Challenges in working with hard-to-reach students in further education

Clients who do not attend can present a number of challenges, not least of which can be organisational. **Enrica Balestra** describes the value of perseverance

Library picture, posed by model

In this article I will present the work I did with a 19-year-old male student who I will call 'John' between November 2009 and June 2010*. I have chosen to turn this particular piece of work into an article for two reasons: first, because it highlights some of the emotional and psychological struggles that male students, an often underrepresented group in counselling statistics, can face during their time at college. And second, because this piece of work shows that what may look like a waste of college resources (ie an irregular pattern of attendance) is often a symptom to be understood and worked with in a flexible and considered manner. I believe this is a particularly important point to make at a time when financial pressures and the need to appear busy at all times might tempt us to 'close the door' on those (often very vulnerable) students who find the very notion of asking for help daunting in the first place.

Indeed, judging from the October 2010 thread on DNAs on the further and higher education (FE/HE) jiscmail lists, as well as the more recent round of cuts and closures to services, it appears that as counsellors in further and higher education we are increasingly coming under pressure from student services managers to account for our time as well as to record and explain potentially contentious figures such as cancellations and no-shows. It is easy to see that from the point of view of cash-strapped institutions, needing to make budget cuts and efficiency savings, a string of unattended counselling sessions can seem like a perfectly logical reason to cut back on counselling services, or question the legitimacy of their existence altogether ('no-show' = 'no need'). The problem can be particularly acute for FE colleagues who often work with vulnerable 16 to 19-year-old students with complex needs: a group known to be particularly hard to reach and to engage with in a consistent and reliable way. This was highlighted in the response of the leading children's charity Barnardo's to the 2008 Child and Adolescent Mental Health Service review, where the need to rethink expectations around attendance and missed appointments is emphasised as crucial for this age group and their families[1].

Missed appointments and cancellations are rife in all age groups and affect doctors' and nurses' appointments as well, a trend that led the Developing Patient Partnership (DPP) to launch its annual 'Keep it or Cancel it' campaign as early as 1998 in an effort to reduce the scale of the problem. Figures from the HSCIC (Health and Social Care Information Centre) show that in 2010-11, 6.8million hospital appointments were missed in the UK[2]. As for our sector, the statistics that we do have point to a national average for DNAs of 17 per cent (with a range between seven per cent and 34 per cent) across all services, and a 19 per cent average for HE[3]. Unfortunately, there is still little or no data available specifically for FE, where counsellors often work alone with no admin support and therefore have little time to collect, analyse and publish data, but I would imagine that the average for DNAs could very well be higher than that in HE. My own figures for 2010-11 were: 18.5 per cent DNA, 13.5 per cent cancellations.

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Faced with such a widespread and contentious problem, it seems particularly important to challenge and reframe the negative perception of DNAs. As an article in the *British Journal of General Practice* highlights, a negative perception of missed appointments may lead to management strategies which are mainly aimed at punishment (such as charging for missed sessions, as well as actual or threatened removal from the GP list). These strategies do not give due consideration to other factors such as resolution of symptoms, time from making the appointment to the actual appointment, ease of making and cancelling appointments, socio-economic variables, age, gender, ethnicity and mental health state[4]. In the context of counselling, and counselling in FE in particular, other important factors to consider in trying to understand missed appointments include: attachment styles, stages of change, as well as whose agenda it is for the student to access the service in the first place.

Indeed, simply viewing the person who misses appointments in a negative light, as well as considering missed appointment time as just wasted, can sometimes be a way for professionals as well as for institutions, not to examine the limitations of their practice as well as the viability of what they offer. In an FE setting this often means providing a minimal service to an often very diverse student population, which is underresourced and overstretched. Counsellors in FE mostly work on their own on a part-time, term-time-only basis; within any given college, a counsellor will often need to be able to work with young adults as well as with mature students and staff. The ability range can also vary from students with moderate and severe learning difficulties and physical impairments, to those working towards foundation skills, GCSE or A levels. In such a context it can be particularly

hard to be able to work flexibly and thus meet adequately the different levels of need which each client will bring. However, as the following case study, illustrates, we can hardly rely on a one size fits all model – where all students are expected to be able to access a service simply because it is offered to them – or on 'blaming the patient' if we are to be truly helpful to some of our most disadvantaged and harder-to-reach students.

John came to counselling at the suggestion of his tutor who had noticed that, although otherwise conscientious and dedicated, he was underperforming in all areas of his work. When I met him it became clear that he was in dire need of help. Polite and soft spoken, John found it difficult to make eye contact, was unkempt, reeked of cigarette smoke, and looked as though he had not had much sleep in quite some time. As he began to talk about his concerns, John revealed that he had been self-harming, as well as drinking and smoking excessively for the past two years. He also revealed that his sleep was severely disrupted. He said that he would often stay up all night drinking while surfing the web, and that he would regularly go without eating.

When I asked John if anything had happened in his life around the time he began to self-harm, he said that his long-term girlfriend had left him. He said he was heart-broken, but thought he should just be strong and carry on. He said he then found a job and was working 12-hour shifts as well as coming to college when his beloved granddad died. Again John said he felt 'all choked up' but did not feel like he could talk to anyone and so he started to drink in addition to continuing to self-harm while working even longer hours. This pattern of poor self-care, overwork and destructive coping mechanisms lasted for about three years, until John reached physical and emotional burnout, and could barely function any more. John also revealed an underlying family history of substance abuse and emotional/physical neglect dating back to his primary school days, which meant that his parents had often been unable to care for him in a consistent and meaningful way.

When I asked John what he made of his ongoing drinking and self-harming behaviours and whether he saw his general lack of self-care as problematic, he said that he did not and that the main thing that concerned him was his lack of energy and the negative way in which it was impacting on his work at college. He said that self-harming and drinking were a way for him to stay alive and to cope with his emotional pain. When I put it to him that his strategy sounded very lonely and self-punishing, John said that he did not want to burden anybody with his feelings. He wanted to be strong and to make people happy. He said he also always wanted to push through and achieve, and give his all to everything he did.

John's case is typical of the way young men are often reluctant to ask for emotional support, and attempt to cope with stress through drink, smoke and drugs. Indeed, Mind research shows that 'almost twice as many men as women drink alcohol to cope with feeling down', and that 'men account for three-quarters of all suicides in England and Wales'[5]. John, like most of the men who resort to substance or alcohol misuse, suffered under the expectation to appear powerful, strong and self-reliant at all times, and regarded the expression of sadness, fear or disappointment as a sign of weakness[6] These attitudes constitute a real barrier to the emotional work that would be required to heal the underlying pain (in this case, grief and anger), contain the self-harming behaviours, and reduce the risk of future relapse. Seeing the counsellor means not only having to face one's long-denied pain, but also revealing it to someone else – a prospect which can be intimidating, or even terrifying if there is an active history of shaming and abuse around the expression of sadness/fear within the family (or with peers).

Typically, these young men will find it difficult to engage with counselling (just as they find it difficult to engage with their emotions) and will therefore have an irregular pattern of attendance – sometimes coming for a few sessions and then disappearing, or coming once in a while – if they manage to come at all. From an attachment point of view, this group could also be described as displaying an avoidant attachment style where negative emotions are barely acknowledged, let alone expressed, and where a highly self-reliant approach is adopted at the expense of seeking contact and support from others[7]. In this specific case, John came for the first two sessions, and then, after saying that coming to counselling meant that he was not as strong as he thought he was, he disappeared. Mindful of the real struggles that John faced in accessing help, as well as the severity of his distress, I kept periodically in touch with offers of appointments and then wrote him a letter in which I acknowledged his difficulty in coming back to see me, encouraged him to make contact again when he felt ready to do so, and emphasised my willingness to carry on working with him.

John responded well to these interventions and eventually made contact again. In the sessions that followed, and which took place over a number of months, the work consisted of a mix of gently challenging the perceived positive aspects of the self-harming behaviour (by which I mean not only the actual cutting, but also drinking, smoking and starving), and a consistent focus on the gradual experiencing and releasing of the underlying emotions in the sessions with me. Although John responded well enough to my letter and offers of appointments to re-engage with the service, his attendance remained irregular, albeit constant over a number of months. Again, mindful of the issues outlined above, I saw the missed sessions as an indication of his ongoing difficulty in attending to himself, as well as of his painful struggle to let himself trust and rely on a caregiving other. I thus decided to keep a regular appointment open for him and to continue to remind him that it was there for him to take.

As a result of this patient and focused work, John's various self-harming behaviours gradually reduced (while the cutting stopped completely), his appearance changed, his energy levels improved, he established an