

**Medical Faculty**

**Clinical Psychology Advisory Service**

**Review and Consultation**

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**THE UNIVERSITY**  
*of* **LIVERPOOL**

## CONTENTS

<b>1</b>	<b>FOREWORD .....</b>	<b>2</b>
<b>2</b>	<b>ADVISORY SERVICE .....</b>	<b>3</b>
2.1	BACKGROUND.....	3
2.2	CONTEXT OF ADVISORY SERVICE .....	5
2.3	RANGE OF SERVICES .....	7
2.4	PREVALENCE OF PSYCHOLOGICAL HEALTH PROBLEMS.....	10
2.5	CAPACITY OF ADVISORY SERVICE.....	13
2.6	TYPES OF PROBLEMS ADDRESSED BY ADVISORY SERVICE .....	14
2.7	REFERRAL PATHWAYS AND LIAISON .....	18
2.8	PROCESSES AND PROCESS ISSUES .....	24
<b>3</b>	<b>CONSOLIDATION AND DEVELOPMENT FOR ADVISORY SERVICE .....</b>	<b>30</b>
3.1	PROMOTION OF ADVISORY SERVICE .....	30
3.2	MANAGING CAPACITY, DEMAND AND MONITORING UNMET NEED .....	30
3.3	‘STUDENT SUPPORT DOCUMENT’ .....	30
3.4	PROMOTE NON-DISCRIMINATION .....	31
3.5	EFFECTIVE LIAISON AND TRANSFER BETWEEN SERVICES.....	31
3.6	FITNESS TO PRACTICE, SUSPENSION OF STUDIES AND PSYCHOLOGICAL HEALTH PROBLEMS.....	31
3.7	SELF-HARM AND PSYCHOLOGICAL HEALTH PROBLEMS .....	31
3.8	STRATEGY PLANNING: MODERATE TO SEVERE PSYCHOLOGICAL HEALTH PROBLEMS .....	32
3.9	OUTREACH SERVICE.....	32
3.10	RESEARCH .....	32
<b>4</b>	<b>REFERENCES .....</b>	<b>33</b>
<b>5</b>	<b>APPENDIX 1.....</b>	<b>34</b>

# **1 Foreword**

The Advisory Service has been in existence for 10 years. It represents a pioneering approach to student support in the provision of psychological therapies for student health care professionals experiencing moderate to severe psychological health problems.

The purpose of this document is to review the function and operation of the Advisory Service and to take a progressive look at the ways in which the service can develop. The functional element concerns clarifying the nature and extent of the psychological health problems the service aims to address. The operational element focuses on reviewing the working interface between the Advisory Services and the University and non-university support services.

Some provisional discussion with key stakeholders has taken place in preparation of this document. However, the document will also serve as a consultation document for key stakeholders about future directions for the service. The review concludes with a summary of consolidation and development statements.

In the document, references are made to Student Support Services and external NHS services and assumptions have been made about their function and operation. The brief descriptions of these services are of necessity oversimplified but are necessary in order to put the Advisory Service into context.

A general note on terminology used in the document. The phrase 'psychological health problems' has been used as the general term for describing the range of emotional, behavioural and interpersonal difficulties experienced by students. This phrase was chosen over terms like 'mental health problems' and 'mental illness', which have connotations to medical illness models of emotional difficulties. There are two reasons for using 'psychological health problems', first it more accurately describes the way in which the Advisory Service views these kinds of difficulties and second the Advisory Service aims to promote a normalising model of psychological distress and believes this kind of terminology promotes this end.

## **2 Advisory Service**

### **2.1 Background**

The Advisory Service was instituted in 1995. The University of Liverpool, Medical Faculty funded the service to meet the growing support needs of health professional students with moderate to severe psychological health problems. One part-time (WTE 0.5) consultant/chartered clinical psychologist delivered the service.

Prior to this, Medical Faculty students with these levels of psychological health problems, which often required longer-term therapies, sought help from the University Student Support services or from NHS secondary psychological therapy services or from other services external to the University. Access to both University and NHS services often involved long waiting times for assessment and therapy due to high demand from service users. Students' psychological health problems not only caused significant personal distress but also posed a serious threat to their training: these problems could lead to students re-sitting exams, re-taking years, suspending studies, or withdrawing from programmes. The aims of the Advisory Service, then, were to provide a timely and quick response, provide appropriate levels of psychological interventions, and support students in maintaining their academic studies and, crucially, their clinical practise with patients. Students supported in this way were more likely to manage and minimise these difficulties and go on to complete their programmes of studies.

In 2001, the Medical Faculty increased the resource of the Advisory Service to one full-time consultant/chartered clinical psychologist. In July 2005, the Medical Faculty increased the resource to two full-time consultant/chartered clinical psychologists. The expansion of the Advisory Service reflected the growth in student numbers within the Medical Faculty and thereby the growth in students with moderate to severe psychological health problems. This recent expansion has also created opportunities for different kinds of service provision and activities which were not possible before. This review, in part, is related to exploring these opportunities for developing new service provisions and activities.

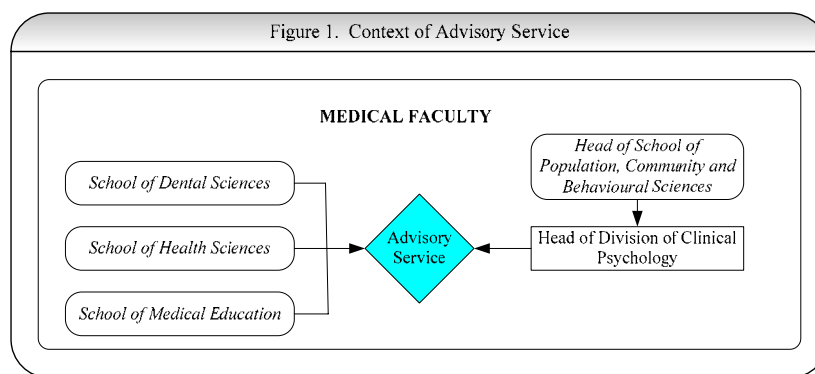
From a national perspective, at the time of its inception, the provision of the Advisory Service to the Medical Faculty was new and innovative amongst Medical Faculties in the UK. The Advisory Service continues to represent a modern and progressive provision in supporting students with moderate to severe levels of psychological health problems.

The service aims to promote an open setting for acknowledging and addressing psychological health problems among students and staff in Medical Faculty and to develop processes and structures that both ensures and reassures students that they will be supported without discrimination

## 2.2 Context of Advisory Service

The University of Liverpool Medical Faculty comprises several Schools and numerous Divisions within Schools. The primary referral population for the Advisory Service is the undergraduate students from the Schools of Dental Sciences, Health Sciences and Medical Education. This referral population also includes students intercalating from these Schools in the School of Biomedical Sciences.

Managerially, the Advisory Service is located in the Division of Clinical Psychology, which is part of the School of Population, Community and Behavioural Sciences. The two consultant/chartered clinical psychology advisors are line-managed by the Head of the Division of Clinical Psychology and in turn by the Head of the School of Population, Community and Behavioural Sciences. The Advisory Service is set up to operate independently, in terms of its clinical work with students, both from the Medical Faculty and from the Schools from which it takes referrals (Figure 1).



The Advisory Service is centrally located within the University in the department of Clinical Psychology. Each clinical psychology advisor has an office within the department that also serves as a consulting room. There is a general waiting area for students attending the Advisory Service. Student appointments at the Advisory Service are during office hours (09.00 to 17.00hrs), Monday to Friday. Out-of-hours contact is not available.

Departmental administration personnel support the clinical psychology advisors with administration and secretarial duties and provide reception services for students attending the Advisory Service. The administration support is equivalent to WTE 0.3 and is currently being reviewed following the expansion of the service. The feasibility and need for providing an outreach service for students on placement encompassing Barrow, Kendall and Lancaster is also under discussion.

Funding for the consultant/chartered clinical psychology advisors comes from the Medical Faculty. The day-to-day operational budget has been largely subsumed within the Division of Clinical

Psychology and partly from external funds generated by the Advisory Service. The Advisory Service has made development-fund bids in the past for the purchase of self-help materials to loan to students. The operational budget is being currently reviewed. An application for an annual operational budget has been submitted to the Medical Faculty in order to cover the cost of test and clinical evaluation questionnaires, self-help materials to loan to students, advisors' continuing professional development course fees, publication and promotion materials and general day-to-day expenditure for running the service.

## 2.3 Range of Services

Paxton and D'Netto (2001) provide a summary of the main activities of clinical psychologists relevant to the provision of the Advisory Service. They list four activities associated with this role.

These include:

1. direct clinical services in the form of psychological assessments and interventions, using a range of psychological models;
2. disseminating and promoting wider use of psychology in health care, through teaching, supervision, consultation and production and dissemination of guidance materials;
3. research and development, including needs assessment and service evaluation projects; and
4. organisational and service development work in which psychological knowledge is applied to the management, planning and development of the organisation in which psychologist work.

**Clinical Services:** The effectiveness of psychological therapies for a range of psychological problems now has a significant evidence base (Department of Health, 2001). Clinical psychology, as a profession, has played a major part in developing and researching psychological therapies. The primary training and additional specialist psychological therapy training enables practitioners to provide comprehensive assessments, formulations and interventions for psychological problems ranging from mild to moderate to the severe and complex.

According to the Review of NHS Psychotherapy Services (1997), clinical psychologists are able to provide therapies, which involve multi-theoretical case-formulation based interventions and formal psychological therapies practiced within specific theoretical models, for example, cognitive-behavioural therapy, interpersonal therapy. This range of therapy skills is necessary for working psychologically with students with moderate to severe psychological health problems and represents the main clinical psychological therapy work carried out by the Advisory Service.

The clinical aims of the services are to provide effective interventions, optimise engagement in therapy work, minimise crisis and reduce risk associated with psychological problems (Table 1).

Table 1. Range of interventions

*The range of interventions that follow-on from referral include:*

- *Assessment or consultation only;*
- *Regular one-to-one sessions involving guided self-help and support;*
- *Regular one-to-one sessions to work through short-term treatment protocols for specific psychological problems (e.g. cognitive-behavioural therapy for anxiety disorders) (approximately 6-12 sessions); and*
- *Regular one-to-one sessions for longer-term psychological therapy (12+ sessions up to a maximum of 24) with moderate to severe psychological problems.*

Face-to-face contacts can be supplemented with phone and email contact within office hours. Sessions are weekly in the early stages of therapy, and fortnightly or monthly during longer-term therapy. After completing a programme of therapy, either a student's file is closed and the work ended or follow-up sessions for a limited period offered.

With the increased resource of the Advisory Service and the increasing demand for help with psychological problems, other modes of clinical contact are being explored. At this time, the Advisory Service is looking to develop self-help materials and the use of web-based materials to supplement the one-to-one contact with therapists.

**Assessments and reports:** As there are now two advisors the Advisory Service can provide independent assessments of psychological health problems for purposes other than providing therapy. The nature of requests for these kinds of assessments and reports may concern, for example, part of a disability assessment of need, assessment of psychological functioning in relation to a student's suspension of studies or their fitness to practice. One important principle maintained is that any such assessments and reports are independent of therapy work, that is, the advisor preparing a report cannot act as therapist for the student and vice versa.

**Psychological health promotion:** The Advisory Service has a psychological health promotion and education role within the Medical Faculty. Attitudes towards people with psychological health problems in the wider society continue to be prejudicial and discriminatory (Angermeyer & Matschinger, 2001) and this may occur in academic settings amongst staff and students alike. Education and promotion can play a positive role in reducing prejudice and discrimination of people with psychological health problems.

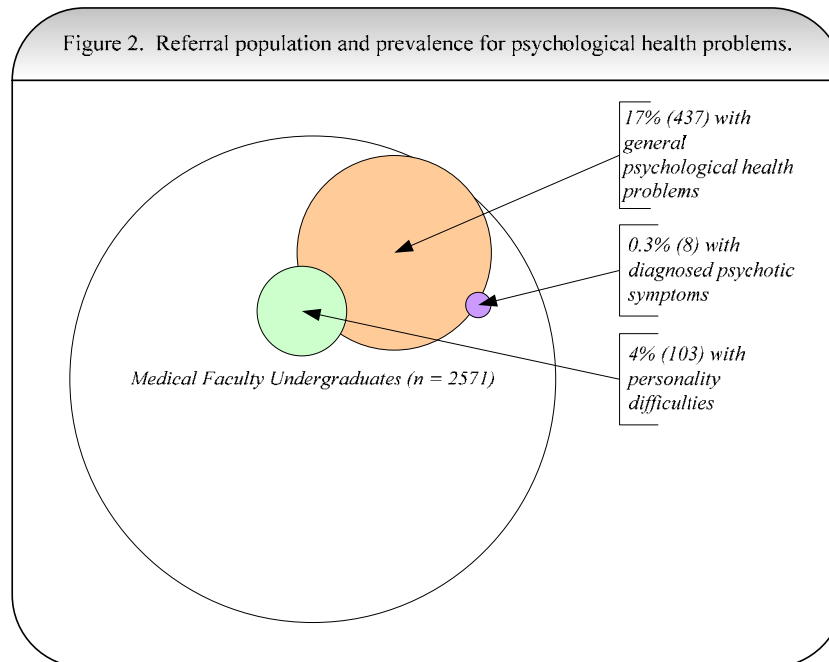
Clinical psychology views psychological health problems as problematic expressions of common every-day experience, for example, the experience of anxiety is seen as shading from mild anxiety, experienced by everyone at some time, to more severe debilitating anxiety, potentially

experienced by all, but actually experienced by a few, at any one time. This approach promotes a non-pathologising attitude towards psychological problems and advocates a normalising and potentially non-discriminatory approach towards understanding students with psychological health problems.

The Advisory Service plans to promote the service widely to Faculty and to students. It is preparing information leaflets and university web-pages to promote understanding and guidance about managing psychological problems also to provide access to appropriate self-help information.

## 2.4 Prevalence of Psychological Health Problems

**Prevalence:** The main referral population for the Advisory Service is the undergraduate students from the Schools of Dental Sciences, Health Sciences and Medical Education. The size of this referral population is 2,571 based on 2005 figures, the majority of students coming from the School of Medical Education (1,500).<sup>1</sup>



The Office of National Statistics (ONS), Psychiatric Morbidity Survey, (Singleton, Bumpstead, O'Brian, Lee & Meltzer, 2000) reports a 17% prevalence for general psychological health problems. The ONS survey estimated the prevalence for personality problems likely to cause distress and interference in day-to-day functioning and relationships (4%) and psychotic symptoms, e.g. schizophrenia (0.3%).

Projecting from the ONS survey, about 500 Medical Faculty students in total would be expected to experience psychological health problems, personality difficulties and psychotic symptoms.<sup>2</sup> Figure 2 represents this by scale. The ONS, in their survey, suggested that half of those with psychological health problems would experience a level of moderate to severe distress that would require active treatment and half would experience a level of psychological health problems that would cause distress and interfere with day-to-day functioning.

<sup>1</sup> The remaining students are from the School of Health Sciences (674) and the School of Dental Sciences (397).

<sup>2</sup> An estimate of 437 for psychological health problems, 103 for personality difficulties and 8 students with psychotic symptoms.

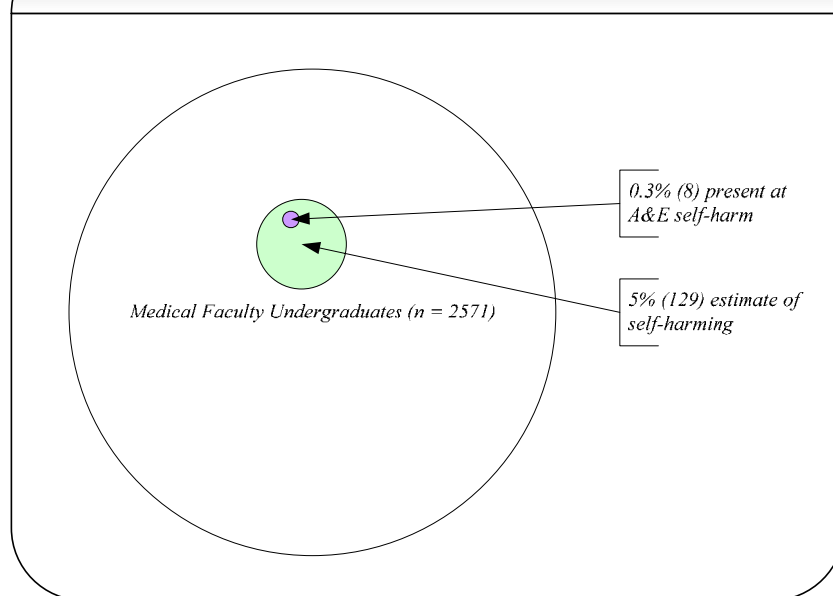
The overall estimate of psychological health problems, including personality difficulties and students experiencing psychotic symptoms will be less than the sum of the above. There is co-morbidity between personality difficulties and psychological mental health problems (shown by the overlap in Figure 2) and people with personality difficulties tend not to seek help unless they develop a psychological health problem.

Prevalence rates decrease as severity in psychological health problems increase. It follows that there will be more students with mild to moderate psychological health problems compared to students with moderate to severe psychological health problems. Many students with mild to moderate level psychological health problems may use self-help strategies, including diet, exercise, regular sleep and avoidance of alcohol and drug use to manage their difficulties, or access support from family, friends and professional systems such as the Student Support Services and GPs.

The primary group for the Advisory Service are students with moderate to severe levels of psychological health problems and or personality difficulties, and when appropriate students with psychotic symptoms. It is difficult to estimate the size of population relevant for the Advisory Service from general estimates, but an approximate estimate is between 100 to 150 students, assuming a notional five hundred students are experiencing psychological health problems over the course of a year.

**Risk:** Risk assessment and management are important components of the Advisory Service since risk tends to increase as severity of the psychological health problems increase. The NICE (2004) guidelines on Self Harm state that the majority of self-harm (self-poisoning and self-injury) goes undetected. Survey data suggests the average general population prevalence for self-harming is 5%, with self-injury and self-poisoning occurring in a ratio of 2:1. However, the incidence of individuals presenting at accident and emergency departments with an acute history of self-harming is 0.3% and of these 80% are incidents of self-poisoning. Figure 3 provides an estimate of the prevalence of self-harm in the Medical Faculty student population.

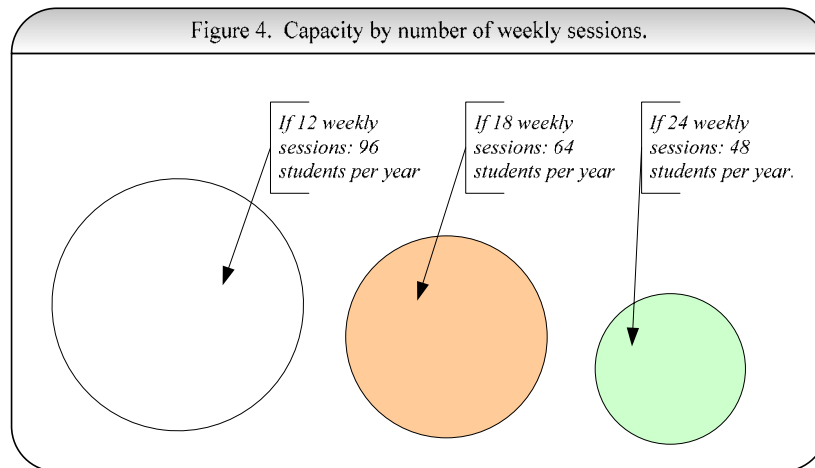
Figure 3. Referral population and estimated prevalence of self-harming.



Both the severity and the nature of risk have implication for the operation of the Advisory Service.

## 2.5 Capacity of Advisory Service

**Capacity:** The Advisory Service's capacity based on two full-time clinical psychologists providing face-to-face sessions over the course of a year is estimated below.<sup>3</sup> Figure 4 broadly illustrates the variability in capacity based on weekly therapy sessions for different lengths of therapy programmes assuming a uniform number of sessions.



An average operational capacity is estimated at  $98 \pm 10$  completed programmes of therapy over the course of a year (assuming an average of 12 sessions per student). Generally, the more severe and complex psychological health problems will require longer programme of therapies.

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<sup>3</sup> Main factors determining service capacity: the number of people delivering the service, time allocated for face-to-face clinical work with students, the time allocated to a session and associated administration, the number and frequency of sessions required.

## **2.6 Types of Problems Addressed by Advisory Service**

The range of complexity, severity and chronicity of psychological problems has led to the provision of a number of levels of health care delivery in the NHS, e.g. primary, secondary and tertiary care, as well as the provision of specialist services.<sup>4</sup> This kind of organisation is necessary to provide services that are appropriate to the range of needs across individuals. Similarly, higher education establishments are in the process of developing services that recognise the diversity and complexity of psychological problems amongst students.

A number of frameworks relating psychological health needs to service provision have been developed. Medical diagnostic classification represents one approach to defining psychological health problems. However, services defined exclusively in psychiatric terms can lead to unintended stigmatisation and overt assumptions of illness. Other, frameworks focus on practical criteria, such as severity, complexity, chronicity and level of risk. These frameworks lead to simple groupings of problems in terms of being (1) mild to moderate, (2) moderate to severe or (3) problems involving psychotic symptoms. This simple ordering of psychological health problems is important when understanding the position of the Advisory Service with the Student Support System.

As already indicated, when considering service planning, it is important to be clear about the full nature and extent of psychological health problems across the range of complexity, severity and chronicity. As already indicated the relative prevalence of mild to moderate psychological health problems will be the largest over all and will require a service provision of practitioners skilled at working with short-term interventions, facilitating rapid resolution of difficulties. For students with moderate to severe psychological health problems, although the relative prevalence of these kinds of problems will be smaller, it is likely that a higher frequency of face-to-face contact will be required and an overall longer period of contact. Both prevalence and overall contact time are relevant when considering the planning and operation of the Advisory Service.

Health status for an individual is not static. It follows that psychological health problems also vary over time. Health care systems need to be responsive to the variability making provision for students to move between levels of care in order to ensure their psychological health care needs are met

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<sup>4</sup> Eating disorders service, drug and alcohol services and chronic fatigue syndrome service.

properly. Maintaining continuity of psychological care provision in the face of this kind of movement is crucial. Integrated services and effective liaison are essential for ensuring this continuity.

A model that has proved helpful in thinking about NHS provision is a four Tier model of psychological health services that allows movement between levels of service so accommodating variability in psychological health needs (Paxton & Straubb, 2000). Table 2 provides an outline of the Tier model with a schematic view of existing Student Support Services mapped on to the model. At each Tier level examples of the nature of problems, types of appropriate response to the identified needs, and appropriate professionals or service provision are given.

Table 2. Tier levels, types of problems, types of response.

Tier Level	Types of Problems	Types of Response	University Services
<i>TIER 1: Transient or mild problems which cause distress but do not markedly affect functioning</i>	<i>Reactions to life events, e.g. grief stress. Relationship and family issues - not chronic or complex. Mild anxiety, depression or anger problems. Self-esteem and confidence problems.</i>	<i>General support. Self help materials. Information on access to support groups, educational resources. Drop in support and guidance.</i>	<i>Personal tutors. Academic sub-deans and senior tutors. Student Support. Student Health. Student Counselling. Disability Service.</i>
<i>TIER 2: Problems which may need more specific skilled intervention but still permit day to day coping.</i>	<i>Moderate depression and anxiety. More complex family and relationship issues. More complex loss issues.</i>	<i>Specialist assessment and consultation. Counselling. Brief therapies. Short-term groups. Guided self-help. Support.</i>	<i>Student Support. Student Health. Student Counselling. Student Disability.</i>
<i>TIER 3: Complex and/or long-standing problems significantly impairing functioning.</i>	<i>Problems above for which other interventions have failed. Obsessive compulsive problems, eating problems, reactions to trauma and abuse. Personality problems.</i>	<i>Specialist assessment and consultation. Specific evidence based psychotherapies. Longer-term therapies. Multi professional/agency interventions.</i>	<i>Student Support. Student Health. Student Counselling. Student Disability. Advisory Service.</i>
<i>TIER 4: Severe problems having major impact on functioning and relationships</i>	<i>Psychotic symptoms. Severe depression. Severe eating problems. Complex co-morbidity.</i>	<i>Multi-professional support and intervention for both service user and carers. Psycho-social interventions.</i>	<i>Student Support Mental Health Service. Student Health. Psychiatry and CMHT Advisory Service.</i>

The system requires confidential, effective, efficient liaison between services, clear inter-service referral pathways, and a means of establishing continuity of care for individuals when there is movement between Tiers.

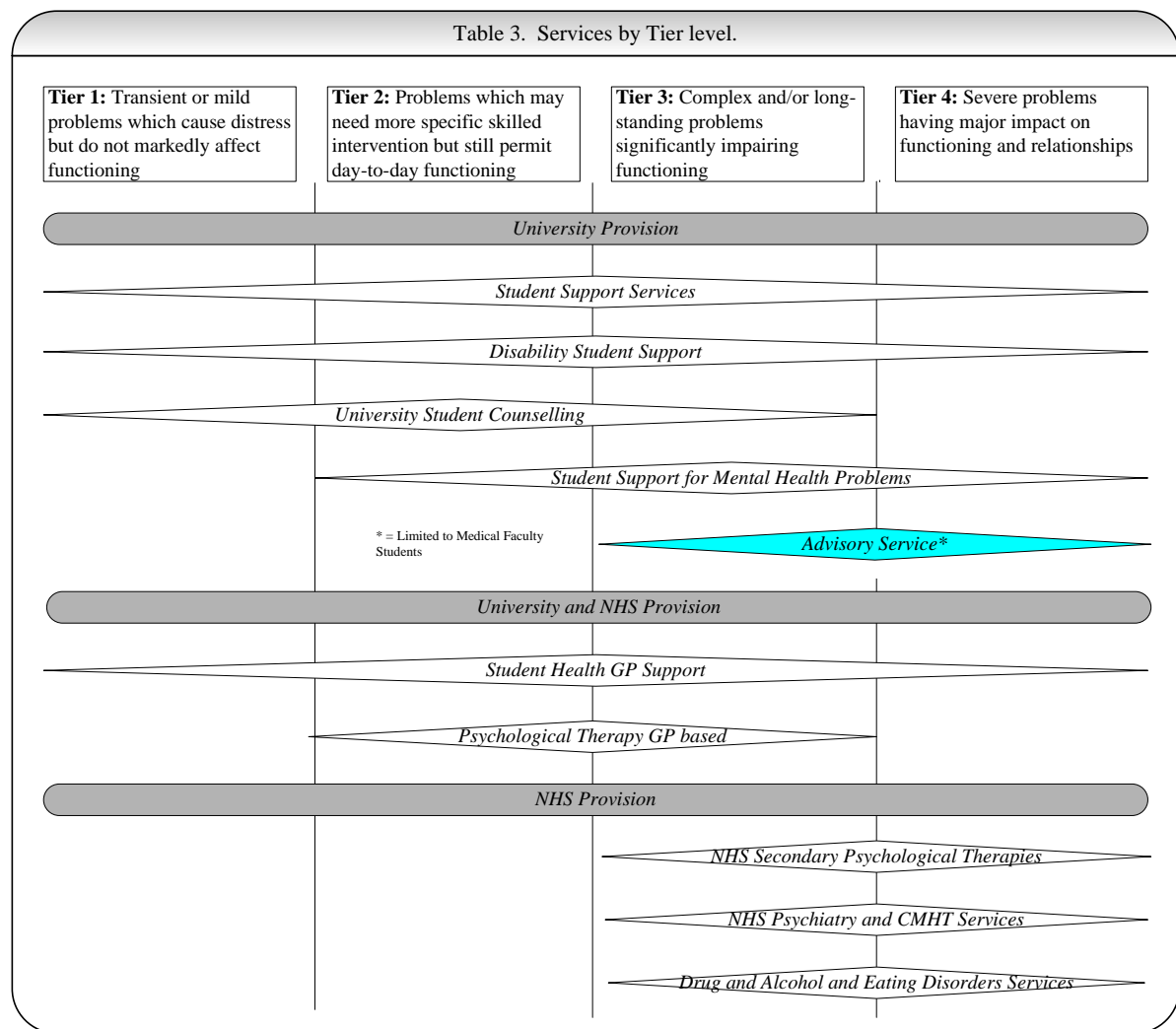
In terms of student care, the University of Liverpool has established a significant number of services responding to the psychological health needs of students.<sup>5</sup> The local NHS services link in with University Services including specialist services.<sup>6</sup>

Table 3 provides a schematic representation of both University and NHS services mapped onto the Four Tier model. It assumes all services have a primary target population in relation to the psychological health problems that they aim to address. The services are located within the Tier model using this presumed primary population, however it is recognised that many services overlap with the Tier levels either side of their primary population. It is likely that many services represented in Table 3 would not see themselves as exclusively limited to the level of psychological health problems as indicated; services often work with students from Tier levels other than their primary group. The diagram is illustrative rather than prescriptive of how these services operate.

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<sup>5</sup> These include Student Support Services, Support Services for Disabled Students, University Student Counselling, Student Health GP Services, Advisory Service and Student Support Services for Mental Health Problems.

<sup>6</sup> For example, Eating Disorder Services, Drug and Alcohol Services, Psychotherapy Services, and Psychiatric Services and Community Mental Health Teams.



Within this scheme, the primary target group for the Advisory Service are students appropriate for Tier 3. The Advisory Service also has a role for working with students with Tier 4 levels of need. This role requires liaison with, Psychiatry, Community Mental Health Teams (CMHT) and other NHS agencies and may involve the University Student Support Service for Mental Health Problems.

The Tier model highlights the importance for integrative working between the Advisory Service, the University Student Support Services and NHS services. It reinforces the need for clarity in the referral criteria for the different services. The Advisory Service aims to formalise clearer referral criteria for its service and foster more active liaison with potential referrers. This will be achieved by defining the referral pathway to the Advisory Service and making referral criteria more explicit.

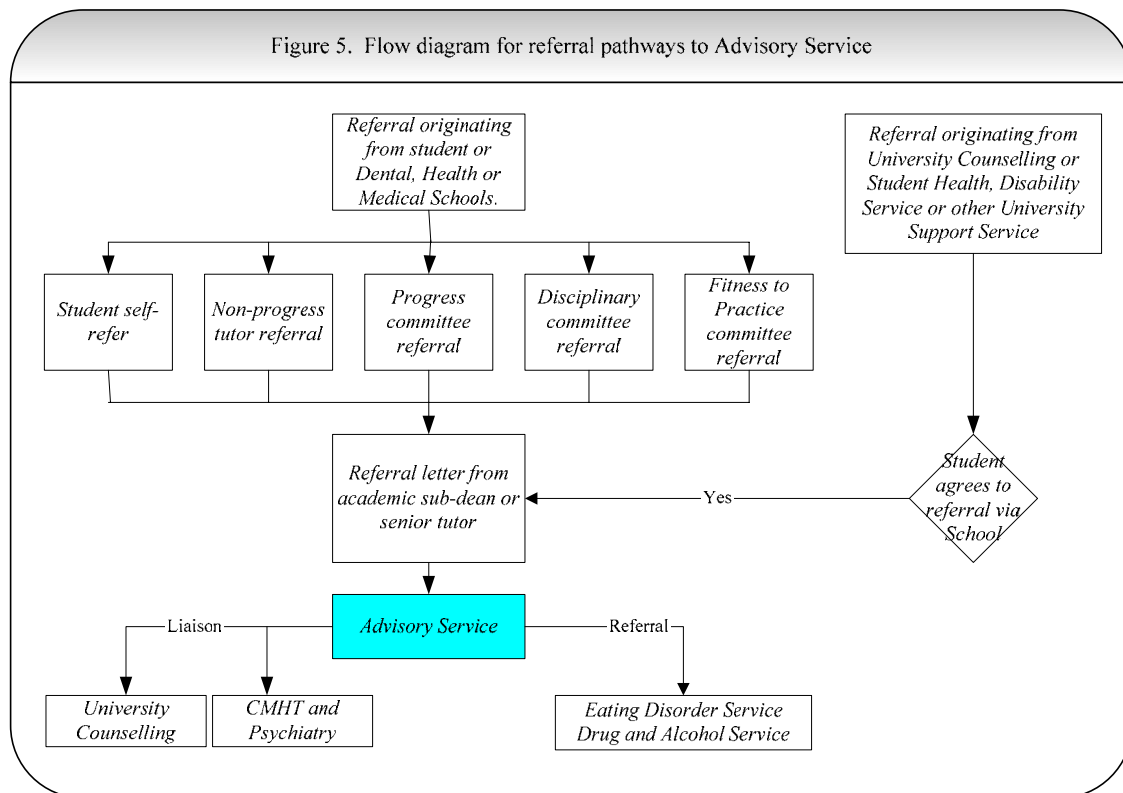
## **2.7 Referral Pathways and Liaison**

Active referral management is a key process in the Advisory Service for balancing demand and capacity. A number of referral pathways to the Advisory Service exist, some can be viewed as direct and others indirect. The direct referral pathway is via the academic sub-deans and senior tutors for the student's School who act as effective gatekeepers to the Advisory Service. The academic sub-deans and senior tutors receive referrals from other services, so creating indirect referral pathways, such as the University Counselling service and Student Health GP services. The Advisory Service refers to specialist NHS services and has therapy liaison links with Community Mental Health Teams and Psychiatry, Student Disability Support Services and other Student Support Services. Figure 5 shows the referral pathways from the Dental Sciences, Health Sciences and Medical Education Schools to the Advisory Service.

Referrals may arise in several contexts. Students, irrespective of whether they progress in their studies, may approach a personal tutor because they have concerns about their psychological health. The personal tutor may recommend the student to the academic sub-dean or senior tutor who can make a referral to the Advisory Service.

An awareness of psychological health problems affecting a student's well-being can arise in a number of formal Medical Faculty, boards, committees and panels. One outcome from these formal settings might be to offer a student a referral to the Advisory Service. For example, a Progress Interview or a School Progress Committee may deem that psychological health problems are a relevant factor in adversely affecting specific students' studies as well as affecting their well-being. Depending on the nature of these psychological health problems, such students can be offered and consent to a referral to the Advisory Service. The referral would come via the academic sub-deans and senior tutors for the student's School.

An offer of referral to the Advisory Service to address psychological health problems could occur in the context of a University Advisory Board on Discipline or Board of Discipline or Fitness to Practice Panel. The Advisory Service does not participate in the decision making of these formal settings.



**Sub-deans and Senior tutors:** The academic sub-deans and senior tutors are an intrinsic part of the Advisory Service. They provide a key supportive point of contact for the students within the Schools. Effective liaison and communication between the Advisory Service, the academic sub-deans and senior tutors is central to the operation of the Advisory Service.

Students and other health care providers have questioned the necessity for the inclusion of the academic sub-deans and senior tutors in the referral pathway. One concern has been that the School's awareness of students' psychological health problems may result in prejudice and discrimination. This perception needs to be addressed both by the Advisory Service and by the Schools.

A major, seemingly contrary, reason for the School's role in the referral pathway is the prevention of prejudice. A parallel that can be considered in this context is University procedures for students who have a disability. In order to receive appropriate support students with disabilities discuss their needs with the Support Services for Disabled Students. Without this explicit recognition of the dysfunction related to their disability students may not have their needs met appropriately, and consequently, they may suffer disadvantage. Yet students need to know that their disclosure is to their advantage and will not lead to discrimination. The University has structures and procedures in place that are aimed to prevent discrimination on the grounds of disability, further it is obligated to meet the disability needs of students as far as reasonable as outlined in the Disability Discrimination Act

The Disability Discrimination Act also applies to psychological health problems provided certain conditions are met. The Act applies to students where there is an increased likelihood for impairment in the student's day-to-day functioning due to these problems, and there is the likelihood that the impairment persists over a relatively long time. This is more likely for those students with moderate to severe psychological health problems. Students who feel unable to disclose such problems to academic sub-deans or senior tutors may experience disadvantage.

The Medical Faculty Advisory Service is one service whereby the School aims to ensure that students' 'disabilities' resulting from their psychological health problems are appropriately supported while ensuring confidentiality. Consequently, the academic sub-deans and senior tutors are in a key position to counter potential discrimination arising from students' functioning within the School and on clinical placements.

The academic sub-deans and senior tutors manage the confidential correspondence between the Advisory Service and the School. These roles require that the sub-deans and senior tutors be involved with indirect referrals originating from the University Counselling Service, and Student Health GP and Brownlow Group Practice.

**University Counselling Service:** Attendance at the University Counselling Service is by self-referral. Counsellors may refer Medical Faculty students who they assess as requiring longer-term psychological therapy via the academic sub-dean or senior tutor to the Advisory Service. The University Counselling Service obtains consent from the student to be referred in this way.

**Student Health and Brownlow Group Practice:** Medical Faculty students can seek help for a psychological health problem from Student Health GPs or the Brownlow Group Practice. GPs can refer Medical Faculty students with moderate to severe psychological health problems through the academic sub-deans or senior tutors, to the Advisory Service. The GPs obtain consent from the student to be referred in this way.

**Psychiatry and Community Mental Health Teams:** As shown previously, the estimated prevalence for diagnosed psychiatric problems within the target population is small. Occasionally a Medical Faculty student may experience such a problem. Following the acute phase and when there is some stability for the problem, it might be considered appropriate to offer the student psychological therapy. It is likely that a Community Mental Health Team (CMHT) and Psychiatric Services will operate a Care Programme Approach (CPA) with a case manager to co-ordinate the care of the student.

The Advisory Service would liaise and work within the context of the CPA and CMHT. The University also provides a Student Mental Health Advisory Service for supporting students with severe mental health problems.

**Specialist NHS Services:** Figure 5 show a referral pathway to specialist NHS services. The Advisory Service can refer students on to specialist NHS services for example the Eating Disorder Service and the Drug and Alcohol Services. While the Advisory Service works with individuals who present with these kinds of psychological health problems, on occasions there might be greater therapeutic benefit in referring and liaising with these specialist services. In these cases, the Advisory Service may provide a mix of supportive and therapeutic input if the waiting times are long for assessment and therapy at specialist services.

**Disability Support Team:** The implementation of the Disability Discrimination Act in 2005 has implications for the status of some students attending the Advisory Service. For example, if students were to meet criteria for 'disability' due to significant psychological health problems or if psychological health problems occurred in the context of physical disability then close liaison between the Advisory Service and Disability Support Team would be required.

The Disability Support Team prepares Student Support Document both for the students and for the School outlining the nature of need and the role of the student and School in addressing these needs. The Advisory Service would like to adopt a similar model for communicating student's needs related to psychological health problems to referrers within the Schools.

The Disability Support Team may assess Medical Faculty Students where part of the identified need may include referral for psychological therapy at the Advisory Service. This again would come via the academic sub-deans or senior tutor.

**Non-University GP:** The Advisory Service may liaise with non-university GPs where students are under the care of such GPs, or where the student is involved with other NHS mental health services. The Advisory Service may request GPs to offer support, monitor students and refer student to other health services, for example, physical health assessments in the case of eating disorders, or referral for psychiatric assessment or medication review. The Advisory Service does not take direct referrals from these GPs.

The Advisory Service is working towards clarifying liaison links with the University Counselling Service and Student Health and Brownlow Group Practice. Links with CMHT and Psychiatry, Disability Support Team and specialist NHS services are also currently being reviewed.

**Services for all University students with moderate to severe psychological health**

**problems:** There are limitations in reviewing one service in isolation without a systematic review of all services involved in student support. The remit of this review was specific to the Advisory Service. Nevertheless, there does appear to be one issue for wider considerations in relation to the provision of support for students with moderate to severe psychological health problems across the whole university.

One conclusion appears to follow from the general review above. With the exception of the Medical Faculty, there appears to be a lack of clarity about the specific provision of services for students who experience moderate to severe psychological health problems. It is likely that much of this is managed within University Counselling and GP Student Health services. However, because these levels of psychological health problems often require long-term support these services may not be resourced to meet the needs of these students or meeting the needs of these students may impact on a primary focus to provide support for students with mild to moderate psychological health problems.

The university's student support services are interlinked. Therefore, when there is a lack of provision or a bottleneck in one part of the system this will influence the functioning of other parts of the system. Students with moderate to severe psychological health problems may seek help through their GP services or approach Student Support Services. These services may decide not to make a referral to a Tier 3 service, for example, NHS psychotherapy services, eating disorder service etc., because of long waiting times for assessment and or therapy also because of stringent referral criteria set by these services. These students with longer-term psychological health needs often end up being supported within existing student support services. This impact on service provision for these services, that is, it may block access to other students, with mild to moderate problems. Students with mild to moderate problems may have to wait or be directed to other services, with the consequence of an increase in demand and lengthening waiting times for assessment and therapy in all services. For example, Medical Faculty students with problems appropriate for GP support or University Student Counselling may, because of pressure from managing students with moderate to severe psychological health problems, be re-directed to the Advisory Service with the consequence that the Advisory Service sees a significant increase in referrals of students outside of their targeted referral group.

Undoubtedly, there are many possible knock on effects when changes occur in one part of a system for other parts of the system. What seems evident from the issue discussed above is that there is scope for examining the nature and level of psychological health need in the University overall with particular relevance to students with moderate to severe psychological health problems. The Advisory Service provides a model for meeting the specific needs of students with longer-term psychological health needs within the Medical Faculty.

## 2.8 Processes and Process Issues

**Clinical responsibility:** Clinical psychologists are accountable to their professional body for their standards of clinical practice. The Advisory Service is exploring honorary status with NHS to link in with the Clinical Governance principles underpinning the delivery of health care services.

The Advisory service clinical psychologists are accountable to the Medical Faculty via the Schools. The Advisory Service accepts clinical responsibility when the student consents to engage in a programme of therapy. At this point, the Advisor has a legal responsibility and duty care towards the student for provision of therapy and management of risk. These obligations continue up to the time of the student's service file is closed.

Figure 6 provides an overview of the different stages and decision points related to referral, therapy and closing of students' files. These are described in terms of practical management issues. In particular, communication between the Advisory Service, students, referrers, GP and others.

**Correspondence:** Ensuring clarity and continuity of information between the Advisory Service, students, referrers and student support services are essential.

During the initial assessment sessions students are informed about the standard letters, written about appointments, attendance and file closure, which are sent to referrers. All letters about students are copied to them.<sup>7</sup> Students may consent for non-standard letters to be sent providing more detailed information where required. In this instance students receive a copy to apprise the content prior to their being sent.

The Advisory Service communicates frequently with students to arrange appointments or re-arrange appointments and send information. Most of these communications are sent either by post or email or both and would not be copied to other individuals.

Confidentiality is an issue for students, many being concerned about the confidentiality of correspondence and possible discrimination. All correspondence from the Advisory Service is headed 'private and confidential'. The letters also have a statement that reads:

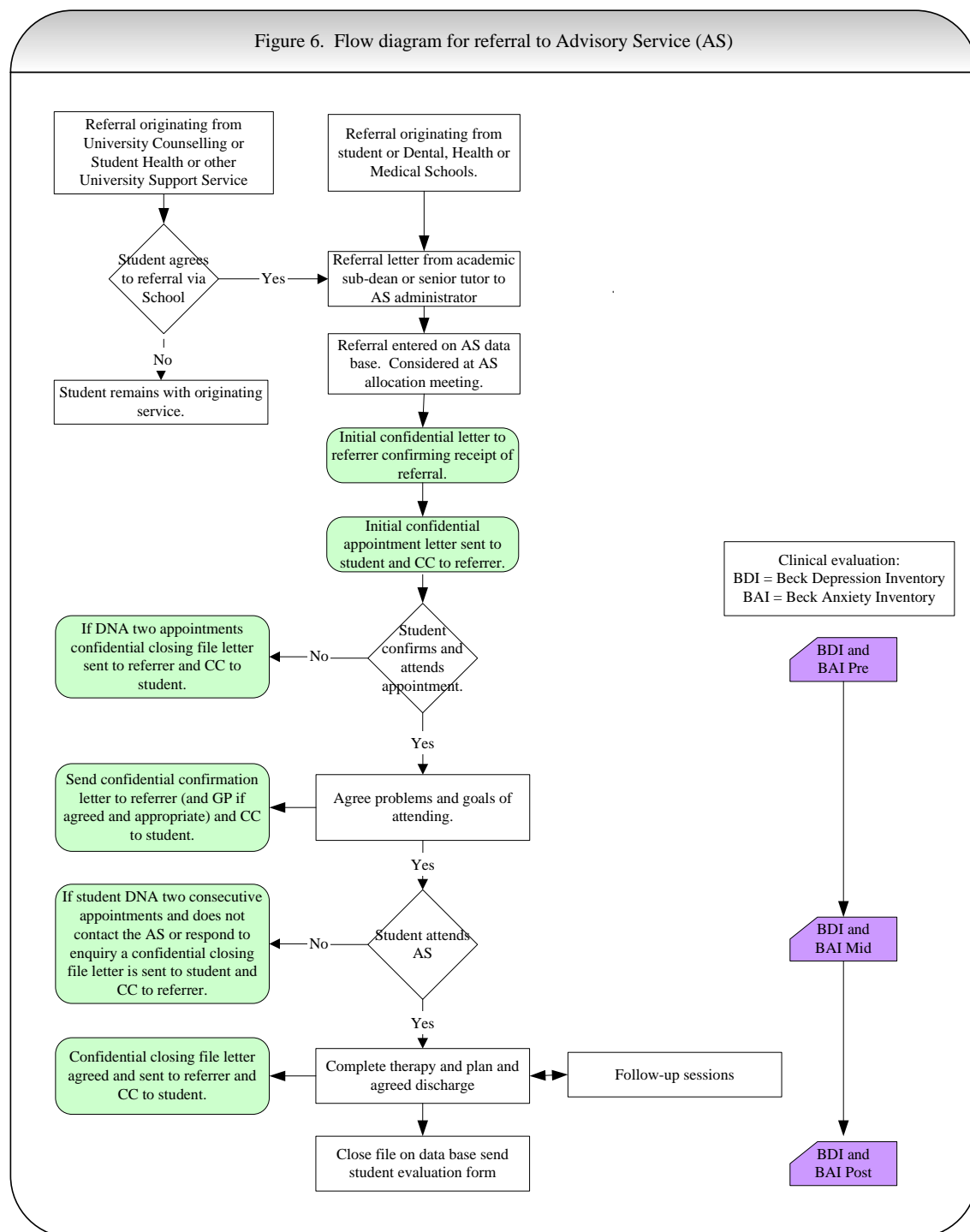
'This letter may contain information which, in the interest of the student, should be disclosed only with the student's permission'.

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<sup>7</sup> Letters marked in green in Figure 6.

Students will be aware that recipients of these letters are obligated to manage this correspondence in the way requested. Nevertheless, students may request specific assurances that correspondence of this nature is kept separate from general student academic files. It is assumed that each of the Schools will have procedures for managing correspondence in this way.

Figure 6. Flow diagram for referral to Advisory Service (AS)



GPs will be informed about students attendance at the Advisory Service when there is a need to know and with the students consent.

. **Referrals:** Figure 6 shows the basic direct and indirect referral pathways. This has already been described previously so will not be detailed here. Referrers are asked to discuss the referral with students and obtain consent before the referral is made. Students can be given the Information Leaflet (Appendix 1) about the Advisory Service at this time.

**Administration:** To centralise the referral process all referrals should be addressed to the Advisory Service administrator. Once received, the administrator will enter the student's details into the database and open a case file for the student. New referrals are discussed and allocated weekly basis.

**Initial appointment:** A letter is sent to the referrer confirming receipt and confirming that the student has been offered an appointment. A letter and email are sent to students stating that a referral has been received and offering them an initial appointment. Students are asked to confirm that they will attend this appointment, but if the appointment is not convenient, to contact the service to re-arrange. A copy of this letter is also sent to referrer.

If students do not attend (DNA) their first appointment a follow-up letter is sent asking them to contact the service to arrange a further appointment. If the student does not respond to this letter within a specified time or does not attend a second arranged appointment the student's file is closed with the service. A letter confirming this is sent to the student and copied to the original referrer.

**Assessment and opt-in to therapy and agree goals:** The initial 2-3 meetings generally provide time to outline the nature and extent of the problems, clarify the nature of the student's goals and to introduce the student to psychological models and therapy models. Completing these tasks enables the student and the advisor to decide whether the service is likely to be suitable and helpful. If the student decides to attend for therapy, a provisional schedule of 6 appointments is made, with the final session being a review of therapy to date.

**Clinical evaluation:** Clinical evaluation measures are given at the start and at two subsequent times in therapy including one at the end of therapy (see Figure 6). The two clinical measures always used are the Beck Depression Inventory 2<sup>nd</sup> Edition (BAI-II: Beck, Steer & Brown, 1996) and the Beck Anxiety Inventory (BAI: Beck & Steer, 1993). Other questionnaires and inventories are employed in therapy as appropriate and the results always discussed with the students.

Students are asked to complete an initial self-assessment on the severity of their specific problems, and an evaluation of therapy satisfaction at the end of therapy.

**Attending appointments:** Students are seen between 09.00 and 17.00 and from Monday to Friday. A number of practical issues commonly arise for students attending appointments. Most students express concerns about being absent from lectures or clinical placements. Their concern frequently relate to the impact on their studies the anticipated negative effects of staff and fellow students noting their absence and their associated qualms about explaining the reasons for missed sessions. Unexpected changes to course timetables sometimes prevent students from attending. Where students are based off campus it is time-consuming, and can prove difficult, for students to travel in for appointments. The Advisory Service aims to be pro-active in addressing these issues by informing the academic sub-deans and senior tutors who may be able to support the student's attendance within the School.

When students DNA an appointment letters are sent asking them to confirm their attendance at their next scheduled appointment, or to confirm that they would like a further appointment. If students DNA subsequent appointments or do not make requests for a further appointment it is assumed that these students no longer wish to attend and the students' files are closed with the service. A letter is sent to the student and copied to the initial referrer confirming this.

**Risk management in ongoing therapy:** Advisors monitor risk on a session-by-session basis with all students. Risk may remain low throughout therapy. Students are informed at the outset, when discussing confidentiality that advisors are obligated to disclose information to a third party, their referrer or GP, if students are a serious risk to themselves or others.

Risk management involves a therapeutic negotiation between the advisor and the student. It is considered inadvisable to make therapy contingent on asking students to stop their risk behaviour as it often functions as a form of coping. However, it is prioritised as a short-term goal in therapy. The main approach to management will involve understanding the triggers for self-harming behaviour, and to monitor and manage where possible associated risk factors.<sup>8</sup>

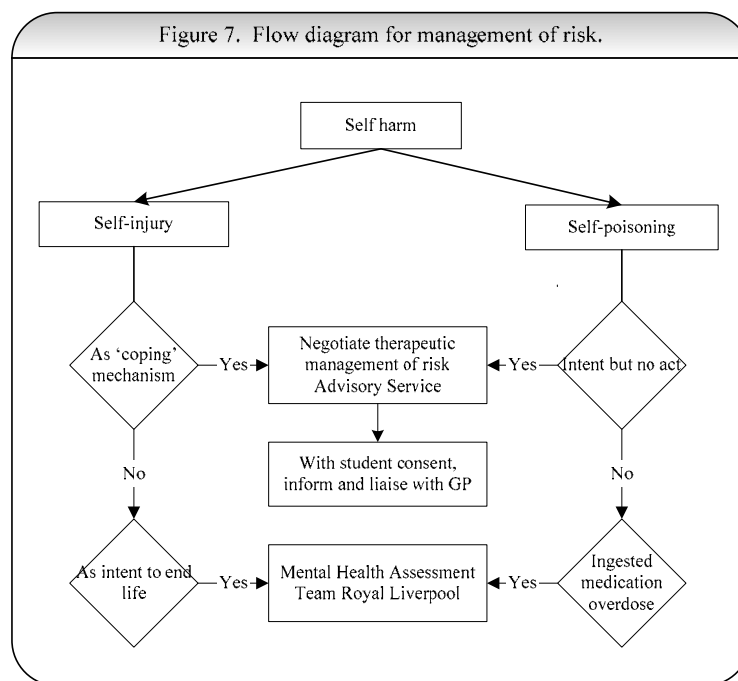
Self-harm takes two main forms, self-injury, such as cutting or burning, or self-poisoning, such as overdosing on analgesics. Many forms of self-injury are not intended as life ending acts.

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<sup>8</sup> e.g. negative life events, breakdown of relationship, living alone, lack of social support, poor problem solving, high helplessness, depression, alcohol use and impulsivity.

Self-harm may function as a form of ‘coping’, aimed at reducing distress, or function as self-punishment. Advisors will encourage students, where necessary, to seek physical treatments for any injuries inflicted and explore alternative forms of ‘coping’ with them that do not result in physical injury.

Threats of self-poison are potentially more serious since they often self-poison and not seek appropriate medical help. The commonest medication for overdose is Paracetamol, which untreated leads to liver damage and can be fatal so urgent physical treatments may be required. All instances of overdoses are disclosed to GP or to Mental Health Assessment Team at the Royal Liverpool Hospital. Figure 7 shows a simplified overview of decision related to risk management in the case of non-suicide intent behaviour and suicide intent behaviour.



**Concluding therapy work:** When the Advisory Service closes students’ files, they are formally declaring to the School that the involvement of the Advisory Service has ceased. There are five possible endings to therapy work (Table 4).

Table 4. Concluding therapy work

*There are five categories of closing students' files:*

- 1. File close student not seen;** *Students referred not attending their first appointment, nor contacting the department to arrange a further appointment and not responding to follow-up enquiry letters. The invitation for re-referral is included in letter.*
- 2. File closed referred to other service;** *Students seen, assessed and alternative appropriate service identified, e.g. Eating Disorder Service. Referrers advised of referral on.*
- 3. File closed assessment and report only;** *Student can be seen and assessed for the purpose of a specific report rather than therapy.*
- 4. File closed assessment, started therapy and discontinued;** *Students are assessed, consent to a programme of therapy but discontinue.*
- 5. File closed completed therapy;** *Students complete a programme of therapy and agree plan for finishing therapy. Some students may be offered follow-up within a specified time period.*

**Risk management related to closing files:** The issue of risk is considered when closing a file where no assessment has been made, the closing letter to the referrer advises them that no assessment, including risk assessment, has been made. The letter also indicates that the Advisory Service will accept a re-referral for the student.

Should a student discontinue prematurely it is likely that the advisor will have made an ongoing risk assessment. The formal closure letter to the referrer and GP, if necessary, will indicate whether there is an issue of risk. Copies of these letters would be sent to students.

### **3 Consolidation and development for Advisory Service**

This document is both a review and a consultation document. One of the main purposes of this review has been to reflect on the function and operation of the service, to identify areas of practice for consolidation and to look at possibilities for service development. From the inside looking out there are several strategic areas for development and consolidation that the service would aim to work towards. These are summarised below.

#### **3.1 Promotion of Advisory Service**

Development: The Advisory Service aims to publicise and promote the service to students, tutors and referrers through the distribution of information leaflets and a dedicated web-site.

Development: The Advisory Service aims to provide psychological health promotion talks for students and academic and clinical tutors.

#### **3.2 Managing capacity, demand and monitoring unmet need**

Consolidation: All direct referrals will continue to come via academic sub-deans and senior tutors. The Advisory Service will liaise with direct referrers to clarify referral criteria.

Development: The Advisory Service will liaise with indirect referrers to clarify referral criteria and the referral pathway.

Consolidation: The Advisory Service aims to operate a maximum waiting time of three weeks for initial meeting and a maximum waiting time two months for therapy.

Development: A quarterly statement will show the status of the Advisory Service in terms of referrals, students in therapy, closed files and an estimation of referral capacity for the next 3 months. And will serve as a means for communicating with relevant referrers.

Development: To look at the processes and management of unmet need for students with different levels of psychological health problems.

#### **3.3 ‘Student support document’**

Development: The Advisory Service aims to explore the use of a modified version of the confidential Student Support Document (Disability Support Team) when completing assessments with students. This will detail needs that can be met by the School both in terms of University work and clinical placement needs.

Development: The Advisory Service aims to work closer working with the Disability Support Team.

### **3.4 Promote non-discrimination**

Consolidation: The Advisory Service aims positively to promote a normalising model for understanding psychological health problems.

Development: The Advisory Service will approach the management and support of students with moderate to severe psychological health problems using the principles underpinning the Disability Discrimination Act.

### **3.5 Effective liaison and transfer between services**

Consolidation and development: The Tier model highlights the fact that students' needs may change over time. In order to maximise its efficiency and benefits to students, the Advisory Service, will liaise and manage transfers both in to, and out from, other services as appropriate, for example, University Student Counselling, NHS Eating Disorder Service.

### **3.6 Fitness to practice, suspension of studies and psychological health problems**

Development: The Advisory Service is able to assess fitness to practice and suspension of studies issues when related to moderate to severe psychological health problems. The formulation-based approach of clinical psychology would identify specific problems, maintenance factors and targets/goals for change.

### **3.7 Self-harm and psychological health problems**

Development: The issue of self-harm is a complex matter in relation to students in health care professional training. Self-harm can be conceptualised as a maladaptive form of coping. When it occurs, there are concerns both for the student and for their role as health care professional. The management of self-harm in the context of psychological health problems requires trust and confidence in the helping service. The Advisory Service aims to look at policies and procedures that will address both areas of concern above. The Advisory Service aims to have clear policies and procedures to work in close collaboration with GPs and hospital services when self-harm behaviour requires medical attention. The Advisory Service aims to develop clear policies and procedures for working with Schools to reduce the risk of self-harm.

### **3.8 Strategy planning: moderate to severe psychological health problems**

Development: The Advisory Service would aim to share its expertise in strategic planning of University wide support services for students with moderate to severe psychological health problems. Unmet need in this area is likely to impact on all existing systems of student support.

### **3.9 Outreach service**

Consultation was started about the feasibility of running a service for Medical students on placements geographically distant from Liverpool based on a significant number of students attending therapy sessions who were away for one year. The discussions were ongoing, and now is a timely point to review this case.

### **3.10 Research**

Development: Research falls within the remit of the advisory service. The service is well placed to examine issues to do with psychological health problems and fitness to practice. A number of research topics have been identified: for example, perceptions of psychological health problems and fitness to practice; discrimination and psychological health problems in health care professionals; assessment and decision making about psychological health problems and fitness to practice.

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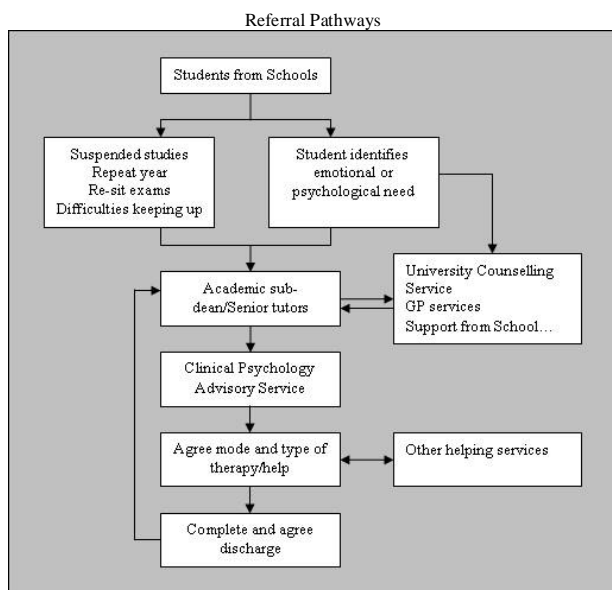
## **5 Appendix 1**

Direct referral contacts:

<i>School</i>	<i>Contact secretary for appointment</i>	<i>Tel:</i>
Dental Students	Senior Tutor (secretary)	0151-7065225
Health Students	Academic Sub-Dean (secretary)	0151-7945799
Medical Students	Academic Sub-Dean (secretary)	0151-7948701

Other useful contacts:

University Counselling Service	0151-7943304
Student Health Service	0151-7944720/5820
Disability Support Team	0151-7945863
Student Mental Health Advisory Service	0151-7942320



Where are we? No 11 on map.



The service is open Monday to Friday, between 09.00 to 17.00 hours.

Contacts

Division secretary: Caroline Gaunt

Clinical Psychology Advisors:

Juliet Morton and Pierce O'Carroll

Address:

Division of Clinical Psychology, Whelan Building,  
Brownlow Hill, Liverpool, L69 3GB

Tel: 0151-794 5485

Email: [advisory@liv.ac.uk](mailto:advisory@liv.ac.uk)

Webpage: [www.liv.ac.uk/clinpsy/advisory](http://www.liv.ac.uk/clinpsy/advisory)



THE UNIVERSITY  
of LIVERPOOL

## Advisory Service

For students from the

School of Dental Sciences

School of Health Sciences

& School of Medical Education



### *Meeting the need*

The Medical Faculty recognises that health professional students face challenges both from academic pressures and from the interpersonal demands of their practitioner roles. Maintaining the required academic standards and professional conduct can be emotionally demanding, and for some students, a trigger for experiencing intense stress.

### *University Student Support Services*

The University Student Support Services are set up to support students from all Faculties. These include University Counselling Service, Student Health Services, and the Disability Support Team (contact information overleaf). In addition to these services, the Advisory Service provides support for students within the Medical Faculty who require longer-term psychological therapies.

### *Deciding which service to use*

Students who are unsure about which student support service to contact, can discuss their concerns with their academic sub-dean or senior tutor. Alternatively, a student can approach either Student Counselling or their GP in Student Health who can refer on to the Advisory Service via the sub-deans or senior tutors (see contact details overleaf).

### *Advisors*

The Advisory Service is provided by two chartered clinical psychologists (see overleaf). They work to the professional guidelines and codes of conduct set out by the British Psychological Society. They are employed by, but work independently from, the Medical Faculty.

### *Initial meeting*

Following referral, an initial meeting will be arranged with an advisor. After two or three

## **Advisory Service**

The Medical Faculty commissions the Division of Clinical Psychology to provide an Advisory Service for students in the Dental, Health and Medical Schools. The service aims to provide a quick response to referral and starting therapy, to be accessible and comprehensive in meeting the psychological health needs of students.

Attendance at the Advisory Service is voluntary and each student receives individual and confidential support.

sessions, the student will have some idea about the mode and type of help that could best meet their needs also how long this work might take. The practicalities of attending regular sessions are discussed with students and, where needed, support for this will be sought from the academic sub-deans and senior tutors.

### *Confidentiality*

Student confidentiality is taken seriously and boundaries strictly observed both by referrers and by the Advisory Service. Confidentiality issues are discussed at the initial meeting.

### *Modes of helping*

Modes of helping can include:

- 1 regular sessions guiding the student through self-help materials;
- 2 regular one to one sessions of brief therapy (6-12 sessions); and
- 3 regular one to one sessions of longer term therapy (12+ sessions up to 24 sessions with optional follow-up).

Sessions can be weekly, fortnightly or extended over longer periods towards the end of therapy. The Advisory Service web-site provides links to educational and self-help materials.

### *Types of therapy*

Clinical psychologists use a formulation approach when assessing and working with

problems. Developing a formulation involves a student and advisor working together to construct an explanatory model to understand what has led to the development of their problem, and what keeps it going. The clinical psychologists use a number of evidence based therapies to address individual problems, e.g. cognitive-behavioural therapy, interpersonal therapies. Therapy plans are explained and agreed with students before students consent to proceed in therapy.

### *Sessions*

Each session involves agreeing a plan for the session, addressing immediate need, reviewing ongoing therapy work, discussing formulation for understanding problem, support and encouragement and planning future therapy work. Both the advisor and student have tasks to do in and outside of sessions.

### *Completing work*

Towards the end of therapy, students and therapist prepare for concluding work together. The nature of the work means that students will continue to use therapy ideas after this time. The advisor will prepare students both for the completion of work and for any follow-up they may need to do.

### *Partnership working*

In each School, academic sub-deans and senior tutors can discuss in confidence the psychological health support needs of students. This may arise because students are falling behind in their studies, re-sitting exams, repeating years or suspending their studies. In addition, they can consider students' needs related to problems in their clinical practice. The sub-deans and senior tutors, in partnership with Advisory Service and other University Student Support services aim to facilitate students by enabling them to continue and complete their studies.

### *Referral pathways*

- 1 Students can self-refer via their academic sub-dean or senior tutor.
- 2 GPs should obtain student consent for referral via the academic sub-dean or senior tutor (see overleaf).
- 3 University's Counselling should obtain student consent for referral via the academic sub-deans or senior tutors (see overleaf).

All appointments take place at the Clinical Psychology Department (see overleaf).

The waiting time from referral to first appointment is normally 2-3 weeks. Normally, therapy follows on from the assessment.