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University
Of
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Supporting Students with Complex Mental Health Difficulties

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Supporting Students with Complex Mental Health Difficulties

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Abstract

The project 'Supporting Students with Complex Mental Health Needs' was undertaken primarily by staff from the Student Health and Well-Being section of the Student Services Department at the University of Sheffield in 2009-2010. The aim was to review the whole system of support for students with complex mental health/ psychological difficulties and make proposals for its further development.

The study drew upon previous clinical research but was also grounded firmly in the experience of the University community, giving full weight to the voices of students and staff through the use of questionnaires and focus groups.

The findings indicated that there are significant numbers of students suffering from complex mental health difficulties at the University of Sheffield. Many of the students who responded to the study found the university experience very challenging, both socially and academically, and this was amply evidenced in the verbatim responses to the student survey. The most frequent categories of distress experienced by students almost never occurred in isolation but as part of a constellation of problems, often mutually reinforcing. Staff also reported finding the task of supporting these students very demanding.

The study concluded that what was required for the support of students with complex mental health difficulties was a clear strategic purpose, leading to a more structured approach to their support, tighter collaboration between services and earlier intervention to prevent later crises. The project leaders used information gathered to put forward a number of recommendations, based upon the strategic purpose of: 'Containment not cure - enabling students with complex mental difficulties to live and learn successfully in the University community.'

Although this project focused on a relatively small group of students, its findings, the strategic purpose and the recommendations that it makes seem highly relevant to student mental health systems as a whole.

1 Executive summary

Background

This report sets out the findings of the 'Supporting Students with Complex Mental Health Needs' project undertaken primarily by staff from the Student Health and Well-Being section of the Student Services Department at the University of Sheffield in 2009-2010.

This study was undertaken in response to the apparently rapidly growing numbers of students experiencing complex mental health difficulties and a mounting concern about the strain that this was imposing upon both specialist support services and other university staff supporting students.

The aim of the project was *'To review the whole system of support for students with complex mental health/ psychological difficulties and make proposals for its further development.'*

It is important to note the innovative nature of this study. Clinical research has been carried out in this field before but no study, to our knowledge, has previously focused so sharply upon students in a university context. The value of this study to us, therefore, is that it draws upon previous clinical research but is also grounded firmly in the experience of our own University community, giving full weight to the voices of students and staff.

Main findings

1. It would appear that there are very significant numbers of students suffering from complex mental health difficulties in the University. This is demonstrated in part by the very strong responses to our surveys but can also be inferred from studies included in our literature review.
2. The most frequent categories of distress experienced by students almost never occurred in isolation but as part of a constellation of problems, often mutually reinforcing. The kind of experiences described would be consistent with seeing 'complex psychological problems' as long-term, relatively stable features of personality rather than acute 'mental illnesses'. This finding has had a fundamental impact upon our recommendations for service development.
3. However, whilst members of staff were more likely than students to highlight the more dramatic and external manifestations of psychological distress, such as psychosis and self harm, students themselves were more likely to highlight low self-esteem/confidence, low motivation/concentration and relationship problems. The difference may be partly because students may sometimes *"appear to be highly functioning but very distressed behind closed doors."*
4. Many of the students who responded to the study find the University experience very challenging, both socially and academically and this is amply evidenced in the verbatim responses to the student survey. Staff also reported finding the task of supporting these students very challenging indeed.

5. Students were particularly aware of the relationship between academic pressure (particularly deadlines), resulting stress, maladaptive coping and subsequent decline in academic performance. Though there is no evidence to suggest that they are low achievers – our respondents represented all student groups, from UG to PGT to PGR – we could conclude that these difficulties may often prevent them from reaching their full potential.
6. The study concluded that what was required for the support of students with complex mental health difficulties was a clear strategic purpose, leading to a more structured approach to their support, tighter collaboration between services and earlier intervention to prevent later crises.

Recommendations for action

The project leaders used information gathered to put forward a number of recommendations, based upon a strategic purpose of:

'Containment not cure - enabling students with complex mental difficulties to live and learn successfully in the university community'.

These are grouped under the following headings:

- **Collaboration**
- **Student involvement**
- **Early intervention**
- **Supporting staff.**

Benefits of the project

There were several benefits of undertaking this project: a better understanding of how key elements of the support to students were being delivered, the identification of areas where service provision required development, and the construction of a strategic framework for further service development. It is hoped that both improved student support and improved understanding about complex mental health and psychological difficulties- and their impact- at a policy level within the University may be the future consequences of the work undertaken.

Finally, it is notable that although this project focused on a relatively small group of students, its findings and the strategic purpose and recommendations it sets out are highly relevant to the student mental health system as a whole and should be of great help to us as we work on developing a sustainable support system in the approaching era of financial restraint.

2 Introduction

This report sets out the process and findings of the 'Supporting Students with Complex Mental Health Needs' project undertaken primarily by staff from the Student Health and Well-Being section of the Student Services Department at the University of Sheffield in 2009-2010. This project was undertaken in response to the increase in numbers of students at the University who appeared to be experiencing more complex mental health difficulties.

Students who might fit this category experience complex psychological problems which are long-standing rather than being brief episodes of distress; problems that do not arise in isolation and are enduring, complex, and sometimes self-reinforcing. Whilst not all such students would meet the criteria necessary for a diagnosis of 'personality disorder', they do experience difficulties with managing emotions and impulses, and relating to others. At the same time, many such students are high achieving, with the potential for a significant academic future, and the consequences of not supporting them may be high both for them as individuals and for the institution.

However, the emotional costs of supporting this student group is also high: staff and other helpers were reporting that their endeavours to help these students often left them feeling anxious, frustrated, emotionally drained, angry, stressed- and at times unsupported by colleagues and other professionals. There was also evidence that whilst such students were seeking help from multiple sources, sometimes this was done in ways that made the help given less effective. Whilst the system of pastoral care at the University could be considered as exemplary, departments and professional services were not always able to work together most effectively.

This led the project leaders to believe that the whole system of support for such students needed to be evaluated, rather than developing further resources and services in a piecemeal fashion. Another reason for carrying out the project was to present a well-researched picture to senior university management, who may not have been sufficiently well-informed on this issue

The aim, therefore, of this project was 'To review the whole system of support for students with complex mental health/ psychological difficulties and make proposals for its further development.' The definition of what was meant by 'students with complex mental health difficulties' for the purpose of the project was:

- *Students suffering from mental health difficulties whose conditions make it difficult for them to engage effectively with the University experience and whose distressed and distressing behaviour can have a major impact upon others (both students and staff)*
- *This would include those with a diagnosis of personality disorder*
- *This would not include students with Autistic Spectrum Disorder unless they are concurrently experiencing shorter term mental health difficulties (eg anxiety, depression), and therefore are dealing with a complex set of difficulties*

This report consists of a literature review of the current key papers relevant to this student group, with a summary of any recommendations that they make. This review makes useful reading for anyone unfamiliar with concepts such as 'personality disorder' and gives a useful overview of the difficulties faced by this student group and of those who are involved in their care and education. The literature review has also been a useful way of comparing, validating and benchmarking data gathered by the current project.

The methodology chapter outlines how the project was undertaken, using a variety of methods, including a working group, on-line questionnaires to students and staff, focus groups and in-depth, semi-structured interviews. The project was an internal needs assessment and service improvement project, not a piece of research, but care was taken to ensure that ethical standards with regard to informed consent, confidentiality, and safety of those involved in the process were carefully considered.

The results from the data collection are presented in two parts. Data from questionnaires and focus groups were given to professional researchers from CPSR¹ to analyse. Results from working group discussions and interviews are presented in the second half of the Results chapter.

A discussion of the results is offered by the project leaders, followed by their recommendations and conclusions.

¹ CPSR: Centre for Psychological Services Research, University of Sheffield

3 Literature review

The following section summarises the recent literature available on the current prevalence and impact of the 'complex' student group, together with current recommendations. In subsequent chapters of this report there are findings both quantitative and qualitative that give a more detailed, richer, and relevant picture of the current situation at the University of Sheffield.

3.1 Quantitative data

The Royal College of Psychiatrists' report on the mental health of students in higher education (2002) states that:

'There has been a progressive increase in the number of students presenting to counselling and student health services, and in the severity of their mental health problems'. (p6)

The project at the University of Sheffield focused on the students within this wider group whose behaviours and symptoms could be indicative of a personality disorder, although many of these students would not have had a formal diagnosis. The recent NIMHE paper 'Personality disorder: No longer a diagnosis of exclusion' (2003) cites statistics regarding personality disorder²:

'Studies indicate prevalence of 10-13% of the adult population in the community, and show that personality disorders are more common in younger age groups (25-44 yrs) and equally distributed between males and females. However, the sex ratio for specific types of personality disorder is variable e.g. antisocial personality disorder is commoner among males, and borderline personality disorder commoner amongst females.' (p11).

The paper lists various types of personality disorder in 'clusters':

- 'Cluster A (the 'odd or eccentric' types): paranoid, schizoid and schizotypal personality disorder
- Cluster B (the 'dramatic, emotional or erratic' types): histrionic, narcissistic, antisocial and borderline personality disorders
- Cluster C (the 'anxious and fearful' types): obsessive-compulsive, avoidant and dependent' (ibid, p11)

Of these groupings, those in 'Cluster B' would tend to include most of those students who would fit our current definition of 'students suffering from mental health difficulties whose conditions make it difficult for them to engage effectively with the University experience and whose distressed and distressing behaviour can have a major impact upon others (both

² The fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (American Psychiatric Association 1994) defines a personality disorder as 'an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment'.

students and staff). The 2009 NICE clinical guidelines for treatment for borderline personality disorder state that:

'Borderline personality disorder is present in just under 1% of the population, and is most common in early adulthood. Women present to services more often than men. Borderline personality disorder is often not formally diagnosed before the age of 18, but the features of the disorder can be identified earlier'. (p4).

All of these publications highlight the prevalence of these conditions surfacing in late adolescence and early adulthood. Taking into account the current student population at the University of Sheffield, it could be conjectured that there could be more than 3,000 students with personality disorder, and possibly 270 who would fit the criteria for 'borderline personality disorder'. Of course not all of these students display behaviours that cause distress and disruption to others.

3.2 Impact

The impact that such psychological conditions have both on the individuals and those in contact with them has been noted extensively, particularly in psychiatric, medical and psychotherapeutic literature. The Royal College of Psychiatrists report (2002) notes:

'Any protracted illness, physical or mental, will have an effect on a student's career within a competitive environment and the finite time scale for study. Mental disorders have far-reaching impacts that can be threefold: first, on the student; second, on the institution; and third, on the family and society' (p32)

...and notes impaired performance and disruption to studies, both through deferment and dropping out of University as aspects of this impact. More particularly, the report goes on to state that:

'A student affected by a serious mental disorder (including personality disorders of borderline/dissocial type) can be a disruptive influence on other students and may place considerable pressure on the institution's staff and its support, counselling and medical systems. A small number of students with drug problems might become tempted or be pressurised to 'deal' drugs among their peers. There are often complex interactions between health and conduct issues to be addressed. Higher education institutions receive substantial central funding, which might be seen as wasted if students do not complete their studies'. (p32)

The NICE guidelines (2009) give a useful description of the characteristics of borderline personality disorder, which also gives a flavour of the impact that these can have:

'Borderline personality disorder is characterised by significant instability of interpersonal relationships, self-image and mood, and impulsive behaviour. There is a pattern of sometimes rapid fluctuation from periods of confidence to despair, with fear of abandonment and rejection, and a strong tendency towards suicidal thinking and self-harm. Transient psychotic symptoms, including brief delusions and hallucinations, may also be present. It is also associated with substantial impairment of social, psychological and occupational functioning and quality of life. People with borderline personality disorder are

particularly at risk of suicide. The extent of the emotional and behavioural problems experienced by people with borderline personality disorder varies considerably. Some people with borderline personality disorder are able to sustain some relationships and occupational activities. People with more severe forms experience very high levels of emotional distress. They have repeated crises, which can involve self-harm and impulsive aggression.' (p4)

The NIMHE document (2003) also highlights the impact that those with personality disorder have on helpers:

'What is clear is that people with personality disorders make heavy demands on local services, which are often ill equipped to deal with these. One of the characteristics of this group is that they often evoke high levels of anxiety in carers, relatives and professionals. They tend to have relatively frequent, often escalating, contact across a spectrum of services including mental health, social services, A&E, GPs and the criminal justice system. They may present to mental health services with recurrent deliberate self harm, substance abuse, interpersonal problems that may include violence, various symptoms of anxiety and depression, brief psychotic episodes, and eating disturbances.

Many general mental health services struggle to provide an adequate service for people with personality disorder. In many services people with personality disorder are treated at the margins – through A&E, through inappropriate admissions to inpatient wards, on caseloads of community team staff who are likely to prioritise the needs of other clients and may lack the skills to work with them. They have become the new revolving door patients, with multiple admissions, inadequate care planning and infrequent follow-up....Many clinicians are reluctant to work with people with personality disorder because they believe that they have neither the skills nor the training or resources to provide an adequate service. Clinicians may find the nature of interactions with personality disordered patients so difficult that they are reluctant to get involved' (pp12-13).

However, many services are taking more seriously the importance of using service users themselves in their development of strategies and services. For example, service users involved in the compilation of the NIMHE (2003) report said that they often felt blamed for their conditions, and often were seeking acceptance through their help seeking behaviours. The recently published strategy document 'A New Beginning' (Yorkshire and the Humber Personality Disorder Strategy Development Steering Group, 2010) has as one of its aims:

'Find a way to constructively involve service users in the planning, development and investment decisions for current and new services'. (p7)

Alan Phillips's recent (2008) report on Student Mental Health at the University of Sheffield comments that students who might fit the descriptors of personality disorder often absorb a disproportionate amount of clinical time' (p7) and notes that mental health 'crises' often occur in places such as residences and libraries, thus impacting on many other students and staff.

3.3 Recommendations

Drawing upon the documents cited above, there are a number of recommendations that have been made with regard to the treatment, management, help and support that would benefit this student group. For ease of reading these have been grouped under various headings, and are summarised as follows.

Attention to the context of Higher Education

It is particularly important that help offered to students takes into account the context and the demands of their university life. The Royal College of Psychiatrists (RCP) report notes that:

‘Despite their intellectual abilities and potential for advancement, students with mental health problems are a disadvantaged population’. (p6) and ‘late-adolescent students are likely to be struggling with issues of dependence and independence and may be ambivalent about seeking help’. (p54)

The report suggests that there should be:

‘...recognition of pressures specific to students in higher education, i.e. academic, financial difficulties, parental expectations, unstructured time, frequent transitions (geographical and emotional)’ and that:

‘Treatment plans are tailored to the personal and contextual needs and the academic requirements of the student’. (p54)

Times of transition are potentially times of stress for students with complex mental health difficulties and change is a common feature of the university experience. (Phillips 2009) The 2009 NICE guidelines under the heading ‘Managing endings and supporting transitions’ emphasises the importance of handling these times with care, ensuring communication with the service user and their carers, and ensuring adequate support.

Collaboration

The RCP report states:

‘Good practice in student mental health should be based on the following principles:

There is collaboration between HEIs, the NHS and other local agencies (including voluntary organisations) to ensure that students can access appropriate care without undue delay. Careful attention needs to be given to issues of confidentiality’ (p54)

and recommends

‘Active use of the care programme approach (CPA) to ensure effective collaboration in the student’s treatment between the student, university counsellors, college and home general practitioner (GP) and mental health workers, and carers identified by the student, for example family or college officers... (p9)

The 2009 NICE guidelines similarly stress the importance of shared care plans (see below under therapeutic options)

The strategy document 'A New Beginning' highlights the importance of co-ordinated commissioning, good service networks and clear pathways to accessing help.

Therapeutic options

The 2009 NICE guidelines state:

'Teams working with people with borderline personality disorder should develop comprehensive multidisciplinary care plans in collaboration with the service user (and their family or carers, where agreed with the person). The care plan should:

- identify clearly the roles and responsibilities of all health and social care professionals involved
- identify manageable short-term treatment aims and specify steps that the person and others might take to achieve them
- identify long-term goals, including those relating to employment and occupation, that the person would like to achieve, which should underpin the overall long-term treatment strategy; these goals should be realistic, and linked to the short-term treatment aims
- develop a crisis plan that identifies potential triggers that could lead to a crisis, specifies self-management strategies likely to be effective and establishes how to access services (including a list of support numbers for out-of-hours teams and crisis teams) when self-management strategies alone are not enough
- be shared with the GP and the service user' (p18)

The NIMHE (2003) report cites Bateman and Tyrer, who have reviewed possible treatments for personality disorder. They identified guiding principles for therapy for this group, which are that therapy should:

- be well structured
- devote effort to achieving adherence
- have a clear focus
- be theoretically coherent to both therapist and patient
- be relatively long term
- be well integrated with other services available to the patient
- involve a clear treatment alliance between therapist and patient' (NIMHE p55)

Finally, the DOH's NICE 2004 guidelines state:

'A number of therapy approaches have shown some success with personality disorders, including dialectical behaviour therapy, psychoanalytic day hospital programme and therapeutic communities'. (p38)

Whilst all the above recommendations are primarily aimed at those working within NHS organisations, there are clearly a consistent set of themes that could assist the development of this project's own recommendations.

Developmental and relational aspects

The 2009 NICE guidelines are unequivocal about the importance of people developing what it calls 'an optimistic and trusting relationship' with service users:

' build a trusting relationship, work in an open, engaging and non-judgemental manner, and be consistent and reliable' (p13)

' bear in mind when providing services that many people will have experienced rejection, abuse and trauma, and encountered stigma often associated with self-harm and borderline personality disorder' (ibid).

It also stresses the need for service users to have choice and autonomy, and for them to be encouraged to remain actively involved in finding solutions to their problems, to consider different options available to them, and to be aware of the consequences of choices made and actions taken.

Service user involvement

Focus groups that have been used in the past resulted in several recommendations from service users. These included early intervention before a crisis is reached, good communication, clear, shared goals regarding help, respect, consistency, and a focus on education and personal development. Unhelpful experiences included lack of continuity of staff, dismissive/ pessimistic attitudes, and disinterest in causes of behaviour. The strategy document 'A New Beginning' has as one of its five main objectives the use of service users in 'shaping, planning, operating, commissioning and operating services. (p26)

Implications for staff training

NIMHE (2003) summarises the importance not only of the adequate training of staff, but also of the personal qualities that enable them to work with certain mental health difficulties:

'Working in the field of personality disorder is not easy. Staff need a high degree of personal resilience and particular personal qualities that allow them to maintain good boundaries, survive hostility and manage conflict. They need to appreciate the value of team working, be effective team players and feel comfortable working as part of a multi-disciplinary team.

The scoping study suggests that in some important respects, the competencies required to work effectively with people with personality disorder are similar to those required for work with other groups of people with mental disorders, although there are also some key differences. These include emotional resilience, particular clarity about personal and interpersonal boundaries, and the ability to tolerate and withstand the particular emotional impact that working with personality disordered patients can have on relationships within a team and service.' (p44)

Finally, any institution should be mindful of organisational structures that assist its staff to provide appropriate support and care; especially where an element of risk is concerned. The

following is taken from a training lecture for medical staff, but could easily apply to the University context:

'Assessing and containing risk is most effectively done by an organisation that understands its responsibilities and creates a supportive system around its front line clinicians who have the appropriate level of training and experience and a process that is thoughtful and structured'.³

³ University of Newcastle medical specialty training lecture

4 Methodology

The purpose of this project was primarily to discover how best Student Services, and the University of Sheffield more generally could support students who fit the description as given in the project definition. This has been an internal needs assessment and service improvement project, rather than a piece of research and so ethical approval was not formally sought. However, although such scrutiny was not required, the project manager and members of the Student Mental Health Leadership Group (SMHLG) took steps to ensure that ethical standards with regard to informed consent, confidentiality, and safety of those involved were carefully considered. The methods of data collection were agreed upon through meetings with the SMHLG, and as the project progressed, with members of the working group and the Consultant from CPSR⁴.

4.1 Aims and objectives

The aim of this project was 'To review the whole system of support for students with complex mental health/ psychological difficulties and make proposals for its further development.'

The objectives are listed below:

1. Give a clear definition of what is meant by 'complex mental health/ psychological difficulties' and which students may fall within this category.
2. Give an overview, both quantitatively and qualitatively, of the current situation with regard to this group of students at the University of Sheffield.
3. Summarise the impact that this has on the University community.
4. Review the provision of support for this student group, both internally and externally.
5. Summarise current recommendations (where available) for psychological support for this student group.
6. Identify the strengths and weaknesses of the current support system.
7. Make proposals for remedying any weaknesses and for further developing the system.
8. Through the implementation of the project, and through dissemination of its findings, enhance the University community's understanding and capacity to support these students.

4.2 Scope

Included in this project was a review of clinical and non-clinical support provided by Student Services, other Professional Services and staff in academic departments at the University of Sheffield. This was done through questionnaires and focus groups, as described later in this chapter. Not included in the project was the delivery of any enhanced resourcing.

4.3 Assumptions

The project leaders made the assumptions that:

- the University's Student Services Strategy (June 2009) remained operational

⁴ CPSR- Centre for Psychological Services Research at the University of Sheffield

- the Widening Participation Strategic Plan (June 2009) remained operational
- current legislation regarding the provision of 'reasonable adjustments' for disabled students remained in place

4.4 Definition of 'students with complex mental health needs'

A working definition of what was meant by this term was devised at the beginning of the project. The project leaders were aware of the potential to stigmatise or label students in a way that would be inappropriate and unhelpful. At the same time, it was important to capture the seriousness of the difficulties faced by this student group and those who help them. The project manager first summarised a range of presentations that could be categorised as significant mental health/ psychological difficulties:

- Students with a formal diagnosis of bipolar, schizophrenia or personality disorder
- Students diagnosed with severe/ recurring or enduring anxiety disorders, OCD or depression.
- For the purposes of this project, disorders that have lasted or are likely to last longer than 12 months.
- 'Co morbidity,' ie, a combination of any of the above.
- Any student who is eligible for DSA because of mental health difficulties, ie has a '...mental impairment which has a substantial and long-term adverse effect on his ability to carry out normal day-to-day activities.'⁵
- Students with other conditions (such as ASD) who are concurrently experiencing shorter term mental health difficulties (eg anxiety, depression), and therefore are dealing with a complex set of difficulties.

It was also recognised that others may not know, or need to know, whether a student has a formal mental health diagnosis, but that some students give cause for concern on a regular basis. These students are best described in the 'Helping Students with Mental Health Difficulties' guidelines⁶ which give details of situations where there is a more urgent need to intervene; those with suicidal tendencies, threat of serious self harm or harm to others, acute alcohol/ substance addiction, experiencing hallucinations, a complete lack of functioning, or having no sense of reality.

The inclusion criteria were then narrowed down, as the main purpose of the project was to investigate support available for students who may have enduring problematic personality traits, rather than those with acute mental health episodes such as psychoses. The project leaders wanted to make a clear delineation between those experiencing psychotic episodes, (for whom there are clear procedures and defined routes of help and support), and those whose difficulties, as described in the literature review, include '...significant instability of interpersonal relationships, self image and mood, and impulsive behaviour' (NICE 2009) The proposed working definition was therefore agreed upon by the project leaders:

⁵ Disability Discrimination Act 1995, as amended.

⁶ Helping Students with Mental Health Difficulties, University of Sheffield 2009

' students suffering from severe difficulties whose conditions make it difficult for them to function effectively in a university setting and whose distressed and distressing behaviour can have a major impact upon others (students and staff)'

This working definition was presented to the working group in November 2009, and after discussion, the following revision was agreed upon:

- *Students suffering from mental health difficulties whose conditions make it difficult for them to engage effectively with the University experience and whose distressed and distressing behaviour can have a major impact upon others (both students and staff)*
- *This would include those with a diagnosis of personality disorder*
- *This would not include students with Autistic Spectrum Disorder unless they are concurrently experiencing shorter term mental health difficulties (eg. anxiety, depression), and therefore are dealing with a complex set of difficulties*

4.5 Working group

Members of staff across the University, together with mental health professionals from local NHS trusts were invited to join the working group by the project manager (see appendix). As it was important to attempt to recruit academic staff to this project, six Faculty directors of the University were first asked to provide names of suitable candidates for this work from their faculty. Of a total of 19 internal and external people approached, 17 responded and joined the working group. Another staff member who had specialised experience of working with people with complex mental health difficulties was recruited after the first meeting. The membership was therefore as follows:

Sarah Armour Disability Student Advisor Disability and Dyslexia Support Service	Lesley Humar Residential Support Officer Accommodation and Campus Services
Fiona Clifford Mental Health Advisor Disability and Dyslexia Support Service	Audrey Leadley International Student Services
Elaine Dean Head of Customer Support Western Bank Library	Dr Katherine Linehan Department of Biomedical Sciences
Steve Delaney Counsellor/ Skills for Life Coordinator University of Sheffield Counselling Service	Nora McClelland Department of Sociological Sciences
Dave Edwards Counsellor University of Sheffield Counselling Service	Alan Phillips Associate Director of Student Services Student Health and Well-Being
Dr Harriet Fletcher Consultant Psychiatrist Brunswick House Psychotherapy Service	Dr Brendan Stone School of English Literature, Language and Linguistics
Jenni Hastings Students' Union Welfare officer	Kate Tindle Head of Counselling University of Sheffield Counselling Service
Dr Barbara Jackson G.P. University Health Service	Dr Edward Warminski Department of Chemistry

Dr Michael Jennings Academic Unit of Medical Education	Hilary Whorral Careers Service University of Sheffield
Revd. Canon Will Lamb Anglican Chaplain to the University of Sheffield	

Those who joined the group agreed to attend the working group meetings that were spaced across the academic year, and to participate in data collection and analysis.

The working group contributed to discussions in the meetings arranged, and several participated further in aspects of the data collection, for example by facilitating focus groups, contributing to online surveys, or in-depth individual interviews, and through the project's discussion board set up on uSpace

The group met three times: 2 November 2009, 22 March 2010 and 12 July 2010. In these meetings several related topics were discussed:

2 November 2009: The group was asked 'In your experience, what is the frequency of 'events' involving this student group?'

22 March 2010: 'On the basis of the survey feedback, what needs and issues seem most pressing (for students and staff)?' What possible responses might there be?'

12 July 2010: The group discussed the data analysis results, recommendations from the staff and students surveys and focus groups, and how these might be used.

The group's many pertinent discussions which took place over the course of the project through three methods ; uSpace, face to face meetings and a questionnaire, are summarised by the project manager and included in the Results chapter.

4.6 uSpace

A 'uSpace' account was set up by Alan Phillips in November 2009, and was accessible to all members of the working group, plus the SMHLG. This was used to share relevant documents, related documents, minutes of meetings, and to start discussions. For example, the definition of 'students with complex mental health difficulties' proposed by the project manager was posted on uSpace and group members suggested amendments. There was also lively discussion around medical definitions of 'personality disorder' and responses to the project's survey results were posted. At a later point in the project, group members used uSpace to define and agree procedures and questions for focus group facilitators.

Through the above two channels: the working group and uSpace the following methods for data collection were developed and agreed:

4.7 Questionnaires

A series of questionnaires were devised by the project manager, using ideas from discussions in the working group, plus a tool developed elsewhere for helping staff working

with students who were considered 'hard to help' (see Hard to Help Checklist⁷, Appendix). These gathered both quantitative and qualitative data. Surveys were distributed using Survey Monkey, with access to this from emails delivered through the University's central email broadcast and messaging system 'Announce'. See appendix for copies of all questionnaires. Participants in all questionnaires were given the option of including contact details, and were also able to opt out of having their comments quoted verbatim in any reports.

Questionnaire for working group and SMHLG

This questionnaire was sent out to all 19 working group members and an additional 3 members of the SMHLG, by the methods described above. It asked about their experiences of supporting students with complex mental health difficulties, and for any recommendations for the provision of support for these students. Members of both staff groups were informed about the questionnaire at the inaugural meeting of the working group, were subsequently sent a link, and the survey was open to them to complete for one month, in November 2009.

Of the possible 22 people, a total of 16 responded to the survey. Results were initially summarised by the project manager for the working group and SMHLG, and subsequently through data analysis undertaken by CPSR.

Questionnaire to all students

This questionnaire was sent out to all students in November 2009, via an Announce email. The content of the email was given a considerable amount of thought because of the sensitive nature of the subject. It was important to target the right student group, without 'diagnosing' or provoking anxiety. The project manager sought and obtained permission to copy a series of questions developed by a previous project that recruited students via email to a therapeutic group in a university setting.⁸ The safety and well being of students also needed to be attended to in this email, and measures put in place to respond to any distress.

The questionnaire was open for 4 and a half days, and then closed by the project manager. During that time the answers were monitored on a daily basis by the project manager, and all comments were scanned to check for anything of concern. All respondents who indicated any suicidal ideation, and who had given their contact details were then contacted and offered sources of support (see Appendix). Likewise, any students responding to the 'complex@sheffield.ac.uk' mailbox were monitored and responded to / offered support as appropriate. As an additional security measure the project manager also enlisted 3 members of the working group who had counselling qualifications to be on stand by in case the project manager was unable to attend to these responses for any reason. The survey was closed after 4 and a half days because of the volume of responses, and the need to allow time for any respondents to be able to access sources of help through the University services (Counselling and GP practice) before the Christmas break.

⁷ Hard to Help Checklist, developed by University of Manchester and UMIST Counselling Service, 2000

⁸ PIE (Personality in Education) was a joint project between Manchester University Counselling Service, Metropolitan University Counselling Service and Therapeutic Communities Service North, 2005-6

Questionnaire to all staff

This questionnaire was identical to that sent out to the working group and SMHLG, and was sent out to all staff working at the University of Sheffield, by the methods described above, in February 2010, using the 'Announce' email facility. The survey was open for a week, and then closed by the project manager. Responses were noted by the project manager and summarised to the working group in March, but not analysed in any way before the involvement of CPSR in June 2010.

4.8 Focus groups

Focus groups were used as an alternative method of gathering qualitative data that could be correlated with other data. They offered a way of 'triangulating' the data; ie confirming or completing data gathered through other sources. They gave an opportunity for participants to be involved in face to face meetings, not just on line questionnaires, and could allow more 'narrative' of experiences to emerge, rather than repeat the questions already asked on surveys.

Student and staff participants were asked to volunteer for focus groups via the 'Announce' emails already described. Participants could respond directly to the project's mail box in reply to the email, or as a result of filling in the questionnaire. Initially it was hoped that students who were friends/ supporters of other students who had complex mental difficulties could also be recruited via the Students' Union and the Critical Support team, but time constraints meant that this was not possible.

Those that filled in questionnaires were asked if they would be willing to be contacted. Those that agreed to this were contacted by the project manager via personal emails (see appendix).

Three members of the working group agreed to facilitate the focus groups, and in conjunction with the project manager, agreed that Brendan Stone would lead focus groups for students, and Alan Phillips and Katherine Linehan would lead groups for academic/ other staff, allocating volunteers to groups where there would be least likelihood of boundary issues with facilitators. It was agreed that two student groups and two staff groups would be run if there were enough participants. Facilitators then met to draw up a list of guiding questions, plus information sheets for participants (see appendix). Two methods of recording data were chosen; audio tapes and note taking. Angela Marron, Learning and Teaching Support Assistant (Faculty of Science) took notes for these groups which along with the audio recordings were sent to the project manager

Staff focus groups

In total, thirty-one staff volunteered their services: 17 academic staff, four from the Student Services Department, and ten from a wide range of other departments and services. These staff were then contacted by one of the facilitators. Five academic staff attended the first group on 11 March 2010. Attendees were from the departments of English, East Asian Studies, Institute of Lifelong Learning, Molecular Biology and Biotechnology, and Dentistry. The second focus group ran on 25 March 2010, with six attendees from Students' Union, various staff from the Students Services teams, and U Sport.

Student focus groups

A total of 99 students were contacted by email from the questionnaire/ mail box sources (see appendix) and of these 16 offered to attend a group. Of this group of sixteen, four were able to attend the first group on 17 May 2010. The second focus group on 27 May 2010 only recruited one member, although more were expected. The student was still willing to be interviewed, so a semi-structured interview with the facilitator went ahead with audio recording but without a note taker. Care was taken to provide support if needed to the participants: the project manager, a qualified psychotherapist was available on the premises but did not participate in the focus groups themselves. The students in the first focus group spoke with the project manager after their meeting and expressed an interest in hearing about the outcomes of the project, and being involved in the future.

4.9 Clemson Intern project

In May 2010 the project was fortunate to be able to use a postgraduate intern, Melissa Noble, from Clemson University in the USA, for a period of four weeks. Melissa Noble met with Alan Phillips and the project manager and agreed the scope of her work. It was decided that eliciting some ideas from individual members of the working group would make good use both of her time, and of the expertise within the working group. Her full report is included in the appendix, and below is an extract from her report:

'During my internship, I interviewed members of the working group, 'Supporting Students with Complex Mental Health Difficulties.' To prepare, I reviewed available literature, meeting notes, and PowerPoint presentations. From this review, I identified three themes: collaboration, the role of academics, and transition. These themes helped me develop the interview questions:

- 1. How could the university utilize collaboration (a multi-disciplinary approach) to support students with complex mental health difficulties?*
- 2. What role do academics play in supporting students with complex mental health difficulties? What is the relationship between academics and student support services?*
- 3. How does the university support students with complex mental health difficulties during the transition process? Are there areas for improvement?*
- 4. Additional thoughts?*

I contacted each working group member via email (see Appendix). In the email, I attached a handout with the purpose, questions, and confidentiality statement (Appendix). I scheduled interviews with those members who responded.. In total, I interviewed 12 working group members (out of 21). 11 of the participants are student support staff and 1 participant is a faculty member. I met all participants at their respective offices on campus. Participants represented a variety of disciplines including disability service, counselling service, health centre, library, and career service. Each interview lasted approximately thirty minutes. I synthesized the feedback to present to counselling service and student support staff" (Noble, M., unpublished, 2010).

A summary of the findings are included in the Results chapter.

4.10 Involvement of research professionals in data analysis

In March 2010, it became apparent that the project had collected a larger than expected amount of informative data, the analysis of which would take a considerable amount of time. The project was fortunate to secure funding from the head of Student Services, which would pay for the data analysis to be undertaken in a comprehensive way. The project manager therefore commissioned the services of the Centre for Psychological Services Research (CPSR) at the University of Sheffield. Their work forms the bulk of the Results chapter of this report. This was undertaken by Dr Kim Dent Brown, Research Fellow, Anna Thake, Research Associate, and Vanessa Hayes, Psychological Wellbeing Practitioner, all from CPSR. The CPSR team analysed data from the questionnaires and focus groups, but not from working group discussions or the Clemson Intern's report.

4.11 Developing recommendations

The development of recommendations arising from the various forms of data gathered used a variety of processes, based on a 'grounded theory' approach to qualitative research. Data were collected and analysed throughout the project, allowing the guiding principles and recommendations to emerge from the data gathered;

'...grounded theories, because they are drawn from data, are likely to offer insight, enhance understanding, and provide a meaningful guide to action' (Strauss & Corbin, 1998 p12).

The project leaders analysed working group discussions, plus material gathered from questionnaires and focus groups, and semi structured interviews to develop 'categories' of responses. These categories or 'headings' were then checked against the whole data set to ensure relevance and inclusion. Subjectivity was minimised by seeking multiple viewpoints, for example from working group members, consultation with the SMHSLG, and using the expertise of the CPSR researcher to 'triangulate'. Data were then reviewed again in the context of the categories developed. The major categories were then integrated to form one overarching guiding principle that informed and structured the project's recommendations. Finally, the literature review was used to confirm the findings and recommendations, as well as allowing the project leaders to note any additional findings not covered in previous literature.

5 Results

5.1 Report from Centre for Psychological Services Research (CPSR)

This chapter consists of the report provided by Dr Kim Dent Brown from the Centre for Psychological Services Research (CPSR) at the University of Sheffield, who analysed data from the questionnaires and focus groups with his colleagues Anna Thake, Research Associate, and Vanessa Hayes, Psychological Wellbeing Practitioner, both from CPSR.

CPSR Report

Introduction

This document is a report to the complex needs steering group of the results of the data gathering exercise. It is not a complete account of the process undertaken to gather information via the questionnaires and focus groups, a process which is well known to the steering group. Nor does it make recommendations, which is rather a task for the steering group itself, based on the results reported here.

1.1 Aims of study

The aims of the study were to:

1. Give a clear definition of what is meant by 'complex mental health/ psychological difficulties' and which students may fall within this category.
2. Give an overview, both quantitatively and qualitatively, of the current situation with regard to this group of students at the University of Sheffield.
3. Summarise the impact that this has on the University community.
4. Review the provision of support for this student group, both internally and externally.
5. Summarise current recommendations (where available) for psychological support for this student group.
6. Identify the strengths and weaknesses of the current support system.
7. Make proposals for remedying any weaknesses and for further developing the system.
8. Through the implementation of the project, and through dissemination of its findings, enhance the University community's understanding and capacity to support these students.

1.2 Data available

The data gathered to fulfil these aims included:

- Questionnaire responses from 228 students
- A focus group discussion and a 1:1 interview with students recruited via the questionnaire
- Questionnaire responses from 139 members of staff
- Two focus group discussions with members of staff

The fact that such large numbers of students and staff responded to a single email invitation within a very short time frame (questionnaires were open for one week) is itself an interesting and potentially significant piece of data.

Executive summary

Features of respondent sample

- Student respondents to the questionnaire seem to be representative of the University at large as far as age and length of time at Sheffield. Women outnumbered men by 2:1. There seemed to be most respondents from Social Sciences and fewest from Engineering. (pp28-30)
- Staff respondents came from all academic Faculties and a range of professional services Departments. 80% said they had had a role in supporting students with 'complex needs' though the range of contacts they each had was very wide, from none to hundreds of contacts a year (pp 30-32.) Staff felt these problems were becoming more frequent (p 33).

Problems described

- Depression and anxiety were the problems most frequently mentioned by both staff and students (pp 33-34). Staff were more likely than students to highlight problems such as psychosis, bipolar disorder and self harm/suicide attempts. Students on the other hand were more likely to prioritise low self esteem/confidence, low motivation/concentration and relationship problems. The difference may be partly because students may sometimes "*appear to be highly functioning but very distressed behind closed doors.*" (p 36.)
- Staff respondents to the questionnaires were more likely than students to describe acute responses to immediate life stresses, or examples of formal mental illness. (p 37). The most frequent categories of distress experienced by students almost never occurred in isolation but as part of a constellation of problems, often mutually reinforcing. A range of more detailed descriptions of student experience is provided (pp 37-41). The kind of experiences described would be consistent with seeing 'complex psychological problems' as long term, relatively stable features of personality rather than acute 'mental illnesses' (pp 41-42).
- Both staff and students recognised the effects of these problems on the wider University community, with staff being perhaps more aware of this (pp 42-43.) Students were particularly aware of the feedback between academic pressure (particularly deadlines), resulting stress, maladaptive coping and subsequent decline in academic performance (pp 43-44).

- Some problems, while complicated, distressing and even overwhelming, did not fit a pattern of long term personality difficulties. They were better explained by acute stresses such as financial difficulties, caring for others, physical illness, stressful life situations, bereavements or dealing with transition. A small number of students may have had an undiagnosed or untreated mental illness such as bipolar disorder (p45.)

Effects on staff

- Staff members reported a range of effects, including having to deal with high levels of emotional stress, feeling unsupported or under-resourced and trying (not always successfully) to be clear about boundaries and roles (pp 45-47.)

Experiences of the current support system

- Students reported most frequently using family, friends and other (non-University) support for their problems (p 47). When discussing University sources of support, students mentioned issues to do with waiting times and accessibility of services; quality, quantity and relevance of care; continuity of care and information sharing; reactions of academic departments and systems; and visibility of services (pp 48-51).

Gaps in present services, ideas for the future

- Students and staff had a wide range of suggestions (pp 51-57), covering topics such as:
 - Duration and accessibility of support
 - Including more counselling/GP resource, shorter waits, quicker access, longer opening times, possibility for longer term work
 - 'Joined up' working
 - While respecting confidentiality, finding ways to co-ordinate services better and communicate more readily between services
 - Specific ideas for new services/different ways of working
 - Groups, a drop-in service, a 'safe place' to go, using text/email/web resources, wider range of counselling/psychotherapy
 - Having a central consultation and/or co-ordination point
 - To permit staff and students to have a single point of access to information, advice and signposting between services
 - Availability of groups
 - Peer self-help groups, student drink/drugs groups, domestic violence/abuse support, therapeutic group/community
 - More explicit, consistent policies and procedures
 - Clearer guidelines and procedures to standardise responses across departments and prevent the need to make policy 'on the hoof'.
 - Better support/understanding from academic departments
 - Support for particular groups
 - Mature students, overseas students, part-timers, postgraduates...
 - Availability of information
 - Use of the term 'Disability' in service titles
 - Assertive/early intervention

- Training needs
- Selection/admission policies

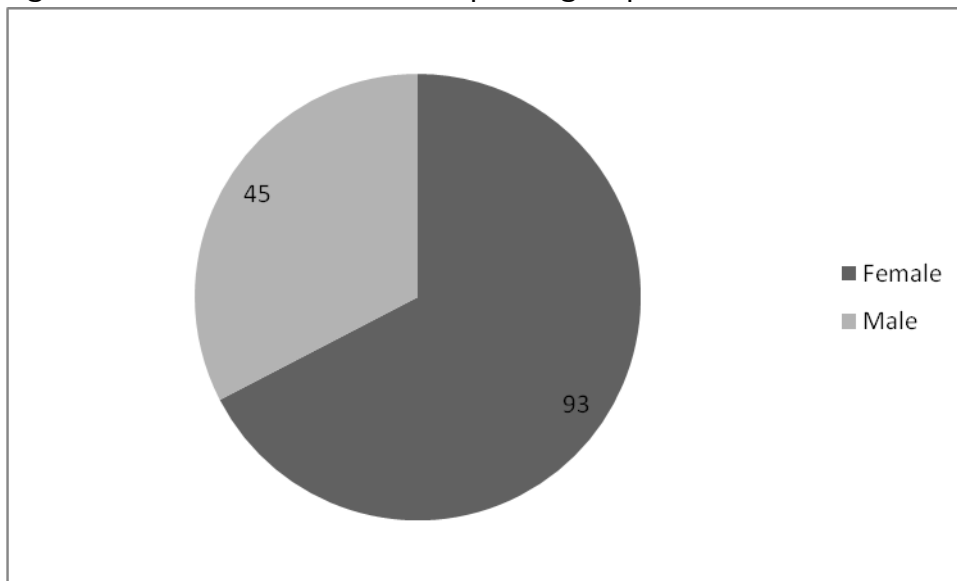
Results

3.1 Demographic summary of student questionnaires (n=228)

Gender of respondents

Women outnumbered men among those who reported their gender by almost exactly 2:1. This ratio is frequently encountered in epidemiological studies of people seeking help for mental health problems in settings such as GP surgeries, community mental health teams and counselling/psychotherapy services.

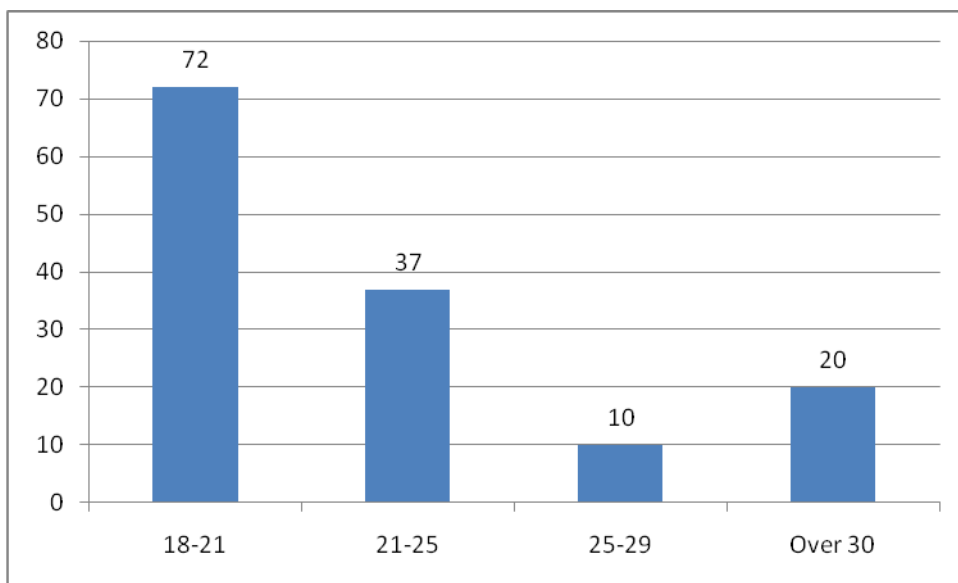
Figure 1: Gender mix of students responding to questionnaire



Age of respondents

The categories for this question and the next (time spent in Sheffield) were as given on the questionnaire and there is some overlap which may have confused respondents. The spread of ages seems to be broadly representative of the total student population, although there may be slightly more older students among the respondents to the questionnaire. 48% of respondents reported being in the higher three age categories, against 52% in the 18-21 bracket. This could be checked more accurately against the known total student age distribution.

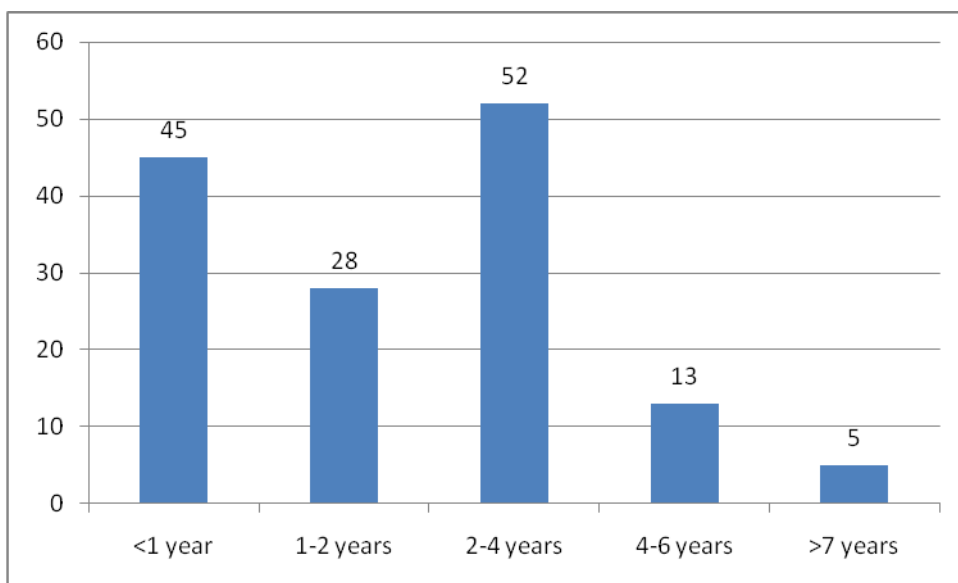
Figure 2: Age of students responding to questionnaire



Length of time at Sheffield

Student respondents reported the following range of time spent at Sheffield. A reasonable range appears to have been collected.

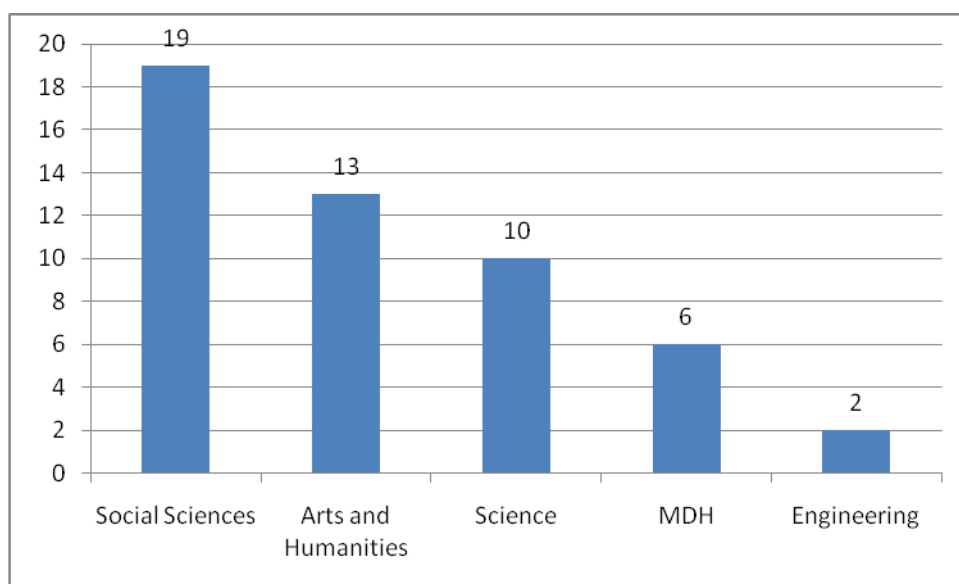
Figure 3: Length of time spent at Sheffield for students responding to questionnaire



Department and Faculty

Only 50 students (22% of respondents) reported their department. As many departments had only one or two respondents, this has not been reported in detail to maintain confidentiality. Altogether 27 different departments were named at least once, with the department with the largest number having five respondents. Grouping responses by Faculty gives the breakdown illustrated in Figure 4. While this does not appear to be representative of the numbers in Faculties as a whole, with no data from 78% of respondents it is hard to rely on the picture this gives.

Figure 4: Faculty of students responding to questionnaire



3.2 Demographic summary of staff questionnaires (n=139)

139 members of staff completed the questionnaire, of whom 50 gave some indication of their job. Those types of posts with two or more people responding included:

Table 1: Posts occupied by responding staff

Teacher, Lecturer, Senior Lecturer, Reader	21
Professor	4
Counsellor	3
GP	2
Senior Residential Mentor	2

The remaining 18 individuals' jobs are not reported here because some posts are recognisably only filled by one person! Of those 18, seven had posts directly involved in supporting or advising students in areas such as careers, disability, mental health or welfare.

The remaining 11 had posts which would not automatically imply such responsibilities, such as research assistant, exams assistant or IT technician.

Forty-six staff identified their department, and the breakdown of these (academic staff grouped by Faculty) was as follows:

Table 2: Faculty/department of responding staff

Faculties	
Arts & Humanities	8
Engineering	3
MDH	4
Science	4
Social Sciences	5
Professional services departments	
Accommodation and Campus Services	2
Careers Service	1
CICS	1
Counselling service	3
DDSS	2
ELTC	1
Library	3
Student Services	4
Students' Union	2
UHS	2
U Sport	1

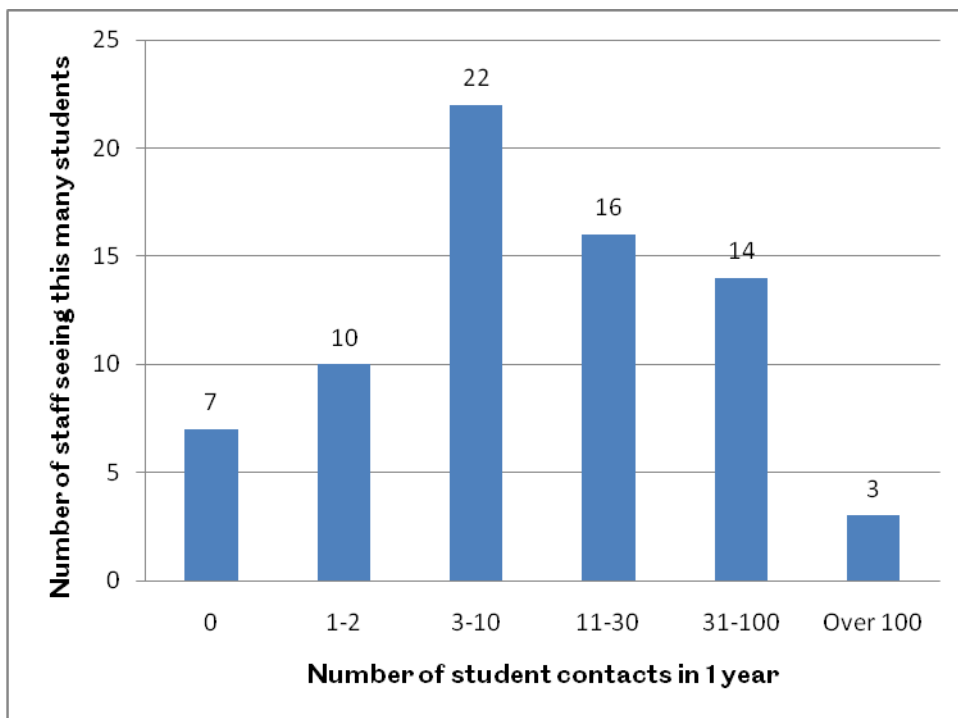
Fifty three per cent of staff who responded said that student support was a formal part of their job description. Of that 53%, most did not have a specified number of hours allocated to this, but did so on an 'as and when' basis. A small number had this role full time.

Eighty per cent of staff said that they had at some point been in the role of supporting a student or students with 'complex mental health problems' as described in the questionnaires such as those described in the survey.

Numbers of students reported by staff

Staff members varied greatly in how many students they saw who might meet the definition of 'complex needs'. Staff were asked to estimate how many contacts they had had with such students they had seen in the past week, month and year. Summarising the responses, the overall picture looks like this:

Figure 5: Numbers of contacts per year

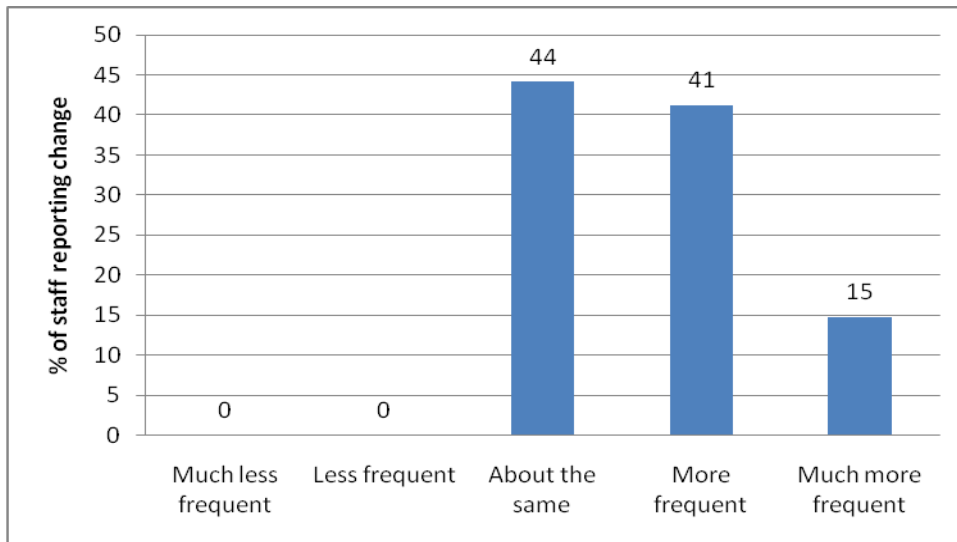


Among the 72 staff members who estimated the number, the mean number of contacts per year was 21, but the range was very large as can be seen. The three staff estimating over 100 contacts a year were a Disability Advisor, a GP and a member of academic staff.

Only a small number of staff (23) made an estimate of the number of hours spent annually with this client group, with a very wide range (2-700 hours). No attempt has been made to generalise from this estimate.

Staff members had worked in the University for a wide range of times, from less than 1 year to over 20 years. They were asked about changes in the numbers of students presenting over that time. 68 staff members responded and the pattern of responses was as follows. No staff thought the problems were becoming less frequent, and 56% (38/68) thought they were becoming more frequent.

Figure 6: Change in frequency over time



Staff were given seven possible issues that students might report, and asked how often (from 'never' to 'very often') they saw students with these problems.

3.3 Nature of problems experienced by students

Formal diagnosis

Only 60 students (26% of respondents) reported having a formal diagnosis, of whom 49 (82%) mentioned depression as the first diagnosis. All diagnoses mentioned (total exceeds 60 because of multiple responses) included:

Table 3: Formal diagnoses mentioned

DIAGNOSIS	NUMBER MENTIONING
Depression	54
Anxiety (including social anxiety)	15
Eating disorders	7
Anorexia	3
Bulimia	2
Not specified	2
Personality Disorder	5
Borderline Personality Disorder	3
Depressive Personality Disorder	1
Not specified	1
PTSD	4
Bipolar Disorder	3
Obsessive Compulsive Disorder	2
Stockholm Syndrome	1

The quantitative, diagnostic responses of Table 3 make the students look like a predominantly depressed group: of the 60 who mentioned a diagnosis, only six did NOT use the term depression somewhere. However the qualitative responses to the question: “Could you give a brief description of the sort of problems you have to deal with in your everyday life” give a more nuanced and diverse picture. Looking at the responses to this question along with the interview data, very few respondents described problems occurring in isolation, reporting instead complex patterns of cause and effect, often self-reinforcing in a negative spiral.

Of the 228 students, 195 gave fuller details of the problems they encountered, sometimes in diagnostic terms but often going beyond this. The kinds of difficulties most often reported (by more than ten respondents in each case) included the following:

Table 4: Problems experienced

RANK	PROBLEM AREA	NUMBER REPORTING
1	Depression/low mood	72 (37%)
2	Stress/anxiety/worry	61 (31%)
3	Poor motivation/concentration	37 (19%)
=4	Social isolation/anxiety/loneliness	36 (18%)
=4	Eating disorder/weight/appetite	36 (18%)
6	Low self esteem/confidence/self loathing	30 (15%)
7	Sleep disturbance	24(12%)
8	Difficulties making/keeping relationships	19 (10%)
=9	Anger, irritability	18 (9%)
=9	Suicidal thoughts	18 (9%)
11	Self-harm/suicide attempts	17 (9%)
12	Alcohol/drugs	15 (8%)
13	Paranoid/mistrustful	12 (6%)

Staff members were also asked to make a free text description of the kinds of presenting problems they encountered. Sixty four staff members wrote such a description, and the most frequently reported problems were:

Table 5: Problems as described by staff

RANK	PROBLEM AREA	NUMBER REPORTING
1	Depression/low mood	28 (44%)
2	Stress/anxiety/worry	18 (28%)
=3	Suicidal thoughts	12 (19%)
=3	Self-harm/suicide attempts	12 (19%)
5	Psychosis	10 (16%)
=6	Social isolation	8 (13%)
=6	Manic/bipolar	8 (13%)
=8	Anger	6 (9%)
=8	Rituals/OCD	6 (9%)
=10	Eating disorder/weight/appetite	5 (8%)
=10	Paranoid/mistrustful	5 (8%)
=10	Ignore deadlines	5 (8%)
=13	BPD	4 (6%)
=13	Homesickness/ managing change	4 (6%)

Both staff and students rated low mood/depression and stress/anxiety as the most frequent problems; to this extent the two groups agreed. Moving away from these two areas there were some interesting differences between staff and students. The simplest way to see these is to compare the ranks assigned by both group. For example, staff and students both ranked low mood/depression as 1st and stress/anxiety as 2nd. However while students ranked poor motivation/concentration as 3rd, for staff members the 3rd place was given to suicidal thoughts. A further table compares the rankings given by staff and students:

Table 6: Differences in staff and student ranking of problems

	Staff rank	Students rank	Difference	Relative salience		
Psychosis	5	17	12	More salient for staff	Equal salience	More salient for students
Manic/bipolar	6	15	9			
Self-harm/suicide attempts	3	11	8			
Rituals/OCD	8	15	7			
Suicidal thoughts	3	9	6			
Ignore deadlines	10	14	4			
Paranoid/mistrustful	10	13	3			
Anger	8	9	1			
Depression/low mood	1	1	0			
Stress/anxiety/worry	2	2	0			
Alcohol/drugs	13	12	-1			
Social isolation	6	4	-2			
Eating disorder/weight/appetite	10	4	-6			
Sleep	13	7	-6			
Relationship problems	16	8	-8			
Low motivation/concentration	13	3	-10			
Low self esteem/confidence	16	6	-10			

Staff were more likely than students to highlight problems such as psychosis, bipolar disorder and self harm/suicide attempts as being a significant part of the presentation of complex psychological problems. This may be because the problems are more external, visible and demanding of attention. Students on the other hand were more likely to prioritise low self esteem/confidence, low motivation/concentration and relationship problems; difficulties which are perhaps more internalised and less immediately obvious to others.

The distinction in staff and student evaluations of the problem is interesting. It is perhaps explained if we consider that several student respondents commented on how they tried very hard to *“appear to be highly functioning but very distressed behind closed doors.”* Others said how it *“can be hard to explain to tutors that you have mental health difficulties”*. One student in the focus group said *“I think that’s almost been one of the hardest things, is that, kind of, apart from when I burst into tears, you know, I appear, pretty normal, I’m very good at putting on a front actually, and I, I’ve almost wished to have a breakdown, or, at one point, it was really stupid, but I considered like stopping eating, and then I would get really*

thin, and then people would see that there was something wrong with me” A good deal of these problems for students then seem to be withheld from staff, and might only be noticed if the withdrawal is very extreme, as in the case of the staff member who described a PhD student: *“She “disappeared” (ie we did not know where she was, if she was ok, she failed to respond to emails or answer the telephone) for several days. Eventually called the critical support line.”*

Staff respondents to the questionnaires were more likely than students to describe acute responses to immediate life stresses, or examples of formal mental illness:

- *Student was suffering a breakdown and was psychotic and posed a danger to herself and staff. I took her to the medical centre and eventually to the Northern General A&E*
- *Psychotic student: suicide attempt, sectioning, three escapes from hospital, major security issues for self, research group and Department, case conferences*
- *trying to arrange support for someone thought to be in a hypomanic state, who has been very paranoid and speaking in a way that has been uncomfortable for peers, tutors and family*

While a smaller proportion of staff respondents did describe interlocking problems of the sort more often described by students:

- *I'm not quite sure if the kind of student I'm thinking of totally fits the bill - bipolar, depressive, OCD, general anxiety, self harming (sometimes in combinations). They don't necessarily distress other students very much, but their presence in a group can have serious implications for teaching.*
- *extreme distress, crying, disorganised thoughts, inability to do coursework, anxiety, bereavement, supervisor problems, depression, borderline personality disorder*

Understandably, those students who present with a much more active, public problem (disruptive or threatening to others, for example) seem to be more readily picked up and remembered by staff, although these students, their problems and those they cause to others may not be typical of the group of student respondents as a whole.

3.3.1 The student experience of 'complex problems'

The most frequent categories of distress experienced by students, summarised in Table 4, almost never occurred in isolation but as part of a constellation of problems, often mutually reinforcing. Some examples of each of the categories will serve to illustrate this, along with providing a better picture of what is meant by each category. Italicised text indicates extracts from students' responses.

Depression/low mood

- *Distress and periods of depression, which make work and socialisation difficult. Moreover, "obsessive" focus on PhD research work led to loss of quality of private life and work.*
- *I suffer from severe depression and have done so for about 4 years. In my everyday life I try to avoid situations in which I may have to talk to other people as I have such low self-*

esteem. When I see a person or group of people laughing I assume they are laughing at me. I frequently have suicidal thoughts and consider myself a burden to society.

- *Eating issues, depression, feeling overwhelmed, constantly being smiley and fabulous on the outside and a mess on the inside.*
- *Complete conflict between home life and uni life. i.e live 2 separate lives. Severe paranoia. Keeping my relationship a secret. Stress, depression, guilt. Problems eating but NOT an eating disorder. Problems sleeping etc*
- *Chronic low mood which affects my concentration. Poor sleep quality. Irritability and intolerance towards others.*

For most of the above it is impossible to say whether they would meet diagnostic criteria for depression, but even if they did this would arguably be a *reductio ad absurdum* of the interlocking complexity of the problems with which they are struggling. It will be noticed that all the above quotes include elements from the other 12 frequently reported categories outlined above.

Stress/anxiety/worry

- *Just feeling lonely quite often, and really stressed whenever I get work, and unsure that I can do it.... Moments of not really having a clue why I'm here or where I'm going with my life, it just all seems so pointless sometimes. Can't sleep well at night at all, my brain won't shut off, and I admit that I do have a poor self image and eat poorly (yet stay the same). I get frustrated because I don't do anything about all these things, but then I feel that I can't- seems like I can't even do little things that everyone else can, like cooking or socialising properly.*
- *I have a diagnosis of Borderline Personality disorder and I suffer with OCD. I find it really difficult to mix with the other students and often feel isolated and anxious.*
- *High level of anxiety and stress, insomnia, some feelings of numbness/emptiness, a sense of things going out of control*
- *I have problems with anxiety most of the time but to different degrees; some days when I'm under a lot of pressure I am unable to leave the house or talk to other people and find day to day activities such as getting the bus or paying in shops very difficult. Most of the time though I function OK day to day. Most of the pressure comes from exams or assessments, but sometimes when my anxiety is very bad I have problems with attendance.*
- *Generic self esteem issues, problems dealing with stress and anger, uncomfortable in most social situations; strong anxiety about talking to people and how they might perceive me. Feeling that I'm constantly wasting my potential and my time*

Motivation down/concentration

- *Problems with eating. Reluctant to trust anyone, even those closest to me Low self-esteem Suicidal thoughts Difficulty in meeting deadlines and concentrating on work because of these things*
- *I suffer from depression, which badly affects my concentration and motivation. I find it very difficult to get out of bed in the morning, and my work and university experience both suffer.*

- *Lack of motivation, not eating, irregular sleep patterns*
- *I have problems with depression, directly impacting on motivation and self-esteem. I struggle to keep up with my work and have to force myself to come in to University some days. My attendance has suffered severely of late.*

Social isolation/anxiety/loneliness

- *Suffer from some degree of social anxiety. Have problems eating and maintaining any sort of proper routine on food, though I do not suffer from an eating disorder.*
- *Social isolation, emotional distress by being in crowded places. Appear to be highly functioning but very distressed behind closed doors.*
- *Mood swings, emptiness, loneliness, severe bouts of anger, strange dreams*
- *Anxiety, depression, avoiding people, avoiding eating, isolation,...*

Eating disorder/weight/appetite

- *I get upset about things easily and make bad decisions, which leads me to stop eating in order to feel back in control. I feel like I can't get out of this rut - I have been trying to pull myself up but I can't.*
- *Depression, eating disorder. Anorexia with aspects of Bulimia which often causes insomnia, inability to cook, feeling faint, obsessive gym use, lack of concentration, feeling I am failing after small mishaps, panic attacks, unable to work.*
- *I'm an international student so I live apart from my family and friends. It's difficult for me to engage in Uni life as I have very low self esteem. I suffer from bulimia/binge eating.*

Low self esteem/confidence/self loathing

- *I've been through self-harm, stress it tends to be an everyday occurrence and low self-esteem*
- *I don't have low self esteem, I have low worth. I don't crave proper relationships, I always go for inappropriate guys (married, too much older etc) because I don't think I deserve a proper relationship and a happy ending. I eat enough for it not to be dangerous, and I've now stopped cutting types of food out of my diet, but it fills my head and my weight effects how I feel for the day.*
- *I have made very few close friends, which frustrates me, and throws up all kinds of self-confidence issues. And so, I just turn to drink and drugs to make myself feel better about the life I have. I can be anxious, irritable, short-tempered, have trouble sleeping when I go without and this frustrates me even more (because I don't feel myself).*
- *Constant anxious thoughts about my binge eating. Self-loathing associated with this, sometimes extreme and leading to harming myself (or the desire). Swinging between feeling like I exist and don't want to.*

Sleep disturbance

- *Sometimes I am unable to attend university because I can't get out of bed due to depression. People may think "pull yourself together", and I would have once thought that, but when you can sleep for 20 hours a day, every day there has to be something*

wrong. I can't always interact with people properly and get frustrated and angry very easily.

- Confidence issues, low self esteem, can't sleep, can't concentrate, feelings of hopelessness, anxiety, suicidal thought.
- I feel like I am dealing with crises a lot of the time and when I am not, I still manage to find things that are very wrong with my life. As a result, I feel like I spend a lot of my life feeling inadequate and depressed. Sometimes it can spiral, especially when I try to sleep and I find it difficult to sleep.

Difficulties with relationships

- I have relationship issues and cannot stop cheating on my long term boyfriend. I have issues with telling the truth. I also feel empty and suicidal a lot of the time like I'm worthless and people would be better if I was out of their lives.
- I am drawn to relationships that are likely to fail or that hurt me in some way. I have masochistic tendencies (see above) and I have always found it difficult to regulate these problems - for about 75% of the time I am able to deal with them relatively effectively, but when I am feeling unstable I rarely resort to asking others for help
- I feel incredibly low at times, and have difficulties because I feel paranoid about the friendships I have with people. I feel incapable of a relationship. I often cannot deal with stress etc, and end up taking these problems out on myself sometimes through harming myself or through alcohol.

Anger, irritability

- Depression, anger, feelings of acute isolation, failure, inadequacy, feelings of persecution and that I am being punished for something, dislike of company and yet loneliness at the same time, poor relationships, previous drug and alcohol abuse now ceased.
- High stress levels, angry outbursts, feeling constantly under pressure, and untrusting of friends and partner
- I get frustrated and angry and turn (thankfully only verbally) on my partner and make both our lives miserable and, I believe, it's a form of domestic abuse that I hand out - which I find horrifying once I calm down.
- Chronic low mood which affects my concentration. Poor sleep quality. Irritability and intolerance towards others.

Suicidal thoughts

- Have thoughts of self harm and suicide on a daily basis. Very impulsive when it comes to spending money to try and control my eating.
- Suicidal thoughts/attempt, poor concentration, decision making, interaction, confidence etc
- I am often depressed and feel lonely. I cut myself and do contemplate suicide, but I don't have anyone to talk to. I also have eating problems and do drink to deal with issues.

Self-harm

- *I find it hard to deal with change, issues and pressure from university and outside sources, leading me to take part in destructive activities such as cutting myself instead of progressing constructively. It is also impacting on my relationship with my boyfriend who I live with.*
- *I feel like my life is one long series of crises, where things jump from one problem to the next instead of one success to the next. I have difficulty in romantic relationships where I often feel not good enough or only good enough for one thing. Occasional problems with self-harm and binge-drinking to relieve these feelings.*
- *I have bulimia and also have self-harmed, sometimes struggle with going outside and being able concentrate*

Alcohol/drug use

- *I haven't gone a day without alcohol or drugs since I came back after Summer, I'm never happy anymore unless I have something and I need more and more everytime.*
- *Money, juggling finances, paranoia, mistrust, drug use*
- *I can be lazy irritable easily distracted. I used to hide from my problem in drugs but this lead to years of depression and I seem to have replaced the drugs with drink and don't seem to know when to stop*

Paranoid/mistrustful

- *I sometimes find it very hard to connect or talk to people. When I do, I'm constantly paranoid about them and I never truly believe that they like me or want me around, but that they just tolerate my presence because they have to. When I'm not around them, I'm scared they don't think about me and don't involve me in their personal lives.*
- *I have a hard time trusting or getting to know other people. My flatmates don't really ever talk to me and my close friends have a lot of work so I don't often see them. As a consequence I spend a lot of time feeling very lonely and very insecure.*
- *I've been through a lot of things during childhood... and have always seemed to find myself having to prove the world wrong. I find it hard to rely on people and trust them enough. Although I am sociable and always smiling, I feel like I have a burden inside.*

Overall, the interlocking problems as described by the respondents are reminiscent for an NHS mental health practitioner of the broad heading of personality disorders. This is a problematic and stigmatising term in itself, but seems to describe a set of enduring, complex, severe and self-reinforcing difficulties such as those that have been described. The definition of personality disorders from the Diagnostic and Statistical Manual, 4th edition (DSM-IV) published by the American Psychiatric Association describes personality disorders in the following way:

DSM-IV Definition of Personality Disorders:

1. characteristic and enduring patterns of inner experience and behaviour as a whole which deviate markedly from the culturally expected and accepted range (or "norm"). Such deviation must be manifest in more than one of the following areas:
 - a. cognition (i.e., ways of perceiving and interpreting things, people, and events; forming attitudes and images of self and others);
 - b. affectivity (range, intensity, and appropriateness of emotional arousal and response);
 - c. control over impulses and gratification of needs;
 - d. manner of relating to others and of handling interpersonal situations.
2. The deviation must manifest itself pervasively as behaviour that is inflexible, maladaptive, or otherwise dysfunctional across a broad range of personal and social situations
3. There is personal distress, or adverse impact on the social environment, or both, clearly attributable to the behaviour referred to in criterion 2.
4. There must be evidence that the deviation is stable and of long duration, having its onset in late childhood or adolescence.

The four areas of criterion 1 are clearly present in the accounts of many of the survey respondents. This is not to say that the respondents to the survey would necessarily meet formal research or clinical criteria for personality disorder. But it is possible that it may be more helpful to see these complex psychological problems as relatively enduring personality traits rather than as discrete, acute mental health problems. Certainly, the accounts outlined above cover cognitions, affect (emotions), impulse control and relationships. The problems occur across a range of settings, cause considerable distress and there is evidence that they have been of long duration.

3.3.2 Effects on wider community

Most student respondents understandably concentrated on their own experience, rather than how their problems affect those around them. A few respondents did describe their awareness of this however (some extracts repeated from those given above):

- *These cyclic periods of my life tend to occur when I am overwhelmed by a workload of some form. I have noticed this recently and can affect those immediately around me rather negatively (an emotional drain more than anything). I feel distant and lose control of my feelings.*
- *Easily offended by certain things; random rage but no one in particular involved; extreme stress with a lot of things, a little hypochondriac.*
- *I have relationship issues and cannot stop cheating on my long term boyfriend. I have issues with telling the truth*
- *Have issues with anger also which make daily life quite hard. If I have a problem, say with a friend I exaggerate it in my head. I often find myself telling lies and not knowing why.*

- *I get frustrated and angry and turn (thankfully only verbally) on my partner and make both our lives miserable and, I believe, it's a form of domestic abuse that I hand out - which I find horrifying once I calm down.*

A greater proportion of staff respondents described the wider effect on other members of the University community (including themselves):

- *Behaving in a threatening manner towards members of teaching staff.*
- *Students being aggressive or withdrawn in a public area.*
- *Students affected by living with suicidal housemate suffering from long-term mental health issues*
- *Discussion with student and teaching staff over academic and other communications; student also had terrible relations with classmates which generated a fair amount of correspondence. And because staff/other students concerned over this student's behaviour, saw frequent requests for reassurance, further information on action being taken*
- *Aggression and anger issues that did not appear to connect with the student's conscious awareness of what was happening.*
- *Most of the support we provide is to the flatmates of students suffering from mental health difficulties. The impact that a student with mental health difficulties can affect flatmates, especially in cases of attempted suicide. Often the students without the difficulties want to talk about it and need support.*

3.3.3 Relationship with academic performance

Many student respondents reported that the demands of academic work affected their problems adversely. Approaching deadlines in particular were a problem for some people:

- *Occasional periods of what seems to be manic depression, anxiety, unable to sleep at night. Usually around deadlines or if there is some kind of academic trouble. I can go 6 months and be absolutely fine and then have a week of being unable to sleep at night. I also tend to get stressed quite easily and resort to drink.*
- *"obsessive" focus on PhD research work led to loss of quality of private life and work.*
- *My PhD is a nightmare. My supervision is somewhat hostile and I don't like the project I'm doing. It has been moulded into something very far from what I wanted to do and I lost my supervisor in the great cull this past summer.... This makes it impossible for me to do the work the degree requires and that's a real problem. I dislike living in the city and being pretty much destitute but I'm stuck here and that really gets me down.*
- *These cyclic periods of my life tend to occur when I am overwhelmed by a workload of some form.... I feel distant and lose control of my feelings - 'that it's too much for me to deal with', 'I just can't do this', moving onto, 'Why can't I do this, am I no good at working anymore' etc., a spiral of feelings stemming from an overwhelming set of tasks. I feel down, depressed, and when I tend to ignore the problem of the tasks, thinking 'I'm in control if I deny doing the work, rather than not being able to' it deludes me for a short time that everything is ok.*

Equally, student respondents frequently commented on how their problems of low mood and motivation, poor self-confidence and anxiety impacted on their academic work:

- *Problems with eating Reluctant to trust anyone, even those closest to me Low self-esteem Suicidal thoughts Difficulty in meeting deadlines and concentrating on work because of these things*
- *Depression and anxiety - manifests as avoidance of deadlines, difficulty engaging with work (esp written)*
- *Because of my concerns about my ability to do my work, I often miss days which makes the problem worse*
- *I struggle to get out of bed because I don't want to get up and face the world. Everything's a struggle. I feel so detached from everything and my life is consumed by constant rituals. I really have to push myself to turn up to lectures and to study, but most of the time can't do it.*
- *Sometimes I skip lectures or seminars. Sometimes it's because I don't want to face the world. I think it can be hard to explain to tutors that you have mental health difficulties*

3.3.4 Other patterns of 'complex psychological problems'

Not all student respondents would fit the model of personality problems outlined above. Some people clearly described discrete, recent life events or particular current circumstances which were causing immediate acute distress, rather than being part of a long-standing pattern of relating. Examples of such accounts include:

Financial problems

- *The most recurring problem(s) I seem to encounter is stress and depression, and this is largely due to money issues and debt. I have been struggling to cope with university in the first term due to financial problems - partly due to my fault but also because I receive little or no financial help from my parents.*

Caring for others

- *I study part-time, work part-time and have to care for my elderly mother and my partners father! But the GP just tells me it's what happens in your 40's and to get a notebook or diary and just timetable everything!*
- *My dad got into tonnes of debt recently without telling us and we have recently found out and are having to pick up the pieces..... He makes us all feel guilty even though we have tried our best to try and help him but it's so frustrating because he rejects all this help and behaves like a child and wants us.... to take a parental role, and it's not right and it's not something we want to do. On top of that, my mom has had bipolar disorder for about 17 years and it has gradually worsened over the years. It can at times be extremely difficult to deal with especially when she is depressed and has not gotten out of bed or out of the house for months on end.*

Physical illness

- *I began to get ill in 2008..... My symptoms are indicative of a rheumatological disease/illness, but even now I do not have a final diagnosis, despite persistent symptoms. As a result, I had to take a prolonged leave of absence and am now repeating my final year of my degree. I have increasingly struggled with the effects on my psychological health, as well as physical.*
- *Have a mixture of physical / mental health issues which began in my 3rd year when I was hospitalised. Took leave of absence then slipped through the system – no-one knew what to do re student loans etc*

Acutely stressful life situations

- *Medical student; heavy work load, often dealing with very ill/dying patients. Final exams in 2 months.*
- *My fiancée lives abroad and was supposed to join me in Sheffield at the start of my studies here. Every day is a new delay and I'm getting pressured ...This pressure isn't helping me focus on my studies.*

Bereavements

- *Over the last six months I have been dealing with a series of deeply concerning events and bereavements... my granddad died naturally, a close friend was diagnosed with throat cancer, and another friend died suddenly and unexpectedly on a football pitch.*

Dealing with transition to University life

- *I'm stressed as work pressure piles on this year, coupled with homesickness and being really lonely for the first time in ages.*

While a few student respondents did seem to be describing a discrete mental health problem which has not been formally diagnosed (a possible bipolar disorder in this case):

- *I seem to have a cyclical series of ups and downs throughout life. When I'm up it lasts for about 4-6 weeks and I feel invincible then it usually take an event in my life and it swings the other way for about 4-6 weeks, I feel low and completely unproductive. Not nearly as bad as the depression I had at 16-17 (never saw a mental health professional as I didn't realise I had it until after it had passed). Curious to get to speak to somebody about this but not really a destructive influence on my life, just an annoyance I want to investigate.*

Impact on staff members

Members of staff were asked a number of questions about the impact on them of supporting students with complex needs. Most of these negative impacts were not experienced frequently by staff, the most common being:

“Are you left feeling uncertain about your role?” (43% said ‘often’ or ‘very often’)

“Are you left feeling that s/he is hard to reach?” (35% said ‘often’ or ‘very often’)

Staff members made some free text comments about the experience of working with complex problems, which included:

Experiencing stress

- *Supporting this student group can be very time consuming and can create strong feelings of not being in control of the situation. (Student Services)*
- *It was/is upsetting, traumatic and awful.*
- *they are the group you worry about when you get home - their apparent vulnerability can sometimes be quite difficult to deal with (UHS)*
- *The emotionally-laden forms of communication, particular one student who texted me and phoned despite repeatedly being told not to, was very disconcerting and made me angry. Being angry was not the best place for me to continue offering what might be described as pastoral support. (Academic staff)*
- *these students can be very emotionally draining and can cause conflicting emotions -on the one hand I can feel that I really want to help, but on the other hand can feel angry and frustrated in my attempts to help. (UHS)*
- *Sometimes it can be emotionally difficult, and very draining. It can also feel like an enormous responsibility, and leaves one feeling inadequately able to deal with students' problems.....In a critical situation, the crisis support team are superb, and take over the problem, but it's the day-to-day dealing with tears, despair, hopelessness, inability to function / work / meet deadlines and so on that sometimes feels very difficult to deal with. (Academic staff)*
- *Having personal MH issues makes the interaction more acute, yet also gives me greater awareness of the difficulties in accessing services and support. (Academic staff)*

Feeling unsupported or under resourced

- *On principle, I am worried by the fact that, without any training or support, academic staff can be thrown by default into dealing with quite psychologically complex and even dangerous situations - sometimes precisely because the situations are so difficult that trained mental health professionals have failed. Being told to avoid getting involved is about all the training/advice the university has ever given us, and it doesn't help much if a suicidal student turns up... (Academic staff)*
- *I'm not trained, qualified or competent for this kind of support role. Nor should I be. I don't think it should be part of my job.*
- *I am not trained to offer support in any way. I work with my own intuition and will try to talk to colleagues not about specific cases but symptoms. I find this extremely problematic as I don't know whether I always do the 'right' thing. There needs to be much quicker access to support. (Academic staff)*

Role confusion and clarity

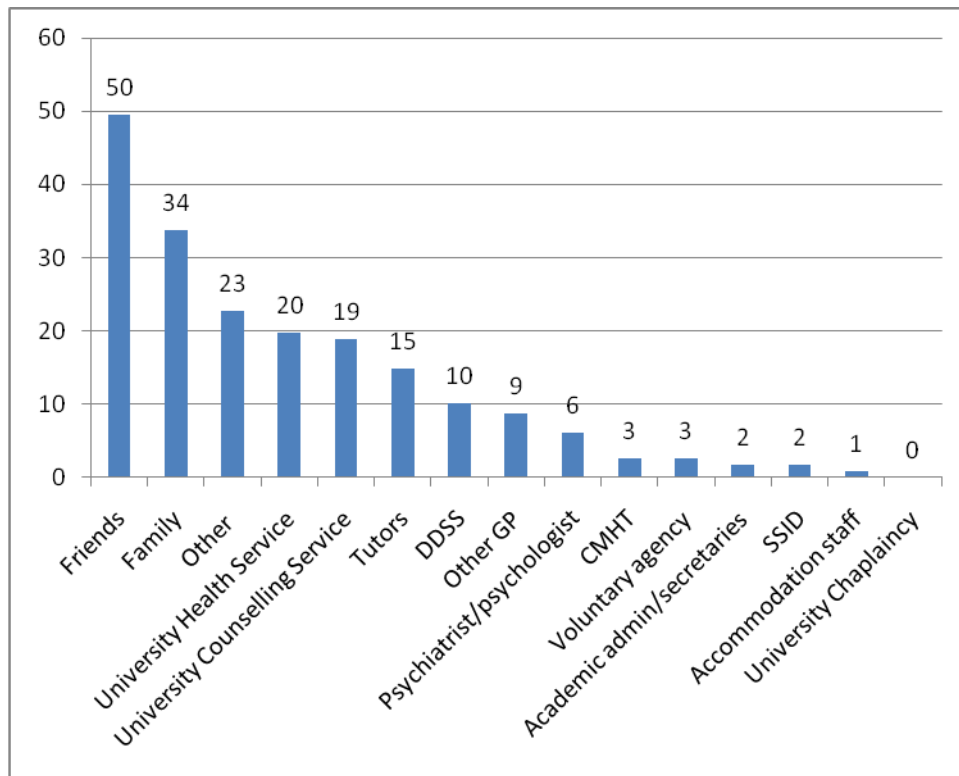
- *I feel that my role is not always straightforward and can change between simply providing information and providing support which may become ongoing. (Student Services)*

- *I am very clear about the boundaries of the academic/student relationship as I see it, and I offer only a "signposting" service, referring the student on to specialist help (of which there is a huge amount at the University of Sheffield, compared to other institutions at which I have worked). I do worry that the term "personal tutor" gives students (and perhaps their parents) the wrong ideas about what academics can do to help with problems that are not academic problems, and I would remove that title and role altogether if I had my way. (Academic staff)*
- *More guidance about where the boundaries lie in helping students - how much we can really be expected to do.*

Current experiences of the support system

In the questionnaire, students were given a list of sources of support and asked how frequently they used these. The percentages of the 228 students reporting access to different support systems were as follows. The categories reported were those listed in the questionnaire:

Figure 7: Percentage of students seeking support from different areas



The three most common sources of help were from outside the University setting. Exactly half of the respondents said that they sought support from their family. The 'Other' category (23% of respondents) had many responses which were only reported by a small number of people. Those reported by at least two people included the following:

Table 7: Numbers of students using 'other' sources of support

METHOD	NUMBER USING
Medication	6
Relaxation	5
Keeping active	5
Creative/arts activities	4
NHS therapy/CBT	4
Self-help books	4
Private counsellor/therapist	4
Exercise	4
Online advice and support	3
Church/spiritual group/prayer	3
Self-motivation, targets, routine	3
Cigarettes	2
Self-monitoring	2
Support\self-help group	2
Computerised CBT	2
Push self, doggedness	2
Partner	2
Sleep	2

Open-ended questionnaire responses and the focus groups allowed some more detailed exploration of staff and students' experiences of these supports. Unless noted, all verbatim quotes come from student respondents.

Family and friends were valued because they are a constant source of support:

- *The personal sources of help like family and friends are a constant*
- *Since it's my family, they're always there for me.*
- *I only get help from friends and family currently, I can trust their opinion, and I know that they are thinking of what's best for me.*
- *The Counselling service was great. My family and friends are the best support system for me though.*

Although for some students family and friends, even when available, were not a sufficient answer:

- *I don't like to rely on family and friends as 'misery loves company'.*
- *There is only so much I can gain from talking to my friends and family about my problems, and many of them are caused by me*

As far as more formal support services go, student respondents sometimes commented on individual services but more often on the whole range of services together. The following extracts relate to some of the emerging themes from these comments, where the specific service used is sometimes, but not always, apparent.

Waiting times and accessibility

- *Waiting times, particularly for urgent cases can be long in the UCS*
- *It is very difficult to get an appointment with X, the mental health helper. (Student using UHS and DDSS)*
- *I'd like the option to return for further sessions e.g. CBT, counselling quickly without having to go back on to long waiting lists.*
- *More counselling staff [are needed]- they are very busy so long waiting times*
- *I've been waiting six months now to see a psychotherapist.*
- *I assumed for ages that by the 8 days waiting time stated on the counselling service website I'd be ok, so I never registered before. I actually got seen much quicker than this.*
- *It took weeks to acquire an appointment with both my home GP's CBT service and the university counsellor - often by then I am out of that particularly bad patch or am on to something new.*
- *I'd like to go back to counselling but for some reason I can never get another appointment, also talking about it is good but I would also like practical help on dealing with day to day issues.*
- *Hard to arrange an appointment with the counselling service.*
- *Acute services not too good (short notice counselling appointments hard to get when they are needed most) Acute appointments with student health usually available Chronic services better - planned appointments work OK. (Academic staff)*

Quality, quantity and relevance of care

- *Feeling rushed when seeing GP (paraphrase, respondent did not want own words used)*
- *(GP at the health service) is fantastic - always willing to listen and able to treat me even though I'm not a "textbook" case - other GPs I've seen [there] have not been so sympathetic*
- *It is consistent, supportive and unquestioning. (student using UHS and DDSS)*
- *My doctor was very helpful and kind, but I didn't follow up on the referral she gave me (eating disorders service)*
- *For sleeping difficulties, the doctor suggested I attend the counselling service relaxation sessions on Mondays - but it's on giving presentations and has no relevance to me.*
- *Staff have always been supportive, professional and non judgemental student using UHS, UCS, tutor, academic secretarial staff)*
- *Most of the relief I get from the above is pretty short lived. [I need] longer term help.*
- *It is impartial, the people who I talk to do not have any biases or hidden agenda for what they want for me (Student using UCS)*
- *I see the mental health nurse at the GP but it is only for brief cognitive behavioural therapy for surface social difficulties.*
- *It is a short, precise appointment, I feel I don't get much across in that time.*
- *I feel well cared for but many people I know feel let down, particularly by the counselling service.*

- *good to get my feelings and problems shared, don't feel as burdened and there is help available (student using UCS and DDSS)*
- *[Need] more long-term aid.*
- *The counsellors were experienced and did give me the opportunity to explore my feelings*
- *Booked an appointment with UCS but counsellor did not attend. I felt let down and didn't go back. (paraphrase, respondent did not want own words used)*
- *Somewhere to offload without fear of condemnation (Student using UCS)*

Continuity of care and information sharing

- *I do not feel there is a strong enough support system that is all connected together. I particularly felt let down with the general procedures for when I went on my leave of absence, and all of the practical, as well as emotional, difficulties experienced as a result. I felt invisible to the university, and largely still do.*
- *Everyone I see will only talk about things from one specific angle, all the support is very fragmented, I see five different people all who want to discuss how it affects certain things but won't talk about other things.*
- *I've seen probably all the doctors at the UHS because it's so bloody difficult to make appointments in advance with the same doctor.*
- *[Would prefer] more regular access to the same person, not be passed around as much.*
- *I feel a bit bounced around various agencies and don't really understand what help I can get, or what would be good for me.*
- *[Departments are communicating with one another] much more than NHS services that I've had at home*
- *communication between UCS and UHS is quite good.*
- *No communication between (UHS) doctors, never mind departments*
- *I think there should be more communication between the health service, academic departments and the counselling service*
- *[Communication] between academic departments (dual course) good - with student services poor, student services seem to have made things far more difficult*
- *Problems with confidentiality, which also protects the students. Services are quite disparate, so not easy to communicate between them. Works well in part, as staff try to communicate in spite of barriers. Difficult to know who is supporting a student. (DDSS)*
- *I have found student services really useful & efficient at information sharing. I have appreciated that greatly. However, there seems to be gaps when the student is registered with a local GP & perhaps this could be improved. (Students' Union)*
- *Communication across departments is not good, but I am sympathetic to the matter of confidentiality. (Residential tutor)*
- *Data protection/secretcy/confidentiality often works to the detriment of effective cooperation between academic, health and service departments. (Academic staff)*

Reactions of academic departments and systems

- PhD supervisor making insufficient allowance for speed I can work at (paraphrase, respondent did not want own words used)
- *a bit of extra time in exams [was helpful]*
- *My tutor is very understanding and helps me liaise with academic staff to avoid penalties. His help makes my life much easier.*
- *I would like it if my department... were more supportive but they seem to take my condition/illness, whatever you want to call it, very lightly indeed. It's as if they don't realise that 'depression' doesn't simply mean feeling down from time to time.*
- *Hard to know how to go about informing my academic department of my problems. Most services dealing with mental difficulties have low visibility and it is therefore hard to know what options there are for support.*
- *My department has poor levels of confidentiality, and does not have transparent or supportive policies for people with depression.*
- *I get unlimited time to hand in coursework.*
- *tutors really need more training in how to deal with students who are having troubles.*
- *I don't dare speak to tutor about problems.*

Visibility of services

- *Although the offered help is sufficient, I think, judging from my own and other people's experiences, that this is not well enough promoted and made known to staff and students.*
- *[I need] more access/information about somewhere I could go to be with people who might understand how I feel.*
- *It is readily available and well-known. It is easy to make appointments.*
- *publicity and awareness! [should be improved]*
- *I think that it would help mature students (like me) if the services were spelled out a bit more. I suppose we just don't look deep enough and, personally I don't spend time hunting around the site to find out what is available.*

Community building

- *When I lived in Ranmoor, in 1st year, it was a real proper community...there were common areas, there were areas where you could meet people, even something as simple as just eating as a hall, meant that you could form much more of a community...the direction that student accommodation seems to be taking is...nowhere to meet people and I think that is really damaging to the student experience as a whole*

Gaps to be filled, proposals for development

Some desired changes can be inferred from the responses outlined in the previous section. Staff and student respondents were asked explicitly what would improve the current situation, and some of the key themes emerging from their answers are as follows (where source is not specified, quote is from a student):

Duration/accessibility of support

- *longer term help*
- *More extensive access to student counselling. Six sessions is often not enough. (Staff member)*
- *longer GP appointments for people with mental health issues*
- *The frequency/availability of appointments with the counsellor.*
- *Amount of contact hours, I am uncertain what I should do outside of set appointment times should anything go wrong.*
- *Easier to get appointments around PGR working day*
- *difficult to get an appointment as I have a busy timetable*
- *Greater availability of counselling services, I have not used them as of yet due to clashes with my timetable*
- *Put more resources into the counselling service. Not rely on personal tutors to do things they are not trained for. (Staff member)*
- *The relaxation and supports groups are only run on one day a week. I think it would be better to offer an alternative date for those students that are in lectures that cannot attend.*
- *Greater availability of support in the evenings, as many students work into the evenings, during term-time.*
- *More appointments with mental health support at the health service.*
- *Counselling is good, but just need more counsellors available to shorten waiting times to see one.*
- *The University seems to have good but limited mental health services. There seems to be a limit on the time available for formal help.*
- *Somewhere to refer students more quickly when they need help (Staff member)*
- *More out-of-hours help; better follow-up of cases; provision for welfare interviews instead of just disciplinary interviews (Residential Tutor)*
- *easy access to support at critical periods (DDSS)*

'Joined up' working

- *Someone to give real understandable guidance who knows about these things and can connect all the services.*
- *If a member of staff (in whatever capacity) really got to know us when we are facing such difficulties, they could help to directly liaise with the different support systems etc and give us more specific advice. I know it is a large university, but I feel this really lets it down.*
- *A whole system needs to be in place that encompasses everything a student has to face when feeling like this, and when having to also cope with practical difficulties, such as physical health problems, and taking a leave of absence.*
- *It would help if the GPs at the health service had a better plan for coping with patients presenting with complex problems. It might also help if the eating disorders nurses had wider training, as the one I saw didn't see that I had other problems as well as eating.*

- *I would prefer not to have to everything so separate. I know confidentiality is important but it's also important that people know what they need to know to help me, it makes me feel even more stigma because everything is so secretive.*
- *A counselling service that is able to communicate with my department to ensure that my problems are noted and dealt with effectively so that my studies do not suffer too badly.*
- *I could do with someone to talk to who knows the workings of the NHS to get an idea of any help I might get when i qualify*
- *Often the various support bodies in the Uni don't seem to know what each other are doing with regard to a student. this makes it very hard for me when I'm trying to liase. (Academic)*
- *Mainly because there isn't a vehicle for this communication in a systematic way so occasionally it works well but takes a lot of effort on the part of usually one member of staff to draw together the services to work in a co-ordinated way. (DDSS)*
- *Too many opportunities for care to be fractures and students to spend a lot of time going between one agency and another, even within the UoS. (Staff member)*
- *More of a bridge between disabilities and counselling as regards provision for support rather than referring them on unnecessarily. (Counsellor)*
- *Knowledge sharing, centralised computer records, someone responsible across end deliverers for a student's welfare, who can orchestrate support. (Residential tutor)*
- *More integrated approach Lead person assigned (Counsellor)*
- *Clear pathways for communication, written and agreed care plans/ agreements with the students, support from/ liason with NHS. (Counsellor)*
- *A way of bringing together services so that support happens in a co-ordinated way and encourages mutual support for holding the student's situation. (DDSS)*

Specific ideas for new services/different ways of working

- *Confidential drop in service*
- *Maybe more informal drop in style meetings that don't require you to sit at a desk with someone and talk things through formally/in a psychological way. Just purely tea-break points where you can talk to people who want to listen to you around campus would be nice. Like Nightline but with a face.*
- *Don't know, place of peaceful relaxed isolation to gather thoughts and get self together away from the hustle and bustle of life.*
- *A clearly defined physical 'go-to' space in the students' union. (Academic staff)*
- *I think if a text/email service to let people know [counselling] appointments were available were in place it would help a lot.*
- *Maybe there can be a computer chat service where you can talk to someone online. This could be time bound I suppose.*
- *I really think that they should have a dedicated like LGBT counsellor, who really understood the combination of LGBT issues and mental health problems*
- *The university could offer a more in depth psychotherapy service for example that would benefit people with more psychological issues than stresses of everyday life.*
- *More of a gateway style assessment and approach would be good in some cases. I.e. a separation between life skills type services and more serious mental health cases*
- *[Would appreciate] different styles of counselling*

- *employ a Psychiatrist for at least one session a week, consider what other therapeutic services might be beneficial that are within University's remit. (DDSS)*
- *Work more closely and have a counsellor employed WITHIN each faculty who is available for drop in sessions (Academic staff)*
- *Some kind of university-backed 'Know your neighbour' campaign would be a really good idea*
- *I don't think there's a lot of people who engage in physical wellbeing to help their mental wellbeing (Staff member)*

A central consultation and/or co-ordination point

- *Someone I could phone who could give me advice and who could speak to students who seem to have a problem. There is a big grey area that I feel uncertain about! (Academic staff)*
- *Offer a confidential helpline for staff who are struggling with the situation, especially those with no experience of these kinds of problems, to provide support and help them avoid situations which are damaging to vulnerable students. (Staff member)*
- *A university service which provides consultation for Departments with ongoing need. (Academic staff)*
- *A specialised service that can be used for debriefing and assistance because sometimes the student is unwilling to let another in if they have built a relationship of trust with you. (Academic staff)*
- *Having a personal advice session with a trained professional about what to do and what advice to give the student. (Academic staff)*
- *A helpline to be able to talk to someone about what is happening. (Academic staff)*
- *For there to be a central case manager who I could liaise with and who would co-ordinate a student's support. I would like more recognition of the time-consuming nature of this role when workloads are drawn up. (Academic staff)*

Availability of groups

- *It might be helpful to be able to be in support groups with others in a similar problems*
- *more access/information about somewhere I could go to be with people who might understand how I feel.*
- *Student Drink and Drugs support groups within the counselling service. it is easier to relate to other students in the same situation. (can be intimidating going to independent AA/NA groups)*
- *Maybe a support group for victims of domestic & sexual violence?*
- *Peer support groups would be useful. (Academic staff)*
- *therapeutic group for students (UHS)*
- *Peer support groups (DDSS)*
- *Setting up a Democratic Therapeutic Community, or similar (Counsellor)*
- *I think some kind of forum where you can meet other people who've also suffered from this, would be really good. I mean whether it's a physical forum, or an online forum, or whatever*

More explicit, consistent policies and procedures

- *University departments have a very inconsistent approach to helping students. Some do it very well, some... may get a bit too involved and some do not appear to take on the responsibility for this at all. There needs to be a consistent approach. (Library)*
- *Very clear guidelines on points of contact and how far my responsibilities should go. (Academic staff)*
- *Clear procedures for responding to critical and less critical incidents that can easily be passed on to frontline staff to give them confidence when dealing with an incident. Also some formal de-briefing sessions for staff who have dealt with incidents. (Library)*
- *sometimes departments try to deal with it alone, so when...someone is presenting with difficulties and perhaps it's got to the point where it is disrupting the [class or activity] that particular area wants to deal with it themselves, without necessarily knowing a standard protocol, and so instead of approaching or having a protocol in place that's been standardised across the university...so that makes it really difficult as well, because often it's just one person's gut feeling with how they should deal [with it]. (Staff member)*

Better support/understanding from academic departments

- *On the whole the University is excellent in providing support, with the Counselling Service and Health Service being a great source of help and advice. However, as I have already stated the department offers me no support at all and doesn't seem to care that I suffer with mental health difficulties.*
- *more help to catch up with academic work we've missed.*
- *I already feel that I get more than I deserve from specific support services. Greater awareness and sensitivity from academic staff would be appreciated.*
- *A reading week! Better social activities. More support from seminar leaders as they're not particularly considerate.*
- *I don't think tutors know how to help at all. I have been to two tutors who were completely unsupportive whatsoever, and seemed so shocked at the situation that I was in that they didn't know what to say.*
- *It's kind of really interesting to talk about like the discrepancies between departments, and I think the university should...have some kind of review of which departments are doing it well, and which are doing it badly*
- *I don't think academic departments work [with other departments/services] very well at all, in my experiences. I just don't think they've got an awareness about the same cases, so they just don't want to deal with it. (Staff member)*

Support for particular groups

- *More accessible groups for PGR students*
- *Perhaps there are some students – eg from abroad like me – who need particular counselling because their position is different from UK students. (paraphrase, respondent did not want own words used)*
- *A lot of the students I deal with are international students, and I just wondered whether there are any cultural dimensions to this that need thinking about. (Staff member)*

- *More support during the first year certainly, especially when people first move away from home.*
- *as a part-time student, I do sometimes find it difficult to access information about where to find help, as I was never assigned a personal tutor or really inducted into the university properly.*
- *I think that it would help mature students (like me) if the services were spelled out a bit more.*
- *I am considered a low-income, self supporting mature student by the Uni.. I receive 'outreach' bursaries on this basis. It can be extremely stressful and depressing at times having no family support (emotional or otherwise), offering some kind of emotional/psychological help alongside those who qualify for financial assistance would be largely appropriate and useful.*
- *I really think there's an issue around being a mature student, with mental health problems, coming back to university and the lack of support there is for someone in that specific case....a few of my friends.. with mental health problems..*

Availability of information

- *I think the University offers a good deal of support, but that they should make it clearer what is available and how to go about getting this support.*
- *A more direct list of contacts for when I feel the need to self harm or an feeling suicidal to a degree I cannot cope on my own. Possibly places, telephone numbers/e-mail and opening times for places. Especially places I can go in person without needing to call anywhere.*
- *As simple as it sounds, some sort of a checklist of, you're going on a leave of absence therefore these people need to be contacted, like, it's a really basic thing, but I think it would make a massive difference, 'cause I was just swamped and I just didn't know where to turn*
- *The counselling service should be promoted more as I did not know we had one until I searched for it on the shef.ac.uk website.*
- *Clearer ways to access service; I haven't the first clue how to go about it.*
- *As far as I know, there is a lot of stuff [mental health services] around, it just might not be particularly well advertised*
- *Clear info (not email and newsletter bombardment!), on help available and phone numbers. Single a 4 sheet i can stick on my wall (Academic staff)*
- *If the university and local support resources were collated together (such as on a specific website) so that staff and the individual had a 'one stop shop'. (Academic staff)*
- *It's obviously all there but it's then getting to it, without having to do a massive search, which when they're feeling really stressed anyway, trying to get the information that's clearly there (Staff member)*

Several students mentioned that at first they had not seen the DDSS as something for them, perhaps because of the connotations of the term 'disability'.

- *My counsellor said 'why don't you access the disability service, you're an ideal candidate' it's really hard to start thinking of yourself as disabled....yeah it's like a labelling...I do think the support they've given me has been invaluable.*

- *At first I was appalled that someone would suggest that I went to a disability service.. invisible illness are the hardest to deal with in that sense*
- *[talking about the name the 'disability and dyslexia service'] I suppose, I wouldn't naturally have considered myself to fall into that category, but I don't have any particular objection to doing so... actually in a way, it's quite a good thing, because it doesn't put mental health in a sort of separate category of, meaning something different*

Assertive/early intervention

- *They don't ever check up on me. Tutors aren't aware of my situation. It is embarrassing to ask for extensions etc, and often I don't.*
- *There ought to be better monitoring systems in the first year, to know if students are turning up or not. So that they are not simply lost in the system because they are having such a miserable time at university.*
- *I personally feel that personal tutors should request to meet their student at least 3 times a year, sometimes people don't seek help because they feel it is hardship for the other person, if the tutor organises a time then it seems like they are interested in helping*
- *Someone on a leave of absence disappears off the radar... not only do they not know what to do with you, they forget about you completely.. anybody, whether it's physical or mental health, that has been on a leave of absence for a health medical reason...there should be a standard process so that no one slips through the net like I did*
- *There is the obvious problem of what to do if you think a problem is "developing" rather than someone who is totally out of control (contact Critical Support) and the student, as is often the case won't seek help. (Academic staff)*
- *identify them as early as possible ,inform them of support available and encourage them to choose a support network and work within it - establish plans for what to do in a crisis and agree with the student (UHS)*

Several staff members reported wanting further training in managing this student group:

- *Training on dealing with this in a public place, referral systems, what's available for students when they're at uni. (Students' Union)*
- *I would like some specific training about dealing with postgraduate research students with mental health problems, both acute/serious, and more chronic/ongoing. (Academic staff)*
- *provide support and facilities and also train staff to deal with them. I have NEVER had any training. (CICS)*
- *Make staff more aware of mental health and characteristics so it's not just specialised staff that have to deal with these cases. (Student Services)*
- *I have wondered about some support workshops, but I doubt that I'd have the time to attend (Academic staff)*
- *I think case discussion meetings would be useful for me as a supporter, plus more training. The student group would benefit from a change of attitude and knowledge about mental health around the University. (DDSS)*

A few staff members suggested taking greater care at the stage of student selection and admission

- *I am concerned that some damaged and damaging students are admitted when they have little realistic chance of thriving in an academically-pressured setting. (Academic staff)*
- *Take care at application stage inform frontline staff (secretaries/ teachers) what is available and what to look out for. (Staff member)*
- *If the students identify their needs becoming coming to the university as part of the admissions procedure that would be helpful but I do understand that students are not always happy to do this. (Academic staff)*
- *Identify existing problems at time of admission, perhaps? Forewarned is helpful! (Academic staff)*
- *I would like to see, when students first apply and they get picked up as having a disability... to get a nominated person allocated to that person, potentially so they're there... rather than wait for the student to go into crisis and hit the services in one way or another (Staff member)*
- *Before they even make the decision to come to Sheffield that information [regarding services] should be available (Staff member)*

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5.2 Working group's discussions and Clemson Intern's report

This chapter consists of three brief reports: the working group discussions, its review of current external services, and a summary of the Clemson Intern's project.

Working group's discussions

It is important not to overlook the contribution that the working group's discussions have made to this project- both the face to face discussions at three meetings, and those held on-line, on uSpace. The content of the meetings has been summarised in note form. Additionally, several members contributed to the staff survey, and their responses can be examined as a sub group of the overall data analysis undertaken by CPSR.

This group of staff were selected for their involvement and /or interest in supporting students with complex mental health needs, and as such they could be considered as an experienced and informed group. They were able to give a comprehensive list of services and resources, both within and outside the University, that are involved in providing support for these students and many have had years of experience as clinicians/ support workers/ academics of working with the 'complex' presentation. Nevertheless, it is noteworthy that they were explicit about the impact of their experiences. Many respondents described strong emotional responses within themselves and others to the sorts of behaviour that they had witnessed, including anxiety, frustration, feeling unsupported, emotionally drained, angry and stressed. In addition, people spoke of how difficult it was to maintain time boundaries with this student group. This is very much in line with reports available elsewhere (see literature review).

The working group had a number of recommendations to make, both with regard to provision for students and support and training for staff. These arose as part of the process of meeting as a group over the course of nine months, and can be categorised under the following headings:

Developing a shared care plan approach

Ideas for this approach emerged in all three forums for discussion, from the early meeting and questionnaire, to a more detailed discussion on line on uSpace:

'Bring in a multi-disciplinary approach (exemplified by the case conference) at a much earlier stage....would enable support to the student to be more joined up at from the beginning – rather than case conference as crisis response' (notes from 22 March meeting)

There was a lot of interest in these ideas, and potential problems were discussed. The group acknowledged that this approach could take time, but would save time further down the line, offer 'containment' to all students and staff, and potentially ward off the crisis case conferences that get called when matters have come to a head. Practical difficulties such as training and allocating staff to the role of case manager were raised:

'Who might undertake such a role in a University context? And would such an initiative receive the required support and participation of academics, medics and other 'relevant parties?...' (contributor to uSpace discussion)

These ideas were developed further at the last working group meeting to consider the idea that the student themselves should take on the role of their own 'care co-ordinator. Other themes were the importance of linking up with other services- and possibly other universities who may be involved in supporting students. It was also acknowledged that the University is not a health service, and that it should be mindful of how much specialist support it can offer.

Student led (peer) support

These ideas emerged in the later stages of the project, possibly in response to the data that was gathered from students, and possibly as the working group became more immersed in the ideas and had time to reflect on the importance of the student's role and position in any system. The importance of user led groups and how these can empower the 'service user' was acknowledged; students themselves can be a significant helping resource to each other. Using focus group members as a potential service user consultancy group and/or peer support point of contact was suggested. Another strand of discussion was a student's own responsibility in initiating a request for support. The use of online forums for support and the issues regarding moderation/ monitoring and effectiveness was raised.

Early intervention

These ideas linked to those of the shared care plan; the importance of putting a network of support in place before things go wrong for a student.

Improved dissemination of information

The group noted that whilst there is already a lot of support available to students at the University, the information about this could be better disseminated. Additionally, the nature and definition of 'disability' was raised: that many students and staff may not be aware that a mental health diagnosis can be classed as a disability, and that additional help could be available via DDSS. Finally, the group discussed the importance of educating others more fully about what is meant by 'complex mental health difficulties'. It was felt that members of staff in academic departments and professional services (outside SSD) need to know about both the needs of these students and the support available.

Support for staff/ recognition for work undertaken

There were several comments from the questionnaire for working group members about the need for recognition for the sort of work undertaken by staff at the University generally:

'Awareness / training would be useful for me and I would like to see the University take a lead on this.'

'More serious recognition amongst staff (other academic staff particularly) that this is a serious issue. More value and recognition accorded to the activity of supporting students by staff and line managers.'

'I would like more recognition of the time -consuming nature of this role when workloads are drawn up'.

It was suggested that hearing how others deal with difficult issues can be useful, so discussion groups about how to help, and how to manage one's own feelings when supporting this student group was one idea. Making staff more aware of support already available was discussed, for example both the duty counsellor system and the Mental Health Advisor; although the group was concerned that advertising this widely may overwhelm either service at their current staffing levels. An idea raised at the last working group meeting was that of having a forum to which staff and students could bring concerns for discussion; perhaps planned regular monthly meetings.

Working group's summary of external help available to students

Members of the SMHLG and working groups together with the project manager collated information about the external sources of help available to Sheffield students who have complex mental health difficulties. This can be summarised as follows:

There is currently no designated dedicated provision for this student group in the NHS or through voluntary agencies in Sheffield. Students can access help through several sources; those described below are obtainable through the University Health Service:

1. GP: if there is any declaration of mental health difficulties on a health questionnaire, the student would be offered and encouraged to attend an interview with their GP who should assess current and past difficulties and risk, advise on sources of support and offer follow up if appropriate
2. Mental Health Worker: If there is co-morbid low mood or stress/anxiety students would be offered psycho-educational workshop and if difficulties are 'complex', they may well be referred for 1:1 with the MHW for further assessment and signposting to any relevant community groups or ongoing support
3. IAPT: Improving Access to Psychological Therapies workers may be involved if CBT is thought to be a useful additional therapy eg if elements of OCD or severe panic disorder are part of the picture.
4. Community Mental Health Team: may be involved if a student would benefit from regular support from a CPN (Community Psychiatric Nurse), particularly if they have been 'stepped down' from the crisis and home treatment team (see below). A consultant psychiatrist may also be involved if a GP needs further guidance on medication or if the patient (student) is on a 'mood stabiliser'.
5. CAHT (Crisis and Home Treatment) :may be involved if student is actively suicidal or repeatedly self harming/overdosing.
6. EIT (Early Intervention Team): may also be involved if there is uncertainty particularly at first presentation over whether or not there is a psychotic element.
7. Eating Disorders Clinic - in house at UHS, or through SYEDA (South Yorkshire Eating Disorders Association) or through St George's, who may be involved if an eating disorder is part of the picture.
8. Specialist Psychotherapy Service - Brunswick House
9. Sometimes students are attached to a mental health worker or psychiatrist at home, which involves collaborative working outside the region.

Secondary care services (eg Sheffield Health and Social Care NHS Foundation Trust) working with those with more complex mental health needs deliver help using the Care Programme Approach, with a care coordinator and regular reviews with the patient. Sheffield Health and Social Care Trust are also in the process of running a Personality Disorder Service Development Project, but do not currently provide a specific service for this patient group. Therapeutic Communities providing such services are outside the region (eg Diverse Pathways in Leeds, and Mandala in Nottingham. Individual counselling and psychotherapy are available through voluntary organisations such as Sheffield MIND, Sheffield Women's Counselling and Therapy Service, SHARE Psychotherapy and Sheffield Rape and Sexual Abuse Counselling Service. Some of these services require a fee to be paid. None are specifically designed for this student group, but most would have relevant experience.

Clemson Intern's report

As already reported, the Clemson Intern interviewed members of the working group to elicit their ideas about what actions they would recommend. Her interviews were summarised by her, and categorised under four headings of her choosing: Collaboration, Academic, Transitions and Other. She also commented on the limitations of her projects and drew some conclusions. A full copy of her report is available in the Appendix. The Clemson intern interviewed 12 out of 21 working group members. 11 of the participants were student support staff and one participant was a faculty member. Participants included staff from DDSS, UCS, UHS, Library and Careers Services Several ideas were offered to refine collaboration:

- *Establish a care coordinator position*
- *Create individualized package for students with self-identified mental health issues*
- *Facilitate a democratic therapeutic community*
- *'Visit the Neighbours' day with student support staff*
- *Create a regular meeting schedule*
- *Case discussion forum*
- *Extend the boundaries of confidentiality*
- *Create an action card for student support staff and faculty members*

The intern also asked interviewees about the role of academic staff in supporting this student group, and identified two different perceptions; some felt that faculty staff should only have an academic role, as they lacked formal training, were employed for their academic expertise, and pastoral care was available elsewhere. Others felt that academics should see pastoral care as part of their job; that academics 'should relate at a human level' and that a holistic approach where students' mental health is not seen as separate from their academic abilities is important. All working group members interviewed agreed that academic staff were vital in the task of supporting this student group.

Several ideas were offered by interviewees to enhance the transition process for students:

- *Older students could mentor first-year students*
- *Effective communication with student accommodations*
- *Workshops for students with mental health difficulties*
- *Induction event specific to students' health and wellbeing*

- *Collaboration with the Students' Union*
- *Offer effective signposting to direct students to the right services*
- *Be mindful of information overload (especially at the beginning of a student's university experience)*
- *Utilize cyberspace/electronic resources*
- *Consult current students*
- *Internal training for departments*

6 Discussion

The content of the Results chapter does seem to indicate that the enquiry into the experiences of both students and staff was a meaningful exercise to all of those who responded to the questionnaires, or attended discussion/ focus groups. The defining description of 'complex mental health needs' developed for the project would appear to have been clear enough for it to be understood and recognised by those who engaged with the process. The responses from student participants would indicate that they would in the main 'belong' to the group of students we were wishing to reach and help. Perhaps the most significant information to arise from the data was the speed at which a large number of both students and staff responded to the questionnaires.

6.1 The experience of complex mental health difficulties – institutionally and individually

The changing landscape of student mental health at the University of Sheffield was first described in our 2008 report (Phillips et al) to the Student Support Forum. It noted:

- consistently heavy use of the main university support services (UHS, UCS and DDSS)
- that generally, services were dealing with serious conditions which could have a major impact upon a student's ability to function effectively at university
- and that there was the emergence of a smaller but fast growing group of students suffering from severe difficulties whose 'distressed and distressing behaviour' can have a major impact not only upon their own lives but upon those of the other members of the university community they interact with, both students and staff.

This group was, and remains, relatively small in number but has a disproportionate impact upon the lives of staff and fellow students. This report has taken a closer look at the experience of these students and of the people that support them, with a view to recommending ways in which they can be better supported and the problematic nature of their impact mitigated. If we use the 'social model' of disability to view the needs of those experiencing complex mental health difficulties, it can be argued that it is the environment that needs to change to provide equality of access and opportunities to participate in the 'normal' life of the University.

The growth of this group is shown best in statistics from the Disability and Dyslexia Support Service:

	2007-8	2008-9	2009-10
Declaring a mental health disability	116	164	260
Active users of DDSS	80	126	186

We know that this is partly a result of better referrals between University services (particularly from UHS GPs to DDSS), partly to the increasing awareness amongst students of the high quality of support available through DDSS but also to a genuine growth in students with such conditions coming to university. It will be recalled that the landmark Royal College of Psychiatrists report on Student Mental Health in HE (2002) predicted that as participation in Higher Education increased, the mental health profile of the student population would come increasingly to resemble that of the general population. That is indeed what we seem to be observing at the University of Sheffield.

In Kim Dent Brown's contribution to this report it was suggested that the students responding to our survey were describing difficulties which arose from relatively stable features of personality, rather than acute episodes of mental ill-health. Our literature review suggests that more than 10% of the adult population suffers from some sort of personality disorder, the symptoms of which tend to surface in late adolescence and early adulthood. We may conjecture therefore that there are potentially a large number of Sheffield students falling within this category and that their difficulties may be exacerbated by the challenging transitions inherent in university life. 228 students responded to our survey, in fairly short order, and it is quite probable that this number represents only part of the full group.

Our experience of the disruptive potential of these students' difficulties, as evidenced in responses from our staff, is also supported by reports from the Royal College of Psychiatrists, NICE and NIMHE. This tends to surface in incidents in university accommodation, academic settings, the university libraries and indeed, university disciplinary processes and proceedings relating to fitness to study.

We can conclude from the above that:

- there are large and growing numbers of students in the University suffering from complex mental health difficulties, many of whom may have some kind of personality disorder;
- that our experience is a reflection of a well-researched phenomenon in society more broadly;
- and that the difficulties of this group of students, unless contained by well thought out services and support processes, have the potential to be damaging to their academic progress and ability to live happily within the University community. In a few cases their behaviour may be highly disruptive.

The problems experienced by students themselves are described vividly in responses to our survey. Anxiety and depression feature strongly and to a lesser but still significant extent do poor motivation and concentration and social isolation and loneliness. There is evidence that many of these students may potentially be high achievers who maintain a façade of effective functioning but are highly distressed 'behind closed doors', with the likelihood that their full academic potential will be seriously undermined unless they are effectively supported. Staff descriptions of the student difficulties bear out the student response but focus much more strongly on the external and more dramatic manifestations. This may be explained in part by the fact that these manifestations are clearly more visible but also by the fact that members

of staff understandably feel much less secure in their ability to deal with, for example, psychotic episodes, self-harming and threats of suicide.

So the internal *distress* of the student may be known only to the student and those closest to them, whereas the more dramatic *external* manifestations are known to a wider group. Institutionally this is a problem, in that the full impact of these mental health difficulties upon student well-being, academic performance and retention have not been sufficiently well-known. The disruptive behaviour that we sometimes experience seems therefore to be the tip of a much bigger iceberg.

6.2 Where do students get their support?

Our research indicates that students turn mainly to friends and family. This places a heavy responsibility on fellow students and we know anecdotally that students will often support friends for long periods of time before turning for help to support services. The University Health and Counselling Services are also extensively used, the Disability and Dyslexia Support Service to a lesser extent.⁹ There are messages here about the need to sustain a system of support across several services, remembering that although DDSS statistics show clearest evidence of growth in demand, other services also bear a great deal of the workload. Any loss of capacity in one will inevitably have consequences in the others.

The other important people to whom students turn are academic staff, though the consensus amongst student respondents was that tutors were not in a position to be of great help. It's fair to say that academic staff tended to agree with this conclusion! Time, lack of training, uncertainty as to whether this is their job and about where to turn for help are all given as reasons. This suggests that we either need to support staff better or to contain student anxieties in a more effective way, such that they are less of a burden for staff.

It is notable that few of the students indicated that they received help from external services such as the NHS. Realistically it has long been difficult to refer to secondary care with any expectation of timely response, though there are now moves in Sheffield to develop services for personality disorder.

6.3 How do students and staff see the support on offer?

Students were generally very positive about the help they received from the main university mental health support services. However, they frequently asked for shorter waiting times and greater accessibility of services, more long term aid and more joined up working between services. In actual fact, access to services is good and more rapid than it has ever been and the level of integration between services has improved greatly in recent years. However, the ideas of both long term aid (though probably not long term therapy) and tighter integration do need to be addressed in terms of this particular client group and

⁹ On the face of it, if only 10% of our sample in this study used DDSS but at the same time we know that DDSS support 186+ students with a mental health disability, this seems to indicate a much greater overall number of students with such difficulties in the University community - more like the NICE estimate of personality disorder in a given community.

feature strongly in our recommendations. In the current, pressing financial circumstances it is not realistic to think that we can improve access to services by gaining extra resources.

Staff wanted help to be more visible and easily contacted and there was a strong theme in their responses of feeling unsupported, unable to access advice and information and generally feeling unequal to the task. This is something of a puzzle, in that there is more information, training and consultancy support available to staff than ever before. Clearly though, we need to think again about how best to disseminate information on student mental health in a large and complex institution, where members of staff have many competing priorities and where information and advice on this subject can be drowned out by information on many others.

6.4 Relationships - at the core of supporting students

A recurring theme throughout the project, and thus in this report, is that of the relational difficulties experienced between the student and the helper. The results of the questionnaires and focus groups paint a vivid picture of the sort of interactions that happen again and again, leaving the student feeling unsupported, insecure and overwhelmed and the helper frustrated, stressed and uncertain about the limits of their role. These interactions link to those described in the literature review, and perhaps form the central difficulty in providing appropriate support for this student group.

One way of thinking about this is to see these interchanges not just as interaction but as 're-enactments' where both parties will, as a default, revert to previous and possibly maladaptive ways of functioning and relating when under stress. For example, someone with such complex mental health difficulties may have had difficult past experiences where they have been ignored, dismissed, misunderstood, and either neglected or over controlled by someone else. The danger is that helpers may inadvertently re-enact these experiences either by distancing themselves for fear of being overwhelmed or by giving excessive attention that cannot be maintained. Neither of these polarities provides the secure, consistent and bounded response that would be helpful.

In developing recommendations for action, therefore, the project leaders were aware of the need to provide input – at an individual and systems level - to 'both sides' of the relationship, so that awareness and self reflection of the 'roles' that each may play can be developed in the parties concerned and that they may both feel adequately supported.

6.5 Ideas for change

Many ideas for change have emerged through this research, via the literature review, the responses from staff and students, from the study carried out by our Clemson intern and, not least, discussions within the project working group. They are described below, with explanation and brief discussion.

Containment. Underlying the debate as to how we should respond to the mental health needs of this student group is the question 'containment or cure?' In other words should we set out to rid the student of their difficulties through a therapeutic process or adopt a more limited objective, of enabling them to live and work more effectively within the university setting, protecting both the student and those that they interact with from the more severe

implications of their anxieties? We concluded earlier that many of these students are exhibiting symptoms of long-standing personality traits rather than of acute episodes of mental ill-health, where 'cure' is difficult (contentious even) and only then in the long term. In the view of the working group, this is beyond the brief and indeed the capacity of University services. In addition, the restricted resources likely to be at our disposal over the next few years mean that, realistically, we cannot go down the role of 'cure'. It is therefore clear that containment has to be our objective, remembering that this can be therapeutic in itself.

What exactly do we mean by containment? The concept comes from psychoanalytic thinking and refers to the ability, originally of the parent, to manage and limit, through responsiveness, attunement, reliability and consistency, an infant's distress, allowing them to feel secure and cared for. There are parallels in a university setting, where those most successful in supporting students are those who are responsive, attuned and consistent in their approach – and who offer clear boundaries. They are aware of the pitfalls of re-enacting difficult relationship styles and of the problems that can occur when care is not joined up. The concept can also be used at a systems level, in the sense that the way we organise our mental health provision can provide responsive, joined up, well-boundaried and consistent support to the student. A system which is designed to offer containment in this way may appear costly but can also be seen as an investment if it reduces distress, illness and repeated crises.

Care planning. A clear recommendation of NICE regarding the treatment of clients with personality disorder is that many will benefit from coordinated care planning and this also emerged strongly from our research. This approach has the potential to sit very well in a university setting. Essentially, all contributors to a student's care and support (clinical staff, academic staff and staff from other relevant professional services) would meet with the student concerned to create a structured plan for their support, continuing to work collaboratively in its implementation. This would have many benefits, including providing a vehicle for tighter service integration and having the student at the centre of service provision, not to mention the sense of containment inherent in a structured, predictable and transparent approach. The working group was very much in favour of this development. We would need to look at how we could use NHS experience to develop a flexible and unbureaucratic version of care planning, together with the implications for staff training.

Early intervention. This emerged as a key concept alongside the two mentioned above. We know that crises often emerge after members of academic and/or clinical staff have struggled to help a student over a long period of time. It is felt, and this is backed up by research from NICE, that if we can get to these students early in their university careers, before their conditions are exacerbated and reinforced by a succession of difficulties thrown up by university life, we have a better chance of avoiding crises further down the line. It was felt that early intervention needed to be strongly coupled with collaborative working. We have spoken of the possibility of regular 'cause for concern' meetings at which worrying student cases can be raised at an early stage. Also, encouraging students to *self-refer* at an early stage seems important, particularly in view of the evidence that very often these difficulties are often known only to the student concerned.

Availability of groups. The idea of a wider range of support groups was widely discussed, building on existing models in the UCS Skills for Life programme and on the recent successful example of a peer support group for students with Asperger's Syndrome set up by DDSS. These would provide a student-centred alternative to 1-1 support, as well as a vehicle for breaking down the isolation that some students experience. It seems unrealistic to expect though, that we could afford to set up some of the more expensive group options, such as Democratic Therapeutic Communities.

Improving information, support and training for staff. There was a strong theme within our research that academic staff, when dealing with these more challenging student support cases, felt unsupported and unable to turn to easily accessible advice or information. A number of solutions were proposed, including a central consultation point for general information and for information on specific student cases. On the other hand we know that most if not all of the things that were asked for are already in place: guidance, such as 'Supporting Students with Mental Health Difficulties' available in hard copy and on the web, readily available advice from duty doctors and duty counsellors and a series of training events under the banner of Supporting the Supporters. Beneath this apparent paradox are two issues: one, the difficulty of getting information through to people amidst the 'noise' in a complex and busy organisation and, second, the understandable ambivalence of academic staff about whether supporting students with complex mental health difficulties is really their job. Solutions are difficult to propose but these issues certainly deserve our attention. One avenue we could pursue is to disseminate information by informal means, such as a mental health network for interested staff, in addition to the more formal channels. This might encourage 'viral marketing' of information.

Better support to students in departments. Alongside the issue of staff feeling unsupported was that of students asking for consistency in the treatment they receive in their academic departments, together with a higher level of support. This may be related to the sheer busy-ness of academic staff, as well as the ambivalence that some feel about this aspect of their role. It may also have something to do with the difficulties that students have in articulating the internal distress that they experience.

Both the issues discussed above centre upon the degree to which staff and students feel supported in dealing with the difficulties which are the subject of this report. They may be aspects of a broader question regarding the ability of academic staff to provide pastoral support to large numbers of students. We may hope that some of the other proposals for change, such as a focus on containment, early intervention and a move towards collaborative care planning, will help to improve experiences at the level of the academic department. But in any event this is a problem which certainly deserves further attention.

Improved waiting times and accessibility and duration of care. A frequent call in the research, principally from students, was for greater accessibility to the main student mental health support services. In fact, and given the level of demand, access to these services is already good. It has been possible for two years, for example, to get an appointment with a counsellor in about a week (or sooner if at risk or in crisis). There were also calls for greater access to longer-term therapy. What this reflects perhaps is the sheer level of vulnerability that some students experience and their need to be 'held' in a psychological sense. But in the

current financial climate we cannot realistically expect to offer long-term therapy to more than a very few students or to constantly drive down waiting times. We need instead to look at this from a different perspective and aim to offer containment through new and different ways of working.

Greater care at the stage of selection and admissions. Some staff respondents felt that, in effect, we should exclude potential students who looked unlikely to be able to survive, from a mental health viewpoint, the vicissitudes of university life. Such predictions would be difficult to make but in any case such an approach would almost certainly be counter to our responsibilities under equality legislation. More seriously, there were also calls for us to 'catch' students with such difficulties earlier in their university career. This is linked to the need for early intervention described above. DDSS and UHS already do much to encourage students to declare their difficulties as early as possible, in order to put support in place but perhaps we could do more.

Student (Service User) Involvement. It is well-established in the literature that enabling service users (in this case our students) to be at the centre of their care and support can be therapeutic in itself and there are a number of other advantages too, such as using them to flag up the need for early intervention (students referring themselves as a 'cause for concern') and providing feedback and ideas which we can use for service improvement. In a general sense it is clear from our own research that many of the students in this group suffer from a real sense of isolation and loneliness. Some of our recommendations for greater involvement may mitigate this and lead to a greater sense of belonging to the University community.

7 Recommendations

7.1 A strategic purpose for our work with students

In developing a set of recommendations, we concluded that it would be helpful – not just in the writing of this report but in putting our ideas into action – to agree an overarching goal. We have called this a *strategic purpose* for our work with students living with complex mental health difficulties:

Containment not cure¹⁰ - enabling students with complex mental health difficulties to live and learn successfully in the university community.

We have proposed this strategic purpose for a number of reasons:

- *The research has indicated that ‘...the ‘complex psychological problems’ experienced by this student group are long term, relatively stable features of personality’.*
- *The main intention in helping them – from a University perspective - is to enable them to function effectively in the University community and to pursue their studies. Containing their anxiety (and that of those who live, learn and work with them) is the best way to achieve this end.*
- *Finally that, for reasons of economy in the current climate, some limit to provision has to be established. Providing access to long-term, in-depth, psychological therapy will be beyond our capacity in all but a handful of cases.*

7.2 Principles for change

It is important to be clear about the principles underlying the pursuit of this strategic purpose, in other words how we should manage the changes proposed.

- We need to bear in mind the major changes that universities are just about to undergo and particularly the resulting financial constraints. We should not, therefore, set up anything that we might have to cut later. That would be particularly damaging for this client group.
- Our recommendations for change should enable us to move towards a structured approach to the support of this client group, based on well thought out principles and processes. We know that this is the way to achieve containment.

¹⁰ Providing ‘containment’ in the sense meant in our statement of strategic purpose is achieved through training supporters (staff or students) to be responsive, attuned and consistent in their approach – and to offer clear boundaries. It involves everyone being aware of the pitfalls of re-enacting difficult relationship styles and of the problems that can occur when support is not joined up.

The concept can also be used at a systems level, in the sense that the way we organise our mental health provision can offer responsive, joined up, well-boundaried and consistent support to the student. A system which is designed to offer containment in this way can be seen as an investment if it reduces distress, illness and repeated crises.

- The changes we envisage will be achieved through the development and involvement of a community of people involved in the support of students, whose awareness of this approach is heightened and who will therefore embody it in their work. This is about developing a 'critical mass' for change.

7.3 Recommendations for action

Our strategic purpose is embodied in the recommendations that follow. These are clustered under four headings – or key areas for action - which have been identified as emerging from the research and the discussions it has stimulated. These recommendations will build upon work that we are already doing in each area.

Collaboration

Perhaps the most 'containing' action that can be taken is to increase the level of collaboration within the broader student mental health system. In particular there should be – for this client group – a more closely collaborative approach to agreeing and setting up packages of support. 'Joined up working' is strongly indicated by the research.

Actions proposed

- Move towards a more tightly integrated student mental health system for students with complex difficulties.
- In particular, develop a case management system, through which packages of support are developed collaboratively – services, student, academic staff, NHS workers, as appropriate.
- Develop our own in-house model of 'support planning' (after consulting externally). Then pilot this approach, with a small number of selected clients. Dramatic change is not required here; we should proceed with care, learning as we go.
- Build a network of people to underpin the approach, involving them in its development.
- Extend collaboration in this field to academic staff, ACS, Security Services and the Library.
- Develop the existing link with the NHS Personality Disorder service development group. Consider joint service provision. (eg a day group for students with personality disorder)
- Arrange regular access to NHS psychiatrist.

Early intervention

Experience suggests that appropriate intervention at an early stage, particularly of a collaborative nature, can prevent later crises. This is indicated in the literature review (eg

NICE guidelines) and in this research study, not least in the requests from staff around the institution for earlier support.

Actions proposed

- Identify problems as soon as possible and take appropriate action.
- Hold case conferences earlier – instead of as a response to later crisis.
- Use a stepped care model; low level interventions first - information giving or access to a peer support group for example.
- Consider establishing a regular, possibly monthly, 'cause for concern' meeting where staff can discuss worries about students. Build on 'Worried about a Student?' (SSG web pages) as a signpost.

Student involvement

Student involvement can be helpful in a number of ways:

- *First, as a containing and therapeutic act, putting the student at the centre of their support and giving them a high degree of responsibility in its organisation.*
- *Second, it is indicated by this research that there is a body of students whose distress is known only to them, who need to be helped to refer themselves for support.*
- *Third, so that the student voice is more clearly heard in the development of our services.*
- *Finally, at a time of constraint on resources, this is a way of sharing the load.*

Actions proposed

- Enable more student initiation of shared support plans – “I’m concerned about myself” – and put them at the centre of the process. Our first action is to design a workable process.
- Use students – both individually (clients) and collectively - as a resource.
- Develop facilitated peer support as one arm of our work (eg groups like the Asperger’s support group already in existence).
- Develop service user groups to inform service development, including those above. Work closely with the Students’ Union. (Recent work with the SU and SYEDA on eating disorders provides a helpful model of good practice).

Supporting staff - build their capacity and confidence

Members of academic staff (and also certain staff in Professional Services) are often closely involved with the support of students with complex mental health difficulties and this research shows that they often feel unequal to the task, unsupported, unable to contact expert help and frequently, stressed by the experience. In addition, there is some ambivalence about the extent to which this is really their role.

Actions proposed

What exactly to do about this is something of a puzzle, since a great deal is already done to reach out to staff and support them in this role, eg:

- *Supporting the Supporters – three levels of mental health workshops/groups.*
- *'Supporting Students with Mental Health Difficulties' booklet, including crisis protocol and contact details.*
- *Consultative support available from Duty Doctor, Duty Counsellor and Mental Health Adviser, together with support from Student Support and Guidance (Critical Support Team).*

Yet they feel unsupported. Perhaps dissemination of information in a large and complex institution needs to be thought about differently, possibly with the help of expert marketing professionals. Possible actions are therefore:

- Build on academic 'supporters' to advise us on dissemination of information.
- Use suggested MH network as a 'viral' means of dissemination.
- Capitalise on self-selected able helpers as a resource.

8 Conclusions

8.1 Summary

There is a changing landscape in student mental health. We hinted at this in our 2008 report on student mental health at the University of Sheffield and now we have the evidence presented by this much more extensive study. High levels of severity, increasing numbers of students declaring a mental health disability and the growth of a group of students with complex mental health difficulties are all features of this landscape.

Our study shows that the latter group – with complex difficulties – is now very significant in number and has a major impact upon the University community. The problems experienced by these students are vividly illustrated in the CPSR contribution to this report. Three features of these difficulties which seem particularly significant are: a constellation of often mutually reinforcing difficulties, the maintenance of a façade of effective functioning in order to conceal great distress ‘behind closed doors’ and the sense in which they battle against their difficulties to maintain academic performance.

We have established that the difficulties of this group, unless contained by well thought out services and support processes, have the potential to be very damaging to their academic potential and to their ability to live happily and thrive in the University community. Sometimes their behaviour can be very disruptive and in these cases we also encounter significant stress being placed upon the members of staff that support them.

In our recommendations for action we have attempted to maintain a dual focus: dealing with the needs of the individual student but also thinking *systemically*, focusing on the workings of the mental health system as a whole in relation to these students and their difficulties.

In doing so, we have arrived at a strategic purpose which emphasises containment. Drawing on this overarching aim, our recommendations are fourfold: tighter collaboration between support services, earlier intervention, greater involvement of students and building the confidence and capability of staff that support them.

Implementing these recommendations will not be a quick fix – it will require a concentrated focus over a number of years. We have commented that the learning from this study is relevant not just to the case of our students with complex difficulties but also to the whole picture of student mental health. In a sense, therefore, setting out to implement these recommendations represents a significant strategic shift in the way we provide student mental health services at the University of Sheffield.

8.2 Benefits

The benefits of undertaking this project were several: a better understanding of how key elements of the support to students were being delivered, the identification of areas where service provision required development, and the construction of a strategic framework for

further service development. It is hoped that both improved student support and improved understanding about complex mental health and psychological difficulties- and their impact- at a policy level within the University may be the future consequences of the work undertaken.

As can often happen, an investigation or review of service provision such as this has impact upon what it sets out to investigate. In terms of 'service users' ie the student group in question, there seems to have been a positive response to the enquiries made of them through the questionnaires and focus groups:

'Thank you for undertaking this study. Just completing the questionnaire has focused my mind and made me realise things aren't going as well as they could and I need to do something more to get things resolved for me (and my long suffering family and friends).'
(Verbatim from student survey questionnaire)

'I think that the very fact that you are conducting this survey shows how much you care about the subject and that you recognise the potential scale of the problem' (verbatim from student survey questionnaire)

The brief meeting the project manager had with the student focus group indicated too that the students were interested in becoming involved with the project and helping other students, not just themselves.

In terms of mutual support for staff, the Clemson intern reported that staff within the working group were using the contacts that they had made with each other to obtain support both for themselves and the students they were helping.

Another example of how the process helped to provide resources is the development and use of uSpace for the working group. This is currently still active, although a 'closed' group, and is a useful source of data, documents, and discussions.

More widely, the project has attracted interest from several professionals working in mental health in the Sheffield Health and Social Care Trust, which has resulted in better links with those that provide services for this student group outside the University. It has also raise the profile of the University's Student Services Department across HE institutions across the UK through dissemination via the HUCS¹¹ and AMOSSHE¹² networks.

8.3 Limitations

The project was devised purely inform any future service delivery to students at the University of Sheffield and support for University of Sheffield staff. The project has not been a research project, and except for the material included in the literature review, no attempt has been made to look at service provision for students offered by other universities.

¹¹ HUCS- Heads of University Counselling Services

¹² AMOSSHE- Association of Student Services Managers in Higher Education

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- Angela Marron of Learning and Teaching Services for providing transcripts of focus group meetings, and Somer Finlay for proof reading
- Students and staff of the University for providing the responses which form the heart of this report. We particularly want to thank the students who, despite their difficulties, had the courage to come forward in great numbers to provide such vivid illustrations of their experience of university life.

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Project Outline

Background

The number of students coming to the University of Sheffield with complex mental health/ psychological difficulties has risen steeply in recent years. One measure of this is the Disability and Dyslexia Support Service which now has some 130+ students under its care. This has placed the team under considerable pressure. But evidence of such pressures have also surfaced in UHS, SSG (Critical Support), ACS in terms of residential support, not to mention academic departments. This has led us to believe that we need to take a look at the whole system of support for such students, rather than develop resources and services piecemeal as we have done up to now.

Another reason for carrying out this review is to present a well-researched picture to senior university management, who currently may not be sufficiently well-informed on this issue.

Aims

To review the whole system of support for students with complex mental health/ psychological difficulties and make proposals for its further development.

Objectives

9. *Give a clear definition of what is meant by 'complex mental health/ psychological difficulties' and which students may fall within this category.*
10. *Give an overview, both quantitatively and qualitatively, of the current situation with regard to this group of students at the University of Sheffield.*
11. *Summarise the impact that this has on the University community.*
12. *Review the provision of support for this student group, both internally and externally.*
13. Summarise current recommendations (where available) for psychological support for this student group
14. Identify the strengths and weaknesses of the current support system.
15. Make proposals for remedying any weaknesses and for further developing the system.
16. Through the implementation of the project, and through dissemination of its findings, enhance the University community's understanding and capacity to support these students.

Scope

Included

- Review of clinical and non-clinical support provided by Student Services, other Professional Services and staff in academic departments. A brief summary of provision available through external services (NHS, private provision, and voluntary agencies)

Excluded

- Delivery of enhanced resourcing.

Main Products/Deliverables

- A summary 'map' of the whole system of support provided to students
- A summary of additional support needs, clinical and non-clinical
- A short strategic statement relating to the purpose of this support

- Recommendations for further service development, both in terms of support for students, and support/ training required for staff

Benefits

Benefit	Realisation
Clarity on the scope and purpose of this work	
Better understanding of how key elements of the support to students is being delivered	
Identification of areas where service provision requires development.	
Strategic framework for further service development.	
Improved student support.	
Improved understanding about complex mental health and psychological difficulties- and their impact- at a policy level within the University	

External Dependencies

- Cooperation from stakeholders
- Availability of resources (time, administrative support) for project management group

Underlying Assumptions

- That the Student Services Strategy (June 2009) remains operational
- That the Widening Participation Strategic Plan (June 2009) remains operational
- Current legislation regarding the provision of 'reasonable adjustments' for disabled students remains in place

Project Organisation

The Project Management Group will be headed by the Student Mental Health Leadership Group;

Alan Phillips, Kate Tindle, Alison James, Jenni Hastings, Claire Shanks and Debora Green, which meets four times a year

A wider working group will be drawn from staff from across SSD, plus ACS residencies, Library, academic departments, Students' Union and if possible external professionals.

The groups will be chaired by Alan Phillips/Project Manager Kate Tindle.

Methodology

Advice will be sought through the SMHLG, and the working group will be used to generate ideas for data collection, analysis and reporting. Data will probably gathered in the following ways-

- Quantitative data- via working group members and statistical data where available from Services and Departments
- Qualitative data- from both staff / students who support this student group, and if possible from 'service users' themselves (i.e. the students being supported)- through on- line questionnaires, focus groups and one to one semi structured interviews if needed

The working group will also be used to collect and analyse data, review current provision and to make recommendations . Data analysis will include a benchmarking exercise using data from other Universities

which will be gathered by Kate Tindle. In reviewing current provision and making recommendations, attention will be paid to current DoH / NICE guidelines for this student group. The report will be written by Kate Tindle, in consultation with Alan Phillips and the SMHLG

Reporting

Reports to be made to the Student Services Strategy Group and to the Student Support Forum.

Stakeholders

Stakeholder	Stake in the Project	Communication/Involvement
SMHLG	Responsibility for SMH strategy	'Core' group. Receive reports from project manager and recommend report to SSG and SSF
ACS/ residences	Responsible for welfare of students in halls/ residences	Representation on working group Involvement in working group tasks and activities
Critical support group, SSG	Provide emergency support to students	Representation on working group Involvement in working group tasks and activities
Students Union	Responsible for Student Welfare and representation	Representation on working group Involvement in working group tasks and activities
DDSS	Supporting students with disabilities	Representation on working group Involvement in working group tasks and activities
Academic staff	Responsible for Academic development of students	Representation on working group Involvement in working group tasks and activities
Counselling Service	Responsible for provision of psychological help for students/ consultative support to other staff	Representation on working group Involvement in working group tasks and activities
University Health Service	Responsible for student health	Representation on working group Involvement in working group tasks and activities
Chaplaincy	Responsible for spiritual support and guidance to students	Representation on working group Involvement in working group tasks and activities
Library IC staff	Responsible for library provision/ learning facilities for students	Representation on working group Involvement in working group tasks and activities
External agencies	Providing external psychological support to students	Representation on working group Involvement in working group tasks and activities

Project Schedule

Project Phases

Phase	Start	End
Clarify definition of terms. Plan methodology, with timescales, and report to Alan Phillips and SMHLG	Aug 09	End Sept 09
Recruit stakeholders to working group	Sept/Oct 09	
1 st meeting of working group, discuss methodology, agree and allocate tasks	Oct/ Nov 09	
Data collection on current situation, and impact on University community	Oct/ Nov 09	Jan 10
Review of current provision of services	Oct/ Nov 09	Jan 10
Identify strengths and weaknesses of current systems	Oct/ Nov 09	Jan 10
2 nd meeting of working group	Jan 10	
Make recommendations for future service delivery	Feb 10	May 10
Write up report, present to SMHSLG	May 10	August 10
Deliver report to SSG and to SSF	Sept 10	

E mail to Faculty Directors 2/10/2009

Dear Faculty Directors of Learning and Teaching,

I am looking for colleagues from academic departments who may be interested in volunteering their involvement as outlined below. I realise that you are all extremely busy people, so if you know someone else in your department who may be available and interested please could you forward this e mail to them?

I am looking for academic staff willing to be part of a working group that will be looking at the University's provision for students with complex mental health needs. I am currently undertaking a project that will run until June 2010, the aim of which is to review the whole system of support for students with complex mental health/ psychological difficulties and make proposals for its further development. As you will already know, the number of students coming to the University of Sheffield with complex mental health/ psychological difficulties has risen steeply in recent years. This has placed several teams under considerable pressure, including DDSS, UHS, SSG (Critical Support), ACS in terms of residential support, and of course, academic departments.

The objectives of the project include:

1. Give an overview, both quantitatively and qualitatively, of the current situation with regard to this group of students at the University of Sheffield.
2. Summarise the impact that this has on the University community.
3. Review the provision of support for this student group, both internally and externally.
4. Summarise current recommendations (where available) for psychological support for this student group
5. Identify the strengths and weaknesses of the current support system.
6. Make proposals for remedying any weaknesses and for further developing the system.
7. Through the implementation of the project, and through dissemination of its findings, enhance the University community's understanding and capacity to support these students.

One of the outcomes will be to provide a report to senior management, through the Student Services Strategy Group and to the Student Support Forum.

I will be working closely with Alan Phillips, and the Student Mental Health Strategy Leadership Group. The time needed to participate in the working group would be two meetings in the coming year, plus a small amount of time (about another 2 hours?) outside of these meetings to gather data.

If you are willing to become involved, please could you let me know.

many thanks

best wishes

Kate Tindle

E mail to staff 5/10/2009

Dear colleague

As you will already know, the number of students coming to the University of Sheffield with complex mental health/ psychological difficulties has risen steeply in recent years. This has placed several teams under considerable pressure, including DDSS, UHS, SSG (Critical Support), ACS in terms of residential support, not to mention academic departments

I am writing to invite you to take part in a working group that will be looking at the University's provision for students with complex mental health needs. I am currently undertaking a project that will run until June 2010, the aim of which is to review the whole system of support for students with complex mental health/ psychological difficulties and make proposals for its further development.

The objectives include:

- Give an overview, both quantitatively and qualitatively, of the current situation with regard to this group of students at the University of Sheffield.
- Summarise the impact that this has on the University community.
- Review the provision of support for this student group, both internally and externally.
- *Summarise current recommendations (where available) for psychological support for this student group*
- *Identify the strengths and weaknesses of the current support system.*
- *Make proposals for remedying any weaknesses and for further developing the system.*
- *Through the implementation of the project, and through dissemination of its findings, enhance the University community's understanding and capacity to support these students.*

One of the outcomes will be to provide a report to senior management, through the Student Services Strategy Group and to the Student Support Forum.

I will be working closely with Alan Phillips, and the Student Mental Health Strategy Leadership Group, but I am looking to recruit about 10-12 people who are willing to meet twice in the coming year, and to give a small amount of time outside of these times to assist with these objectives.

The first meeting of this working group will take place **either** on Friday 23rd Oct am or Monday 2nd Nov am.- venue tbc

If you are willing to become involved, please could you let me know by Friday 9th October, and let me know which of the two dates above would be preferable for you

If you are unable to be involved, but know of someone else in your department who may be available and interested please could you also let me know

Thank you very much

Kate Tindle

Working group membership

Sarah Armour
Disability Student Advisor
Disability and Dyslexia Support Service

Fiona Clifford
Mental Health Advisor

Elaine Dean
Head of Customer Support
Western Bank Library

Steve Delaney
Counsellor/ Skills for Life Coordinator
University of Sheffield Counselling Service

Dave Edwards
Counsellor
University Counselling Service

Dr Harriet Fletcher
Consultant Psychiatrist
Brunswick House Psychotherapy Service

Jenni Hastings
Students' Union Welfare Officer

Dr Barbara Jackson
GP
University Health Centre

Dr Michael Jennings
Academic Unit of Medical Education

Revd. Canon Will Lamb
Anglican Chaplain to the University of Sheffield

Lesley Humar
Residential Support Officer
Accommodation and Campus Services

Audrey Leadley
International Student Support
Student Services Department

Dr Katherine Linehan
Department of Biomedical Science

Nora McClelland
Department of Sociological Sciences
Alan Phillips
Associate Director of Student Services
Student Health and Well-Being

Dr Brendan Stone
School of English Literature, Language and Linguistics

Kate Tindle
Head of Counselling
University of Sheffield Counselling Service

Dr Edward Warminski
Department of Chemistry

Hilary Whorral
Careers Service
University of Sheffield

Invited but did not respond:
Julian Davis (University Health Centre)
Ian Cartwright (Early Intervention Service, SHSC)

Student Mental Health Strategy Leadership Group

Debora Green
Assistant Director, Student Services Dept
Student Support and Guidance

Jenni Hastings
Students Union Welfare officer

Dr Alison James
University Health Centre

Alan Phillips
Associate Director of Student Services
Student Health and Well-Being

Claire Shanks
Disability Coordinator
Disability and Dyslexia Support Service

Kate Tindle
Head of Counselling
University of Sheffield Counselling Service

Questionnaire for supporters of students with complex mental health difficulties

Thank you for logging on to this questionnaire. This forms part of a year-long project running at the University of Sheffield to review the system of support for this student group.

For the purposes of the study, our definition of 'complex mental health difficulties' is:

- Students suffering from mental health difficulties whose conditions make it difficult for them to engage effectively with the University experience and whose distressed and distressing behaviour can have a major impact upon others (both students and staff)
- This would include those with a diagnosis of personality disorder
- This would not include students with Autistic Spectrum Disorder unless they are concurrently experiencing shorter term mental health difficulties (e.g. anxiety, depression), and therefore are dealing with a complex set of difficulties.

All questions in this survey are optional. If you decide to answer them all, including comments boxes, this should take you around 15 minutes, or considerably less if you have not been directly involved in supporting such students.

Data gathered from this report will be reported upon in a way that does not identify any individual students.

We would be most grateful if you could include written responses where asked to do so. Any verbatim comments gathered through the 'comments' boxes will be used, and possibly quoted from, in our report UNLESS you indicate at the end of the survey that you do not wish them to be used in this way. These comments are particularly useful in providing us with qualitative data, which gives a more holistic evaluation of what we offer, and our experiences of this.

We are hoping to gather responses from students and staff in all walks of University life. If you have any difficulties in filling in this questionnaire, please do not hesitate to contact us. If you would like to make comments but would prefer to do this in another way, for example informally, in person, then we would be very pleased to arrange this. Contact complex@sheffield.ac.uk

1. Would you consider yourself as someone who is or has been in the role of supporting this student group (either as staff or student)?

Yes/ No/ Unsure

2. Would you consider yourself as someone who is or has been in the role of supporting this student group (either as staff or student)?

Yes/ No/ Don't Know

3. If yes, how many hours per week are allocated to this?

Have you ever been involved in helping/ supporting a student who fits the description 'suffering from mental health difficulties whose conditions make it difficult for them to engage effectively with the University experience and whose distressed and distressing behaviour can have a major impact upon others'?

Yes/ No

4. Questions for active supporters

a. How many times have you been required to/ volunteered to offer support to students with complex mental health difficulties (i.e. who fit our definition 'students suffering from mental health difficulties whose conditions make it difficult for them to engage effectively with the University experience and whose distressed and distressing behaviour can have a major impact upon others')?

In the past week/ the past month/ the past year

None/ once/ twice/ three times/ four times/ five times/ More than five times

Comments

b. Please give a brief description of the sort of problems that you have had to deal with

c. How much time does this sort of help /support take you?

Per week/ per month/ per year?

d. When supporting people from this student group, how often do they report-

- Self destructive/high risk behaviours?
- Severe depression with low mood, negative thoughts, hopelessness and despair?
- Relationship problems with peers in adolescence
- Difficulties in making rewarding relationships with acquaintances and intimate relationships?
- Being abused (sexually and/or physically, past or present) or a failure to protect from such abuse by a significant other?
- Relationship with parents characterised by emotional distance, hostility or emotional over-involvement?
- Difficulties in previous experiences of seeking or getting help?

Never/ not often/ sometimes/ often/ very often/ Don't know

Comments

e. In terms of the impact that supporting this student group has upon on you, how often-

- Do you feel there is a risk of her/him becoming over reliant on the help offered?
- Does the nature of the interaction between you make it difficult for you to work together in resolving the problem?
- Are you left feeling uncertain about your role?
- Are you left with feelings that get in the way of your being helpful?
- Are you left feeling that you may go beyond what you would normally offer?
- Are you left feeling confused, unable to think or use your usual skills?
- Are you left feeling that she/he hard to reach

Never/ not often/ sometimes/ often/ very often/ Don't know

f. Would you like to comment in any way about your experiences of helping this student group?

g. What other support is available for this student group that you are aware of?

h. Within your department/ Within the University/ In the wider community/ In the NHS/ Other

i. In your opinion, is this sufficient?

Yes/ No/ Unsure

Comments

j. What support is available to YOU with regard to helping this student group that you are aware of?

Within your department/ Within the University/ In the wider community/ In the NHS/ Other

Comments

k.What do you think would be beneficial both for you as a supporter, and for this student group?

5. Questions for all respondents

Do you think that the help available to students with complex mental health difficulties works well in terms of services/ departments communicating with each other?

Yes/ No /Unsure

6.What do you think would be beneficial both for you as a supporter, and for this student group?

For supporters

For the student group

7.How long have you been at the UOS, in any capacity?

- < 1 year
- 1-2 years
- 2-4 years
- 4-6 years
- More than 6 years
- More than 10 years
- More than 20 years

8.Over this period of time, in your experience, have occasions when you have supported such a student become

- Much less frequent
- Less frequent
- About the same
- More frequent
- Much more frequent
- Don't know/ N/A

9.What do you think the University could do to support these students more?

10.Please use this box to add any other comments that you wish to make

11.Can we quote (anonymously) any text that you have written in our report

12.Can we contact you, in confidence, about any of the above?

13.Would you be willing to take part in a focus group to discuss the provision for students with complex mental health difficulties?

14.Thank you very much for completing this questionnaire. If we can contact you, please fill in the following information

Name/ E mail address/ contact number/ Department (optional)/ Are you a member of staff or a student?/ If staff, job title (optional)

Hard to Help Checklist

This checklist can serve to focus your thoughts and feelings when it seems hard to help someone. They may be hard to help because of:

The wider context	The way the person seeks help	Aspects of the relationship between you	Issues arising from their life experiences
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About the wider context

1. Are you and the help seeker unsure about who to ask or where to get appropriate help?
2. Is she/he facing practical difficulties, which impair the effectiveness of the help that can be offered?
3. Do institutional or organisational practices impede the helping process?
4. Are there social and cultural factors (in the broadest sense) that are felt by either party to affect the quality of the helping relationship?
5. Do you find it particularly difficult to identify the precise nature of his/her problem?
6. Is her/his behaviour outside your usual helping experience?

About seeking help

Does she/he appear in need of help but...

7. does not make use of it e.g. by rejecting, avoiding or seeming highly ambivalent?
8. or help is sought (on their behalf) by someone else
9. but embarrassment or pride gets in the way of seeking help or exploring the full extent of their problem?
10. Does she/he seek help from different sources in a way that undermines or confuses the help that can be given or received?

About the relationship with you

11. Do you feel there is a risk of her/him becoming over reliant on the help offered?
12. Does the nature of the interaction between you make it difficult for you to work together in resolving the problem?
13. Are you left feeling uncertain about your role?
14. Are you left with feeling that get in the way of your being helpful?
15. Are you left feeling that you may go beyond what you would normally offer?
16. Are you left feeling confused, unable to think or use your usual skills?
17. Are you left feeling that she/he hard to reach?

About the person/s experience

Has she or he described...

18. self destructive/high risk behaviours?

19. severe depression with low mood, negative thoughts, hopelessness and despair?

20. relationship problems with peers in adolescence

21. difficulties in making rewarding relationships with acquaintances and intimate relationships

22. being abused (sexually and/or physically) or a failure to protect from such abuse by a significant other?

23. relationship with parents characterised by emotional distance, hostility or emotional over-involvement?

24. difficulties in previous experiences of seeking or getting help?

Any further thoughts?

Any action needed?

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Questionnaire for students with complex mental health difficulties

Thank you very much for logging on to this questionnaire. This forms part of a year-long project running at the University of Sheffield to review the systems of support for this student group.

We are trying to canvas opinion from students who think that they might fit this description. We recognise that not everyone finds such labels helpful- so another way of describing this for the purposes of the study might be:

'students suffering from mental health difficulties whose conditions make it difficult for them to engage effectively with the University experience and whose distressed and distressing behaviour can have a major impact upon others (both students and staff'

You may or may not have had a formal 'diagnosis', but if you think this might apply to you, then we would value your opinions.

This questionnaire will ask you a maximum of 16 questions. It could take you as little as 5 minutes to fill in, but if you wish to comment more fully, it could take you a little longer than this. We would be most grateful if you could include written responses where asked to do so. Any verbatim comments gathered through the 'comments' boxes will be used, and possibly quoted from, in our report UNLESS you indicate at the end of the survey that you do not wish them to be used in this way. These comments are particularly useful in providing us with qualitative data, which gives a more holistic evaluation of what is offered to you, and of your experiences of this. However, if you do not wish to answer a question, then please miss it out and go on to the next one

Data gathered from this questionnaire will be reported upon in a way that does not identify any individual students.

We are hoping to gather responses from students and staff in all walks of University life. If you have any difficulties in filling in this questionnaire, please do not hesitate to contact us. If you would like to make comments but would prefer to do this in another way, for example informally, in person, then we would be very pleased to arrange this. Contact complex@sheffield.ac.uk

Thank you- Kate Tindle, Head of Counselling, University of Sheffield

1. Would you consider yourself as someone who could fit into the description as above?

Yes/ No /Unsure

2. Could you give a brief description of the sort of problems you have to deal with in your everyday life ?

3. Do you have any formal mental health 'diagnosis'

Yes/ No/ Don't wish to say

**If you have had a formal diagnosis, can you tell us what this is?
This question is optional**

Experiences of help

1. Do you access any help from any of the sources below?

Family
Friends
Tutors
Academic administrators/secretaries
Accommodation staff
Student Services Information Desk
Critical support team
Chaplaincy
Counselling Service
Disability & Dyslexia Support Service
University Health Service
Other GP practice
Community Mental Health Team
Psychiatrist/ Psychologist
Voluntary agencies
Any other- include ways in which you help yourself

2. In your opinion, is help this sufficient?

Yes/ No/ Unsure

Comments

3. Are you eligible for Disabled Students Allowance?

Yes/ No/ Don't know

4. This question is about your experiences of the help you receive, or have received, from the services/ departments listed above

What is good about the help you get?

What could be improved?

Do you think that the help available works well in terms of services/ departments communicating with each other?

5. More specifically, what support do you think that the University should offer you?

6. Is there anything else that you'd like to add?

These questions ask for some general information about you.

1. Can we quote (anonymously) any text that you have written in this questionnaire in our report?

2. Can we contact you, in confidence, about any of the above?

Thank you very much for completing this questionnaire. If we can contact you, please fill in the following information

Name/ email address/ Contact number/ Department (optional)

Are you female/ male/ don't wish to say

Are you 18-21, 21-25, 25-29, over 30, don't wish to say

And finally- How long have you been at the University of Sheffield, in any capacity?

Less than 1 year, 1-2 years, 2-4 years, 4-6 years, more than 7 years

Announce e mail for students

Does your life seem to be one long series of crises?

Do you feel that your relationships always seem to go wrong?

Does this make it difficult to feel good about yourself?

Do you sometimes feel empty inside?

Do you have problems related to eating?

Do you sometimes hurt yourself or feel suicidal?

Do you find it hard to trust / stay in touch with the services which are supposed to help?

Do you find it difficult to control your angry feelings?

Do you sometimes take things out on other people?

Do you try to deal with your difficulties by drinking or taking drugs?

Are you struggling to keep up with your studies because of these problems?

You may not have experienced all of these things, but if you can answer "yes" to a number of these questions, then we would like to hear from you. We are running a year long project to look at the current provision for students at the University of Sheffield who may feel and act in these ways. You can participate in this project by giving us your opinions in one of the following ways

- Fill in a confidential on line questionnaire
- Take part in a focus group
- Meet with someone face to face in a confidential setting

Log on to the link

<http://www.surveymonkey.com/s/6PQB9R6>

or contact us at the email address given below.

E mail: complex@sheffield.ac.uk

Kate Tindle, Head of Counselling, on behalf of the CMHD Working group

E mail to respondents of service user survey expressing suicidal ideation

Dear

Thank you for filling in our on line survey about you experiences of mental health difficulties. You gave your contact details at the end of the survey, and permission to contact you, so I hope that you don't mind me doing so.

I am monitoring replies, and noted in your response that you expressed some suicidal thinking. You may feel that you already have existing sources of support, but if not, you may find one of the following links helpful

Your GP or the University Health Service: Tel. 0114 222 2100, Internal: 22100. www.shef.ac.uk/health

University Counselling Service- see our website for various ways in which we may be able to help. www.shef.ac.uk/counselling

Disability & Dyslexia Support Service- the Mental Health Advisor may be able to help www.shef.ac.uk/disability

Nightline - Tel: 222 8787 (listening line) 222 8788 (Info line). PLEASE

NOTE: This is a term time only service.

The Samaritans: Tel. 08457 909090.

Student Support and Guidance (Critical Support): Tel. 0114 2224321, Internal 24321

Chaplaincy: Te. 0114 222 8923

In an emergency-

NHS Direct: Tel. 0845 4647.

The nearest Hospital Accident and Emergency Department. For the Northern General Accident and Emergency Department, Tel. 0114 243 4343.

The Emergency Services: Tel. 999.

The University Security Service: Tel. 0114 222 4085, Internal: 24085.

Best wishes

Kate Tindle

Head of Counselling

'Announce' broadcast and email to all staff groups

Monday, 22 Feb 2010 00:00 AM to Thursday, 25 Feb 2010 00:00 AM

Supporting Students with Complex Mental Health Difficulties Request for participants in on-line survey

Dear colleague,

I am writing to invite you to take part in a survey about your experiences of helping students with complex mental health difficulties.

In conjunction with Alan Phillips, Associate Director of Student Services, and the Student Mental Health Strategy Leadership Group, I am currently undertaking a project that will run until June 2010, the aim of which is to review the whole system of support for students with complex mental health/ psychological difficulties and make proposals for its further development.

For the purposes of the study, our definition of 'complex mental health difficulties' is:

* Students suffering from mental health difficulties whose conditions make it difficult for them to engage effectively with the University experience and whose distressed and distressing behaviour can have a major impact upon others (both students and staff)

* This would include those with a diagnosis of personality disorder

* This would not include students with Autistic Spectrum Disorder unless they are concurrently experiencing shorter term mental health difficulties (e.g. anxiety, depression), and therefore are dealing with a complex set of difficulties. You can help in either or both of two ways:

1. Fill in an online survey

The link to the survey is: <http://www.surveymonkey.com/s/KXYCXKK>

All questions in the survey are optional. If you decide to answer them all, including comments boxes, this should take you around 15 minutes, or considerably less if you have not been directly involved in supporting such students. Data gathered from the survey will be reported upon in a way that does not identify any individual students or staff

If you have already filled in this questionnaire, please do not do so again.

2. Put your name forward for a focus group discussion. E mail complex@sheffield.ac.uk and we will send you further details

If you would like to make comments but would prefer to do this in another way, for example informally, in person, then we would be very pleased to arrange this. Contact complex@sheffield.ac.uk

Thank you very much for your help

best wishes

Kate Tindle

Focus group communications

For staff- e mail invitation

Dear All,

Your name has been passed onto me by Kate Tindle as someone who would be willing to participate in a focus group, exploring the provision that the university currently has for supporting students with complex mental health problems.

I would like to run a couple of focus groups next Thursday (11th March) and would be grateful if you could let me know if you are able to attend. The first group will take place from 9.30-10.30 and the second group from 11.00-12.00.

If you could let me know your availability I would be grateful.

Best wishes,

Katherine

Dr Katherine Linehan,
Department of Biomedical Sciences,
Addison Building,
University of Sheffield,
Western Bank,
Sheffield.
S10 2TN
0114 2222347

Information for attenders- staff

Complex mental health project-focus group

How your comments will be used

Thank you for agreeing to participate in this focus group. For analysis and reporting purposes the discussion by the group will be digitally recorded and Angela Marron from LeTS will be taking notes. To provide qualitative data of a high standard you may be quoted verbatim in the final project report, however, all comments will be anonymised. If you have any objection to this please could you let me know after the session, in person or via e-mail (K.Linehan@shef.ac.uk).

What we mean by complex mental health difficulties

The current definition of what the project team mean by students with complex mental health difficulties is still a work in progress, in that staff/students who

participate in the project may wish to make suggestions about how the terminology may be improved.

However, in order that we are all discussing the same issue at the focus group the definition stands as:

Students suffering from mental health difficulties whose conditions make it difficult for them to engage effectively with the University experience and whose distressed and distressing behaviour can have a major impact upon others (both students and staff).

Further comments

In order to cover all the issues pertinent to the project I may at times move the discussion along. Please don't feel that your experiences are not valued. Any further information you'd like to give the project team can be sent to complex@sheffield.ac.uk

Additional help

This session may raise issues for you that you wish to discuss with the appropriate support staff at the University. Alternatively, you just may like to be more aware of the resources available to you to support your students. Marie Feltham is the staff counsellor and can be contacted by phoning (0114) 222 4134 or emailing ucs@sheffield.ac.uk

For students- e mail invitation

Dear student,

You may remember that you responded to a survey that was sent out in November/ December 2009. This was in connection with a project that we are undertaking to look at the needs of, and provision for, students who may be experiencing more complex mental health difficulties. You included your e mail address as someone who was willing to be contacted, and I am writing now to ask whether you may be willing to attend a focus group meeting with other students who replied to the questionnaire. We are very keen to include the student voice in our project, so if you think that you may like to be involved in this, please reply to me at complex@sheffield.ac.uk, and I will let you have some more details

Best wishes

Kate Tindle

On behalf of the 'Supporting Students with Complex Mental Health Difficulties' Project Working Group

There are sources of help and support on the Counselling Service web-site that you may find useful.

These can be found at www.shef.ac.uk/counselling

If you need to see or talk to someone *urgently* contact the following as

appropriate:

Your GP or the University Health Service: Tel. 0114 22 22100.

NHS Direct: Tel 0845 4647.

Nightline - Tel: 0114 22 28787 (listening line) 0114 22 28788

(Info line). PLEASE NOTE: This is a term time only service.

The Samaritans: Tel. 08457 909090.

Student Support and Guidance (Critical Support): Tel. 0114 22 24321

Chaplaincy: Tel. 0114 222 8923

Information for attenders- students

Focus group for students

Thank you very much for agreeing to participate in this focus group, which will be facilitated by Dr Brendan Stone, who is a member of the project's working group, and is a University Teacher in the School of English Literature, Language and Linguistics. Members of the group will be students at the University of Sheffield, who responded to the 'Announce' e mail sent out in November 2009, and either contributed to an on line survey, or offered to contribute their views to a focus group.

This focus group forms part of a year-long project currently being undertaken by the University: '*Supporting Students with Complex Mental Health Difficulties*' - the aim of which is 'To review the whole system of support for students with complex mental health/ psychological difficulties and make proposals for its further development'. The Project Management Group is headed by the Student Mental Health Leadership Group, and the Project Manager is Kate Tindle.

The Objectives of the project are

- Give a clear definition of what is meant by 'complex mental health/ psychological difficulties' and which students may fall within this category.
- Give an overview, both quantitatively and qualitatively, of the current situation with regard to this group of students at the University of Sheffield.
- Summarise the impact that this has on the University community.
- Review the provision of support for this student group , both internally and externally.
- Summarise current recommendations (where available) for psychological support for this student group
- Identify the strengths and weaknesses of the current support system.
- Make proposals for remedying any weaknesses and for further developing the system.

- Through the implementation of the project, and through dissemination of its findings, enhance the University community's understanding and capacity to support these students.

How your comments will be used from the focus group

For analysis and reporting purposes the discussion by the group will be digitally recorded and Angela Marron from LeTS will be taking notes. To provide qualitative data of a high standard you may be quoted verbatim in the final project report, however, all comments will be anonymised. If you have any objection to this please could you let us know after the session, in person or via e-mail (complex@shffield.ac.uk). We will be asking all students who attend the group to respect the confidentiality of other members of the group.

What we mean by complex mental health difficulties

The current definition of what the project team mean by students with complex mental health difficulties is still a work in progress, in that staff/students who participate in the project may wish to make suggestions about how the terminology may be improved.

However, in order that we are all discussing the same issue at the focus group the definition stands as:

Students suffering from mental health difficulties whose conditions make it difficult for them to engage effectively with the University experience and whose distressed and distressing behaviour can have a major impact upon others (both students and staff).

Further comments

In order to cover all the issues pertinent to the project the facilitator may at times move the discussion along. Please don't feel that your experiences are not valued. Any further information you'd like to give the project team can be sent to complex@sheffield.ac.uk

Additional help

This session may raise issues for you that you wish to discuss with the appropriate support staff at the University. Kate Tindle, Head of Counselling, will also be available to discuss these immediately after the focus group meeting, if you need to do so.

Guiding questions for focus group facilitators

What drew you to attending the group today?

Does the definition '.....' make sense? Is this how you see yourself? (Service users)

Does it accurately reflect your experience of these students? (Supporters)

What experiences have people had of supporting students with these particular difficulties?
(Staff)

What impact have these experiences had on you/ others? How have these experiences affected your life (at university)? How have they affected others around you? (Service users)

What support are you aware of for this student group?

Ditto for yourself? Have you felt helped and supported? (Anyone)

How have you been helped? And by whom? (Anyone)

How effective are departments /services at working together to help these students?

Are there institutional/ organisational processes that impede the quality of help given?

Do you think U of S should be doing more/ less/ about the same for this student group?

Do you have any thoughts about what would help? Anything specific in mind?

What would you like to happen next with this information?

Any other thoughts

Working Group Interviews (Clemson Intern's report)

Melissa Noble

The University of Sheffield

Timeline

Week 1

Met with Alan and Kate about the project
Reviewed literature and meeting notes
Met with Kate to offer an interview plan

Week 2

Sent out email to working group members
Attended 'Supporting Students with Mental Health Difficulties' presentation
Scheduled interviews
Facilitated interviews
Scheduled final presentation for counselling service staff

Week 3

Facilitated interviews
Started developing presentation

Week 4

Finalized presentation and transitional report
Presented to counselling service staff
Final presentation for Andrew West and student support staff

Preparation

During my internship, I interviewed members of the working group, 'Supporting Students with Complex Mental Health Difficulties.' To prepare, I reviewed available literature, meeting notes, and PowerPoint presentations. From this review, I identified three themes: collaboration, the role of academics, and transition. These themes helped me develop the interview questions:

How could the university utilize collaboration (a multi-disciplinary approach) to support students with complex mental health difficulties?

What role do academics play in supporting students with complex mental health difficulties? What is the relationship between academics and student support services?

How does the university support students with complex mental health difficulties during the transition process? Are there areas for improvement?

Additional thoughts?

I contacted each working group member via email (see Appendix I). In the email, I attached a handout with the purpose, questions, and confidentiality statement (Appendix II). I scheduled interviews with those members who responded.

Interviews

In total, I interviewed 12 working group members (out of 21). 11 of the participants are student support staff and 1 participant is a faculty member. I met all participants at their respective offices on campus. Participants represented a variety of disciplines including disability service, counselling

service, health centre, library, and career service. Each interview lasted approximately thirty minutes. I synthesized the feedback to present to counselling service and student support staff.

Feedback—Collaboration

In order to best support students with complex mental health difficulties, a high degree of collaboration is necessary. Some members indicated collaboration already exists but there is not enough. Some members also indicated effective collaboration requires consistency. For example, one service may say one thing to a student but another service may say another. Feedback demonstrated the need for a pro-active approach to student support, as opposed to a reactive approach. Student support staff should work to minimize future issues from occurring. One member indicated collaboration is important because the university should reflect the variety of support networks available outside campus. Members felt there is a need for clear expectations in managing and supporting students with complex needs.

Several ideas were offered to refine collaboration at the University of Sheffield:

Establish a care coordinator position

Create individualized package for students with self-identified mental health issues

Facilitate a democratic therapeutic community

‘Visit the Neighbours’ day with student support staff

Create a regular meeting schedule

Case discussion forum

Extend the boundaries of confidentiality

Create an action card for student support staff and faculty members

Based on the feedback, I identified limitations in a multi-disciplinary approach to supporting students with complex needs:

Confidentiality

Student consent to share personal information

Financial support

Dispersing the responsibilities of a care management system

Times/energy on staff

Difficult to coordinate schedules

Requires students to self-identify

Student trust may only extend to one staff member

Feedback—Academics

Recognizing the importance of academics in a multi-disciplinary approach, I asked participants to provide their opinion on the current role of academics. I also received feedback on what academics’ role should be in supporting students with complex mental health difficulties. Upon reviewing the feedback, I identified two common perceptions towards the role of academics. Some participants felt faculty members should have a solely academic role. Others, however, felt faculty should be prepared to provide both academic support and pastoral care. The following outlines why participants felt academics should offer only academic support (A) or both academic and pastoral support (B).

Only Academic

Lack formal training

Employed for academic expertise

Pastoral support is already available

Requires time and energy

Inequalities in student support amongst departments

Relationship should be one of referral

Academic/Pastoral

Should relate at a human level

Should engage in intentional interactions with students

Personal tutor might be the first contact for students

Students' academic success and mental health are not separate

Educate students holistically

Despite discrepancies in the role of academics, working members agreed academics are vital to supporting students with complex needs. Some working members liked the idea of networking.

They believed establishing relationships with other departments could alleviate issues in the future.

Participant F noted it is important for faculty members to recognize that just because a student has academic difficulties, this does not necessarily mean they are 'lazy.' This understanding is especially important when working with students with complex needs. Feedback indicated the University of Sheffield needs to respond as whole. Support cannot be fragmented, it must be collaborative. Ideas were offered to help academics understand how to best support students with complex needs:

Facilitate workshops to faculty members (summer or January)

Case studies

Utilize electronic resources

Create an action card for faculty members

Revisit the university's interpretation of 'fitness to study'

Feedback—Transition

The health centre and disability service already provides support to students who indicate mental health difficulties on the university application. One participant suggested the university's efforts should not just focus on students with mental health difficulties. This could result in singling out a population. Instead, the university should focus on helping *all* students. There is already a wealth of information available to students, but it is finding the best way to disseminate such information. For students with complex needs, it is important to offer structured guidance without encouraging too much dependency.

Several ideas were offered to enhance the transition process for students with complex needs at the University of Sheffield:

Older students could mentor first-year students

Effective communication with student accommodations

Workshops for students with mental health difficulties

Induction event specific to students' health and wellbeing

Collaboration with the Student Union

Offer effective signposting to direct students to the right services

Be mindful of information overload (especially at the beginning of a student's university experience)

Utilize cyberspace/electronic resources

Consult current students

Internal training for departments

Based on the feedback, I identified limitations in the transition process for students with complex needs at the University of Sheffield:

Responsibility of student to self-identify a mental health issue

Associated stigmas/myths towards people with mental health difficulties

University could be acting too soon, anticipating issues before they arise

Potentially interpreted as 'hand holding'

Be mindful not to single out a population

Disability assessment takes 6-8 weeks to process

Feedback—Other

Other ideas were offered to assist students with complex needs:

Feedback was extensive but severely limited by confidentiality

Examine the role of receptionists and offer training/support

A psychiatrist in counselling service could provide a different level of support to staff and students
University should “support the supporters”

Be mindful of how responsibilities are dispersed, many participants indicated they already have a lot to do

Need a formalized system

More transparent resources

Working group acted as a network for collaboration

Support for students with complex needs should not solely rest on the good will of student support staff, needs to be a university priority

Limitations

With any project, there are limitations. One limitation was the number of working group members I interviewed. While I interviewed 12 participants, there are 21 working group members. This brings into question whether or not the feedback is representative of the entire working group. Additionally, I was limited by the short time period. Another limitation was cross-cultural. I recognize I am coming from an American perspective. I may interpret what a participant says in one way, but they have meant something else. This limitation is inherent in any cross-cultural study. Finally, the project was limited by the varying experiences staff had in working with students with complex needs. While this was beneficial in some ways, feedback may have been skewed. I only interviewed one faculty member. If I were to do this project again, I would have tried to interview more faculty members and perhaps, some students.

Reflection

When I first arrived in Sheffield, I was struck by the differences between English and American culture. However, as I prepare to go home, I feel there are many similarities that exist between the two. For one, higher education in both the United States and England are finding ways to meet the increasing mental health needs of students. Furthermore, professionals at both Clemson University and the University of Sheffield are questioning the appropriate level of support offered to students. As a result of this project, I found the interview to be an effective forum for soliciting feedback. Participants seemed open and honest in their responses. Finally, I noticed feedback was associated with the positions participants held. Opinions seemed to be impacted by the perceived level of involvement participants had in supporting students with complex needs.

Email to Working Group

Dear [insert name],

I hope this email finds you well. My name is Melissa Noble and I am a graduate student at Clemson University in Clemson, South Carolina. I am working at the University of Sheffield in University Counselling Service throughout May.

I am contacting you because of your interest in supporting students with complex mental health disabilities. I am working with Kate Tindle and Alan Phillips to interview members of the working group. As you have been a part of the discussions and survey dissemination, we would like your feedback on a course of action. Specifically, your feedback would be appreciated on three ideas developed in the working group meetings: collaboration, academics and transition. If you are available, I would like to meet with you for a thirty minute interview.

The interviews are intended to contribute to the overall knowledge produced from this project. All feedback will remain anonymous and personal identifiers will not be used in relation to this project. The feedback will be incorporated into a final report at the end of my internship and will be utilized within the boundaries of this project. Feedback will also be presented to University of Sheffield Student Services and University Counselling Service staff at the end of May. I have attached the purpose, interview questions, and confidentiality statement. Please feel free to review this document.

If you are available for an interview, please email me back three times between May 11-14th and May 17-20th that work best for you. Thank you for taking time to consider my request and I look forward to hearing from you. If you have any questions, please do not hesitate to email me.

Best regards,

Melissa A. Noble

Participant Handout

You've seen the data, you've taken part in the discussions, now what actions do you recommend?

Purpose: Members of the working group, “Supporting Students with Complex Mental Health Difficulties,” will be asked to participate in an interview in May. The purpose of these interviews is to solicit feedback regarding support for students with complex mental health difficulties. Interviews will elaborate on ideas developed in the working group meetings: collaboration, academics and transition. The interviews are intended to contribute to the overall knowledge produced from this project and will last no more than thirty minutes.

Questions:

1. How could the university utilize collaboration (a multi-disciplinary approach) to support students with complex mental health difficulties?
2. What role do academics play in supporting students with complex mental health difficulties? What is the relationship between academics and student support services?
3. How does the university support students with complex mental health difficulties during the transition process? Are there areas for improvement?
4. Additional thoughts?

Confidentiality: No personal identifiers will be used in relation to this project. Feedback will be consolidated into a transitional report and presented to University of Sheffield Student Services and University Counselling Service staff at the end of May. The information collected will be used to further develop the “Supporting Students with Complex Mental Health Difficulties” project.

Uospace web page

uSpace: Group: Supporting Students with Complex Mental Health Difficulties - Windows Internet Explorer

C:\Documents and Settings\Admin\My Documents\complex diff's project\appendices\Uospace Group Supporting Students with Complex Mental Health Difficulties.mht

File Edit View Favorites Tools Help

uSpace: Group: Supporting Students with Complex M...

The University of Sheffield

uSpace Communicate & Collaborate

Welcome, Kate Tindle (Log out) New Your Stuff History Browse

uSpace > Supporting Students with Complex Mental Health Difficulties

Supporting Students with Complex Mental Health Difficulties

Overview (customize) Members (22) Discussions (5) Documents (21) Blog

Group Overview

This group is comprised of people drawn from different parts of the university, all of whom have offered to support a project which sets out to examine the needs of students with complex mental health difficulties and to determine how best they can be supported.

Owned by:
Kate Tindle
Alan Phillips

Tags: health, services, student, transitions, mental, complex

Group Type: Private Group

Created: 26-Oct-2009

Recent Content

lit review.docx	3 weeks ago	by Kate Tindle
WorkingGroupInterviews.ppt	3 weeks ago	by Kate Tindle
notes from 12 July WG meeting.doc	3 weeks ago	by Kate Tindle
Update for 12th July mtg.ppt	3 weeks ago	by Kate Tindle
correlation recommendations.docx	3 weeks ago	by Kate Tindle
Complex needs [Autosaved].ppt	3 weeks ago	by Kate Tindle
Supporting Students with Mental Health Difficulties	3 months ago	by Alan Phillips
notes from 22 March 2010 working group meeting	4 months ago	by Kate Tindle
Update March 8th 2010	4 months ago	by Kate Tindle
Re: Care programme approach - a practical proposition for us?	6 months ago	by Nora McClelland
Brief summary of results from 'service user' survey	6 months ago	by Kate Tindle
Results of questionnaire sent to all members of SMHLG and the project's Working Group	6 months ago	by Kate Tindle

Actions

- Start a discussion
- Create a document
- Create a blog post
- Create an announcement
- Create a poll
- Manage categories
- Invite people to join this group
- Send email to group
- Leave this group

Manage

- Edit group details
- Manage group members
- Manage group blog
- Delete the group

Notifications

- Stop email notifications
- Group feeds

Latest Poll

There are no polls

Internet 100%

start complex project for K... appendices sent-mail for K,S.Tind... complex project for K... uSpace: Group: Supp... 09:54