Enabling the capability within

Rachel Shepley reflects on the importance of her role as a mental health mentor and outlines why it is much more than a 'poor relation' to therapy

It is now 10 years since I began working as a mental health mentor within universities. My drive to write about this work arose from a personal need to feel clearer and more grounded in my practice: in the absence of a mentoring model which fitted the precise context of my work with students, my role as a mentor has evolved through my counselling training, on-the-job experience and further professional development. Whereas in my early days of practice I felt as if I was operating in some 'poor relation to therapy' capacity, I now hold a solid conviction that mentoring is a valuable activity in its own right.

My route into mentoring

During my training as a person-centred counsellor I identified an interest in working with students, the roots of which were strongly connected with my own experiences of higher education. I took a placement within the counselling service at SOAS (the School of Oriental and African Studies), University of London and my introduction to mentoring came when the disability officer asked if I'd be interested in mentoring Jenny, a student who had a psychiatric diagnosis. Initially I was uncertain about this as it wasn't clear to me what mentoring entailed. I imagined it would be directive, more 'coaching' than therapy. Although the disabled student's allowance (DSA) which funds mentoring had been in place since 1993, I could not find any literature which offered guidelines/

criteria for a student mentor. My person-centred training hadn't looked in depth at mental health/psychiatric diagnoses and I wasn't clear whether I'd be expected to possess particular knowledge about this area. I was by this time, however, firmly committed to working with students and this paid opportunity seemed like a possible way in when I was facing the reality of an uphill struggle to work within a university counselling team.

In our first meeting, Jenny and I explored what she needed from a mentor. She was open about her mental health issues, clear that she did not define herself by them or expect to be defined by them, and unequivocal about what would and would not work for her in terms of regular support. We agreed a trial period of five weeks, which turned into three years. This is what I wrote down after that first meeting:

'I want someone who'll listen to what I need to get off my chest but won't try to tell me what to do. Someone who will help me sort things out with the university if I become unwell. Someone who can help me plan my schedule and organise my work'

This became my earliest template for mentoring and, as my practice has evolved, remains the basis for my more recent ideas around the role of the mentor.

What is mental health mentoring?

In its broadest sense, mental health mentoring is intended to provide a confidential and safe place for students to be supported during their studies and receive help in balancing mental health difficulties with their academic commitments. I view the mentor-student relationship as a collaborative venture which combines good listening, emotional/relational support and more practical problem-solving support.

The funding for mentoring usually comes via the disabled students allowance (DSA) which provides extra financial help if you want to study a higher education course and have a disability, ongoing health condition, mental health condition or specific learning difficulty like dyslexia. (http://www.direct.gov.uk/en/DisabledPeople/EducationAndTraining/HigherEducation/DG_10034898)

Part of the DSA includes provision for a non-medical helper, which includes mentors. Some students, for example those with dyslexia, may require specialist study skills support from a mentor and some institutions prefer a strict emphasis on non-therapeutic intervention regardless of the nature of the student's disability. Others recruit mentors who are therapists, psychologists or those with a mental health background for students who have mental health issues.

Most students referred to me have a psychiatric diagnosis. They are referred to me via the disability officer or mental health advisor and may be funded directly by the university if they are overseas students, students in non-attendance or otherwise not eligible for DSA.

Why is mentoring important?

Students present to me with a wide range of difficulties which, having worked within a university counselling service, are common amongst students generally. Experiencing periodic or regular mental distress exacerbates the demands of an already stressful environment, particularly if they find themselves isolated from former support networks. They may be struggling to come to terms with 'having a mental health issue' and worry about what to say to others: do they tell new friends why their behaviour sometimes seems inconsistent or strange? How much should they tell tutors? Having a safe space in which to talk through these issues and explore choices and strategies can help to make life feel more manageable. Common feedback from students has been that it's good to have a place to come within the university where they don't have to present as 'together' and where the person working with them has no investment in them doing their work. This enables them to explore what they need to in an unpressured way.

How does mentoring differ from and overlap with counselling?

Therapists reading this will identify for themselves similarities and differences between the description of my mentoring practice and the way they provide therapy. I am very clear from the initial meeting with the student that mentoring involves working in a way relevant to the *academic context* and that our focus is upon the *work-wellbeing* balance. Students are coming to see me because they want to be able to apply themselves to their studies, and this is always 'in the room' with us as a mutually agreed agenda.

Mentoring can certainly be therapeutic and beneficial to general wellbeing but if a student requires specialist support, such as help with an eating disorder, I will refer them to the relevant agency. Most students see me in combination with a psychiatrist, CPN or psychologist. Some see psychotherapists, but there are more who want this support but who, for various, often financial, reasons cannot access it.

I am aware that mentoring can look like a therapy session as often students don't want me to actually do much more than listen carefully as they talk through what is important or difficult for them. I think it can be counterproductive to try and engage someone in a dynamic 'doing' working style if they simply want to feel heard and understood, particularly if they feel depressed or stuck. My supervision training helped me to develop a multi-focal presence which I find relevant to my mentoring work: this enables me to be with the student in their process while being mindful of my

responsibilities and 'organisational' expectations. For example when I'm listening to a distressed student talk about a present difficulty and how it may affect their ability to submit an assignment, I will be attending to their feelings while also holding my knowledge of the university's policy on late submission, other upcoming work the student needs to submit, what's helped this person in the past and whether I might need to flag up to the disability team that I have risk concerns about this student.

The first meeting

This is an opportunity for the student and I to see whether mentoring will be beneficial to them. I go through a contracting procedure, similar to the one I do with counselling clients, ensuring that they are clear about the structure within which we will be working, including the limits to my confidentiality.

Given the educational context of mentoring I am interested to know what has brought the student to the university, about their interest and connection to their course and how things are going so far. It's good to have some insight into the student's educational experience to date: if their mental health issues have been longstanding this path may have been interrupted.

Rather than make assumptions about any diagnosis I'll be interested to hear about the symptoms experienced and treatment/support they have had and currently receive. Medication can impact ability to study and regular appointments need to be fitted around the university schedule. A risk assessment is part of this process and it's important that I find out about their support network – friends and family, personal tutors, GPs, therapists, CPNs, and psychiatrists.

Specific support

Offering practical help with living and studying: when students want help with managing their time and schedule, I usually ask what a typical week looks like for them. Certain courses have very few contact hours so some students have large swathes of 'free time' which can feel overwhelming within their lack of obvious structure. We may tentatively explore ways of establishing a routine by 'breaking up' the time into more manageable hourly, daily or weekly chunks and looking at what needs to be timetabled: the 'what' and 'where' of studying, arranging to meet friends, appointments, shopping, doing something more wellbeing oriented, etc. If the student has a very full academic schedule we can identify pockets of time to allow for breaks and self-care.

If a student is currently experiencing life and their symptoms as chaotic, taking things bit-by-bit can ease the mental pressure-cooker effect and give some clarity around the reality of the time they have available, what needs to be prioritised and what can wait. It is important that any plan we make is firm enough to help students feel grounded and safe, yet retains sufficient flexibility so they don't feel all is lost if it isn't rigidly adhered to.

In terms of the work itself, I am clear that I can support them with the process of this but not the content. I am frequently a sounding board for ideas, enabling students to clarify and consolidate their learning.

Maintaining contact with the university

Part of my role is to support students in staying connected with the university and their external support. A period of mental distress may cause a student to miss some classes or a deadline and they may then experience intense feelings of anxiety and shame about their 'failure to keep up', causing further absence. If the student can maintain contact with me at this frightening time they are much less likely to 'fall off the radar' academically. Warmth and reassurance are important as is the formulation of a practical plan involving both appropriate support and contact.

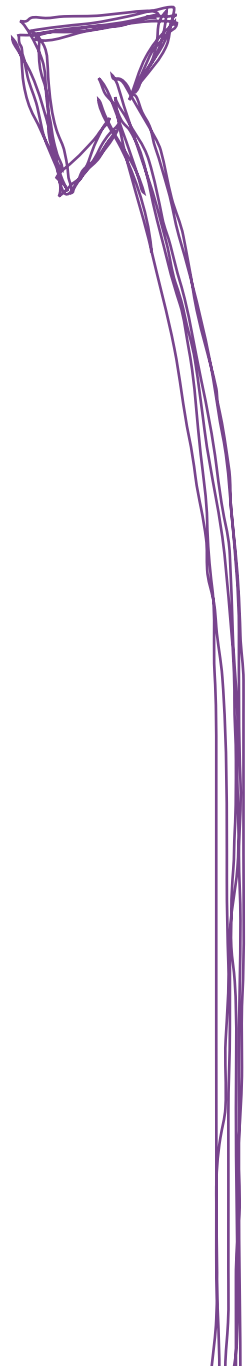
Students often request that I accompany them to meetings with their departments, particularly if they feel highly anxious or misunderstood. I am mindful in this work of wanting to promote a student's self-reliance and trust in their own capabilities. I don't want to 'enable' their sense of being a victim or incapable of making decisions but neither do I want to 'underinvolve' in situations where the student clearly needs some back-up.

My involvement with external agencies is limited as I usually provide information to the disability team who respond appropriately. I check that students are accessing their regular support, and on occasion have contact with GPs, CMHTs and therapists. I have referred a number of students to a wonderful (and all-too rare!) short-term respite centre for the suicidal, which offers some space to breathe and rest for a while.

Helping to manage the symptoms of mental distress

In the last few years my referrals have included more students who have experienced trauma such as childhood sexual abuse, sexual assault and domestic violence. These individuals commonly experience terrifying flashbacks, panic attacks, suicidal feelings, depression, disturbed sleep, dissociation/poor memory and a hair-trigger 'fight or flight' mechanism. There can be a long wait to access specialist support and the student may be with me for months without this as they wait for referrals to come through.

Students who self-harm or engage in rituals often experience intense feelings of shame about their actions but feel as though these are part of who they



are and how they cope. Being able to talk about these difficult aspects of their lives *if* they want to can provide huge relief and I tread a fine line of wanting to understand and accept how life is for them while ensuring that they receive appropriate support if I think they are at risk.

> I am aware that mentoring can look like a therapy session

Over the years I have noticed how the symptoms of mental distress can greatly diminish the capacity for effective study and have educated myself around the psycho-biological impact of stress and trauma upon the mind-body-self, attending workshops and reading widely. Students often think that the reason they find it hard to work is because they're 'stupid' or have somehow 'lost' their academic capabilities – so to have some understanding about why the brain can't work properly when we are stressed can be reassuring. I now encourage students, regardless of their particular diagnosis, to engage in a range of activities that can promote feelings of personal safety and calm, such as:

- Recognising and managing personal triggers
- Self-soothing
- Breathing and grounding techniques
- Journal writing to track and process feelings
- Exercise, meditation, yoga, Pilates, and mindfulness workshops.

Relational difficulties

Students experience significant distress as a result of the way they relate to themselves and others. Those who find crowds difficult or experience feelings of isolation usually desperately want to be 'in relationship', to contribute in class discussions or accept the offer of a coffee after the lecture, but the doing of this can feel impossible due to previous bad relational experiences or deeply ingrained beliefs and fears. I offer support and encouragement through this risky process which holds the potential for rejection and shaming but which can also begin to open up the world and build confidence.

Students often present with intrapersonal difficulties and a fragmented self. Commonly, their academic capable part can feel thwarted by the vulnerable, 'younger' aspects of self which become overwhelmed and terrified by life. There may also be a punitive, critical part which will not accept anything less than perfect. I often feel like I'm witnessing a war within a person as shame, frustration and anger are directed inwards and I talk about being more 'gentle' with the self, noticing with them when they're being overly harsh towards themselves.

The role of the mentor: what is required?

I have benefited greatly from having the freedom to develop my own mentoring practice and am wary of making one size fits all assertions around what can be a creative and fluid activity with a client group whose mental health issues tag obscures and oversimplifies the complexities and individual qualities which make up a person. I do notice that mentoring has become more widespread over the past 10 years as larger numbers of students access this support and I think it is important that universities – many of which now outsource services via employment agencies – ensure the mentors they use are suitably equipped for this work. While my experience of studying and university life is important, it is my grounding in a theoretical, philosophical and ethical framework which has enabled me to offer consistent and containing long-term support to individuals with complex needs.

Universities are often put in the position of 'holding' students in mental distress while they access NHS services, and mental health mentors are often referred distressed and vulnerable students who may have been rightly assessed as unsuitable for the short-term counselling most universities provide. The mentor needs to be both sensitive and robust, as being 'in relationship' can evoke overwhelming feelings around safety, trust and abandonment. As a student struggles to find a position in relation to me that feels safe for them, I can feel stirred up and pushed/pulled as their process impacts and connects with my own. I often turn to my core person-centred training to remind myself of the rationale for my work or to make sense of my experience. I have regular consultation with an experienced supervisor and rely heavily on my own self-care strategies. The role is immensely rewarding but can be demanding, and mentors who don't support themselves well run the risk of burnout: we need to practise what we preach!

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Reference for online DSA:

https://www.gov.uk/disabled-students-allowances-dsas