Perspective of a Student Health Centre

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GP

Background

- Student Health Centre Exeter
  - c18,000 registered – (all students)
  - c 6,000 new registrations each Sept
  - Situated on main campus

Student Health Centre
St Thomas Medical Group

Registered Population

- ‘Atypical’ – young adults 18-24
- First independent use of health services
- ‘Vulnerable’ – social, academic ,financial pressures . Isolation . Loss of support network
- Transitions from CAMHS services
- High patient and parental expectations of support (GDPR)

International students

- Cultural attitude to mental health /‘Approved diagnoses’
- High family /social pressures to achieve/Impact of failure
- Adjusting to ‘western’ lifestyle / social expectations in UK .
- No access to medical history
- Medications from home country
- High expectations of access

Impact on GP services

48 % of GP consultations – mental health

Complexity :

- **Eating disorders : 31 fortnightly risk monitoring**
- **Self harm**
- **Emerging personality disorders / emotional dysregulation**
- **Emerging complex mental health conditions – bipolar disorder , psychosis**
- **Impact of drug and alcohol misuse**
- **First declaration of abuse**

Funding issues for Student Practices

- **Carr Hill Formula – population of young adults –low funded**
- **QOF – does not recognise majority of mental health diagnoses we see - Eating Disorders , Emerging PD etc.**
- **Variability of financial support from Universities**

Registration issues

- Delays obtaining records – unable to summarise most due to volume
- Issues with vacations – many practices do not accept as temporary patients – frequent de-registration and re-registration
- ‘Out of area’ funding issues – MH services – will not accept unless registered GP in area

Clinical Risk Issues

- ‘Home’ GP surgeries refuse to see as T/R – difficult access to MH teams
- Variable transfers from home MH teams when students start – patients can get ‘lost’
- Use of private services – ADHD ,Gender clinics – long NHS waits – risks with prescribing , difference of diagnostic opinion
- Bristol Suicide case – NICE guidance

SHC Strategies to meet need

- 15 min GP appointments Nurse triage
- Dedicated Eating Disorder monitoring clinics
- Protocols for ADHD ,gender reassignment monitoring and prescribing (liaison with NHS services)
- Risk registers
- Close liaison with University Wellbeing services –monthly case discussion meetings ‘1066 service’

What would help?

- Recognition as ‘ atypical’- changes to Carr Hill formula
- Special funding streams e.g. Eating Disorders
- GP registration – improve T/R process

  ? Dual registration
- Access for Primary Care to MH records
- Collaborative working between NHS and University services to tailor provision

UCMHT -New Collaborative service

- Prompted by escalating complex MH presentations , high use of crisis services , difficult access to secondary care MH services
- Struggle to access conventional services – wait , term-times ,transport ,address changes – communications , DNA's
- Not fitting traditional care coordinator model

UCMHT - How achieved ?

- Collaborative discussions DPT ,University Wellbeing services , SHC and DCC
- Joint funded – DPT ,U of E , DCC/CCG
- Three senior MH practitioners embedded on campus – DPT employed , Link psychiatrist Psychology provision including groups
- Different model ,triage of all GP referrals for students, short term interventions, advice for GP and University Wellbeing Services Monthly case meetings .Joint consent .