A city-wide approach to cross-boundary working with students with mental health needs.

Abstract

The aim of the research was to study a city-wide approach to meeting the mental health needs of UK students involving a range of professional and non professional support. The creation of a network for agencies and individuals concerned with the mental health of students in further and higher education offered an opportunity to examine issues of access to services, transitions between services and the need for interagency working. The attitudes and experiences of a range of professional and non-professional providers of support were explored using semi-structured interviews within a multiple case study methodological approach. Interagency working across professional and organisational boundaries was believed to offer the best means of enabling students with mental health needs to continue with their studies. However, issues of resources limitations, professional identities, work boundaries, role confusion, codes of ethics and confidentiality presented barriers to integrated support and interprofessional collaboration.

Introduction

The expansion of the further and higher education sectors and the emphasis on widening participation has led to a significant increase in the UK student population over the last two decades. This has led to a more diverse student population, including many whose families have no prior experience of higher education. Additionally, central government has been promoting social inclusion for people with long term mental health problems (Department of Health, 1999 and 2009), increasing the expectation that more service users will enter education and employment. In tandem with this has been a rise in the number of reported mental health problems in student populations (Royal College of Psychiatrists, 2003).

The majority of UK university students, 78% according to a recent study (BBC News, 2009), live away from home for the duration of their studies, resulting in separation from previous sources of support. The typical age group for UK undergraduate students is 18-22 years, while further education students can be as young as 16, ages at which emerging mental health problems can first manifest themselves (Jacobson, 2002). Although students now form a significant proportion of the population in many cities, there are few mental health services providing targeted support for their needs. This has had an impact on student counselling services, which offer an alternative or parallel means of accessing support to that provided by NHS (National Health Service) services, but how these different services handle cross-referrals can be problematic (Lago, 2002).

Citizens in the UK have access to comprehensive and free healthcare and students living on university campuses may be provided with campus-based primary health care services, while those living within the community can register with general practitioners who serve the population in that locality. However, accessing specialised mental health services can be problematic as the waiting times involved can be longer than the university term times (UK undergraduate degree courses typically run over three years spread over three terms). This transient and time-limited nature of student life can make access to secondary and tertiary services and continuity of care highly problematic (Quinn et al., 2009).

The need to consider issues of housing, social networks and participation in employment and other activities for service users is increasingly recognised in the mental health sector. The National Service Framework for Mental Health in England and Wales (Department of Health, 1999) required health services to consider issues of social inclusion. Onyett (2003) has described the need to support service users in their communities, an approach which is used in social work and in the context of community mental health teams. Models of rehabilitation and recovery (Repper and Perkins, 2003) also emphasise the value of supporting individuals

to pursue their goals through participation in mainstream activities including education. These approaches suggest the need for interprofessional and interagency working and, in many cases, also to involve non-professional supporters in order to promote social inclusion. The relationships between professional and lay supporters has not received a great deal of attention. However, Milne (1999) has suggested that mental health professionals could usefully extend their traditional roles to promote the availability and quality of social support for their clients. Although there is movement towards professionals encouraging carer participation (Roulstone and Hudson, 2007), students who live away from home are likely to receive social support from a range of people who may not be formally recognised as 'carers'.

Despite arguments in favour of greater collaboration, there are practical difficulties. Colombo et al. (2003) examined the implicit models of mental health held by different groups of professionals, patients and informal carers. Elements of different models: medical, social, cognitive-behavioural, psycho-therapeutic, family interactions and conspiratorial, were found across these groups, but in each group some models were more dominant. Overall, medical practitioners wielded the greatest control over decision making, which posed challenges to interagency co-operation unless other parties were willing to accept this dominance. Secker and Hill (2001) found that partnerships between mental health services and community agencies were hindered by a reluctance to share information, role boundary conflicts, lack of resources, misunderstanding of roles and differences in professional perspectives. Research on professionals sharing information with carers identified similar issues which reduced the likelihood of providing effective support in the community (Institute of Psychiatry and Rethink, 2006).

Students experiencing mental health problems have particular time-limited support needs, which, if unmet, are likely to lead to withdrawal from studying and reduced chances of gaining future employment. A collaborative approach to providing support and treatment

would seem to offer the best means of enabling students to complete their studies whilst also managing to maintain their mental health (Stanley and Manthorpe, 2002). An important aspect of this approach is the identification of barriers which need to be overcome and opportunities which could be developed, these formed a significant part of the research described in this article which was undertaken in order to establish a city-wide mental health network for supporters of students.

Methods

A network for providers of support to students with mental health problems was established within a city with a population of approximately 150,000 residents including around 28,000 full-time students. Initially a three year project funded by the Higher Education Funding Council for England, this network provided the opportunity to research formally the nature of support provided to students, and to investigate the experiences, beliefs and attitudes of those providing that support. A multiple case study research approach was chosen (Stake, 2000; Yin, 1993). The cases studied being two universities (one a former polytechnic the other an old university), a college of further education, a primary care trust and a mental health care trust. These were chosen as they were the main umbrella organisations for the individuals involved in the network of providers of support to students. Each institution was distinct from the others in their roles and responsibilities, but their responsibilities for care sometimes overlapped, for example a student could be supported by staff in their university, the local primary care trust and the mental healthcare trust. Ethical clearance was obtained from the Research Ethics Committees of both the local health authority and the university which hosted the research.

At the beginning of the project, a survey form was mailed to 146 local support organisations and service providers asking about the number of students amongst their users and the types

of support given to them. Forty five were returned, of which 38 contained useable data, this low response rate may reflect the pressure under which these services were working. The survey provided useful quantitative and qualitative information on some of the key services provided locally, but the return rate, despite follow-up, was too low to enable general conclusions to be drawn from these data.

In order to gather more in-depth qualitative data, purposive samples of student peer supporters and staff in each of the organisations studied were approached. They took part in semi-structured interviews which explored the nature of the problems encountered, the types of support offered and issues arising from working across the boundaries of professions and organisations. For each interview detailed notes were made at the time, typed up afterwards and then offered to interviewees for corrections and additional comments. The response rate was high with only nine people declining to take part. Seventy six individuals were interviewed in this manner. In addition to the research interviews, meetings were held with groups working in the field involving another forty individuals. The respondents included: student peer supporters, counsellors, residential staff, academic staff, health and social care staff, administrative staff, voluntary sector staff, and advice workers. Nine workshops and two conference events on student mental health issues were run within the network over a two and a half year period, with a further eight workshops or presentations for external bodies. The issues raised by speakers and those attending all these events were noted and formed another valuable source of data. Documentary evidence was collected from each of organisations studied and used as another source of case study data.

A thematic data analysis approach (Holliday, 2002) was used to identify the main issues arising from the research. During the first year of conducting interviews and meetings, data from the different organisations studied were compared for similarities and differences in approaches to providing support. From this work initial data categories were established and

described. In the subsequent years, as more data were explored, categories were added, merged and refined. This process continued until a stable set of categories was agreed upon between the researcher and the two research supervisors.

Findings

The research findings are presented in a sequence reflecting how students accessed and used support and how transitions between different sources of support were managed.

Access to support.

> [We see] 'the entire range of mental health problems. Compared with the community at large, students present with higher adjustment, loneliness and relationship problems but fewer with major psychotic problems probably because these are so disabling that they would make it difficult for someone to become a student. However, quite a few psychotic problems are seen.' (NHS General Practitioner)

This research indicated that many students experienced the wide range of emotional and mental health problems found in other populations, but only a minority required or achieved access to secondary and tertiary mental health services. Nevertheless, the high number of students in the city had an impact on services. For example the survey showed that: students formed 20% of the users of one community mental health team, 40% of the patients in one hospital ward and 40% of patients receiving, or waiting for, specialist psychological treatment. Students with probable psychotic conditions, severe eating disorders or suicidal behaviours were referred to secondary and tertiary mental health services with some urgency, whilst many others with conditions such as depression, anxiety and phobias, if they accessed services at all, were more likely to see a general practitioner (GP) or a university counsellor.

Unlike the majority of the general population, the university students had relatively quick access to free counselling services. During the study's first year approximately 6% of the

local student population accessed their university counselling service. In the Further Education College access was more limited owing to limited resources for student counselling. General Practitioners did not have information available on the number of students approaching them for mental health problems, but studies from other university populations indicate that the figure may also be around 6% (for example Surtees et al., 2000). The local social services department reported that their involvement with mentally-distressed students was minimal.

Given the high levels of psychological distress reported in studies of student populations (Storrie et al., 2010) it is likely that there were many distressed students who might have benefited from professional interventions, but were instead either trying to cope on their own or were relying on social support. Fellow students frequently provided informal support but at times found this to be over-demanding

> 'I think that students with problems rely on their friends for support too much and can overwhelm them… everything comes out at ten at night with the student in tears.'
> (Student peer supporter)

Both universities had set up support mechanisms intended to head off problems or detect them early and encourage access to support services. Examples included students taking on roles of welfare officers, peer supporters, telephone and drop-in centre support workers and residential assistants. Certain staff in academic settings were expected to look out for vulnerable students; in the further education college this role fell mainly on tutors, whilst in the universities residential staff also took on aspects of pastoral care. The students, academic and residential staff interviewed all gave examples of supporting students who were reluctant to seek professional help. Some academic and student support staff reported occasional difficulties in getting GPs to take their concerns about certain severely distressed students seriously.

The student peer supporters interviewed felt that the emotional support offered by tutors varied and comments from counselling and healthcare staff confirmed this view. Some counsellors stated that certain tutors would refer students to them whose needs could have been met within a supportive tutorial relationship, whilst others were seen as getting inappropriately over-involved with certain students' problems.

> 'Without awareness, staff can develop false dependency relationships with students, or in good faith set up relationships with student whose needs they can never fulfil. This situation can be serious when they get out of their depth and there is a crisis, the relationship breaks down and they demand and expect immediate help for the student from the Counselling Service.' (University Counsellor)

University counsellors managed access only to their own service, whilst GPs could also seek referral to specialist mental health services for the student. The decision whether to treat or not, or to encourage use of other services, was based on a number of factors including: the severity of symptoms, the perceived risk of suicide, the potential danger or disruption posed to others and consideration of the student's personal circumstances. Students presenting with symptoms of depression and anxiety were likely to be treated with medication, counselling or a combination of the two. Whether they first approached a GP or a university counsellor, there were no protocols for cross-referral and so the choice of treatments offered depended on the attitudes of the practitioner first encountered.

> 'I sometimes think that some students are down in mood rather than being clinically depressed, but are prescribed antidepressants, which of course don't work, and I would prefer that they were referred for counselling first. There are quite a few students on antidepressants.' (University Counsellor)

Virtually all students who presented with psychotic symptoms were referred on; by counsellors to GPs, and by GPs to secondary mental health services. There were differing

opinions amongst university counsellors as to whether they would offer counselling to students diagnosed with psychotic conditions. Those that would, only did so once they knew that the individual was also receiving psychiatric support. Similarly, students with severe levels of depression, anxiety, phobias, eating disorders, self-harm and personality disorders were recognised as needing specialised help. Both of the university counselling services retained part-time psychiatric consultants to help their staff manage to manage the boundaries between what was seen as appropriate to counselling or psychiatry.

The research indicated that many providers of primary care, counselling and social support continued to offer support to severely distressed students, not because they felt they could best meet their needs but because of the difficulties in accessing secondary and tertiary mental health services. One GP expressed concern about the quality of services available, citing this as a reason for not making early referrals:

> 'I suspect in this practice we are quite slow at transferring patients and try out all sorts of things first. The outpatients service seems to be interested in trying out the latest antidepressants rather than anything more patient-centred…. As inpatients, what they do with them when they have got them is not always perfect, and you may get people seen by a succession of different registrars, but that is the way they are set up.' (NHS General Practitioner)

Moving between services – managing transitions.

The city had a range of services beyond the primary care level including: in-patient and out-patient hospital services, community mental health teams, clinical psychology and psychotherapy services, self-harm and attempted suicide services, addictions and eating disorders units. All of these were accessed by referral from GPs or secondary care staff.

'Psychotherapy is a minefield, many GPs don't promote it. What if you don't feel a link with the first person you are referred to for therapy? And if that doesn't work, then what?' (Student peer supporter)

As this quote indicates, transitions between services can raise anxieties for the service user, and yet there are also many benefits in being able to access more specialised support for complex mental health problems. Ideally the transition from one service to another occurs soon after the need for that service has been identified and agreed upon. Unfortunately, the reality was that community mental health teams and hospital-based services were already working at capacity, resulting in long waiting times for all but the most urgent cases. An NHS clinical psychologist commented that their service could only provide therapy to one in six of those assessed as needing it. Waiting times for cognitive behavioural therapy were running at around nine months during the research period. The nature of the academic year and the effects of term times and vacations made delays in accessing specialist services a particularly difficult issue for students.

'A huge issue for many students is when it is agreed that NHS psychological or psychiatric treatment would be the best outcome, but due to the grotesquely impoverished resources, such treatment is not available.' (University Counsellor)

One of the consequences of these delays in accessing NHS psychological treatment was that occasionally some GPs and some mental health service staff referred quite distressed student patients to their university's counselling services instead. Those working in the counselling services often did not see such referrals as appropriate, as their remit was to support students struggling with a wide range of life issues rather than to treat individuals with diagnosed mental health problems.

Another concern was raised by the providers of children's and adolescents' mental health services (CAMHS). When their users reached the age of eighteen they had to transfer to adult

mental health services, resulting in a significant drop in the level of support available just at the time they were having to manage significant life transitions, including moving into further and higher education.

The division between primary and secondary mental health care was felt to have widened, making patient-centred interprofessional collaboration difficult to achieve. Changes in the way that primary care was funded and organised also affected the ability of GPs to tailor services to their local populations.

> 'Previously the Practice had a number of psychologists and could offer a quick service. Previously, as a fund-holder Practice, we could buy in the services we needed. The change to PCT happened in the name of equity but was a backward step for this Practice's patients.' (General Practitioner)

In the secondary and tertiary services, some nurses, clinical psychologists and psychotherapists mentioned examples of psychiatrists and clinical services they viewed as taking an overly medical approach to their clients. Although many practitioners valued the contribution of both medical and psychological approaches to treating mental health problems, there were indications of some interprofessional tensions about which treatments were the most appropriate for their clients.

> 'Doctors tend to look for symptoms, they want to label the condition. Nurses are more holistic and will look at psycho-social stuff e.g. what might have triggered the illness? And what their needs might be afterwards.' (NHS Psychiatric Nurse)

Some of the GPs and the NHS mental health staff interviewed tended to see the universities' counselling services as being dominated by a psychodynamic approach, whereas they had a preference for cognitive behavioural therapy. This made these practitioners more reluctant to encourage student clients to use these services even though they might have been appropriate

for certain conditions. Some counsellors in turn felt that certain GPs were too ready to encourage the use of antidepressants. There was a lack of clear communication channels between these two sets of professionals which was possibly linked to these underlying differences in approach.

> 'I don't think that the dialogue between GPs and the counselling service is easy or clear. Some GPs think the service is great others are not so sure. There is no template for how counsellors and GPs relate to each other.' (University Counsellor)

Returning to or continuing with student life. Despite the problems in accessing mental health services, the pathways into the increasingly specialised levels of care were reasonably clear to those involved in the referral process. However, the pathways back to student life following an intensive period of treatment were not so identifiable.

> 'It would be helpful to have closer contact with colleges and have accessibility. It would be useful to meet people like tutors and see what support networks are in place. There are occasions when we do need to make contact… then we can know what support is available and gradually reintegrate the student.' (NHS Psychiatric Nurse)

Respondents in mental health services found it difficult to work beyond the boundaries of the immediate provision of treatment, partly because they were under pressure to start working with the next intake of patients from the waiting list. The need to negotiate practical issues, such as where the student was going to live and how they could take time out from their studies, was commonly recognised. Other issues to do with social integration, dealing with stigma and discrimination or managing the stresses associated with academic study, were acknowledged by some staff in mental health services but they did not have systems in place for addressing these more social needs.

'How do you know as a medical practitioner, who to approach in a university or college? I feel that this needs guidance. Information sharing also works the other way e.g. if a tutor knows a student has a mental health history and he/she is worried they should be able to talk to the mental health team. The tutors need to be alerted when things are going wrong.' (NHS Psychiatrist)

Healthcare practitioners reported difficulties in knowing what support was available to students back in their colleges and universities. They also felt constrained by ethical considerations, such as the need for confidentiality, which prevented them from sharing information with those university and college staff who had a responsibility for their students' welfare. This was a source of considerable frustration for a number of respondents, particular those working in residential settings.

'There are so many issues with confidentiality. I know it wouldn't be fair for counselling to reveal everything about a student, as it might prejudice others against them, but other people could be in danger so they need information. Wardens are respectful of confidentiality and wouldn't abuse information given to them. You don't get much information, so you don't know the other causes and effects on the student, and you don't know whether you need to know or not!' (University Hall of Residence Staff Member)

Healthcare staff could see many potential benefits of working across organisational boundaries to support students who were patients. They felt that they could help staff working in academic institutions to recognise emerging mental health problems. Medical and psychological practitioners had ideas about the role social supporters could play in enabling access to mental health services, but fewer were certain about how such supporters could contribute to the students' pathways back into academic life. Fellow students could play a key role in supporting students with varying levels of mental health problems. However, the

nature of their role in supporting the re-integration of students returning from treatment for serious mental health problems has not been formally recognised:

> 'Students' friends do a lot of work in containing people in the community and they are not getting a care allowance for doing so! So friends are very important ...' (NHS Clinical Psychologist)

In contrast to the respondent above, most of the mental health staff interviewed did not show an awareness of the role that fellow students might play in providing social support. Similarly there was no mention of any contact with either of the universities' disability advisers. Apart from contact with the Head of Student Services at the newer university and with some tutors in the universities and local colleges, the only other sources of support they seemed aware of were the universities' counselling services.

Many respondents identified the need to develop effective interprofessional and inter-organisational collaboration. The majority felt that a more holistic approach should be developed, recognising that a whole range of needs could be addressed including: medication, psychological treatments, housing, educational and social support.

> 'It is important that networks are in place. Not just those that express an interested but the key people in place. The CMHT managers will be essential… Knowing that a student mental health network is there will keep people interested.' (NHS Mental Health Service Manager)

At meetings organised by the student mental health network, staff working at different levels in the healthcare and educational sectors discussed ways of developing and improving interagency collaboration. Senior managers from each sector agreed to meet throughout the year to review policy issues. At the grassroots level, people providing direct support to distressed students held joint training events to share skills, knowledge and experiences

between the health, social care and educational settings. In addition printed and web-based materials on student mental health support issues were made widely available, all of which enhanced the potential for a wide range of supporters to promote the social inclusion of students affected by mental health issues.

Conclusion and reflections

Although this study covered a wide range of practitioners, two specific groups, community psychiatric nurses and general practitioners, were under-represented amongst the respondents. However, the aim of exploring diverse roles, experiences and perspectives was largely achieved. The city in which the study took place was relatively small and in other locations students might not form such a significant proportion of the population. Nevertheless, there are likely to be issues in common with any community which contains a transient student population and, with the growth in higher education, there are now many cities which contain at least two universities.

Students facing mental health issues may warrant consideration as a sub-group with special needs, affected by their transient and geographically mobile lifestyle, suggesting targeted services (as has increasingly happened for a number of groups, not least because of the guidance linked to the National Service Framework for Mental Health). The presence of GP services and on-campus counselling support linked to universities and colleges helps a number of students with low level mental health problems but is not always sufficient for those with more complex needs (Lago, 2002).

Issues of professional identities, work boundaries, resource limitations, role confusion and codes of ethics and confidentiality were found to present barriers to collaborative working. The exchange of information is a particularly sensitive topic in the health and social care field and practitioners have been criticised for sharing either too little and or too much.

Consultations with service users about the benefits, risks and means of sharing information between different agencies concerning their needs could usefully be developed.

Different theoretical orientations and professional affiliations (Colombo et al., 2003; Secker & Hill, 2001) were particularly evident in the relationships between university counsellors and NHS practitioners, psychiatrists and nurses, and psychiatrists and psychologists, and this affected the types of support offered. Limited resources for specialist mental health care affected not only students but also GPs and counsellors who continued to support students whose levels of need went beyond what they would ideally see as being within their remit. Increasingly mental health trusts have developed specialist services such as those for substance abuse, eating disorders, self-harm and psychological treatments; a large student population is likely to increase the need for such provision.

Most of those interviewed identified that individuals experiencing mental distress were affected by social issues and needs which could not be met within treatment services. However, the promotion of social support (Milne, 2003) for those most seriously affected was limited by professionals' concerns about sharing information, reflecting a situation which affects carers more generally (Institute of Psychiatry and Rethink, 2006). The establishment of services promoting informal social and peer support could be beneficial to students experiencing a wide range of mental distress.

Despite the barriers to partnership working, many of the interviewees saw the benefits of a more integrated approach to providing support. There was a willingness to explore ways of working across boundaries and to tackle issues of sharing information and expertise, provided that clients could provide informed consent. Given the numbers of institutions involved, the most likely way of achieving this was seen to be through employing someone to permeate the boundaries of the different organisations facilitating greater understanding of different but complementary roles, both professional and informal. This research has identified many

issues which need to be addressed in order to provide a joined–up approach to supporting students experiencing mental health problems, and it suggests some areas for further research.

The role of informal social supporters, other than family members, has received little attention in the research literature and yet such support could be crucial in promoting inclusion in education, employment, social and cultural activities. Similarly, although interprofessional and interagency working has been researched and analysed there is still much to learn about the relationship between professional and lay supporters. This research has focused on a student population, who can be seen as having particular vulnerabilities, but there are many parallels for the support needs of the wider population as the dangers of social exclusion associated with mental health problems become more widely recognised.

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