



# Identifying good practice among medical schools in the support of students with mental health concerns

**A report prepared for the General Medical Council by:**

**Andrew Grant**

Institute of Medical Education, Cardiff University

**Andrew Rix**

Prepare to Share

**Karen Mattick**

University of Exeter Medical School

**Debbie Jones**

Independent Researcher

**Peter Winter**

Institute of Medical Education, Cardiff University



## **Acknowledgements**

We wish to express our Thanks to the many colleagues and participants who helped with the production of this report:

Mari Ann Hilliar - Assistant Subject Librarian

Tom Holt - Statistician

Clare Owen - Policy Analyst (GMC)

Tom Jones - Research Policy Manager (GMC)

### **Steering Group**

Prof Tim Dornan - Prof of Medical Education at Maastricht University; Prof Paul Kinnersley - Personal Chair, Institute of Primary Care & Public Health; Dinesh Bhugra - Prof of Mental Health & Cultural Diversity at the Institute of Psychiatry, London; Rakesh Patel - NIHR Academic Clinical Lecturer in Medical Education; Blanche Lumb - Medical student (Intercalated); Richard Donovan - 4<sup>th</sup> Yr Medical student.

Thanks to the participating Medical Schools:

Aberdeen, Barts, Birmingham, Brighton and Sussex, Bristol, Cambridge, Cardiff, Dundee, Edinburgh, Glasgow, Hull-York, Imperial, Keele, King's College London, Lancaster, Leeds, Liverpool, Manchester, Newcastle, Norwich (UEA), Nottingham, Oxford, Queen's Belfast, , Southampton, St. Andrews, St. Georges, Swansea, UCL.

Thanks to the participating Student Support Services:

Aberdeen, Birmingham, Bristol, Dundee, Edinburgh, Hull-York, King's College London, Manchester, Newcastle, Sheffield, St. Georges, UCL.

Special thanks to medical students at Cardiff University for their participation and comments, particularly Avril Gibbons, Lori Black and Thomas Lemon responsible for participant recruitment and for support from Dr. Debbie Cohen (Senior Medical Research Fellow) and Ben Lewis (Director of Student Support Cardiff University and chair of the Association of Managers of Student Support Services in Higher Education).

### **Disclaimer**

The research and report was funded by the General Medical Council (GMC). The views expressed are those of the authors.

## SUMMARY

---

Medical students are more prone to mental health issues than their university contemporaries by reason of predisposition and situation. The literature shows that medical students who do develop mental health problems are less likely to access the help that they need.

The General Medical Council (GMC), as the body responsible for the registration and regulation of doctors, and, as the result of a working group set up under the chairmanship of Mr Stephen Whittle wishes to provide guidance to medical schools on how to improve access to support. This is to ensure that medical students can complete their studies and have successful careers whilst minimising any potential risk to the public.

Research was commissioned to inform the development of guidance for medical schools on how they can best support students with mental health concerns. A systematic review was undertaken along with a mapping exercise of current practice, and an exploration of interventions which have the potential to work well. All 32 medical schools in the UK were given the opportunity to take part in the research through an e-survey (24 responded), a programme of structured telephone interviews (n= 15) and visits by the research team to five medical school sites to explore areas of good and innovative practice. Seven focus groups were held with students across five medical schools and biographical narrative interviews were conducted with 11 current students who had experienced, usually serious, mental health problems.

The research confirmed the extent to which students are reluctant to acknowledge and reticent to seek help about their mental health issues. The report concluded that, while there were many examples of excellent support processes, medical schools are failing to respond to the big issue of the stigma that attaches to mental illness, which directly impacts on students' reluctance to seek help. While attempts have been made, with varying degrees of success, to use Fitness to Practise (FtP) procedures as a way to support students this has to been seen in the context of a culture which encourages fierce competition, where illness, and particularly mental illness, is seen as a weakness, where work and study schedules are relatively inflexible (compared with other undergraduate programmes). Many of the successful role models students are exposed to, particularly in hospitals, espouse values that encourage students to hide rather than seek help with problems. The tendency for medical schools to take a clinical interest in their students illnesses, while laudable in its intention and its ability to treat each case individually, may have the undesired consequence of further positioning mental health issues as something outside routine expectations of student life – a 'secret' and certainly not a topic openly discussed.

The researchers conclude that there are a number of practical steps that medical schools can take to improve the support on offer including better performance monitoring, the development of the role of personal tutor and greater transparency in medical school procedures based on occupational health models. However these are of little value if the underlying issue of stigma is not addressed via concerted efforts to normalise mental health through the use of role models, everyday dialog, and integration of services at institutional level.

An important finding is the extent to which peer support is used and valued and the opportunities this provides, not just to address immediate needs of fellow students, but to provide an important skill which will serve tomorrow's doctors, and society, well. The report proposes training that will enable students to perform this role at a basic level, recognising that signposting is an appropriate outcome in many cases.

The report contains: a summary of the systematic review, a discussion on why medical schools and medicine are 'different' and how that has moulded provision, an overview of current practice and suggested changes, where possible indicating the strength of supporting evidence. The report also contains summary case studies, derived from biographical narrative interviews, of medical students who have suffered serious mental health problems and examples of good practice from UK medical schools.

Most importantly it calls for clarification of policies in respect of mental health and careers in medicine, and the need to provide protection for students as a means to bring about change.

6<sup>th</sup> March 2013

## CONTENTS PAGE

---

<b>CHAPTER 1: MEDICAL STUDENT MENTAL HEALTH</b>	<b>6</b>
<b>CHAPTER 2: SYSTEMATIC REVIEW</b>	<b>13</b>
<b>CHAPTER 3: SUPPORT FOR MEDICAL STUDENTS WITH MENTAL HEALTH PROBLEMS: A BROAD PICTURE OF PROVISION IN THE UNITED KINGDOM</b>	<b>30</b>
<b>CHAPTER 4: CONTEXT: WHAT'S SPECIAL ABOUT MEDICAL EDUCATION AND MEDICAL STUDENTS?</b>	<b>62</b>
<b>CHAPTER 5: HOW DOES THIS IMPACT ON INDIVIDUAL STUDENTS?</b>	<b>84</b>
<b>CHAPTER 6: DISCUSSION</b>	<b>97</b>
<b>CHAPTER 7 – CONCLUSIONS AND A VISION OF GOOD PRACTICE WITH LINKS TO EXAMPLES</b>	<b>107</b>
<b>REFERENCES</b>	<b>111</b>
<b>APPENDICES</b>	<b>117</b>

# Chapter 1: Medical Student Mental Health

---

## Introduction

### The Problem

Research studies have repeatedly shown that medical students have poorer mental health than age-matched controls (de Oliveira E Sousa Leao et al., 2011, Dyrbye et al., 2006, Dahlin et al., 2005, Dahlin and Runeson, 2007, Compton et al., 2008, Goebert et al., 2009, Roh et al., 2010, Schwenk et al., 2010, Sen et al., 2010, Ahmed et al., 2009, Sreeramareddy et al., 2007, Bunevicius et al., 2008, Curran et al., 2009, Jadoon et al., 2010, Tjia et al., 2005). There is evidence that when they do suffer mental health problems medical students are reluctant to disclose their illness through a fear that this will result in negative consequences for their career (Chew-Graham et al., 2003, Hillis et al., 2010). Students are also anxious that any disclosure will not be treated with adequate levels of confidentiality (Chew-Graham et al., 2003, Roberts et al., 2001a, Louie et al., 2007, Reynolds and Clayton, 2009, Givens and Tjia, 2002). It is clearly of concern to everyone that the next generation of doctors should have good mental health and that facilities are in place to prevent mental ill-health wherever possible and to provide timely, appropriate support for medical students who do experience problems.

The work presented in this report was commissioned by the GMC.

In this chapter we will outline the data we have collected from multiple sources and will introduce the theoretical model of provision that we developed after our preliminary survey of publically available medical school and university information.

### Data collection

Data presented in this report comes from six sources (see figure 1):

1. A preliminary (stage one) examination of data from published material such as brochures, prospectuses and medical school websites
2. A systematic review of the literature relating to medical student mental health
3. An e-survey of medical school and university support staff
4. Telephone and face-to-face interviews with medical school and university support staff
5. Focus groups with medical students
6. Biographical narrative interviews (Wengraf, 2008) with students and junior doctors who have personal experience of mental illness while at medical school.

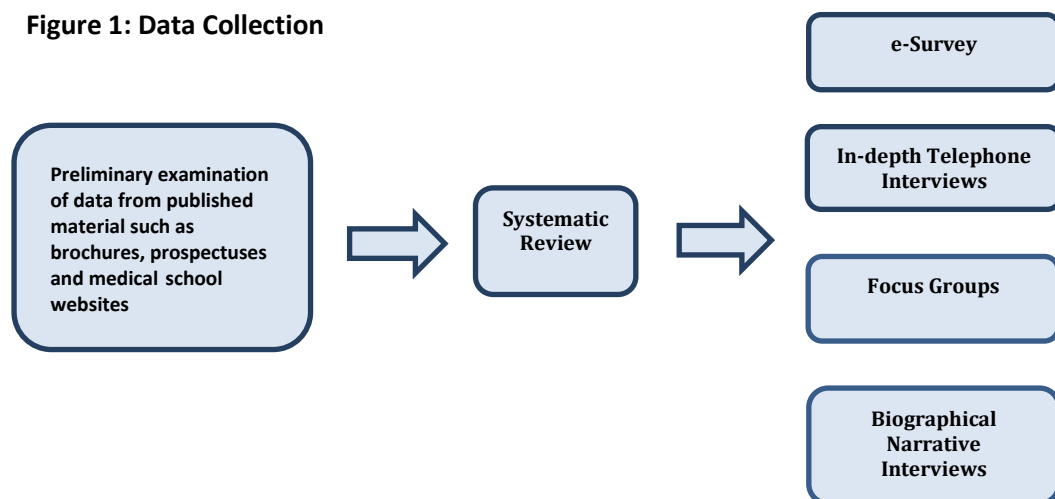
The preliminary data collection in stage one made it possible to find out what facilities medical schools offered to their students and potential students. It was also possible to determine what support services were on offer to all university students as well as those on offer only to students of medicine. Medical school websites vary in the tone that they take towards students and student health problems. Some express support and friendliness

while others are impersonal. Additionally, two organisational characteristics of medical schools appeared to influence support in relation to student health.

Smaller medical schools appeared more willing and able to get to know their students as individuals. In some medical schools where small group learning such as problem-based learning was a feature of the curriculum the tutors, either officially or unofficially, took some responsibility for providing pastoral care for the students.

We, therefore, drew up a sampling framework of UK medical schools based on school size and the presence or absence (based on website information) of small-group learning (see table 1).

**Figure 1: Data Collection**



**Table 1: Sampling framework showing school size and presence or absence of small group learning as a central feature of the curriculum (i.e. at least a weekly occurrence with the same tutor). \* denotes schools where a site visit was carried out.**

School	Size	Small group learning?
*Aberdeen	M	X
Barts/London	L	✓
Birmingham	L	X
Bristol	L	X
Cardiff	L	X
Dundee	M	X
*Hull/York	S	✓
Imperial	L	✓
Keele	S	✓
Kings	L	✓
Leeds	L	X

Liverpool (Lancaster)	L(S)	✓
Manchester	L	✓
Oxford	M	✓
*Sheffield	M	X
*St Georges	M	✓
Swansea	S	X
*UCL	S	X

### Recruitment

We made contact with members of staff at the medical schools included in the sampling framework using contact lists for medical school deans and quality leads held by the GMC. We also contacted university support staff via the Association of Managers of student support services in Higher Education (AMOSSHE).

Five schools were selected for site visits to gather in-depth qualitative data about a practice or practices that we regarded as significant from the e-survey. For example, one medical school officially gave its small-group learning tutors the role of personal tutor to the members of their group. Following this, Medical school and university support staff participated in one-to-one interviews at each site. Staff at each site also helped us recruit students to interview as part of the focus groups and one-to-one biographical narrative interviews. Notices via email and virtual learning environments, as well as some personal contacts were sufficient to identify students who were willing to be interviewed about their own experience of mental illness.

Interview guides were developed for all interviews except the one-to-one interviews with students where the biographical narrative method was used (Wengraf, 2001). The interview guides were all based on the staged model of student support developed at the end of stage one which is presented in the last part of this chapter.

### Breadth and depth of cover

The combined effect of our data from varied sources meant that we were able to combine breadth from the e-survey with depth from all one-to-one interviews and focus groups. The systematic review of the literature enabled us to include work already published from many parts of the world.

### Analysis

The quantitative data collected in the e-survey is presented descriptively.

Transcriptions of student one-to-one interviews, focus groups and staff interviews have been analysed thematically. Members of the research team have looked at samples of data from one source and identified emerging themes. Themes facilitated the development of an analytical framework which guided analysis.

For validation we have discussed our findings within the project group and have shown earlier drafts of our report to the steering group. Students who had participated in focus



groups were invited to a follow-up feedback presentation where we presented a summary of our findings and recommendations. Their comments were noted carefully.

### A staged model of support

In this section we present a generic process model, which provides a template against which provision can be mapped, and student experience tested. We do not present this model as evidence-based theory but rather as a staged framework on which we developed research questions and from them interview guides for data collection in stage two. In chapter six we will present an amended model based on our research and systematic review findings which better supports recommendations supported by evidence from the literature and from our own research.

### Stages in the process

The process, whilst generic, is predicated on an epidemiological model of problem solving which assumes that:

- Awareness is a prerequisite for prevention and provision of help
- Early identification leads to better outcomes
- A range of treatment options is needed
- The client's exercise of choice is important.

The problem/treatment process may be cyclical or iterative. Re-integration, or support for alternatives, are equally valid outcomes. We start with this *medical* model because the signals from medical school literature strongly suggest this is their starting point. More general student services material suggests a *psychosocial* approach. In later stages of the project we have explored more fully the implications of these different starting points for service delivery.

What the model does not explore, but which our systematic review (see chapter 2) does, is the wide range of antecedent and situational factors that medical students especially bring to this process. These situational factors – what makes medical students different – and what makes medical schools themselves different within academic institutions is a much-researched area (Ey et al., 2000, Roberts et al., 2001a, Louie et al., 2007, Radcliffe and Lester, 2003a, Givens and Tjia, 2002, Reynolds and Clayton, 2009, de Oliveira E Sousa Leao et al., 2011, Hooper et al., 2005, Brimstone et al., 2007, Roberts et al., 2000a, Dyrbye et al., 2006).

The stages of the process are shown in figure 2 below.

### Prevention

Institutional support services are widely flagged up to students in all institutions and play a prominent part in recruitment literature. Medical schools tend to mention support services in a way other academic departments do not. So while almost all academic units describe some sort of personal tutor system, websites typically make reference to the wide range of support services available at an institutional level. By contrast, medical schools are much more likely to spell out school level support, while at the same time linking this with the school's responsibilities in relation to ensuring Fitness to Practise; the link between a

student's 'problems' and future prospects is thus made, or more likely reinforced, at a very early stage. This may be linked to how mental health issues are 'framed' by medical schools (see *medical vs. psychosocial models in 'Stages in the process', above*). Key messages include the importance of seeking help early, professional services and confidentiality.

This stage in the process is largely unmediated i.e. the student is given access to a range of material, ranging from basic information about access to services, indicators of problems, self-diagnostic aids, self-help guides and treatment guides/options. There is often poor differentiation between prevention and self-help/self-treatment.

### Identification

This stage might usefully be split into self-identification and identification of mental health issues by others. Students are encouraged to seek help and there are strong messages about confidentiality, the importance on outcomes of early identification and on support or treatment options.

Personal tutors are students' first point of contact in most medical schools. GMC guidelines stress the importance of separating out performance and pastoral issues – to the extent of having different people taking on these responsibilities. However, academic staff are expected to respond to what they see and what they might be told through students raising concerns about their peers. This may depend on the way contact with students occurs/is organised, which in turn may be affected by style of teaching e.g. small group learning versus more formal lecture programmes.

### Referral

However raised, at some point a student issue may have to be referred on. All medical schools have access to a range of services. Institutional student support services are characterised by very responsive triage systems so that issues are dealt with promptly. They also have strict rules about confidentiality and contacts with referring departments.

### Escalation

A proportion of student mental health issues will escalate either because the nature of the illness becomes more serious; the requirement of treatment more onerous or the impact on studies becomes critical. For some, where onset is sudden or prior signals have not been picked up, the process might start here. At this stage there are likely to be a number of agencies involved and a need for partnership working.

### Treatment

Ultimately treatment decisions are very much the decision of the student who will be influenced by knowledge of availability, timeliness and effectiveness. A key decision is about taking time out and the impact this has on continuation/having a break in studies. Students continuing their studies may need to attend appointments and may need to have placements adjusted to accommodate these.

### Re-integration

The aim of support should be to allow the student to complete their studies or to successfully pursue an alternative career. Given the extent of prior investment by both the student and the school, re-joining the journey to a career in medicine is the preferred option for most students.

Epidemiological models tend to suggest multiple and iterative points of entry and exit into the disease and treatment pathways with better outcomes associated with early detection and treatment and reduced options for those referred into the process later. In our model this is shown by the feedback line, which, hopefully, reintegrates students into their course.

### **This report**

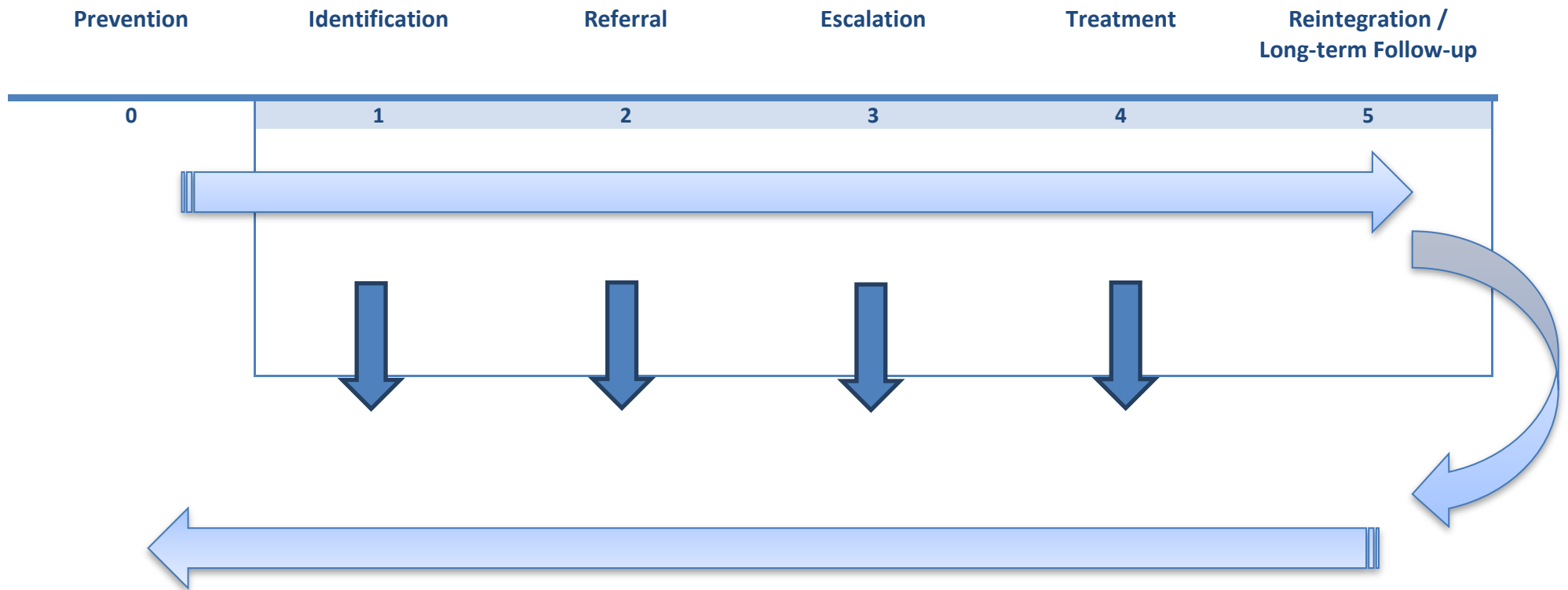
In the next chapter we will present our systematic review of the literature relating to medical student mental health. We will present our results under the headings of the process model presented above. Chapter three will present data from multiple sources including the e-survey, interviews with staff and focus groups with medical students. It will also provide a detailed presentation of the support currently available in UK medical schools. Chapter four will present the context in which medical students live and in which they will need to access help if they become ill. Chapter five exhibits case studies based on interviews with medical students who have experienced mental ill-health. Chapter six uses data from all these sources to bring together a new model of support for medical students with mental health problems. This is based on key values from interview data supported by findings from the systematic review. Chapter seven suggests a vision of good practice reinforced by examples from our data. Chapter eight sets out our conclusions.



### **Examples of good practice**

During our data collection we identified a number of areas of outstanding practise in the support of medical students with mental health problems. We have included short write-ups of these and placed them at the most appropriate place within the text. We have added comments in relation to the applicability of these interventions in other medical schools and some advice in relation to implementation.

Figure 2: Stages in the Process



## Chapter 2: Systematic review

---

### Introduction

We carried out a systematic review of the literature relating to medical student mental health. Our goal was to find and evaluate published literature relating to support for medical students with mental health concerns.

### Review Question

We formulated the following review question:

*‘What does the peer-reviewed research literature tell us about the support provided for medical students worldwide with mental health concerns?’*

### Staged process model

The staged process model, developed from our survey of medical school websites and other publically available data (see page 12, figure 2) was used as a framework for classification and presentation of studies identified by our search strategy.

### Search terms

We developed a focused search strategy. Our knowledge of the literature made it possible to identify key papers, which, in turn, helped to identify specific, inclusive search terms.

After some experimentation and revision we used the following search strategy:

**Table 2: Search terms**

List A	List B
Students, Medical/ medical adj3 student	Mental Health/ mental health.mp.
Education, Medical, Undergraduate/ Schools, Medical/ Education, Medical, Continuing/ continuing medical education.tw.	Depression/ depressive disorder/ depression.mp. Stress, Psychological/ Anxiety/ anxiety.mp.
Education, Medical, Graduate/ medical curriculum.tw. curriculum adj3 medic*).	Anxiety disorders/ Paranoid disorders/ Eating Disorders/ Eating disorders'. eating adj1 disorder Substance-Related Disorders/ Alcohol-Related Disorders/ Drugs and alcohol

We decided to restrict our review to research published between 2000 and 2012 as this covered the greatest concentration of work in the field. Preliminary searches also suggested that we were likely to find papers from a variety of backgrounds and for that reason we did not make methodology an exclusion criterion but we systematically assessed the quality of included studies at the data extraction stage using a rating scale (see box 2.)

We included articles with at least one item in list A and at least one in list B (see table 2).

### Short listing

The search identified 1,281 potentially relevant articles and, after the exclusion criteria were applied (see table 3), 80 articles were shortlisted.

### Exclusion criteria

As our review question related specifically to support for medical students with mental health concerns we drew up a list of exclusion criteria that would help us to focus on the most relevant studies. Table 3 shows the numbers of papers excluded in the shortlisting process with reasons for exclusion.

**Table 3. Exclusion criteria**

Criterion	Include/exclude	Number
Not relevant;		
Not about medical students	Exclude	520
Not about mental illness	Exclude	290
About mental illness but focussing on its prevalence rather than support	Exclude	140
About prevalence of alcohol, tobacco & drug use	Exclude	63
About mental illness but does not cover support for mental health problems	Exclude	131
Duplicate	Exclude	77
Not in English language	Exclude	None
Does not contribute to body of knowledge (editorial, letter, commentary, opinion article)	Exclude	1
No Abstract/online access	Exclude	4
About mental health as part of the curriculum	Exclude	126
About mental illness but relates to <i>screening</i> medical students rather than support	Include	4
Relevant = support for medical students with mental health problems or interventions to diagnose early or prevent mental ill-health among medical students	Include	76

### Inclusion criteria

We set the following as the original inclusion criterion:

- Relevant = support for medical students with mental health problems or interventions to diagnose early or prevent mental ill-health among medical students

Because some studies explored ways of identifying medical students who might be in need of supportive interventions we added a second inclusion criterion;

- About mental illness but relates to *screening* medical students rather than support.

#### Data extraction

In order to make data extraction as consistent as possible we designed a data extraction form (see box 1).

##### Box 1: Data extraction field

- Title
- Author(s) & year published
- Journal
- Type of paper (research paper, original article, letter etc.)
- Aim of the study
- Study design
- Country
- Setting
- Results
- Conclusions
- Related references
- Comment
- Rating (see Box. 2)

##### Box1: Rating scale used for evaluating impact of shortlisted studies

- 1 = no clear conclusions can be drawn: not significant
- 2 = results ambiguous but there appears to be a trend
- 3 = conclusions can probably be based on the results
- 4 = results are clear and very likely to be true
- 5 = results are unequivocal



## Findings

Two members of the team read each of the 80 studies. During this process a further 28 studies were excluded leaving 52. Checking the lists of references of the 52 included papers identified a further 21 relevant studies which were included bringing the total to 73.<sup>1</sup>

## Overview of findings

In this section we will present interventions that have been introduced specifically to address medical student mental health. We will also present studies that influence access to and delivery of supportive interventions.

It is noteworthy that our search revealed a large number of studies and articles relating to stage 0 (Prevention), and fewer relating to stage 1 (Identification) and 2 (Referral). Our search detected only one study relating to stage 3 (Escalation) and none relating to stages 4 and 5 (Treatment and Reintegration). Many of the studies examined interventions to encourage students to engage in activities aimed at maintaining good mental health (often referred to as “wellness” interventions). While very similar, other interventions were aimed at students with early and as yet undetected mental health problems. Some of these studies were based on small samples, had short follow-up periods and lacked comparison groups with the result that they lacked generalizable findings.

Studies aimed at helping students with early, undetected problems included signposting to services and the provision of self-help and self-diagnosis tools. We have included studies focussing on medical students’ reluctance to engage with available mental health services and their reticence to reveal any health problems to medical school staff. We also present studies that describe the effects that being a medical student may have on help-seeking behaviour.

Finally, we have included a section on changes to grading procedures that have been introduced with the expressed intention to improve student wellbeing and to reduce unwanted effects from competitiveness and perfectionism.

The coping reservoir is a useful model of medical student resilience based on a review of the literature. Student coping is enhanced by psychological support, social/health activities, mentorship and intellectual stimulation. It is adversely affected by stress, internal conflict and time and energy demands. The authors propose that it is the balance of these factors that determine a student’s resilience at one any time and that by manipulating these factors resilience can be enhanced (Dunn et al., 2008).

---

<sup>1</sup> A table of the included papers is given in Appendix 1

## Prevention

### *Encouraging students to look after themselves*

Many studies promote active interventions by medical school staff to help students develop resilience and to decrease the likelihood of stress, burnout and mental illness (Howe et al., 2012). Self-care recommendations include modelling of good self-care by staff as well as instruction in skills that will help students become more resilient (Henning et al., 2009, Lee and Graham, 2001). Greater guidance and support may be particularly valuable in reducing stress at times of transition for medical students (Radcliffe and Lester, 2003b).

Approaches aimed at encouraging healthy students to take better care of their own health were evaluated (Gaber and Martin, 2002). Mindfulness Based Stress Reduction (MBSR – see box 3) formed the basis for some programmes aimed at reducing medical student stress levels (Rosenzweig et al., 2003, Warnecke et al., 2011). Although benefits to students' wellbeing were demonstrated research is required to determine the long-term value of mindfulness based interventions. In one study medical students who participated in an MBSR program scored significantly lower for Total Mood Disturbance (TMD) at the end of the study compared to controls despite a higher mean score at the outset (Rosenzweig et al., 2003). At Monash University, Australia, Mindfulness is included in the core curriculum along with the importance of addressing spirituality, stress management, nutrition, exercise and creating a supportive environment in a Health Enhancement Programme (HEP) (Hassed et al., 2009). An evaluation of the programme involving 148 students using psychometric measures found significant reduction in students' post test scores for depression and anxiety, hostility and psychological distress (Hassed et al., 2009). There were also improvements in psychological and physical quality of life.

Other medical schools include caring for personal health care and prevention of burnout in their curriculum as part of personal and professional development courses (Tennant, 2002, Brazeau, 2010, Roberts et al., 2001b). The question is raised whether the priorities of medical education and medical practice should be revisited. Without any wish to dilute the importance of patients' needs being put first it is suggested that the need for the student/physician to attend to their own health needs should be included (Louie et al., 2007).

At one school 343 students elected to participate in a course that involved them developing a behaviour change plan and supporting them through this over a six-week period. While most students opted for exercise, sleep or nutrition for their area of behaviour change of the nine students who chose mental/emotional health six (66.7%) reported that they had achieved their goal (Kushner et al., 2011, Dyrbye and Shanafelt, 2011).

### Box 3: Mindfulness-Based Stress Reduction

Initially introduced in the University of Massachusetts medical centre **Mindfulness-Based Stress Reduction (MBSR)** has been widely used to help patients with a wide variety of physical ailments to deal with associated stress. MBSR involves a combination of attitude change and meditation practices. Awareness (mindfulness) of breathing is at the centre of many of the meditation techniques.

MBSR techniques have been combined with cognitive behaviour techniques and used specifically to help prevent recurrence in patients with depression. MBSR techniques are widely available in self-help audio materials and via commercially available classes and meditation retreats. Newcomers to MBSR usually participate in a course of eight weekly classes and are expected to meditate daily for approximately 45 minutes during that time.

Other brief stress-reducing interventions including yoga, electro acupuncture, visual journaling and an elective in “Mind-body medicine” have been shown to be beneficial in improving positive wellbeing and reducing anxiety and depression. However, students involved in some of these studies are relatively small in number and the follow up is relatively short (Bughi et al., 2006, Simard and Henry, 2009, Mercer et al., 2010, Benbassat et al., 2011, Finkelstein et al., 2007., Melo-Carrillo et al., 2012). Visual journaling consists of techniques that help the participant to identify negative or stress-causing emotions and to elucidate them through drawing. In their study Mercer et al. (2010) used guided visualisation to help health professions students and doctors to visualise causes of stress and then asked them to represent these causes using a variety of art materials. Reflection and a second visualisation helped the participants to represent the contents of the first image in a less disturbing way (Mercer et al., 2010). Although their small number of participants did not make it possible to demonstrate significant changes it is worth noting the comments made on the disturbing content of their first image and drawing. Although the numbers of students was relatively small, a study by (Austenfled et al., 2006) showed that the act of writing about their emotions helped students with a high initial level of hostility to reduce this.

A systematic review of empirical studies of stress management programmes in medical education between 1966 and 1999 demonstrates the scarcity of generalizable research in the field (Shapiro et al., 2000). Of the 600 hits found by their search, the authors were only able to include 24 studies and of these only six were found to be of adequate methodological quality. Many studies reported positive benefits for doctors from stress management programmes including improved immunologic function, reduction in depression and anxiety, increased spirituality and empathy, enhanced knowledge of alternative therapies, improved knowledge of the effects of stress, greater use of positive coping skills and the ability to resolve role conflicts. However the power of most studies to make generalizable conclusions was diminished by reliance on participant evaluation of interventions and lack of randomisation, control groups and rigorous outcome measures (Shapiro et al., 2000).

### *Training students to support their peers*

Peer support offers one way of providing support to large numbers of students at little financial cost. Peer discussion groups can offer opportunities for students to process conflict and nurture self-awareness (Lee and Graham, 2001). Such groups can help students to realise that they are not alone in their struggles and to learn coping techniques from others. Although the authors do not evaluate any specific intervention in this paper Dyrbye et al. (2005) conclude that programmes to promote student wellbeing will benefit the patient, the public and the profession as well as the individual. While, the primary aim of the reported studies was to evaluate students' ability to support their peers it was argued that the training would also make students better informed and better able to access help if they should experience problems themselves (Hillis et al. 2010; (Hillis et al., 2012). A "Dummy's guide to helping a mate" is recommended in the form of a simple flowchart outlining sources of help for peers with specific problems (Willcock, 2002). For an example of a study involving a large number of participating students over a number of years see box 4.

#### **Box 4: Prevention - stress management at Oklahoma State University**

At Oklahoma State University, Institute of Health Science the Stress Management Program provides group support for first year medical students. The groups are facilitated by volunteer second-year students who are specially trained for this role (Redwood and Pollak, 2007).

The objectives of the program are; facilitating adjustment to medical school, aiding development of stress management skills, aiding development of a peer support system, and providing a confidential forum for discussion of concerns. The group meets nine or ten times and there is a specific topic for discussion at each one. These include the role of peer support, reframing thoughts, conflict resolution, study and test-taking skills, relaxation, empathic listening and wellbeing and personal relationships. The students receive a lecture on the health effects of stress between the first and the second group meetings.

1,111 (87% of participants) completed an evaluation which consisted of scoring a number of statements using Likert scales. Participants rated support from the other group members most highly and of the group activities they particularly valued; training for relaxation, empathic listening, study and test-taking, reframing thoughts and relationship issues.

### *Student wellbeing committees*

Some medical schools have encouraged their students to develop an infrastructure to provide support for their peers resulting in the emergence of student support/wellbeing committees (Abramovitch et al., 2000). The Vanderbilt medical school in Nashville, Tennessee has a Student Wellness Committee as part of its comprehensive student wellness programme (Drolet and Rodgers, 2010). Although the authors present the programme with great enthusiasm they have not, to date, published an evaluation (Drolet and Rodgers, 2010).

### *Actively reducing depression and suicidal ideation (see box 5)*

A research programme at the University of Hawaii, John A Burns School of Medicine made the reduction of depressive symptoms and suicidal ideation among their students its goal (Thompson et al., 2010). They did this through three interventions. A staff education programme focussed on reasons for and presenting symptoms of depression. Counselling services were enhanced both on and off campus and students were issued with a comprehensive student wellbeing handbook and were given an hour-long lecture on the risks of depression. Students in third year prior to and in the first year of these interventions were asked to complete the Centre for Epidemiologic Studies Depression Scale as well as a question about suicidal ideation. 44/58 returned questionnaires in the pre-implementation group while 58/62 completed them in the post-implementation group. This suggests more interest in the post-implementation group with the possibility of a Hawthorne effect. Bearing this in mind and the relatively small numbers of participants the authors did show a statistically significant reduction in depression at both mild to moderate and severe level as well as in suicidal ideation (Thompson et al., 2010).

#### **Box 5: Suicide prevention and depression awareness, University of California, San Diego**

Following a successful suicide prevention programme in the US air force the The Suicide Prevention and Depression Awareness Program at the University of California, San Diego School of Medicine was set up to identify and offer treatment to medical students and doctors who were depressed and at risk of suicide.

Participants completed a pack of psychometric and descriptive measures of their mood and their ability to function including the PHQ-9 questionnaire. Respondents whose score suggested that they might be at risk of depression were contacted by a counselor who offered face-to-face or online contact. Out of 498 medical students who were contacted, 132 completed the online screening and 42 entered into a dialogue with a counselor. Fifteen students were referred to a mental health professional (Moutier et al., 2012)

### *Managing student expectation*

As well as providing a supportive environment and signposting students towards various activities that might improve their wellbeing, it is possible to help students to manage their expectations. Students may enter medical school with a very idealistic view of what medicine involves and might find a mismatch between the biomedical focus of their training and the psychosocial presentations and problems of most of the patients they see (Benbassat et al., 2011).

### *Replacing graded assessments with Pass/Fail*

A number of studies reported changes to grading systems to reduce the adverse effects of competitiveness and perfectionism, particularly in the early years at medical school (Enns et al., 2001, Bloodgood et al., 2009). Changing to pass/fail grading has been shown to improve students' mental wellbeing and team cohesiveness (Rohe et al., 2006) (see box 6). A systematic search of the literature

between 1980 and August 2010 revealed limited literature on pass/fail grading in medical education. Four studies were found which examined the effects of pass/fail grading on student wellbeing and another five were confined to the academic consequences (Spring et al., 2011). The authors conclude that student wellbeing is enhanced by pass/fail grading with no harm to learning or performance in assessment. It was thought possible that students who had attended a school using pass/fail assessment might encounter difficulty when applying for some postgraduate rotations (Spring et al., 2011, Dyrbye et al., 2005). Reducing competitiveness by introducing pass/fail grading is one of five recommendations for creating a supportive, nurturing learning environment based on the positive psychology movement (Slavin et al., 2011). The other four recommendations promote positive emotions, facilitate engagement with activities outside the classroom, encourage development and maintenance of strong relationships and encourage/celebrate achievement (Slavin et al., 2011).

#### **Box 6: Prevention; pass-fail versus graded assessments at US medical schools**

A survey used validated questionnaires to measure burnout and psychological distress in US medical schools with a variety of grading practises (Reed et al., 2009). They found students at the schools not using pass/fail assessments more likely to suffer from burnout (OR 1.58, CI 1.23 – 2.01). They also had higher perceived stress scores, higher emotional exhaustion and lower mental quality of life. The response rate was 52% which meant that 1,192 students participated (Reed et al., 2009).

## **Identification**

### ***Student monitoring***

Some medical schools have put mechanisms in place that are designed to detect early signs that students are faltering. A simple “toolkit” developed by retrospectively looking at the records of students who had struggled on the undergraduate medical course identified five markers (Yates, 2011). These were failure of three or more exams in any one year, an overall average < 50%, health or social difficulties, failure to complete hepatitis B immunisation on time and remarks about poor attitude or behaviour. Box 7 describes an instrument that has been developed specifically for the identification of medical student problems including mental health problems.

#### **Box 7: Identification - The Medical Student Wellbeing Index**

The medical student wellbeing index (MSWBI) is a brief evidence-based questionnaire designed specifically to detect students who may have problems including mental health problems enabling help to be put in place early (Dyrbye et al., 2011). In their validation of this instrument involving 2,248 students from seven US medical schools the authors demonstrated the cut-off scores that would detect students at increased likelihood of Low mental quality of life, suicidal ideation and thoughts of leaving medical school. Studies evaluating this instrument in practice are awaited now that it has been rigorously validated.

Some work has also been done to identify personality traits, which are associated with higher prevalence of mental health problems. Impulsivity, neuroticism and conscientiousness all predict an increased incidence of mental health problems while “hedonists” who have low levels of neuroticism and conscientiousness are protected (Dahlin and Runeson, 2007, Tyssen et al., 2007).

In a multi-centre study involving 3,080 students factors associated with the learning environment most associated with student burnout were remediable (Dyrbye et al., 2009). For students in years one and two dissatisfaction with the learning environment and the perceived level of support were strongly associated with burnout. Later year students influenced by the organisation of clinical placements and having a cynical supervising registrar (resident) also reported learning environment dissatisfaction associated with higher levels of burnout (Dyrbye et al., 2009). 792 students completed a burnout inventory as well as a package of measures of characteristics that might be associated with burnout. Factors positively associated with recovery were: perception that their learning was a priority for the staff teaching them; not being in paid employment; experiencing less stress and ethnic minority background (Dyrbye et al., 2010).

In monitoring students for burnout, stress or depression the effects of debt should be taken into account (Ross et al., 2006). However, it was the conclusion of Ross and colleagues that it was students perception of their level of debt rather than the actual amount owed that correlated to scores on the General Health Questionnaire which they used (Ross et al., 2006).

#### *Helping students monitor mental health and access support*

Students’ reticence in engaging with mental health services has been addressed by providing tools that enable them to “find health for themselves” (Rakel and Hedgecock, 2008). Confidential, and in some cases anonymous, access to services was offered to students in need of support. One study asked 54 medical students to complete a paper-based questionnaire about their health habits including sleep patterns, alcohol intake, depression symptoms and areas of life satisfaction. Half the students were given written feedback with advice pointing out where they might make changes towards healthier lifestyle. This feedback influenced some sleep and exercise behaviours but did not alter overall emotional or academic adjustment (Ball and Bax, 2002).





## Self-identification, self-help and mediated help

Reluctance to acknowledge mental health issues and reticence in seeking treatment are recurrent themes in this report. While individual case studies indicate that many students suffer in silence for too long there are also signs that some quite simple on-line diagnostic aids may help to motivate them to seek appropriate support.

One university has developed a graduated approach which holds much promise. As part of a wider Mental Health and Wellbeing strategy all students have access to Well-Connected, an online self-assessment tool. For most users the assessment provides reassurance – stress and difficulty coping are part of everyone's life at some point. For others it confirms that they might benefit from sharing their problem. If they are not ready to do this face to face they can access the Tavistock Institute's White Wall on-line counselling service which offers different levels of help, ranging from further self-assessment to telephone counselling. At any point students can avail themselves of the university's counselling service. For the reluctant and reticent this gives a measure of control that divulging to a tutor might not. Given the fear of 'ringing alarm bells' many medical students exhibit, this graduated approach is ideal.

### Worth thinking about:

- If there is mistrust of current confidentiality arrangements – computers don't talk in the staffroom
- If resources are scarce – the 'front end' is cheap allowing counselling services to put their resources into more needful cases
- If you have split/remote sites – anyone can access and a further benefit is no-one is seen using the service

### You will need to:

- Buy a licence
- Train some staff so they can act as mediators
- Publicise its availability
- Integrate with other services



Another online programme helped students to create their own plan for self-reflection, health and wellbeing. It included items on diet, exercise, substance use and spirituality. Participants were asked to complete an evaluation immediately after completing the programme. Of the first 500 participants 89.4% thought that the programme had helped them to understand what they needed to do to improve their own health & quality of life. This response was immediately after the intervention (Rakel and Hedgecock, 2008).

An experimental online forum for medical students with concerns about their mental health was set up to help students “realise that they are not alone and that a lot of resources are available” (Rosenthal and Okie, 2005). Medical school staff had no access to postings but a psychiatrist monitored them. In the ten days that the experimental site ran it received 1,000 hits and more than 100 postings (Rosenthal and Okie, 2005). The authors propose that being able to discuss concerns about the effects of disclosure on their career with like-minded peers is more appealing than meeting even a sympathetic member of staff (Rosenthal and Okie, 2005). Medical students on a two-week student selected module (elective) in “mental health first aid” decided to create a mental health resource for their peers. They provided user-friendly online information about mental health, set up a confidential online forum and offered confidential email counselling (Lau et al., 2007). The students underwent training to act as facilitators and email counsellors with a senior teacher in clinical psychology. The website recorded 1,900 hits in its first year, seventeen students entered the online form and one student accessed email counselling. Two hundred and fifty-three students (response rate 42%) returned an evaluation questionnaire. Of these 110 (44%) had concerns about their own mental health (Lau et al., 2007). The information supplied by the website was widely accessed by students who acknowledged its usefulness both about mental health in general and about their own mental health. However, the reticence towards use of the forum and the online counselling suggests that students may have had some concerns about confidentiality in relation to a service developed and run by their peers. The authors express concern about the longevity of this project set up by student volunteers.

#### ***Students with a history of mental health problems on admission***

Students who have mental health problems while they are at medical school are more likely to have experienced mental health problems prior to admission (Yates et al., 2008). Researchers at the university of Nottingham examined the occupational health record of students who were struggling on the course. Significantly more of those who struggled had a history prior to admission of mental health problems, eating disorders or psychological counselling (Yates et al., 2008). In the normal course of events the content of the occupational health file is not accessible to medical school staff (limited access was granted specifically for this study).

## Referral

### *Fears around disclosure*

Medical students have higher rates of mental illness including depression and anxiety than age-matched controls but they are less likely to access treatment (Tjia et al., 2005, Dyrbye et al., 2006, Ey et al., 2000, Roberts, 2010, Saadat et al., 2010). Stigma associated with stress, mental illness and use of mental health services, and fear that a diagnosis would be entered in their academic record acts as a barrier to students accessing the help they need (Tjia et al., 2005, Hillis et al., 2010, Holm et al., 2010, Holm et al., 2007). In a study involving 322 students 49 (15.2%) were classified as depressed with 10 (3.1%) reporting suicidal ideation. The authors found that medical students with depression were undertreated, while younger students with no previous history of depression least likely to have accessed treatment. Personal or close family history of mental health problems was found to be a factor in students referring themselves or other students with depression to support services (Nuzzarello and Goldberg, 2004). The observed differences were not due to availability of effective treatment which was accessible to all (Tjia et al., 2005).

#### **Box 8: Referral - views of UK medical students**

Avoidance of help-seeking behavior (self-referral) because of perceived stigma begins early in medical training.

This was a finding of Chew-Graham and colleagues (2003) who carried out a qualitative study with a purposive sample of 22 medical students. As they acquire medical knowledge through their training medical students start to apply this knowledge to decisions such as whether or not to see their GP, and are willing to practice limited self-diagnosis. Perceptions of stigma associated with mental illness were prevalent among students (Thistlethwaite and Quirk, 2010, Brimstone et al., 2007).



## All you need to know....

For students finding the right support service to match their needs can be difficult especially when they are feeling depressed and isolated. The specifics of where to go, who to ask for and where to look on the website may be difficult to recall from all the information presented during induction. Brightly coloured cards giving this information 'just in case' address this need. The 4" x 3" card is produced by students for students with two very simple messages:

1. You are not the only one – in fact everyone has problems at some time
2. Plenty of help is available and it's easy to access

A dozen common concerns from anxiety to sleep problems are matched to up to 9 sources of help with phone/email/website details. Medical students are given the cards as they queue for their occupational health sign-off and anyone who talks to student groups about mental health and wellbeing is primed to flash the card to reinforce the message. Piles of the cards are left in accessible places.

### You should consider if:

- You don't already have one
- There is more than one source of help (Student Services/medsoc/union)
- You want to convey the message that mental health problems are normal.
- You want to reduce confusion caused by apparently competing services

### You will need to:

- Talk to all the service providers
- Agree a joint approach (annually)
- Pay for design and printing
- Let the student body do the distribution
- Give modest financial support for posters etc.

### *Unwillingness to reveal mental health problems*

Some studies have shown that students are unwilling to disclose mental health problems because of the effect this may have on their future career (Thistlethwaite and Quirk, 2010, Reynolds and Clayton, 2009). Stigma is widely perceived to be attached to mental ill-health including stress by medical students (Chew-Graham et al., 2003, Hillis et al., 2010). Admitting to a mental health problem is widely seen as a sign of weakness, a view that is seen to continue throughout the medical profession (Alison et al., 2008). Following a student's suicide staff at the University of Alberta, Canada, made a twice-yearly appointment with an adviser (counselor) mandatory thereby taking away any stigma associated with this initial contact (Yiu, 2005).

In a questionnaire completed by 1,027 US medical students (52% response rate) students expressed fears of "academic jeopardy" in relation to illness (particularly substance misuse, HIV and psychiatric problems) and 90% preferred to receive personal health care away from their training institution (Roberts et al., 2001b). The perception of the threat that disclosure posed to students' careers varied between medical schools participating in this study. The authors attributed this finding to a difference in the perceived confidentiality of medical care at the different institutions. They also propose that there is a difference in students health needs, especially mental health needs across different institutions (Roberts et al., 2001b).

A questionnaire study with 194 medical students found, using the Beck Depression Inventory that 46 (24%) participants had depressive symptoms but that only 10 (22%) of these were accessing mental health counseling services. After lack of time, lack of confidentiality and stigma were the most common reasons for students not accessing support (Givens and Tjia, 2002). This finding was consistent with a study carried out in Brazil (de Oliveira E Sousa Leao et al., 2011).

### *Barriers to seeking/using health care services*

Medical students start bypassing normal routes to medical care early in their training. In many cases students seek informal consultations with colleagues (Roberts et al., 2000b, Brimstone et al., 2007). A questionnaire study involving 164 UK medical students (80% response rate) showed that many students consulted colleagues and accessed prescriptions and referrals without involving their GP despite almost all students being registered (Hooper et al., 2005). Students saw this behaviour as normal.

### **Escalation**

In New South Wales medical students with impairment *which impacts on patient welfare* must be referred to the NSW Medical Board. Medical schools are encouraged to refer early. The impairments that are most difficult to manage include intermittent psychosis, severe personality disorder and addiction (Wilhelm, 2002). The authors make the point that it is unethical to allow someone to continue in an undergraduate medical course if the course is not preparing them very well for any alternative career.

## Summary of Findings Chapter 2

In this review we have identified studies that look at ways of helping medical students avoid getting mental illness using a variety of techniques. We have also presented studies looking at processes for identification of mental illness and referral to appropriate sources of support. Identification and referral can either be enacted by the student or by the medical school or university staff. Our search did not pick up any studies relating to, treatment or reintegration.

The process model we presented in figure 1 does not adequately cover our findings. In particular, the model does not include the effects of stigma and of students' fears about confidentiality. We will return to this in chapter 6 where we have revised the model (see figure 3) to reflect on findings of this review and our data from the e-survey, focus groups and interviews.

## Chapter 3: Support for medical students with mental health problems: a broad picture of provision in the United Kingdom

---

### Introduction

In this chapter we present data from analysis of websites and materials available for download; the e-survey sent to Deans and quality leads within medical schools<sup>2</sup> and to centralised University support staff<sup>3</sup>. We also present data gathered from in-depth, semi-structured telephone interviews conducted with medical school and University student support services staff.

Results are presented thematically, and focus on:

- Medical student recruitment and screening
- A brief consideration of the role of the personal tutor in supporting medical students, and alternative organisational arrangements
- Systems for monitoring student progress and wellbeing
- Flags that may indicate escalation of a problem or cause for concern
- A mapping of services provided by medical schools and University services
- Data on leave of absence rules and arrangements
- Respondent thoughts on the experience of students re-integrating following a period of absence, and Fitness to Practise issues.

Medical School and University support staff from twenty-three UK HEIs with medical schools responded to the e-survey. The Tables highlighting e-survey results present responses initially in percentages followed by actual respondent numbers in brackets. Examples of good practice are highlighted throughout.

The chapter concludes with a series of quotes taken directly from respondents to the e-survey which highlight what they identified as their institution's strengths in relation to student support, and where services might be improved.

### Recruitment and screening

Websites play a key role in promoting what the institution has to offer prospective medical students. There is a wealth of information available which in most cases, includes detailed information about school size, course length, curriculum, teaching methods (traditional, integrated, problem based learning), how early in the course

---

<sup>2</sup> Names and emails of contacts were provided by the GMC and supplemented by contact details from the Medical Schools Council (MSC)

<sup>3</sup> Identified by research team from University websites. An invitation to participate in the e-survey also appeared in September's edition of the AMOSSHE member's newsletter - the UK student services organisation.

patient interaction begins and, details of links to the local community of medical professionals aiding placements, transition into F1 and so on.

There are also quite strong indications with regard to the ethos of the medical school e.g. how supported a medical student might expect to be, with some schools presenting a very clear sense of support through messages about working in partnership with the student to achieve their (shared) aims. In many cases, mental health support (at University level) is presented as very accessible with medical schools and University Student Support Services promoting their services across a number of platforms, as illustrated in Table 7. Services available to students include:

- Advice about accessing student services (what's available, opening times, staff, location etc.)
- Arrangements in place for counselling services (what type of counselling, opening hours, location, potential commitment, how to make appointments – by phone, email, drop-in etc.)
- Policies such as the institution's mental health policy. Some institutions having a number of health policies at both University and School level e.g. Mental Health policy (University), Drugs and Alcohol policy (School), Careers policy (University)
- Medical School specific information such as Arrangements for Occupational Health (what they do, how and when they might be contacted), Fitness to Practise procedures (what is Fitness to Practise, what prompts a Fitness to Practise investigation, the procedure), Medical Student Code of Conduct.
- GMC duties of a doctor and GMC medical student guidance.

**Example 1: Support 1 click away**

One of the University websites had a dedicated student wellbeing 'help' page where the first item on the home page reads '*I have a mental health issue and need support*' – one click takes the student through to information on a range of services offered by the Student Mental Health Team, contact details and protocols.

Included in medical school recruitment materials specifically, is information on student mental health issues (29% (9)), student support services (90% (28)) and arrangements for reasonable adjustments in relation to disabilities (97% (30)).



## Regent Scheme

While almost all students have a tutor within their academic department, students at this university are also paired up with a senior clinician in the hospital, which is co-located with the medical school.

The pairing takes place at a social event in induction week and is for the full five years of the MBBS programme. Regents are recruited by the course administrator and given a briefing about their role, which is a combination of mentor, role model and advocate. The course administrator also monitors contact so that only active Regents remain on the list, although the scheme is so well embedded that hospital staff see it as part of the day job. Contact is not enforced – students are ‘encouraged’ to make contact at least twice a year – and the evidence is that most do.

For students the benefit is an extra contact *‘who actually works in the NHS’*, who has *‘experienced the stress of moving around teams’* and who *‘is willing to listen and is a bit more independent’*. Advice on career and option choices are valued and some students have found opportunities for involvement in research through this scheme. Even those who don’t make a great deal of use of their Regent know they are there.

Motivation for Regents includes maintaining contacts with the medical school, keeping abreast of changes in training and even some talent spotting for their own team. Most Regents have 3 or 4 students spread across the year groups but they are not encouraged to take on more than they can reasonably commit to and, if circumstances change, can reduce their commitment.

Worth considering if you want to:

- Foster closer links with real medical work
- Give students access to an independent view
- Improve the range of extra-curricular activities open to students

You will need to:

- Dedicate some administrative time and have someone who is persuasive to promote it
- Be selective in your choice of Regents: they need the skills and motivation to befriend students not the urge to impresses them with scare stories.

Like many voluntary support schemes it relies on someone holding it together administratively and actively promoting it. The latter is helped by student presence on the wards very soon after induction so having a link into working doctors is not as remote as it might be in more traditional pre-clinical teaching establishments.



### Mental health at application and admission to medical school

Fifty-nine percent (17) of responding medical schools screen potential students for mental health issues. Of those, the majority use Occupational Health questionnaires followed by a face-to-face meeting and/or a meeting with the Disability and Dyslexia service where appropriate. Screening of applications and student agreements<sup>4</sup> is also undertaken by some institutions.

Respondents were asked how many medical students, on average, declare a history of mental health at the point of admission to their medical course; most respondents did not know, those who did, as can be seen from Table 4, reported that the numbers are low.

**Table 4: Average number of medical students declaring a history of mental illness at the point of admission**

Number	% (No.)
0 – 2	14 (4)
2 – 4	14 (4)
5 – 6	-
7 – 8	3 (1)
9 – 10	7 (2)
>10	-
Don't Know	62 (18)

n=29

While 48% (15) of e-survey respondents indicated that they believed students declaring a history of mental illness was on the increase, when this was explored further in telephone interviews, interviewees were unable to say whether they thought that this was due to mental illness being more prevalent or to mental illness becoming more accepted in medical schools (reflecting changes in society as a whole). As one interviewee put it,

*“Permission to disclose is important to our students - they initially have reservations regarding disclosure and so they sign a form which allows them to control who is given information and who is not. This allows trust to be built up in preparation for disclosing to GMC and Foundation upon graduation” (e-survey, Dean)*

---

<sup>4</sup> The Medical School Agreements is based on General Medical Council statements on the duties of a doctor (Good Medical Practice, 3rd Edition May 2001). The declaration is confirmed annually. If there is a difficulty for any student with any element of the statements the University and Medical School will work with the student to seek a resolution where possible. A student who has not satisfactorily completed a Student Agreement will not be permitted to register and attend classes in the following session until such time as this has been satisfactorily completed.

**Table 5: Perception of the trend for medical students declaring a history of mental illness on admission**

Number	% (No.)
Increasing	48 (15)
Decreasing	-
Staying the same	29 (9)
Don't Know	23 (7)

n=31

Figures provided by e-survey respondents for the number of medical students accessing student services due to mental illness once enrolled ranged from 0-10 (8% (2)) to 50+ (27% (7)).

**Table 6: Average number of enrolled medical students accessing Student Services due to mental illness each year**

Number	% (No.)
0 – 10	8 (2)
11 – 20	35 (9)
21 – 30	23 (6)
31 – 40	4 (1)
41 – 50	-
50+	27 (7)
Don't Know	4 (1)

n=26

### Support services

In this section we present examples of support services available to medical students that are accessed via the medical school and University student support services. Data were gathered about methods used by medical schools and student support services use to convey information to students and about available services.

Once medical students are enrolled, a range of information about services and School and University-wide policies is conveyed to them via a variety of methods as illustrated in Table 7.

**Table 7: How information is conveyed to medical students**

	Written material	Website	USB Stick	Lectures/ briefings	Email	VLE/Student intranet	Text message
<b>Services</b>							
Advice about accessing student services	94% (29)	87% (27)	3% (1)	87% (27)	39% (12)	68% (21)	3% (1)
Arrangements in place for counselling services	77% (24)	77% (24)	3% (1)	71% (22)	19% (6)	42% (13)	-
Arrangements for Occupational Health	74% (23)	58% (18)	3% (1)	68% (21)	32% (10)	32% (10)	-
<b>Policies/information</b>							
School's policy on mental health	45% (14)	68% (21)	3% (1)	68% (21)	13% (4)	29% (9)	-
Information about Fitness to Practise referral	81% (25)	58% (18)	3% (1)	68% (21)	23% (7)	16% (5)	-

n=31

Medical student inductions and subsequent annual briefings represent key opportunities for institutions to publicise their support services. Presentations from Personal Tutors, Students Union Welfare Officers and other staff with pastoral responsibilities include information on support for a variety of issues, including mental health. Emails are used to a lesser extent to publicise support than written material, websites, briefings and intranet. The example, below exhibits how email is used:

**Example 2: Use of emails to publicise support**

The Disability Liaison Officer (DLO) emails all students regarding their role and reassures students regarding disclosure. This email is sent annually at the beginning of the new academic year. The Director of Support (DoS) also sends out an email to students regarding their role, the support available and how to contact them. Occupational health and deputy year leads and advisors can also inform students of DLO and DoS contact details if they identify a student who would benefit from additional emotional support and can encourage the student to self-refer.

Follow-up telephone interviews with medical school staff explored how medical schools present information to students about mental health issues specifically and found that this is not the practice at all medical schools. Instead some schools

promote access to University student services or the personal tutor system as the first point of call for students experiencing problems,

*“Our guidance is given in general terms and is quite clear about who to contact if students have a problem however we do not specifically mention Mental Health issues specifically”* (e-survey, Lead on medical student pastoral care)

Across all Universities there was a standard range of services available to all students, generally in the form of a centrally-located one-stop-shop. In most cases, there was what appeared to be quite a sophisticated triage system within a main campus student building, often located close to the Student’s Union. In some cases many services were replicated at satellite sites where the campus is split across a town/city (often at University Hospital/ medical school sites). While most services were centrally based in some institutions mental health/counselling was situated separately. Provision of support services included, as a minimum:

- Advice and Guidance
- Counselling
- Disability and Dyslexia
- Financial Support
- International Studies.

### Self-Help Resources

A significant element of student support is covered by what could either be preventative measures or early interventions. These take the form of self-help resources, provided almost exclusively through centralised Student Services. Core services include:

- Hard-copy and in some cases downloadable leaflets for both University resources and external organisations such as ‘Mind’
- Contacts and links for internal sources of support
- Contacts and links to further sources of support with links to external and national organisations such as The Samaritans.

Resources offered by Student Support Services differ from those provided by medical schools (see tables 8 & 9 below) and provision varies significantly between institutions.

**Table 8: Resources within Student Services to support students with mental health issues**

Provision	% (No.)
1:1 Counselling	100 (31)
Bibliotherapy	19 (6)
Group therapy	45 (14)
Workshops	55 (17)
Peer support programmes	52 (16)
Downloadable podcasts	3 (1)
Leaflets (hard copy)	84 (26)
Leaflets (downloadable)	68 (21)
Lists of sources of external support	84 (26)
Other (mental health adviser)	23 (7)

n=31

**Table 9: Resources within the medical school to support students with mental health issues**

Provision	% (No.)
Personal tutors	100 (28)
Counsellors	57 (16)
Peer support programmes	39 (11)
Intranet advice	57 (16)
Other:	29 (8)

n=28

In some Universities, the range of self-help resources available to students is extensive offering a variable selection of the following:

*Bibliotherapy:* Self-help books and in some cases films offered through either a loan service or through prescription. A range of leaflets and links to national organisations are also made available (hard copy and downloadable) e.g. Mind, The Samaritans, Papyrus Prevention of Young Suicide, Students Against Depression, NHS Direct.

*Downloadable podcasts:* from trusted sources, e.g. Mental Health Foundation and NHS, offering stress management techniques such as effective breathing, relaxation and imagery podcasts.

*Online multi-media programmes:* that offer self-help tools to identify, motivate and educate around common mental health issues such as anxiety, depression, insomnia and stress, addiction, eating problems, abuse, anxiety, loneliness, relationships, helping a friend, homesickness, and self-injury.

*Online mental wellbeing support (enabling anonymity of user) offering:* 1:1 counselling, Peer support, Creative therapies, Resources to aid self-care.

*Equipment for loan,* e.g. a Seasonal Affective Disorder (SAD) light box.

*Raising Awareness of Mental Health:* There was evidence at some Universities of proactive, student led campaigns, in association with student services that aim to

raise awareness of Mental Health issues and reduce stigma surrounding Mental Health, holding events to improve/promote everybody's mental wellbeing.

### **Mediated Services**

Mediated services offer a variety of interventions such as counselling (offered on an individual basis) and self-help groups and workshops facilitated by counselling staff, where learning takes place in a group environment and students can learn and practice new skills in an atmosphere of peer support. This enables them to cope better with the demands of University life. The following is a list of descriptions of the various services available (although not all services were available at all institutions):

*Counselling:* Therapeutic approaches available include CBT; existentialism; person-centred; psychodynamic; transpersonal counselling, delivered via face-to-face, telephone and e-counselling; advice lines manned by trained advisors and counsellors; and referral to other support services.

*Themed workshops:* one-off events that run for 2-3 hours that students can sign up for. They offer students information that promotes an understanding of their problem. It is an opportunity to learn some new skills and get some tips and advice on how to overcome specific difficulties. Skills offered include assertiveness skills training, coping with pressure, stress management training.

*Therapeutic Groups:* tend to be longer-term than themed workshops and are run over a number of weeks (e.g. 4 or 6 weeks) and kept to small numbers. The facilitator of the group will offer information/advice and introduce healthy ways of coping with specific problems.

*Student Support Clinics:* Run by senior medical school staff for students in years 1 and 2 these clinics are held throughout the week during term time. Both pastoral and academic matters can be discussed during these sessions. The majority of appointment times are pre-booked.

*Training Courses:* A variety of courses on offer from general transferable academic skills; interpersonal and communication skills learning about healthy lifestyles that promote health and wellbeing, to very specific preventative measures aimed at equipping students with the skills to identify causes for concern amongst their peers e.g. Suicide Prevention Intervention Skills Course.

*University Chaplaincies:* offer access to chaplains from a number of religious backgrounds, some of whom are ordained ministers. They offer listening support and guidance to students. Activities that engage with the students' spirituality are also arranged. Chaplaincies offer a friendly place for pastoral support and help and confidential, non-judgemental listening. Some offer out-of-hours emergency support.

*Listening Services:* Nightline is a telephone listening service (8pm-8am) run by trained student volunteers in a number of Universities offering an anonymous, confidential, non-directive, non-judgmental service. Some also offer an information giving service and email listening service where they aim to reply within 48 hours and can ensure complete anonymity for the student through hidden emails.

*Peer Support Schemes:* offer the student space to talk through issues to someone who is outside the immediate situation, and in doing so can help clarify feelings, and options. Peer Support offers the student a tailored provision to suit the needs of the individual that can take place in a variety of situations – walks, going for coffee, one-off chats or regular meetings.

*Wardennial Services:* Wardens and assistant wardens in halls of residence, one of the first points of contact for resident students who need support.

*Mentoring schemes:* can be solely focused on student progression or also encompass their welfare and in some cases mentors act as the student's advocate. Contact is not necessarily on a 1:1 basis; there are examples where students are brought together from different academic years in small groups with one Personal Tutor.

*Peer Support:* including 'peer-parenting', partnering new students with a 'family' of more senior students who can offer advice and support based on their own experiences is operated in a small number of medical schools, usually Year 2 students are allocated to a new medical student.

Self-help resources not only encourage proactive help-seeking behaviours for students who have identified a need; but for medical students in particular, they offer a low-risk source of help for any student who may be concerned about any Fitness to Practise-related information going on their record. This self-referring approach also offers a 'toe in the water' opportunity for students who may be initially reticent about accessing 1:1 sources of help to build trust. It also offers remote access for those with limited time available and those away on placement.



## Wellbeing Week

A large number of studies address student “wellness” in a wide variety of ways. These include: a student wellness programme that identifies stress points in students’ lives during medical school (Drolet and Rodgers, 2010); a cognitive behavioral exercise that helps develop necessary skills to promote resilience (Dyrbye et al., 2011); and a General Wellness Programme focusing on physical fitness and psychospiritual wellbeing (Gaber & Martin ( 2002). A number of these initiatives were wholly or partly student-led and these have a number of advantages.

In Wellbeing Week mental “wellness” is presented along with a number of health-related issues, including diet, exercise, relationships etc. Secondly the very fact that the events are run by students with many students participating creates a sense of openness in which students feel more able to talk about problems they may have. The students union at one medical school runs Wellbeing Week annually covering a broad range of topics including mental health, physical health and work/life balance. Each day is assigned a particular theme with appropriate activities. Students at this medical school also celebrate

World Mental Health Day with a poster campaign about famous people including sports stars who have had mental health problems. The posters gave the message that mental health problems should not be a barrier to success as well as giving a web address for further information Both these initiatives were successful due to the energy of a few students within the students union.

### Worth considering:

- An excellent way of getting mental health issues more easily raised by students
- Counters the message that mental illness = weakness and failure

### You may need to:

- Suggest a wellness initiative to your student union officers
- Give modest financial support for posters etc.



### The role of the tutor

All medical schools responding to the e-survey operate some form of Personal Tutor scheme for students, however the role (responsibilities, duration, frequency of contact, whether or not contact is mandatory etc.) and forum vary significantly. In some schools, there is a clear distinction between academic and pastoral provisions; while other schools have schemes in place where this distinction is blurred. In this case a member of the medical school staff may provide support for both academic and pastoral matters or may refer on to specialist services as appropriate. An example of this is the Regent Scheme (see page 40), where every medical student is assigned an experienced member of staff who, for the next five years is that student's regent, tasked with providing support and guidance on "any matter" and to act as mentor and to help with the student's professional development. This contrasts with a specifically Academic Tutor role which may change each year or even each term if linked to core modules.

### Examples of good practice

The following examples illustrate how existing personal tutor systems have been or are currently in the process of being fine-tuned to meet the needs of medical students and the staff supporting them.

*Regular student/personal tutor meetings:* A factor that varied significantly between institutions was whether and how often student contact with personal tutors was compulsory: One respondent told us their personal tutor system had previously been, "...just a crisis system that students occasionally use when things get difficult for whatever reason" (Telephone interview, Faculty Senior Tutor). As a result, this institution is in the process of making it far more systematic instigating regular meetings between students and tutors and placing a greater focus on academic as well as personal issues.

*Tutor selection:* Where an institution has been in a position to select key individuals from within the University to join their scheme. This includes NHS and non-clinical staff who have been identified as having the qualities needed to be an effective student support and have been invited to join the scheme. On agreement, the process is further refined by asking the tutors to identify how they feel their skills would be utilized most effectively,

*"We've identified ... staff who are prepared to engage with the scheme and asked them to identify whether they feel that they're more appropriately assigned to the academic support arm or the pastoral support arm" (Telephone interview, Deputy Dean)*

*Selective allocation of tutor to student:* Where possible, one institution matches personal tutor experience of specific conditions to student needs to ensure the best possible level of support for that student. The extract, below exhibits this:

*"Because the personal tutors are all trained and supported to actually support the students, and X is quite careful in the way she allocates the students, so if X*

*knew that somebody, for example we've got quite a few students with dyspraxia and we've got quite a few personal tutors who have got experience of dyspraxia. So we would allocate those students to those tutors because they can give them better support and be more understanding as well"* (Telephone interview, Dean/Vice Dean)

*Limiting the number of students per tutor:* In 2012, one institution introduced a limit of four students per tutor for each academic year, meaning that when this has been fully embedded in three-year's time, the maximum tutees any tutor will be responsible for is 12.

*Including medical students in decisions:* Through the Student Support Committee at one institution, medical students are able to have an input into "...the actual goings on in the personal tutor system" (Telephone survey, Director of Student Support)

Beyond the personal tutor there is a further tier(s) of support within most medical schools where students can be referred should their support needs demand. Without exception, institutions stress that their personal tutors are aware that should they have concerns that a student has additional support needs over and above the remit of the personal tutor role, they refer the student on to more appropriate support. This ranges from encouraging students to contact their own GP, to referring on to a single, senior member of staff known to all, to office staff and centralised University support services,

*"[The personal tutor scheme] is supported by two Associate Directors and an administrator. Where a student has significant issues there is an Academic Sub-Deans system which assists students in managing progress issues and liaises with Occupational Health ... Other general points of contacts for students include placement tutors and Learning and Teaching office staff"* (e-survey, Dean/Vice Dean)

### Alternative points of contact

The following examples outline some alternative 'first points of contact' to the personal tutor role in meeting the support needs of medical students.

*Pastoral tutors:* Allocated to students who have been identified as needing additional support through perhaps having been borderline in examinations or low attendance; having come to the attention of staff with previous health concerns; or being registered with the disability support services.

*Academic mentors:* One institution has replaced their personal tutor system in favour of academic mentors who are clinicians with the remit of ensuring students are "on track"; they meet with the students two or three times a year and discuss their progress academically and help them to think through their career plans,

*“We’ve also recently introduced ...an e-portfolio where students map their academic and clinical progress. The meetings with the academic mentor are noted in their e-portfolio as well, so it’s part of their professional development which helps to keep conversations focused”* (Telephone interview, Faculty Education Manager)

*Academic mentor as team leader:* An academic mentor, providing dedicated student support, is employed on a half-time consultant post at another institution; as students are referred, or self-refer to him, he is able to address their concerns and can further draw on the team of designated pastoral tutors allocated to students identified as needing support e.g. academic support pastoral support and general advice.

*Student support coordinators:* This high-profile team of three Student Support Coordinators (advisors) is the first point of contact for students with concerns at this particular institution: The coordinators speak to the students in the Year 1 and Year 3 induction to advise on the support they provide and how students can contact them; a member of the team also visits Year 5 students on placement. Tutors, lecturers and support staff are reportedly well aware of the service and will put students in contact if they feel it necessary. The coordinators can be contacted via phone or email or by dropping into their offices which are located in the two main medical teaching buildings.

*Clinical Mentors:* All students with a non-clinical personal tutor are additionally allocated a clinical mentor (who is trained to undertake this role). They work with the students around particular clinical issues, e.g. to prepare for application for Foundation school.

*GPs:* Reportedly, the informal choice of mentor for some students. One medical school has found that through small group teaching, relationships can be built with a GP tutor which can have a secondary benefit - a conduit for seeking advice and support leading to a separate ‘informal’ support mechanism (effectively, students choosing their own personal tutor),

*“[the GPs] are there primarily to be delivering teaching within the general practice environment, but because they get to know the students in the group very well, students often, if they’re having problems, will use that as a source of support and advice”* (Telephone interview, Deputy Dean)

*The Cohort Tutor:* The tutor’s role is to keep the students up to date with things that are going on to keep them informed about any changes in policy and practice and to act as a go-between for the school and the cohort. The cohort tutor also has a support role should a concern form be raised about a student.



## Referral for personal tutors

The role of personal tutors as first point of contact for students with a wide range of problems has already been presented. Because most personal tutors will look after a very small group of students and this will be just a small part of their work they will, in most cases, not have acquired a great level of knowledge and skills in supporting students.

Therefore, in order to support tutors when they are faced with a problem outside their skill and experience it is important that they can call upon more knowledgeable and experienced staff at short noticed.

One medical school addresses this problem by organising sessions where students can book an appointment with a senior member of medical school staff where they can get help with their problem. Referrals are made by other members of staff such as small group facilitators and students can make an appointment on their own volition.

### Worth considering:

- Excellent resource for personal tutors who need expert help
- Enables senior staff to see students who need their attention in a bookable “surgery”

### You will need to:

- Make times and details of making bookings clear to all

## Monitoring

All students are monitored through a combination of paper-based and electronic management information (MI) systems used by medical school committees and working groups that meet periodically to ensure that all students are progressing as required and that no students are showing signs of faltering progress. Again, operating systems and processes between institutions vary, as does responsibility for monitoring the data and how frequently this is undertaken,

*“...the Progress and Professionalism Director goes through all the students very quickly every two weeks, just to make sure that there’s nothing arising. So there’s an on-going monitoring of all the students, and then we have the formal meeting where we all sit round and go through every student, we have that once a term”* (Telephone interview, Dean/Vice Dean)

*“The Progress Committee: tracks students that are struggling, informed by MBChB etc. exam boards and exam committees. The two associate directors and the administrators meet on a weekly basis to deal with all the operational issues, in terms of personal tutoring system, students who've got issues etc. The Student Support Committee meets once a term. Within the Student Support Committee there is the MBChB Student Support Team that meets on a weekly basis to prepare personal tutor training, personal tutor sessions, deal with any concerns regarding students, or generalised concerns that students have raised within, essentially a working group that gets on with the day-to-day business”* (Telephone interview, Director of Student Support)

Some institutions operate their monitoring systems by amalgamating data from separate sources and find that this works well, while other institutions felt that their MI systems were key to supporting students and something that could be strengthened,

*“...management information systems and knowledge management systems is all ...we've different systems, for instance we've got a progress file, a university system ... our system that [records] academic information, it would be nice if somehow there was a system where every contact was tracked and... all the information was in the one place rather than in different places”* (Telephone interview, Director of Student Support)



## Performance monitoring

Creating an environment in which students feel able to get help for problems early is highly desirable. It is also possible to monitor students' performance and to enquire whether there are any issues with which a student needs help when their progress is seen to be falling off. Assessments provide an obvious measure of student performance but it is possible to use other parameters to monitor performance. At one UK medical school Students who have failed an assessment, formative or summative are offered the opportunity to speak to a member of staff who will enquire whether there are any underlying reasons. Most importantly, if any issues do come to light the member of staff will determine what support can be put in place to help put the student back on track. Assessments of students' performance where they are observed such as on clinical placement or in the skills lab may give rise to recognition that their performance is below their usual standard and an appointment is organised. Failure to carry out routine administrative tasks such as completion of an elective form on time can also be a trigger for enquiry whether the student needs support.

You should consider if:

- Student problems currently come to your attention late
- It is not possible for all students to be known to medical school staff
- Students most in need of support don't ask for it

You will need to:

1. Make performance monitoring a normal part of medical school life
2. Have a clear set of procedures for calling students in for review
3. Be clear this is a friendly enquiry whether the student needs help

### Example 3: Integrated record system

One institution has recently redesigned their systems so that almost all student information is held in one 'integrated record system'. Not only does this make monitoring student progress – and potentially identifying early warning signs of problems – easier, but is apparently viewed very favourably by all, including the medical students who appreciate being able to access all their data. The integrated record operates on a 'need to know' basis e.g. information on a student's additional needs is only accessible to their personal tutor if the student has given permission to release it,

*"...they [students] can access their own [record] but they can't access anybody else's...It was partly for the students really so that everything was in one place...the final bit of the jigsaw we haven't quite done is that all the written assessment results don't go in yet because they're stored somewhere else but that's our mission for the year ... they are asked to sign a disclaimer that information is released to the relevant person and the personal tutor is one of those people"* (Telephone interview, Dean/Vice Dean)

### Escalation and cause for concern

Regular monitoring of student data enables Schools to identify what could be early indicators of more serious problems, to be flagged for further investigation. Example 3 illustrates the criteria that one institution uses for flagging students for follow-up by the Progress Committee.

### Example 4: Monitoring flags

At one medical school, the MI system automatically puts a red flag against a student's name if they match any of the following criteria:

- Attendance: that falls under 80%
- Performance: a low result on a clinical placement record (score 1-4, students scoring 4 are flagged), failed exams
- A physical disability, mental health or a learning disability (flags here mean that that committee just looks at the whole profile of the student, makes sure the right things are in place in terms of support and monitors the student's progression).

Commonly the senior tutor will arrange a meeting with a student where concerns about performance have been raised and will refer the student to sources of help and put appropriate monitoring in place. In a very small minority of cases the progress committee may refer the student to an informal Fitness to Practise hearing.

Where situations escalate and the student's mental or physical health may prevent them from continuing their studies or may pose a threat to patients a referral will be made to the occupational health service. The majority of e-survey respondents (65%

(20)) reported that they would refer the student to the University Occupational Health Service. Those stating 'other' (19% (6)) further qualified that students must agree for this referral to take place and that they may need an additional independent psychiatric review which would be paid for by the school.

**Table 10: The medical school's procedure for students needing to obtain occupational health advice**

Procedure	% (No.)
Referral to university Occupation health service	65 (20)
Referral to NHS provider	39 (12)
Referral to private provider	-
Other	19 (6)

n=31

As with information about general student support services, medical schools use a variety of methods to give students information about Occupational Health, written material (78% (24)) and lectures/briefings (74% (23)) being the main methods. Of the 11% (3) who stated 'other' 'personal contact', 'one-to-one meeting with disability Liaison officer', and 'one-to-one meeting with the Student Support Coordinator' were included.

### Procedures for maintaining contact

Procedures for maintaining contact with students with known mental health problems vary within and between institutions. The support might involve contact with a single member of staff (personal or pastoral tutor, personal mentor, administrator for student welfare, phase directors of study, Occupational Health physician, director of student support, named case manager, Year tutor), a combination of individuals and student support units (student support coordinators, dedicated University mental health staff), Dean's offices (academic sub-dean system), specialist staff (Disability Liaison Officer) and committees (Professional Development Committee, Fitness to Practise Committee, Academic Progress Group). Methods for keeping in touch with students who have suffered mental ill health included phone, email, text, one-to-one meetings and liaison with the community psychiatric team, "...if relevant and with student's permission" (e-survey, Lead on medical student pastoral care).

E-survey responses about medical school procedures for keeping in contact with these students included,

*"We keep a register of students who have taken an interruption of studies for health reasons and review this termly. If we do not hear from a student due to come back after a year out then we contact them"* (e-survey, Dean)

*"Usually via the pastoral tutor network - via email or regular meetings if the problem is more severe"* (e-survey, Lead on medical student pastoral care)



*“Senior Pastoral Tutor follows-up students returning from Leave of Absence (LoA) and with students known to be in difficulty; Occupational Health assessments and regular reviews if appropriate. The pastoral support network in the clinical learning environment provides appropriate levels of support” (e-survey, Lead on medical student pastoral care)*

*“[We] request regular telephone contact (or appointments if necessary according to individual circumstances) with pastoral tutor of that year group. School office helps to 'keep tabs' that they attend” (e-survey, Disability Officer)*

*“The student would regularly be reviewed by one of, or a combination of the Personal Tutor, Professional Development Committee or, depending on the circumstances, the Fitness to Practise Committee. The Personal Tutor, however, really is the key person” (e-survey, Dean)*

*“Contact is maintained by the Academic Progress Group that regularly reviews students. Regular contact is also maintained with the personal or senior tutor. The Fitness to Practise committee may require regular meetings” (e-survey, Deputy Lead on pastoral care)*

*“The Disability Liaison Officer (DLO) has contact with all students who have declared a mental health concern. Often the contact is frequent on first initiation - this is then tailored to the student’s specific needs. Students are encouraged to contact the DLO should they require a meeting and the DLO will contact all students for an update if there has not been contact for a while. A meeting is often arranged in the first term of the academic year and then frequency of meetings arranged from that meeting. All year 5 students meet with the DLO even if there has been minimal concern for a few years” (e-survey, Disability Liaison Officer)*

#### **Liaison between the medical school and postgraduate deanery regarding students who have health concerns or a disability**

Every final year student has the option of completing the Transfer of Information (ToI) form. In this they can include any information that they think will be helpful for the foundation school and the NHS institution that will be employing them as an F1.

Procedures broadly follow this pattern:

1. Appropriate students are identified at some point between August prior to the start of the first foundation year and the following January
2. Students are seen to discuss their ToI forms – their consent is gained to exchange information
3. Colleagues from the Deanery are met to discuss anything relevant to that student’s support needs.

The following example illustrates one institution's approach to supporting their medical students in completing the Tol form.

**Example 5: The Transfer of Information (Tol)**

Students known to the Disability Liaison Officer (DLO) have a meeting in year 5 to talk through transfer of information to the deanery and GMC. Completed transfer of information forms are reviewed by the DLO and any students who need support are sent for an early Occupational Health referral arranged by the medical school. The Foundation Director has on occasion been contacted via email by the DLO to discuss any specific concerns in order for support to be in place on commencement of foundation programme.

"The transfer of information form for every student is examined for accuracy before it is signed off. We have an initial meeting with each student we are aware has a mental health problem or disability to discuss completion of the form"  
(Telephone survey, Dean/Vice Dean)

In completing the Tol, the question of what level information to pass on to the postgraduate deanery poses a dilemma for some medical schools, i.e. ensuring that sufficient details about the student's support needs are included, while not revealing any more than that, and with full knowledge and permission of the student. Some feel the Tol in its current form does not fully meet requirements,

*"... a lot of people haven't felt it's very good...people feel that it's too generic and it's not specific enough for the individual, and that it doesn't actually give the information that the deanery needs. It's the deaneries that have complained"*  
(Telephone survey, Dean/Vice Dean)

*"...some people feel we ought to be more specific because it is a confidential process and the clinical advisers are all consultants and, you know, physicians who know about confidentiality"* (Telephone survey, Dean/Vice Dean)

*"I have spoken to the students about it and said there will be some transfer of information from year two to three and... how you got on in years one and two, but I kind of assured them that firstly it's confidential and secondly it is rather generic and not very, very specific"* (Telephone survey, Dean/Vice Dean)

Mechanisms vary in different regions/medical schools. For example, in one region deanery and medical schools staff meets quarterly to discuss any final-year student/foundation doctor who may be in need of special support for problems of any nature. This enables the deanery and the employing NHS health board to make necessary adjustments for students as required, an alternative procedure is illustrated in the following example.

#### Example 6: Liaison with Postgraduate Deanery

Meetings can be annual or up to three times a year between the Medical school-Deanery Liaison Committee and the Joint special circumstances meeting taking the following form:

- Meeting with Head of School and Head of Student Support to discuss students with Foundation Programme Director
- Disclosure form has to be completed by students
- Tol written by the Phase Leader in consultation with Student Support and with the knowledge of the student
- A hand over meeting with the local Deanery where it is decided what level information will be passed on
- Once decided a letter on behalf of the Dean to the relevant person in the relevant Foundation School is sent
- Liaison through MB ChB Programme Director.

Other descriptions of liaison with the Postgraduate Deanery from the e-survey and follow-up telephone interviews are revealed, below:

*“The School meets regularly (at least 3 times per year) with the Postgraduate Deanery and information is exchanged with the student’s consent”* (e-survey, Senior Administrator with responsibility for student support)

*“The pastoral Tutor for final year and the chair of student progress meet and discuss the various students with the Foundation school director in January with the student’s consent”* (e-survey, Dean)

*“The Director of Undergraduate Studies meets with the Postgraduate Dean to transfer information. Students are aware of, and agree what will be said prior to this and its emphasis is supportive to ensure they get further support in Foundation as necessary”* (Telephone survey, Dean/Vice Dean)

*“Annual formal meeting, plus regular informal contact between Director of Studies and Foundation School Director”* (e-survey, Dean/Vice Dean)

#### Leave of absence rules and arrangements

All medical schools have the capacity to allow a student to take Leave of absence due to illness under university regulations. The amount of time that a student can miss before having to take leave of absence and repeat the year varies. There was also some variation in the amount of study completed prior to taking leave of absence that would have to be repeated. In some medical schools all students who take leave of absence have to repeat the entire year’s study.

**Table 11: The maximum period of sickness absence that students can take without having to repeat a year**

Period of sickness absence	% (No.)
3 weeks	11 (3)
4 weeks	18 (5)
6 weeks	18 (5)
8 weeks	4 (1)
80% attendance	12 (3)
1 week in a 5-week block	4 (1)
Varies according to individual circumstances/stage of course	23 (6)
Don't know	7 (2)

n=27

### **We asked e-survey participants ‘what is the maximum period of sickness absence that students can take without having to repeat a year?’**

*“Varies from year to year - in final year students need to complete their attachments satisfactorily” (e-survey, Lead on medical student pastoral care)*

*“This is dealt with on a case by case basis, often depends upon time of year, year of the programme, etc.” (e-survey, Senior Administrator with responsibility for student support)*

*“Hard to translate into weeks - minimum 80% attendance is required to pass each module, although if there are mitigating circumstances the Exam Board can decide to allow a student to progress anyway. Were a student not to complete 80% attendance overall, they would probably be asked to repeat the year.” (e-survey, Student Support Coordinator)*

*“Depends where in the course, but we say 3 weeks and can be flexible around that.” (e-survey, Lead on medical student pastoral care)*

*“Depends - we try to keep them in the system, but if miss more than about 6 weeks it's hard to make up” (e-survey, Lead on medical student pastoral care)*

### **Re-integration**

When asked what procedures are in place to support students who return from interruption of studies and have to enter a new cohort, as with a number of the e-survey questions the most common response was ‘it depends’ suggesting provision is tailored for the student as appropriate e.g. *“Procedures vary with circumstances”* (e-survey, Dean/Vice Dean) and *“Advice and re-induction according to individual needs”* (e-survey, Lead on medical school pastoral care). However, that may not be the case at all institutions, other responses included, *“I am not aware of any”* (e-survey, Disability Officer) and *“...nothing specific...normal support structures that would include regular contact”* (e-survey, Programme Manager).

Generally, there are key members of medical school or welfare staff given responsibility for keeping in contact with the student on a fixed and/or ad hoc basis, including individual personal tutors, academic tutors, academic mentors, clinical tutors, bespoke follow-up with Student Welfare, named case managers and regular follow-up with the relevant pastoral tutor,

*"We tell the personal tutors to monitor their wellbeing" (e-survey, Dean/Vice Dean)*

*"[we] can ensure students have a sympathetic Academic Tutor, who is informed" (e-survey, Student Support Coordinator)*

*"Pre-return meeting with student support and Occupational Health; allocation of experienced Academic or Clinical Tutor; regular checking in for term of return" (e-survey, Lead on medical student pastoral care)*

*"Routine appointments with pastoral tutor. Individual information re: counselling and university support services. These are often arranged before the student returns, to ensure maximum support is available when they restart" (e-survey, Pastoral Tutor)*

*"Ongoing support from Director of Student Support, referral to clinical psychologist if appropriate" (e-survey, Lead on medical student pastoral care)*

*"The Year tutor will see them. If it is a clinical year they attend a revision of Clinical Skills course run by fifth year students principally for students returning from intercalation" (e-survey, Vice Dean)*

*"Ongoing support from Director of Student Support, referral to clinical psychologist if appropriate" (e-survey, Lead on medical student pastoral care)*

*"The Year tutor will see them. If it is a clinical year they attend a revision of Clinical Skills course run by fifth year students principally for students returning from intercalation" (e-survey, Vice Dean)*

However, some institutions have more rigorous procedures in place to support reintegrating students:

*"They receive written information about the process. They meet with the senior tutor to discuss their personal learning plan, support required and integration into the new cohort, in particular issues around disclosure of information. There may also be a joint meeting arranged between the student, senior tutor, university support team and/or personal tutor/academic lead /examination secretary. The exact make up of such a meeting would depend on the issues to be discussed. Their progress will be reviewed by the Academic Progress Group" (e-survey, Deputy Lead on pastoral care)*

*"The student is informed of the support available through personal advisor, Disability Liaison Officer and Director of Student Support. With PBL groups - they are placed with an experienced tutor so that group dynamics can hopefully be supported" (e-survey, Disability Liaison Officer)*

*"Students have regular meetings with phase director of study and the administrator. They enter an enhanced support system" (e-survey, Director of MBChB)*

*"Students are offered a range of workshops. There is extensive information at induction on every year and vulnerable students, those who have failed, suspended or have joined the school from overseas are offered routine appointments with the pastoral tutor. There is also regular communication with the year lead to identify any students who have increasing absence or who are failing attachments" (e-survey, Pastoral Tutor)*



## Student support card scheme

Having to request time off from clinical placement or to have to ask for other medical needs to be accommodated can be difficult for a student. This is made worse if this has to happen very early on in a placement when they have not previously met the consultant who is going to be responsible for them. Sometimes students are very embarrassed when they are asked for details of the condition that makes these adjustments necessary.

One of the UK's largest medical schools has addressed this problem. Students who have health problems see a senior course tutor and tell him/her the condition they have and the needs this places on them (e.g. attending a weekly psychotherapy appointment). The course tutor then issues a wallet-sized laminated card stating that the student has a medical condition and the adjustments made necessary by that condition. At the bottom of the card the name and contact details for the course tutor are given should the further information be required. For as long as necessary the student carries the card and shows it whenever adjustments such as time away from placement need to be negotiated. Experience to date has been that no requests have been made for further information.

### Worth Considering:

- A very simple way of reducing awkwardness when students have to ask for adjustment due to illness particularly at the beginning of a placement
- Authorises adjustments without any need to reveal any details of the student's condition
- Delivers a message that it is expected that students with physical and mental health problems will have adjustments made that enable them to continue with their career.
- The details of the medical condition and the issuing of the cards could be carried out by occupational health staff thereby not involving medical school staff at all.
- Very cheap

### You may need to:

- Ensure that all teaching staff are aware of the card and its function.
- Remind staff that they are not expected to question students about the information on the card
- Make it clear that further information will be given out on a need to know basis.

## Occupational Health Advice

What is almost universal practice for a student returning from a period of leave of absence due to illness is to undergo an occupational health assessment to ensure that they were fit to return to their studies. Medical schools are dependent on occupational health advice in relation to potential and current students. Opinions were divided about the relationship with and the service provided by occupational health departments. While some medical schools said that they had a close working relationship others expressed dissatisfaction with the advice given in some cases saying that it was not appropriate or did not take relevant circumstances (i.e. was a student fit to be seeing patients) into account,<sup>5</sup>

*“Occupational Health rarely provides helpful information regarding Fitness to Practise”* (e-survey, Lead on medical student pastoral care)

*“We are not told by Occupational Health of conditions declared on entry and therefore sometimes only discover an issue if a crisis ensues”* (e-survey, Lead on medical student pastoral care)

*“We sometimes feel that the bar is set very high both in terms of entry and ability to stay at medical school and that we are then undermined by the Occupational Health judgment in advising a student to take time out”* (e-survey, Lead on medical student pastoral care)

## Fitness to Practise

E-survey respondents were asked what prompts a Fitness to Practise investigation; as illustrated in Table 12, 7%(2) of institutions indicated that a mental health problem would with a 71% (20) indicating that mental health would only present a problem where patient safety is at risk. However, the 36% (10) of respondents who further qualified their responses stated mental health issues would only trigger Fitness to Practise if:

- It was causing student behavioural problems or putting staff, student or patients at risk; or if the student could not be trusted to manage the problem or was refusing treatment (15% (4))
- Absence from the course was related to chronic health issues of any kind (7% (2))
- Any health issues posed a threat to patient safety e.g. substance abuse (4% (1))
- There was unprofessional behaviour on clinical placement (7% (2)).

---

<sup>5</sup> The following three quotes were taken out of the e-survey section addressing what medical schools believed were weaknesses in their current systems for supporting medical students with mental health concerns



**Table 12: What prompts a Fitness to Practise investigation?**

Factors	% (No.)
Disciplinary problem	93 (26)
Conviction for a crime	96 (27)
Mental health problem	7 (2)
Mental health problem only where patient safety is at risk	71 (20)
Other	36 (10)

n=28

Medical schools repeatedly told us that Fitness to Practise procedures are rarely required – ideally, support systems will prevent problems escalating, monitoring systems will identify potential problems at a sufficiently early stage to avoid the need for further exploration. In many schools, there are ‘pre-Fitness to Practise’ procedures. Example 7, below, involves a progress and professionalism hearing, and, illustrates how bringing the right people together with the student to explore issues can be done in a formal way so there is a record but avoids Fitness to Practise procedures immediately. Only if concerns continue and initial measures are not successful is a Fitness to Practise investigation instigated. Where Fitness to Practise or Fitness to Study issue does occur, an Occupational Health assessment will be involved.

**Example 7: Progress and Professionalism Hearing:**

Stage 1: Concern generated, dealt with by cohort tutor  
Stage 2: Monitoring by personal tutor  
Stage 3: A hearing

**Strengths and weaknesses of the current system for supporting medical students with mental health issues**

The final section presents a series of quotes taken directly from the e-survey which highlight what respondents listed as their institution’s strengths when considering student support, and where services might be improved; in some cases this includes commentary from respondents about their ‘ideal’.

**Strengths: they said...**

**Supportive structures**

*“Strengths are our approachability and our record which makes students more confident that declaring a problem will not mean the end of their career” (e-survey, Lead on medical student pastoral care)*

*“Supportive structures and attitudes” (e-survey, Dean/Vice Dean)*

*"No views. Satisfactory and supportive" (e-survey, Dean/Vice Dean)*

*"There are excellent support services around. The main disadvantage is that there has been an extensive change to the organisation of all services within the university which has taken some adjustment" (e-survey, Pastoral Tutor)*

### **Multiple access routes to support**

*"We have a pastoral support system which gained much praise from the GMC QAE visit two years ago. It is rare that students cannot access counselling services or support from the mentoring system at the main University. Each student has a personal tutor with whom they are obliged to undergo annual appraisal, and are encouraged to keep in touch during the year. Students with severe problems are encouraged to take time out of the course with ongoing support and appropriate referral to mental health services" (e-survey, Lead on medical student pastoral care)*

*"There is good student support at Faculty level and University support services are excellent. When the students are more remote each LEP has a named clinician responsible for the support and pastoral care of student on placements" (e-survey, Lead on medical student pastoral care)*

*"Students can access a wide variety of support both in the school and the university" (e-survey, Director of MBChB)*

*"Student Centre, Student Welfare, good counselling service, training for personal tutors - we like the fact that the academic tutor is often also the personal tutor as they see a lot of their students and pick up when there is a problem, the consultant psychiatrist session is very valuable" (e-survey, Dean/Vice Dean)*

*"Very good university support services; very good personal tutor and staff awareness; very good peer support mechanisms" (e-survey, Deputy Lead on pastoral care)*

*"Named Director of Student Support mean students know who to ask for help, small cohort means that most staff get to know all students and help spot students in difficulty, Clinical psychologist team affiliated with Medical School provide specialist help promptly" (e-survey, Lead on medical student pastoral care)*

*"The University Occupational Health Department reviews all students around admission time and highlights with the student's permission any mental health issues. Our role is to identify, co-ordinate, facilitate and review such students. We have:*

- *Availability of confidential counselling and emotional support via the Student Wellbeing Service*
- *Swift process for referral, assessment & review by Occupational Health*
- *Joined up student support network throughout region*
- *Personal Tutors, Professional Development Committee, good liaison between the medical school and NHS psychiatric services as well as the PG Deanery” (e-survey, Lead on medical student pastoral care)*

*“This system complements other systems within the school including the Academic Sub-Dean System, ICU/placement tutors and Year Heads” (e-survey, Dean/Vice Dean)*

*“Complementary portals for accessing help and support: colleges with personal tutors, chaplains or counsellors, college nurse and doctor” (e-survey, Dean/Vice Dean)*

*“We are reasonably confident that Students are picked up or present themselves appropriately” (e-survey, Lead on medical student pastoral care)*

### **Small group support**

*“Support works very well due to small student body, as tutors/lecturers/admin/Student Support staff have close and frequent contact with students. Therefore issues are often picked up early and very easy to follow-up to see how a student is doing and if they have accessed further support” (e-survey, Student Support Coordinator)*

*“Small school, medical school staff know all students by name: students who are having difficulties do not disappear below the radar” (e-survey, Lead on medical student pastoral care)*

*“Small group support, allocation of personal tutors” (e-survey, Assistant Registrar)*

### **Peer support**

*“We have difficulty persuading students with depression to come forward as they believe it will be on their record and they won't get a job. We disabuse them of this at every opportunity, but the rumour persists, which is very frustrating. The Feel Bright campaign run by students with our support is helping this” (e-survey, Lead on medical student pastoral care)*

## **Effective multi-agency working**

*"There is increasing communication between the various support agencies and my new role (as Disability Officer) has meant that I am developing an overview with some indication of where the gaps are. We have developed a Disability Discrimination working group across the whole university. Regular Pastor tutor meetings" (e-survey, Disability Officer)*

*"Good links with university counselling and disability/mental health support services" (e-survey, Student Support Coordinator)*

*"Comprehensive in that we have a team approach" (e-survey, Lead on medical student pastoral care)*

*"I think the strengths are the close liaison between the DoS wellbeing team, Occupational health within the university and the DLO within the medical school. The medical school is fairly small so staff and students are aware of the DLO's role in supporting students" (e-survey, Disability Liaison Officer)*

## **Benefits of specialising**

*"Clear demarcation between Student Support service (which is confidential) and teaching/admin staff" (e-survey, Student Support Coordinator)*

*"Student Support Coordinators focus on particular phases of the course, and so have rapport with students and staff, and are familiar with course outline and requirements" (e-survey, Student Support Coordinator)*

*"University rather than NHS Occupational Health Service" (e-survey, Dean/Vice Dean)*

*"Medical school with associate dean for pastoral care who sees all students for a personal appraisal" (e-survey, Dean/Vice Dean)*

## **Named first point of contact**

*"Over the last 3 years the school has made significant investment in enhancing the Personal Tutor system as to ensure that students have a clear point of first contact for support and development advice. All Personal Tutors within this system have to attend training events and are supplied with material that both supports them in their role and provides advice regarding signposting students to other more specialist University services" (e-survey, Lead on medical student pastoral care)*

*"Named contact for those with known issues, and bespoke support" (e-survey, Senior Administrator with responsibility for student support)*

## Weaknesses: they said...

### Nature of mental health

*“There is difficulty when a chronic or relapsing condition repeatedly impairs continuity of learning that can in time become a Fitness to Practise issue” (e-survey, Dean/Vice Dean)*

*“Declaration at admission is important but a lot of the mental health problems we see manifest for the first time during the undergraduate programme” (e-survey, Dean/Vice Dean)*

*“While OH might declare “fitness to work/study” under disability legislation, this is not giving the student a clean bill of health” (e-survey, Student Support Coordinator)*

### Student reluctance to access support

*“Weakness would be around students’ reluctance to access this support due to social stereotyping and fear of implications for their career” (e-survey, Director of MBChB)*

*“Students are worried about admitting they have a mental health problem; at most points in the degree if temporary withdrawal is needed it is for a year; for the period of temporary withdrawal they are no longer enrolled as a student and so may lose access to the university support services” (e-survey, Deputy lead on pastoral care)*

*“Biggest problem is inability to persuade students to disclose either at entry or on course” (e-survey, Programme Manager)*

*“We feel we have supportive network but ineffective if not aware of students’ problems” (e-survey, Programme Manager)*

*“Early identification is not always perfect. Many students with mental health problems will not properly access the support available no matter how good it is or how well advertised it is and ensuring we recognise and identify difficulty as soon as possible is key” (e-survey, Dean/Vice Dean)*

*“I believe that we have a robust system of support for these students but - as ever - the system is only as good as the information it receives, and we encourage students to raise concerns about their peers where appropriate in accordance with developing good medical practice” (e-survey, Lead on medical student pastoral care)*

### **Difficulty accessing services**

*"Our main weakness is the lack of Psychiatric services available on an urgent basis for those who need more significant intervention. At present the only available option is to refer students through the regular NHS referral pathway which has long waiting lists. Also access to cognitive behavioural therapy is very slow - over 12 months"* (e-survey, Lead on medical student pastoral care)

### **Lack of resources**

*"We do not have the resources to see all students on a regular basis"* (e-survey, Lead on medical student pastoral care)

### **Fitness to Practise**

*"The OH service can sometimes be unrealistic about students who cannot attend teaching's ability to successfully complete. We do not have so much of a problem with students with e.g. psychosis, bipolar disorder, OCD, severe depression as we do with students who have personality disorder, anxiety or stress. The latter groups cause enormous worry as they lack the essential ability to work in a team or in a stressful environment and one worries about whether they will be able to do the job of a doctor. It is difficult to get this right on occasion. We also have students who get medical evidence of having been depressed when they have failed and as a doctor myself I know this is not always the case, frequently these are the children of doctors who have ready access to professionals who will write on the student's behalf"* (e-survey, Lead on medical student pastoral care)

*"Probably too lenient!!!"* (e-survey, Lead on medical student pastoral care)

*"Sometimes difficult to get an appropriate independent psychiatric report. We work through occupational health but can be difficult to get an independent opinion on whether the mental health issue affects their Fitness to Practise and we have organised independent psychiatric assessments"* (e-survey, Dean/Vice Dean)

### **Consistency**

*"The weakness is that the course is complex with large number of students, placements and teachers; so ensuring consistency is hard"* (e-survey, Dean/Vice Dean)

### **Potential gap in support**

*"We need to think about services for an increasing no of overseas students"* (e-survey, Pastoral Tutor)

## Size of school

*"Small size of School can mean students are over-scrutinized"* (e-survey, Student Support Coordinator)

*"Small cohort means that students may be concerned that it is more difficult to hide mental health issues from colleagues or staff"* (e-survey, Lead on medical student pastoral care)

## Confidentiality

*"Can be difficulties in sharing information between internal support, OH as an external provider, and central university services"* (e-survey, Student Support Coordinator)

*"We protect confidentiality but may need to consider involving academic Year leads more at certain times. Variability in advisers' approaches"* (e-survey, Dean/Vice Dean)

*"Declarations to occupational health are confidential so only seen if the student chooses to declare"* (e-survey, Lead on medical student pastoral care)

## Other points made

*"OH services, non-disclosure of issues, some central services difficult for medical students to access due to time and location of clinical placements"* (e-survey, Senior Administrator with responsibility for student support)

*"Difficulty with identifying mental health issues at an early stage; reluctance among teaching staff to document concerns that may indicate mental health problems; practical difficulties for students accessing University Student Wellbeing Services whilst based around the region"* (e-survey, Lead on medical student pastoral care)

## Strengths and weaknesses: summary

Medical schools and student support services report that they are strong in a number of areas of student support provision e.g. a good variety of support on offer, a range of effective support structures and a number of different routes for students to access support. However, schools have also identified areas where they would like to see improvements e.g. for students to feel confident that they can disclose and self-refer when they are experiencing difficulties and conversely, for staff to feel confident in documenting concerns that may indicate student mental health problems; to have sufficient resources to see all students on a regular basis facilitating close and frequent contact between students, staff and support staff; and some would like to see more effective communication between support agencies,

Occupational Health emerging as one of the agencies medical schools would like to have an increased dialogue.

### Summary

In this section we have identified provision of readily accessible information about services and how to access them, several practices, provision of personal tutors and alternative arrangements, early warning systems for recognition and of faltering students. We will make recommendations in relation to these areas as well as presenting examples of good practice in chapters six and seven.



## Chapter 4: Context: what's special about medical education and medical students?

---

### Introduction

Staff at every medical school we contacted described efforts made by that school to provide support for medical students with mental health concerns. Staff at each school have developed support systems that are unique to that school and that reflect tutoring and mentoring schemes as well as senior staff structures and the school's governance system. There are a number of themes that recurred in our data collection and we present those in this chapter. Medical students, medical school and university support staff all expressed the view that medical students are different from other students. Repeatedly the view was expressed to us that medical students were reluctant to disclose any mental health problems and were reticent about accessing support. This view had already emerged clearly from the systematic review (Chew-Graham et al., 2003, Hillis et al., 2010, Roberts et al., 2001a, Louie et al., 2007, Reynolds and Clayton, 2009, Givens and Tjia, 2002). During our site visits we became aware of differences in the services provided by generic university support as opposed to the care provided by medical school staff. We explore all three of these issues in some depth in this chapter. The remainder of this chapter is dedicated to ways in which medical schools have addressed these issues, particularly in relation to admissions, personal tutoring and in including students' health as part of the curriculum. This chapter is based on contextual data, gathered from site visits and telephone interviews with:

- a) Medical school staff with a responsibility for student performance and welfare
- b) University staff working in student support services
- c) Medical students who took part in focus groups
- d) Additional interviews with individuals with a specialist interest in medical student mental health.

Interviews with staff followed a topic guide which was based around the process model developed for data collection in the e-survey (see, figure 2). Focus groups were more open-ended, with students being asked to respond to two statements<sup>6,7</sup>. Students also took part in an exercise to rank the importance of sources of support and their willingness to access them, the results of which are reported in Table 13.

---

<sup>6</sup> *Socio-cultural pressures to which medical students are subjected render them more susceptible to mental illness and, through fear of stigma and adverse fitness to practise procedures less likely to seek the help they need when they do develop mental illness.*

<sup>7</sup> *'Medical schools face a dilemma of care. They must care for their students, who have an increased risk of developing mental health problems, and they must care for the public, who could potentially be exposed to considerable risk from doctors who have unresolved mental health issues'.*

Results are presented thematically, with reference to the initial process model and the Systematic Review, with additional material supported by the views of respondents.

### Perception that Medical education is different

A common starting point for all three sets of respondents – medical school staff, university student support staff and students themselves – was a very strongly held belief that the whole process of medical education is different from other forms of university teaching, including other vocational subjects. This belief drives much of the special support provision to which medical students are offered unique access.

*“I think there is so much pressure on us generally. We have really high-pressure exams and just generally a lot of work to deal with which other courses don't necessarily have. And especially on the socialising with other people who don't have as much work as we do, there's just so much to balance and live up to. I think that does maybe make us more susceptible to illness” (FG3)*

### Views of medical school staff

Interviews with support staff in medical schools revealed seven principle ways in which they believe that medical education is different from other undergraduate university courses of study:

#### Duration

Only architecture has as long an undergraduate programme. Medical students can spend up to five years in the same place and then go on to take their first job there too. Not all students do this; some cannot or choose not to pursue the clinical component of the course in the same university. This itself causes issues of transition – see work placement section below – and integration.

*“I mean all medical education is stressful, but ours because it's such a packed four year programme with hardly any holiday and it's just one thing after the other, very pressurised, they've no time hardly for remediation, recovery and taking a breath, really” (Telephone interview medical school staff)*

#### Intensity

The ‘working week’ of a medical student is more akin to a full time job with fixed, long hours and an explicit assumption of additional study in ‘free time’. The medical school year is longer at 40 weeks instead of 30. The curriculum is crowded and largely compulsory and is based on the frequent testing of knowledge, competency and skills. There is little flexibility in the order in which modules can be taken.

*“Well we try and be as flexible as we can really. The problem is if they miss more than about six weeks through sickness we then really ask them to suspend and then they would have to come back and probably repeat a period of their studies really” (Telephone interview, Lead on medical student pastoral care)*

## Subject matter

The subject matter of medicine involves dealing with matters of life and death. These are not abstract topics; they involve social interaction with patients and relatives who are themselves in a vulnerable state.

*"It's this pressure from day one to be doing communication skills, talking to patients, they are 18 years old... I meet them and I seriously am terrified at the thought that you're going out and talking to patients"* (Telephone interview, Student Services staff)

*"We have had a number of students with mental health problems we have not known about who have had psychiatric placements as part of their clinical programme who've had some kind of if you want to call it 'breakdown' or 'exacerbation of their problem' as a result of being confronted with psychiatric cases similar to their own"* (Telephone interview, Dean/Vice Dean)

## Work placement

All medical education contains a placement element that looks and feels like 'real work', including being, at least temporarily, part of a work team with responsibilities to 'real patients'. Some placements are often far from the student's base, requiring domestic adjustment as well as getting to know a new work team and their way of working.

*"I think it's this stress thing...I don't think they realise quite often how it's going to be [placement] and of course they can't realise how it's going to be until they do it. And it's really hard to prepare students for transition, we know that"* (Telephone interview, Head of school)

## Regulation

Medicine is a regulated profession, and while technically that regulation does not apply to students, in practice medical schools mimic the regulations in order that their students are able to register at the completion of their studies. Medical schools' procedures in relation to performance monitoring and professional behaviour accountability tend, therefore, to be based on the GMC Fitness to Practise requirements.

*"Well I think it's always difficult because the more, particularly because of the way the GMC is more regulatory than it ever was I think we have to emphasise the Fitness to Practise side of things, we can't not do that"* (Telephone interview, Lead on medical student pastoral care)

## Tradition and location

Many medical schools predate the institution in which they now sit and historically have exercised considerable autonomy in their relations with students and organisations they deal with on a daily basis e.g., hospitals. This is often reflected in their location on a separate campus that has very significant implications for integration into mainstream university life.

*"We tell our students as soon as they come to medical school they need to start to behave professionally and then they look around and all their other colleagues...well they're being university students"* (Telephone interview, Dean/Vice Dean)

### Nature of staffing

Medical schools have always employed staff that also work as clinicians and a significant proportion of staff thus work part-time as medical educators. This, coupled with the work placement issue, above, means that students are exposed to workplace attitudes and experiences which are beyond the control of the medical school itself.

*"You normally get it in terms of like, ward rounds for example, we've seen it, you know, tutors belittle students by saying, 'oh in my time we had more work, you've got it easier these days' and the messages are conveyed quite implicitly in that way, basically"* (Telephone interview, Dean/Vice Dean)

*"I guess there's a problem which is we don't know exactly what these places are like. We do have some twinned institutions where we have very good contacts, but there are some ... you know, because the students choose their placements... we don't actually necessarily know the personnel there"* (Telephone interview, Lead on medical student pastoral care)

### Views of University support staff

Those working in a more widely based university student support service did not wholly agree with some aspects of this argument. For instance, they pointed out that the time taken to undertake vocational training and qualification for many professions has increased to near that of doctors. Additionally, other vocational courses that have a placement element e.g. teaching, have developed their own ways of supporting students through transitions and other highly stressful early work experiences, which are more integrated into generic university support processes.

University support staff also thought that medical schools tended to exaggerate the differences between their students and what was often referred to as a 'normal' student. They point out that, even assuming that this mythical student exists, a more realistic age and ability comparison would be between a fifth-year medical student and a second year Ph.D student with responsibility for expensive, potentially dangerous equipment, engaged in long-term experimentation on toxic substances.

They also expressed some unease about the way that medical schools procedures were out of tune with the wider University student regularity framework and their tendency to over-medicalise student problems.

*"The medical school made similar agreements to develop processes and never shared it with anyone so at that stage there was still quite a closed approach to how they deal with their students. So I have no idea what protocols they've got in place, they've never involved us and never shared anything with us"* (Telephone interview, Student Support Service Staff)

However, staff in university support services do see medical students as different and at least to some extent this is reflected in the services they offer and the, sometimes grudging, acceptance that medical schools will always be in a position to exercise some autonomy in relation to looking after their students' wellbeing. The difference in perspective, however, is one of extent rather than the denial of intrinsic differences.

*"You can't get away from the fact that the course structures [for medical students] are radically different from the majority of under-graduate students, so that's your starting point I think. Academically, you know, it's probably the most intense programme from the point of view of timetable hours. Very, very rapidly and more so than ever used to be the case students are outside the university"* (Manager Student Support Services)

*"I think because of the course structures the administrative services have to be different"* (Student Services manager)

*"They tend to be quite insular in that ...there's all sorts of medics groups which you wouldn't expect to exist. There was a medic's choir, a medic's jazz orchestra, a medics ... so there's med-soc which is the medic society and there's all these sort of ... this huge range of medics groups, so we kind of joke there's almost another students union up there. So they're really engaged and really involved with student activities, but you do sometimes wonder why there's a medics choir, but not a ... you know, a geography choir"* (Telephone interview, Student Support Services staff)

### **Perceptions that medical students are different**

Medical students themselves were acutely aware of their differentness from other students in ways which are broadly similar to those reported by medical school staff, but with a slightly different emphasis. Additional points raised in the student focus groups can be grouped into eight main headings:

#### **Early commitment**

Medical students point out that the decision to become a doctor is made very early and is largely irrevocable. Subject choices are effectively made in high school at age 13-14. Other students they observe have made no such commitment – rather the reverse; they are using the experience of university to explore or defer options and decisions.

*"...everything in my mind was always central to me becoming a doctor because from the age of seven I knew I wanted to study medicine"* (FS5)

*"You're always singled out you...your friends come and go and you're still here...they go out on the weekends and you're at home preparing for an exam or OSCE, whatever"* (FG1)

#### **Greater investment**

They also believe they have worked harder than other students to achieve their place at university, not just academically but also by having to demonstrate other

personal characteristics which either mark them out as special or show qualities important for a career in medicine.

*"I think because we've invested so much...mentally...and time...and money ...it's like family support and everything to do our degree...and you know it lasts such a long time...me personally...I would be terrified dropping out at this point" (FG1)*

### Greater expectations

Strongly linked to a record of high achievement are the expectations of family, school and peers. The substantial minority who come from medical families carry a cultural model of succeeding while those from non-medical backgrounds carry the weight of being the first – either way these expectations represent considerable parental emotional and financial investment.

*"I think a lot of people who come to medical school have an upbringing or have been driven in their upbringing or have been sheltered in a sense" (FG6)*

*"I can understand academic pressures, maybe family pressures and sort of expectations you give yourself can cause problems" (FG2)*

*"You go to your family like they don't offer...I come from like a completely non-medical family and often they don't understand.... she's [mum] like 'yeah it will be fine you always pass exams'...well 'no'" (FG1)*

### Privilege and reward

Medicine is a highly paid and high status profession and medical students recognise that financial and social rewards place greater responsibilities on them than for students who have yet to make a career choice. They also recognise that regulation is part of the price they pay for privilege and reward.

*"If you're a normal student on a normal degree the only thing that's going to happen if you don't get your degree is...it doesn't really have any repercussions beyond that necessarily whereas a Fitness to Practise thing...it's much more like I can't carry on with the career that I wanted if I don't get this degree and it's going to be on my record forever like because it's part of you know medicine as a whole and something that you are continuing as a career for the rest of your life...I think that's one of the main problems is the fact that it's not just a degree...it's the rest of your life" (FG1)*

*"You are worried that the information will get out and you won't get a job, or whether it'll just be that people in the future will know or judge you differently. That it will affect your patients. I suppose that's probably a worry for a lot of people in a lot of careers I guess" (FG7)*

*"I think there are a lot of students don't really understand Fitness to Practise, not that they don't understand it but they don't maybe know what circumstances ... you hear about it a lot on the medical news doctors getting called up and people getting sued all the time. There's a big litigation fear driven into us from medical*

*school. You have lecturers standing up and going, 'don't do this, don't miss this, you will get sued'" (FG7)*

### **Social bonding**

Medical students recognise that there are benefits and drawbacks to a five-year course. While there are benefits in respect of building long lasting friendships, both in terms of mutual support and forming the foundations for future professional networking, there can be a downside. Social isolation is a danger for those who don't quite fit in and over-competitiveness can destroy relationships. Because they are together for longer they tend to look to each other for friendship and more formal social engagement via very active MedSocs.

*"For the first couple of years you do spend a lot of time at the Union but because the med school is so separate we don't have lectures down there and things like that, we don't see a lot of the things that are going on there." (FG7)*

*"Well, medical school itself can become its own community so the idea of community and networking is important" (FG4)*

*"I think there's definitely a bit of pressure from peers because if someone sees that you are struggling and either going to go one way or the other, they are either going to be really helpful and supportive or they are going to think, 'Oh no, they're not fit to be doing what they're doing.' Like when that person becomes a doctor what's going to happen to them then?" (FG7)*

*"Lots of students will come in to med school and are then alienated for not being prepared for the kind of life stresses that they're going to face during their medical school time... not all medical students are like all bright eyed and you know bushy tailed about medicine" (FG1)*

*"I think we are a lot better here [compared to USA], people do lie to people, people do tell people wrong information. We've had cheating and things like that. In terms of being kinder to each other, I think it's difficult. I don't know whether there are groups of students who naturally do it and those who don't really care for others but themselves" (FG6)*

*"Everyone knows each other and you all hang around in the same big group and so you automatically have a sense of sort of loyalty..." (FG6)*

### **Work and study**

Medical students refer to their day to day activity as 'work' or 'the job', recognising that it has much more in common with employment than it has with the more casual approach to working hours and 'turning up' they observe as the norm for other students. This makes it difficult for them to interact with students on other programmes. Taken together with the social bonding noted above, this results in a



reference group which tends to be led by junior doctors/senior students, closely resembling the hierarchical nature of the medical profession.

*"People don't realise when you're a medical student you're supposed to be in like... a lot of the time...you haven't really got time for a part time job as a lot of other students maybe would have...because their degrees aren't as a task as such...not maybe so intense...um so you do have like financial problems as well...especially towards the end of the degree" (FG1)*

*"When you're working [placement] you have a certain number of days a year that you can book off and take off...like family holiday...family weddings or things like that...at med school it's like 'no you can't have any time off'" (FG1)*

*"As a medical student your holiday is when they give it to you and that is it... maybe I should just deal with that and that's just part of medical school but I feel like I'm an adult now it's a bit of hassle it's like we're treated like kids" (FG1)*

### Constant transition

Coupled with the intensity of being in the same peer group for five years is the necessity to abandon its support and undertake placements where everything and everybody is new and different and which might be accompanied by domestic upheaval as well.

*"There's also the sudden shift between pre-clinical and clinical medicine. If that shift isn't bridged properly it can very much force some issues" (FG4)*

*"Obviously the other medical students you're on placement with ... we all try and get on and everything but they might not necessarily be people that you want to know ... they are probably not ... the likelihood is they are not your close friends so you don't necessarily want them to know that you've got..." (FG7)*

### Fear of failure

For medical students success is very narrowly defined as becoming a doctor while other students may see graduation as an end in itself. This fear of failure impacts in three main ways:

- A tendency to play by the rules, to tick the right boxes, to be seen to be doing the right thing (conformity)
- A reluctance to take small risks, especially drawing attention to possible weaknesses (risk aversion)
- Pressure to take very big risks, especially if the alternative is total loss (irrational response to uncertainty or subjective probabilities) (Gigerenzer, 2003).

*"It's obviously a very competitive environment and people don't like to admit that they've got problems that they can't deal with on their own. Medicine is all about being the best type of person and being able to handle extremely pressureful [sic]*



*situations and stressful situations and people get to a point that when they can't actually handle it they don't like to admit it because that's perceived as a failure to other people" (FG6)*

*"And that is why it is so terrifying as a medical student because you are working very, very hard to become a doctor and your future career might be threatened by the fact that you have an illness. And a lot of the time medical students don't want to be seen as struggling" (FG6)*

### **Students' fears of adverse consequences of disclosure of a mental illness**

A consequence of the factors raised in this section result in medical student concerns that revealing a mental illness will adversely affect their career. The Systematic Review produced ample evidence that medical students are reluctant to acknowledge their mental health problems and are reticent about seeking help even from services dedicated to their needs (Chew-Graham et al., 2003, Hillis et al., 2010, Roberts et al., 2001a, Louie et al., 2007, Reynolds and Clayton, 2009, Givens and Tjia, 2002). The programme of site visits enabled us to explore this issue in some depth, especially the narrative interviews with students who had suffered episodes of mental illness. As we describe in the next chapter reluctance to disclose and to seek help about mental illness is a feature common to most of the stories gathered. An understanding of the reasons for the lack of engagement is vital to any attempt to realign services:

Again, there was much common thematic ground between the three sets of respondents but perceptions of both the magnitude of the problem and the range of potential solution(s) varied considerably.

Medical school staff were well aware of the problem and recognised that they were dealing with a group who were likely to have mental health issues and to have considerable motivation to conceal them. Both these characteristics were known to predate admission to medical school, so, for instance, there was an acknowledgement that declarations made as part of both the application and admission process, although rising, represents a tiny proportion of those who have a problem.

Medical school and university support staff cited efforts to combat this via explanations on web sites, making sure that it is mentioned during admission processes and reinforcing messages when students enrol and have to declare (freedom from) medical conditions via Occupational Health Services. Support staff stress that even at this stage the reluctance to reveal is very heavily entrenched.

*"...I suspect that they are unlikely to declare it actually if they've suffered from depression or anxiety...I don't think that many would declare it if they did have a pre-existing condition" (University Student Support manager)*

*"They'll just ignore it and carry on for as long as they can. So we've got people who have been ill for the three years we've been seeing them, they're*

*now in the second or re-sitting or whatever in the medical school, you have significant personality disorders and things that worry us but the medical school continue to be virtually unaware because they hide it..."* (Director University Medical Service)

Although university support staff report increases in the numbers declaring an incapacity many of these relate to dyslexia and physical disability rather than to pre-existing mental health conditions.

*"Very often it's students with dyslexia, that would be the most common. So not necessarily mental health difficulties at all, in fact off the top of my head I can only think of this one student that I've had a lot of contact with personally"* (Disability advisor)

University support staff report a strong sense of stigma attached to mental health conditions.

*".....it's often now a perceived stigma rather than a real one in that I have a lot of students come into my office and talk to me about things and say, 'But I absolutely don't want anybody to know because they are not going to take me seriously'"* (Disability advisor)

Staff who design and deliver initial induction know they must strike the right balance but are aware that messages, particularly about mental health can readily be lost among the many topics covered in these sessions.

*"There's a huge amount of information, there's the student handbook, the student website, the student portal, there's posters, leaflets, and we as a service go out and do regular talks to departments. ...But there's lots of publicity, lots of information circulated"* (Medical school dean)

One of those high level messages is almost certainly about the way the profession, and, by extension, entrants to it, is regulated and the way stable mental health is seen as a pivotal factor in the Fitness to Practise process which lies at the heart of those regulations.

*"I think it's very difficult and I try to tell people at induction and at other times there isn't a stigma associated with it and that they should not avoid seeking help because of their concerns about Fitness to Practise or things going onto their medical school record, but they don't believe that...well not everyone does"* (Telephone interview, Dean/Vice Dean)

*"We're constantly putting the message out there that a degree of mental health difficulties is not that unusual and that if the students are seen to be dealing with it appropriately then that is something that we encourage them to see as good practice"* (Telephone interview, Dean/Vice Dean)

*"...we do reassure them of confidentiality and try and make it clear that, you know, having to have a Fitness to Practise review is quite rare really. It is a bit of an uphill struggle though. I think students think anything they do is somehow recorded and put in their file"* (Telephone interview, Lead on medical student pastoral care)

The way these messages are interpreted by students is central to the issue of identification of students with mental health problems – the deterrent effect is very significant.

*"I think when they're saying about adverse Fitness to Practise procedures, that's always something that would be playing on a student's mind ...are they suddenly going to say, 'Oh no, you have to withdraw from the course because you're a lunatic and aren't safe to be seeing patients?'"* (Third year medical student)

The nexus between mental health and Fitness to Practise is a message students universally report despite many of them also acknowledging that they know no examples of people being excluded from medical school as a result of mental health issues. The mythology of the connection is stronger than the facts,

*"On the whole people don't want to seek help because they are worried about Fitness to Practise. I think that is a real concern, there's not like a list saying 'if you have this you'll still be okay to practise.' But if you had a list ... those questions, there's a lot of rumours and scare stories that go on. So it's not really made very clear what it means you are not fit to practice"* (Third year medical student)

Students recognised that in the Fitness to Practise stakes, mental health posed a greater risk, or at least one marked by greater uncertainty, than some of the more common misdemeanours which the procedures are felt to be better suited to dealing with. Violent assault, drink driving, theft of hospital or patient property, and sexual offences were seen as clear cut reasons for someone not to be allowed to practice medicine.

*"...nobody knows from us what psychiatric issue is actually compromising your Fitness to Practise...you know schizophrenia is a big thing you know...because you lose insight into things but...we sort of avoid this topic* (Third year medical student)

The belief that Fitness to Practise in relation to mental health issues poses a greater risk than other issues, which medical schools are at pains to dispel, is often reinforced on clinical placements by practitioners who set very high expectations.

*"It would just not go down well. You wouldn't want to tell the consultant on placement"* (FG3)

Although Fitness to Practise and hence failure to become a doctor, was frequently cited as the biggest perceived threat this term was used to cover any one of a

number of lesser but nonetheless significant threats such as enforced leave of absence.

*"Medical school gave me time off as well but there's an upper limit to the time you can take off. So if it's more than two years you are out. So for example I've used up my two years in total. So if I did have a severe illness I know I would have to go and tell them but that could mean the end of my medical school career because I'm not allowed to take any more time off"* (Medical student)

Taken together these factors present a strong reason to conceal mental illness: in risk assessment terms the risks of disclosure outweigh the benefits.

Reluctance to admit to a condition in the first place is exacerbated by deep suspicions about services intended to help them. Medical students seek help in a cautious way, predicated on a lack of confidence in the confidentiality of any disclosure and its feared impact on their career prospects.

Staff in both generic student services units and within medical schools as well as the students themselves are clear that one of the major issues is about confidentiality – although they tend to approach this somewhat differently.

*"....they would be referred to counsellors [and] they maintain their confidentiality to a 100% degree"* (Manager, University Support Services)

*"We had lots of discussions with student health service...have agreed a protocol that they'll use where they feel a threshold has been reached where they need to breach their confidentiality with a patient and let us know about an issue"* (Faculty Manager)

*"They do worry a bit about who knows about their illness and so on and we try to reassure them best we can that it is completely confidential, but occasional transfer of information is needed. Transfer of information is always with permission, unless there's a very particular problem when we tell them we're going to transfer information with or without their permission if there's any patient safety issue"* (Sub Dean)

*"Some people we don't even know they are being treated for depression and we [medical school] find out coincidentally. They have chosen to keep that confidential and go through the NHS and not involve medical school. Whereas there are those who will want the extra support that can be provided by the medical school and help them"* (Sub Dean and Director of Clinical Studies)

*"It's done through the university's occupational health department with whom we [student support] have a very close relationship but I mean it's all confidential obviously but we would use the occupational health department as a conduit for receiving reports from healthcare professionals and advising us as to whether they're well enough to be on the course or not"* (Director of Professional Development & Welfare)

Students in focus groups were asked to discuss and rank lists of available sources of support in terms of their willingness to access them. The results of the ranking are given in table 13, below.

**Table 13: medical students' willingness to access sources of support**

First choice	Second choice	Third choice	Fourth choice
Friends 55%	Family 25%	Medical school contact e.g. tutor/year head 28%	Helpline 25%
Family 25%	GP 25%	GP 22%	Medical school e.g. tutor/year head 20%
Self-help 10%	University Student Support 15%	University Student Support 15%	Medsoc peer support 12%
Other 10%	Medical school contact e.g. tutor/year head 15%	Medsoc peer support 15%	GP 6%
	Other 20%	Other 20%	External counselling 6%
			Placement contact 6%
			Other 25%

These results show that the person the student is generally supposed to use as a first port of call, a nominated tutor or year head, actually appears as a second or third choice and then only for a minority of students. Much of the discussion about personal tutors is contained in section 3.3, however, focus group discussions revealed results that are very much in line with what the literature tells us. Student discussions revealed a marked preference for not discussing problems with or seeking help from anyone at all, so that even the decision to discuss with friends or family represents a preference that may have been taken after a period of doing nothing. Fear of something 'getting back' to 'the school' was almost universally cited as the reason for not seeking help.

*"...I said to my GP, do you think I should ask for help? Do you think I should tell the medical school? And he has resoundingly said absolutely not, 'they will use it against you'" (Medical Student)*

So, although the notion of the medical student as a reluctant revealer is strongly reflected in their choices, with stronger preferences more remote from their medical school than weaker ones, so is the idea of the student wanting to control how much and when information is revealed as reflected in their choice of support giver.

This reflects a very basic belief held by the vast majority of medical students: – systems and processes put in place ostensibly to help them are not to be trusted and the nearer these are to the medical school the more likely this is to be the case.

Generic support service providers know this and emphasise confidentiality as a key value. Students are less likely to see this quality in advisors located within medical schools and this extends to specialist staff such as psychiatrists engaged specifically to advise 'problem' students.



## Feel Bright – myth busting

True or False?

- If I tell medschool I'm not coping they will send me to Fitness to Practise
- If you have 'mental illness' on your record you can't be a doctor
- If I tell medschool I am depressed they will throw me out
- I can't be a good doctor if I have a mental illness

All false – but widely believed!

This Medsoc-led initiative has paid staff and uses a website to dispel myths about mental health by getting across three key points:

- Mental health problems are quite common for medical students
- They get over it
- Self-help and sharing with peers improves prevention and recognition.

The website contains:

- Access to free self-help courses which are downloadable ('Relaxation and Mindfulness' booklet, meditation podcast, breathing and relaxation exercises).
- Sessions which use handsets ('clickers') to stimulate discussions on common stressors (examinations, competitiveness, isolation), how they coped and how to recognise the onset of depression.
- Particularly powerful is the personal story of a student who did not recognise that he had a problem

Sharing includes:

- Student reps running relaxation sessions
- Inviting ex-students with experience of mental illness to talk to current students about how they succeeded as doctors.

Worth considering if:

- You want students to recognise stress and depression themselves and among their peers
- You want to empower students
- You want to break down barriers caused by myths

You will need to:

- Recognise that peer activity is valuable
- Hand over some of your budget to students
- Practice what they/you preach by not reinforcing the myths

### Institutional response to mental illness in medical students

According to the generic providers of student support within universities key elements of support provision are clarity of performance measures and how offers of support are triggered. Provision will need to include staff who recognise when a student's issues need more expert support than they can themselves provide and a network of support into which the student can be referred, which itself has clear rules about what can be provided and on what conditions. The conditions include a presumption that students are to some extent vulnerable and need independent advocacy, including a guarantee, except in the most extraordinary circumstances, of confidentiality. Later there would need to be an assumption of continuation or re-engagement in study on a no-detriment basis. Central to this is the independence of the service from the decision making process *and the acceptance of this independence by academic departments.*

Services are integrated with provision of a one-stop shop for students and a more centralised approach in terms of student referral and guidance on support to academic staff. These service providers point to the advantages of economies of scale and breadth of service arising from this model.

The phenomenon of clinical tutors acting as doctor (officially or unofficially) to their students is unique to medical schools.

Although there is dialogue between the medical school staff and university student services, and referral of students by school staff, the two parties have very different models of intervention.

Student services units start with the premise that many will encounter problems at some time. Indeed, many of the problems presented are so common that they are routinised into self-help, information or advocacy solutions. Where a rarer or more complex problem presents it is addressed equally in terms of the adjustments required to redress disadvantage or disability and changes the individual might reasonably be expected to make themselves (reciprocal flexibility). This social model of disability lies behind legislation in the discrimination field.

*"We give lectures at the beginning of term for the first years saying, 'Your health is really important, essentially if you have any problems come and see us sooner rather than later, don't let things get to a crisis'. The sooner we can intervene the better the outcomes and that's proven by guidelines such as NICE (National Institute for Health and Clinical Excellence) guidelines*

*for Bulimia. So we say to them, 'Actually, it's quite normal, the whole population, one in four will have a problem at some point in their lives, one in six in the room around you,' and everyone looks around at each other, 'Will have a problem especially with mental health'" (Director of Student Health)*



Further assumptions are that those who ask for help are clients who have rights including expecting their wishes to be respected, to be treated fairly and to expect confidentiality in all save the most exceptional circumstances.

*“Student Support basically consists of two main areas; one is the counseling service, which is in a different building, professional counseling service, person centre to counseling and completely 100% confidential. So it is the one place that students can go to knowing that the information won't at any point get back to their regent or their academic school etc.”* (Head of Student Support)

Because there are a range of services available efforts initially are focused on triage and signposting, and usually include sorting out immediate problems very quickly while putting in place longer-term support identified as part of an assessment procedure. In terms of mental health such units can deal effectively with crisis and longer term needs, often having very direct access to NHS provision if it is needed.

*“If you send somebody to [the university support service] we know because we track the data, we know from student satisfaction, you're not passing them off from pillar to post. We will deal with it. You know, they're getting a good service when they come there”* (Director of Student Services)

Self-referral is by far the most common route (70%) into such services for students with mental health issues. Although mental health issues represent a very small proportion of cases (5%) they represent a significant amount (30%) of the total volume of work.<sup>8</sup> Generic providers report that medical students form the largest single group of users.

*“They ... predominantly they self-refer. Something like 67/8 ... 68% self-refer of the medical students. Across the board it's more like 78% self-refer and we prefer it that way”* (Head of Student Psychological Services)

Students we talked to were aware of these services and some said they might access them. They valued their impartiality, trusted their confidentiality promises and for the most part saw them as offering a professionally appropriate service to those with mental health problems. They thought it unlikely that information would filter back and be used in the Fitness to Practise process.

Barriers to use included fear of being seen using the service, the service being located on another part of the campus, and taking time off, which might signal to others that they had a problem.

However, two other reasons given were that these services were not really meant for them and the ‘talking therapies’ on offer were not genuine, clinically tested treatment and unlikely to work:

*“Counselling isn't real medical treatment”* (Medical student)

---

<sup>8</sup> Averaged from a number of sources and internal reports

*“They (medical school) don’t like you accessing university services – they have the expertise here” (Medical student)*

The medical school model is different and carries a different set of assumptions, not least of which is that medical students with health problems are a minority. The assumption that the individual has to be repaired in order to fit in with a system that cannot change is very much a medical model of mental health and one that is entirely in keeping with the heavy demands of the curriculum and the need to be ‘at work’.

Students, who we have noted elsewhere, are very competitive and driven to succeed are to some extent prepared to accept this approach. Compliance brings success, or at least damage limitation. It does not however, address the issue of reluctance to come forward in the first place, rather it presents significant barriers. Firstly, students recognise a danger of escalation in a system that takes a clinical approach to management of common mental health conditions. Second, if every case is treated on its merits it is difficult to predict the acceptability of outcomes unless they are treated on their merits too (treatment appropriateness). Third, while adherence to treatment provides evidence to satisfy Fitness to Practise needs it also provides evidence of the existence of the illness.

In-house medical school provision tends to be quickly accessible. Some medical schools have psychiatrists on their staff thereby making referrals easy and swift. Generic support service providers questioned the appropriateness of treatment that stemmed from medical schools’ tendency to make clinical referrals and interpret problems as medical conditions.

Table 14, below, compares characteristics of medical school and university provided support. There are aspects of both which may appeal to students, and evidence from service providers that students pick and mix from the menu.

**Table 14: Comparison of medical school-provided and University- provided support**

Support Services		Medical school
Model	Social model of disadvantage	Medical model of incapacity
Services	Integrated, triage to specialists, holistic	Restricted to performance and pastoral
Resources	Large, breadth, depth	Small, focused
Transparency	Advertised widely, menu/portfolio	Formal system transparent, informal hidden
Confidentiality	Absolute except when danger to self or others	Conditional on circumstances
Options	Anything the student thinks is a good outcome	Course completion/becoming a doctor
Expectations	Flexibility	Compliance

Although in some schools there is good cooperation between university and medical school forms of support in others lines of communication and mutual support are lacking

*“We don't want to have that partnership operating in tension or a degree of duplication and very blurred territory where no-one knows what anybody else is doing, but we absolutely must have sort of a continuum of provision where it's very clear that the frontline is in the academic department”* (Director Student Services)

*“I have no idea where the medical school has got to with that and as I said they don't liaise with us....they have a fairly low level of correspondence with us. So over the years they have developed on their own ... we only hear about in passing, so I genuinely don't know what the state of affairs is in the medical school now”* (Director of University Health Service)

*“Clearly we welcome that but having been told that in the past to get back in our box we've been quite careful about emailing the medical school because there are still people there who have their own personal set views about what our role is and they don't like to be told what to do. They basically don't like to hear that their medical students have any issues at all. And their message, they are very on-message, is that there are no problems or very few problems and if there are we are dealing with them fine, thank you”* (Manager university support services)

### Responses to student perception of mental illness

The site visits shed some light on the rationale behind responses to the issues of disclosure and concealment raised in this chapter which are included below. They are admissions, personal tutoring and the inclusion of medical student mental health in the curriculum.

#### Admissions

Reluctance to disclose mental health problems starts at the time that students apply to medical school. Despite being given multiple opportunities to do so and assurances from the highest level that such a declaration will:

- a) Be treated confidentially
- b) Be acted on in the student's best interest
- c) Be treated in the same way as any other disability concealment is still an issue.

Of the twelve students interviewed six had experienced recognised mental illness at the time that they applied but only one declared this. In one medical school the member of staff responsible for student support in the early years addresses groups of applicants when they attend for interview and points out that many students have mental health problems and that declaring a problem enables support to be put in place from the time the student starts the course.

*"One shocking discovery was the medical school clung to this idea, well they have a pre-course medical, so before they leave school a medical has to be done to say they are fit to come to medical school and study to be a doctor. So by definition when they arrive they are all fit and well essentially and I said, 'Okay, so what you've got is a form that they fill in and they get signed by their GP and therefore you are happy with that?' And they said, 'Yes.' And I said, 'Okay, what if their GP is in fact mummy?'" (Director University Health Service)*

### Personal tutoring

The role of the tutor is discussed in some detail in the preceding chapter. However, respondents on site visits brought further insights to the importance of this role and how it might be developed. In particular it was highlighted that students needed a personal tutor that they would be happy to approach when a problem arose. This was much more likely to be the case where students already knew the tutor (for example by occasional compulsory contact) and where the tutor had previously been approachable and supportive.

Medical school staff are aware of the value placed by the GMC, via its quality visits, on the separation of pastoral and performance issues and its clear preference, expressed in its quality reports, for these roles to be carried out by separate people. While there is general agreement that there is a need to recognise that pastoral care and performance monitoring are activities which should not be confused, there is less agreement that they cannot be handled by the same person as long as the student is happy with the arrangement and the tutor recognises boundaries and takes appropriate action when potential conflicts of interest arise. In any event, the choice of confidante lies at least in the first instance with the student – making the rule that the first point of contact should be their tutor ignores the fact that disclosure of mental health problems is at least as much to do with who the student feels 'safe' with as it is about adherence to procedures.

Some types of teaching arrangements (PBL/small group work) encourage close relationships with staff and in any case allow staff a much better viewing point of student behaviour than others (large lecture based courses), so the first point of contact may be more dependent on student choice and staff opportunity. One school that we visited exploited this relationship making the students' PBL tutor also their personal tutor. Satisfaction with personal tutoring under this relationship was very high.

*"Because we work a PBL based curriculum the students have one PBL facilitator, well they have two throughout the course of an academic year and so there's a close relationship between the student and the PBL tutor, so again if a PBL tutor picks up that something is not quite right with the student it's much easier to pass that along" (Medical school director)*

Medical school staff made three main points about how the role (as opposed to the position) of tutor had changed: First, an understanding that almost every staff member was likely to be approached by students for one type of advice or another;

Second, tutors need to be more trained for the role; Third, not everyone is cut out to be a tutor.

Therefore, whoever is taking the tutor role must be trained and be ready to refer on students to appropriate sources of professional help when needed. University support services reported that they have been making efforts to improve the quality of tutors. Key to this training is:

- a) An element of selection in who gets to be a personal tutor
- b) An understanding of 'warning signs'
- c) Knowledge of what is on offer from the university wide services
- d) Clear messages about knowing when to refer on to these services.

Heads of student services acknowledged that 'selecting' tutors was a luxury they seldom had, which made the other elements of the training all the more important. Two of the five sites visited had monitoring systems in place for tutors, which allowed them to engage in a limited amount of 'de-selection' of unsuitable tutors, but the main efforts were directed at training, which heads of support services would have liked to be made compulsory. Heads of service reported that staff in medical schools were less likely to attend training than colleagues in other parts of their university.

Several sites had developed a more senior kind of tutor (**Über-tutors**) who oversaw a group of tutors but was also available for students who didn't want to approach their regular tutor. In two institutions they had employed peripatetic staff as independent student tutor advocates with specific ring-fencing of their role. Both **über-tutors** and independent advocates were medically qualified, usually with an interest in mental health. Their role was not primarily to 'treat', however but to act as a trusted person, one step removed from the educational performance process. Several of the sites had appointed psychiatrists to accept referrals directly from tutorial staff in the medical school, i.e. direct provision of treatment within the school.

Medical students, in focus groups, reported a mixed experience of tutors ranging from 'never there'....'doesn't answer emails'...'tells me students today have it easy' to 'very helpful'...'always available'...'introduced me to a counsellor'...'really felt she was there for me'. However, students saw mental health as a special sort of problem, and in this respect they were wary of tutors. They emphasised that having someone who they could trust was more important than having an 'official person' to seek help from.

### **Inclusion of mental health/self-care in the curriculum**

In chapter two we presented a number of ways in which medical schools indicated to their students that mental illness was a common occurrence and that all students should access available activities to reduce the likelihood of mental health problems (Dyrbye et al., 2005, Gentile and Roman, 2009, Roberts et al., 2000b, Tennant, 2002, Benbassat et al., 2011, Ball and Bax, 2002, Shapiro et al., 2000, Redwood and Pollak,

2007, Brazeau, 2010, Wilhelm, 2002, Spring et al., 2011, Bughi et al., 2006, Mercer et al., 2010, Simard and Henry, 2009, Dyrbye et al., 2011). One way to address reluctance to engage with mental health support is to include student (as opposed to patient) mental health in the curriculum.

*“Because they think of it as some luxury whereas if we're part of the curriculum then it's seen 'yes, this is very important to you as professionals’”*  
(University Counselling Service Lead)

Information about common mental illness and how students might recognize these in themselves was mainly delivered in lecture format. As well as medical school staff professionals from general practice and addiction services are involved. These sessions present another opportunity where information about personal mental health and about mental health problems in peers overlaps. In this instance the primary topic was students' own mental health but how to identify mental health problems in a colleague was included.

*“Sort of healthy living I suppose and helpful and unhelpful coping mechanisms. We've also got the kind of concerned colleague system, so ways to let them know about reporting concerns they have about their friends”*  
(Medical school staff)

#### Chapter 4 Summary

In this chapter we have outlined how life as a medical student may pose specific problems. This includes the major commitment required to be a medical student and the widely-held fear that revelation of a mental health problem may bring about the end of a career in medicine. We have looked at the different models of care provided by medical schools and generic university services. We have presented data on some of the ways that medical schools have responded to these factors, particularly in relation to admissions, to provision of personal tutors and to the need to include students' personal mental health in the curriculum.

In Chapter 6 we will combine data from this chapter with data from other sources to develop a new model of care.

## Chapter 5: How does this impact on individual students?

---

### OVERVIEW

In this section we present brief case histories of ten medical students and one junior doctor all of who experienced mental illness while they were medical students. We have omitted a twelfth case history, which describes the experiences of a student who had recently been unwell and had been diagnosed with a serious physical illness. We provide a summary of the case histories areas where systems have not worked as well as possible with recommendations how this might be addressed.

### FS1

Starting with an illness at the age of 10 this student had a long and complicated mental health history that included multiple suicide attempts. Because of her medical history and its consequences she did not start medical school until the age of 22. By this time she was well and considered her mental health history to behind her. However, she encountered problems once she entered the clinical part of the course and had to take repeated periods of leave of absence. She had several admissions to psychiatric hospital during her time as a medical student. Despite her major struggles she considered becoming a doctor to be a core part of her identity and does not contemplate withdrawal from the course. The student support mechanism with allocation of a case-worker by her medical school had been something that she valued highly.

*"I'd recommend anyone who's struggling a bit. It's amazing that the University have put this in place. Because it's really, really helped me. Instead of hiding away and thinking, 'Ooh, if they find out you're a mess, that's it!' Actually they've helped" (FS1)*

### FS2

Although it has never interfered with her academic performance this medical student has had episodes of depression since the age of 14. She describes her past self as *"A highly stressed student who always came top of the class"*. When applying for university she was worried that declaring a mental health problem would prejudice her application. She did not feel comfortable discussing how she should handle this with anybody at her school.

She describes the undergraduate medical programme as *"a sociable course"* and how this becomes a problem when she is depressed. Clearly having to communicate with patients and relatives is more of a challenge when she is unwell but she also describes difficulty keeping contact with her peers.

This student had the misfortune to become unwell when she was doing her psychiatry rotation. Not surprisingly she felt keenly that she understood the patients'

experience but was not certain whether this was a help or a hindrance to her own recovery.

A chance encounter meant that she discovered that she and a fellow student both suffered with depression. This led to a mutually supportive, cathartic relationship where she clearly gave and received a great deal of support. She was the only student interviewed who described feeling able to discuss her illness openly with her peers. Indeed she often deliberately took her antidepressants in front of her fellow students.

*“To hear that somebody else had gone through what he'd gone through and just like someone there to support him, I think it helped him quite a great deal and it helped me really to see that I'm not the only one” (FS2)*

*“I think medical students are scared of admitting their problems - to their friends, to the medical school because the scary thing is you think, ‘If I admit this, will I be unfit to practise? Will I be thrown out of medical school? Will they tell me to take some time out when I don't want to?’ So I think we do get scared and I think a lot of medical students do have mental health problems” (FS2)*

## MS1

This student gave a clear history of emotional abuse during his childhood and adolescence. When he started medical school he found that he was unable to concentrate in lectures because of his persistent, anxious thoughts. He felt alienated from his peer group and describes being in a lecture theatre with hundreds of his peers and feeling completely isolated.

As he realised that his constant high levels of anxiety might not be everybody's experience he sought help from the university counselling service. After long periods of counselling with two professionals he has been able to make a major difference to his day-to-day life. He is now able to concentrate in lectures and has capacity to take part in friendships and leisure activities without intrusive anxious thoughts.

Although his existence was chaotic at times this student always performed well academically. At the time of his admission to medical school he did not see himself as someone with a mental illness but with hindsight thinks that he has been *“depressed for many, many years”*. He expresses gratitude for the counselling that has been accessible to him via the university, which has made such a major difference to his life.

He has clearly developed skills of covering up his mental health problems as peers to whom he has revealed his illness have been surprised stating that he has always seemed in good spirits.

*“I've had a lot of counseling over the past year and a half to two years which has been of tremendous use, as well as stuff like cognitive behaviour therapy, as well*



*as reading books, like self-help books for people who had experienced forms of child abuse” (MS1)*

*“It was incredibly useful having free counseling I think because if it wasn’t free I don’t think I would have got it. Yeah, because I’ve been someone that worries about money in the past and definitely it kind of ties in with anxiety” (MS1)*

## MS2

This student suffered from a depressive illness before starting medical school with many episodes of self-harm. He was not well when he started medical school and had a rapid worsening of his condition in his first few months as a student. This resulted in a crisis where he initially tried to consult a psychiatrist who had treated him near his hometown. However, he returned to medical school and sought help via his GP who encouraged him to seek help provided by the university, as this would be more readily available. At an appointment at this time with a nurse in the university’s occupational health unit he understood her to have said that he should be suspended from the medical course as a result of his current mental state. Understandably, this caused him a great deal of distress and fortunately he was able to approach a senior academic in the medical school who was able to reassure him and to direct him to appropriate sources of help. Throughout this time he continued to perform well academically and got a good grade at the end of his first year.

He is very selective about which fellow students he tells about his illness and had one friend react negatively when he did reveal the story of his mental health problems. When he was unwell he isolated himself, at times just sitting alone in his room. His family have been very unsupportive.

*“Going back to the night where I felt suicidal, at about 4:00am I didn’t really know what to do, so I called the Hospital, asked if there was any psychiatrist who could take my call, I explained the situation to them, they said, ‘Go talk to your GP,’ and at this point obviously 4:00am isn’t exactly a good point to talk to your GP” (MS2)*

*“When I was being assessed for CBT I told the nurse that ... the nurse at occupational health about my situation and she then said ... because feeling suicidal that I would ... she would recommend a suspension for me from the course or I would need supervision...I said I’d much rather have supervision. I became very, very upset at this point that my mental health might cause me to become suspended from the course” (MS2)*

*“Student welfare officers/representatives...seem perfectly approachable, friendly and they understand the importance of confidentiality. They’re all medical students as well, so I think they understand what we’re going ... well, going through in terms of when exam stress comes in or when trying to find a house and situations like that” (MS2)*

### MS3

This student doesn't give any history of mental illness before medical school. From starting medical school his life involved the use of drugs and alcohol on a regular basis. The student alcohol-centred social life and in particular a student drinking club provided some cover for his excess alcohol use. He describes going home to detox during the university holidays.

Later, he became socially withdrawn and could not attend his clinical placements, eventually scarcely leaving his room at all. He became adept at communicating by text with his peers who were concerned about his non-attendance.

A very serious suicide attempt after an alcohol binge resulted in him being admitted to hospital and then to a psychiatric unit.

After a year's leave of absence and some intensive therapy he is back at his studies and is abstinent from alcohol.

He voices the insights that he is able to bring when dealing with patients who have suffered problems similar to his own.

*"People have said this to me. Like, 'Oh the drinking culture, you know, that is around universities,' and that was certainly convenient for me because it kind of legitimised a lot of drinking. You know, I was in a drinking society for goodness sake. But I would always go further..." (MS3)*

*"One of the reasons I didn't talk to anyone was because I didn't hear anyone else in my position say this" (MS3)*

### FS4

This student had no history of mental health problems prior to starting medical school. She was a high-achieving student who was an accomplished singer as well as doing well academically. She had ambitions to become a neurosurgeon. At the beginning of second year she became aware that the workload had increased and stopped participating in some of her extra-curricular activities.

She worked hard to keep up with the work sometimes working into the early hours of the morning. She was approached by her friends in the latter part of the second year saying that she appeared to have lost a great deal of weight and they were concerned for her welfare. When she shrugged off their concern they approached a member of medical school staff. It was not until the summer holiday and with the combined input of her mother and the family's GP that she accepted that she had an eating disorder. She contacted staff at the medical school who readily agreed to a year's leave of absence. This was a very bad time, not only was she having to accept that she had a major mental illness but also that her medical studies, a very important part of her life for many years, had been taken away.

After prolonged treatment in a specialist unit she is recovered and has returned to her studies.

*"[The Medical school] were incredibly understanding and they got back to me straight away and said, 'We totally understand, we think it's an incredibly professional, mature decision to make to take a year out. We would highly recommend that you took the year out rather than come back and try to juggle the two.' And they also said that if one year's not enough take two. So the fact that they then said, 'You've got a year, you don't actually have just one year, you've got two years to get better.' It was a huge lift of pressure off me. I thought, at the time one year felt like an awful long time but in the grand scheme of things I think one year is incredibly insignificant it goes so quickly"* (FS4)

*"I went to see ... she's part of the occupational health team, and she said, 'If there is something that you're unhappy with or...' she was basically telling me all the options, saying that if you're on a ward placement which you feel you're not coping with, or there's a certain ward where there are consultants you just can't deal with, maybe the amount of criticism or it's just geographically too far away, they said, 'We can change that, move things around. If you need to do exams in a separate room, you can do your exam in a separate room. We can change...' They were like, 'We can basically alter the entire course for you.' I was like, 'Okay,' that made me feel so much better"* (FS4)

## FS5

This student had an upbringing characterised by frequent physical abuse. She had mental health problems in the year before she started medical school. After starting medical school she had to take 2 years leave of absence, firstly because of depression then because of hypomania. After being diagnosed with a bipolar illness and receiving appropriate treatment she has been able to stabilise and has had a number of years of successful study at medical school.

She had not revealed anything about her illness to any of her peers, even those she lives with. She says she does not have any friends at medical school as a result of this.

*"I went to the guy that's in charge of our course and said to him ... I don't know if I said 'I'm not coping', I just said 'I can't ... I've not been able to sit the exams 'cause I can't write, I'm not very well.' I said, 'Is there any chance of me being able to come back?' I didn't think there was and he said, 'Yeah, there is, everyone has a chance of taking a year out and coming back.' And I didn't know that. And I knew I was so ill because I went to him ... 'are you being serious, like really?' And I repeated myself a hundred times and he ... I think I was really freaking him out because he goes to me, 'I don't think you're going to be well next year. I think it's going to take you two years to recover, so I think you should take two years out'"* (FS5)

#### MS4

This student had developed a depressive illness prior to starting medical school. It occurred after he was treated for a major physical condition. He gained some support from his GP and the clinicians monitoring his physical illness. His fears were that if he disclosed his illness he would be forced to take a year's leave of absence and that the medical school would "use it [knowledge of his illness] against me".

*"What gets on my nerves, though, is what I see as complete lack of support for medical students and there is two main reasons I'd say that; one is when I, at times I felt down during this degree I said to my GP, 'Do you think I should ask for help? Do you think I should tell the medical school?' And she has resoundingly said 'absolutely not!, they will use it against you' and I've also been told that by the people I follow up with" (MS4)*

*"[Talking about a friend who declared his mental illness to the medical school] They're saying to him you need to do, take another year out and come back again. And he's a post grad like me and I physically, I literally could not afford to pay my tuition fees up front again and he's the same, he's already been made to do it so I guess I feel very frustrated that I know he's been through that and I also...because I said to him, I know it's no good me saying this to you now but this is why I haven't approached them" (MS4)*

*"And then I hear about my friend who's been, sort of forced to have a year out, it's like well there's no way I'm going to chance that [approaching the medical school with a mental illness], I can't afford it" (MS4)*

*"With the mental health bit there is no way ever I would mention that on my UCAS form, I feel like I particularly don't want to mention it because what I've been told" (MS4)*

#### FS6

This student was well into her time at medical school before she experienced any significant mental health problems. When it did emerge, her mental health problems took the form of panic disorder. She had panic attacks which were, in part, influenced by her medical knowledge. She describes monitoring her pulse to detect the onset of an attack. The attacks became very disruptive in her life.

Towards the end of her time at medical school she realised that she was not coping and requested leave of absence. As this happened towards the end of an academic year she returned to join the next cohort fairly soon. However, she soon became unwell again, this time withdrawing to her room and not requesting help from the medical school.

Due to her prolonged absence she was, eventually, summoned to a Fitness to Practise panel. She was invited to bring someone along for support but in her

depressed state was unable to arrange this and attended alone. She describes thoughts of suicide as she comes to terms with the panel's decision.

Now successfully back at her studies she is insightful about her illness and is happy with the monitoring and the clear conditions that have been put in place to make clear the behaviour that is expected of her if she is to remain a medical student. She describes in glowing terms the one to one support that she was given by a consultant surgeon (arranged by the medical school) to enable her to regain some confidence before she returned to her studies, and in particular, to the clinical environment.

*"So I had the formal Fitness to Practise proceeding, panel of people, absolutely terrifying, family weren't up here. I thought it was going to be the end of my life" (FS6)*

*"This is the trouble, when I started to get ill I buried my head in the sand [reading a book]. So instead of rationally thinking, 'Right, I have a problem, let's go to [the medical school] talk to them, say I've had a problem. I think I actually left it until like the last day. Because I just head, sand, ignore" (FS6)*

*"I was unprepared, I was unwilling to face head on my housemates to make myself some toast let alone come in front of a panel of people to discuss all these things that were causing my depression. Me trying to keep on top of a pile of things when I couldn't even keep on top of my washing. When I got the letter through I was just sort of like hopeless in a way" (FS6)*

*"Because it was my second time around [starting Yr 5] and everything in my life was crumbling, everything was going wrong at home. This was something I knew and something I could be quite proud of that I was in the final year of my degree. And if that were to go too I was considering suicide and things at that point. So it was kind of like, 'Stay on the course, or die.' Do you know what I mean? So I did maybe, well I definitely did try and reassure the [medical school] staff that I was fine when really I wasn't" (FS6)*

*"It's quite nice to have somewhere [NHS Practitioner Health Programme (PHP)] where they kind of expect you to be in the medical profession and with mental health issues without any sort of ... you're able to be honest about the things without sort of ... you can be honest without the shame" (FS6)*

*"So I saw the psychiatrist quite rarely [at the NHS PHP], maybe every month or so. It wasn't really regular but I saw the psychologist once a week. I found it quite interesting that they would be able to give you a weekly psychologist appointment for as long as you needed it. There was no like twelve [minutes] and then done, or 20 [minutes] and done. It was just 'you're welcome to just come once a week, just organise it with us, on-going until you go back to [the Medical School].' And that was quite nice because previously you would have ten sessions and 'that's all we're funded for.' They were really good in that respect.*

*And we got through a lot of things and, as I say, we focused on the concrete like day to day behavioural changes that I could put into action. Because I found that much easier than, 'How did that make you feel?' Frankly I just ignore all ... I behave impulsively" (FS6)*

*"I was terrified about coming back. I'd had a really long time off and the year subsequent to me being told I had to terminate my studies I wasn't really going in very much. So it's been about two years since I've properly been engaged with the course and doing decent examinations and even though I've been trying to keep up with the revision recently and with the PHP, there is still a long time since I did my fourth year exams and as a consequence I'm ... there's nothing for it, I'm definitely going to be behind the other fifth years. I'm going to be rusty. And am I going to be able to cope with being rusty given my lack of self-esteem and past and everything? The reason probably that my face lit up is because of this [consultant surgeon] is just a remarkable bloke who just really held me by the hand quite a lot for the first few weeks before fifth year started just to be like, 'Right, let's see your exam, don't worry about getting it wrong,' he was so easy going about it" (FS6)*

*"[About the second Fitness to Practise hearing] I remember not really knowing what to expect. I didn't know how closely I'd be questioned, I'd been spending the past few weeks preparing a statement of how I'd got better so I kind of read through that and had an idea of what I wanted to say. [University Student Support Officer] was great because the first fifteen minutes or so before I went in we had a meeting separately and she took me through the nitty gritty of what was going to happen" (FS6)*

## **FS7**

By the time this student entered medical school she had been admitted to a child and adolescent psychiatric ward and had made multiple attempts on her life. Having been told by staff at her school that she was not fit to be a doctor she declared her history of mental illness when she applied to medical school. She describes a very distressing consultation with an occupational health doctor. She had further medical problems while she was at medical school and was diagnosed with a bipolar illness. Her behaviour during a hypomanic episode resulted in her having to leave her shared house thereby isolating her from her previous circle of friends. Always performing well academically this student describes how when well, she has been able to undertake a number of activities successfully including travelling to Tanzania for her elective.

*"[Having ticked 'yes' to having a mental health problem on the occupational health questionnaire] And I was called in to see a doctor who I think was quite mad herself, but was quite hysterical and it was suddenly this big method, the same method that a couple of teachers have told me that you can't come into this medical school, you know, you've been a complete mess and she suggested that instead I join the biomedical science degree" (FS7)*

*"[The occupational health doctor] pretty much just told me she wouldn't clear me for the course and I burst into tears because I thought I've worked so hard for an entire year to get to this point and it's not just because I've worked to get to medical school, I've worked, I mean, when I say I was recovered, the amount of energy, mental energy it takes to overcome something like an eating disorder and those kind of self-destructive behaviours and low moods, you know, the amount of therapy and the amount of...I was just a fighter and I've worked so hard" (FS7)*

*"I just begged her [the occupational health doctor], I cried, I just said, 'please', you know, and so we agreed that I would start, that she would review me every month or something and every time I saw her I dreaded it because she scared me and there was a constant threat. I mean actually she was, in the end a couple of people made big complaints about her, I don't think this is a normal...I think a lot of people with mental health problems go to medical school and they don't get this kind of horrific treatment, this is a one off but she really quite scared me" (FS7)*

*"So within about a couple of months I just decided to go to the counseling service just, not for anything in particular but just to, sort of, open ended...I just went there and said, look I've had all of these problems in the past, I'm finding medical school quite overwhelming and I just need something, some background support somewhere I will feel I'll be able to come to. And they were very, very good, I ended up just having very open ended counseling, it wasn't like a kind of set...I suppose maybe I didn't present with a very specific problem, it wasn't like they just said, oh here's six to ten week, you know, sessions type thing, it was just, I don't know I mean the counselor I saw, maybe he just recognised the complexity of my problems and that they weren't just going to go away, that I needed, sort of, longer term support in the background" (FS7)*

*"They [The PHP] saw me within 24 hours and then what they do is they don't (inaudible 00:40:48 [forget??]) to get you hooked into services quite quickly, they got, you know, I mean it was all kind of on the NHS but they made sure an NHS psychiatrist saw me that week, I wasn't...and I remember hearing some of their staff saying over the phone 'no, you know, she's not having an appointment next week, she's a doctor, she needs one' and it was very, they push for you to be treated" (FS7)*

## **FS8**

Comments from her two sisters made this student realise that she had an eating disorder. She was well supported by medical school staff and accessed treatment during the summer vacation after her first year. She is now recovered and has been able to continue with her studies without disruption.

*"I was probably in denial of the fact that I'd been losing too much weight. And I think because my sisters are people I trust massively it was seeing them and realising that...I think it was seeing them and them saying to me, 'You have a problem' and I realised 'yes, actually they're right'" (FS8)*

A less than satisfactory experience with a personal tutor in the past had an effect on the choices she made when she had a problem and was in need of help.

*"... so I went to see [medical school contact] because I thought, well he was probably the person I knew the best in the bioscience and I get a sense of trust from him" (FS8)*

*"I had a very poor personal tutor who turned up in the first session [in the first year] and said, first of all she didn't contact us and I had to contact [medical school contact] to say our personal tutor hadn't contact us, so eventually she organised a meeting and she turned up and said, 'Look I don't particularly want to be here, I don't think you want to meet me either' and I didn't see her for the rest of the year. So I wouldn't say I had a personal tutor for the first year" (FS8)*

*"I wouldn't ever go to see ... because I didn't know who she was, I mean I think that it was quite a personal issue, I think it was still quite raw, I wanted someone that I could trust to talk to. I didn't feel like she was the right person to go to at all" (FS8)*

*"He [medical school contact who became new personal tutor] was really supportive to me actually, yeah he was fantastic and he said, I kind of sat down and said, 'Look I need to come and talk to you' and I explained and he was like, yeah, he was like, 'I can say that you do look too thin at the moment' and he talked through what I was going to do in the summer, he was fantastic, he was like, 'I'll contact you in September so we can have a catch up, see how you got on' and he was like, 'I'd like to see you again next year' and he then even joked and said, 'Look if I ever see you looking too thin I will tell you! (laughter). So yeah he was fantastic actually and it gave me a lot of confidence that the medical school would help me" (FS8)*

*"I think he's [medical school contact who became new personal tutor] a professional person and I trusted him. I didn't ... and he said as well he was like, 'Look I hope you don't think this will ever ...' not come back to haunt you but 'it won't ever go on your record, it's not going to have a negative effect in the future', and so he was very supportive" (FS8)*

*"When I came back in September he emailed me which made me happy because I thought maybe I'd have to prompt him, but no he remembered which was really nice. And it just made a difference because it meant that there was someone there who was keeping an eye on me, apart from my friends and family etc., so yeah" (FS8)*



## Summary

The strongest common thread within these case histories is students unwilling to disclose a history of mental illness to staff at the medical school fearing reprisals for their career if they do. Six out of eleven students had a history of mental illness at the time of admission to medical school but only one of these disclosed their illness. The student who did disclose her previous history describes an interview with an occupational physician during which she thought that she was going to be barred from entry to medical school. Some students, undoubtedly, thought that their mental illness was behind them and was no longer relevant. However, for some students the opportunity to put appropriate care in place was lost by this fear of the consequences of disclosure. One student describes how, apart from her mother, there was no-one she felt comfortable discussing this with. Current students also demonstrated a reluctance to disclose histories of mental illness potentially cutting them off from support services. Almost all the students described some form of social isolation due to their illness taking away the social support that most medical students depend on. Students who were attending and coping with the course were still isolated some having very few friends and keeping themselves shut away. An episode of depression meant that a normal sociable student became withdrawn and could not participate in their usual social activities.

In the case of two students opportunities were lost in supporting them when their attendance at the medical school was poor due to illness. One undoubtedly set out to deceive the medical school about the reasons for his non-attendance but the other was summoned to a Fitness to Practise hearing which may have been inappropriate.

Students identified positive support from their medical school when they were ill. One student had been allocated a caseworker by the support mechanism at her school. The caseworker had provided her with excellent support for which she expressed gratitude. Another student, when acutely unwell was able to talk to a senior member of medical school staff who was very supportive and helped him to get in touch with appropriate help. The accessibility of free counselling to (university) students was seen as a major advantage of being at medical school.



## Case worker approach

One of the UK's bigger medical schools has a dedicated student support unit headed by an Occupational Health physician. Referrals may come from many sources within the school, where they may be triggered by performance or personal issues. In practice most students self-refer or are initially attracted by the support unit's other offers of study skills, communications coaching and practical help. Independence is paramount and it's staff, while having medical school backgrounds have been able to keep their distance through a separate funding stream, an off campus location and by promoting their role as the student advocate in formal university proceedings such as Fitness to Practise hearings.

A key part of the 'offer' is a case worker within a multi-disciplinary team so the student gets continuity of support while simultaneously benefiting from oversight from a wide range of professionals. Information passed back to the medical school with the student's consent is strictly on Occupational Health lines – not a clinical diagnosis but a medically informed view of both the student's capacity to study and an assessment of the reasonable adjustments needed to keep them on course. Having this view from a specialist 'of the medical school but not in it' has overcome some of the historic hostility to Occupational Health Medicine.

### Worth considering if:

- There is no credible OH service locally
- You want to combine an in-house facility with an independent service

### You will need to:

- Commit quite a lot of resource
- Expect competition from generic university support services
- Maintain highly visible Chinese walls

### Possible Improvements

Students' reluctance is the single biggest barrier to medical students getting the support they need when they have mental health problems. This applies to students before and during their time at medical school. Undoubtedly these perceptions need to be addressed in medical schools and throughout the medical profession.

However, it is likely that these ingrained attitudes may take considerable time to change. Therefore, in order to bring about prompt change it is necessary to develop mental health services that are acceptable to medical students while current attitudes prevail. In order for this to be the case services need to be clearly separate from the medical school. Where students' health impacts on their ability to pursue their studies the medical school has to be informed but this should be carried out on an occupational health model where an independent clinician assesses the student and recommends necessary adjustments disclosing the minimum detail of the student's condition.

Similar procedures need to be put in place for students at admission. Again students will be difficult to convince that declaring a history of medical illness on application to medical school will not result in automatic rejection. Prospectuses, websites and open days all present opportunities for presenting this message.

It was clear that some students, although fit to study, were in need of support as a result of their on-going illness. A named case worker, preferably not a member of medical school staff or not involved in assessment and progression decisions might keep in contact with the student and be an obvious source of support at times of need.

Attempts to monitor students' performance and to identify early when they are faltering are to be commended. Students who are not attending or whose grades are falling off need to be investigated but this investigation needs to ascertain whether the student is ill or whether there are potential disciplinary problems. Particular care should be taken when investigating faltering performance of students with a known history of mental health problems.

## Chapter 6: Discussion

---

### Introduction

The process model (see, figure 2) that we developed as a structure to our main data collection proved to give an incomplete picture of provision of support services for medical students with mental health problems. Although staff at every medical school we interviewed and visited were aware of the difficulties experienced by medical students with mental health problems and every school was striving to address them there remain major barriers that we did not anticipate. Evidence from the systematic review and interviews with students and school and university staff showed that medical students have major concerns about the consequences of revealing a mental illness on their subsequent career.

We have added 3 new elements to the process model (see, figure 3). Two new boxes (coloured in blue) represent major barriers to identification and referral. Students' fears for their career prevent them from effectively identifying that they have a mental health problem and from getting referred to the support services that they need.

Having identified this significant barrier the emphasis for prevention (Box in red) also has to change to overcome these barriers (Dyrbye et al., 2005), to address students' fears and to provide services that students will find acceptable and use.

Our findings, mainly based on what students told us, but backed up by findings from the systematic review and data from staff can be summed up as follows:

- Medical students will, if they can, conceal any illness from their medical school because they think this will be perceived as weakness or result in the end of their career in medicine
- Medical students who have a health problem choose to consult friends and family first and medical school much later if not last
- Fears for their future career is currently stopping medical students from getting timely help for mental health disorders
- Some medical students have mental health problems, some of these severe, when they are admitted to medical school. Most do not disclose their illness because they fear that this will result in them not being admitted
- Medical students are wary of disclosing mental illness to their GP and to generic university support services because of concerns about [lack of] confidentiality.

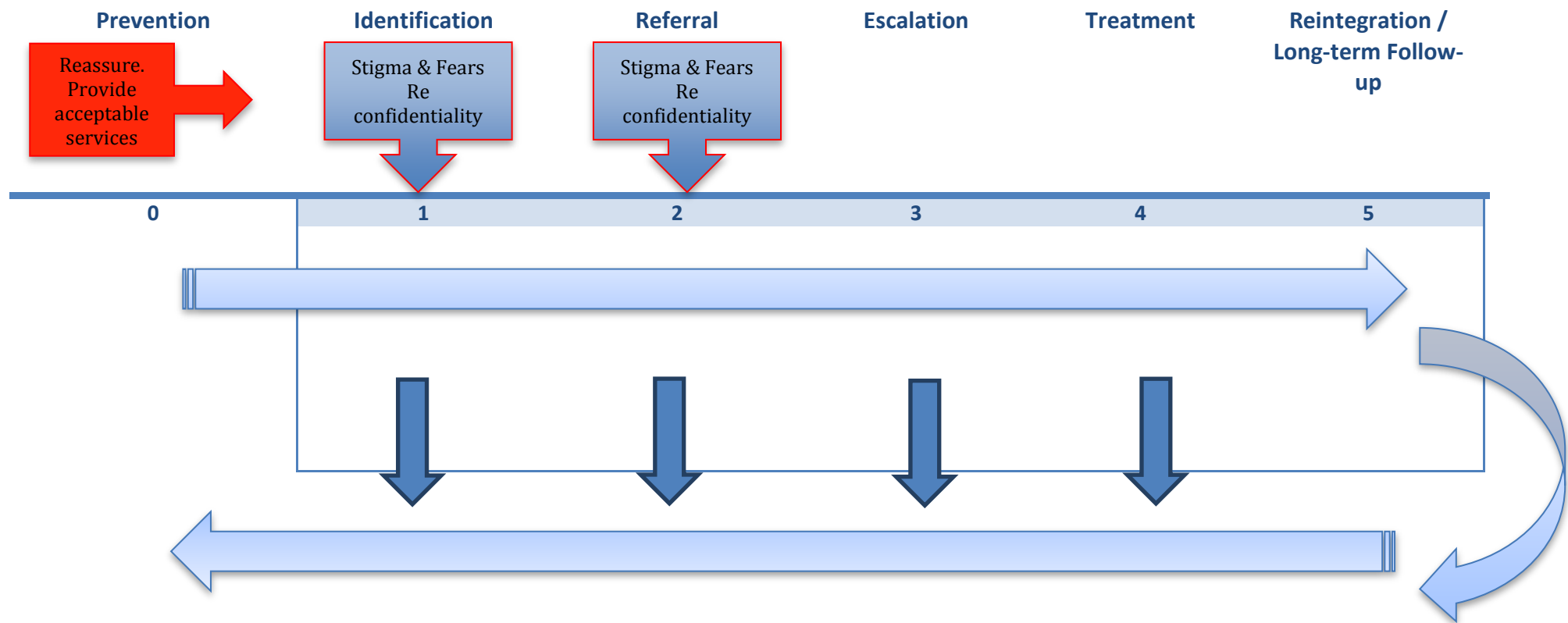


Figure 3: Revised process model to include effects of stigma and student fears around confidentiality

Chapter 4 examined the rationale for the way medical schools have responded to the problem. In it we concluded that two types of service are on offer, neither of which is fully trusted by students and that this is adding to the problem. While there are understandable reasons why medical schools have taken on the burden of support for students, and many examples of good practice, this may add to the stigma of mental ill health. Similarly, while generic student support services are more trusted, they are also seen, by medical students as offering less medically based solutions and taken together with the trust issue, creates a tension for students which adds to reluctance and reticence.

Chapter 3 described in more detail what support is on offer and how it is organised. Chapter 5 provided some graphic examples of the serious problems that students can encounter and the consequences of cultural and systems failures to support them but also how support has led to reintegration and success. All the students interviewed were continuing their medical studies and some were achieving excellent grades.

This leads to a conclusion that while individual elements are clearly working, and individually show great promise for further development, the way support is currently configured is unlikely to redress the fundamental and strongly-held belief that mental ill health is a significant threat to having a medical career.

Both the perceived threat and the behaviours that flow from it need to be eradicated. The current prevailing view of mental health and the reluctance of students to admit to problems could be replaced by a more realistic and positive one which results in engaging students in looking after their own and fellow students wellbeing. Fear and very reluctant compliance need to be replaced by normalisation and reciprocity.

### **What we propose**

Achieving this reversal can only be achieved through a combination of:

- Three high level policy clarifications
- Some practical micro-system change based on
- Guiding principles derived from the evidence of what works.

### **Policy clarification 1**

Public messaging needs to change to reflect mental health problems being normal and:

- Common – in fact more prevalent in medical students
- Expected – a fact of life
- Planned for – reflected in flexibilities in training.

This message needs to be given and reinforced at every stage of a student's career and particularly at times of high-stakes assessment and transition. It also needs to be disseminated more widely to the medical profession.

### Policy clarification 2

Policy needs to reflect the power differences that exist in the relationship between a medical school and its students not. In organising and providing support for their students medical schools need to ensure that it is

- Independent
- Routine
- Accessible
- Timely
- Confidential
- Trustworthy (in the students' perception)

Students must have access to services knowing that only in very exceptional circumstances will medical school staff be aware of their contact with those services. This means providing some clear distance between those who support and those who make judgements about performance and progression. University support services tend to have more credibility than medical school services for this reason.

### Policy clarification 3

Student mental health is a joint responsibility. Students have responsibility to look after their own health, medical schools & universities have a responsibility to support them. Students have the right to the same access to health care as any member of the public: institutions have a right to know if a student is at risk or poses a risk to others. Institutions cannot provide support for a student whose illness has been concealed from them, much less protection for the public.

Students need to be given a clear message that:

- Many people with a mental illness have a successful career in medicine
- Only in very exceptional circumstances do students or doctors leave the profession because of mental health problems
- Medical school and university services are there to help
- Appropriate adjustments can be made.

These are preconditions for a reciprocal duty for students to seek the help and support they need with any health issue. As a bonus, students have a great deal to offer in terms of prevention, mutual support and resilience.

## **Evidence based principles reflected in good practice**

In addition to the policy clarifications above we have identified the following principles of good practice from our examination of the literature and from the data we have collected.

### **1. Positive model of mental health**

**Objective:** Mental illness should not be a barrier to practicing medicine: appropriate adjustment, not rejection or exclusion from the medical course, should be the expectation.

**Evidence:** While mental illness among medical students is a fact of life; the majority of sufferers recover fully and continue on the course.

### **2. Independent advice and support**

**Objective:** The need for independence of help and support, free from conflicts of interests about academic and other judgements, is paramount.

**Evidence:** Students are more likely to access medical help, and to access it early, if it is genuinely independent from those who make decisions about performance, progression and Fitness to Practise issues.

### **3. A nurturing, supportive learning environment**

**Objective:** Medical students and medical education are best served by building a supportive organisational environment in which people are valued, learning is rewarded and the rules are clear and fair.

**Evidence:** While high workload and contact with illness, dying and death are often cited as reasons for increased risk of mental illness other factors such as unnecessary competition and unclear parameters about workload and assessments are known to exacerbate the risk and can be remedied.

### **4. Transparency and trust**

**Objective:** Systems, rules and procedures need to encourage students with mental health issues to access help early. This requires them to be clear and equitable and above all trusted.

**Evidence:** Systems designed around an informal 'each case on its merits' approach are not trusted or seen as credible.

### **5. Continuity of support**

**Objective:** Students should have one named individual coordinating their support and be actively involved in decisions that affect them

**Evidence:** Continuity and coordination of support is a major factor in achieving a successful outcome for a student with mental health issues,



including the decision to change career direction. Such continuity is best provided by a case management approach involving multi-disciplinary/agency review and planning and where students are involved in decisions about them.

## ESSENTIALS FOR DELIVERY

To complement the policy clarifications and principles of good practice we have set out here some practical steps, identified throughout this review designed to assist the delivery of improved support for medical students with mental health problems. Delivery of change depends on having strengths in four key areas:

The responsible tutor  
 An occupational health approach  
 Proportionate, transparent monitoring  
 The responsible student.

All four areas need to be addressed.

**Table 15: Key areas for delivery of change**

The Responsible Tutor	An occupational health approach	Proportionate transparent Monitoring	The Responsible Student
TRAINED	CLEARLY DEFINED PROCESSES	QUALITY CONTROLLED	TRAINED SUPPORTED
REQUIREMENTS	REQUIREMENTS	REQUIREMENTS	REQUIREMENTS
Appropriate training. Available facilities & lines of referral Supported by school (über tutor). Able to refer on. Very clear role with limits. Role valued by institution, included in job planning etc.	Good working relationship between school and occupational health dept. Clearly-written process. Confidentiality maintained except in very exceptional circumstances.	Good systems where detection of performance problems are routine. Removal of any knowledge/interest in students' illnesses by clinicians who teach them.	Train as a peer supporter but accept this makes student better at supporting themselves (Hillis 2012). Modest facilities. Students' initiatives supported by school.

## The responsible tutor

We found effective personal tutoring at the core of all medical schools' provision of support so we make the following recommendations based on good practice exemplars identified from the research and make suggestions that may be useful when schools are reviewing their personal tutor system.

### Selection

1. A clear set of criteria for the skills and attributes of a personal tutor
2. Volunteers or better still willing personnel selected/invited due to their matching a clear set of criteria. People who are willing, able and available.

### The Role

1. A clear set of role definitions (aims, objectives, outputs, success criteria); is this role primarily academic only, pastoral only or both?
2. Clear guidance on the boundary of the role e.g. what is the personal tutor tasked with doing (listening or advising? Trouble-shooting and support? Suggesting action for other issues? Encouraging student self-referral?)
3. When/in what situations must the tutor refer the student on?
4. How frequently will the personal tutor change?
5. If/when there is a change, who will provide continuity of care e.g. medical school support team/University Student Support Services?

### Training

Compulsory training for tutors:

1. Two to three workshops a year
2. A different focus for each workshop
3. Scenario, case-based workshop generating discussion and possible courses of action
4. Training and advice on how to refer and what counselling services etc. can offer.

### Limit the number of students per Tutor

Limit the number of students per tutor, 8-12 annually is suggested.

### Make personal tutor contact compulsory

1. Provide clear guidance on the number of times that a tutor and student must meet e.g.
  - Start of year introductory meeting
  - Mid-year progression review and feedback meeting
  - End of year progression review and feedback meeting
2. Stipulate dates 'by when' the student must have met with their personal tutor
3. Develop a systematic meeting format/content driven by a 'session log' which must be completed during each session.

### Things to consider

- What supports are available /contact details etc.?
- Would something like a handbook for tutor and complementary student version be useful? E.g. outlining the importance of the meeting, the process, what students can expect to get from the meetings, a list of internal and external contacts
- Who makes first contact?
- How many times per annum should the meetings be scheduled?
- Ad hoc meetings: how many 'additional' meetings is too frequent and actually signals need to refer?
- Should the meeting become part of the student's wider 'progression review' metrics?

### An occupational health approach

It is essential to recognise the potential conflict that could be caused by medical schools, many of whose staff are medically qualified, becoming involved in the clinical care of their students. Following an occupational health model (see, figure 4) students should have an assessment of their illness and the need for adjustments this places on their working environment carried out by a third party, an occupational health unit, which is separate from the medical school. Discussion about student illness should be no different with medical school staff than with staff in any other school in the university. The Occupational Health unit can then make recommendations without any person in the medical school needing to know the diagnosis or details of the illness. This model can also be applied to admissions.

The message needs to be given, and is much better given face-to-face, than not declaring a mental health problem at admission is not an option but that an appointment can be made with the Occupational Health without any disclosure of the nature of the illness to school staff. Elsewhere in this report we have supported the provision of a personal tutor with as much continuity as possible in the student's time at medical school. It is likely that the personal tutor will be, in many cases, the member of medical school staff to whom students are most likely to reveal a mental health problem. It is highly desirable that students should feel comfortable about discussing their problems openly with their personal tutor. If a student reveals a health problem the personal tutor should refer them to the Occupational Health unit thereby removing the need for any other, more senior, member of medical staff having any information about the illness other than any adjustments deemed necessary.

Our data suggests that core medical school staff are realistic and on message about mental illness in medical students. The schools need, however, to find out and address the messages that are being given both overtly and covertly, for example when students are on clinical placement. These may include:

1. Mental illness = weakness
2. People with mental illness have no place in medicine
3. The way to behave when ill is to come in to work come what may (presenteeism).

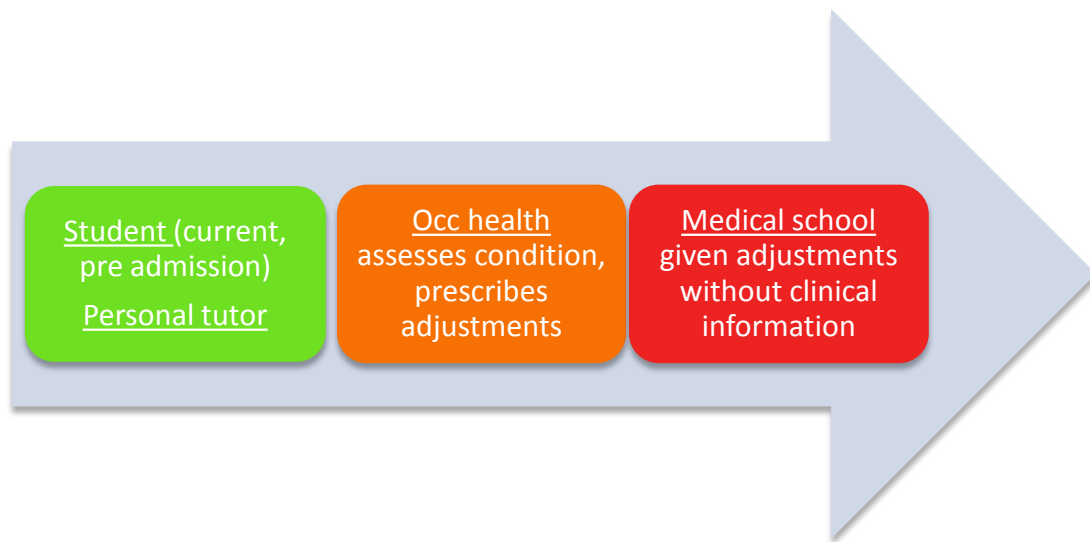
### **Proportionate, transparent monitoring**

Our recommendations in this section have focussed so far on creating an environment where medical students feel safe revealing and asking for help with mental health problems. We have said that it is important that mental illness is seen as a part of life for some medical students and that facilities are in place in readiness to help those students who need it. Many medical schools have systems in place that make it possible to identify early those students who are faltering in their academic progress whatever the cause. For example, support for students via mental illness performance monitoring should be normalised into medical school life. An enquiry about a student's performance should be perceived as a supportive medical school enquiring whether they are experiencing difficulties of any kind and whether the medical school can offer support or refer to an outside agency that can.

### **The responsible student**

Medical students turn first to their peers when they are in need of support. Focus group participants and medical school staff were in no doubt about this. It is also no accident that some of our examples of good practice are student led, peer support initiatives, often run on shoestring budgets and meeting both immediate and longer-term needs. Some initiatives, such as students having a student in the year above acting as a mentor involve large numbers working across year groups, while others involve smaller numbers but require training and the development of new skills (for instance, Nightline, an out of hours telephone crisis helpline attracts large numbers of medical student volunteers).

**Figure 4: Flow diagram showing referral by student and personal tutor, assessment by Occupational Health unit and appropriate information given to medical school**



There is evidence that training volunteers not only helps them to better help others but also has a positive impact on the personal resilience of those trained (Hillis et al., 2012). Providing some very simple training for every medical student on helping a fellow student in need of support could be part of a professional development course and would cover:

- The range and prevalence of mental health issues encountered by medical students
- The reluctance of medical students to seek help
- Sources of help and support
- Staying within the boundaries of being a supportive friend.

Students told us that case histories/scenarios, discussed in small groups, would be a popular and effective way of delivering such training.

## Chapter 7 – Conclusions and a vision of good practice with links to examples

---

In this final chapter we will use the revised process model to describe a vision of good practice in relation to supporting medical students with mental health problems.

### Prevention

#### Conclusions

The core of prevention of mental ill-health among medical students demands openness about mental illness in general and its prevalence among medical students in particular. In the systematic review we have presented numerous attempts to engage medical students in activities designed to offset the effects of medical school life that make them prone to stress, burnout and mental illness.

#### Vision

Although the activities offered in each of these initiatives is laudable and each evaluation suggests that the participants have benefitted the real value may be in the activity being offered at all. The message from their medical school that stress and burnout are common and that students should think of ways to counter this is powerful. Moreover, some student bodies have developed highly imaginative interventions to help their fellow students combat stress and recognise mental illness when it occurs.

#### Example

Feel Bright Scheme, p. 79

### Identification

In this section we will include identification by the student themselves that a mental health problem exists as well as identification by the institution that a student has a problem and is in need of support and/or appropriate adjustments.

#### Conclusion

Our work has shown, from multiple sources, that medical students are reluctant to reveal a mental health problem because of fears for their career. There appears to be no factual evidence to show that this is, indeed the case but the belief is held widely and strongly nonetheless. This calls for action in two, separate ways. There have been efforts in medical schools led by students and staff to undo the damage caused by this unfounded belief. These efforts demonstrate that mental illness is something to be expected, is normal and as long as students (and doctors) get the medical support they need then it need not be a hindrance to a successful career.

This alone will probably not be enough to ensure that all medical students with mental health problems get access to the support and the healthcare they need.

Efforts to date to convince students that they can and should disclose a mental illness have not met with much success.

### **Vision**

We propose that medical students should be able to access health care with only the minimum possible information about their illness being disclosed to their medical schools and that this is done via an Occupational Health unit. In most cases it should be sufficient, where any information needs to be disclosed to the medical school at all, that the medical school is informed that the student has a medical condition for which certain adjustments need to be made.

Online, written and face-to-face services that enable students to find out whether they have a mental health problem are an excellent resource that students can approach without fears about confidentiality.

Performance monitoring by medical schools should be routine and seen as supportive not punitive

### **Examples**

Student card scheme p.55, Online self-help p.24

### **Referral**

Again this section refers both to students referring themselves for the support they need and being referred by professionals.

### **Conclusion**

In the case of self-referral it is vital that students feel that they can access the care that they need without prejudicing their career. Medical schools give their students the message that they do not need to know about students' health problems unless their ability to do work is affected or patients are put at risk. Students who are taking the necessary steps to get treatment for their mental health problem are complying with the need to ensure that their health does not compromise their work or the safety of the patients they see.

### **Vision**

For students whose mental health problem is known to medical school staff it is important to be clear about lines of referral. Medical students should be referred to university support staff. Where clinical care is required the student should be supported to access this from the NHS via their General Practitioner. Clinical referrals from medical school staff directly to practitioners should be avoided. The medical school staff member's role should be kept clearly as that of university tutor and not as clinician caring for the student. Where there are concerns about the student's ability or safety to continue in their studies or where adjustments are necessary all clinical assessment and communication with clinicians involved in the students care should be carried out by the Occupational Health unit. Medical school staff should make efforts to form a working relationship with their Occupational Health colleagues.

### Example

Case worker approach p.98

## Escalation

### Conclusions

Some of the students in this study revealed how the decision for them to take a year's leave of absence was very difficult. One student, in particular, said it was the lowest point in her episode of illness.

### Vision

We encourage medical schools to have a procedure beyond the necessary filling of university forms that is required in order for a student to take interruption of studies. It is important to determine whether the student is going to be supported by family or friends and where they are going to stay, particularly in the first few days after this decision has been made.

### Example

Case study FS4 p.90

## Treatment

### Conclusions

Students known to be unwell but remaining at their studies will need multidisciplinary support. Students who have taken interruption of studies may or may not wish to have regular contact with medical school staff.

### Vision

Some medical schools have a disability officer and some employ case workers. These people act as the student's main point of contact with the school although other professionals will be involved. The disability officer/case worker will not usually have any disciplinary or progression involvement and they need not divulge any information about the student's illness to other medical school staff.

It is important for somebody on behalf of the school of medicine to determine the contact that is desirable with students on leave of absence. Clearly a student who is acutely ill may not want any contact but it is clear that once a period of convalescence is reached students may be pleased to have some contact and discussion about their return.

### Example

Case worker p.98



## **Reintegration**

### **Conclusion**

Almost all medical students who suffer from mental health problems recover and return to their studies. It is very important that students return, especially when they have taken leave of absence, that their return is planned. For some students this is a very difficult time. Although, some medical school staff members told us that the students were returning to a new cohort along with many other students who had intercalated and changed year cohorts some of the students still found this time very difficult.

### **Vision**

A case worker or disability officer that is able to meet the student, find out their concerns and arrange their return accordingly can make this time much easier. Some students have left after a period of illness and then been away sometimes for more than a year. Not surprisingly their confidence in general and in their clinical skills in particular is low. A clinical attachment before the formal return to clinical studies with an allocated tutor helped these students a great deal.

### **Example**

Case study FS6 p.92

### **Final conclusion**

Mental ill-health will continue to be an issue among medical students and among the population at large as it is endemic. However, treatment, recovery and reintegration need not continue to be if there is a change of vision and practice.

## References

- ABRAMOVITCH, H., SCHREIER, A. & KOREN, N. 2000. American medical students in Israel: stress and coping - a follow-up study. *Medical Education*, 34, 890-896.
- AHMED, I., BANU, H., AL-FAGEER, R. & AL-SUWAIDI, R. 2009. Cognitive emotions: depression and anxiety in medical students and staff. *Journal of Critical Care*, 24, e1-7.
- ALISON, H., SCRIBANTE, L. & KRUGER, C. 2008. Medical students' perceptions of accessibility and barriers to the utilisation of the University of Pretoria's support systems. *Afr J Psychiatry*, 11, 276 - 281.
- AUSTENFELD, J. L., PAOLO, A. M. & STANTON, A. L. 2006. Effects of writing about emotions versus goals on psychological and physical health. *Journal of Personality*, 74, 267-286.
- BALL, S. & BAX, A. 2002. Self-care in medical education: Effectiveness of health-habits interventions for first-year medical students. *Academic Medicine*, 77, 911-917.
- BENBASSAT, J., BAUMAL, R., CHAN, S. & NIREL, N. 2011. Sources of distress during medical training and clinical practice: Suggestions for reducing their impact. *medical Teacher*, 33, 486-490.
- BLOODGOOD, R., SHORT, J., JACKSON, J. & MARTINDALE, J. 2009. A change to pass/fail grading in the first two years at one medical school results in improved psychological well-being. *Acad Med*, 84, 655-662.
- BRAZEAU, C. M. L. R. 2010. The surest way to prevent burnout in medical school and beyond. *Acad Med*, 85, 569 - 570.
- BRIMSTONE, R., THISTLETHWAITE, J. E. & QUIRK, F. 2007. Behaviour of medical students in seeking mental and physical health care: exploration and comparison with psychology students. *Medical Education*, 41, 74-83.
- BUGHI, S. A., SUMCAD, J. & BUGHU, S. 2006. Effect of brief behavioral intervention program in managing stress in medical students from two Southern California universities. *Med educ Online*, 11, 1-8.
- BUNEVICIUS, A., KATKUTE, A. & BUNEVICIUS, R. 2008. SYMPTOMS OF ANXIETY AND DEPRESSION IN MEDICAL STUDENTS AND IN HUMANITIES STUDENTS: RELATIONSHIP WITH BIG-FIVE PERSONALITY DIMENSIONS AND VULNERABILITY TO STRESS. *International Journal of Social Psychiatry*, 54, 494-501.
- CHEW-GRAHAM, C. A., ROGERS, A. & YASSIN, N. 2003. 'I wouldn't want it on my CV or their records': medical students' experiences of help-seeking for mental health problems. *Medical Education*, 37, 873-880.
- COMPTON, M. T., CARRERA, J. & FRANK, E. 2008. Stress and depressive symptoms/dysphoria among US medical students: results from a large, nationally representative survey. *Journal of Nervous & Mental Disease*, 196, 891-7.
- CURRAN, T. A., GAWLEY, E., CASEY, P., GILL, M. & CRUMLISH, N. 2009. Depression, suicidality and alcohol abuse among medical and business students. *Irish Medical Journal*, 102, 249-52.

- DAHLIN, M., JONEBORG, N. & RUNESON, B. 2005. Stress and depression among medical students: a cross-sectional study. *Medical Education*, 39, 594-604.
- DAHLIN, M. E. & RUNESON, B. 2007. Burnout and psychiatric morbidity among medical students entering clinical training: a three year prospective questionnaire and interview-based study. *BMC Medical Education*, 7, 6.
- DE OLIVEIRA E SOUSA LEAO, P. B., NOGUEIRA MARTINS, L. A., MENEZES, P. R. & BELLODI, P. L. 2011. Well-being and help-seeking: an exploratory study among final-year medical students. *Revista Da Associacao Medica Brasileira*, 57, 379-386.
- DROLET, B. C. & RODGERS, S. 2010. A Comprehensive Medical Student Wellness Program-Design and Implementation at Vanderbilt School of Medicine. *Academic Medicine*, 85, 103-110.
- DUNN, L. B., IGLEWICZ, A. & MOUTIER, C. 2008. A conceptual model of medical student well-being: Promoting resilience and preventing burnout. *Academic Psychiatry*, 32, 44-53.
- DYRBYE, L. N., SCHWARTZ, A., DOWNING, S. M., SZYDLO, D. W., SLOAN, J. A. & SHANAFELT, T. D. 2011. Efficacy of a Brief Screening Tool to Identify Medical Students in Distress. *Academic Medicine*, 86, 907-914.
- DYRBYE, L. N. & SHANAFELT, T. D. 2011. Medical Student Distress: A Call to Action. *Academic Medicine*, 86, 801-803.
- DYRBYE, L. N., SZYDLO, D. W., DOWNING, S. M., SLOAN, J. A. & SHANAFELT, T. D. 2010. Development and preliminary psychometric properties of a well-being index for medical students. *BMC Medical Education*, 10.
- DYRBYE, L. N., THOMAS, M. R., HARPER, W., MASSIE, F. S., JR., POWER, D. V., EACKER, A., SZYDLO, D. W., NOVOTNY, P. J., SLOAN, J. A. & SHANAFELT, T. D. 2009. The learning environment and medical student burnout: a multicentre study. *Medical Education*, 43, 274-282.
- DYRBYE, L. N., THOMAS, M. R. & SHANAFELT, T. D. 2005. Medical student distress: Causes, consequences, and proposed solutions. *Mayo Clinic Proceedings*, 80, 1613-1622.
- DYRBYE, L. N., THOMAS, M. R. & SHANAFELT, T. D. 2006. Systematic review of depression, anxiety, and other indicators of psychological distress among U.S. and Canadian medical students. *Academic Medicine*, 81, 354-73.
- ENNS, M. W., COX, B. J., SAREEN, J. & FREEMAN, P. 2001. Adaptive and maladaptive perfectionism in medical students: a longitudinal investigation. *Medical Education*, 35, 1034-1042.
- EY, S., HENNING, K. & SHAW, D. 2000. Attitudes and factors related to seeking mental health treatment among medical and dental students. *J Coll Student Psychother*, 14, 23-39.
- FINKELSTEIN, C., BROWNSTEIN, A., SCOTT, C. & LAN, Y. 2007. Anxiety and stress reduction in medical education: an intervention. *Med Educ*, 41, 258-264.
- GABER, R. & MARTIN, D. 2002. Still-Well osteopathic medical student wellness program. *J Am Osteopath Assoc.*, 102, 289-292.
- GENTILE, J. P. & ROMAN, B. 2009. Medical student mental health services: psychiatrists treating medical students. *Psychiatry (Edgmont (Pa. : Township))*, 6, 38-45.
- GIGERENZER, G. 2003. *Reckoning with Risk*, London, Penguin Books.

- GIVENS, J. L. & TJIA, J. 2002. Depressed medical students' use of mental health services and barriers to use. *Academic Medicine*, 77, 918-921.
- GOEBERT, D., THOMPSON, D., TAKESHITA, J., BEACH, C., BRYSON, P., EPHGRAVE, K., KENT, A., KUNKEL, M., SCHECHTER, J. & TATE, J. 2009. Depressive Symptoms in Medical Students and Residents: A Multischool Study. *Academic Medicine*, 84, 236-241.
- HASSED, C., DE LISLE, S., SULLIVAN, G. & PIER, C. 2009. Enhancing the Health of Medical Students: Outcomes of an Integrated Mindfulness and Lifestyle Program. *Advances in Health Sciences Education*, 14, 387-398.
- HENNING, M. A., HAWKEN, S. J. & HILL, A. G. 2009. The quality of life of New Zealand doctors and medical students: what can be done to avoid burnout? *Journal of the new Zealand Medical Association*, 122, 102-10.
- HILLIS, J., MORRISON, S., ALBERICI, F., REINHOLZ, F., SHUN, M. & JENKINS, K. 2012. 'Care Factor': Engaging medical students with their well-being. *medical Education (Really Good Stuff)*, 46, 509-510.
- HILLIS, J. M., PERRY, W. R. G., CARROLL, E. Y., HIBBLE, B. A., DAVIES, M. J. & YOUSEF, J. 2010. Painting the picture: Australasian medical student views on wellbeing teaching and support services. *Medical Journal of Australia*, 192, 188-190.
- HOLM, M., TYSSEN, R., STORDAL, K. I. & HAVER, B. 2010. Self-development groups reduce medical school stress: a controlled intervention study. *BMC Medical Education*, 10.
- HOLM, M., TYSSEN, R. & HAVER, B. 2007. Prevention of mental health problems among future doctors: A controlled group intervention study among medical students in Bergen. *European Psychiatry*, 22, S274-S274.
- HOOPER, C., MEAKIN, R. & JONES, M. 2005. Where students go when they are ill: how medical students access health care. *Med Educ*, 39, 588-93.
- HOWE, A., SMAJDOR, A. & STOCKL, A. 2012. Towards an understanding of resilience and its relevance to medical training. *Medical Education*, 46, 349.
- JADOON, N. A., YAQOOB, R., RAZA, A., SHEHZAD, M. A. & ZESHAN, S. C. 2010. Anxiety and depression among medical students: a cross-sectional study. *JPMA - Journal of the Pakistan Medical Association*, 60, 699-702.
- KUSHNER, R. F., KESSLER, S. & MCGAGHIE, W. C. 2011. Using Behavior Change Plans to Improve Medical Student Self-Care. *Academic Medicine*, 86, 901-906.
- LAU, K. S., SIONG, K. H., TANG, H. Y., CHENG, P. W., CHEUNG, K. S., CHAN, S. W., LEE, P. W. H. & WONG, J. G. W. S. 2007. An innovative web-based peer support system for medical students in Hong Kong. *Medical Teacher*, 29, 984-986.
- LEE, J. & GRAHAM, A. 2001. Students' perception of medical school stress and their evaluation of a wellness elective. *Med Educ*, 35, 617-8.
- LOUIE, A., COVERDALE, J. & ROBERTS, L. W. 2007. Balancing the personal and the professional: should and can we teach this? *Academic Psychiatry*, 31, 129-32.
- MELO-CARRILLO, A., VAN OUDENHOVE, L. & LOPEZ-AVILA, A. 2012. Depressive symptoms among Mexican medical students: High prevalence and the effect of a group psychoeducation intervention. *Journal of Affective Disorders*, 136, 1098-1103.
- MERCER, A., WARSON, E. & ZHAO, J. 2010. Visual journaling: An intervention to influence stress, anxiety and affect levels in medical students. *Arts in Psychotherapy*, 37, 143-148.

- MOUTIER, C., NORCROSS, W., JONG, P., NORMAN, M., KIRBY, B., MCGUIRE, T. & ZISOOK, S. 2012. The suicide prevention and depression awareness program at the University of California, San Diego School of Medicine. *Acad Med*, 87, 320-6.
- NUZZARELLO, A. & GOLDBERG, J. H. 2004. How perceived risk and personal and clinical experience affect medical students' decisions to seek treatment for major depression. *Academic Medicine*, 79, 876-881.
- RADCLIFFE, C. & LESTER, H. 2003a. Perceived stress during undergraduate medical training: a qualitative study. *MEDICAL EDUCATION*, 37, 32-38.
- RADCLIFFE, C. & LESTER, H. 2003b. Perceived stress during undergraduate medical training: a qualitative study. *Medical Education*, 37, 32-38.
- RAKEL, D. & HEDGECOCK, J. 2008. Healing the healer: a tool to encourage student reflection towards health. *medical Teacher*, 30, 633 - 635.
- REDWOOD, S. & POLLAK, M. 2007. Student-led stress management program for first-year medical students. *Teach Learn Med.*, 19, 42-4.
- REED, D., DYRBYE, L., SZYDLO, D. & SHANAFELT, T. 2009. Pass-fail grading is associated with enhanced well-being among medical students: A multi-institutional study. *J Gen Intern Med*, 2009, 132.
- REYNOLDS, C. F., III & CLAYTON, P. J. 2009. Commentary: Out of the Silence: Confronting Depression in Medical Students and Residents. *Academic Medicine*, 84, 159-160.
- ROBERTS, L., WARNER, T., CARTER, FRANK, E., GANZINI, L. & LYKETSOS, C. 2000a. Caring for Medical Students as Patients: Access to Services and Care-seeking Practices of 1,027 Students at Nine Medical Schools. *Academic Medicine*, 75, 272 - 277.
- ROBERTS, L. W. 2010. Understanding depression and distress among medical students. *JAMA*, 304, 1231-1233.
- ROBERTS, L. W., WARNER, T. D., LYKETSOS, C., FRANK, E., GANZINI, L. & CARTER, D. 2001a. *Perceptions of academic vulnerability associated with personal illness: A study of 1,027 students at nine medical schools* [Online]. Netherlands: Elsevier Science
- Netherlands. Available:  
<http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=psyc3&NEWS=N&AN=2001-16347-001> [Accessed Aoun, H. (1989). When a house officer gets AIDS. *N Engl J Med* 1989; 321: 693-696. 42].
- ROBERTS, L. W., WARNER, T. D., LYKETSOS, C., FRANK, E., GANZINI, L. & CARTER, D. 2001b. Perceptions of academic vulnerability associated with personal illness: A study of 1,027 students at nine medical schools. *Comprehensive Psychiatry*, 42, 1-15.
- ROBERTS, L. W., WARNER, T. D. & TRUMPOWER, D. 2000b. Medical students' evolving perspectives on their personal health care: Clinical and educational implications of a longitudinal study. *Comprehensive Psychiatry*, 41, 303-314.
- ROH, M.-S., JEON, H. J., KIM, H., HAN, S. K. & HAHM, B.-J. 2010. The Prevalence and Impact of Depression Among Medical Students: A Nationwide Cross-Sectional Study in South Korea. *Academic Medicine*, 85, 1384-1390.

- ROHE, D., BARRIER, P., CLARK, M., COOK, D., VICKERS, K. & DECKER, P. 2006. The benefits of pass–fail grading on stress, mood, and group cohesion in medical students. *Mayo Clin Proc*, 81, 1443–1448.
- ROSENTHAL, J. M. & OKIE, S. 2005. White coat, mood indigo - Depression in medical school. *New England Journal of Medicine*, 353, 1085-1088.
- ROSENZWEIG, S., REIBEL, D., GREESON, J., BRAINARD, G. & HOJAT, M. 2003. Mindfulness based stress reduction lowers psychological distress in medical students. *Teach Learn Med*, 15, 88-92.
- ROSS, S., CLELAND, J. & MACLEOD, M. J. 2006. Stress, debt and undergraduate medical student performance. *Medical Education*, 40, 584-589.
- SAADAT, H., LIN, S. L. & KAIN, Z. N. 2010. The role of "wellness" in medical education. *International Anesthesiology Clinics*, 48, 131-8.
- SCHWENK, T. L., DAVIS, L. & WIMSATT, L. A. 2010. Depression, stigma, and suicidal ideation in medical students. *JAMA*, 304, 1181-90.
- SEN, S., KRANZLER, H. R., KRYSTAL, J. H., SPELLER, H., CHAN, G., GELERNTER, J. & GUILLE, C. 2010. A prospective cohort study investigating factors associated with depression during medical internship. *Archives of General Psychiatry*, 67, 557-65.
- SHAPIRO, S. L., SHAPIRO, D. E. & SCHWARTZ, G. E. 2000. Stress management in medical education: A review of the literature. *Academic Medicine*, 75, 748–759.
- SIMARD, A.-A. & HENRY, M. 2009. Impact of a short yoga intervention on medical students' health: A pilot study. *Medical Teacher*, 31, 950-952.
- SLAVIN, S. J., HATCHETT, L., CHIBNALL, J. T., SCHINDLER, D. & FENDELL, G. 2011. Helping medical students and residents flourish: A path to transform medical education. *Acad Med*, 86, e15.
- SPRING, L., ROBILLARD, D., GEHLBACH, L. & SIMAS, T. A. M. 2011. Impact of pass/fail grading on medical students' well-being and academic outcomes. *Medical Education*, 45, 867-77.
- SREERAMAREDDY, C. T., SHANKAR, P. R., BINU, V. S., MUKHOPADHYAY, C., RAY, B. & MENEZES, R. G. 2007. Psychological morbidity, sources of stress and coping strategies among undergraduate medical students of Nepal. *BMC Medical Education*, 7, 26.
- TENNANT, C. C. 2002. A student mental health and welfare program in a medical faculty. *Medical Journal of Australia*, 177, S9-S10.
- THISTLETHWAITE, J. & QUIRK 2010.
- THOMPSON, D., GOEBERT, D. & TAKESHITA, J. 2010. A Program for Reducing Depressive Symptoms and Suicidal Ideation in Medical Students. *Academic Medicine*, 85, 1635-1639.
- TJIA, J., GIVENS, J. L. & SHEA, J. A. 2005. Factors associated with undertreatment of medical student depression. *Journal of American College Health*, 53, 219-224.
- TYSSEN, R., DOLATOWSKI, F. C., ROVIK, J. O., THORKILDSEN, R. F., EKEBERG, O., HEM, E., GUDE, T., GRONVOLD, N. T. & VAGLUM, P. 2007. Personality traits and types predict medical school stress: a six-year longitudinal and nationwide study. *Medical Education*, 41, 781-787.

- WARNECKE, E., QUINN, S., OGDEN, K., TOWLE, N. & NELSON, M. R. 2011. A randomised controlled trial of the effects of mindfulness practice on medical student stress levels. *Medical Education*, 45, 381-388.
- WENGRAF, T. 2001. *Qualitative Research Interviewing: Biographic Narrative and Semi-structured Methods*, London, Sage.
- WENGRAF, T. 2008. Life-histories, lived situations and ongoing personal experiencing: The Biographic-Narrative Interpretive Method (BNIM). Guide to BNIM interviewing and interpretation. London: London East Research Institute, University of East London, UK.
- WILHELM, K. A. 2002. The student and junior doctor in distress. *MJA*, 177 Suppl, S5-8.
- WILLCOCK, S. M. 2002. Reports from breakout groups. *MJA*, 177 Suppl, S30-1.
- YATES, J. 2011. Development of a 'toolkit' to identify medical students at risk of failure to thrive on the course: an exploratory retrospective case study. *BMC Medical Education*, 11.
- YATES, J., JAMES, D. & ASTON, I. 2008. Pre-existing mental health problems in medical students: a retrospective survey. *Medical Teacher*, 30, 319-321.
- YIU, V. 2005. Supporting the well-being of medical students. *Canadian Medical Association Journal*, 172, 889-890





# Appendices

## Studies of support provided for medical students worldwide with mental health concerns, including interventions

### Literature identified

IL = Israel; ZA = South Africa; US = United States; AT = Australia; SE = Sweden; UK = United Kingdom; BR = Brazil; CA = Canada; NO = Norway; MX = Mexico; PK = Pakistan

		Context			Methods		Results
	Study	Country	Type of paper (empirical, editorial, letter etc)	Type of mental health issue	Aim	Study design	Effectiveness of support system/intervention
1.	Abramovich et al. (2000) (1)	IL	Empirical - questionnaire study/follow up	Stress	To evaluate the impact of changes made in Med school	Before and after	Change had led to improved student mental health and satisfaction and decreased dysfunctional and heavy drinking
2.	Alison et al. (2008)	ZA	Empirical/original article	Major depressive disorder	To evaluate a website set up to help medical students access existing services	Evaluation	Unusually they found lower rates of depression in medical students than among their "other student" control group.  Medical students perceived that accessing

## Appendix 1

					after a class-mate committed suicide.		<p>services was a sign of weakness.</p> <p>There were other "administrative" boundaries</p> <p>The website didn't make any difference to uptake of services.</p>
3.	Austenfeld et al. (2006)	US	Empirical	Psychological health	To compare writing about emotional topics (EMO) to writing about goals as the "best possible self" and evaluate emotional approaches to coping.	Intervention - RCT	<p>In participants with higher baseline hostility, the EMO condition was associated with less hostility at 3 months compared to the BPS and control conditions.</p> <p>This isn't written as a pilot of an intervention to be rolled out for medical students but it would be feasible to use on a large scale.</p>
4.	Ball & Bax (2002)	US	Empirical	Emotional adjustment and depression	To examine effects of an educational intervention promoting self care on the emotional and academic adjustment of first year medical student.	<p>Before and after</p> <p>RCT (of sorts)</p>	<p>Educational intervention promising on changing behaviour.</p> <p>Some intervention, lecture &gt; feedback at the beginning of medical school might help some students to develop health practices that might result in healthier physician behaviour</p>
5.	Benbassat et al. (2011)	IL	Lit review	Distress	To identify common stressors (from the	Narrative review of the literature	They add 2 items to the list of medical stressors. 1. Unrealistic expectations (e.g. to be respected, or to "help people") and 2. the

## Appendix 1

					literature), to add a few more and to suggest ways of reducing the impact of those stressors		disparity between highly biomedical content of a lot of medical training and the biopsychosocial nature of a lot of the work of the medical profession.
6.	Bloodgood et al. 2009	US	Empirical	Satisfaction and psychological wellbeing.	To measure the effects of a change from ABCDF grading to pass fail on students academic performance, achievement at USMLE and gaining residency jobs. Also the effect on Student wellbeing	Intervention	There was no diminution in students' academic performance nor in the USMLE or in securing residency jobs. In the 1st 3 out of 4 semesters measured there was a statistically significant improvement in psychological factors related to; anxiety Depression, positive wellbeing, self control vitality general health.
7.	Brazeau (2010)	US	Letter to editor (Barrier to Healthcare)	Burnout	Share opinion	n/a	Author points out the common sources of physician and medical student stress. Author explains his medical school in NJ already include classes pointing out sources of burnout and its possible consequences. They offer burnout prevention techniques in their classes which the students receive well. Learning to reduce burnout is just another skill needed for a successful life as a clinician.
8.	Brimstone et al. (2006)	AT	Empirical/Research report	All mental health	To define willingness/reluctance to seek help from various sources by	Quantitative comparative study - working with scenarios	Students more likely to seek advice from friends/family with regard to mental or physical health

## Appendix 1

					students in medicine and psychology (undergrad & postgrad).		
9.	Bughi et al. (2006)	US	Empirical	Stress/Anxiety	Effect of program on stress management	Before and after	Intervention led to decrease in reported stress by half and lower anxiety levels and higher positive wellbeing. However, Relatively small numbers . Possible hawthorne effect
10.	Chew-Graham et al. (2003)	UK	Empirical	Stress and distress	To explore the attitudes of medical students to the causes of stress and views on help-seeking.	Qual 22 semi-structured interviews	Students preferred to consult family and colleagues and were afraid of the effects (stigma) if they revealed the weakness of a mental illness or stress. Stigma very prevalent, avoidance of help-seeking starts early.
11.	Dahlin & Runeson (2007)	SE	Empirical	Burnout and psychiatric morbidity	To examine clinically significant psychiatric morbidity and burnout at 3rd year of med school	3 Year prospective interview study. Prospective study. Same cohort in 1st and 3rd years.	Their interview based psychometric testing found 25% had diagnostic levels of mental illness. High burnout was predicted by Impulsivity trait. Depression in 1st year predicted psychiatric morbidity in 3rd year. Impulsivity in 1st year and 3rd year workload were predictors of 3rd year burnout.
12.		BR	Empirical	Wellbeing	To investigate the relationship between wellbeing (including anxiety and depression), perceived needs	Cross sectional survey	A significant proportion of students who reported anxiety depression did not access the student mental health service despite knowing of its existence. Being female or having a higher score for anxiety correlated with likelihood of use of the

## Appendix 1

					and help-seeking among final-year medical students		service.
13.	Dias et al. (2012)	BR	Journalistic piece	Stress	To determine whether acupuncture would have an effect on stress-related symptoms in medical students.	An RCT pilot study	Electroacupuncture was associated with a significant reduction of stress-related symptoms, etc. They do show a significant difference in sleep disturbance between the treatment and the non-treatment group. There was no control
14.	Drolet & Rodgers (2010)	US	Article	Wellness	To describe and evaluate wellness program	Evaluative – single time point. Descriptive statistics	A fascinating descriptive paper. They introduced a tripartite student wellness programme. The 3 parts were Advisory College (a bit like houses in school but with a director and other faculty and senior students available to offer support &

## Appendix 1

							mentoring. VMS live - wellness retreats Student Wellness committee. This is clearly the most comprehensive attempt by a medical school to address the mental & physical health of its students.
15.	Dunn et al. (2008)	US	Observational/Special article	Depression, stress, suicidal ideation	Proposes and illustrates a conceptual model of medical student wellbeing.	n/a	The coping reservoir metaphor needs to be empirically validated. A useful model on which to base planning of screening & interventions for medical student mental health support
16.	Dyrbye et al. (2005)	US	Lit review	Distress	To summarise themes of medical student distress in literature including causes and strategies to reduce distress.	Lit review	Including students on curriculum development, off campus confidential resources, teaching skills for stress management and promoting self-awareness, helping students promote personal health.

## Appendix 1

17.	Dyrbye et al. (2009)	US	Empirical - survey with validated intervention	Burnout	To examine the connection between medical student burnout and; Learning environment, resident cynicism, personal life events. clinical rotation characteristics	Observational. One point survey, cross-sectional survey	Personal characteristics, life events and the learning environment are all independently related to burnout in medical students.
18.	Dyrbye et al. (2010)	US	Empirical	Burnout	Identify factors that are associated with student burnout.	Prospective multi-site study	Resilient students were less likely to be employed, had experienced fewer stressful life events, reported higher levels social support and perceived their learning more positively. Doesn'
19.	Dyrbye et al. (2011)(1)	US	Commentary	Distress	To comment on Kushner et al. (2011)	n/a	Pass/fail grading as an intervention. Learning required in student wellness programmes. Cognitive behaviour approach to improve wellness. Wellness as a core competency



## Appendix 1

							Self-care should be recognised as a core competency Research to identify successful strategies
20.	Dyrbye et al. (2011) (2)	US	Empirical	N/A	To determine whether the Medical Student Wellbeing Index (MSWBI) can identify medical students in severe psychological distress	Correlational survey	They show convincing statistical evidence that this tool is effective. the 3 things they measured it against were a. mental quality of life b. suicidal ideation c. thoughts of dropping out of medical school.
21.	Enns, M.W. et al. (2001)	CA	Empirical	n/a	To compare the perfectionism profile of medical students with that of a general arts student group and to examine the relationship among perfectionism, distress symptoms and academic expectations and satisfaction.	Longitudinal survey	Distinguishing adaptive and maladaptive aspects of perfectionism is important in understanding the cross-sectional and longitudinal implications of perfectionism for medical students.
22.	Ey .et al. (2000)	US	Empirical	Psychological distress	To find out medical and dental students' mental health status, their levels of perfectionism,	Questionnaire survey	23% had significant levels of distress. Most of these were not in Rx. Despite university counselling being free students were afraid to access it and didn't want to be seen attending the service. Students were concerned about attitudes of staff and peers towards seeking

## Appendix 1

					treatment status and attitudes to mental health care		mental health care. Students who scored for perfectionism were more likely to be depressed and less likely to seek help.
23.	Finkelstein et al. (2007)	US	Empirical	Stress and anxiety, burnout	To assess the effectiveness of a Mind-body elective on Year 2 medical students and to assess the sustainability of any noted improvement.	Intervention	Evidence that the 'Mind-Body Medicine: an Experiential Elective' is an effective way to decrease anxiety in pre-clinical medical students.
24.	Gaber & Martin (2002)	US	Empirical/Marketing piece	General wellness program focuses on mind (emotional, intellectual, and vocational development), body (physical development), and spirit (environmental and	To describe and evaluate wellness programme	Intervention	Greatest stress before med school = financial and time pressure. At first during course of year 1 decrease in exercise and sleep. Then it resumed, perceived stress declined...

## Appendix 1

				spiritual development ).			
25.	Givens & Tjia (2002)	US	Empirical/Research report	Depression	To identify barriers to use of MH services		Barriers were lack of time, confidentiality, stigma, cost, fear of documentation on academic record, and fear of unwanted intervention. These issues need addressing to promote early treatment.
26.	Hassed et al. (2009)	AT	Empirical	Wellness	To evaluate the HEP (Health enhancement programme a programme of self-care strategies for a balanced and healthy lifestyle. The content of this [health improvement] course was to some extent integrated into the year 1 course.	Before and after	<p>Programme significantly increased student wellbeing.</p> <p>Demonstrates improvement in medical student mental health</p> <p>The study appears to have been carried out rigorously follow up is too short</p>
27.	Henning et al. (2009)	NZ	Thought piece/lit review	Burnout	To review what is known about quality of life of depression and MI and the ramifications of a poor quality of life and recommend	Literature review	<p>A qual study (20) found MS reported the pressure of academic and professional demands provided sig sources of stress. Students with sleep deprivation were prone to depression.</p> <p>1) Support interventions - Select personality characteristics for med school</p> <p>2) Curriculum - Resilience and self care, good</p>

## Appendix 1

					ways of addressing.		study habits and coping strategies, attention to burnout, mentoring
28.	Hillis et al. (2010)	AT	Empirical	Wellbeing	To explore medical student views on wellbeing teaching and support services	Survey-one point	55% believed stigma associated with stress and distress. 56% require formal teaching on stress and distress.  Med students prefer to be taught to care for a peer than self
29.	Hillis et al. (2012)	AT	'Really good stuff'	Wellbeing/burnout	To implement and evaluate a peer-care intervention	Empirical, one point evaluation	94% participants - would recommend 88% - would change approach to own stress and distress
30.	Holm et al. (2007)	NO	Abstract for poster session	n/a	n/a	n/a	n/a
31.	Holm et al. (2010)	NO	Empirical	Stress	To evaluate an intervention to reduce stress	Controlled intervention study	Intervention had a positive effect on perceived medical school stress
32.	Hooper et al. (2005)	UK	Empirical - descriptive	All healthcare? – limited Wellness/self-care	To explore Yr 2 and Y4 4 students' health-seeking behaviour and attitudes to self-care.	Questionnaire survey of Year 2 and 4 students,	Med students bypass GPs.  The results of this study show that medical students have a disturbing tendency to bypass conventional routes into health care and utilise their privileged access to initiate investigations, referrals or treatment.
33.	Howe et al. (2012)	UK	Applied literature	Resilience	To explore concept of resilience and its	Literature search	Resilience should be explored in Med Ed practice and research.

## Appendix 1

			search		potential relevance to medicine. To consider whether a focus on resilience might be useful in medical training.		
34.	Kushner et al. (2011)	US	Empirical	Self-care	To describe an innovative approach to teaching principles and practice of health behaviour change and self care	Single timepoint quant and qual evaluation	87% set Behaviour change plan (BCP) goals related to exercise, nutrition, sleep. 40% achieved their goals, 79% achieved themselves healthier, 82% would use process again
35.	Lau et al. (2007)	HK	Short communication	Mental health	To describe an intervention that provides mental health information e-mail counselling and an online forum for med students	Intervention - united evaluation prevented - questionnaire	n/a
36.	Lee & Graham (2001)	US	Empirical – qual analysis of essays	Prevention which focused on stress reduction and personal wellness.	To explore students' perceptions of medical school stress and to assess their perspective on the wellness	Post-intervention analysis + 2 Year follow up.  Students were asked	It was found that the students felt that: (1) wellness issues should be important for physicians; (2) their own wellbeing had been diminished by the burden of information to be learned in medical school; (3) talking to peers was a useful coping mechanism, and (4) the elective gave permission to engage in wellness

Appendix 1

				elective.	to write a two-page essay in which they were to critique the elective, describe the stresses they encountered in medical school, and discuss their present coping behaviours. Essays were then explored using the constant comparative method (CCM)	activities without additional guilt.
--	--	--	--	-----------	---	--------------------------------------

## Appendix 1

37.	Louie et al. (2007)	US	Thought piece, reasoned argument	Occupational stress when working with emotional and behavioral disorders.	n/a	n/a	Work life balance should be addressed as med school students are busy, worried about cost/confidentiality to access better self-care as part of professionalism
38.	Melo-Carrillo et al. (2012)	MEX	Empirical	Depressive symptoms	To evaluate impact of psychoeducation intervention - a talk and support group	Before and after	Psychoeducation as verbal therapy for depression. 36% depressive symptoms prior. 25% after.
39.	Mercer et al. (2010)	USA	Empirical	Stress, anxiety and affect levels	To evaluate visual journaling as a possible stress-reduction technique	Before and after	Decrease in anxiety and negative affect levels among nearly all participants from pre-test to post-test.
40.	Moutier et al. (2012)	USA	Empirical	Suicide and depression	To describe programme and how it developed and the evaluation	Intervention	13% completed screens, 27% met criteria for sig risk of depression and suicide, 13% referred for MH evaluation and treatment
41.	Nuzzarello & Goldberg (2004)	USA	Research report	Depression	To examine role of perceived risk and personal and dean experience in med	Questionnaire study	Diagnosis in scenario more likely if high perception risk, experiences or had personal treatment for depression

## Appendix 1

					schools treatment seeking behaviour for major depression		
42.	Radcliffe & Lester (2003)	UK	Empirical	Stress	To explore views of Yr 5 med students on causes and stress during training undergrad ME	Semi-structured interviews	Pressure of work = most stressful esp transition periods and perceived lack of support
43.	Rakel et al. (2008)	US	Empirical - evaluation	Not explicitly about MH 'mind body influences' and 'spiritual connection'	Create a tool that encourages self-reflection, education and self-care for physicians-in-training.	Post intervention survey.  Intervention (web-tool)	The results support the main objectives of the tool, which were to encourage self-reflection, positive lifestyle habits and education towards key aspects of health and wellbeing.  Developing own health plans can encourage self-care and help to teach health promotion to patients.



## Appendix 1

44.	Redwood & Pollack (2007)	US	Empirical	Stress	Describes a student-led stress management program for and summarizes program evaluation data from 1,111 participants.	Post-Intervention survey	Based on longevity, participation, and student feedback, the program has been successful. Recommendations for creating and maintaining similar programs are offered. Mean annual participation was 94% 72% valuable learning experience 88% should be offered to future classes 68% hoped to manage stress better
45.	Reed et al. (2009)	US	Conference Abstract	Psychological distress	To examine association between grading scales and burnout, stress and quality of life.	Multi-institutional comparative	Psychological distress is prevalent among medical students regardless of grading schema; however students in a pass/ fail curriculum report more burnout, higher stress, worse mental QOL, and are more likely to seriously consider dropping out of medical school.

## Appendix 1

46.	Reynolds & Clayton (2009)	USA	Commentary	Depression	To reinforce the call to action made in separate reports. To suggest barriers can and must be prevented.	n/a	Reiterating barriers to approp health care seeking e.g. education, time, money, concerns about confidentiality
47.	Roberts et al. (2000)(1)	USA	Empirical/Research report	Emotional distress, symptoms of mental illness, and maladaptive substance use	Questionnaire study looking at access to healthcare by medical students.  To explore health care needs, health concerns, attitudes to care, access to services, care seeking practices.	Survey (subset repeated at 2nd time point)	Preferred to obtain healthcare at a remote site, tended to seek informal care from colleagues, high levels of stress of concern, prof jeopardy.  Many students didn't access health care because they didn't have time and some were concerned about confidentiality Many students had "curb side consultations" for investigations and prescriptions.

## Appendix 1

48.	Roberts et al. (2000) (2)	US	Research report	Is this strictly about mental health?	To determine attitudes to, and experiences of personal illness among students at 9 US medical students.	Self-report questionnaire/survey	Students have problems with access to health care because of time issues. Students use curbside consultations for diagnosis, investigation and prescriptions. Students caring behaviour is shaped by their own illness experience.
49.	Roberts et al. (2001)	US	N/A	Perception of academic vulnerability (distress?)	To determine attitudes to physical and mental illness among medical students and willingness to seek	X sectional survey	52% RR. 47% MH or substance related health issue prefer healthcare outside their training institution (confidentiality). Varying concern about academic jeopardy, with physical = least concern and alcohol above most concern. Fear of reprisal prevents health seeking women, minority and clinical students more women.

## Appendix 1

					help.		They picked up students underestimation of their likeliness of getting mental health problems and their unwillingness to seek help when they did. Big numbers
50.	Roberts (2010)	USA	Editorial	Depression and distress	n/a	n/a	Useful summary of other research including Dyrbye's distinction between professional and personal distress.
51.	Roberts et al. (2011)	US	Empirical	Mental and Physical illness	To explore dual role as learners and patient when a medical student seeks care at his/her training institution	Vignette based survey	Students more likely to accept dual role of pre-existing patient role, students sought to avoid dual role if stigmatising women
52.	Rohe et al. (2006)	US	Empirical	Stress, mood, group cohesion	To determine the effect on medical student stress, mood and group cohesiveness of change in the grading system to pass-fail from a 5 point grading system.	Prospective study. Same cohort in 1st and 3rd years.  2 group comparison – historical controls	Statistically significant improvement in class cohesiveness and less perceived stress. Non-significant improvement in mood

## Appendix 1

53.	Rosenzweig et al. (2003)	US		Psychological distress	To compare MBSR with a "control" of some didactic teaching on complementary medicine. They give convincing reasons for choosing MBSR as their intervention.	Prospective non-randomised cohort comparison study	Students self-selected so not surprisingly the intervention group had higher distress levels at outset. They did improve.
54.	Rosenthal & Okie (2005)	US	Literature review/Perspective	Depression, (transient, "reactive" depressed mood)	n/a	Observational	Rosenthal & Okie highlight how Kansagra's innovative approach gave students a safe place to talk and to help them "realize they aren't alone and that there are a lot of resources available" that provide emotional support. Messages were posted anonymously and reviewed by a psychiatrist in Duke's student counselling service. This project then led to open discussion about mental health where in the subsequent week a psychiatrist made 2 referrals for depression counselling.
55.	Ross et al. (2006)	UK	Empirical	Anxiety	To determine the effect of debt on medical student stress and academic performance	Electronic survey – linked to assessment performance	Students level of debt didn't affect their stress levels or their academic performance but worry about debt did.  No direct correlation between debt, class ranking or general health score. But a subgroup

## Appendix 1

							said worryingly about money affected their studies and had high debt and low performance.
56.	Saadat et al. (2010)	US	Thought piece/lit review	Stress and Burnout	n/a	n/a	Decline in positive attitudes as med school progresses. Ways to promote wellbeing: Coping mechanisms, promote resilience by understanding rise factors, better understanding of effects, discussion groups, problem solving coping, forums for confidential discussion
57.	Sayer et al. (2002)	UK	Empirical -An Evaluation	Prevention/s tress	To evaluate the pastoral pool. They replaced their personal tutor system with a small group of willing tutors nominated by the students and trained.	Evaluating case notes and questionnaires with PP staff and students	Very few students accessed the system at all 3% and they all accessed 2 members of staff. Students were concerned about lack of confidentiality. Only enthusiastic staff involved. But reliance on self-referral therefore secondary support to those with insight into problems and motivated to seek help.
58.	Shaikh et al.	PK	Prevalence study		To assess the perception of stress among medical students and their coping strategies.	Cross-sectional survey	The recommendations are not supported by the data. Exams are the only identifiable source of stress detected
59.	Shapiro et al. (2000)	US	Empirical - Systematic review	Wellness/stress	To determine the utility of interventions to reduce medical students stress	Systematic review	Although they initially identified 600 papers they included only 24 in the review and only 6 of these had any degree of rigour.
60.	Simard et al. (2009)	CA	Short communicati	Anti-burnout prevention	To measure the effect of practising		A small study comparing 1st year medical students (16 students , 15 female, half with

## Appendix 1

			on		hatha yoga (postures, breathing & meditation) on medical students' wellbeing.		previous experience of yoga) did hatha yoga twice weekly. They completed the GHQ before during and after and reported improvement in scores.
61.	Slavin et al. (2011)	USA	Editorial/ Commentary / Opinion piece	Wellness			<p>In order to help medical students flourish it is necessary to</p> <p>Promote comprehensive programmes to reduce stress and promote student wellness</p> <p>Foster opportunities for student engagement outside the classroom &amp; library. eg. through longitudinal electives and volunteer programmes</p> <p>get rid of grades and promote faculty and peer mentoring. All this to promote strong relationships</p> <p>Invest in opportunities for meaning-making in students work e.g. through medical humanities, healing arts, reduce workload</p> <p>Find ways for students to achieve and demonstrate excellence other than through the course &amp; assessments.</p>
62.	Spring et al. (2011)	US	Medical Education in Review	Wellness	To determine the effect of pass/fail grading on medical student wellbeing and academic outcomes	Systematic Review	<p>Student wellbeing is enhanced and academic performance is not adversely affected by pass/fail grading. Some residency programme directors appear to be prejudiced against applicants from pass/fail schools.</p> <p>There is an overall paucity of literature (none from outside USA?).</p>
63.	Tennant (2002)	AT	Show and tell		To describe the Personal and Professional	Descriptive	

## Appendix 1

					Development and Ethics theme of the curriculum		
64.	Thistlethwaite et al. (2010)	UK & AT	Short communication	Seeking help for MH problems	1. To examine medical students' perceptions of doctor-student interactions (with medical student as patient) and the effect this has on help-seeking. 2. To examine developing professional identity and its effect on help-seeking.	22 Interviews and identified common themes (follow up study)	Students were reluctant to consult a GP about a mental illness (because of fear of effects on their future career). Some students were conscious of hypochondriasis related to their studies They were worried about attending a practice when their class-mates were on placement there.
65.	Thompson et al. (2010)	US	Short report	Suicide prevention	To evaluate the effects of a programme designed to address the endemic medical student depression at their institution.		They instructed the faculty to look out for depression giving instruction what to look for. They spoke to the students annually about depression, what it is, how it presents, what to do They coached faculty how to talk one to one with students who may be depressed They enhanced student counselling including cut-price, off site psychiatric care. Their follow-up data shows significant reduction in depression at various levels of severity and suicidal ideation after the programme
66.	Tijia et al. (2005)	US	Empirical	Depression	To measure the prevalence of	Cross sectional	Medical Students have a higher prevalence of mental health problems and are less likely to



## Appendix 1

					depression among American medical students and to measure access to treatment in the form of counselling and antidepressant medication.	survey: beck depression inventory and sociodemographic questionnaire.	seek treatment.  15% depressed = 20% suicidal ideation ..
67.	Tyssen.et al. 2007	NO	Empirical	All Mental Health issues	To examine personality types of medical students at the beginning, middle and end of UME. This was correlated with measures of stress	Multicentre study	Particular personality types notably Conscientiousness and neuroticism were associated with higher stress levels as was female sex.  Brooders (high conscientiousness and high neuroticism, low extrovert) were protected against stress
68.	Warnecke et al. (2011)	AT	Empirical	n/a	To evaluate the effects of daily mindfulness practice for 8 weeks on the stress, anxiety and depression levels of senior medical students	Single-blinded randomised, controlled trial	If medical students can be persuaded to use mindfulness techniques their stress levels will probably improve
69.	Wilcock (2002)	AT	Detection of MH problems				They produce a set of bullet points on how to provide support for "impaired students". They recommend A "Dummy's guide to helping a mate". Peer's are usually the 1st to recognise that a fellow student is struggling but they don't know what to do.  A structured process of identification and

## Appendix 1

							<p>notification. They suggest an annual meeting where students can be "screened" for distress</p> <p>An independent body to assist distressed or impaired students</p> <p>Stigma needs to be addressed</p> <p>A database of mentors available at all campuses/placements.</p> <p>Mentoring, especially at times of transition</p> <p>Special programmes for specific groups (but without making students alienated).</p> <p>GMC and FtP processes need to be explained and demystified.</p>
70.	Wilhelm (2002)	AT	Thought piece/Literature review	Stress, distress and impairment (Impairment implies some effect on academic performance).		Observational	<p>Their response to medical students concerns were</p> <ol style="list-style-type: none"> <li>1. To provide scholarships to help with student hardship</li> <li>2. To ensure that every student was registered with a GP</li> <li>3. To appoint a student support officer (GP) provide liaison &amp; support for students in need/distress. To coordinate counselling</li> </ol> <p>The also created a short referral form for health service providers.</p> <p>She posed a set of questions about the consequences of addressing "impairment" among students including attitudes of the public &amp; the profession and workload implications.</p>
71.	Yates et al. (2008)	UK	Short communication		To determine Look back in the Pre-course occ health records of medical	Descriptive statistics	<p>Suggests that a mental health history declared on the pre-course questionnaire correlates with</p>

## Appendix 1

					students to see whether being a "struggler" (come to attention of the SPC, Being excluded, being suspended or left the course voluntarily.		
72.	Yates (2011)	UK	Research Article	Anxiety, depression and eating disorders	An exploratory case study was conducted to determine whether there were common indicators in the early years, over and above academic failure, that might aid the identification of students potentially at risk.	Retrospective case study	By looking back in the records of students who had failed or struggled they recognised the following "checklist" for struggling students <ol style="list-style-type: none"> <li>1. Failure of 3 or more exams/year</li> <li>2. An overall average of &lt;50%</li> <li>3. Health or social difficulties</li> <li>4. Failure to complete hep B vaccination</li> <li>5. remarks about poor attitude &amp; behaviour</li> </ol>
73.	Yiu (2005)	CA	Commentary	Wellness			She describes what they did at her institution of Faculty of Dentistry & Medicine, University of Alberta which was to; <ol style="list-style-type: none"> <li>1. First &amp; second year student support groups</li> <li>2. Wellbeing seminars</li> <li>3. support for a student wellbeing committee</li> <li>4. Drop in hour (to see trained advisers)</li> </ol> <p>When many students didn't access the advisers they made seeing an a advisor mandatory.</p>



**Identifying good practice among  
medical schools in the support of students with mental health  
concerns**

Interviewee: .....

Role:.....

University: .....

Date: .....

Interviewer:.....

**Interviewer Brief**

- Complete consent form ☐

***Brief introduction to the study***

The Institute of Medical Education, Cardiff University, in collaboration with colleagues in Exeter and Prepare to Share has been commissioned by the GMC to undertake research to identify good practice among medical schools in the support of students with mental health concerns. The overall project aim is *‘for the GMC to understand how medical schools currently support students with mental health issues’* with the primary aim of producing guidance that will be helpful to medical schools on how they can best support such students.

You have been identified as a key stakeholder in the provision of support to medical students and we are therefore very keen to know your views and understand how students are supported at your institution.

This interview/site visit contributes to a wider programme of research which includes a systematic review of research in this area; a mapping of support services, resources and models of support across UK Universities; an e-survey; an in-depth telephone survey and targeted one-to-one, key-stakeholder interviews with selected University staff; a series of focus groups with medical students who

## Appendix 2 Site visit interview schedule

have had no personal experience of mental ill-health; and one-to-one narrative interviews with medical students who have experienced mental health concerns.

Your participation in this survey would be much appreciated and will contribute to developing future GMC guidance for medical schools in the support of students.

- Confirm re: confidentiality ☐
- Any questions? ☐

### A How is student support organised?

1. *Prompt*; centralised, campus based, range of services (own student health service?)
2. Where does it fit in terms of the institutional structure? Who does it report to?
3. Are any special arrangements in place for the medical students? Dedicated staff
4. How do students access mental health services? On-line? In person?
5. Are medical students allocated a personal tutor? What is the role of the personal tutor? How is the PT system organised? Training/monitoring?
6. What are students told/how about PT role? Compulsory interviews/frequency of contact?

### B Prevention

1. Does the school address mental health issues (i.e. medical students' proneness to mental health problems) with the students in any format?
2. How? (e.g. personal tutor support, peer support, mindfulness meditation, online programmes like "*Beating the Blues*"/lectures/seminars on 'Wellness').
3. How is this included in the curriculum?

## Appendix 2 Site visit interview schedule

### C Identification

1. How does the institution/ medical school encourage medical students with mental health concerns to seek appropriate support?
2. Approximately, how many potential medical students declare a history of mental illness
  - At application?
  - On admission?
3. What kinds of conditions are declared? (e.g. anxiety/depression/bi-polar?)
4. Are records kept of declarations? (*prompt*: if so, by whom?)
5. Are there any trends observed (e.g. increase/decrease/willingness to disclose)?
6. What, if any, assumptions are made about medical students' previous emotional/ mental health history?
7. Do students know who to contact if they have a MH concern?
8. What messages are conveyed to students about the school's role in providing support as opposed to monitoring fitness-to-practise (FtP)
9. What messages are conveyed to students about the schools role in monitoring FtP?
10. How are these messages and roles balanced?
11. What are the respective roles of the school and the university?
12. How is information about access to services conveyed?
13. What access or provision is there for students who are **away on placement**?

### D Referral

1. What services are available to support students with mental health problems?
2. What are students told about arrangements for occupational health referral? How?

## Appendix 2 Site visit interview schedule

3. Are students encouraged to follow internal procedures rather than seek external sources of support? (*prompt*: why might that be?)
4. How in practice do students come to the attention of mental health support services – routes in? (*prompt*: what happens when a student with mental health concerns approaches their personal tutor?)

### E Escalation

1. What are students told about the procedure for FtP referral? (*prompt*: how much of a threat does this pose to students?)
  - How is this information conveyed?
  - Does this include information on what prompts a FtP investigation?
2. How does the school balance responsibility to the individual students with its duty of care to the profession and the public?
3. How is multi-agency working handled? (*prompt*: confidentiality?)

### F Treatment

1. How flexible can the school be in supporting medical students with mental illness? (*prompt*: time off? What are the rules?)
2. How much time off can they have before having to repeat the year?
3. What does the school do to minimise the stigma of:
  - Having a mental illness
  - Receiving treatment from mental health services
  - Not being able to complete course requirements on time?



## **Appendix 2 Site visit interview schedule**

### **G Reintegration/ long term follow-up**

1. What arrangements are there to support students to reintegrate?
2. How does the school keep in regular contact with students who have had a period of mental illness?
3. How does the school liaise with the postgraduate deanery about the needs of students who have experienced mental illness?
4. How is the transition between support from external services and in-house support (e.g. from a personal tutor) managed?
5. What happens to a student who enters a new cohort?
6. What is the procedure for a student who can't complete the undergraduate medical programme?
  - Are they advised about other careers?
  - Do they receive some sort of degree?

### **Final question**

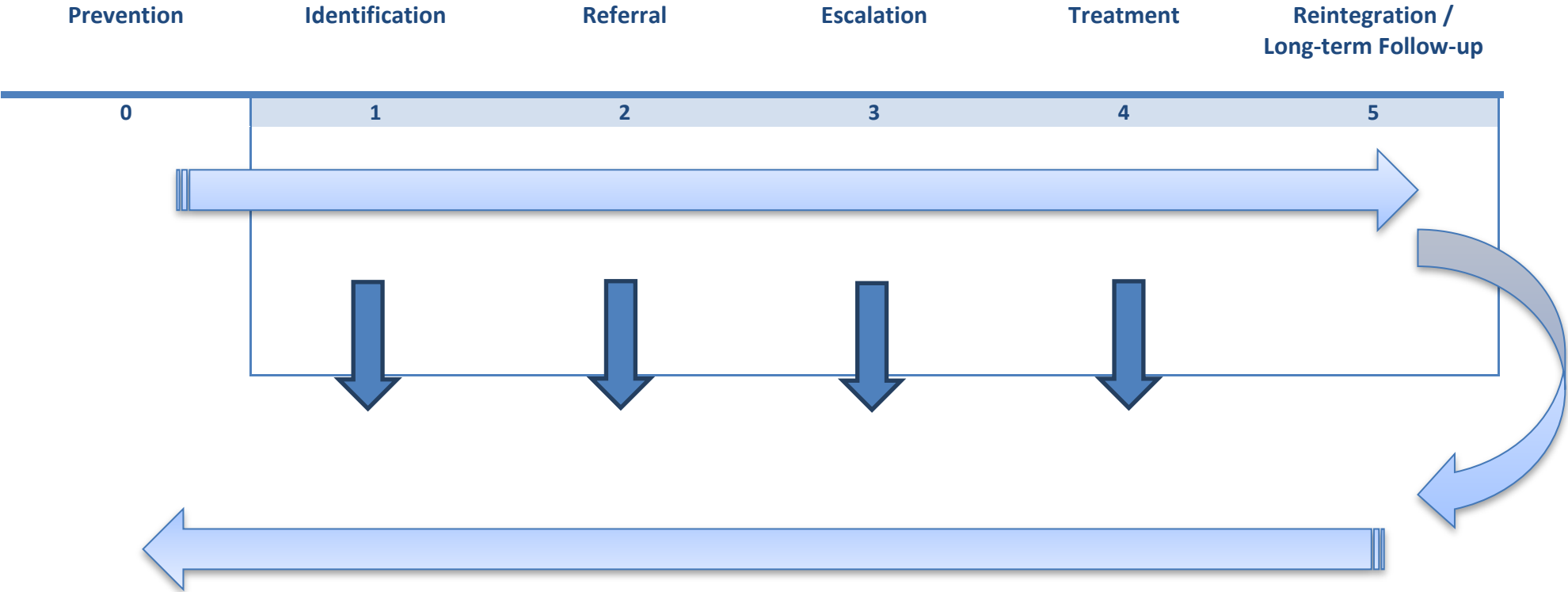
1. What are the strengths & weaknesses of the current system for supporting medical students with mental health problems?
2. How could it be improved?

***Remind respondent re: confidentiality***

***Thank you***

Appendix 2 Site visit interview schedule

Figure 1: Staged model of provision of support for medical students with mental health problems



## **Appendix 3 Focus group interview guide**

### **Focus Group Interview guide**

#### **Research purpose**

To seek out models of care for medical students with mental illness and to identify areas of good practice.

#### **Central Research question**

How can the experience of every medical student with mental illness be as good as the best?

#### **Conceptual framework**

Socio-cultural pressures to which medical students are subjected render them more susceptible to mental illness and, through fear of stigma and adverse Fitness to Practise procedures less likely to seek the help they need when they do develop mental illness.

#### **Prevailing attitudes**

How do medical students and the medical profession perceive doctors and medical students with mental illness?

What might reduce the stigma of mental illness?

How are students who have had mental health issues treated?

By staff?

By fellow students?—

What are the pressures to complete the course in the expected time?

#### **What are students told**

Does the medical school encourage students with mental health concerns to come forward?  
How?

Do students know who to contact?

Inside/outside the school

Do they know what services are available?

Pros and cons of going 'outside' for help?

What messages do schools give to students about mental health?

What are the impacts(s)?

What is the "danger" of revealing a mental health concern to a member of medical school staff?

How safe do you feel about the separation of performance and personal issues?

What messages are conveyed about providing support v monitoring Fitness to Practise?

What prompts a FtP investigation?

## **Appendix 3 Focus group interview guide**

### **Care for all students**

What is the role of personal tutor?

How many have made contact?

How are performance and pastoral issues separated?

### **Care for students with MI**

What resources are there to support students with mental health issues?

What advice is given about accessing services?

How helpful is the school in facilitating flexibility [around mental health needs]?

### **Rehabilitation of students with MI**

What is the procedure when a student is unable to complete the undergraduate medical programme?

### **Overall impression of provision of support.**

What are the strengths & weaknesses of the current system for supporting medical students with mental health problems?

How might they be improved?

## Appendix 4 Interview guide for telephone interviews with medical school and university support staff

### Identifying good practice among medical schools in the support of students with mental health concerns

Interviewee: .....
Role:.....
University: .....
Date: .....
Interviewer:.....

#### Telephone Interviewer Script

Thank you for agreeing to take part in our telephone survey.

As you know from our earlier correspondence, the Institute of Medical Education, Cardiff University, in collaboration with colleagues in Exeter and Prepare to Share has been commissioned by the GMC to undertake research to identify good practice among medical schools in the support of students with mental health concerns, with the primary aim of producing guidance that will be helpful to medical schools on how they can best support their students.

You have been identified as a key stakeholder in the provision of support to **medical** students, **some of which may be medical students**, and we are therefore very keen to know your views and understand how students are supported at your institution.

We have prepared a brief series of questions to enable us to explore models of student support from looking at preventative measures, such as how the institution/medical school encourages **medical** students with mental health concerns to seek appropriate support, through to models of support for students who have experienced mental illness.

The questions are intentionally broad to enable us to tailor the interview according to your responses. All of your responses will be anonymised as we will only report on themes and exemplars that we identify from interviews. The interview should take approximately 25-30 minutes.

#### A How is student support organised?

7. Prompt; centralised, campus based, range of services (prompt: own student health service?)
8. Where does it fit in terms of the institutional structure? Who does it report to?
9. Are any special arrangements in place for the medical students? Dedicated staff
10. How do students access mental health services? On-line? In person?
11. Are medical students allocated a personal tutor? What is the role of the personal tutor? How is the PT system organised? Training/monitoring?

## **Appendix 4 Interview guide for telephone interviews with medical school and university support staff**

12. What are students told/how about PT role? Compulsory interviews/frequency of contact?

### **B Prevention**

1. What messages are conveyed to students about the schools role in providing support as opposed to monitoring Fitness to Practise.
2. What messages are conveyed to students about the schools role in monitoring Fitness to Practise?
3. How are these messages and roles balanced?

### **C Identification**

14. How does the institution/ medical school encourage medical students with mental health concerns to seek appropriate support?
15. Approximately, how many potential medical students declare a history of mental illness
  - At application?
  - On admission?
16. What kinds of conditions are declared? (e.g. anxiety/depression/bi-polar?)
17. Are records kept of declarations? Are there any trends observed e.g. increase/decrease/willingness to disclose?
18. What assumptions are made about medical students' previous emotional/ mental health history?
19. Do students know who to contact if they have a MH concern?
20. What are the respective roles of the school and the university?
21. How is information about access to services conveyed?
22. What access or provision is there for students who are **away on placement**?

## **Appendix 4 Interview guide for telephone interviews with medical school and university support staff**

### **D Referral**

23. What services are available to support students with mental health problems?
24. What are students told about arrangements for occupational health referral? How?
25. How in practice do students come to the attention of mental health support services – routes in?
26. Are students encouraged to follow internal procedures rather than seek external sources of support? (why might that be?)

### **E Escalation**

27. What are students told about the procedure for FtP referral?
  - How is this information conveyed?
  - Does this include information on what prompts a FtP investigation
28. How does the school balance responsibility to the individual students with its duty of care to the profession and the public?
29. How is multi-agency working handled? Confidentiality?

### **F Treatment**

30. How flexible can the school be in supporting medical students with mental illness?  
Time off? What are the rules?
31. What does the school do to minimise the stigma of
  - Having a mental illness
  - Receiving treatment from mental health services
  - Not being able to complete course requirements on time.

## **Appendix 4 Interview guide for telephone interviews with medical school and university support staff**

### **G Reintegration/ long term follow-up**

- 32. What arrangements are there to support students to reintegrate?
- 33. How does the school keep in regular contact with students who have had a period of mental illness?
- 34. How does the school liaise with the postgraduate deanery about the needs of students who have experienced mental illness?
- 35. How is the transition between support from external services and in-house support (e.g. from a personal tutor) managed?
- 36. What happens to a student who enters a new cohort?
- 37. What is the procedure for a student who can't complete the undergraduate medical programme?
  - Are they advised about other careers?
  - Do they receive some sort of degree?

### **Final question**

What are the strengths & weaknesses of the current system for supporting medical students with mental health problems? How could it be improved?



## Appendix 4 Interview guide for telephone interviews with medical school and university support staff



### Identifying good practice among medical schools in the support of students with mental health concerns

The Institute of Medical Education, Cardiff University, in collaboration with colleagues in Exeter and Prepare to Share has been commissioned by the General Medical Council (GMC) to undertake research to identify good practice among medical schools in the support of students with mental health concerns. The overall project aim is *'for the GMC to understand how medical schools currently support students with mental health issues'* with the primary aim of producing guidance that will be helpful to medical schools on how they can best support such students.

You have been identified as a key stakeholder in the provision of support to medical students and we are therefore very keen to know your views and understand how students are supported at your institution. We would be very grateful if you could take the time to complete our e-survey, which will take approximately 10-15 minutes.

This e-survey is part of a wider programme of research which includes a systematic review of research in this area; a mapping of support services, resources and models of support across UK Universities; an in-depth telephone survey and one-to-one, key-stakeholder interviews with selected University staff; a series of focus groups with medical students who have had no personal experience of mental ill-health; and one-to-one narrative interviews with medical students who have experienced mental health concerns.

Your participation in this survey would be much appreciated and will contribute to developing future GMC guidance for medical schools in the support of students.

Thank you

Page 2

After page 1 Continue to next page

Name

Organisation

Do you work in a School of Medicine? \*

Yes

#### **Appendix 4 Interview guide for telephone interviews with medical school and university support staff**

No

Page 3

After page 2 Continue to next page

Note: "Go to page" selections will override this navigation. Learn more.

Is your role:

- a. Mainly concerned with medical education within a school of medicine
- b. Mainly concerned with student support within a school of medicine

Other:

Please indicate from the dropdown list the title which most accurately describes your role

Page 4

After page 3 Continue to next page

What resources exist within Student Services to support students with mental health issues? (please tick all that apply)

- a. 1:1 Counselling
- b. Bibliotherapy
- c. Group therapy
- d. Workshops
- e. Peer support programmes
- f. Downloadable podcasts
- g. Leaflets (hard copy)
- h. Leaflets (downloadable)
- i. Lists of sources of external support

Other:

What resources exist within the medical school to support students with mental health issues? (Please tick all that apply)

- a. Personal tutors
- b. Counsellors
- c. Peer support programmes
- d. Intranet advice

Other:

How is the role of personal tutor defined?

- a. Provider of pastoral care
- b. Provider of academic support
- c. Provider of both academic support and pastoral care

Other:

Page 5

After page 4 Continue to next page

Is it compulsory for students to see a personal tutor?

Yes

No

How often do students usually see a personal tutor in a year?

Never

#### **Appendix 4 Interview guide for telephone interviews with medical school and university support staff**

Once

Twice

Three times

More than three times

Page 6

After page 5 Continue to next page

Does the school screen potential students for mental health issues?

Yes

No

Page 7

After page 6 Continue to next page

Note: "Go to page" selections will override this navigation. [Learn more.](#)

If yes, what method is used? (Please tick all that apply)

a. Test (e.g. UKCAT, BMAT)

b. Interview

Other:

Page 8

After page 7 Continue to next page

Which of the following appear in medical school recruitment materials?

a. Student mental health issues

b. Support services

c. Fitness to Practise issues

d. Arrangements for reasonable adjustment in relation to disabilities

How is the school's policy on student mental health made available to students?

(Please tick all that apply)

a. Written material

b. Website

c. USB stick

d. Lectures/briefings

e. Email

f. VLE (Virtual Learning Environment - Student Intranet)

g. Text messages

Other:

How is information about arrangements for occupational health made available to medical students? (Please tick all that apply)

a. Written material

b. Website

c. USB stick

d. Lectures/briefings

e. Email

f. VLE (Virtual Learning Environment - Student Intranet)

g. Text messages

Other:

Page 9

After page 8 Continue to next page

#### **Appendix 4 Interview guide for telephone interviews with medical school and university support staff**

How do students know who they should contact in the medical school if they have concerns about their mental health?

How is advice given to students about accessing Student Services? (please tick all that apply)

- a. Written material
- b. Website
- c. USB stick
- d. Lectures/briefings
- e. Email
- f. VLE (Virtual Learning Environment - Student Intranet)
- g. Text messages

Other:

Page 10

After page 9 Continue to next page

How does the medical school encourage students with mental health concerns to come forward?

Are students informed of the arrangements in place for counselling?

Yes

No

If yes, how? (Please tick all that apply)

- a. Written material
- b. Website
- c. USB stick
- d. Lectures/briefings
- e. Email
- f. VLE (Virtual Learning Environment - Student Intranet)
- g. Text messages

Other:

Page 11

After page 10 Continue to next page

How do students know whom they should contact in the medical school if they have concerns about their mental health?

What is the medical schools' procedure for obtaining occupational health advice?

If yes, how? (Please tick all that apply)

- a. Written material
- b. Website
- c. USB stick
- d. Lectures/briefings
- e. Email
- f. VLE (Virtual Learning Environment - Student Intranet)
- g. Text messages

#### **Appendix 4 Interview guide for telephone interviews with medical school and university support staff**

Other:

Page 12

After page 11 Continue to next page

##### **CARE FOR STUDENTS WITH MENTAL HEALTH ISSUES (3)**

At the point of admission, on average how many medical students declare a history of mental illness?

0 – 2

2 – 4

5 – 6

7 – 8

9 – 10

>10

Don't Know

In your experience, are numbers of medical students declaring a history of mental illness on admission:

Increasing

Decreasing

Staying the same

Don't Know

[[[TO BE DELETED]]] Approximately how many medical students declared a history of mental illness in:

.....2011/12.....

.....2010/11.....

..... 2009/10

0 – 2

2 – 4

5 – 6

7 – 8

9-10

> 10

Don't Know

[[[replace with grid??]]] On average, how many enrolled medical students access Student Services due to mental illness each year?

range1

range2

range3

What is the maximum period of sickness absence that students can take without having to repeat a year? (ENTER NUMBER OF WEEKS)

Page 13

After page 12 Continue to next page

##### **CARE FOR STUDENTS WITH MENTAL HEALTH ISSUES (4)**

What procedures are in place for liaison between the school and the postgraduate deanery regarding students for whom there are health concerns or who have a disability?

#### **Appendix 4 Interview guide for telephone interviews with medical school and university support staff**

What is the school's procedure for keeping in regular contact with students known to have suffered mental health problems?

Page 14

After page 13 Continue to next page

##### **CARE FOR STUDENTS WITH MENTAL HEALTH ISSUES (5)**

Are students who are unable to complete the undergraduate programme routinely offered advice on alternative careers?

Yes

No

Do students who have to leave the programme receive any form of degree or qualification?

Yes

No

If yes, what qualification?

What procedures are in place to support students who have to enter a new cohort?

Page 15

After page 14 Continue to next page

##### **FITNESS TO PRACTISE**

How is information about FtP referral conveyed to medical students? (Please tick all that apply)

- a. Written material
- b. Website
- c. USB stick
- d. Lectures/briefings
- e. Email
- f. VLE (Virtual Learning Environment - Student Intranet)
- g. Text messages

Other:

What prompts a FtP investigation? (Please tick all that apply)

- a. Disciplinary problem
- b. Conviction for a crime
- c. Mental health problem
- d. Mental health problem only where patient safety is at risk

Other:

Page 16

After page 15 Continue to next page

##### **SUMMARY**

What are the strengths & weaknesses of the current system for supporting medical students with mental health issues at your institution?

Page 17

#### **Appendix 4 Interview guide for telephone interviews with medical school and university support staff**

After page 16 Go to page 24 (Thank You)

##### **AMOSSHE - INTRODUCTION**

Is your role:

- a. Mainly concerned with student support within an HE institution which includes a medical school
- b. Mainly concerned with student support within an HE institution that DOES NOT include a medical school

Other:

Please indicate from the dropdown list the title which most accurately describes your role

Page 18

After page 17 Continue to next page

##### **RESOURCES**

What resources exist within Student Services to support medical students with mental health issues? (please tick all that apply)

- a. 1:1 Counselling
- b. Bibliotherapy
- c. Group therapy
- d. Workshops
- e. Peer support programmes
- f. Downloadable podcasts
- g. Leaflets (hard copy)
- h. Leaflets (downloadable)
- i. Lists of sources of external support

Other:

How is advice given to medical students about accessing Student Services? (please tick all that apply)

- a. Written material
- b. Website
- c. USB stick
- d. Lectures/briefings
- e. Email
- f. VLE (Virtual Learning Environment - Student Intranet)
- g. Text messages

Other:

Which of the following are mentioned in University recruitment materials? (please tick all that apply)

- a. Support services
- b. Arrangements for reasonable adjustment in relation to disabilities
- c. Student mental health issues

Other:

How is the University's policy on student mental health made available to medical students? (please tick all that apply)

#### **Appendix 4 Interview guide for telephone interviews with medical school and university support staff**

- a. Written material
- b. Website
- c. USB stick
- d. Lectures/briefings
- e. Email
- f. VLE (Virtual Learning Environment - Student Intranet)
- g. Text messages

Other:

How is information about arrangements for occupational health made available to medical students? (please tick all that apply)

- a. Written material
- b. Website
- c. USB stick
- d. Lectures/briefings
- e. Email
- f. VLE (Virtual Learning Environment - Student Intranet)
- g. Text messages

Other:

Page 19

After page 18 Continue to next page

#### **CARE FOR STUDENTS WITH MENTAL HEALTH ISSUES**

How do Student Services encourage students with mental health concerns to come forward?

How do students know who they should contact in the University if they have concerns about their mental health?

What is the procedure for students needing to obtain occupational health advice?

If other, please state

Page 20

After page 19 Continue to next page

#### **CARE FOR STUDENTS WITH MENTAL HEALTH ISSUES (2)**

Where students are required by their school to declare a history of mental illness prior to admission, e.g. to study medicine, would Student Services be made aware?

Yes

No

If yes, what is the procedure for this?

Page 21

After page 20 Continue to next page

#### **CARE FOR STUDENTS WITH MENTAL HEALTH ISSUES (3)**

At the point of admission, on average how many medical students declare a history of mental illness?



#### **Appendix 4 Interview guide for telephone interviews with medical school and university support staff**

0 – 2

2 – 4

5 – 6

7 – 8

9 – 10

>10

Don't Know

[[[replace with grid??]]] On average, how many medical students access Student Services due to mental illness each year?

0 – 10

11 – 20

21 – 30

31 – 40

41-50

>50

Don't Know

Page 22

After page 21 Continue to next page

#### **CARE FOR STUDENTS WITH MENTAL HEALTH ISSUES (4)**

What procedures are in place for liaison between a medical school and Student Services regarding students for whom there are health concerns or who have a disability?

Does Student Services have a procedure for keeping in regular contact with students known to have suffered mental health problems?

Yes

No

If yes, please state what these procedures are

Page 23

After page 22 Continue to next page

#### **CARE FOR STUDENTS WITH MENTAL HEALTH ISSUES (5)**

Are students who are unable to complete the undergraduate programme routinely offered advice on alternative careers?

Yes

No

---