Helping students with mental health issues

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How the best practices in working with students with learning disabilities are paving the way to improve outcomes for students who are emotionally distressed.

Photos by Shanghoon.

University campuses across Canada are struggling with a mental health tsunami that is reordering priorities in every community and educational institution. Dealing with crises and the potential for suicide has altered the lives and agendas of people working in schools, hospitals, municipalities and service agencies, as well as parents and students. If mental health is the problem, suicide and suicide attempts are the outcome that tells us that we have to do better.

At this point, more people in the world die from suicide than in wars, domestic murders and natural disasters combined. This statistic reflects life out of balance and speaks to the loneliness and isolation of people who find their suffering too much to bear. People who feel isolated often withdraw further from face-to-face interaction, and yet compelling research shows that more “screen time” translates into greater loneliness. It is ironic, therefore, that many of the resources developed to treat troubled youth are web-based and are likely insufficient to pull withdrawn individuals out of their isolation.

Postsecondary students who are depressed or anxious have difficulties with academic discipline. This leads to underachievement and often to dropping out of school. When students drop out, the loss of income to universities can add up to significant sums. Of course, the loss of human potential is beyond calculation.

Dealing with mental health problems that involve stigmas, isolation and loneliness requires solutions that are individualized, constant and personal. This means a relationship between two people and access to more resources. Often it involves counselling services, though many services are booked beyond capacity and can’t respond quickly enough. Moreover, these services are sometimes avoided by students who don’t feel they have mental health problems or who know they have problems but want to avoid the stigma of going to counselling. This is especially the case with international and first-generation immigrant students who may see any mental health problems as a mark of shame.

But solutions to this crisis have emerged that *have* been staring us in the face.

During the past 20 years, postsecondary students with learning disabilities in Ontario have gone from likely failure to likely success. The reasons for this are deliberate and clear: There was a concerted effort to develop best practices for supporting learning-disabled students by the Learning Opportunities Task Force led by former Ontario cabinet minister Bette Stephenson from 1997 to 2002, and as a consequence all colleges and universities in Ontario contributed to this success[1].

The Paul Menton Centre at Carleton University has, over the last three years, taken what we’ve all learned from working with learning-disabled students at university and college and has deliberately applied these lessons to students who are suffering from non-diagnosed mental health problems. The results have been excellent, and they have encouraged us to further develop our program and to share our findings with colleagues at other institutions through conferences and outlets such as *University Affairs*.

What we know through working with learning-disabled students is that the best practices involve services and supports anchored by the therapeutic alliance – a close working relationship between the student and coordinator.

Support includes concrete assistance such as learning strategies and time management as well as emotional support. Since the diagnosis of a learning disability requires a comprehensive psychoeducational assessment, the coordinator knows the student and knows better than anyone else how that student learns.

A few years ago we posed a question that went like this: What if we applied the basis of this learning-disabled model to students with mental health issues? In other words, what if we provided educational testing, a dedicated and knowledgeable coordinator and an expectation that students commit to a program and are accountable on a weekly basis? Furthermore, to really prevent mental illness, what if we provide the program to students who are stressed and overwhelmed but have not yet been diagnosed with a psychiatric diagnosis (based on the *Diagnostic and Statistical Manual of Mental Disorders*)?

It is our long-held contention that for some students, the traditional student services are not enough. Many of these students fall between the cracks; they are bright, capable students with the potential to succeed but without the means, motivation or wherewithal to translate their intentions into action. In answering these questions, our program, From Intention to Action (or FIT:Action), was born.

The students who take part in FIT:Action have a wide range of differing experiences, but they all graduated from high school with grades that meet program requirements for university. Some have dealt with chronic low-level anxiety that undermines their work. Others have had to cope with a major stressful life event such as a death in the family or a break-up with a fiancé. Several have chronic medical conditions (including epilepsy, irritable bowel syndrome and chronic pain) that add uncertainty to their lives. Some were pushed into programs that did not motivate them.

Others have learned English as a second language and, while their speaking skills are often strong enough, their reading skills are much weaker. Some bright students who were successful in high school without having to develop study skills are shocked and discouraged when their native ability isn't enough to obtain the grades they always had.

The unifying factor is that they want to change and will respond when a lifeline is offered.

FIT:Action, however, is not for everyone. The challenge of translating intention to action means that students – regardless of their profile or difficulties – must agree to fulfil the basic tenets of the program, including assessments, weekly meetings and follow-up exercises. The fact is that no one is able to translate intention into action without a deliberate leap. Students who are struggling often appear passive and unengaged in their own lives, and we know that the best defence against mental illness is to create a structure that requires constant engagement, human contact, personal accountability and plain old work.

More than half of our FIT:Action students are seen by counsellors who are master's students in educational counselling, working on an unpaid practicum. Our program is a highly sought-after placement that is required to complete graduate degree requirements. Our interns are bright and caring, have taken essential counselling courses and are highly motivated to make a difference.

All of our FIT:Action students meet with psychologist John Meissner and receive copies of all assessment results. In each case, Dr. Meissner and the student collaboratively develop goals to begin the program, and these goals provide a starting point. Emphasis is on time management and work scheduling as well as other learning strategy systems. Students do not have to talk about personal problems if they don't want to, but eventually almost all do because these problems interfere with school.

Students also have their transcripts reviewed in the form of an audit. In this way they learn what courses they have to take and in what order to meet department and university requirements. They also come to better understand what grades they require. As one student noted, "It's easier to find out where you are going when you know where you are, and way better than being lost."

In our first two years of FIT:Action, we recruited from a pool of students who were on probation. At the end of the 2011-2012 school year, we compared the marks of our FIT:Action students with a group that had been matched by overall grade point average and program from the previous year (whom we call the pre-FIT:Action group). All FIT:Action students had been struggling with academics and life situations that contributed to academic stress and underachievement.

Our research shows that improved mental health is directly linked to improved retention. The students in the FIT:Action program made significant improvements ($p<.001$) in their major grade point average and overall grade point average, while the comparison group had no changes in overall GPA and only a trend towards improvement in major GPA ($p<.10$). (See chart on this page.) And, the most recent (2013) FIT:Action group of students are continuing to show improvement in their GPA.

We were buoyed by these results and sought to recruit students who felt persistently “overwhelmed,” not just those on academic probation, and we advertised our services to all students and to staff throughout the university. We succeeded in finding just over 150 such students, as well as roughly 70 from the pool of students on probation. Self-referred students were distressed; intake testing showed they had significantly more emotional problems than students recruited due to weaker grades.

In December 2011, we collected data on a quality-of-life screening questionnaire (the SF-36 Quality Metric) that evaluates physical and mental health reliably and accurately. At the end of the academic year we conducted exit interviews and re-administered the questionnaire, looking specifically at mental health composite scores that have been used to screen for depression in youth populations, allowing the detection and treatment of emerging depressive symptoms.

Significant improvements were seen in the mental health composite scores on the questionnaire administered at the end of the fall term and just before finals in the winter term. A “dose effect” was seen as well: students who had had 10 or more support sessions showed significant improvement while students with four to nine sessions did not improve significantly.

We were most concerned about those students who scored below the normal range on the quality-of-life questionnaire. The bottom third of our combined groups showed significant improvement in mental health scores, with the average shifting from below the normal range (which is 40 to 60) to the normal range. Students in the top two-thirds, who were in better shape initially, did not change – nor did they need to. (See chart at left.) In sum, this shows that we can positively affect students’ well-being and can do so without formal psychiatric diagnoses in a program that uses graduate-student interns to provide counselling for most students.

As we move forward, our plan is to target and support the most vulnerable students who make up a very small percentage of the student population. We have developed a pilot project with the Ottawa-Carleton District School Board where we are seeking referrals from each high school for graduating students who have been accepted at Carleton University. We have asked school counsellors and teachers to identify students who have required extra help in high school and who would benefit from FIT:Action support (and who do not qualify for extra support, such as learning disability support). If this program is effective, we will expand it to include six other school boards in the region that contribute 50 percent of our first-year students.

The success we have seen can be simply represented with graphs and numbers. The real meaning, though, is personal and is based on commitment, hard work and development, but most importantly on the connection between people. It is this alliance that reduces isolation and brings individuals back to themselves so that they can better achieve their potential.

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[1] The Transitions Longitudinal Study showed that postsecondary students with learning disabilities who received appropriate supports had a seven-year graduation rate of 91 percent, compared with the provincial average of 78 percent for students in the general population.