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Collaboration and Leadership for Improving Mental Health and Wellbeing

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What does improving mental health and wellbeing mean for how adult community learning leaders engage in collaborative working with mental health services?

ABSTRACT

International evidence shows that adult learning[1] has a positive impact on mental health and wellbeing, as well as on a range of other aspects of adults' lives. This paper asserts that this impact tends to be most effective when organisations, national and local, work collaboratively in ways that involve local communities.

In the context of increased devolution and delegated adult education budgets to local areas, this paper asks:

- What are the shared values and benefits of collaborative working between the primary care mental health service and adult and community learning sectors?
- What could a shared vision of collaborative working between the two sectors look like?
- What are the key leadership characteristics needed to make such a vision the reality?

The purpose of this FETL Fellowship study is to encourage the adult community learning sector to think about the answers to these three questions, to strengthen the potential for learning to contribute positively to wellbeing and mental health in local communities.

The study includes findings from the author's primary research, which used qualitative research methods and was undertaken between July 2017 and March 2018. It gathered data from professionals across the adult community learning and health sectors, and adult learners who have lived experience of mild to moderate mental health difficulties.[2]

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[1] Adult learning encompasses formal, non-formal and informal learning of adults. This study uses the definition of adult community learning as formal and non-formal learning for adults who may have had poor experience of compulsory education or may be at risk of marginalisation due to their socio-economic circumstances.

[2] Mild to moderate mental health difficulties' refers to common mental health problems, such as depression, anxiety, phobias and post-traumatic stress disorder (NICE, 2011).

The study concludes that responsibility for collaborative ways of working needs to be shared across different organisations and stakeholders, from central government, local partners and professional disciplines, to local communities. Adult community learning's critical leadership role should be to accept their own responsibility and mobilise other stakeholders in building a shared purpose. It should also be part of their role to broaden the narratives about both the purpose and potential of adult community learning and the discourse about mental health, from narrow medical approaches.

To develop and sustain this work, adult community learning leadership needs whole-system approaches and the ability to build and sustain relationships. Their work needs to be underpinned by a commitment to equality and inclusion and a new culture of learning, as well as by a belief in the importance of the social value of learning as a key determinant of mental health. The leadership needs to accept it does not have all the answers as it pursues the development of collaborative working through unchartered territories.

This study suggests that sector leaders can revitalise thinking about the sector's capacity for its own development, as well as about its impact on mental health and wellbeing systems.

1. INTRODUCTION

This study was carried out against a backdrop of growing public and political attention on mental health and wellbeing as a socio-economic problem, which requires new ways of working (Centre for Mental Health, 2018). There is a strong argument in favour of preventative and collaborative approaches to mental health and wellbeing, in response to the need for efficiency of services in times of austerity and a growing number of voices of people with lived experience wanting choice and holistic approaches to prevention and recovery. At the same time, there is a recognition that strong links between primary care mental health services (PCMHS) and community-based services can help in addressing the wider social needs that impact on people's mental health (Mind, 2016). Concurrently, there is evidence that adult learning has positive impact on health and wellbeing (Marmot, 2015; GOS, 2008; UIL, 2016).

However, there is little robust evidence of scalable or sustained collaborative working arrangements between PCMHS and adult community learning (ACL) services (DfE, 2018). They mostly operate in silos, despite the fact that both are focused on meeting the needs of local communities. Also, there is no evidence that previous initiatives of joined-up working, such as the Care Services Improvement Partnership (2005–2008), have had a lasting impact on the development of system-wide thinking for mental health and wellbeing (CSIP and NIMHE, 2007). The lack of national overarching policy in this area does not support the development of scalable collaborative work.

Such a situation implies that PCMHS and ACL are not sufficiently harnessing each other's expertise in order to deliver the best possible positive benefits for local adults who experience mild to moderate mental health difficulties or could be at risk of developing them. It can also be argued that not maximising benefits of collaborative working represents an uneconomical use of scarce public resources.

As mental health and adult education undergo policy changes leading to the transfer of budgets and accountability from central government to local agencies and devolved authorities to meet local needs, this is potentially a unique opportunity for the two sectors to develop and sustain effective collaborative working.

This study sets out a model of collaborative working between the two sectors, describes how this might be realised, and identifies the leadership changes required. The vision described in this study is drawn from the views of diverse participants; it aims to incorporate their distinctive perspectives and to reflect a culture of learning from each other.

This study suggests that sector leadership can lead regeneration and revitalise thinking about the sector's capacity for its own development, as well as about its impact on mental health and wellbeing systems.

1.1   The policy context in England

This section outlines key public policy in England related to ACL and adult mental health and highlights particular areas of interest for this research.

Policy related to the ACL sector is developed in the context of rapid legislation and government changes. The sector has received the same funding allocation in cash terms since 2006/07 (Trodd, 2017), which represents less than 10 per cent of the overall budget for adult skills. The Skills Funding Statement 2013–2016 stipulates that ACL providers must work in strong local partnership, lever-in additional revenue and make savings to ensure maximum impact on adults who are experiencing social and/or economic disadvantages (BIS, 2014b).

In the last 30 years, there have been 6 ministerial departments, 48 secretaries of state with relevant responsibilities and 28 pieces of legislation related to further education and skills (Norris and Adam, 2017). FE and skills policy development is underpinned by a weakness to plan long-term (ibid.). Such policy and related funding uncertainties contribute to the low visibility of further education and skills within mental health policies, and vice versa.

The UK has experienced a recent surge in political, media and general public interest in the impact of poor mental health, demands for parity between mental physical health services and the need to improve the experiences of people with mental health difficulties within and beyond the National Health Service (NHS). At a time when reduced resources are available to NHS, there is even a hope that social prescribing, which encourages primary care professionals to refer patients to non-clinical services so that they can address their needs in a holistic way, may lead to the reduction in the use of NHS services (The King's Fund, 2017). As a result, cross-government mental health policy focuses on collaborative approaches to preventative and early-intervention work, improvement of care and improving access to care by all. Early in 2017, the Prime Minister announced measures aimed at transforming mental health support in schools, communities and workplaces. She highlighted the responsibility of each institution to recognise the role it can play in achieving parity between mental and physical health 'at every stage of life' (May, 2017).

Since the coalition government's mental health strategy, *No health without mental health: a cross-government mental health outcomes strategy for people of all ages* (HM Government, 2011), which emphasised the need for parity of esteem between mental health with physical health, there have been a number of policy developments. In 2014, *Achieving better access to mental health services by 2020* (DH, 2014) focused on the five-year plans for improved access to mental health services and national waiting time standards. Two years later, in 2016, the independent Mental Health Taskforce published *The NHS Five Year Forward View for mental health* (NHS, 2016). This made recommendations for the NHS and government on how to improve prevention, access, outcomes and experience of care. Some

recommendations focused on commissioning for preventative and quality care, research and innovation for change as well as leadership 'within the NHS, government and wider society'. In the same year, NHS England published its response, *Implementing the Five Year Forward View for mental health* (NHS, 2016a), confirming that it accepted the recommendations and outlining its implementation plan. Three out of six key principles of the plan are directly relevant to this study: 'co-production with people with lived experience of services, their families and carers'; 'working in partnership with local public, private and voluntary sector organisations, recognising the contributions of each to improving mental health and wellbeing'; and 'identifying needs and intervening at the earliest appropriate opportunity to reduce the likelihood of escalation and distress and support recovery' (2016a, p. 5). The NHS Shared Planning Guidance (2015) promoted the development of joint proposals for implementing the *Forward View* through local collaborations. As a result, on a practical level, NHS and local councils are developing shared proposals about how to improve health and care in local areas (sustainability and transformation partnerships). These are based on the principles of collaborative work among local leaders, development of a shared vision, involvement of the local community, and learning and adapting. Yet, there is no specific mention of the potential for collaboration with adult community learning.

With regards to a mental health policy related to education, the Department of Health and the Department for Education published a joint Green Paper *Transforming children and young people's mental health provision* in 2017. This Green Paper prioritises early intervention and prevention linked to schools, general FE colleges and universities up to age 25. For young people in education aged 16–25, it describes a new national strategic partnership focused on improving the mental health of this group of students.

The mental health of adult learners aged 25 and above is not covered by the Green Paper and is not a policy priority for the Department of Health and Social Care or the Department for Education. Neither is there an overall government strategy for ACL.

Public policy frequently relies on the ability of adult community learning providers to be responsive to local needs in order to reach adults with

challenging socio-economic circumstances or difficulties in accessing learning opportunities. ACL is influenced by wider policy changes related to further education and skills. The current key policy drivers are economic and social mobility in the UK, young people and technical skills gaps. For example, recently, the *Integrated Communities Strategy* Green Paper (MHCLG, 2018) identified a role for adult community learning to support adults to improve their English language skills. The Green Paper also suggested a new strategy for English language in England.

The new industrial strategy (BEIS, 2017), which is focused on improving productivity centred on technical education, confirms a lifelong need for education, a requirement to address basic skills as well as the introduction of a National Retraining Scheme. The strategy also announces the devolution of adult education budgets to local areas from 2019, with the aim of transferring accountability to local areas to make decisions on how to spend budgets to boost local economic growth. Large cities will have more autonomous decision-making and budget spending powers related to economic development, transport, skills and social care in their areas. All of these policies have implications for ACL, yet it is rarely mentioned. They allude to a lifelong need for education, yet there is no lifelong learning policy.

In this context of devolution and delegation of budgets to local areas, as well as the changing dynamics between local and national players, the way ACL is delivered, paid for and led will change. This presents an opportunity to develop new ways of working to maximise the social purpose of adult community learning, including its positive impact on the mental health and wellbeing of its own learners and local communities.

1.1.1　What is adult community learning?

ACL is part of a wider further education and skills sector, whose overall purpose is to 'provide the skilled workforce employers need and help individuals reach their full potential' (www.gov.uk, undated). Its outcomes are individual, economic and social.

The Electronic Platform for Adult Learning in Europe (EPALE) describes adult learning as learning activities which adults participate in after leaving their initial education and training. Learning activities can be related to vocational or other subject areas and can include a

combination of formal, non-formal and informal learning (EPALE, 2011). In England, 'adult community learning' (ACL) or 'community learning' usually refers to adult learning aimed at adults who may have had poor experience of compulsory education or may be at risk of marginalisation due to their socio-economic circumstances. Demographically, in nearly every local authority area in England, this includes people with mental health problems (Public Health England, undated).

The Education Skills Funding Agency (ESFA), which funds most non-higher education adult learning in England, states that community learning 'helps people of different ages and backgrounds gain a new skill, reconnect with learning, pursue an interest, and learn how to support their children better, or prepare for progression to more formal courses/employment' (ESFA, 2018, p. 42). The government's community learning funding (ring-fenced within the Adult Education Budget until 2019/20) is assigned to the development of:

> The skills, confidence, motivation and resilience of adults of different ages and backgrounds in order to:

- progress towards formal learning or employment, and/or
- improve their health and well-being, including mental health, and/or
- develop stronger communities (ESFA, 2018, p. 33)

In England, ACL is delivered annually to over 700,000 adult learners through local authority services, some general FE colleges, independent third sector providers and the institutes of adult learning (HOLEX, 2016). ACL providers have a long tradition of working collaboratively and innovatively, to tackle a range of complex social, economic and health issues, such as unemployment, troubled families, refugee integration, health literacy and mental health (HOLEX, 2016).

For ease of reference, this report refers to adult community learning as a 'sector', to distinguish its distinctive provision from other forms of a wider further education and skills provision, such as apprenticeships, work-based learning or 16–19 learning.

1.1.2   What is primary care mental health?

This study adopts the following definition of primary care mental health, 'Primary care mental health refers to mental health services and support which are embedded into primary care such as within GP practices, the work of community pharmacists, health visitors and others, as well as Improving Access to Psychological Therapy (IAPT) services' (Mind, 2016).

The IAPT programme was introduced in 2007 and 'provides evidence-based mental health support for people with mild to moderate depression and anxiety, plays a role in a wider primary care mental health service, but will not cover all aspects of mental health support needed within primary care' (Mind, 2016, p.11).

1.1.3   What are mental health, wellbeing and mental health difficulties?

Mental health is defined as a 'state of wellbeing' (World Health Organisation, 2003) and it refers to the capacity to deal with the challenges that life can present, live in a fulfilling way and make a contribution to the community. The National Institute of Adult Continuing Education (NIACE) *Mental Health Matters for FE Teachers Toolkit* defines mental health as more than the state of our mind: 'it is about emotional resilience, self-esteem and confidence. It affects our ability to communicate, to build and sustain relationships, to learn and work, and to achieve our potential and aspirations' (NIACE, 2010, p.1).

The meaning of wellbeing in this report is based on the World Health Organisation (WHO) definition. It refers to a person's subjective experience of their life and an objective comparison of their life circumstances with social norms and values (WHO, 2012, p.9). Health, housing, education, work, social relationships, work–life balance, environment and civic engagement are considered life circumstances, whereas, an individual's sense of overall personal wellbeing, emotional state and psychological functioning are considered part of individual's experience of their life.

1.1.4 What is the relationship between mental health and wellbeing?

There is a correlation between mental health and wellbeing (DH, 2014b; GOS, 2008; Stroll *et al.,* 2012). Subjective wellbeing impacts on health and is considered a health risk factor, such as healthy diet (Diener and Chan, 2011, cited in DH, 2014a). On the other hand, mental health difficulties can affect people's wellbeing and may contribute to other problems, including relationships, physical health, unemployment and problems at work (Robotham, 2011; HM Government, 2011; GOS, 2008; Stevenson and Farmer, 2017).

In this report, the term mental health difficulties refers to 'those difficulties that people experience in accessing, remaining and succeeding in learning and skills and employment that arise from, impact on or relate directly to their mental health and wellbeing. This may not include all people with a mental illness. It may include people without a mental illness but with a poor sense of wellbeing' (LSC, 2009, p. 3). Mental health difficulties impact on individuals, their families and productivity at work, bearing both economic and social costs.

Mental health outcomes are strongly associated with social determinants and, in particular, socio-economic factors and physical environments (WHO, 2014; UIL, 2016). The WHO states that the experience of social, economic and environmental inequalities can be a cause and a consequence of mental health difficulties. 'Mental health problems are more common in areas of deprivation and poor mental health is consistently associated with unemployment, less education, low income or material standard of living, in addition to poor physical health and adverse life events' (WHO, 2014, p. 35). Furthermore, 'policies which promote social interactions have been found to improve wellbeing' and those that 'target a reduction in inequality and promote antidiscrimination legislation promote social inclusion' (DH, 2014a, p. 6).

1.2. What is meant by collaboration?

There are various definitions of collaboration, each emphasising a different aspect of a relationship between two or more parties, such as a shared vision, shared learning, shared product or policy-driven shared interest

in the same outcome (Bell, 2016). Other definitions outline that the collaborative relationships imply the underlying concepts of sharing, power, partnership, interdependency and process, (D'Armour *et al.*, 2005).

This study suggests and uses a hybrid definition of collaboration as the process of joint work between two or more parties, aimed at achieving a shared goal and underpinned by mutual trust, distinctive contributions, shared accountabilities and a learning culture.

1.3.   Structure of this report

This research report is organised in three parts, in line with the three key research questions:

> **Section 2:** What are the current benefits, obstacles and enablers to collaborative working between adult community learning providers and primary care mental health services?

> **Section 3:** What could a shared vision of collaborative working between the two sectors look like?

> **Section 4:** What are the key leadership characteristics needed to make such a vision the reality?

Each section begins with a brief summary of the key literature followed by the findings from this study's primary research. Overall conclusions and recommendations follow the above sections.

1.4.   Research rationale

This study is underpinned by the assumption that the positive impact of adult learning on health and wellbeing can be harnessed through collaborative working and systems leadership. Apart from some local examples of collaborative practice between adult community learning and primary care mental health services, there is no national or scalable and sustained model of collaborative working supported by current government policy.

While the country is grappling with major challenges related to mental health and wellbeing across different ages and segments of society, the *Transforming children and young people's mental health provision* Green Paper is an important first cornerstone of progress within education. But, there remains a significant gap when it comes to adults.

Firstly, the mental health of students aged 25 and over is, at best, a low priority and, at worst, not a priority at all. Secondly, there is no overall government strategy for lifelong learning, and, therefore, no framework for developing or promoting the sector's practice to support the mental health and wellbeing of its learners and local communities. The lack of such overarching policy commitment, to maximise the positive benefits of adult community learning on mental health and wellbeing, means the ACL sector needs to be an active agent of change.

1.5.   Data collection and analysis

This research has been organised around an analytical framework, designed to investigate and draw out capabilities required to address leadership challenges. It is based on the view that the type of leadership needed is influenced by the nature of the challenges. The framework was developed for Leadership for Healthcare (Hartley and Bennington, 2011) to help '… analyse public leadership as a dynamic and contested process within the context of a complex, changing and adaptive whole system' (2011, p. 9).

The ethical framework used is that linked to British Education Research Association (BERA) guidelines of the UCL Institute of Education. Great care has been taken to preserve the anonymity of all participants.

The research follows an inductive approach and a qualitative methodology. Surveys and focus groups were used in the first part of the research, while semi-structured interviews were used in the second phase.

The design of the survey and focus group questions was influenced by the emerging themes from the literature review. Emerging themes from the phase one surveys and focus groups then informed the content of the interview schedule for phase two.

Focus groups explored how people talk about the subject, how their ideas are shaped through discussion with others and how their insights can deepen as a result of a focus group (Richie and Lewis, 2003). All focus groups and interviews were recorded and transcribed, before being analysed.

One hundred and eight participants were involved in this study as follows:

- Thirty-four ACL managers, representing 27 (out of a possible 57) different ACL providers who were part of the DfE Community Learning Mental Health (CLMH) research (DfE, 2018 submitted for review), responded to a survey administered through SurveyMonkey in June 2017.

- Eighteen managers from the same organisations also took part in a focus group in the same period. Care was taken to ensure that the questions were not specific to their experience of working within the CLMH research to avoid too narrow a focus.

- Fourteen health professionals involved in delivering, managing or administering talking therapies in a south London borough completed an online survey administered through SurveyMonkey in July 2017. They worked within a local primary care mental health team. The majority (79 per cent) were psychologists. A couple had management responsibilities while the other respondents provided professional and support services.

- In October 2017, the same survey questions were distributed through HOLEX to its members.[3] Thirty-five people responded: 15 were managers; 9 were non-managerial staff in academic and professional services; and 11 had executive roles within organisations and included CEOs, heads of services and principals.

- Sixteen learners with lived experience of mild to moderate mental health difficulties took part in a focus group in November 2017. They were either current learners or had attended adult community learning classes in the past. No demographic data was collected for them.

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[3] HOLEX is a national sector membership body for ACL providers.

- Phase 2 involved semi-structured interviews, conducted between November 2017 and March 2018 with nine leaders from national organisations with a remit for adult and community learning or mental health.

1.6.   Limitations

This research is based on data collected from a sample of professionals working in the two sectors and a cohort of adult learners with lived experience of mental health difficulties. The focus of the study is England and all respondents were working or learning in England. The study does not pretend that the findings are reflective or representative of all provider or practitioner perspectives.

Within the healthcare system, the research focuses only on a specific segment of primary care mental health services. This is to ensure that the investigation focused on preventative and collaborative approaches to the most common mental health difficulties in the UK (e.g. depression, anxiety). Within the healthcare system, these difficulties are typically dealt with by primary care mental health teams, such as IAPT. Mental health professionals involved were mainly London-based and smaller in number than the adult learning professionals.

Most professionals taking part in the study held management or executive roles, compared with a smaller percentage of non-managerial and support staff.

The author's professional experience is adult community learning, within an organisation which was a research site for the DfE Community Learning Mental Health project (DfE, 2018).

2.0 WHAT ARE THE SHARED VALUES AND BENEFITS OF COLLABORATIVE WORKING BETWEEN THE TWO SECTORS?

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2.1   Literature review

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This section provides a short summary of the literature which aligns the social value that drives the provision of many public services with the contribution adult community learning makes to wider outcomes, including health. This is then explored in terms of collaborative working.

The literature reveals the interpretations of the legislation related to the Social Value Act 2012, which impacts on the design of public services (Wood and Leighton, 2010; Allen and Allen, 2015). 'Social value refers to the wider, non-financial impacts of programmes, organisations and interventions, including the wellbeing of individuals and communities, social capital and the environment.' (Wood and Leighton, 2010: 20). Some literature expresses a view that government departments have been slow adopters of the Act (Allen, 2016). Much of the literature links social value with the potential for organisations to achieve additional benefits for communities and maximise limited public resources (Allen and Allen, 2015; Wood and Leighton, 2010).

Creating social value is also associated with efforts to reduce health inequalities by addressing the social determinants of health. Public Health England (PHE) and the UCL Institute for Health Equality published a report that states '... defining social value with reference to the social determinants of health can help to reduce local inequalities, improve the health and wellbeing of local people and, in the longer term, reduce the demand on health services and other services.' (Allen

and Allen, 2015, p. 5). Acting for social value is also presented as an opportunity for organisations to meet expectations stipulated in national legislation, such as the Local Government Act 2000 and the Equality Act 2010 (Allen and Allen, 2015). This implies that addressing social determinants of health and health inequalities through the embedding of social value can be linked with the Equality Duty 2010 (HM Government, 2010).

In the context of public services, the positive contribution learning makes to health and wellbeing, at a societal and individual level, is well-documented in the literature (Feinstein *et al*., 2003; Feinstein and Hammond, 2004, UIL, 2016, Sun *et al.*, 2013; Narushima, 2008). Learning supports people to progress in other areas of life, develop a sense of purpose and make social connections (What Works Centre for Wellbeing, 2017; UIL, 2016). Adults who 'keep learning' report greater sense of wellbeing, self-esteem and ability to cope with stress (What Works Centre for Wellbeing, 2017; Stoll, Michaelson and Seaford, 2012). Learning also supports adults to achieve greater control over their lives and provides them with a means to contribute to their communities, work productively and have better coping strategies (UIL, 2016).

Subsequently, adult learning can improve health behaviours which can, in turn, lead to reduced reliance on healthcare (UIL, 2016). As a result of participation in learning, adults can make better decisions about their healthcare which has been found to result into fewer visits to GPs (ibid.). Therefore, beneficial health outcomes from adult education have the potential to benefit the NHS indirectly. This suggests a strong incentive for finding a common purpose between adult community learning and primary care mental health, based on the potential social value of ACL on the social determinants of adults' mental health, and the need to reduce health inequalities while maximising the impact of public resources.

Some of the literature shows that adult community learning providers are used to measuring the value that learning adds to people's lives by focusing on wider outcomes of learning. The sector has been exploring various approaches to measuring its impact. This includes research to monetise the impact of adult learning in different aspects of life,

including health (New Economy, Manchester, 2018; Fujiwara, 2012). Organisations tend to use a wide range of outcome frameworks and tools (LWI, 2017; Stevens et. al, 2018). This could be both a reflection of the mix of provision that the sector has developed, in response to different local needs, as well as of the lack of nationally agreed outcomes for the sector.

In the last few years, rhetoric has been developing about the need for the sector to demonstrate how it can contribute to priorities in different policy areas (LWI, 2016). As part of this, impact measurement is seen as one of the means that can help the sector in building new collaborations (Fujiwara, 2012), as well as supporting quality improvement and curriculum development. Some authors recognise that it is critical that the sector can make a compelling case so that it can secure sustainable funding (LWI, 2016; Pember, 2018).

> In order to make the case for continued funding to local skills commissioners, providers will need to be able to describe the role and contribution of the sector in achieving local priorities. They will be required to have in place robust approaches to collecting and using data to demonstrate that they understand the patterns and levels of need in their area, are developing provision to respond to this, and can show impact and accountability (LWI, 2016, p. 5).

The absence of agreed outcome measures may make joint working difficult to develop.

The NHS has a longstanding culture of using outcome measures to monitor and commission services. They are used to providing cost-effective, high-quality and improved health care.[4] The National Institute for Health and Clinical Excellence (NICE) is responsible for evidence-based guidance on the most effective ways to prevent, diagnose and treat ill health. This also includes session-by-session outcome monitoring by IAPT services, which are obtained before and after treatment for 98 per cent of patients. These are regularly recorded and publicly reported on (NHS Digital, 2018).

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[4] https://www.england.nhs.uk/commissioning/how-commissioning-is-changing/

This approach reflects the important principles behind the government's evidence-based policy-making in public services, especially in times of scarce public resources (HM Government, 2013).

Mental health and wellbeing outcome data from the Learn2B ACL project in Northampton has been contributing to their local NHS IAPT returns for 8 years (Robotham, 2011). During the DfE Community Learning Mental Health (CLMH) research, ACL providers across 62 local authority areas collected data from circa 23,000 adults using the same internationally-validated mental health and wellbeing outcome measures as the NHS IAPT programme nationally. This suggests it is possible for the ACL sector to use the same outcome measures as the NHS and, potentially, vice versa.

2.2   Key findings from the primary research

The primary research explored the values and benefits of collaborative working between the ACL and PCMHS sectors, in order to investigate the viability and scalability of joined-up work.

Ninety six per cent of the research participants thought that exploring possibilities for collaboration between the sectors is worthwhile and that there is great potential in this relationship. Most frequently, they cited the benefits of joined-up working as a way of addressing adults' needs in a holistic and functional way. They saw collaboration as a means to more accessible services, informed choice and more effective ways of addressing adults' wider needs. Within such collaboration, the role of adult community learning was seen as important for addressing adults' personal, social, academic or employment aspirations. Many cited the key assets of the ACL sector as its non-stigmatising environment and accessibility, as well as the benefits brought through learning in a group, compared with often individualistic health service models of support.

Some research participants' views were in line with the findings in the literature around the need to clearly demonstrate the wider outcomes of adult community learning, as well as its purpose:

The sector is trying to do a lot and it understands that it's trying to do a lot with a whole wide range of outcomes, some of which are wellbeing, some of which are employability, some of which are parenting. ... It is a particular type of service that fulfils a lot of different needs and has a lot of different outcomes, but if you can't explain that ... the outside world probably doesn't understand it. ... How do you explain that? How do you talk about that to be convincing? I think it's a crisis of communicating what it is about (P: AE2).[5]

In our society, we have a cultural narrative that says that you learn to gather skills to become more economically productive and, therefore, all the measures of community learning are based on the extent to which you take someone with a low skill base, you improve their skills and they get employment and they become a taxpaying, contributing citizen to the overall project of modern cultural western social-democratic capitalism. There are other narratives that are as important. I'm not for one moment saying that our country doesn't have to earn and pay its way, but one of the narratives that we seem to be missing is that, in that drive for economic pursuit or a pursuit of the economic outcomes, we sometimes lose the social and psychological outcomes of community learning (P: MH3)

The key values that professionals from the two sectors felt their organisations identified with were:

- equality of access and treatment,
- commitment to quality,
- respect and dignity,
- collaborative working.

Interestingly, adult learners who took part in the focus group overwhelmingly shared the same views. They emphasised the importance of equality, inclusion, quality and being listened to.

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[5] These codes refer to research participants. 'P' stands for participant; 'AE' refers to adult education sector; 'MH' refers to mental health sector; and 'AESurMon' refers to responses received through SurveyMonkey.

2.2.1   Equality

The following quotes illustrate adult learners' views on the sense of empowerment and equality they experience through adult learning:

> Everyone was the same. … Just that space where no one was 'in-charge'. The teacher was in-charge, the people were in-charge, but no one thought they knew more than anyone else or that they were going to take charge (P: AS8).

> There is a really obvious baseline. We are all naked together. We are all learning. (P: AS8).

> There is something very humbling, very humbling about learning. To peel away all of that front that you try and keep up most of the time, like yes, I'm normal… (P: AS11).

Many research respondents commended the ability of adult community learning to reach out to a diverse range of adults, including many with barriers to engagement:

> Community learning provides people the opportunity to socialise, to integrate; to meet with people like themselves and not like themselves. That sense of learning together gives a very protective factor to people's mental health (P: MH3).

> I hope to be part of the community and really that is what you want. Health care is all institutionalised. But, what you want is to be a functioning part of the community and share with others with the same experience. And that is what the colleges can offer. (P: ASX).

2.2.2   Respect

Research respondents from PCMHS and ACL services, as well as adult learners with personal experience of mental health difficulties, agreed that respect and dignity are important values for them. The following quotes illustrate this:

> [There is] a big difference between patronising and empathising. … There's something so bluntly distasteful … I have learning difficulties, but I don't want to be treated like I've got one. There's no need to change–your–speech–when–you–speak–to–me (P: AS8).

For people like this, it's important that they feel like others understand and that they respected and not ridiculed (P: ASX).

[The classroom is a] safe place where you can be, and you don't have to explain about your mental health or be judged or have to go through whole thing of trying to explain this out and ... [deal with] some stigma around mental health (P: AS8).

2.2.3 Quality

Learners recognised three ways in which adult learning complements the current mental health care system:

1. It is easier to access learning provision than mental health services.

2. Adults can spend a longer time engaged in learning than they can in therapy.

3. There are multiple positive impacts of learning on skills, confidence, progression, sense of purpose and structure, resilience and community integration.

It's so difficult to try and access help. It's so difficult, keep trying to push to try and to get something to happen. ... I don't know why it's impossible to penetrate. ... Because I'm not serious enough to need intensive treatment, it's just like I'm not sick enough but not quite well enough for something ... I like to stay home, it's easier just not to go and then find some courses (P: AS8).

We did ... that course which was amazing and life-changing. And since that, I have enrolled to do an NVQ as a teaching assistant. Without having done those sessions, I wouldn't have had the personal confidence that I could get here and find my way to cope with everything. I could do that in bite-sized chunks. Using that as a launchpad. ... I've now done something, which, for the first time since my brain injury, has given me a perspective on having a future, which I didn't have for a couple of years (P: AS9).

2.2.4   Collaborative working, involving learners

The research participants from PCMHS and ACL ascribed value to collaborative working. At the same time, adult learners said that being listened to was very important to them:

> [Adult community learning] can play a huge role because of how it can help to mobilise communities and maximise access to resources that are not provided by the state. I think there is an enormous appetite and potential in [collaboration] (P: MH1).

> If I was setting this up in my local area, IAPT service is responsible for evidence-based [services], adult education is responsiblefor the [learning] provision and education governance and co-production sits in-between the two, with the support of recovery colleges (P: MH1).

> I was on the point of going to the doctors to get medication. By chance, [I] saw the [adult community learning] leaflet when I came to my other class here. I came to that. That stopped me from taking medication. I think that's a very direct example, how it can take you away from being a burden on the NHS potentially (P: AS7).

2.3   Summary

A review of recent relevant literature on shared values and the benefits of collaborative working between the ACL and PCMHS sectors highlighted the link between social value in the design and delivery of public services, and what ACL can bring to wider aspects of adult life. It illustrated the need for both sectors to clearly demonstrate their shared outcomes and to communicate the additional value ACL can bring in terms of wider participation and improving the wellbeing of individuals and communities. Building a compelling case, in ways that can quickly and easily be recognised and understood by both sectors, becomes especially important in developing new collaborations.

Some of the literature (Robotham, 2011; James, 2018; DfE, 2018) shows ACL can collect appropriate outcome data for research purposes. In her interviews with CLMH leaders, James (2018, pp. 10–11) found that:

> [using the outcome measurement tools] was one of the biggest challenges for leaders, they all saw using the tools … as the catalyst to enabling them to bring about many of the outcomes that they achieved. … Having data alongside illustrative learner stories gives [ACL] a new language and a more powerful narrative for strategic buy-in and local decision-making on how the Adult Education Budget is used … [and] through which they can engage strategic partners, demonstrate the value of what they are offering and feel greater justification in sitting at the table of local strategic planning.

This raises questions about the extent to which the sector can support evidence-based policy-making with the types of evidence it currently collects and communicates. To do so, and to demonstrate its social value and cost-effectiveness, the sector may need to improve the robustness of evidence collected as well as the way the evidence is communicated and shared across the provision.

The primary research showed that the three different groups of participants held the same values. The positive value ascribed to equality, respect and quality suggests that holistic approaches to mental health and wellbeing are seen as important, as well as medical approaches. The importance the three groups ascribed to the social value of adult community learning in potential collaboration with primary care mental health services, make the values of equality, respect and quality a pre-requisite to viable collaboration between adults with mental health problems, PCMHS and ACL services.

3.0 WHAT COULD A SHARED VISION OF COLLABORATIVE WORKING BETWEEN THE TWO SECTORS LOOK LIKE?

3.1   Literature review

In public sector literature, the need to work collaboratively with other organisations to achieve shared aims is frequently described as the solution to challenges. Collaborative working with further education and skills is most often described in terms of delivering local priorities related to social and economic imperatives, such as skills gaps, skills shortages, low productivity, what employers need/want, unemployment, community cohesion, and more recently social mobility (LSIS, 2010, p. 2).

The Community Learning Trust pilots highlight the value of reviewing collaborative arrangements to ensure they meet the demands of changing community learning contexts, policy and funding. Reviewing the nature and purpose of its external collaborations is important for enabling the sector to respond more creatively and effectively to complex demands (NIACE, 2013).

The identification of mental health as a cross-government challenge is not new, and neither are policy calls for collaborative solutions between adult education, employment and mental health services in order to reduce demands on services and/or improve outcomes for people with mental health problems. For example, in 2004, the Social Exclusion Unit was concerned that the participation rate by adults with mental health difficulties in further education was 0.25 per cent (SEU, 2004) and called for collaborative action to increase participation.

Today, the number of learners in FE declaring mental health difficulties is higher. The Mental Health in Further Education (MHFE) network reflects on how such increases in participation by any other protected group

would be seen, through an equalities lens, as a huge success, but when it's people with mental health difficulties it's 'a problem' or 'a crisis', putting teachers/organisations under strain and requiring mental health services to step in and help them manage and support learners (Barrett, 2017).

The Association of Colleges (AoC) 2016 survey of general FE colleges in England expressed concerns about increasing numbers of students with mental health conditions and the demand this placed on organisations and staff. The AoC found '85 per cent of the colleges that responded reported an increase in students with mental health issues in the past three years, 54 per cent said the total number of students of all ages with mental health difficulties had significantly increased in the past three years' (AoC, 2017, p. 2). Although colleges said they generally had good relationships with local mental health services, nearly half (48 per cent) said their relationship with local clinical commissioning groups was 'non-existent', and 61 per cent said their relationship with the director of public health was 'non-existent'. To address this, AoC started its own national mental health group, which:

> As well as principals and practitioners, also includes representatives from DfE[6]; DH[7]; NHS England; CCGs[8]; Health Education England: NAMSS[9] and NUS[10]. This enables the voice of further education to be clearly heard across all these agencies to ensure that any new initiatives are inclusive of further education (AoC, 2017, p. 12).

The literature contains a number of past and present examples of collaborative working by further education and skills in the context of mental health and wellbeing and guidance on how to secure such collaboration (James, 2004), but relatively few of the initiatives are sustained in the longer term or scaled.

Nationally, James' *Prescribing Learning* research was a vital demonstration of the potential for positive outcomes through collaboration between primary care services and adult education, that improved access to and success in learning for adults with mental health difficulties (James, 2001; James, 2004).

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[6] Department for Education
[7] Department of Health
[8] Clinical commissioning groups
[9] National Association for Managers of Student Services
[10] National Union of Students

From 2004 to 2010, NIACE coordinated a formal national and regional partnership programme with the NHS (Care Service Improvement Partnership) to reduce the social and economic exclusion of people experiencing mental health difficulties in further education. This programme consisted of extensive research and development work, publications and events. It also facilitated cross-sector networks in each of the 9 English regions. Each network involved up to 2,000 practitioners, managers and volunteers from adult education, the NHS and social care, employment, social housing, citizens advice, and museums, libraries and galleries, as well as adult learners with lived experience of mental health problems.

In 2009, this partnership programme was described as helpful to the Learning and Skills Council (LSC) to 'align its work with the broader government agenda of inclusion, social justice, health equality and economic competitiveness' (LSC, 2009, p. 3). The National Social Inclusion Programme (NSIP) also documented that the partnership work built the sector's capacity to better meet the needs of adults with mental health difficulties (NSIP, 2009). The partnership ceased in 2010.

What remains are some highly-committed adult educators who, with their local mental health services, have kept the work alive and sustained their collaboration. Examples include, Hackney Community College, Highbury College, Sunderland College, and Wirral Metropolitan (Barrett and Creed, 2011) and the Northampton Learn2B project (Robotham, 2011). At times, each of these exemplar providers finds their good practice recognised and celebrated and, at other times, they find that changes in one or other sector or in funding threatens their continuation.

In addition to the AoC's aforementioned focus in the last four or five years on young people's mental health in general FE colleges, more recently, as part of the CLMH research, a number of new local collaborations have been developed. These involve some or all of the following providers: adult community learning and voluntary sector, recovery colleges and primary care mental health services, especially IAPT (Ipsos MORI, 2015). Whether they will be sustained will depend on the findings of the research and whether there is a continuing vision and effective leadership for continued collaboration in each separate ACL service.

Local collaborations have different features, depending on local needs, shared aims and the assets and capacities of each stakeholder. This diversity of local arrangements may indicate why common outcome measures across collaborations and providers from different sectors are of such great importance. The measures can help monitor the quality and impact of interventions on communities' mental health and wellbeing, to ensure that it is improving.

Learners' needs are the key priority in forming local collaborations. For collaborations to be effective, the following principles are considered important: local leadership, learner involvement, supportive internal management structures, agreed information sharing processes, involvement of mental health specialists, positive past history of joint working and trust and respect for each other's expertise (Barrett and Creed, 2011).

There is also some discussion in the literature about the delicate balance between collaboration and competition. The UCL IoE (2015) reports that the English national education system favours markets, and that competition presents a leadership challenge (2015, p. 10). The legacy of the Community Learning Trust Pilots suggests it may be possible to manage competition and collaboration through a shared protocol for all partners which eliminates the need for ultra-competition (LWI, 2014).

For all of the local good practice and extensive national and regional work from the 2000s, the current literature does not outline a present national framework that supports the sustaining and scaling-up of collaborative working across ACL or across the whole of the FE and skills provision.

3.2   Primary research key findings

This primary research shows there are many examples of local collaborative arrangements between adult community learning and primary care mental health providers. They have different arrangements, such as cross-service referrals, sharing information about local needs and services or cross-service workforce development. In some cases, the two sectors co-design parts of a learning offer or are beginning to explore joint commissioning arrangements. There are also collaborations

involving recovery colleges, ACL and mental health services, or voluntary sector and ACL providers.

Some examples of existing collaborations, explored as part of the research, showed there had originally been tensions in relationships between health and education services. These arose from mistrust of the role that adult learning can play in supporting mental health and wellbeing. Adult education was seen as a competitor to the NHS services, which potentially brings risk to the employment security of NHS staff. However, in time, for some of them, collaborations grew into relationships marked by mutual respect of distinctive professional expertise.

3.2.1   Guiding principles

Based on research participants' views, the following have been drawn out as key guiding principles for building collaboration between adult community learning and primary care mental health:

- distinctive roles of partners,
- part of a wider system,
- holistic view of people's needs,
- learner involvement.

3.2.1.1 Distinctive roles of partners

Research participants expressed asset-based views about the roles of each partner in collaboration, focusing on distinctive roles of each to support joint aims.

> [Mental health professionals] are referring people to you, not because you are a mental health service, but because you are a learning service. You are not there to treat. You are there to enable them to learn. (P: MH3).

> What we're not saying is that a community learning educator is de facto a psychiatric nurse. We're saying a community learning educator is a community learning educator. When they need to refer to a psychiatric nurse, they know when that boundary is. It's called task

shifting. I'm not taking your job away from you. You and I are working together mutually to support the client (P: MH3).

3.2.1.2   Part of a wider system

Research participants saw this collaboration as part of a wider system to address a variety of communities' needs (e.g. IAG, housing, education) and supportive of mental health and wellbeing – making the overall provision 'accessible, timely, joined-up and compassionate' (Student focus group, 24 Nov 2017). Some suggested that this network of services should be coordinated, and quality-assured by an umbrella organisation. The overarching umbrella organisation would stop local competition by helping to define the distinctive role of each provider and it would also assure quality.

One health professional said:

> I know that we are talking about adult education, but even so – we need to be thinking about children and families because many of these adults would be parents and have caring responsibilities. And I think that connectedness in our mind-sets will help us go beyond the individualistic model and really maximise the benefits of community-based approach (P: MH1).

One adult learner said:

> Could this [collaboration] be called: a route to normal living? Give us some pathways to actually having a normal life. That's what we want. Things where we can actually be qualified and go get a job somewhere. Is that too much to ask? (P: AS11)

3.2.1.3   Holistic approaches to people's needs

All research participants considered adults' holistic needs important, reiterating the fact that it is not mental health needs that define a person:

> If I want to feel like I have good quality of life and I have some sort of fulfilment, I need to do things that make me feel good about myself. Going and talking about depression… it's good; you find out things. But, that's where it ends (P: AS15).

When you are dealing with any form of human service, you have to understand the social, emotional and psychological aspects of people's lives (P: MH3).

What joined-up approaches can do is give people a set of more external resources. A learner or person with a mental health challenge is more enabled by a joined-up approach into a self-management position. (P: MH1).

3.2.1.4   Learner involvement

Research participants emphasised the value of the collaboration being developed with clear understanding of learners' needs. Some learners offered to be ambassadors for community learning:

Using the experience of people who have experience of mental health challenges to both design, deliver courses and lead. To be amongst leaders (P: MH1)

3.2.2   A shared vision of collaborative working

Based on the above guiding principles and the key values research participants agreed on *(Section 2), Box 1* presents an emerging vision of collaborative working.

Box 1. Collaboration would:

- Be supported by an overarching government strategy, with the flexibility for local models of collaboration to be tailored to local community needs.
- Provide high-quality, accessible and complementary provision, tailored to local needs and involving local adults as equal partners in collaborative arrangements.
- Recognise how adult participation in learning can:
    - tackle inequalities of access to services,
    - promote and improve mental health and wellbeing locally,
    - build the resilience and emotional health of individuals and local communities.

Some research participants suggested different features of collaborative working. For example, joint design and delivery of needs-led services or courses were considered important by some, as well as a joint delivery of some learning programmes, to raise awareness of mental health and wellbeing. Some professionals and learners thought that a model of social prescribing would work very well, where adult learning may represent one of the choices that people are given. Some saw education having a contributory role in the support packages of specific groups of adults (e.g. adults in prisons; those with substance misuse issues; learners who are struggling on longer accredited programmes or in apprenticeships, in need of support through an additional curriculum focused on wellbeing and mental health; learners who may be at risk of a negative impact from social media).

3.3   Summary
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The vision described by research participants reflects democratic ownership. It is also not strictly connected to the medical model of mental health. It adopts a broader perspective of health and wellbeing, recognising the importance of social value and holistic views of adults' needs. It is founded on the shared values of the stakeholders, particularly equality, quality, respect and dignity and collaborative working, including the direct involvement of communities.

Evidence collected through this primary research showed that participants envisaged adult community learning and primary care mental health services as part of a wider, interconnected system which is visibly focused on meeting the holistic needs of individuals and communities. The complementary nature of the two services seemed to be important.

It also raised a question about the possible difficulties balancing collaboration and competition. A move to collaborative working may require a different culture and type of behaviour. For example, learning from each other to harness the knowledge and expertise of each partner may help manage competition, for the benefit of shared vision and goals.

An overarching government strategy may support the vision to develop, as well as protect it against a short organisational memory which can jeopardise its sustainability.

4.0 WHAT ARE THE KEY LEADERSHIP CHARACTERISTICS NEEDED TO MAKE SUCH A VISION OF COLLABORATION A REALITY?

4.1 Literature review

The recent literature about leadership focuses on current social and economic challenges and the type of leadership required to address them. Texts examine the changing and compound nature of problems at global, regional, local and institutional levels, and focus on the fact that problems often span across different levels (UCL IoE, 2015; Greany *et al.*, 2014). There is a consistent recognition of the enormity and complexity of challenges, referred to as 'volatile environments' by some (Greany *et al.*, 2014) or 'wicked problems' by others (Rittel and Webber, 1974, as cited in UCL IoE, 2015). As a consequence, the further education and skills sector can be seen as part of a much bigger interconnected system, susceptible to unpredictable influences (UCL IoE, 2015; Grainger, 2017; Londesborough, 2016). Consequently, leadership functions within and beyond organisational boundaries, as well as across different layers of the system (Greany *et al.*, 2014). Further education and skills leadership is seen in ways that are far from traditional and heroic (Hartley and Benington, 2011; Greany *et al.*, 2014). It is easy to see that the literature does not have ready-made solutions for such significant leadership challenges. Public leaders are 'learning to lead and govern in ways that are not only multi-level, but also polycentric – developing new patterns of networked governance and public leadership across several different nodes' (The King's Fund, 2011, p. 20).

Current texts explore a multitude of leadership models, such as adaptive, altruistic, compassionate, ethical, affirmative, hero vs. anti-hero, distributed leadership and many more (Wilson, 2013; UCL IoE, 2015; University of Hull, 2016, Heifetz, 1994; Bennet, 2013; MHFE, 2016). Though the models vary depending on how the challenges are interpreted, what they have in common is a focus on leadership behaviours in response to changing circumstances (Greany *et al.,* 2014). The key leadership requirements are described as cooperative working, distributed accountability, agility, whole-system thinking, working with ambiguity, finding innovative solutions, learning from others and the ability to build and maintain relationships. (UCL IoE, 2015; Greany *et al.*, 2014). The literature further outlines that leaders should be focused on their own organisation but remain outward-facing and mindful of their organisation's position within a wider world (Greany *et al.*, 2014; The King's Fund, 2011). The notion of 'altruistic leadership' has begun to emerge (UCL IoE, 2015). This model takes account of the wider needs of people and the importance of the wellbeing of a whole system, within which an institution operates.

In addition to external challenges, the literature also outlines personal qualities that underpin leadership relationships with others. The NHS Leadership Academy's Healthcare Leadership Model (2013) states that managing ourselves is a central part of being an effective leader. Self-management features span across different leadership skills and qualities:

> It is vital to recognise that personal qualities like self-awareness, self-confidence, self-control, self-knowledge, personal reflection, resilience and determination are the foundation of how we behave. Being aware of your strengths and limitations in these areas will have a direct effect on how you behave and interact with others, and they with you. Without this awareness, it will be much more difficult (if not impossible) to behave in the way research has shown that good leaders do. This, in turn, will have a direct impact on your colleagues, any team you work in, and the overall culture and climate within the team as well as within the organisation (NHS Leadership Academy, 2013, p. 3).

Even though there is an increasing recognition that adult community learning can play a much more active and enterprising role locally, the

current literature focuses much less on this aspect in further education and skills. The frameworks, used to organise thinking about the sector's leadership, are mainly focused on the skills-ecosystem and vocational education. Academics and researchers looking at further education and skills focus much less on other types of eco-systems where the further education and skills sector already plays an important role, such as health and wellbeing.

4.2   Primary research key findings

The section below focuses on participants' perceived challenges to achieving the vision *(Figure 1)*. In order to illustrate the quality of current mental healthcare, a subsequent section outlines the experiences and views of adult learners with lived experience of mental health difficulties. These are then followed by research participants' views of leadership characteristics required to make the collaboration possible.

4.2.1   Challenges to collaboration between ACL and PCMHS

The research revealed three categories of perceived challenges to building collaborative arrangements. These are grouped in three categories: central government; individual organisational contexts; and local partnerships (with the NHS, local authorities etc.). See *Figure 1*.

4.2.2   Experiences of current mental healthcare

The research asked adult learners about their experiences of mental healthcare in order to explore the quality the current care system *(Figure 2)*. This further supports a consideration about why it is important to develop collaborative arrangements and what priorities the collaboration would need to address, based on what users consider important. It also helps in exploring the role that each stakeholder could have in a collaborative relationship. It further illustrates the context that leadership would need to operate within while building a scalable collaboration.

Figure 1. Categories of challenges to collaboration

Category	Perceived challenges
Central government	• Constant changing of the overarching infrastructure within central government leading to short-term planning and a lack of policy focus. • The lack of organisational memory; and inadequate system for capturing lessons learnt from previous projects. • Lack of joined-up thinking at a national policy level. • Lack of commitment to joined-up working across government departments. • Separate commissioning arrangements and under-resourcing. • Lack of accountability in central government for mental health and wellbeing in adult community learning. • No national strategy and/or policy framework for adult community learning. • Lack of national promotion of the benefits of adult education.
Individual organisational context	• Lack of time. • Lack of commitment to joined-up working. • Lack of belief in pursuing the agenda.
Local partnerships	• Lack of commitment to joined-up working. • Restrictions imposed by different professional identities. • Organisational differences. • Lack of coordinated approaches in local areas and competing local priorities. • Competition among providers and issues with the recognition of expertise within local areas.

Figure 2. Adult users' experiences of mental healthcare

Experiences and views of local communities and learners	• Difficulty in accessing mental health support quickly.
	• Overreliance on medical and individualistic approaches to mental health.
	• Poor quality and short length of support, due to limited resources.
	• Non-empathic staff attitudes, caused by disproportionate workloads or focus on performance targets.
	• Difficulties with receiving accessible information about other services.
	• Loss of confidence that users' views are taken into account.

4.3   Discussion and summary

Leadership characteristics needed to overcome perceived challenges and make participants' vision of collaboration a reality.

Leadership actions and characteristics are strongly linked to the myriad of challenges to collaborative working, identified by research participants.

The sources of challenges – and solutions – relate to different parts of the system, from central government to individual organisational contexts as well as the collaborative partnerships themselves. It is not always clear how decisions are made within each part of the system, or who takes responsibility for which problem that affects people who use mental healthcare services. However, even though the challenges are spread across the system, they are interconnected and each can impact on the others. Leadership of one part of the system, whilst not in charge of another part of the system, still needs to operate within it. For example, even though college leadership is not in charge of government policy, it is affected by it and needs to lead and operate within the context of government policy, or the absence of it. In order to develop collaboration between ACL and PCMHS that has a shared vision and purpose, its leadership needs to take into account not only the present barriers to collaborative working, but also the quality of users' experience of current mental healthcare system.

Hulke *et al*. (2017) suggest that such leadership requires: a compelling shared vision of transforming health and wellbeing, a shared commitment to work together for the longer term, frequent contact between leaders, shared agreement to surface and resolve conflicts transparently, a commitment to collaborative problem-solving and commitment to behave altruistically towards each other's organisations. The vision of collaboration drawn out of this study confirms the importance of an overt commitment towards building a shared vision and practice that benefits the whole community. Within this context, research participants listed a range of the required leadership skills, personal qualities and competencies, which are described below as: relational leadership skills and competencies and personal qualities conducive to collaboration.

4.3.1   Relational leadership skills

Participants pointed to the need for leadership to work simultaneously with multiple stakeholders, to collaborate with them, learn from them, mobilise and empower them. This implies the need for leadership skills that can help them build and maintain relationships. They are referred to here as 'relational skills'.

For example, research participants thought it was necessary to:

- mobilise and influence local and national policy and decision-makers,
- share a compelling narrative which inspires commitment across different stakeholders,
- lead change across partnerships and within their own organisations,
- collaborate with and co-design with learners/communities,
- empower local adults to have an equal footing in these relationships and build feedback mechanisms that ensure that the representation of local adults is meaningful, consistent and supported,
- shift their own role from leader to a collaborative partner.

As it is says in *Place-based systems of care: a way forward for the NHS in England:*

> The effectiveness of governance arrangements hinges on the ability of leaders to work collaboratively in an environment where they may have less authority than has often been the case in the past. This requires the development of a new kind of system leadership based on negotiation and influence rather than direction. Leadership of this kind is often best developed through teams rather than individuals, involving a guiding coalition taking responsibility to lead system-wide change (The King's Fund, 2015, p. 20).

Research participants said:

> I would like to see every ACL service convince their governing board or their council members that this is an important stream that they want. There is nothing getting in their way. ... What is stopping you do this, if you know it's important? (P: AE4).

> The sector is trying to do a lot with a whole wide range of outcomes, some of which are wellbeing, some which are employability, some of which are parenting. ... It is a particular type of service that fulfils a lot of different needs and has a lot of different outcomes, but if you can't explain that, this can cause a bit of a, not an identity crisis within itself, – because I think it probably does understand what it's trying to do – but the outside world probably doesn't. The sector is unable to articulate that offer ... It's not an identity crisis – I think it is crisis of communicating what it is about (P: AE2).

Similar to other classifications of leadership relationships (e.g. Hartley and Benington, 2011), the findings in this study identify three types of leadership relationships (illustrated in *Figure 3)*:

- Horizontal relationships.

These refer to collaborations between adult community learning with primary care mental health professionals and other local partner

organisations. They identify negotiation, building shared goals and inspiring joined-up working.

- Vertical relationships.

These are relationships developed and maintained with central government and local policy- and decision-makers, as well as local adults, communities and adult learners. Through the changes in the process of devolution, relationship dynamics also change with adjusting priorities and accountabilities. For example, they may encompass providing guidance to decision- and policy-makers, especially in the light of the continuously shifting overarching structures, or demonstrating a compelling narrative about the purpose and values of one's organisation and service. This includes continuous relationships with local communities whose needs are constantly changing.

- Inward relationships.

These refer to leadership's relationship with their own organisation and the relationship with oneself. As mentioned in the literature review, by being part of a wider system, the leadership needs to remain focused on their own organisation but remain outward facing, while being mindful of their own organisation's position within a wider world (Greany *et al*., 2014; ETF, 2014; Hartley and Benington, 2011).

The research has shown that adult community learning providers, who have pioneered collaborations with primary care mental health providers, have undergone culture and curriculum changes. New relationships led to shifts of internal resources, changes in the culture of working or amendments to staffing structures.

Each of these relationship types imply the need to inspire/influence stakeholders, collaborate with them and empower them to take an equal part and accountability through joined-up working. What action is taken depends on the assets and commitment of each stakeholder and the maturity of the relationship between stakeholders.

Figure 3. Categories of stakeholders and types of leadership relationships

- Inspire / influence
- Collaborate with
- Empower

4.3.2 Competencies and personal qualities conducive to collaboration

Research participants also identified more traditional leadership characteristics, such as the knowledge of contexts, operational management skills and personal qualities. (See *Figure 4* for a full list).

4.4 Key values which underpin leadership and practice

In addition to skills and personal qualities, research participants highlighted two key values which underpin the leadership requirements and practice:

- Commitment to the equality and inclusion agenda, including mental health and wellbeing;
- Commitment to a new culture of learning.

Figure 4. Leadership characteristics, relationship types and challenges to address

Challenges related to:	Relational skills:	Competencies
Central government	**Vertical:** collaborate with, mobilise, (empower through influence on policy)	**For collaboration:** • Able to acknowledge limitations of one's own views • Good interpersonal skills • Able to build networks • Comfortable with ambiguity **For influencing:** • Able to inspire with a compelling narrative • Able to build a strong, shared vision • Able to negotiate • Able to facilitate dialogue **For empowering:** • Able to facilitate involvement and growth of others **Operational management skills:** • Resource management skills **Knowledge:** • Good knowledge of local context • Good knowledge of wider context • Good knowledge of their own organisation • Good knowledge of impact of learning **Personal qualities:** • Able to take risks • Personal resilience
Individual organisational contexts	**Inwards:** collaborate with, mobilise, empower	
Local partner organisations	**Horizontal:** collaborate with, mobilise, empower	
Addressing the experiences and views of local communities and learners	**Horizontal:** collaborate with, empower, influence	

Overarching values:
• Commitment to the equality and inclusion agenda, including mental health and wellbeing
• Commitment to a new culture of learning

4.4.1 Commitment to the inclusion agenda, including mental health and wellbeing

As mentioned earlier, the research participants considered it was fundamental to recognise and address adults' holistic needs through joined-up approaches. This is a leadership requirement and a foundation for building the vision of collaborative working. One senior professional said that a leader needs to be 'willing to keep something going when it stops being a government priority', and an adult learner with personal experience of mental health difficulties said:

> For people like me, it's important that it … sort of ... feels like people understand and I am respected and not ridiculed (P: ASX).

The *Healthcare Leadership Model* (2013) by the NHS Leadership Academy describes the importance of leaders' sensitivity to the needs of different individuals and organisations, to 'use this to build networks of influence and plan how to reach agreement about priorities, allocation of resources or approaches to service delivery' (2013: 13). This commitment can also influence leaders to take risks and make brave decisions for the benefit of services.

As one of the research participants said:

> I think that's important and you have to be a quite strong person to think, 'Well, there's no rules to follow but I'm going to do this anyway' (P: AE2).

4.4.2 Commitment to a new culture of learning

In the development of collaboration, a new culture of learning within and between all stakeholders involved is important. As Thomas and Brown point out (2011), this type of learning is based on knowledge which is evolving and where imagination is important for one's ability to fully manage and participate in the world.

This commitment includes a range of leadership capabilities, such as willingness to work in multidisciplinary ways, humility, receptiveness to change, ability to acknowledge limitations of one's own view and adaptability. Relationships with other parts of the system provide a constant flow of information from diverse perspectives. These can

help generate ideas and support leadership in improving services. New information and feedback is essential for the leadership development of new strategies, systems or processes. They also encourage the investigation of the root cause of issues, and, as such, represent a key leadership skill to evaluate information (NHS Leadership Academy, 2013). This was confirmed by research participants:

> We need leaders who would be able to work very collaboratively and want to understand the other world, willing to give up some of what is precious to them to work with others. Generosity to work in partnership (P: MH1).

> [The vision] needs to be developed from the ground up. Do have a vision but don't have a fixed vision, unless you're standing for parliament. Have one that can grow (P: AE1).

> Leaders need to take a current situation and work with it. To prepare to live with uncertainty … and allow this thing to evolve through the process of co-production. Bringing all the potential partners together to co-create a vision in which we all have a very clear role … and for those coordinators to start to work out what this looks like logically. So that leaders can appreciate and build on the strengths in the room to create a mould that all the detail can be put in. This needs to be an organic evolving thing … and to have a structure that assures quality (P: MH4).

> I think the stuff around continuous improvement, so not just doing stuff that you've done before because that's how you've done it. It's your baby and you're wedded to it and it's worked before, why would it not work now? Or, we actually don't even know if it's worked before because you've never actually reflected on it or evaluated it. I think that open mindset for thinking I could do stuff differently, willing to look, just even across the border at the next door local authority and how they do it, I think that sometimes doesn't exist. It all gets a bit insular so that is a leadership mindset that is willing to question whether what you're doing is always the right way (P: AE2).

> We might not get it right first time but actually, we're going to try it like this. Not necessarily across the whole of our services, but in a

small place, see what works, adapt, reflect and think: 'Well, actually that didn't quite work, let's tweak it'. *[You need to]* be willing to try something new. That is important (P: AE2).

Willingness to listen and learn but also to challenge and defend the strengths that adult and community learning would bring to the table (P: AESurMon)

The best skill you can have as a leader is to be able to listen. Your partners will talk endlessly. If you listen, you will find your way to find a place of common ground where you walk together for a while. It's the Wizard of Oz. Real, unlikely characters on a journey (P: AE1).

Research participants have highlighted the importance of an overt attitude to changing circumstances through learning. Such an attitude also implies the leadership ability to accept the uncertainty of relationships and contexts. This can suggest how important it is for leadership to be comfortable with the uncomfortable, which is brought about by not knowing all the answers and solutions. While having an unwavering commitment to inclusion and equality, acceptance of the limitations of one's knowledge and experiences represents an important leadership requirement in the context of collaborative working for mental health and wellbeing.

5.0 DISCUSSION

This section focuses on three key narratives, which are relevant to the discussion about collaborative working between ACL and PCMHS, based on the findings of this study. They form a foundation for ACL leadership priorities which will enable scalable and sustained collaborative working to develop.

The three key narratives relate to the:

- approaches to mental health and wellbeing,
- purpose and potential of adult community learning,
- requirements of adult community learning leadership.

5.1.   Narrative about mental health and wellbeing

This study has highlighted the importance of holistic approaches to mental health and wellbeing, which take account of the whole person, including their social circumstances.

Sole reliance on medical approaches poses a risk to our effectiveness to address social determinants of mental health and wellbeing. Preventing mental ill health and promoting wellbeing includes the need take account of many social factors and influences, as well as a correlation between mental health and wellbeing and the difference between mental health and mental health difficulties. This study's research participants strongly suggested that therapeutic measures may provide internal resources, but insufficient resources to address social issues, which could be causing low levels of wellbeing or poor mental health.

In the words of one of them:

> The sense of learning together in community learning, gives a very protective factor to people's mental health. The society as whole benefits from social, psychological and emotional benefits of a person (P: MH3).

This is consistent with Friedli:

> A preoccupation with individual symptoms may lead to a 'disembodied psychology' which separates what goes on inside people's heads from social structure and context. The key therapeutic intervention then becomes to 'change the way you think' rather than to refer people to sources of help for key catalysts for psychological problems: debt, poor housing, violence, crime. There is a need to think more critically about the relative contribution to mental wellbeing of individual psychological skills and attributes (e.g. autonomy, positive affect and self-efficacy) and the circumstances of people's lives: housing, employment, income and status (Friedli, 2009. p. v).

Therefore, the environment in which health inequalities are associated with adults' social circumstances, may continue to foster a sore and unjustifiable lack of the equality and inclusion of all adults. For that reason, acting for social value, to address the social determinants of health and improve mental health and wellbeing, is in line with meeting the expectations of the Equality Act 2010 (HM Government, 2010). Building a fairer and healthier society is a responsibility of all parts of the system, where all stakeholders are subordinated to the same aims.

5.2 Narrative about the purpose and potential of adult community learning

The well-evidenced role of adult community learning in building social capital and empowering adults is linked to the social determinants of mental health and wellbeing. This indicates that there is a strong potential for future collaboration with healthcare. This study confirms that this potential of ACL is not being sufficiently harnessed. This is partly because of the policy and funding context, which does not

support the whole of the FE and skills sector to develop and harness its capacity to support the mental health needs of all its learners and their local communities. Partly, this is down to whether there is a continuing vision and effective leadership in each separate ACL service.

Considering that the current prevailing narrative related to further education and skills is linked to employment and skills, it is important to broaden a narrative about the unique contribution that adult community learning makes for health and wellbeing of local communities. In the context of devolving budgets and accountabilities, it is vital that the sector can communicate its purpose in clear and compelling ways. It is also equally important that the sector can demonstrate the contribution it is making to mental health and wellbeing by measuring demonstrable and recognised outcomes.

5.3.   Narrative about requirements of adult community learning leadership

The leadership model that comes out of this research is in line with current thinking related to systems leadership (Greany et al., 2014; Collarbone and West-Burnham, 2008). The findings imply that responsibilities for mental health and wellbeing lie across different organisations and stakeholders. Being part of a bigger interconnected system and understanding mental health and wellbeing in a holistic way, means that leadership is not about bringing miraculous changes through heroism. It is about relationships with other parts of the system, who are both part of the problem and the solution to it. Key leadership characteristics are: relational skills, whole-system thinking as well as self-management and learning. They are underpinned by a commitment to equality and inclusion, and a new culture of learning.

Continuous changes within the system mean the requirements of leadership change too. For example, leadership characteristics required to develop collaboration would differ from the attributes and skills required to maintain collaboration.

A vision of collaborative working between the ACL and PCMHS sectors focuses on the recognition of preventative, supportive and empowering roles of adult community learning, as well as the involvement of local

communities as equal partners. This study began with the question related to collaborative working between the two sectors and ends with a firm reiteration of the need for wider collaborative relationships and democratic ownership of the vision of collaboration. The development of the vision is dependent on its co-creators' values, their ability to learn from each other and persistence to make the collaboration possible. It depends equally on national and local commitment, which allows for the vision to be shaped and developed by local assets and local needs. Existing examples of local collaborations between adult community learning and primary care mental health services provide interesting examples of different models of work, all tailored to specific contexts, needs and assets of collaborators.

Most importantly, for the vision to become compelling, ambitious and shared, it needs to be invested in and allowed to grow. For it to grow, there needs to be clear mechanisms that ensure consistent and meaningful engagement of local adults as well as other stakeholders. This requires long-term planning and building on previous legacies of good practice; something that has proved difficult in a context of frequent reorganisation of the provider and commissioning landscape.

5.4   Conclusion

What are the leadership priorities for ACL leadership?

Developing a shared vision and collaborative arrangements takes time and effort. It requires questioning assumptions about what we know learners' needs are, how effective our current approaches are and what other stakeholders can contribute to joint working. It is the process of listening, learning and developing new ways of thinking that is important. The process includes learning about oneself and one's organisation. It also implies gaining practical skills, such as data-collection or effective communication.

The ACL leadership faces a challenge of needing to mobilise, inspire and empower policy-makers, local partners, commissioners of services and local communities. It is also a culture shift and changing mindsets that will help all stakeholders to recognise their own accountability

for mental health and wellbeing within the system. Therefore, the key priorities for adult community learning leadership are to:

- Embrace their responsibility related to the promotion of mental health and wellbeing, while accepting they do not have all the answers.
- Broaden the narrative about mental health, from a narrow medical narrative.
- Broaden the narrative about the purpose and potential of adult community learning.
- Reach out to other stakeholders in order to learn and build a shared purpose.

The ACL leadership requires humility to accept it does not have all the answers and the courage to pursue this agenda through the unchartered territories. This requires the unwavering belief in the inclusion agenda and in the importance of the social value of learning within the social determinants of mental health.

In the words of a research participant:

> *I think that's important and you have to be quite a strong person to think: 'Well, there's no rules to follow but I am going to do this anyway'* (P: AE2).

6.0 CREATING A WHOLE SYSTEM APPROACH

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Key areas for action

6.1.   Adult community learning providers
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Secure representation on Health and Wellbeing Boards, Sustainability Transformation Partnerships or Integrated Care S ystems teams in their localities.

Continue to invest in the robust collection and analysis of validated mental health and wellbeing outcome measures.

Lead the conversation with local partners about the validity of outcome measures.

Develop a compelling case for their organisation as an important contributor to mental health and wellbeing in their locality.

Self-assess their current capacity to form new collaborations with primary care mental health services and seek training/support where required (e.g. outcome measures, communication skills, staffing etc.).

Invest in workforce upskilling and awareness raising of mental health and wellbeing issues, and develop relevant whole organisational approaches.

Continue to embed the active citizenship curriculum to ensure that local communities are continuously supported to take an active role in addressing the issues relevant for their local areas.

Continue evaluating and improving the mechanisms of stakeholder involvement, especially learners, to ensure that they are fit-for-purpose and can lead to co-production of collaborations.

6.2.   Central government

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Take the lead to develop a strategy for adult community learning, including specific policy focus areas on mental health and wellbeing within the remit of adult learning.

Seek to engage all stakeholders in creating policy, including adult educators and local communities.

Extend the remit of the mental health strategy to include adult community learning provision.

Invest resources into developing new internal methods for managing learning and policy development, as well as archiving previous policies and projects.

Make easily-available and accessible, robust data and evidence on the impact of adult community learning that can be adapted for use locally, to help to build a robust case for community learning.

6.3.   Professional training organisations could develop education training programmes to support the ACL leadership with

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Embedding of robust collection, analysis and use of validated outcome measures for mental health and wellbeing.

Gaining skills, knowledge and competence in developing whole organisational approaches to support social inclusion, mental health and wellbeing.

Understanding spheres of influence and skills required to influence and lobby.

Regular programmes of 'lessons learnt' from past projects and research programmes.

6.4.   NHS England

Work with clinical commissioning groups, to include in their planning guidance collaborative activities with local partners (e.g. with adult community learning providers) to contribute to wider mental health and wellbeing outcomes.

6.5.   Public Health England

Work with local councils to assess the mental health needs of their population and plan collaborative strategies to improve mental health and wellbeing of adults, involving partners such as adult community learning providers.

6.6.   Local governments and commissioners

Encourage the representation of adult community learning providers on Health and Wellbeing Boards, Sustainability Transformation Partnerships or Integrated Care Systems teams in their localities.

Identify the existing good practice and provision in the localities to inform future work.

Engage in conversation with local adult community learning providers around joint work on achieving improved mental health and wellbeing in their localities.

Revise local health strategies and commissioning rules to recognise the contribution that adult community learning makes for mental health and wellbeing.

Develop whole-system approaches in their localities to mental health and wellbeing.

6.7.   Education funding agencies

Build into their mission and purpose collaborative working around the issues of social inclusion and mental health and wellbeing.

6.8. Academia and researchers

Invest in further research into the conceptual framework for effective collaborative ways of working of public sectors, using lessons learnt from previous projects and history.

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