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Conceptions of lifelong learning as applied to adults with enduring mental illness: a survey of mental health professionals and practitioners across eight European countries

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ABSTRACT This paper presents the results of a survey of mental health professionals' conceptions of Europe's lifelong learning policy and practice as applied to mental health. The aim of the survey was to obtain evidence, first-hand, from mental health practitioners about their perceptions of their countries' regional and national lifelong learning provision and, in particular, its application to adult with long-term mental illness. The study finds differences in the factors that have encouraged or facilitated the take up of lifelong learning among the general population and among mental health service users. These differences have a lot to do with the individual country's lifelong learning tradition/culture as it is with the constructions of the meaning of lifelong learning. What is noticeable is that the same or similar factors apply to mental health service users in half of the countries surveyed—i.e. Bosnia and Herzegovina, Greece, Spain, Poland and the UK. Nonetheless, the findings from this survey would provide insights into some of the main factors that have given mental health service users the confidence to engage in lifelong learning—factors which include an increased social inclusion and an increased power and influence of the service user movement.

Keywords: Lifelong Learning, Mental Health, Social Inclusion, Service Users, EMILIA, European Union

Context of study: the EMILIA Project

EMILIA is an abbreviation for 'Empowerment of mental illness service users: lifelong learning, integration and empowerment'; it is a framework 6 research and intervention project, funded at €3.4 million. The EMILIA project is one of a number of European development programmes funded by the European Union, part of a wider effort to address the problem of exclusion of multiple disadvantaged groups such as unemployed people with long-term mental illness. EMILIA remains the European Union's largest ever funded research and intervention project on lifelong learning and mental health/social inclusion. The project has 16 partners in 13 European countries; one of these countries—Norway—is outside the European Union region. A major goal of the EMILIA project was to explore the use of lifelong learning, through EMILIA intervention activity or lifelong learning (job-related) training, as a means of achieving improved social inclusion of people with long-term mental health illness. The EMILIA training programmes ran across eight demonstration sites in eight European countries – namely the United Kingdom, France, Norway, Greece, Spain, Poland, Bosnia and Herzegovina and Denmark. The project's sought to achieve the integration of European policy in the areas of lifelong learning, social inclusion, employment, and information technology as applied to mental health. The findings from the EMILIA project on the whole showed an appreciable increase in the number of mental health service users in open, competitive employment and that EMILIA lifelong learning training participants remain competitively employed for significantly longer months. EMILIA's findings also showed that lifelong learning opportunities for mental health service users should be an integrated part of recovery focused provision. There is a need to achieve a balance between the medical approach and the recovery (psychosocial) approach in the management and delivery of mental health care. The latter finding clearly underlined the critical importance of education and training—learning, in particular—to recovery and the critical need to embed lifelong learning in the future delivery systems/mechanisms for mental healthcare.

Introduction—defining lifelong learning

The European Union underlined the 'evergreen nature' of its lifelong learning agenda with its proclamation 1996 as the European Year of Lifelong Learning (Ogunleye, 2007). Lifelong learning has many definitions—depending on the contexts in which it is defined or, in some cases, the concept/s that is used to explain it. In its simplest form, lifelong learning can be defined as all learning activity undertaken throughout life. The emphasis in this definition is *learning* which can be undertaken for personal/leisure reasons or professional/employment reasons, or both. This *learning* can take different forms and can take place in varied range of settings or contexts—be it formal, informal and non-formal settings (see for example Stenfors-Hayes et al., 2008; Ogunleye, 2010). The European Union's definition of lifelong learning is purposely broad and but no less definitive. According to the European Commission policy document *Making the European Area of Lifelong Learning a Reality* (Com, 2001), lifelong learning is defined as:

> … all learning activity undertaken throughout life, with the aim of improving knowledge, skills and competences, within a personal, civic, social and/or employment-related perspective.

The Commission's definition intensely focused on the Lisbon policy strategy which was meant to highlight priority action areas for national governments in the Member States of the European Union. Although the linchpins of the European Commission's definition of lifelong learning are economic growth and jobs—including knowledge and skills development and competences—there is, equally, a genuine underlying focus on social dimension of the Lisbon strategy. The elements of this social dimension include community cohesion and integration, citizenship, and cultural renewal. These elements are often referred to by their collective term of *social inclusion*. The European Commission (Com, 2003) relates social inclusion approach to education and training as follows:

> a social-inclusion approach [to education and training] which mainly targets those whose initial experience of education and training has been unsatisfactory or inadequate, certainly in relation to the modern world, and which seeks to re-engage them with a learning experience which may, especially at the initial stages, focus on personal development and bringing them up to a level of personal and basic skills which …' (Com, 2003).

Social inclusion has become wedded to the European social policy agenda, an agenda that places an emphasis on tackling exclusion especially of people from multiple disadvantaged groups including those experiencing severe long-term mental illness. Lifelong learning is considered not only a tool for achieving the Europe's vision for a high-skills, full knowledge economy, but it is also, at the same time, considered a tool for achieving the social inclusion of people from the disadvantaged groups (Ogunleye, 2009a, 2009b, 2011, 2013). It is this dual-role that makes lifelong learning the bedrock of the Lisbon policy agenda.

Methodology

This study used survey questionnaire to collect data from respondents. The respondents were 12 experts made up of three academics and nine practitioners with significant specialist knowledge, experience and expertise in lifelong learning and mental health across 8 EMILIA demonstration centres in 8 European countries. These experts have background in mental health nursing, psychiatry and medicine, theoretical and clinical psychology, social work, and education. The experts were selected based on their leadership and representational role in their countries' EMILIA demonstration sites, which is located in eight European countries—UK, France, Denmark, Norway, Greece, Poland, Bosnia and Herzegovina and Spain. The two countries under survey are France and Denmark. The respondents' organisations include a university, a mental health clinical laboratory, psychiatric hospitals and mental health day care centres and a non-

governmental psychiatry association. The respondents were required to draw on the European learning policy and practice and on their individual country's national strategies for lifelong learning in formulating their answers to the survey questionnaire questions. The survey questionnaire used a mixture of fixed-and free-response questions (see Jordan, 1998; Oppenheim, 1992). These questions include: 'How important is lifelong learning to your national culture?' 'What are the most important factors or actions that have encouraged or facilitated the take up of lifelong learning courses among the general population?' 'Give two examples of strategies that your country has used to inspire or motivate citizens/residents to continue to engage in lifelong learning?' 'What are the most important factors or actions that have given mental health service users the confidence to engage in lifelong learning in your country?' 'What is your professional view on the lifelong learning motivation or attitude of mental health service users in your country?' 'How adequate is the awareness of lifelong learning opportunities for mental health service users in your country?' 'What is the policy thrust/s or focus of your country's lifelong learning policy?' '(a) mainly economic reasons—i.e. to develop or update skills for employment purposes, (b) cultural/social reasons — e.g. to gain basic skills for leisure, and or social/empowerment purposes, (c) other reasons (please insert).' These questions require greater thought on the part of the respondents as to how to respond to them.

The purpose of the survey was to complement findings from the review of literature and policy documents of the European Union on lifelong learning and workplace as applied to mental health service users. The EMILIA project was interested in gaining demonstration sites' experts views and understanding about the importance of lifelong learning to national cultures, the extent to which the reasons for the take up of lifelong learning by the general population differ from those of people with long term mental illness, and the policy thrusts of the national strategies for lifelong learning. Since one of the EMILIA project's main goals was to use EMILIA intervention—lifelong learning training—to improve the employment prospects of service users, the survey reported in this paper fed into that goal as it evaluates the extent to which national policy thrusts of lifelong learning policies in EMILIA's demonstration sites' countries relate to skills development and update for employment. The use of the questionnaire therefore complements evidence from the review of literature especially where country-specific empirical evidence on lifelong learning provision for people with long-term mental illness was poor and sporadic. The questionnaire was administered through email. There is a practical reason for the use of email to collect data considering the geographical locations of the respondents. Besides, the use of email is particularly well-suited to this study, as it provided a good way to produce rich written accounts of the respondents (see Gibson, 2010). The respondents were given one month to complete and return the questionnaires.

It must be remembered that the research reported in this paper is just one aspect of the EMILIA research as a whole, which involved a total of 212 participants aged 18-64 in eight demonstration centres across Europe. These eight demonstration sites delivered the EMILIA intervention to the participants. There are two strands to EMILIA data collection via interviews and questionnaire—strand 1 data collection took place at individual level and strand two data collection took place at organisational level (see

Griffiths et al, 2011). EMILIA collected data from the participants at baseline and at 20 month. The EMILIA project research aimed to evaluate the extent to which EMILIA lifelong learning training intervention impact (positively) on the recovery of the mental health service users (i.e. on the 212 representative sample/participants). However, the research reported in this paper was directed to mental health practitioners and educators and the aim was to evaluate national strategies for lifelong learning as applied to mental health services users.

Results/analysis of data

Respondents' organisations' involvement in lifelong learning training

The respondents were asked to state whether their organisations/institutions offered lifelong learning training programmes/courses besides running Emilia training programmes. Respondents from six countries—France, Greece, Spain, Poland, Norway and the UK—stated that their institutions/organisations offered lifelong learning training programmes/courses besides their work on the Emilia project. The respondents from Bosnia and Herzegovina said their organisation did not offer lifelong learning training programmes besides Emilia.

The respondents stated that their organisations offered a range of lifelong learning training programmes/courses for mental health service users and professionals and practitioners. Lifelong learning training/courses these organisations offered to service users include 'basic' professional skills and communication skills as applied to psychosocial rehabilitation. The main aim of the psycho-education and training is to teach service user-trainees 'how to live with a mental illness' (Greece) and how to cope with mental illness (Poland). In addition to psycho–education and training, the respondents from Poland stated that their institution offered courses/training in personal hygiene, communications skills, information technology skills, English and general literacy skills—for example, 'How to write down CV; and job interview skills—i.e. 'how to talk with potential employer'. Norway runs training on Liberman social skills (see Liberman et al 1989). Social skills training is aimed at people with severe long-term mental illness and it is designed to help them to undertake 'those physical, emotional, social, vocational, familial, problem-solving, and intellectual skills needed to live, learn and work in the community with the least amount of support from agents of the helping professions' (Anthony, 1979). Norway's lifelong learning training includes 'Coping with psychotic symptoms.' In Spain, lifelong learning training to mental health service users are offered in communication skills, gender and equality, domestic violence, 'trans-cultural training' and 'violence in the work-place training'. The respondents' organisation in the UK is a university; it offered a variety of lifelong learning 'opportunities for students, staff and professional organisations—e.g. companies, other universities, etc.—this also includes work based learning. In Denmark, the focus on lifelong learning training for mental health service users was on 'patient education', which has the goal of helping users to return to employment and to wider society.

The respondents' organisations and institutions also offered lifelong learning training/courses for mental health professionals and allied health practitioners many of

whom work 'in the services that need specific skills for their profession, clinical knowledge, and the knowledge of the environment in which they work' (France). The ultimate goal of the lifelong training is to enable healthcare professionals (staff) to gain requisite qualifications—e.g. a diploma—necessary to change jobs, or to enable them acquire more general skills such as literacy and information technology.

> Working in the mental health [in France] area requires continuous training in several key areas: clinical psychiatry; psychosocial rehabilitation; somatic care; psychiatric emergency care; handling violence; respecting users. The training programmes have as an objective to maintain and update professional competencies, within the framework of health policy. In an uncertain economic context, with rapidly evolving professional roles where competency is key to keeping your job, lifelong learning plays an essential role. It is a powerful institutional lever and the only way of guaranteeing high quality care (France).

Greece, too, offered continuous professional development and training for mental health professionals, 'on selected job related items.'

Lifelong learning and national culture

Studies have shown relationships between a country's culture/tradition and education (see Entwistle, 1978; Qvarsell and Wulf, 2003). The respondents were asked to state the importance of lifelong learning to their national cultures. From their answers, it is clear that lifelong learning is important to national cultures. The following are examples of the respondents' description of the importance of lifelong learning to their national culture:

> It is extremely important. There is an old saying that "one learns as long as one lives", which is often quoted. This concept was especially emphasised during the socialist reign, through the so-called workers' university, a kind of open universities that people could attend free of charge (Bosnia and Herzegovina).

> Lifelong learning is vastly important to our national culture. It is the belief of government that lifelong learning is essential for maintaining and improving the nation's economic competitive edge. Both national and local Government objectives include creating a learning society where everyone is able to learn and improve their skills via lifelong learning. Learning is at the heart of the local community and fundamental to academic, social, economic and cultural development. There is a tradition of active participation in lifelong learning within the culture of the UK. Great progress has been made in increasing the variety and acces-

> sibility of lifelong learning provision over the last 60 years. Lifelong learning provision is continuously being developed, and it is evolving to meet the interests and needs of the population (UK).
>
> It is becoming more and more important. In Norway training and education is widely available to the population (Norway).

As the evidence from the review of literature in the preceding sections shows lifelong learning is government-driven and the respondents in this survey corroborate that literature evidence. The respondents acknowledged the 'heavy' State involvement in and support for lifelong learning which is manifested, as expected, in the context of 'implementing European Union directives and programmes' (Greece). According to the Greek respondents, the reported 83 per cent increase in the number of people from the general population, and 150 per cent increase in the number of people from the disadvantaged groups that have attended lifelong learning courses and training programmes in the last few years is attributed to a changing attitude/culture of people. But the Greek respondents questioned the effectiveness of recent 'actions' in engendering a culture for lifelong learning as well as wondered whether lifelong learning courses and programmes were not just being offered because of the financial incentives from the European Union:

> Most of the actions and the programmes [currently offered] are not effective and there is a common belief that they are not actually improving people's knowledge and learning but are [undertaken] mostly [as] a way to extract funding [from the European Union]. Evaluation of lifelong learning programmes is compulsory but it is being done just for typical reasons [of compliance] (Greece).

Although Bosnia and Herzegovina regards lifelong learning as 'extremely' important to its national culture, however:

> the concept [of lifelong learning] has become satiated with the overall ideology, so there seems to be a kind of resentment against it as if it were a remnant of the overturned regime with no value in itself. It may also be noted (although not enough sociological research has been conducted to explore the issue in depth) that the overall disappointment that people feel after the war includes a concept according to which education doesn't guarantee welfare, since there are many examples of people who benefitted from the war in dishonest ways (Bosnia and Herzegovina).

Lifelong learning is important also to national culture in Denmark and France but it orients more towards employment. As the respondents from France explained:

> France adopted lifelong learning policy very early…initial training and continuous training were conceived of as being part of an overall right to lifelong learning: including, a legal obligation for employers to contribute to staff access to lifelong learning. Employers are obliged to contribute to a specific fund which proposes training to employees (=1% of the mass salary expenditure of every enterprise); and the distinction between the employer's training policy (plan de formation) and the individual employee's right to take leave to access training (*congé individuel de formation*). Later national policy changes include: validation of experience (*validation des acquis de l'expérience: VAE*); the 5 décembre 2003 interprofessional agreement and the Law of 4th May 2004; individual right to training (*droit individuel à la formation: DIF*); professionalization; specific employee support; increased employer contribution; increased negotiation between employees and employers on these questions. The question is how does this work in the hospital [settings]? [Take the development in 1975, 1990 and 2008, for example.] In 1975, hospitals, very wealthy during this period, provided personal and even recreational training, in accordance with employees' wishes. In 1990, a new law (now revoked) imposed competency as the main training tool. In 2008, training becomes an individual right; this makes dialogue essential between the employee (nurse, doctor, administrator, etc) and hospital management. Health services are obliged to train their employees – for example to facilitate their integration into their job, to be rapidly operational, to adapt to change, to get advancement [or make career progression].

The responses from Poland suggest that lifelong learning is, at the moment, not considered very important to national culture—they cited evidence from a Eurostat (2009) report which shows comparatively low participation rates among 25-64 year-olds Poles in lifelong learning:

> People in Poland, when asked, declare that high and continuously actualized qualifications give better position on work market, the higher earnings hence better standard of life, also larger possibility to active participation in social and political life of the country. So they see lifelong learning as the remedy on unemployment, poverty and social exclusion. But…Poles' participation in lifelong learning is low—among EU member states Poland occupies in ranking the bottom place. It seems that besides expressed opinions there is lack of awareness of necessity to actualize and "reload" qualifications, lack of need to do it. There is deeply rooted conviction that once knowledge is acquired it will suffice for the whole life. The people are older the conviction is more

> pronounced. Besides, the lack of funds is recognised as a significant barrier [to] participation in lifelong learning.

However, Poland's low participation in lifelong learning may have had a lot to do with preventable barriers such as lack of funds than national learning culture or tradition.

Evidence from the review of literature suggests that national policies on or strategies for lifelong learning across Europe have been predicated primarily on economic and, to a lesser extent, on cultural and social factors. The respondents were asked to highlight which of the policy thrusts or focus apply to their individual countries. Respondents from the UK, Greece, Bosnia and Herzegovina, Denmark, France and Poland described the policy thrusts or focus of their countries' lifelong learning as 'mainly economic reasons – i.e. to develop or update skills for employment purposes'; and 'cultural/social reasons – e.g. to gain basic skills for leisure, and or social/empowerment purposes.'

> Economic pressure and employer-employee negotiations have led to France's very complex lifelong learning legislative and organisational structure leaving more and more place to economic factors and employer needs. This remains true in spite of regular attempts to support employee priorities, such as individual training leave (1982 Law) (France).

However, the respondents from the two other countries, Norway and Spain, described the policy thrusts or focus of their countries' lifelong learning as 'cultural/social reasons – e.g. to gain basic skills for leisure, and or social/empowerment purposes' (Norway) or 'mainly economic reasons—i.e. to develop or update skills for employment purposes' (Spain). It ought to be noted that the respondents from Spain prefaced their answers with the point that their views may not reflect the situation nationally as they were based in Barcelona.

The respondents were asked to outline, in their professional view, the most important factors or actions that have encouraged or facilitated the take up of lifelong learning courses among the general population in their individual countries. Their answers were not too dissimilar. In most cases, the State has been a significant driving force for participation or take-up in lifelong learning among the general population. This has been achieved through both targeted policy/legislative frameworks and through the implementation of the European Union directives (especially in countries such as Greece where lifelong learning programmes or actions were co-financed with significant European Social Fund):

> Better access to lifelong learning [coupled with] improved local provision; better access to information about the provision of lifelong learning e.g. [central government-funded] *Learn Direct* helpline and website; financial support from both local and national government for lifelong learning provision; [concerted national] efforts to provide equal access to lifelong learning; [concerted national] efforts to increase the social inclusion of dis-

> advantaged groups, e.g. immigrants, mental health service users, ex-prisoners, etc. [government-funded] adverts to make people aware of the value (economic and self fulfilment) to them of taking part in formal lifelong learning, e.g. adverts for: *Earn While You Learn* (UK).
>
> [A particular government's campaign aimed at] focusing on groups in society, who normally lives a very quiet life [or who are disadvantaged] (Denmark).
>
> A [new] legislative right to individual training courses (DIF) and Individual Training Leave (CIF) (France).
>
> [Major drivers are] the funds and the directives from the European Union and especially the European Social Fund (Greece).

Other important factors or actions that have encouraged or facilitated the take up of lifelong learning courses among the general population were economic/employment, and personal. For example, in Spain, employers demand that certain courses undertaken by employees be certified and accredited; also in Spain, another major factor that has encouraged more take-up of lifelong learning is improved internet access, which has enabled an increasing number of people to undertake part-time distance learning courses, and still able to work full-time. Personal interests/situations, such as the need 'to achieve personal goal'—for example, many people have come to see lifelong learning as a means through which to develop new skills. In Poland, there is a general perception that undertaking lifelong learning courses or training would lead to 'better quality of life and prestige' and some people even considered lifelong learning 'on retirement as way of living'! In Norway, health and general well being are a pull-factor for lifelong learning coupled with more readily available lifelong learning training courses across the country. Another factor, in Norway, is the 'increased user involvement at all levels.' In the case of Bosnia and Herzegovina, culture was an important driver for lifelong learning before the war, but 'now this trend [participation in lifelong learning] is seriously decreasing, being replaced only by motives of financial gains.'

When asked whether the factors that have encouraged or facilitated the take up of lifelong learning courses among the general population were the same or similar for mental health service users, respondents from Bosnia and Herzegovina, Greece, the UK and Spain answered in the affirmative:

> [All of the listed factors above] apply to mental health service users. In addition improvements in the care and support of mental health service users may have encouraged and facilitated the take up of lifelong learning courses among mental health service users (UK).
>
> Yes – because users also want to improve and develop skills that can help them to get/maintain a job. However, unlike other life-

> long learning participants in the general population, for mental health users there is a greater need to do the lifelong learning training physically and not on-line. The fact of attending the training and meeting with others in a group is in itself a fundamental step to improve their social inclusion. Another difference between users and the general population regarding lifelong learning is that the personal experience that users already have before starting the lifelong learning training is huge, many have been users in mental health service. However they do not realise the wealth of experience that they have until they start the lifelong learning training (Spain).

In the case of Poland, the same factors apply, 'but at the moment mental health service users are not very keen on taking up lifelong learning courses' due to access barriers and other personal reasons. The same factors 'partly' apply in Norway; for example, 'there has been a [government] push towards increased service user involvement and empowerment … with government guidelines encouraging this.' The respondents from France and Denmark stated that the same factors do not apply to mental health service users to their countries suggesting a more exclusive approach.

The respondents were also asked to identify two examples of strategies their countries have used to inspire or motivate citizens/residents to continue to engage in lifelong learning. National strategies for lifelong learning range from direct government funding and promotion of lifelong learning, reform of the delivery systems and mechanisms for lifelong learning, to policy frameworks and legislative instruments. Examples:

> Government funding of public lifelong learning institutes based in national universities; regional research funding aimed at investigating minority populations in need of formal training (Spain).

> Increased funding to schools and colleges has resulted in a wide range of lifelong learning courses being made available (Norway).

> The establishment of the General Secretary for Lifelong Learning aiming to design, coordinate and implement lifelong learning actions at a national level; European Commission's Lifelong Learning Programme 2007-2013 [under Framework 7] (Greece).

> [Through] the Act on employment promotion and work market organizations, 20th April 2004, for example; [and through] the tax laws: educational organizations are free from VAT regarding income from educational services (Poland).

> [Through] Job Information Centres; Lifelong Learning and Employment Centres (Cité des metiers at the City of Science and Industry, Paris); [also], validating experience (validation des ac-

> quis de l'expérience) gives charity organisation volunteer, for example, the right to certification in the field they are specialised in, in order to rise the level of their initial diploma (France).
>
> National Reference Point – Skills for Life: which provides latest news and guidance relating to Skills for Life professional development; London 2012 Olympic Games and Paralympic Games: which encourages young people to understand a global perspective (a role for development education), seeks to inspire people from the five main Games boroughs in London to enter the pre-volunteer programme (a role for youth and community workers), and targets the upskilling of customer service skills of those in the hospitality industry (UK).

The respondents from Bosnia and Herzegovina reported 'none' strategies 'after the war', which lasted between1992-1995.

In all the eight countries except in Bosnia and Herzegovina (to which the question did not apply) and Denmark (which gave no answers), the same or similar strategies used to inspire or motivate citizens/residents to continue to engage in lifelong learning are also used to engage mental health service users in lifelong learning. However, in Greece, mental health service users 'may benefit from these actions [the same or similar strategies], but [in reality] only a small part is especially for service users.'

Engaging mental health service users in lifelong learning

The respondents were asked to give their professional views on the adequacy—or lack of it—of the awareness of lifelong learning opportunities for mental health service users in their countries. The respondent from Denmark believed the awareness of lifelong learning opportunities for service users the situation in their country was 'adequate'; the respondents from Norway judged the awareness 'neither adequate nor inadequate'; the respondents from Greece, Bosnia and Herzegovina, France, Poland, Spain and the UK all judged the awareness of lifelong learning opportunities for service users in their countries 'inadequate'. The respondents from the UK commented:

> Awareness is rarely, if ever, fully adequate.

The respondents identified a number of important factors or actions—both statutory and non-statutory—that, in their professional view, have given mental health service users the confidence to engage in lifelong learning in their countries. These factors include 'free' [European Union-sponsored] training courses and programmes for people 'with disabilities, especially in Warsaw. For mental health service users it is quite easy to be included in such projects, free of charge' (Poland). Similarly, in Norway, there are 'readily available programmes for mental health service users and the government has recommended centres which work towards increased psycho education.' In Denmark, personal motivation has played an important part in given mental health service

users the confidence to engage in lifelong learning especially 'the possibility to see one self as a person with resource … [or] a person who makes a different [to] others.' Other factors identified by the respondents include:

- Increased social inclusion;
- More effective mental health medication and better side effect profiles of mental health medication;
- Increased power and influence of the service user movement;
- Support from care professionals;
- Support from mental health charities;
- Support from within the mental health community; and
- Increased levels of empowerment partially due to the above factors (UK).

> The relevant laws support employment of people with various disabilities including mental health service users, i.e. are favourable for users attempting to get employment—for instance, they can easily return to the state benefits even if such attempts fail (Bosnia and Herzegovina).

> Lifelong learning actions that are especially designed for mental health services users (and not for wider vulnerable populations) and in which users are actively engaged (Greece).

> [Due to the] recent introduction of Therapeutic Education as an essential part of healthcare, this does not lead to accredited training. [Also] several universities across the country have begun diploma-accredited training for healthcare actors, many of whom are users, to become *health mediators.* Furthermore, the 2005 Disabilities Law establishes the principle of access to training and employment for people with disabilities. In practice, this is taking off only very slowly for people with mental health problems (France).

The respondents from Spain highlighted the importance of international projects such as Emilia, not only in raising awareness but, also in giving mental health service users the confidence to engage in lifelong learning:

> On a local basis [from our experience in Barcelona], the implementation of [the] EMILIA [training intervention] and the great amount of dissemination work carried out by the Barcelona Team—e.g. conferences/congresses, publications, radio interviews, a newspaper article, television documentary—has lead to

> an increased awareness about the need to introduce lifelong learning not only among mental health service users but also among mental health professionals (Spain).

The respondents' gave their professional views on the lifelong learning motivation or attitude of mental health service users in their individual countries. There is a general agreement that there has been some noticeable increased in the personal motivation of mental health service users due to some of the factors or actions identified in the preceding paragraphs. The respondents acknowledged the 'variable nature' of mental health service users' motivation and attitudes—respondents from Poland, for example, acknowledged the link between the individual service user and their diagnosis as an explanation for the variable nature of mental health service users' motivation:

> Generally people with schizophrenia diagnosis have problems with motivation regarding all aspects of their life. People with affective disorders, neurosis are usually highly motivated and their achievements depend on individual background, needs, etc.

> The motivation and attitudes of service users can of course vary but on the whole they are positive—especially amongst groups that one thought would not be so motivated (Norway).

There is, however, a real recognition that much work is still needed to be done to instil confidence on mental health service users:

> There is a lot of work to be done so that the attitude will change and users will trust more of these actions and they participate. This can be done by disseminating examples of good practice (like EMILIA) and by supporting [and empowering] associations of users that will be not depending on professionals (Greece).

> **...** it is difficult to say a great deal about attitudes to lifelong learning other than it is hoped that attitudes to lifelong learning have become more positive with increases in social inclusion, support and empowerment (UK).

> A political strategy would [help to] improve mental health service users' motivation and attitude for lifelong learning—so that they see its value and usefulness in society (Denmark).

In France, a major factor that has impacted on the motivation and attitude of mental health service was their ignorance or lack of appreciation of their rights and a lack of know-how on how to enforce their rights. In addition, 'the generous French health and social care system often creates comfortable niches from which it proves difficult to "escape".

The respondents from Spain – using their Emilia experience in Barcelona—believed the motivation and attitudes of service users are due to a self desire to be socially and economically active:

> Mental health service users want to get out of the house, become involved in something new, meet people, feel understood by others, ideally get some form of accreditation, ideally get skills for a job, learn how to avoid relapse and learn how to live with their illness.

In Bosnia and Herzegovina, although service users' motivation is said to be 'extremely high' [however], 'the conditions, the ignorance and the neglect [caused] by the relevant authorities,' have [had an adverse impact on] the mental health service users' motivation.'

The respondents, from a professional view point, identified what they considered the main factors that hinder the take up of lifelong learning courses or training among service users in their individual countries. These factors are both personal and non-personal. Personal factors can be linked or related to the individual service user's conditions or situations (which suggest that given appropriate support these can be addressed). For example, mental health problems (France) and treatment side effects of mental health medication (UK) affect the take-up of lifelong learning by service users as are the fear of relapse and the fear of being hospitalised (Spain). Other personal factors identified by the respondents from Spain, Poland and France include:

- fear of not being able to finish training,
- being stressed by the training,
- [individual] economic situation,
- lack of support from family,
- lack of time if already involved in some other activity e.g. voluntary work,
- difficulty of getting up or arriving at training on time in training starts early,
- lack of motivation (Poland),
- lack of self-confidence (to be successful in doing learning courses or trainings) (Poland),
- lack of self-confidence (France), and
- internalised stigma (France).

Another major factor is individual service user's economic situation (Spain). For example, many service users are unlikely to be employed. Although they would be entitled to social security and welfare benefits, the associate costs of undertaking lifelong learning training or courses— e.g. reading and writing materials, computer, etc—cannot possibly be met from their welfare/benefit money. These are some of the financial issues identified:

- The cost of lifelong learning and cost of transportation to attend formal lifelong learning, and
- The cost of materials for lifelong learning, e.g. books, computer equipment and internet access (UK).

A number of major non-personal factors were also identified by the respondents. These non-personal factors can also be described as service delivery issues including staff professionalism – e.g. 'attitudes' of healthcare staff. According to the respondents from Norway:

- They [healthcare staff] don't always seem to think it [lifelong learning training intervention] will get anywhere. Plus that there may be a burst of engagement from staff but then either they leave or loose interest.

- [A major factor is] the lack of will and understanding on [the part] of the majority of mental health professionals (it would take up too much of their time), health officials in general, and higher levels of authorities [in particular] (Bosnia and Herzegovina).

- … the relationship between users and professionals [is] sometimes controversial (Greece).

Another delivery issues identified are: the lack of continuity in services—for example between treatment, rehabilitation, training, support, etc (Greece); lack of wide-spread information on lifelong learning opportunities/lack of awareness (Poland); inadequate human/financial and material resources and a disproportionate focus on the treatment as opposed to non-medical model of recovery as well as aspects of mental health care such as psycho-education (Denmark).

The respondents from the UK, Greece and France identified more wider issues – they include 'lower levels of social inclusion and empowerment than the general population (UK); problem of stigma and discrimination facing mental health service users, and the difficult of evaluating, recognising and accrediting informal training or knowledge gained or acquired in informal education settings (France); and the unavailability of formal lifelong learning provision for mental health service users (Greece). In fact, where formal lifelong learning provision are offered:

> [they] are not especially designed for mental health users but wider people facing social exclusion (Greece).

In other words, delivering non-relevant, one-size-fits-all lifelong learning provision will not address the particular needs and desires of mental health service users and may not be the best way to use scare financial resources.

Similarly, in Spain, despite the availability of lifelong learning programmes for other disadvantaged groups, there are 'still not for mental health patients'. The Spanish re-

spondents however pointed out that lifelong learning is a 'new concept in the field of mental health and one of growing importance.'

When asked the geographical locations of the service users they serve, the respondents from the UK, Spain, France and Poland described their service users are 'urban-based,' while those from Greece, Bosnia and Herzegovina, Denmark and Norway described their service users as 'rural- and urban-based.' This suggests that the respondents' organisations services covered a whole spectrum of service users' population.

Identification of the disadvantaged groups

The respondents were asked to identified the groups of people have been identified in their individual country as 'disadvantaged' at whom European policy on social inclusion could be targeted. All the respondents from the eight countries identified mental health service users and disabled people as disadvantaged groups at whom European policy on social inclusion could be targeted. Also, all the respondents except those from Norway identified long-term unemployed people; all the respondents apart from those from Poland and Bosnia and Herzegovina identified immigrants or refugees; all the respondents apart from those from Norway and Bosnia and Herzegovina identified lone parents; the respondents from the UK, Greece, Denmark, France and Spain identified Ethnic minority and/or no, or low, skills and Travellers (Gypsies). The respondents from two countries, Poland and the UK, identified two new disadvantaged groups that are peculiar to their individual countries: these are 'young homeless people' (Poland) and 'A "white underclass" which has been "neglected" by existing equalities policies…' (Trevor Phillips, chairman of the Equality and Human Rights Commission) (UK).

Discussion/concluding remarks

The aim of the survey questionnaire analysed in the preceding paragraphs was to obtain evidence, first-hand, from mental health practitioners about their perceptions of their countries' [regional or national] lifelong learning provision and its application to mental health service users. The overall aim of the questionnaire was to complement evidence from the review of literature especially where country-specific empirical evidence on lifelong learning provision for mental health service users was poor, patchy or sporadic. It is clear from the analysis of the questionnaire that lifelong learning is an important facet of cultural/national life across the eight countries surveyed, but less so in the contemporary national life in Greece, Poland and Bosnia and Herzegovina. In Greece, although people are beginning to engage lifelong learning as evidence by the reported increases in participation among both the general population and socially vulnerable groups including mental health service users, questions have been asked as to the effectiveness lifelong learning actions that are currently being implemented. In the case of Poland, where participation in lifelong learning amongst 24-65 year-olds is low, access barriers such as training/course fees and a general lack of awareness of the lifelong learning opportunities were more likely to explain its low participation rather than an absence of culture for lifelong learning. Bosnia and Herzegovina presents a different

picture: lifelong learning is reported to be 'extremely' important to (pre war) national culture but remain a challenge the country continues to grapple with. What is important to note is that the preceding findings support the literature evidence which indicates that countries such the UK, France, Norway, Denmark and Spain have comparatively higher participation in lifelong learning than Greece, Poland and Bosnia and Herzegovina (see, for example, Eurostat, 2009).

Another finding from the preceding paragraphs, which is also supported by the literature, is policy thrust or focus of lifelong learning across the eight countries surveyed. From the United Kingdom to Poland and from Denmark to Bosnia and Herzegovina, lifelong learning is predicated on mainly economic, and to a lesser extent, cultural and social factors. These national policy thrusts of lifelong learning are consistent with the Lisbon strategy which sets out both the economic and social agenda for the European Union Member States, but which has an ultimate goal of making the European region the most competitive economic region in the world initially by 2010, now by 2020. The finding from this survey underlines the effectiveness of the European Commission's leadership in the implementation of the policy demands of the Lisbon strategy.

Perhaps, as expected, respondents reported differences in the factors that have encouraged or facilitated the take up of lifelong learning among the general population and among mental health service users. These differences have a lot to do with the individual country's lifelong learning tradition/culture, as it is with the constructions of the meaning of lifelong learning. However, what is noticeable is that the same or similar factors apply to service users in half of the countries surveyed—i.e. Bosnia and Herzegovina, Greece, Spain, Poland and the UK; the same or similar factors did not apply in France and Denmark due to reasons that are yet to be explored. What could be further investigated is the effectiveness of the mainstream factors as applied to mental health service users and the extent in which the success of such approach in Bosnia and Herzegovina, Greece, Spain, Poland and the UK can be duplicated or adopted more widely. The findings from the preceding paragraphs also provide insights into some of the main factors that have given mental health service users the confidence to engage in lifelong learning—factors which include an increased social inclusion and an increased power and influence of the service user movement. These findings will now add to an expanding repertoire of good practice in social inclusion and as well as serve as excellent examples of how to engage in lifelong learning socially vulnerable groups, including all the groups identified as disadvantaged in the preceding paragraphs.

Limitations

The use of survey questionnaire in this study is prone of possible errors. One error relates to 'intentional misreporting of behaviours by respondents to confound the survey results' (Glasow, 2005, p.1.2). The sampling may also be prone to error as the 8 countries were selected due to the fact that they house EMILIA demonstration sites.

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