal levels, I would argue that the investment costs would be outweighed by the benefits, particularly as in some cases it was found that students became less reliant on health care because of experiencing greater well-

being due to attending college. This could be an area for future study. Moreover, offering more adult and community courses, whose main purpose is not primarily to upskill students for employment, would need to be made accessible financially to those on low incomes. This could then enable vulnerable adults to build up their confidence levels incrementally as they progress gradually at their own pace, potentially onto more demanding courses or employment. However, unless such investment is made, the positive ways in which learning can enhance the lives of this group of vulnerable adults as identified in this study, will not materialise.

In terms of the implications for practice, this work can add to the current sharing of good practice among FE providers in relation to working with this group of vulnerable learners. The findings illustrated that there needed to be a two-tiered level of support made available to enable these learners to benefit fully from their adult learning, which were in relation to the teacher and the college based Mental Health Advisers (MHAs). In the case of the former, this will involve the teacher having a relationship with the student in which the student can feel valued and safe, employing certain teaching and learning strategies in class that were identified here and making reasonable adjustments in the classroom to accommodate the student's needs. In the case of the latter, this will involve employing more MHAs to provide a number of levels of support within the college. These levels of support would first, involve supporting students pastorally and practically on a one to one basis; second, educating the staff about mental health problems and ensuring that the college develops and implements a mental health strategy and third, giving tailored ongoing support to the teachers, when they have a student with mental health problems in their class. Additionally, this work could be used to help carers and family members gain insight into the experiences of adults with mental health problems and the ways in which they would like to be understood and helped. Also, these contributions could extend to advocacy work which promotes education among people with enduring mental health problems, and how this can assist with promotion well-being and a pathway to a different future.

At a local level these results will be shared, in conjunction with the MHAs, with both the college and health staff as well as sessions being carried out with my own current students and the past participants who would like to return, to discuss the findings. Finally, at an academic level, dissemination will include writing for a variety of academic journals in relation to mental health problems and well-being, transformative learning theory, and work concerning the ethical and methodological issues surrounding interviewing vulnerable participants in a non-clinical setting.

In relation to the implications for research, this work will add weight to the current public discourse which is arguing for more money to be spent on addressing mental health problems generally. Specifically, it will propose that this spending should include expanding work such as this, in terms of working to maximise opportunities for people with mental health problems to benefit from taking part in formal learning. Added to this, given the argument outlined above that the cost of investing in such learning opportunities could be outweighed financially by the benefits they incur, I would suggest that research involving a cost benefit analysis would be a worthwhile area for further study, in order to substantiate this proposal. Another idea would be to organise a longitudinal qualitative study that would help to discover the sustained effect of the learning for adults such as the ones who took part in this study which could ideally, also involve greater numbers of former students who did not complete their courses. Although this would be an ethically sensitive project, as contacting them may be a painful reminder of their perceived failure, it could be extremely enlightening as it may enable there to be a deconstruction of the factors that led to their non-completion.

11.3 Concluding thoughts

This thesis has highlighted how, despite the wider societal factors that may adversely affect the lives of adults with mental health problems, learning can positively affect their well-being, for some in a transformative way. Additionally, the thesis identified the factors which may hinder this process of life enhancing changes happening, as well as outlining why and how there needs to be a provision in which health and education work together, to

facilitate such positive learning experiences. I would argue that just as a multiplicity of factors may have contributed to the participants in this study experiencing mental health problems, there needs to be a multiplicity of ways in which to encourage these adults to engage in formal learning and to help them complete their courses and so reap the benefits that being involved in learning can bring. Providing such opportunities and support could give adults with mental health problems the chance to discover that learning itself may serve as a catalyst, to not only positively influence their levels of well-being but also to potentially experience learning in a transformative way. It is such transformations that may lead to significant shifts in their lives, in ways that were previously unimaginable, as described by some of the participants in this study. It seems therefore to be appropriate to conclude with a former quote from Louise who was most grateful for the 'second chance' that her college learning had offered her, particularly in terms of how her sense of self had shifted:

> Becoming a patient, I just thought I was nobody…In the hospital I'm being treated as if I'm heavily sedated or I'm still sick, but to be in college and all the classes, I think I'm being treated as normal. I have a sense of purpose that I can actually do something. It builds me up.

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Appendices

Appendix One: Demographic features of the area in which the college was situated

In 2016, 7.3% people in this borough claimed Employment Support Allowance (Britain = 6.3%). Although in 2006 the unemployment rate was 11.6% this had fallen by 2015 to 6.9% (Britain = 6.1%) as the borough had become more prosperous due to its popularity, culture wise.

To protect the identity of the area and college, please see the author if further details are needed.

Appendix Two: Definitions of mental health problems referred to in the thesis

1.*NICE (2011) make the following distinctions:*

A **mild** mental health problem is when a person has a small number of symptoms that have a limited effect on their daily life.

A **moderate** mental health problem is when a person has more symptoms that can make their daily life much more difficult than usual.

A **severe** mental health problem is when a person has many symptoms that can make their daily life extremely difficult. Layard and Clark (2014, p. 29) state that this would include bipolar disorder, schizophrenia and personality disorder.

2.*The following definitions have been taken directly from Mind (2017)*

Depression: This is a low mood that lasts for a long time and affects your everyday life. When most severe, depression can be life-threatening because it can make you feel suicidal or simply give up the will to live.

Schizophrenia: Symptoms may include: a lack of interest in things; feeling disconnected from your feelings; difficulty concentrating; wanting to avoid people; hallucinations; delusions; disorganised thinking and speech and not wanting to look after yourself.

Schizoaffective disorder: this includes psychotic symptoms, similar to schizophrenia and mood symptoms of bipolar disorder. 'Schizo' refers to psychotic symptoms and 'affective', to mood symptoms.

Psychosis: this involves when you perceive or interpret reality in a very different way from other people; the most common type of hallucination and delusion although you may also experience disorganised thinking and speech.

Borderline personality disorder: this is a type of personality disorder. Personality disorders are a type of mental health problems where your attitudes, beliefs and behaviours cause you longstanding problems in your life.

Appendix Three Participant demographics

All participants were asked the following information at the beginning of the interview

Ethnicity

Ethnicity (their descriptions)	White	3
	Mixed race	4
	Asian	2
	Black Caribbean	3
	Black African	1
	Black British	2

Ages

Ages ranges	18-25	3
	26-35	0
	36-45	3
	45-60	9

Previous qualifications

Highest previous qualifications	Level 1:Foundation level	3
	Level 2: GCSE level	7
	Level 3: Advanced/ A' levels	3
	Level 4: degree level	1
	Level 5: Postgraduate level	1

Level of college course

Level of college course attended	Level 1: Foundation level (my cookery class)	5
	Level 2: GCSE level	5
	Level 3: Advanced/ A' levels	3
	Level 4: degree level	2

Appendix Four: Ethical approval

The ethics procedure

This proved to be a very long process as many months were spent discussing with the university ethics co-ordinator and my tutors as to whether I actually needed NHS approval as opposed to the university approval. The reasoning for needing only university approval was because this study would take place on college premises and the questions were concerning their involvement in college only and not their experience of clinical services. Alongside this, the Head Occupational Therapist said she would not give me permission to interview any of the students from the discrete group, due to the 'changing nature of the group'. I had a lot of difficulty arranging to meet her to discuss these issues and so it took many months before she agreed to meet up. When we did so, she immediately agreed that I could interview them with a few inclusion criteria that are incorporated in my work (see next page). However, it would only be on the proviso that I got NHS approval.

The next issue that arose was whether I would need full NHS approval or not. I discovered that this study would not be viewed as a research study in terms of the NHS criteria and so could go through a shorter application process, which I did via the Ethics Sub-committee from the East London NHS Foundation Trust.

Ethical Approval from the Clinical Director Dr Richard Evans
East London NHS Foundation

Project 300: Mental Health and Education: the experiences of learning for students with mental health difficulties (Denise Buchanan)

Thursday 4th September 2014

Dear Denise,

Thanks for this information.
Please go ahead with the project.

Best Wishes
Richard Evans

Appendix 5 Participant information sheet and consent forms

UCL Institute of Education, London University
A research project
The experiences of learning for students with mental health difficulties
January 2015 – July 2015

Please will you help with my project?

My name is **Denise Buchanan**
I teach cookery at this college but am also a PhD student at London University.
This leaflet tells you about my research project. I hope the leaflet will also be useful, and I would be pleased to answer any questions that you have.

What is the purpose of this study?
I would like to find out about your experiences of attending classes at college. Also, to use this knowledge to discuss with the teachers how best they can support students with mental health difficulties, in order to encourage effective learning.

Why have I been invited to take part?
You have been invited to take part as you have at some point been in contact with xxxxxxxxx (the college Mental Health Advisors) or attended my cookery class in college.

Do I have to take part?
No, it is purely voluntarily. If you want to take part and, even if you say 'yes', you can drop out at any time or say that you don't want to answer some questions. If you become unwell during this time, you will not need to continue taking part. You can tell me that you will take part by signing the consent form.

What will happen during the research?
Most students will be interviewed by me twice in college, for 30-60 minutes. A few students, if they are willing, will also be quietly observed in one of their classes.

What will happen to me if I take part?
If you agree, I will tape record our discussions and type them up later. I am not looking for right or wrong answers, only for what everyone really thinks. These will be securely stored by me and safely disposed of once I have written up my findings. I will change all the names in my reports including the

name of the college so that no one knows who said what. Everything will be **confidential** unless you tell me something that raises concerns in relation to you or another who is in some sort of immediate danger, as then I would have to mention that to the Mental Health Advisers.

What possible risks are there if I take part?

I hope you will enjoy talking to me. Some people may feel upset when talking about some topics and so if you do become upset, then I will stop the interview. I will let the Mental Health Advisors know that this has happened and they will be happy to chat to you, if you would like that.

What are the possible benefits of taking part?

I hope you will enjoy helping me. The research will mainly collect ideas to help students with mental health difficulties in the future and those who teach them.

Also, it will help me learn to be a researcher so that I may do more research in the future which will help other people. After the second interview is over, I will give you a £10 gift Argos voucher to thank you for giving me your time.

Who will know that I have been in the research?

I will not anyone else what you tell me unless I think someone might be hurt. If so, I will talk to you first about the best thing to do and then xxxxxxx
If you have any problems/ complaints with the project at all, please tell myself or xxxxx

What questions will I be asked?

Questions will be about any fears you had before joining college; any fears you have in class; what you have experienced in the class with the teacher and other students; what has helped you learn best; whether you perceive these experiences in college as being positive or negative.

Will I be able to know the results?

If you request to know the results, I will send you a short report when it is written up (1-2- years later).

Who is funding this project?

I am funding it myself.

The project has been reviewed by the Ethics Sub-Committee from the East London NHS Foundation Trust

Thank you for reading this leaflet.

Denise Buchanan

Leading education and social research
Institute of Education
University of London

Appendix Five: Consent forms

Consent form for the project: Mental Health and Education

Researcher: Denise Buchanan

The experiences of learning, for students with mental health difficulties January 2015– July 2015

I have read the information leaflet about the research.
Yes/ No

I agree to be interviewed and what I say will be treated confidentially
Yes/ No

I agree to being observed in class (if applicable)
Yes/ No

I understand my taking part is voluntary and I can withdraw at any time
Yes/ No

I understand that should I become upset, the interview will be stopped and the Mental Health Advisors will be informed
Yes/ No

I give permission for Denise Buchanan to tape and transcribe our interviews and dispose of the information securely once the results are written up
Yes/ No

I agree for the results to be used anonymously for the PhD, related articles and reports Yes/ No

Printed name of participant Signed
Date

Printed name of researcher Signed
Date

Leading education and social research
Institute of Education
University of London

Consent form for the students in class observations

Project: **Education and well-being**

A study looking into ways that education and learning can support well-being.

Researcher: **Denise Buchanan**

Consent form

I agree to be observed in my class on the understanding that any information gathered will be treated confidentially.

I am over 18 years old.

Name

Signed
date

Researcher's name

Signed
date

Leading education and social research
Institute of Education
University of London

Consent form for the teachers in class observations

Project: **Education and well-being**

A study looking into ways that education and learning can support well-being.

Researcher: **Denise Buchanan**

Consent form

I agree to be observed in the class I am teaching, on the understanding that any information gathered will be treated confidentially.

Name

Signed
date

Researcher's name

Signed
date

Appendix Six: Possible interview questions (over 2 interviews) round 1

Warm up questions

Demographic information – name/ age/ address/ gender/ethnic group/how they would describe their mental health problems/ highest previous qualification /name and level of present course. (Turn recorder on now)

How are you enjoying the class? ……how long have you been doing it?

Before joining the class

Why did you choose to join this class?

Could you tell me what things you were concerned about beforehand?

Who helped you and supported you as you joined the college? How did they help you?

Disclosure – how did you feel about telling the college that you had a mental health problem?

A. In class

Think about your experiences inside the class itself…..tell me how that has been?

What things did you/do you find difficult? What worried you?

What differences have you noticed between this experience and when you went to school?

teacher/ teachers? Is this relationship important to you?

other students?

homework done?....assessments?

B. Positives about coming to college?

Academically helped? hindered?

Social skills

Group skills? Levels of confidence? Motivation? Becoming more independent? Self belief?

What do you value and hope to achieve?

C. Negatives about coming to college?

Academically

Social skills

D. How could college do things differently in order to help students with m.h.d?

E. Your mental health

How do you think your mental health problem affects your work in college?

What's the attitude to your family about mental illness?

What is your cultural attitudes/ beliefs about mental health problems.

Are you currently on any medication that may be affecting your ability to engage in learning? If so, are there any side effects the teacher needed to know about?

Do you feel you have been given or offered the support you have needed, to help you cope with your course?

Do you notice any relapse indicators that help to tell you that you are becoming ill?

F. The future

Hope for the future? Desires/ hopes for getting a job or……voluntary work or further study? Short term goals? Long term goals?

Wanting to do more courses? Motivation to learn more? What is, or may hold you back from reaching those goals?

Some people say that taking part in learning can be change their lives: what would you say to that? Have you noticed any changes? In what ways has this experience changed you?

Overall, how would you describe your experience of coming to college? (e.g. a positive experience/ a stressful one/ disappointing?)

Any other comments?

Remind of the MHAs being willing to see them if they feel upset due to the interviews.

Round 2 :

*1. **The first interview** was mainly about getting a picture of your family and educational history and this one will be asking more about being in the classroom itself.*

2. Left over questions from first interview

Look at participants questions at the end of their first transcript……..

3**. Home life**

Finance how do you manage financially? Do your benefits cover everything? Food bank? Bedroom tax? Homelessness ever?

Can you eat healthily or do you think it's expensive to do so?

4**. Emotional safety**

Do you think it's important for a student to feel safe in a classroom in order to learn? Physically/ emotionally

With teacher?

With other students?

Do you think you would be able to learn**, if you did not feel safe in the classroom?**

5. MHAs

What do MHAs do that you find to be so helpful? Are they a go between?

What is their specific input?

Is this emotional support impacting their educational experiences??

How does college differ from their healthcare in terms of what it can offer you?

6. Pedagogy (Hidden pedagogy)

Are there particular teaching techniques that you find help you?

e.g. Teacher talking? Demonstration? Group work?

Any situation when you think you are **not actually learning**?

Do you think that education meets a need that health and social care is not providing? Can education meet some unmet needs not provided elsewhere? (Like prescribing gym and heating…..?)

How does it help you if the T tells you, **you are competent?** Is it important?

Are you being pushed beyond what your comfort zone is?

Is learning about addition or change?

Do you find being in class **therapeutic** in any way?

7. Positive changes

Do you feel learning has changed you? In what ways do you think that? Has it helped your mental health? If so, how?

Is learning a benefit when you are unwell? Or does it help you to become well? Does it only work when you are well enough?

Protective? Life enhancing?

Is education therapeutic?

8. Sense of self

Do you see yourself differently as a result of becoming a student and learning new things?

How has learning changed how you see yourself?

Do you think you **could change as a person through learning if you did not feel safe in the classroom?**

Autonomy – how much control you have in your life/ freedom to determine one's own actions and behaviour. **Do you feel you have …….**

9. Future hopes

When you were a young adult, or before you had any mental health difficulties, did you have any ideas of what you would like to do **workwise**?

Repeat question on hopes for the future

10.Afterwards

Give voucher for participating.

Remind of the MHAs being willing to see them if they feel upset due to the interviews.

Appendix Seven: Field notes from a class observation for June

Observation of Sociology AS level class (10.45-12.15)

Wednesday 22nd April 2015 (a few weeks before the AS exams)

Number of students – normally 14 but today only 9 as specific revision classes. P arrived 10 mins late and 1 arrived 30 mins late. 2 were under 18 so exempt from the observation (add into methods section). Seated on joint tables but P sat alone and worked on her own work throughout, totally concentrating. Basically, P does not get up and join in the group work unless asked but continues to work on her own, making notes as she is really ahead (due to motivation and resit) and they are a weak ability class.

Critical incident

The teacher mentioned Ps name 3 times to me at the beginning, in front of the others so I had to remind her it was confidential. I did not speak to P except to get the consent form signed and ask about her essay briefly.

Lesson – revision class on social policy

a. Whole class work - Started with a brainstorming revision task, about social policy. T said, joked at one point …'if you did all that you would have a breakdown!' - just noticed how stigmatising this comment is.
b. Worksheet exercise – P had already done this and so only joined in when asked to explain things to the rest of the class. The others may have missed the class (all at different stages due to this and not completing homework), in which it was originally done and so were happy to get Ps answers. She explained things very well.
   P speaks a bit too fast and is asked by Ss to slow down. She stammers at times. Peer teaching.
c. Activity – look on wall at previous work and talk about the stages
d. Essay question practise - Again this does not involve P as she has completed it at home as a practise question. T comes and reads over it to mark it. T puts Ps essay onto board as a sample and the others ask for her to e mail it to them and P agrees.

Quiet class. They obviously appreciate Ps input and like her help to explain things when asked.

Confirms what she said in the interview – she is completely ahead of them and the teacher includes her to do peer teaching. T has seen no signs of

mental health problems except that she gets stressed before exams. ‘She’s a bright motivated girl’.

Appendix Eight: The data analysis process. Annotated transcript of first interview with Gordon

Gordon interview one 4th February 2015

Interviewer questions in italics. Mhd or mhp = mental health problems. K= mental health adviser (MHA), O and E = the teachers

So Gordon you have just finished the DTTLS course. What does that stand for?

Diploma for teaching in the lifelong learning sector

And you have finished the course and have just a little bit of coursework outstanding? Yes

And how long was that course?

Just over a year

Why did you choose to join the class?

That's interesting. I had attempted the PGCE on 2 separate occasions previously and on both those occasions I failed because I had a relapse in my mental health. I was walking by the college one day and thought I would pop in and say hello to J if he was there. I came in and asked at the desk and they said K was in. he came to see me and I came upstairs. He mentioned about his PGCE and I said, Do you remember when I tried and failed. He said oh they're doing a new course now! I did not come in with that intent. The he went out of the room and when he came back he had E with him! I was mortified because before I felt I had let E down because she had tried to get me though the two previous times. So I got on my knees and said I'm so so sorry! She said, don't be so silly and she went and got me an application form. She said 'fill this in' and I said 'why' and she said 'because we are starting a course...don't you want to be on it?' Oh, I said. The course was to start next Thursday – less than a week away! I filled it in, bemused and totally and utterly perplexed! I filled it in, gave it to her and she told me to come in next Thursday – 'you're on the course!'

Wow, good old you!

Can you believe it? Prior to coming through these gates I had no intention of doing it. I thought I had blown my chances. I wanted to do it. Don't misunderstand me but I thought how can I? Because I wanted to pursue my teaching, and this just happened!

That's amazing!

I would not have had the temerity to ask if I could do it again!

Yet K said to me that you are an excellent teacher – to think that you might have missed that! So you only had one week's notice. Was it an anxious week?

It was it was! Absolutely. I remember the first time when I was accepted on the 747, I came here for an interview we sat a panel – 3 people interviewed us, went back....they rang back and said, sorry Gordon, you haven't made it but we will keep your name in case there is another course again. A few days later I was in hospital and they rang my phone and they said, G, somebody can't make it can you come in? And I just said, of course I can, without thinking about it. Then I thought G what have you just said? And I came on the course then. But this was worse than then cos here I just didn't know! 4.15 then I was really anxious!

Were you anxious because of your history of not finishing it?

Yes I thought I can't let E down again! Twice I tried it before and twice I didn't. I know what happened. I remember being in my flat and I remember being paralysed sometimes and I really plummet and I get very depressed and nothing, nothing, nothing, nothing, nothing happens. On one of those occasions I tried to kill myself, I remember, I had a suicide attempt and it was the course and everything. Yea but...so yea it was because I knew I had failed before but the fact they gave me another opportunity. And I did want it, I did want it, I did want to teach, I did want that course...so...

So just picking up on your choice of words...from my limited perspective, I would look back and say, you didn't fail but you weren't able to complete the course because you were ill.

I call it a failure. You know what sticks in my mind? Outside the college I was standing in an alley nearby and E was coming along and in short conversation she said, sorry, G you've failed or you've not passed, somewhere along those lines. Cos after my relapse I came back on the course but I couldn't do enough. Sorry G and those words were inedibility etched in my mind

I bet E didn't even use that word fail

Maybe she didn't, maybe she didn't! Maybe it's just me colouring it but yea, yea, wow

The first time you started the PGCE, how did you come to this college?

Okay good question. I was having mental health problems. I was very, very bad – I had a social worker, a key worker, a psychiatrist and I remember I was in *** psychiatric wing of the hospital and a lady used to and teach IT. Can't remember her name. Once a week she would teach IT and I would go to the class. I always had an interest in IT from year and year and years back. I don't know how it happened but I ended up teaching her class in her absence! She would be saying Gordon can you take my class? Gordon can you do this for me and that for me? And I did that. Before that a MHA worker had come to the hospital and he tried to engage us – is there anything we can do to get you engaged in the community? And he mentioned, Gordon have you ever thought about doing a course at the college? No I said I hadn't. They're doing a teaching course, 747. I'll put you down for it. I did nothing with it and K pushed me to and I filled the forms in. Then I came in for the interview.

So again, it just suddenly came about!

The MHA was very good, he just eased me into it. G I really think you will do well. You are showing here that you have the ability to take this class so that's how it came about.

So what kind of work had you been able to do beforehand or had you been too ill to work before?

Before the breakdown I had my own company. I was an IT consultant – programming and analysis and stuff like that. And I earned a fair wage as it was quite lucrative! Before that I was into shop fitting and the PC work was the early 80s.

So that's how the teacher came to involve you and show she had confidence in you. So what did you feel like when she asked you to take the class?

I felt alright actually and I knew some of the guys (as were all in hospital together). I felt alright and some of them were saying, G you should get paid for this! I was having issues clearly but...

It helped your confidence?

I think so.

Yea that was quite a compliment wasn't it to have gone in as a punter and ending up teaching!

3.

And before you had your breakdown had you had any mhd before that?

I must have had and I didn't recognise it cos my sister suffered with depression very badly and I didn't know this (she hadn't told him). Funnily enough, she was the one who awakened me to it because, in a way, she said to me – I was feeling really, really bad, doing terrible things, awful – and she said G have you ever thought of going to the doctor with this issue? And I hadn't, I hadn't at all! I went to the doctor and immediately, immediately they wanted to section me and they wanted to put me into the psychiatric wing in the hospital. I was very, very bad. And they put me in this mh place called the N centre which is a respite home for a couple of weeks and the symptoms that I was showing before, clearly was depression.....it was awful, it was awful, but I didn't know what depression was before I went to the doctor.

That must have been a shock?

Yes it was.

And did they section you?

No I went voluntarily – I called my wife and eventually I went into this respite home, cos I was suicidal.

Good your sister said to go.

Yea and I didn't know she suffered and then she said 'You know mum was like it?' And I said, no! So there were things she told me about my parents that I didn't know at all! Cos I'm the youngest of 4 so whether that's been blocked out of my memory, I don't know. But she would say things like, it's no wonder you're depressed!

And are you still with your wife?

No, no we're divorced. It came through 2-3 weeks ago. I'd been trying for a while, different things and it stopped and it started...I'd to get some help – legal aid – and then it stopped.

And how long were you married for?

30....34 years? I'm not too sure about that.

Gosh you've had a lot to cope with. Amazing then that you managed to finish your course!

Well.... before when I relapsed and K helped me get back in but I still failed but this time he's been there to help me cos there were times, like I said when I did plummet. And things would happen but K been really encouraging and you, bless her, bless her and O...they've all helped me.

How did you feel about college knowing that you had a mhd?

Do you know what, very unsure or..... cos I had an experience on occasion in class where people were making fun of mental health students and it just immobilised me. Like, a part of me wanted to say, hold on I've got mhd but part of me was scared, scared to, they might make fun of me. I told K this and he was mortified and he couldn't believe it. But yea.

And they were the trainee teachers?

Yea, I remember on more than one occasion...you know I'm sure in their own way it was innocent, they weren't thinking whatever, it was like, oh she's mad or he's mad or she's mad. So that wasn't a good experience and knowing that I don't know, like I said I do like teaching and when I failed those 2 times I did think of how I can do this, it often crossed my mind and then this came up. So I said, G, try and grab it because I know my Mum before she died really encouraged me to try and do the best I can.....so that might have overshadowed the little fears I have, I don't know.

Was that a one off when you heard them making fun of people with mhd?

More than once.

That's quite shocking to me. How does college differ from the way you remember school? Or how did you enjoy school?

Oh I loved school. I loved academia! I came top of my class all the time! I absolutely loved it – loved the lessons, loved the teachers, got high grades....loved going, loved the work and the writing, loved it, loved it, loved it!

So you were really in your zone. So after school what did you start working in?

Okay I went into a shop fitting company. I spent a long time there and it was there I was introduced to computers actually. I worked in the drawing office as a draughtsman. Loved that and went onto 'estimating' where you estimate jobs/ cost jobs. From there I went to

computing as they saw something in me and I ended up fixing their computers, going to their houses – the director's house! Having lunch with his family and so on and going all over the country to help with this and that so I did like that part. It was at the end of that my mh issues came about.

So what age were you when you had your first m.h. issue?

2001/2002 (14/13/years ago). I was going to church at the time; devout church goer, religiously going to church.....and....it's been hard to say it but I think that contributed somewhat to my breakdown. There was a lot of pressure on me – a hell of a lot of pressure.

What church was it?

It was an Assemblies of God Pentecostal church. Very well renowned, very, very doctrinal and thorough in everything we did. (17.30)

Was there a lot of pressure on you within the church?

Yes, I was a leader, I was the pastor! I was an ordained pastor. So I did various teaching and training to I became ordained as a minister, so it was my church if you like. I was really...you know...so that was difficult and its difficult now to speak about to be honest with you. That's an area that I can't revisit. It's very, very sensitive. My son wants his baby to be christened in the church I can't attend and I said I can't go there...I can't walk past the place, I can't go near the place. I really freak out. I get very, very, very.....

Well you never know what might happen in the future given how you managed to finish this teacher training course. So when in the class did you find the teachers approachable?

Oh yes, O and E were very approachable, very understanding. O knows of my mh history so I expect she told E. I would have been clear on any forms.

So you never had to have conversations with E about your mhd?

Yes, I did thinking about it. Towards the end of this course, again I stopped coming. My attendance was 100%; towards the end of it, I stopped coming. Whether it was because in my mind I thought, the last 2 times you didn't finish. You won't finish this one. This time I stopped coming. I got depressed, I got dishevelled and everything. I spoke to J about it and

eventually I had to speak to E as well. I said I'm not sure if I want to continue, if I want to finish. She encouraged me to and to cut a long story short, they helped me through that.

That's great so did you have some time off at that stage?

Yea I did. I took some weeks off and berated myself because when I'm at home that happens and you know it's awful. I really lambasted myself – you should get qualified.

You are very hard on yourself aren't you?

Yea it was no fun being there when I know I should be here but I just didn't come...I just didn't come.

But were you just not well enough to come at that stage?

I don't know. I just see it as me being an idiot...why don't I come and why don't I.....oh I don't know

So how did you manage with all the assignments cos there are an awful lot?

Yes, yes I was behind with those. That's why, you know I didn't want that because you know dear, dear...I set myself I suppose unrealistic targets. I wanted to do everything. So for example when I had the summer break, I thought that any outstanding assignments I had, I would do those plus the ones she gave us to work on over the summer break. In fact I will hand it in earl! I will come in the week before term starts and give it to them – of course I didn't do anything! And I mean anything! I took them with me when I went places to read them but I didn't do it all...and that backlog exacerbated the fact I just didn't want to come in again. (The course was Sept 2013 – Dec 2014 so longer than a year). Before I'd be punctual I'd be on time, I'd be here! And the assignments began to pile up and pile up so that was a huge struggle. The thing is that when I start to write and I get into it, I like it, I like the research, and I like the thinking.....it's just starting it sometime, it's just.....once I'm into it for half an hour I just carry on and carry on so I don't know what that's about.

So you have some work outstanding now?

Well I'm seeing E after this...mm all the observations have been done, it's just handing in all the paperwork cos when you're observed you're meant to give some feedback and such

like. All the assessments have been done. I just don't think they were marked so I'm expecting some changes to be made...but it's getting there.

Well done...do you get any therapy help at the hospital now?

I used to get so much of that yea.... Counselling and psychologists etc.

Was that helpful?

Sometimes yes, sometimes not. I'm not seeing anyone at the moment but again I'm supposed...I don't open any of my letters. J told me I've got a few here. I open them and of course they send me appointments and I have missed them...so that's all up in the air at the moment.

Is that a similar avoidance technique that you had with your assignments that summer?

It's possible. I just can't open my letters....to my detriment many a time, many a time. Pause So I'm not getting any therapy at the moment – I have had and may have in the future. Sometimes if I think I'm plummeting I will ask for it. I'm a bit better now cos it I sense sometimes happening which if I'd check will lead to problems so I will try and get it sorted out.

So do you have a better idea of you relapse indicators?

I think so.....if I'm indoors for a long long time (25.26) it can get bad then so I think okay then let's try to someone or do something...or I'll end up in a bad way

That's understandable. So once you began writing your assignments did you usually manage to pass them?

Mostly, I think there was one rewrite I had to do. E would say, that's fine – I wouldn't think so but she would!

So what were the positives of coming to college academically and intellectually?

Engaging and meeting with people and getting out of the house. My problem was staying in...I would stay in and stay in bed for hours and hours and days and days. College gave you something to come out to...somewhere TO go, people TO meet. I've got things. And although I don't do this myself it should encourage you that you are achieving and doing

things but I have an immensely hard time with patting myself on the back, so I just do it and expect the worst really. If I was in a class even now and there was that discussion in a group and someone made a wise crack about mh, again I would just freeze. I'd say nothing. I'd like to....would I be to be able to say something or have something said for me? I'm not sure.

Do you think there is still a big stigma?

Oh yes, absolutely and it's in the class itself with some of these trainees teachers. Whether they're aware of it...or aware of its impact or see me as being normal, for want of a better word. Forgive me, what is normal? And therefore feel free to say those words whereas if they saw me drooling and .....

Yes you definitely do ~~you~~ look like someone who may fit their stereotypical views of someone who has had severe mhd.

But nonetheless the mentality of them, not only to think that but to voice it is well.....I just find that...I wouldn't like to go into another class...I wouldn't like to have that experience again...but what could avoid that happening?

I'm having a picture of you going in some time doing some teaching with K – educating the teachers

It's helpful for me to have someone who can articulate that so clearly, but it is quite shocking to think that even trainee teachers are like that. I remember one time in role play we had to be someone who didn't interact. Very taciturn. So when it came to me turn they were asking me questions and I'd just look at them, none of the others did that. And then some of them were sort of laughing and in a sense that really was me I was panicked: I was unsure what to say. And what they saw was not me pretending to be this person but it was really me. But they didn't know that.

So why didn't they know that?

Maybe some of them did. Maybe E 'cos she knows about the situation but really I was, cos normally after a few prompts you would say something

You were a very good actor as well!?

I just thought, wow.

9.

Socially did you find you were uncomfortable in the class?

At times, absolutely

Due to your mhd and you felt a bit scared?

Some of those. Yea I underestimate myself a lot. And it's wearing. It's interesting that when I did stop...and one time I was here and a fellow student (from the TT class he left early) was there, and I just started crying and he said, what's wrong? What's wrong? And I said I don't know and he was beside himself...oh let me get you a cup of coffee...and whether he said something to others in the class but they were afterwards more sympathetic and said, Are you alright G? Are you sure you are all right? Let me sit with G today and we'll work together and.....so

Was that quite nice that people were helpful?

In a way....and in a way not.

Tell me....

Because it would taken him to have let them know ,as how would they have known otherwise?

But would they ever had seen your vulnerable side before?

Maybe not enough to go on. So maybe it's a bit unfair of me to expect ...I don't want any special treatment or anything like that but I certainly would like an awareness of.....i don't know, would it be proper for a lecturer to say maybe, right, in our class just be aware that there may be some people with mh issues? So no funny jokes or anything?

I think that ground rule would be a great thing in any class. What were the negatives academically?

The pressure to try and complete stuff, so assignments, come n and so on. Be regimental and be timely. For someone who doesn't have a structure and I didn't have one prior to it at all. I would like go to bed in the morning and wake up and then just sleep all during the day and then I'd just get up. So there isn't that structure of eating and washing etc. And so to introduce it into one's life, such a regime is a paradigm shift.

10

And so did you manage to impose that structure?

Yes I tried. Like I said, I wanted to do this course. I knew what it meant. I had done things before academically so I knew what it meant being on time, getting this and that done. Yea home was always so disorganised – papers all over the place! It takes me x5 as long to do something for college as for a normal person to do! But yea I ploughed through it and so on.

And it was a one day a week course so did you do your written work on those other days?

Sometimes, sometimes I didn't and I'd just sleep and procrastinate a lot and I'd put things off and I'd get to the end and my daughter said, 'Dad you work well under pressure'!

How many children have you got?

4 children, 25-30years old.

And do you see them?

Not as often as I'd like. The divorce left a very bitter taste in my mouth and mostly theirs as it was me who filed for it. They didn't want me to go for it, they wanted me to stay...and my mh issue was part of it in fact, it was a big part of it. So that's very difficult and I don't see them as much as I would like to. And there's a chasm not between you that wasn't there before... and again, I think of myself as a hopeless father – I've had that for years. Hopeless at what I do and so on and it just exacerbates it and so this happens and I'm worse now.

Are they in L?

Yes and I had 2 marriages last year, only weeks apart which was a big shock...it was hard, (going to the wedding) it was hard. They wanted me to give a speech...I was mortified.

And did you?

I did. I stumbled through something (we laugh)

How did you cope with your teaching observations?

Awful. Many times in the class I have just absconded. I have not turned up....such was my state I just didn't turn up! This time I only didn't turn up for one. I cancelled it...nerves or something. I hated them. I've done that before, not turned up and let the consequences be what they may.

Socially were there any negatives about being in college?

I worried at first, would I fit in? I thought we've got people here who are proper teachers.....I don't belong here...there were deep questions and I managed some kind of answers but I've always thought I don't belong! I somehow lucky enough and they made some sort of administrative mistake!

You still feel that after passing?

Yes definitely.

Were you in hospital ever whilst doing those courses and K needed to come in to chek up on you?

No but I may have been in the N centre which is this respite home cos I was in and out of there quite a bit. It's closed now.

Would K have come in?

I wouldn't have told him...I just wouldn't have come in. I only told one good friend.

So when you came back and had to explain your absence?

Can't remember but they would say I'm sure we can get you back on the course G....which they did.

Did you mhp affect your classroom work (as a student)...e,g, concentration

Yea yea, sometimes I wouldn't say something....sometimes I would be other times I had these negative voices sometimes – you shouldn't be here, you're not as good as them. I would always think lowly of myself, I don't belong here. I think if I didn't have my mhp I could do better. I don't know but it has impacted in some way.

What has been the attitude of your family to your mhp?

It's seriously a problem – let's talk next time about that

Any other ideas on how college could help students with mhp? E,g, Teachers better educated?

12.

Absolutely, yes, yes and not assume because everybody looks alright that they are fine...that lurking beneath there are deep seated problems so that when people make such comments you are crushed. Be aware be aware....make it part of the ground rules about being respectful.

I Yes we talk about being respectful of others religion and culture, but not mh! And the MHAs?

Absolutely, I wouldn't have finished it without K. doubtless...that's key. I've been using these services for years back with S was doing it

Can you imagine if you hadn't had them?

I wouldn't even have started the course without the service they provide. You need someone who understands people from the mh side of things. It's not just an occasional headache or not feeling well but deep seated things that negate you way of living.

Okay G I think we should finish now as it's been a long interview. Thanks a million....

Initial analysis of group B

This group fell into two distinct camps as 2 were studying for A levels and 3 on less academic courses (hospitality and catering level 2/ book keeping level 1). A marked difference in the stress that exams cause as the A levels are high stakes and the girls were aiming for high grades.

3 vocational students

They all had needed the stepping stones of coming via easier classes (esp those provided by the rehab centre)

All had severe mhp for which they were hospitalised for many years (5-10 years) including in Daisy's case, a secure unit and now a section 37/41 criminal restriction order. They all recalled sad times in hospital and stories including children being taken into care.

For Danny and Daisy they had improved so much they were lowering medications and Daisy was in process of getting the restriction order negated.

All needed help with basic literacy and numeracy as these skills were low.

Found the structure imposed by college as helping them to organise and structure their lives positively, especially as the medications could cause too much sleeping otherwise (Charlie and Danny).

All valued the social aspects of being in class although it had not been a good one for Charlie as he felt 'left out' (all the other students were female and eastern European for whom English was a second language)

For Charlie, paid employment was not possible but staying in education every year and carrying on voluntary pursuits helped him to keep well.

All lived on their own in supported accommodation– past failed relationships and children who they not rear (Daisy and Danny)

Money worries for Danny moving into work.

2 were churchgoers

None had been in hospital within the last two years

2 **A level students**

Both were slightly older than the other A level students and so did not socialise outside of class, but they got on well with them. Both were isolated intellectually in class as they were more motivated with high aspirations. Tended to do a lot of work on their own as ahead of the others and taught the others a number of times. Pressure due to the low standards of their peers. Both did a lot of peer teaching. Both able to speak in public. Both have a great thirst for knowledge

Pressure of having to earn money whilst studying, due to their families having little money, impacted them negatively time and stress wise.

Felt that the MHAs could give them the time that the teachers did not have and also their background understanding of mhp helped enormously.

Both spoke of crying and being absent due to mhp

Both had economic pressures at home. Huge money pressure on them both

All students

Only one spoke of hearing voices. 2 mentioned suicide attempts

Inattentive / misbehaving classmates was a problem for a few

All had a thirst for knowledge

Needed to be well enough to learn – could not learn when acutely ill.

Most had good relationships with family members

Transformative learning? Yes for Daisy (though not translated into everyday life given her obesity) Prem and June

Danny? T L in terms of self efficacy and identity but not knowledge although he had gained loads but would not admit it - check.

All 3 said it helped their self-respect and the importance of steps in their educational recovery – stepping stones

Found learning to be a **benefit** - the intellectual challenge of it made it different from and superior to therapy. All felt that education provided something challenging that hospital groups could not provide.

Three/four who were on medications spoke of how the fatigue and 'fogginess' of the medications made learning difficult at times.

All relied heavily on the MHAs at points

4 of them would say they were **flourishing** due to coming to college (excludes Danny even though he had successfully got a job upon completion).

Disclosure – only one was happy to disclose to teachers and other students and this was because he felt less pressure when people knew (Charlie).

Confidence improving for all and increased feelings of competency

3/5 mentioned their emotional therapy and how it helped.

3/5 welfare benefit issues

Hope was a theme that was mentioned a lot with all of them hoping to progress onto the next step (Charlie was a bit different)

Negatives

3 had suffered negatively due to problems in the college- disorganised departments with teachers not turning up for classes/ on poor A level history teacher whose classes they stopped going to/ no 1-1 dyslexia support for those who were entitled to it. Danny ****

Previous schooling for 3/5 had been a negative experience

3/5 spoke of being absent due to mhp

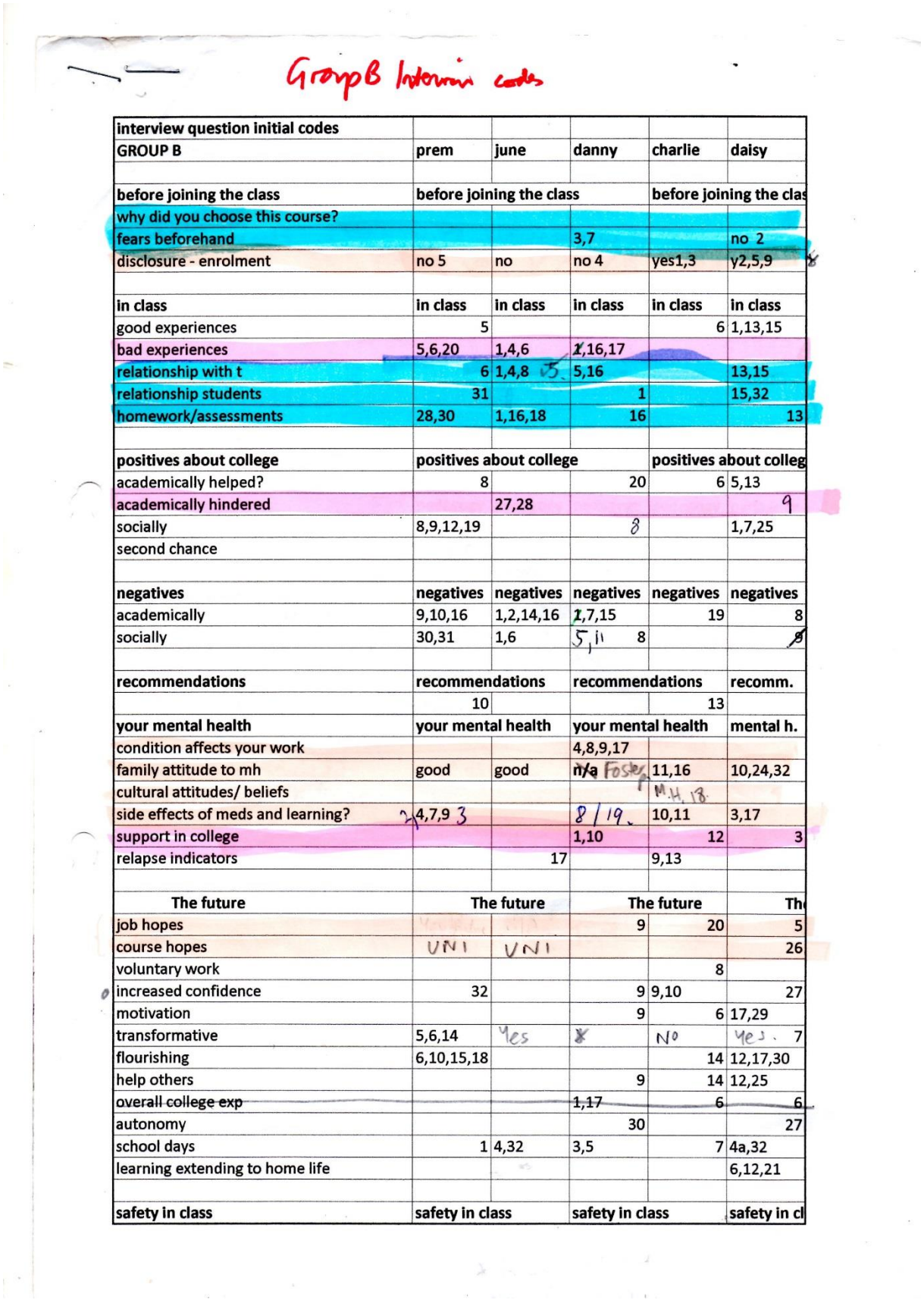
Identity changed? Yes for all of them EXCEPT Charlie. 2 from mh patient to student! (daisy/ danny)

All aside from Charlie, were aiming for employment and actively taking steps towards that through learning.

Safety in class	
Emotionally	Yes x3
Physically	Danny fight 16
Learning addition or change	Addition Only 1 change (Prem)
Teacher	All except Danny who had a mixed relationship with teachers
Students	Yes but mixed for June and Prem due to age and ability
Change thro learning/ Comfort zone	All except Charlie in bookkeeping
Well-being improved	Yes for 4. Danny was not sure but kept put of hospital for years and he is now qualified fro the first time ever and employed.
identity	All but charlie
Adaptable	All except charlie

demonstration	**Irrelevant for prem and june. Others yes but not too much at a time (danny)**
Group work	June/ prem yes, if same level as you. N/A catering. Charlie – speed problem
Teacher talk	No good – lose concentration/ focus (Charlie) irrelevant - june
Teacher says competent	Yes except danny due to self doubt
Meeting a need healthcare cant	Yes for june/ prem/ daisy/charlie. Danny - no therapy helped june/ danny
Can you learn if ill	No – prem/daisy/?danny. yes june/ charlie
Learning v therapy	No prem/june/Charlie. Daisy therapeutic
Not learning anything	All except daisy. Danny – bad lesson planning/ Charlie too much info/ june – irrelevant
Structure	All (except prem who did not mention it) esp daisy
Challenge/ purpose	Prem but exams are pressure/ daisy

Example of a coding sheet



Group B Interim codes

interview question initial codes					
GROUP B	prem	june	danny	charlie	daisy
before joining the class	before joining the class			before joining the cla	
why did you choose this course?					
fears beforehand			3,7		no 2
disclosure - enrolment	no 5	no	no 4	yes1,3	y2,5,9
in class	in class	in class	in class	in class	in class
good experiences	5			6	1,13,15
bad experiences	5,6,20	1,4,6	1,16,17		
relationship with t	6	1,4,8	5,16		13,15
relationship students	31		1		15,32
homework/assessments	28,30	1,16,18	16		13
positives about college	positives about college			positives about colleg	
academically helped?	8		20	6	5,13
academically hindered		27,28			9
socially	8,9,12,19		8		1,7,25
second chance					
negatives	negatives	negatives	negatives	negatives	negatives
academically	9,10,16	1,2,14,16	1,7,15	19	8
socially	30,31	1,6	5,11 8		
recommendations	recommendations		recommendations		recomm.
	10			13	
your mental health	your mental health		your mental health		mental h.
condition affects your work			4,8,9,17		
family attitude to mh	good	good	n/a Foster	11,16	10,24,32
cultural attitudes/ beliefs				M.H. 18	
side effects of meds and learning?	4,7,9 3		8/19	10,11	3,17
support in college			1,10	12	3
relapse indicators		17		9,13	
The future	The future		The future		Th
job hopes			9	20	5
course hopes	UNI	UNI			26
voluntary work				8	
increased confidence	32		9	9,10	27
motivation			9	6	17,29
transformative	5,6,14	Yes		NO	Yes. 7
flourishing	6,10,15,18			14	12,17,30
help others			9	14	12,25
overall college exp			1,17	6	6
autonomy			30		27
school days	1	4,32	3,5	7	4a,32
learning extending to home life					6,12,21
safety in class	safety in class		safety in class		safety in cl

Example of a mind map