

“A light at the end of the tunnel I could aim for. There was some hope. I’ve been suicidal, thinking I’m going nowhere.”

Quote from a man who was a long-term user of mental health services about his return to learning.

This is the thirty-fourth in a series of briefing sheets which aim to provide an introduction to a variety of lifelong learning issues

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Introduction

There are enormous health inequalities in this country. ‘Inequalities to Health’ published in 1980 and ‘The Health Divide’ published in 1998 revealed that in the UK the biggest determinant of health and mortality is social class. The reports concluded that risks to life for lower occupational classes were much higher than those of the highest occupational classes at most stages of life: still-births, death among babies, children and adolescents and deaths of working-age adults are higher among people who are poorer. The evidence also shows that the full range of disease, with very few exceptions, affect the poorer classes more than the rich. Furthermore, people in manual, semi-skilled and unskilled occupations have higher rates of chronic disease and disability than non-manual groups. People in lower socio-economic groups also have lower fitness scores and register a lack of psychological well-being, evidenced by lack of energy, pain, sleep disturbance, physical immobility, emotional distress and social isolation.

These findings have to be seen in the context of what we also know about the learning divide. In the 1999 NIACE survey of adult participation in learning, age, class and experience of initial education were shown to have the biggest affect on access to learning and the confidence to participate in learning. 50% of all upper class and middle-class respondents to the survey were current or recent learners, compared with 36% of the skilled working-class, and 24% of the unskilled working-class and people on limited incomes. Those in work, or seeking work, are twice as likely to be participating in learning as those not working or who are retired.

Length of initial education is another indicator of participation in adult learning. Those who left school at age 16 or earlier had participation rates of 25%, compared with participation rates of 61% among those who stayed on in education post-age 20.

Government policy places a high importance on lifelong learning for all, and widening participation in learning. Yet surveys reveal that those at risk of poor health are the groups who do not participate in learning, and that poor health, disability, and low self-esteem are still significant barriers to learning for some people, particularly among some groups.

Does It Matter?

The increasing evidence suggests that yes it does matter. Aside from issues of equality of access and individuals right to access to services and resources, it also matters that some individuals don't have access to continuing education because of the impact it has on health and well-being.

Hammond, in her report 'Learning To Be Healthy' states that the correlation between years in education and physical and mental health and well-being is strong. For example, she cites data from the British cohort in 1970 to show that respondents with no qualifications were, at age 26, almost four times as likely to report poor general health as those with the highest educational qualifications. With regard to depression there is also a stronger correlation, for example, 36% of women, and 18% of men with very low literacy skills suffered from depression, compared to 7% of women and 6% of men with good literacy skills.

Hammond maintains that there are five groups of mediators through which learning affects health –

- economic factors – educational success is associated with higher earnings, higher socio-economic status and lower rates of unemployment. Higher income tends to allow for a healthier lifestyle through being able to afford more nutritious but more expensive food, as well as better housing and holidays etc. Higher level occupations tend also to allow for greater autonomy and self-direction, which Hammond relates to well-being and protection against stress and depression;
- health-related behaviours – studies suggest that people with more years of education and higher level qualifications tend to exercise more, eat more nutritious and healthy diets, and smoke less etc. There are

many mediating factors which may affect this, such as awareness, future-oriented thinking, social effects, or a feeling of personal control over life. It may also be that adverse socio-economic conditions creates stress that triggers a psychological need for unhealthy behaviours such as smoking, sugary or fatty foods, or excessively drinking alcohol;

- resilience and dealing with stress – this suggests that education enables individuals to learn problem-solving skills, a sense of purpose and future, social competence, which instils in individuals a greater sense of belief in their ability to cope with adversity. Of course, educational success may lead to a socio-economic situation which is less stress-inducing in the first place;
- relationship with medical professionals and access to medical services – availability of and access to medical care tends to be lower amongst populations that are more deprived;
- education and healthy societies – countries that have the best health care are not the richest countries, they are the most egalitarian. Countries with the poorest health outcomes are characterised by financial inequality, and that countries and regions that have high levels of financial inequality are also characterised by inequality in educational opportunities. Hammond argues that there is evidence that proves “a mechanism through which the provision of education that is genuinely equal has a positive effect upon a nations health.”

So we see that putting resources into education will have a positive impact on the physical and mental health of individuals. Initiatives such as the National Healthy School Standard (NHSS) recognise the potential of schools as settings for health promotion.

What about adults?

Much of the evidence that links education to health and well-being uses years in education and level of qualification as the indicator by which to

measure the effects of education upon health and well-being. But is it then too late for adults who left school at 16 with little or no qualifications and who haven't returned since? What about individuals who do have qualifications and professional employment experience who become ill? Does education still have a role to play for them in improving their health and well-being?

Again, the answer has to be a resounding yes.

Over the past few years, providers of adult and further education have sought to widen participating in learning among individuals who would not normally access formal learning opportunities. This includes people who have mental health difficulties and people who accessed learning through NIACE projects like 'Prescriptions for Learning'.

There exists a wealth of qualitative evidence provided by learners themselves which indicates that learning has many beneficial effects on individual's physical and mental well-being.

The 'Impact of Learning on Health' study conducted by NIACE in 1999 of 473 adult returners to learning, revealed that 89% said that returning to learning had a positive impact on their mental health. 87% said that returning to learning had a positive impact on their physical health and 30% said that it helped them to manage pain more effectively.

What else is NIACE doing in its Learning and Health Work?

The Learning and Health work at NIACE has two strands:

- access to learning for people with poor health;
- understanding how learning impacts on the health of adults who return to learning.

In working to improve access to learning for people with poor health, NIACE has formed partnerships with different agencies and in particular the National Institute for Mental Health in England (NIMHE) through a two-year partnership project (www.nimhe.org.uk). NIACE has worked with other mental health agencies and learning providers to promote access to education

for people with mental health difficulties and to disseminate good practice through conferences and publications.

NIACE is also involved with evaluating the impact of learning on health and has done this by evaluating projects such as 'Prescriptions for Learning' and through a scoping exercise on the link between health and basic skills.

NIACE has also developed work across the two strands of promoting access to learning and exploring the impact of learning. For example:

- the Consortium of Prescriptions for Learning supports practitioners to develop projects that widens participation in learning among individuals with poor health and is exploring a common evaluation framework for assessing the impact of participation in learning on the health of those individuals;
- a common difficulty for individuals with poor health and well-being is the loss of self-esteem. NIACE has completed a report into low self-esteem as a barrier to learning and raised self-esteem as an outcome of learning. A conference on self-esteem and adult learning is being organised and training materials for practitioners being developed;
- NIACE is also keen to explore and promote the concept of a Healthy College and recognises that if improved health is an outcome of learning then this may be maximised if adults learn in health promoting environments.

For further information on Learning and Health work contact Kathryn James, Development Officer, Learning and Health, Renaissance House, 20 Princess Road West, Leicester, LE1 6TP, 0116 2044281 or email kathryn.james@niace.org.uk.

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References and Further Reading

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Prescribing learning : a guide to good practice in learning and health. Kathryn James. NIACE, 2001. ISBN 1 86201 135 4 £9.95

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Winning hearts and minds. Kathryn James. NIACE, expected publication, August 2003. ISBN 1 86201 159 1 £9.95

NIACE, the national organisation for adult learning, has a broad remit to promote lifelong learning opportunities for adults. NIACE works to develop increased participation in education and training. It aims to do this for those who do not have easy access because of barriers of class, gender, age, race, language and culture, learning difficulties or disabilities, or insufficient resources.
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