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**MANAGING STUDENT MENTAL HEALTH: THE CHALLENGES FACED BY
ACADEMICS ON PROFESSIONAL HEALTH CARE COURSES**

Abstract

Aims

To explore how academics on nursing and healthcare programmes are managing their roles and responsibility in relation to student mental health.

Background

There is growing concern about the mental health of university students in general and healthcare students in particular. Shifts in Higher Education policy, encouraging a 'whole university approach,' may place greater responsibility for student mental health on academics. However, little is known about the challenges that poor student mental health creates for academics on healthcare programmes.

Design

A qualitative approach, using semi-structured interviews and focus groups, provided the opportunity for in-depth analysis.

Methods

Fourteen academics on healthcare programmes, including seven lecturers from nursing programmes, were interviewed between May and June 2017. Constant comparison analysis was followed to support grounded theory.

Results

Four key themes emerged. Academics had difficulty identifying and maintaining boundaries due to competing academic and professional identities. Student disclosures are accompanied by challenges arising due to professional responsibilities. Supporting student mental health on placement is difficult. Academics are aware and concerned about the potential negative impact of course content and practice on student mental health.

Conclusion

This is the first study to explore in-depth the challenges faced by academics on healthcare programmes by the rising prevalence of and concern for, student mental health. The findings indicate that leaders of nursing education programmes and their managers, need to be aware that academics face complex challenges in managing and responding student mental health and may struggle to maintain boundaries due, in part, to competing professional identities.

Key words: nurse, education, nursing students, mental health, university, teaching staff, higher education students, psychological distress

INTRODUCTION

It is estimated that between a quarter and a third of university students will have experienced a common mental health disorder in the past 12 months (Auerbach, Mortier, Bruffaerts et al., 2018; Auerbach, Alonso, Axinn et al., 2016). Further, the prevalence of mental distress among university students appears to be increasing (Neves & Hillman, 2017; Williams et al., 2015), while general student resilience and well-being is declining (Curran & Hill, 2017).

This is a cause for concern, especially as poor mental health appears to significantly contribute to student withdrawal and academic underachievement (Lindsey, Fabiano, & Stark, 2009; Verger, Guagliardo, Gilbert, Rouillon, & Kovess-Masfety, 2010; Auerbach et al., 2016).

There are specific concerns about the mental health and well-being of students on professional healthcare programmes (e.g. nursing and medicine; Cleary, Horsfall, Baines, & Happell, 2012; Stephens, 2013). Many students on professional programmes exhibit poor health behaviours and significant levels of emotional distress (Cleary, Horsfall, Baines & Happell, 2012; Deasy, Coughlan, Pironom, Jourdan, & Mannix-McNamara, 2016; Slavin, Schindler, & Chibnall, 2014). Further, health programmes can in themselves have a negative impact on student mental well-being (MacLean, Booza, & Balon, 2016). Not only might the realities of clinical placement put student mental health under stress, curriculum content can challenge personal beliefs and generate levels of cognitive dissonance that create additional psychological distress (Stephens, 2013; Thomas & Asselin, 2018; Thomas & Revell, 2016). This is particularly concerning given that students on health programmes need to be able to respond to difficult situations and maintain good mental well-being (Thomas & Asselin, 2018; Thomas & Revell, 2016). Glass (2009), for instance, has shown that resilience is a necessary quality in everyday nursing practice.

While university services providing mental health support are reporting significant increases in demand (Williams et al., 2015; Thorley 2017), most students with mental health problems do not seek formal support in an appropriate or timely manner (Hunt & Eisenberg, 2010). As a result, there have been calls for universities to take ‘whole institution approach’ to student mental health (e.g., Universities UK, 2017; Reavley, Ross, Killackey & Jorm, 2013). These calls acknowledge that reactive services alone cannot meet the challenge of supporting student well-being effectively, given the numbers of students experiencing problems and the numbers that do not seek formal support. To address student mental health, it is argued, universities should ensure that every aspect of a student’s experience is designed to support their mental well-being (Hughes, Panjwani, Tulcida, & Byrom, 2018; Universities UK, 2017).

This poses a challenge for the role of academics, as the ‘whole institution approach’ potentially shifts more responsibility for student mental health towards them. For most students the only guaranteed contact points with their university are their curriculum and their academics, hence universal approaches to student mental health need to engage academics. There are already proposals in the literature for health curricula to be re-designed to better consider the well-being of students (e.g., Slavin et al., 2014). However, less attention has been paid to the specific role of individual academics in responding to student mental health. Academics on healthcare programmes may face exaggerated and unique challenges, due to the additional strain that healthcare programmes can place on student mental health and the demands of a professional training programme. In this context, we urgently require greater understanding of the challenges faced by these academics. Addressing this gap, we consider the roles and responsibility of academics who are teaching on professional healthcare programmes.

BACKGROUND

The challenges that healthcare academics may face in managing student mental health can be considered in the wider context of the role and experience of all academics in relation to student mental health. These challenges are not new; in 1997 Johnston reported that academics felt it was ‘becoming increasingly difficult to provide adequate pastoral care’ for students (Johnston, 1997). Previous studies have identified that it is common for academics to provide support for students with mental health problems (Margrove, Gustowska & Grove, 2014; Reavley, McCann & Jorm, 2012; Farrer, Gulliver, Bennett, Griffiths, 2015; Hughes et al., 2018) and that academics are in a frontline position regarding the provision of support (McAllister, Wynaden, Happell, Flynn, Walters, Duggan, Bryne, Heslop & Gaskin, 2014; Hughes et al., 2018).

While it is common for academics to provide such support, many academics do not feel equipped to manage this role (Gulliver, Farrer, Bennett, Ali, Hellsig, Katruss & Griffiths, 2018) and do not feel that the necessary structures and cultures exist to support this work (Hughes et al., 2018). Specifically, academics often feel unable to differentiate between normal emotional challenges and mental health difficulties (Laws & Fielder, 2012; Hughes et al., 2018; McAllister et al., 2014). These knowledge deficits reduce the confidence of academics working with students (Clearly, Walter & Jackson, 2011; Margrove et al., 2014).

However, previous personal or professional knowledge around mental health has been identified as increasing self-confidence, leading to a more positive experience when supporting students (McAllister et al., 2014). It is thus possible that, in contrast to academics without a background in healthcare, healthcare academics may find supporting student mental health both to be easier and a more positive experience.

Regardless of experience, provision of support for student mental health remains emotion work. Emotion work is an essential component in establishing a trusting relationship between teacher and student (Huyton, 2009). Substantive emotional costs have been identified in

academics supporting students with mental health difficulties, including; distress in response to the student disclosure, apprehension about becoming involved, anxiety about their ability to provide support, being emotional drained and fears for the student's safety (Gulliver, et al, 2018; McAllister et al., 2014).

The emotion and time cost of supporting student mental health is not adequately recognised by universities (Hughes et al., 2018). Academics feel that time spent supporting student mental health detracts from other work that is part of their performance requirements and as such, there is a professional cost to providing pastoral care (Laws & Fielder, 2012; Hughes et al., 2018). Huyton (2009) cautioned that failure to recognise the value of emotion work will have a detrimental effect on tutors and the service they provide students.

The lack of support in this area appears systemic; while academics do not recognise supporting student mental as part of their job description, it feels an inevitable part of the role (Laws & Fielder, 2012; Hughes et al., 2018). Academics commonly describe institutional support for their role in responding to student mental health as insufficient or unavailable (McAllister et al., 2014; Hughes et al., 2018). Where academics are not supported in responding to student mental health needs, staff can avoid deep investment with students and may establish a protective distance where possible (Laws & Fielder, 2012).

METHODS

Aims

The aim of the study was to explore how academics on nursing and healthcare programmes are managing the additional complexity of their roles and responsibility in relation to student mental health.

Design

A qualitative approach, using semi-structured interviews and focus groups, provided the opportunity for in-depth analysis of the issue. Data were collected and analysed following principles of grounded theory, with iterative identification and assessment of concepts over the data collection stage (Strauss & Corbin, 1998).

Participants

As part of a wider study considering the role and experience of academics in relation to student mental health (reported elsewhere; Hughes et al., 2018), 14 academics, identified as teaching on professional courses related to health and social care, were interviewed individually or in focus groups. This variation provided the opportunity to assess whether academics on healthcare programmes discussed common concepts in different contexts.

Academics were recruited with the assistance of university senior management. Of these academics, seven participated in focus groups and seven in interviews. Of the focus group participants, four attended one focus group comprised entirely of healthcare academics (Focus Group 1; See Table 1). The other three were participants in focus groups made up of academics from a range of subject disciplines.

To understand how issues around student mental health influence healthcare academics across high education, purposive sampling was adopted to capture a spectrum of experience and seniority, as summarised in Table 1. All academics had a student facing role and direct contact with students. Academics teaching on nursing and midwifery programmes were predominantly working on pre-qualification programmes. Interviews were conducted at five institutions, representing a range across England, including large and small institutions, and single campus and city-based multi-campus universities. One institution was founded in the 19th century, two were founded before 1992 and two after 1992.

Data Collection

Focus groups and interviews, completed in May and June 2017, followed a semi-structured set of questions, with the same questions for both focus groups and interviews. Each interview ran for approximately 30 minutes. Focus groups ran for an hour. The questions, summarised in Table 2, addressed how the academic would become aware of a student experiencing problems with their mental health and how they have responded to students experiencing mental health difficulties. Academics were asked whether they had sufficient resources to support students to manage their mental well-being and where they turned to for support.

No questions were asked about challenges that are specific to healthcare programmes. The themes recounted below emerged naturally and without prompting as healthcare academics described their experiences and practice.

All focus groups and interviews took place in a quiet and private room at the participant's work place and were run with one female and one male interviewer present (NCB and GJH). NCB is a lecturer in psychology and both facilitators have extensive training and experience in qualitative research. The participants were not known to the researchers prior to interviews and focus groups, however both researchers have a strong understanding for the context, of Higher Education, where the participants are working. Specifically, NCB has been working in the area of student mental health in the UK for a decade, supporting non-clinical approaches to improving mental health across higher education. GJH is a psychotherapist with 20 years' experience working in mental health and well-being services in Higher Education.

Ethical consideration

Participants were given the option of participating in either a focus group or one-to-one interview. All participants were provided with information about the study, including the

rationale for the research (to better understand how academics are managing the risk in concern around student mental health), several days prior to participating and encouraged to consider whether they felt participation was appropriate for them. All participants provided informed consent. Interviews and focus groups were completed with a qualified and experienced psychotherapist present (GJH), to provide additional support, should distress arise. Ethical approval was granted by the university research ethics committee.

Data analysis

Following the principles of grounded theory, analysis was supported by reflection and discussion between researchers after each interview or focus groups. This process allowed a rough version of categorisation and coding to take place with constant comparative analysis. Further, as theories emerged, we were able to test these in subsequent interviews until a point where a level of theoretical saturation was achieved.

In addition to this process, each focus group and interview was recorded and transcribed. Transcription was completed by the researchers, providing a second in-depth opportunity to review the interviews and focus groups. A second process of analysis then took place with transcriptions, with detailed categorisation and coding completed independently by the two researchers (NCB, GJH). This process was supported by NVivo. The results of this analysis were synthesised through a process of discussion between the two researchers. Where differences arose, discussion continued until consensus was reached.

RESULTS

Four key themes, relating to the experience of academics on healthcare programmes, were identified. In summary, academics had difficulties in identifying and maintaining boundaries due to competing academic and professional identities. Further to this, student disclosures of difficulties were accompanied by additional challenges arising due to professional

responsibilities. Academics reported problems associated with supporting student mental health on placement. Academics were aware and concerned about the potential negative impact of course content and practice on student mental health.

Quotations from the transcripts have been provided as illustrations. The source of each quotation is identified at the start of the quote. For participants in Focus Group A, individual participants have not been identified and quotes from this group are attributed to the group (GA). Where participants have been quoted, alternative quotations supporting the same point also exist.

Theme 1 – Academic vs Professional Roles

Academics on health programmes (healthcare academics) identified that the boundaries of their role, in responding to student mental health, are often blurred and that many students seek support, for their mental health, from their academics. Healthcare academics encounter additional challenges and complexity in identifying and maintaining appropriate boundaries.

The first of these challenges derives from the fact that healthcare academics occupy two professional roles and identities – as lecturer and as health professional:

GA.1: It is difficult because we are not just academic staff, we are on a professional register as well and it is difficult to keep these two things apart and not, sort of, try to do too much in the role as personal tutor.

GA.2: Being a nurse, doesn't help, with blurring those lines... so this can become a bit of a challenge

On several occasions healthcare academics used language to suggest that they saw significant overlap between supporting students and their clinical roles:

P5: When I stopped being a practitioner to become an academic, I was worried that I'd stop being a practitioner and end up becoming [just] an academic and that hasn't happened at all. It's just like I am doing practise really.

P6: I think one of the difficulties is that we have said things to them like look 'in our professional role this is like a doctor patient relationship, you tell me anything and it stays with me, unless you indicate otherwise.'

GA: But when they drop in and they are crying, actually me saying "I need to do this marking and you haven't made an appointment" it is not helpful. So, you end up seeing them and then, yeah, everything else just has to wait. So then again, it kind of makes it feel like that kind of, um nurse – patient relationship, where patients just drop in and dump all their problems, with no appointment, so you go back to that, what feels very natural to me, the nurse-client relationship, not the teacher-student relationship.

Difficulty in separating out role identity can be driven by motivating factors on behalf of both the academic and the student.

First, healthcare academics often have a professional desire to help and possess a skill set that means they could support a distressed student who sought their assistance. Understanding which professional responsibility they should maintain and sometimes resisting the desire to step into their professional health role, when confronted with a distressed student, seemed understandably difficult:

GA.1: A lot of nurses want to make it better, I think that is sometimes the danger, we hold onto stuff that other people wouldn't hold onto, we take a bit too much responsibility for trying to make students happy.

GA.3: Thinking of a couple of my colleagues, one of them was very clear to say to her colleagues, “you are their personal tutor, you are not their therapist” I think we struggle.

P14: I’m not here as a practising occupational therapist, you know... but I have that knowledge and that background that helps me pick up on those things.

One participant in the study discussed the fact that sticking to the boundaries of the role of academic and signposting a student to support services, can be personally challenging:

P14: ...its more drawing on other services to help you in that process or actually handing that over and that’s VERY HARD, as an occupational therapist that very, very hard to do because you naturally want to be more involved.

Second, the relationship between academic and student, that occurs on health programmes, can create a challenge for boundaries. The nature of programme structure, practical aspects of the course and periods of time on placement, away from campus, can place additional focus on a student’s relationship with their academics that make them the obvious source of support when problems occur:

P5: So, from my perspective, relationships are foundational to my practise, partly because there is a huge amount of taught element that, in terms of, my own approach are kind of seen as role-modelling. And how to build relationships with people is foundational to kind of what we’re doing, really. With mental health nursing is about building relationships with people.

The existence of strong positive relationships with academics means that students can be more reluctant to accept signposting or support from other services:

P9: The thing I find most difficult is that, we do have a good relationship with our students, because we teach in small classes and we cap the number of students on our

course and so we always have very small cohorts in front of us, so you know them really well and one of the difficulties is, when they come to you, they don't really want you to send them somewhere else.

Theme 2 – Professional Responsibilities

Healthcare academics identified a further challenge in maintaining clarity about the boundaries of their role. While students may turn to them for support, healthcare academics often have a duty to ensure that students are not too ill to practice on placement. If a student is deemed to be mentally unwell, the academic providing support, may also be the person triggering a process to remove the student from placement. This can create conflicting responsibilities and a dual role for the academic; on the one hand protecting patients, while on the other, wanting to support their student and recognising that removing them from practice may have a further negative impact on their mental well-being:

GA: You need to let them know, that, depending on the context, we may need to refer them onto occupational health or take them out of practice and let them know that while on the one hand we might be saying, for whatever reason, we don't want you in practice at the moment, that doesn't mean that you won't go back into practice. But there is no guarantee that you will, so it is somehow balancing and supporting that student but in that professional context and then making sure that they understand that we are also on the register and have that duty of care to them and to the rest of the student group and the clinical areas.

Professional programmes face significant additional requirements when compared with other degree level courses. External awarding bodies are explicit in demands that students complete minimum hours of attendance in the classroom and on practice. Students carry a responsibility to maintain professional standards of behaviour and practice from the moment

of enrolment onwards. Healthcare academics highlighted that this can make it more difficult to offer the kinds of support that may be available to other students:

P13: We have a professional regulation of our programme. They have to do a certain amount of time in university and in practice. Which means they can't just step off for a week or two, or it is harder for them to do so, because of the implication, if they are not doing the hours that are required, they are not going to succeed in the programme. So, it becomes a real tension really.

Theme 3 – Placement

Time spent outside of the traditional university environment on placement was highlighted as potentially problematic, both in terms of the additional stresses it can place on students and the fact that responding to student mental illness can be more difficult when they are on placement.

Healthcare academics suggested that students can feel isolated on placement and that the challenge of practice can place mental well-being under further pressure:

P13: We have students isolated on placement in the sense that there will only be two or three of them working out in a hospital.

P14: Especially for someone who's still in a practice environment, it's totally new to them, they might not have the most wonderful relationship with the practice educator.

GA: Yeah, they do, their first bereavement on practice and things like that, or they see reflections of themselves in the patients that they look after. I see that quite often...

Perhaps because of the challenges encountered on placement, it appears that mental health difficulties often occur or become more visible during this time:

GA: Sometimes [mental health difficulties get] identified in practice and you'll get a phone call or frantic email with concerns about a student in practice. I think that is one of my most difficult experience.

P13: Our practice colleagues, when they are in practice, because they are working with the public, if there are mental health issues demonstrated in practice sometimes the supervisors will contact us and flag that they are concerned about the student's welfare.

P11: I have for example been out to a student in a clinical placement setting... [She was] doing very well academically on her course, gone out on her first placement and struggled due to health issues and became suicidal as a result.

However, responding effectively to these presentations of mental ill health, is made difficult by the fact that the student is out of the university environment, at a distance from academic staff and therefore at a distance from support services and regular observation from their tutors:

GA: I mean I've had situations where people have been very manipulative in practice and that is very difficult to manage because they are telling everyone a very different story... it isn't a black and white judgement.

P11: I'll get to visit them once a month, over a three-month period, so they don't get to see me very often. They'll be more reliant on their clinical colleagues for support. Although obviously I'm contactable by email.

While a solution to some of these challenges might lie with occupational health, one academic, identified this as an area for potential improvement:

P5: There's occupational health, all the stuff you'd expect to see in place. But the connection between myself and them and how they work, isn't very close.

Theme 4 – Potential Impact of the Academic Programme on Student Well-being

Healthcare academics identified that their programme of study can, in itself, have a negative impact on the well-being of their students. Several the participants agreed that the nature of professional health programmes require students to be resilient and psychologically able to respond to difficult situations:

P11: [Students] will deal with people from people from day one. With patients, with emotions, with people dying, so they need a mental health that is stronger.

P13: When they go into practice, they have to be able to problem solve, find their own meaning of things, deal with change, you know and look after themselves emotionally, spiritually and physically.

In addition to the challenges of the programme, healthcare academics had witnessed issues encountered on placement and with the course content, having an impact on pre-existing problems:

P14: It might be that in placement allocation, we suddenly find that a student feeds back, actually, that an eating disorders clinic placement isn't suitable for [them] or that mental health setting isn't suitable for [them] because... and we didn't know that... But we then do have to take into account, is this going to affect them in practice because we do need our students to have a range of practice environments so it's about making realistic real judgements.

GA: One of my challenges is I teach palliative care, so I tend to get... people come up to me at the end of lectures and talk to me about bereavements and such and so it is an issue that I do, sort of, it is something that happens quite a lot.

One academic also suggested that encountering academic criticism of models of health practice, can undermine an individual student's conceptual model of their own previous recovery, thereby putting their mental health at risk:

P5: I think for folks who have had experiences of using services without debate, so they've just been told "this is what it is, there's your diagnosis, there's your treatment" and then they arrive and then they could encounter; 'Actually it's not as simple as that, there's whole other ways of looking at it.' I do actually worry about those folks because their recovery is founded on 'This is how it is, I've got my head around that now, I've got it thank you very much,' and suddenly they're being told that 'Well that's one way of looking at it, just a model, it's not the truth of anything.'

DISCUSSION

The findings of this study concurred with previous observations in relation to how academics, in general, are managing student mental health. This included the observation of a frontline position (McAllister et al., 2014; Hughes et al., 2018) and that supporting student mental health felt common place (Margrove et al., 2014; Reavley et al., 2012; Farrer, 2015; Hughes et al., 2018). There was further acknowledgement of the emotion work required in this role (Huyton, 2009; McAllister et al., 2014). There were also areas where healthcare academics appeared to face unique challenges and had different experiences from academics working in other subject areas.

Identification and maintenance of boundaries, in relation to responsibility for supporting student mental health, is particularly challenging for healthcare academics. While academics in general do not recognise supporting student mental health as part of their formal role description (Laws & Fielder, 2012; Hughes et al., 2018), healthcare academics are translating their professional caring responsibilities into their education role. Healthcare academics thus

require greater clarity around the boundaries of their role in relation to pastoral support for students.

Unlike academics in other subject areas (Hughes et al., 2018; McAllister et al., 2014) and indeed, in contrast to previous work with academics in nursing (Laws & Fielder, 2012), healthcare academics in this study did not report feeling unequipped to support student mental health. However, academics did identify a lack of confidence in their ability to put boundaries in place. This appears to reflect a structural challenge inherent in their role, rather than a skill deficit.

Previous literature has identified that professional knowledge around mental health may increase self-confidence and lead to a more positive experience responding to student distress (McAllister et al., 2014). This study suggests that there is also a cost to this professional knowledge. While provision of mental health support for students is not part of the role description, having the skills to provide support may make it harder to maintain boundaries and rely on other university support services.

Healthcare academics have a complex role, adhering to two separate codes of practice (Adams, 2011). This creates structural challenges around divergent responsibilities.

Healthcare academics feel they have both a professional responsibility to act in a student's best interest and to act in the best interest of patients and protect their safety. Where these interests conflict, such as when fitness to practice concerns arise, healthcare academics are placed in an invidious position. One solution may be to separate out pastoral support from the responsibility of identifying and pursuing fitness to practice concerns.

Academics working on healthcare related courses raised concerns about the impact that student mental health problems have on educational engagement. While this concern has been raised in the wider higher education literature (Lindsey et al., 2009; Verger et al., 2010),

it is apparent that the structure of healthcare related programmes creates additional challenges for students, seemingly increasing academics concerns about the impact of mental health problems.

The potential negative impact of course content and practice on students is also worthy of further consideration. Supporting previous observations of the negative impact of health programmes on student mental well-being (MacLean et al., 2016), academics are aware and concerned about the impact of their course content on student mental well-being. As Slavin, et al., (2014), have shown, carefully designed curriculum to support the development of well-being and resilience of healthcare students can have a positive effect. Given concerns about sickness in the healthcare workforce (e.g., Royal College of Physicians, 2015; AbuAlRub, 2004; Schneider & Weigl, 2018; Forbes, 2018; Perry, Lamont, Brunero, Gallagher & Duffield, 2015), there would appear to be a strong argument for ensuring the development of personal well-being as a key component of professional health courses. This may require joint action from universities and external awarding bodies to review and revise current curricula and practice.

In particular, placement was highlighted as being potentially problematic for the mental well-being of some students. Given the need identified in the literature for healthcare staff to be resilient (Glass, 2009), benefit may be gained from more explicit pre-placement preparation, to help students develop strategies to better support their mental health when confronted with the challenges of practice.

Finally, this space may benefit from further work to improve relationships and practice between academics, occupational health providers and student services. It may be that other services are better placed to provide ongoing support to students, thus reducing conflicts of interest and strain on academic staff.

Limitations

This paper is based on qualitative data drawn from in depth interviews and focus groups with a relatively small number of participants. For that reason, care should be taken in assuming that the findings reported here are replicable across all healthcare programmes. Further quantitative studies would provide an opportunity to assess the universality of the themes identified here and directly compare the prevalence of these themes across institution, seniority and subject design.

Importantly this paper considered the challenges faced by academics exclusively from the perspective of the academic. The focus here was to understand how student mental health is being managed by and is having an impact on academics. This work needs to be considered in the wider context of student mental health and would be complemented by further work exploring the role of academics from the student perspective.

Conclusion

Academics on professional courses, related to health and social care, face additional challenges and complexity in responding to student mental health, including complications around identifying and maintaining boundaries, competing professional identities and the potential negative impact of their course on the mental health of students.

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