Mental health of students in higher education

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Royal College of Psychiatrists

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We thank the many university counselling services who submitted examples of good practice. We regret that there was space to include only a representative sample.

Acronyms

AMOSSHE, Association of Managers of Student Services in Higher Education

AUCC, Association for University and College Counselling (a division of BACP)

BACP, British Association for Counselling and Psychotherapy

CBT, cognitive–behavioural therapy

CMHT, community mental health team

CORE, Clinical Outcomes in Routine Evaluation

CVCP, Committee of Vice-Chancellors and Principals (now Universities UK)

DDA, Disability Discrimination Act

DSA, Disabled Students' Allowance

HEFCE, Higher Education Funding Council for England

HUCS, Heads of University Counselling Services (a special interest group of AUCC)

IAPT, Improving Access to Psychological Therapies

MWBHE, Universities UK/GuildHE Working Group for the Promotion of Mental Well-Being in Higher Education

QAA, Quality Assurance Agency for Higher Education

QOF, Quality and Outcomes Framework

SCOP, Standing Conference of Principals

SENDA, Special Educational Needs and Disability Act 2001

UMHAN, University Mental Health Advisors Network

Executive summary and recommendations

The main purpose of this report is to provide an update to a previous Royal College of Psychiatrists document, *Mental Health of Students in Higher Education*, published in 2003. Over the past decade, the demographics of the student population have undergone many changes that are of relevance to the provision of mental healthcare. The numbers of young people in higher education have expanded and they have become more socially and culturally diverse. There have been increasing numbers of students drawn from backgrounds with historically low rates of participation in higher education and growing numbers of international students. Social changes such as the withdrawal of financial support, higher rates of family breakdown and, more recently, economic recession are all having an impact on the well-being of students and other young people.

Providing mental health support for students

There are many agencies that play a role in the provision of mental healthcare to students. The majority of students with mental disorders receive care from general practitioners (GPs) and other clinicians in primary care settings. Students whose mental ill health is more severe or disabling can be referred to specialist psychiatric services. In addition to the National Health Service (NHS), the large majority of higher education institutions offer services such as counselling and other forms of support to students with mental health problems. In an environment in which resources are constrained it is important that services are well coordinated to provide the most cost-effective care to students. One problem with coordination is that different agencies may have different concepts of the nature of mental disorder. This is reflected in the multiplicity of terms that has come into use when this matter is addressed, such as 'mental illness', 'mental health problems', 'mental health difficulties', 'mental health issues'. Estimates of the prevalence of mental disorders in students can vary enormously depending on how these are defined and ascertained.

Research

The changes that have taken place in the demographics of the student population mean that epidemiological research becomes rapidly obsolete.

Epidemiological studies conducted more than 10–15 years ago cannot be generalised to the present population of students and hence may form a poor basis for planning the provision of services. The growing number of international students at UK universities means that estimates of the prevalence of mental disorder in students carried out in other countries are increasingly of direct relevance to psychiatric practice in the UK. We have not attempted an exhaustive epidemiological survey but have focused on studies that provide data on the prevalence of mental disorders in different student populations and trends over time.

There is a need for long-term prospective research covering a range of higher education institutions to obtain a full picture of mental disorder in students. One development that may assist this process is the use of internet-based survey methods. Nearly all students now have a university or college email address and access to the internet. Campus-wide email systems have already been used to recruit cohorts of students. Students seem to be willing to participate in surveys using this method and response rates have been highly satisfactory.

Disability discrimination legislation

In the past 15 years, disability discrimination legislation has become of increasing importance in the context of mental disorder in students. This report provides a detailed account of the history and current status of this legislation. In September 2002, the Special Educational Needs and Disability Act 2001 (SENDA) extended the Disability Discrimination Act 1995 (DDA) to include education. Education providers now have a legal responsibility to students with disabilities, including those with severe or enduring mental illnesses. The requirement for institutions to meet their legal obligations has provided a further stimulus to the development of specialist services for these students. The DDA laid down that there is a duty of care incumbent on higher education, with the potential for legal redress if 'reasonable adjustments' are not made, for instance by making adjustments in the study environment to compensate for disabilities. In addition to reasonable adjustments, the DDA stipulates that there is a positive duty to promote the equality of students and staff with disabilities.

Student counselling

Nearly all higher education institutions offer counselling services to students. A recent survey indicated that across the UK approximately 4% of university students are seen by counsellors each year for a wide range of emotional and psychological difficulties. Counsellors working in higher education offer their professional skills and can also utilise their understanding of the connections between psychological and academic difficulties, their knowledge of the educational context and their integration with the wider institution. No counselling service would undertake the diagnosis or treatment of severe mental illness but all would consider it important to be sufficiently well informed to recognise the various forms of mental illness and to know when referral to medical and psychiatric services is necessary. The establishment of links to these services for consultation and referral has always been seen

as an essential part of the work of a counselling service in a higher education institution.

Mental health advisors

One professional group that has expanded enormously since the previous College report (Royal College of Psychiatrists, 2003) is that of mental health advisors. The majority are educated to degree level and have professional qualifications in fields such as psychiatric nursing, occupational therapy and social work, or are graduate members of the British Psychological Society. A major role is assessing how mental disorders in students may affect their learning. Mental health advisors can then recommend strategies and interventions to reduce barriers to learning and to enable successful progression through higher education. They can also offer support to newly enrolled students with experience of mental ill health during their transition to university.

Other roles include liaison between higher education institutions and NHS mental health services and staff training and support. Mental health advisors provide guidance to higher education institutions on policies and services in relation to students with mental disorder. They may also take a lead role in developing mental health promotion within the institution.

Disabled Students' Allowance

Any student with a diagnosed mental disorder may be eligible for the Disabled Students' Allowance (DSA). This is a grant to help meet the extra course costs that students can face as a result of a disability, including those arising from mental disorder and specific intellectual disabilities such as dyslexia. This allowance is paid on top of the standard student finance package and does not have to be repaid.

Role of university setting in student mental health

The social environment of higher education institutions is unique in many important ways that are relevant to mental disorder in students. This is perhaps one time in a person's life in which work, leisure, accommodation, social life, medical care, counselling and social support are all provided in a single environment. Furthermore, this environment is one that has research and development as one of its core functions. This provides opportunities to develop and evaluate new possibilities for the prevention and treatment of mental disorders that may be difficult to achieve elsewhere. The 'Healthy Universities' initiative has adopted an ambitious rationale in relation to student health. The university or college is seen not only as a place of education but also as a resource for promoting health and well-being in students, staff and the wider community. It has long been appreciated that settings such as schools and workplaces enable health promotion programmes to be implemented. However, the settings-based approach moves beyond this view of health promotion in a setting to one that recognises that the setting itself is crucially important in determining health and well-being.

Care pathway

The usual route into specialist NHS care is by GP referral. In some institutions more direct lines of referral have been established. For example, some mental health advisors have established links with NHS early intervention for psychosis teams that have allowed them to 'fast track' acutely disturbed students into psychiatric care. Early intervention is especially important in students to diminish the risk that mental illness will lead to drop-out from university.

A major problem is that NHS services are not usually adapted to the timescales of student life. Waiting times for specialist services such as clinical psychology or psychotherapy are often lengthy. This can mean that a student receives a first appointment when he/she is fully occupied with examinations or about to return home or go elsewhere for the summer vacation. It also means that therapies of longer duration are disrupted by vacations. We recommend that services take account of this disadvantage and try to ameliorate it when it comes to managing waiting lists.

Primary care

It is very important to emphasise the major role that primary care plays in the management of mental disorders in the student population. The majority of patients with mental disorders are treated exclusively in GP clinics without referral to mental health services. Those GP practices with a significant cohort of students on their patient lists have an involvement and experience in the management of mental disorders which is considerably greater than that provided in routine GP settings. In such cases, GPs often liaise directly with student counselling services, disability services, mental health advisors, academic staff and support services. The general practice often exercises a pastoral and advocacy role as well as the core clinical role.

General practices with large student populations are facing financial disadvantage as a result of the current methods by which GPs are reimbursed in the UK. These include payments for the attainment of disease-management targets in a range of conditions. The student population is relatively healthy and will therefore generate lower income for these practices. The long-term future of practices such as these may be threatened as a result of diminished remuneration and consequent difficulties in recruiting staff and funding services.

A case for collaborative healthcare

It seems self-evident that mental healthcare would improve if there were closer collaboration between NHS and higher education providers. There are some important practical impediments to this. These include restrictions on the transfer of confidential information between agencies and loss of the distinctive contributions that can be made by higher education services. Nevertheless, a number of models of collaborative working have been established across the country. Some of these are described in Appendix 1. We hope that these will provide a stimulus to similar developments elsewhere.

Pitfalls for prospective students

In many cases, young people with serious mental illnesses are able to enter higher education. This may involve a move to a new location. In such a circumstance, there is a need to ensure continuity of care. If the student is on long-term maintenance medication, it is essential that arrangements be made for continued prescription of this. The 'home' mental health team should make every effort to ascertain the service or services that would be appropriate for the patient and should make the necessary referrals before the student starts at university. If the university or college has a mental health advisor, referral to this person before the young person starts their studies may help facilitate the process of transition to higher education.

A successful application to university or college by a young person with a history of mental illness will usually be viewed in a spirit of optimism and hope. It may be seen as the opening of a new chapter and an attempt to move on from a period in the person's life dominated by illness and disability. In many cases, optimism and hope will be fully justified. In others, it is important that these feelings are tempered by realism about the young person's capacities to adjust to a new life and to cope with the demands of college or university. We discuss some of the factors that will require careful consideration if someone with a history of mental illness is embarking on higher education.

International students

Universities and other higher education institutions are under enormous pressure to improve funding by the recruitment of international students. International students come from a wide range of cultural, ethnic and religious backgrounds. When considering their mental well-being, it is important to be aware of the additional challenges that they face in adjusting to living and studying in the UK. They have to undertake a major process of adjustment to a new academic and cultural environment. They may be unable to afford regular visits to their home countries. Academic attainment may be curtailed by inadequate English language skills. International students usually come to the UK with high hopes of success and can become very troubled if their academic performance falls short of their expectations and the expectations of their family who are often providing financial support.

Mental health of medical students

Medical and other healthcare students are prone to the same risks and problems as other students. There are a number of reasons why these students are of particular interest to health services. One is that these students are the NHS professionals of the future and the NHS has an interest in ensuring that its workforce is able to practise safely and competently. There is a further concern that arises from the fact that these students come into contact with vulnerable patients. The existence of a mental disorder may lead to risk to patients, both now and, even more so, when the student graduates and enters his or her chosen profession.

Psychiatrists who are involved in the treatment of medical and other healthcare students may face a potential conflict of interest if there is concern that the mental disorder that the student is experiencing is one that creates a possible risk to patients. The duty to maintain confidentiality may come into conflict with duties to third parties, such as patients with whom the student will come into contact. A conflict can also arise if a psychiatrist is asked to assess the suitability of a student to continue with his/her studies. Any psychiatrist taking on this role should not also assume responsibility for treating the student.

A further problem is the risk of a breach of confidentiality. This can arise if the student is treated at a teaching hospital that is used by his/her academic institution. Some services have been able to set up reciprocal arrangements with neighbouring psychiatric facilities for the treatment of students. Where this is not possible, every effort should be made to protect the student's confidentiality.

RECOMMENDATIONS

FOR PSYCHIATRISTS AND THE NHS

1 National Health Service providers of mental healthcare are urged to recognise and respond to the particular mental health needs of the student population and the difficulties that many experience in gaining equal access to services. Specific difficulties can arise for this group as many students live away from home during term time but then return home (or go elsewhere) during vacations. Policies that pay consideration to the following should therefore be put into place:

   a. if significant disruption to academic progress is to be avoided, it is very important that students are seen quickly for initial assessment;

   b. if a student is then referred on for treatment such as psychotherapy, the waiting list needs to be managed so that appointments are sent at a time when the student is able to attend, paying due regard to term and vacation dates;

   c. therapy needs to commence at a time that will allow this to be completed without the disruption of examinations and the summer vacation, and before the student graduates.

2 Clinicians are strongly urged to give due regard to the needs and vulnerabilities of patients with mental disorders who are embarking on higher education for the first time. Arrangements are needed to ensure continuity of care between home and university and back again.

3 Students often benefit significantly by being able to gain access to dedicated student health services. General practitioners who work in these services acquire considerable experience and knowledge of mental health problems in students. These practices can offer a range of additional services, such as practice-based counsellors and psychologists. These services have come under threat with changes in the ways in which general practice is funded. This has led to substantially lower remuneration for GPs who work in settings such as these. In the longer term this will create problems with recruitment

and retention of staff and may even threaten the viability of these services. We recommend that the departments of health in the UK home countries make some form of special funding provision for these services.

4 At present there is no national professional grouping for psychiatrists who work with students. There are informal networks, such as the London Student Mental Health Psychiatric Network, which play useful roles such as peer support and exchange of information. The Royal College of Psychiatrists should consider the establishment of a student mental health special interest group, which could provide a forum for the development of services and research. It could also provide a formal point of contact between the College and higher education institution bodies such as the Universities UK/GuildHE Committee for the Promotion of Mental Well-Being in Higher Education (MWBHE; www.mwbhe.com). The College should also promote the development of a student mental health network, such as the one that prepared the current report. This could have representatives from providers of health services and from higher education institutions. A group such as this could act as a forum for continued dialogue and could undertake a review of the current report when this becomes necessary.

For higher education institutions

5 Higher education institutions have long established systems for student support such as counselling, personal tutoring, financial advice as well as services for international students and those with disabilities. Such services often operate within an overall student services framework. We recommend that this provision, which greatly enhances the student experience, be maintained and, when possible, expanded.

6 A promising development in recent years has been the recognition in many higher education institutions of the needs of vulnerable students with disabling mental health disorders and the consequent expansion of numbers of staff, such as mental health advisors, with a specific remit to support them. Staff with this remit, together with those in counselling services, can play a central role in the coordination of care provision to students and can assist higher education institutions in the development of mental health policies. They can offer direct advice and support to troubled and vulnerable students with mental disorders. Another important role is to make links between higher education institution provision for mentally troubled students and NHS services. Although many higher education institutions have appointed mental health advisors or have expanded the role of other staff, some remain underresourced in this area. We recommend that all higher education institutions give careful consideration to enhancing the academic and personal support available to mentally troubled students.

7 It is recommended that all higher education institutions have a formal mental health policy. This should ensure that they meet statutory obligations under disability legislation. It should also cover areas such as health promotion, the provision of advice and counselling services, student support and mentoring, and special arrangements for examinations (Universities UK/GuildHE Working Group for the

Promotion of Mental Well-Being in Higher Education, 2006). It is strongly recommended that all higher education institutions ensure that training in the recognition of mental disorder and suicide risk is offered to academic and other institutional staff who work with students.

8 It is recommended that higher education institutions consider the adverse impact of alcohol misuse in students. Steps should be taken to curtail inducements to consume alcohol, for example 'happy hours' and sales of cheap alcoholic drinks on campus. Health promotion efforts should recognise the importance of sexual victimisation and violence perpetrated by intimate partners as a cause of mental distress. These efforts should focus on potential perpetrators as well as potential victims.

9 The 'Healthy Universities' systemic and holistic approach is commended and should be adopted as widely as possible. Mental health and well-being is an integral part of a healthy university and this approach has the potential to enhance the well-being of both students and staff.

For all sectors

10 Higher education institutions and NHS psychiatric services who provide care to students should establish some form of coordinated working relationship. The form that this should take will depend on the existing organisation and configuration of NHS services and the level of provision of counselling and other services by the higher education institution. If a mental health advisor is in post, he/she would be ideally placed to take a leading role in this. We have described a range of options in Appendix 2. These include direct involvement of psychiatrists in primary care or counselling services, where they function both as clinicians and supervisors, the establishment of referral pathways to NHS care, and the development of NHS/higher education institution networks for consultation, education and the coordination of service provision.

11 There would also be benefit from closer collaboration between higher education institutions and the NHS with regard to the formulation of local and national policies in relation to the mental well-being of students. All relevant parties are urged to explore further possibilities for closer working relationships at a strategic level.

12 All sectors are encouraged to recognise and pay attention to the needs of particularly vulnerable subgroups such as international students and students with a history of mental disorder.

13 The student mental health working group was struck by the paucity of recent, high-quality research into the nature and prevalence of mental disorder (including drug and alcohol use) in the UK student population. There is a need for systematic, longitudinal research into the changing prevalence over time of mental disorders in students. We need to know more about academic and social outcomes in students who go to university with pre-existing psychiatric illnesses. The changing demographic background of students highlights a need for up-to-date research to identify risk factors within students such as

social background, ethnicity and current or past exposure to abuse and psychological trauma. We need to attend to environmental risk factors such as financial hardship, academic pressures and the availability of support and mentoring from teaching staff and others. Finally, we need to know more about the effectiveness of treatments offered to students and the efficacy of policies aimed at the prevention of mental disorders in students. This is important for a number of reasons. It is difficult to plan provision of care without detailed knowledge of the underlying needs for this. The impact of mental disorder on academic performance and retention is an important area for higher education institutions. The NHS has a particular interest in the mental well-being of those who are training to be doctors, nurses and other clinicians. Bodies such as the Royal College of Psychiatrists and the MWBHE should take an active role in promoting research.

14 Rates of treatment uptake have been found to be low in some studies of student populations. There is a need to identify the reasons for this and where possible take remedial action.

Introduction

The purpose of this document is to review and update the previous report from the Royal College of Psychiatrists on the mental health of students in higher education (Royal College of Psychiatrists, 2003). The report has been influential and its contents have been drawn upon by other bodies such as the MWBHE (see Appendix 8) and by many individual higher education institutions.

In this current report, we will attempt to provide an update on some areas covered in the previous publication, such as the epidemiology of mental disorder in students and age-matched populations. We will discuss some of the issues that lead to vulnerability in students but also those that promote resilience and mental well-being. We will cover the particular issues that arise in dealing with students of health and social care professions. These include the role of psychiatrists, in collaboration with other professions, in determining fitness to practise and the need to ensure appropriate confidentiality. We will outline the ways in which higher education institutions have responded to concerns about the mental well-being of students and describe the obligations that those institutions have to their students. Some of these are statutory responsibilities that have been created by disability discrimination legislation. Others have arisen as a result of policies that have been proposed by bodies such as Universities UK (formerly the Committee of Vice-Chancellors and Principals).

We will describe the various pathways to care that may be embarked upon when a student is experiencing psychological distress. Students will usually gain access to specialist psychiatric care by the normal route of referral via his/her GP. Others will seek help through counselling and other services provided by higher education institutions. At present, there is often a lack of coordination and integration between NHS and higher education institution services. We hope that this report will encourage interprofessional working.

Higher education institutions have long provided counselling and disability support for their students. A newer professional group that has grown in numbers since the last report is mental health advisors. These individuals are appointed by higher education institutions and undertake a range of roles. They specialise in assessing how mental health difficulties affect learning. They recommend appropriate adjustments within the higher education setting to enable learning and liaise with external agencies to support students in accessing appropriate treatment and support. Many have professional NHS backgrounds and are thus well placed to coordinate activity at the interface between higher education institutions and the NHS. Mental health advisors are often charged with responsibility for mental health promotion. They advise on mental health policy and disability rights for students with serious and enduring mental health difficulties.

There are a number of barriers on the pathways to care which are particularly applicable to the student population. Some students, particularly international students, may be sensitive to the fear of stigmatisation. There may be long waiting lists for services such as clinical psychology and psychotherapy. Achieving access and maintaining continuity of care can be difficult when students are in one place during term time and return home or go elsewhere during vacations.

We will discuss how the efforts of NHS services and those provided by higher education institutions might be better coordinated. Although they tend to focus on different parts of the spectrum of psychiatric disorder, there is a large overlap between the activities of these services and considerable scope for improvements in collaborative working. There will be a need to give consideration to developing appropriate protocols for the sharing of confidential and sensitive information.

Since the publication of the previous report in 2003, the concerns highlighted there have shown no sign of abating and in many respects have become more pressing. The demand for counselling and mental health advisor services continues to rise as the percentage of school leavers entering higher education increases. The student population is becoming increasingly diverse and some of this diversity is creating new pressures on counselling and mental health services. At the same time there have been changes in universities and other higher education institutions which have made them less able to cope with mental disorders in students. Staff:student ratios have declined through failure to increase staff numbers in proportion to the increase in numbers of students. Academic staff are under constant pressure to maintain and improve research output as well as to develop their teaching. It seems likely that pressure on public finances will exacerbate these problems in the next few years.

Traditional universities tended to be based on a single campus, with most students living on campus or in close proximity to their institution. The majority of students lived away from home and were drawn from a fairly homogeneous social background. In contrast, newer universities are often dispersed across multiple sites, often in large conurbations. Increasing proportions of students live at home and may have to commute long distances to study. There is an increase in modular learning which can result in students progressing through courses over differing timescales. As a result, students may be less able to form stable relationships with their peers or academic staff. The personal tutor system, which used to play a very important role in offering personal and academic guidance to students, has been eroded in many higher education institutions.

Students are subjected to the same risk factors for mental disorder that apply to the general population of young people. Rates of family breakdown have increased enormously over the past few decades. When parents separate, the resources of the family are more thinly spread and there may be less financial support available for a young person at university. Some students experience diminished family support following parental separation as a result of the breakdown in the relationship between the student and one or other parent.

At the same time support for students from public finances has decreased drastically and student grants are largely being replaced by loans. Students often have to take part-time work in order to meet their basic needs. This detracts from the time and energy available for academic study and personal development and places some students at an unfair disadvantage in relation to their more affluent peers. Students who are

managing mental health difficulties can experience financial disadvantage if they have to repeat modules or years of study. They may be less able to cope with the demands of both study and work.

Students are at a stage of transition between dependence and independence. Many have to cope with the stresses of moving from home to university at an age when they are negotiating significant developmental changes. They may have to adjust to the change from an educational curriculum that is structured and closely supervised to one in which they must take a more active role in managing time and planning their studies.

On the plus side, there are new opportunities for developing friendships and pursuing social, recreational and sporting interests. The higher education environment offers a wide range of easily accessible student support services. Students may be more able than others to benefit from psychiatric and psychological help, especially psychotherapy. They are usually bright, articulate and knowledgeable. They are more likely to be psychologically minded and curious about themselves. Times of change can present opportunities for growth and maturation as well as presenting challenges. If attention is paid to ensuring that the higher education environment and relationships are conducive to enhancing mental well-being, many difficulties can be ameliorated. Higher education may offer benefits to students with a history of mental illness or psychological difficulties. It can provide new sources of self-esteem and opportunities for engagement with peers and the wider society. Students are at a stage in life when the future is open to a range of possibilities. If problems that arise are caught early, it may be possible to set someone on a path in life that is more positive and less fraught with difficulties.

We have attempted to produce a report that will be of practical help to those who are attempting to improve the care and treatment of mentally troubled and vulnerable students. We hope that the report will also assist higher education institutions and others who are seeking to establish policies and procedures for the prevention of mental disorders. To this end, we have considered the need for professions to work collaboratively to ensure that services are efficient and effective. We have described the role of counselling and mental health advisory services. A series of papers which describe a range of initiatives that have been developed across the country have been appended. We hope that others will be inspired to emulate these.

Mental disorder in students

What do we mean by mental disorder?

The first problem to be faced in discussing this issue is the amorphous nature of the concept of mental disorder. A multiplicity of terms has come into use when this matter is addressed, such as 'mental illness', 'mental health problems', 'mental health difficulties' and 'mental health issues'. The psychiatric profession has had great difficulty in reaching a consensus as to what is or is not a mental disorder. There is an obvious and understandable wish to avoid the stigmatisation that can arise when a diagnosis of mental illness is made. However, there is also a need for the health service to focus its resources on those who are, in some sense, mentally unwell. A formal psychiatric diagnosis may therefore be a necessary 'admission ticket' to NHS psychiatric services.

This conceptual uncertainty probably contributes to some of the widely discrepant figures that are quoted when attempts are made to measure the prevalence of mental disorder in students. For example, only 0.53% of first-year UK-domiciled undergraduates in 2009/2010 declared a 'mental health difficulty' as a reason for disability (Higher Education Statistics Agency, 2011). In contrast, some studies have shown high rates of mental ill health when this is assessed by screening instruments such as the General Health Questionnaire (GHQ). MacCall *et al* (2001) found that 65% of female and 54% of male undergraduate students attending a student health service scored positive on the GHQ. A study by Monk (2004) found a prevalence of GHQ 'caseness' of 52% in a cohort of students. The fact that the reported prevalence of a problem can vary by more than 100-fold depending on how it is ascertained and defined creates obvious difficulties with regard to planning provision of care for those with mental disorders.

In recent years, mental health services have been encouraged to focus on the needs of patients with more severe mental illnesses. This may have contributed to a sense that it is increasingly difficult for students with less severe problems to gain access to NHS services. There is a perception that student counselling services are facing demands from students who would formerly have been offered NHS care. Doubts have been expressed about whether it is the role of counselling services to compensate for what seem to be shortfalls in NHS provision (Cowley, 2007). This problem is now acknowledged by the NHS and considerable efforts have been made to generate solutions. These have been taken forward by programmes such as Improving Access to Psychological Therapies (IAPT) in England and Doing Well by People with Depression in Scotland.

Mental disorders exist on a spectrum of severity. At the severe end of the spectrum are illnesses such as schizophrenia and bipolar disorder.

Students who experience conditions such as these should be a primary concern of NHS psychiatric services and will usually be managed by multidisciplinary mental health teams. Tertiary care services in the NHS should also be available for students with other diagnoses such as severe eating disorders, addictions and personality disorders.

At the less severe end of the spectrum are conditions that are milder with regard to distress and disability. Nevertheless, these may still have a deleterious impact on a students' ability to complete their coursework on time or to revise effectively for their examinations. There are various treatment possibilities in such cases. Some of these conditions are self-limiting and will simply remit with the passage of time. In other instances, the student will be able to draw on non-professional support such as family and friends as a way of achieving the resolution of symptoms. Other students will seek the help of a tutor, student service or GP. Some practices employ counsellors or psychologists on a sessional basis and can manage a range of conditions without the need for referral to secondary services.

If one accepts a broad-range definition of mental disorder (e.g. a positive score on the GHQ), it is unrealistic now (and probably for the foreseeable future) to expect health or counselling services to be able to offer direct face-to-face therapy for all those who may wish to avail themselves of it. There is therefore a need to prioritise demands against the resources available to meet these. This prioritisation should be based on factors such as severity of distress, disability, impact on academic progress and the likelihood of benefit in response to whatever treatment is on offer. A further option is to increase the availability of, and access to, self-help programmes such as proprietary or web-based interactive cognitive–behavioural therapy (CBT) (e.g. Beating the Blues (www.beatingtheblues.co.uk) and MoodGYM (http://moodgym.anu.edu.au) for people with mild and moderate depression, and FearFighter (www.fearfighter.com) for people with panic and phobia).

Why focus on students?

Student service managers, counsellors and mental health advisors report increasing numbers of clients and an increase in the severity of the problems that trouble them. Some of this increased demand is a result of the unprecedented expansion in the number of young adults entering higher education. Just over 80% of the respondents to a recent survey of UK higher education institutions undertaken by the MWBHE reported that demand for mental health provision had significantly increased over the previous 5 years, and a further 13% thought that it had 'slightly increased' (Grant, 2011). Although there are examples of good practice in prevention, treatment and rehabilitation, in general there is a pressing need for an increase in the availability of comprehensive assessment and treatment services as well as mental health promotion activity both at organisational and individual level. Several important factors highlight the importance of this issue to individuals, their families and the wider society.

There is a perception among some health professionals that students are privileged young people and that their demands for mental health services should therefore be lower. However, young adults between the ages of 18 and 25 are at high risk of developing serious mental illnesses such as schizophrenia and bipolar disorder. Such conditions can sometimes be difficult to diagnose in their early stages. There is a growing body of

evidence to the effect that delayed diagnosis in schizophrenia is associated with treatment resistance and a poorer long-term outcome. Students who have severe mental illnesses are at considerable risk of academic failure and drop out. There is a relatively high prevalence of eating disorders in student populations. Ensuring continuity of support and appropriate monitoring can be particularly challenging when those affected move away from their home environment to live in a university community.

The student population is in some ways more vulnerable than other young people. First-year students have to adapt to new environments and ways of learning. Academic demands and workload increase and university courses require much more self-directed learning and the capacity to manage time and prioritise work. Both of these can be easily disrupted by mental disorder and misuse of drugs and alcohol. As a result students can face academic decline that can result in the need to repeat academic years or even to withdraw from university or college. Also, even less severe mental disorders can lead to failure on the part of an individual to fulfil his/her potential. Early adult life is a crucial stage in the transition from adolescence to independence as an adult. Underachievement or failure at this stage can have long-term effects on self-esteem and the progress of someone's life.

Psychiatrists may be involved in decisions about the fitness of students to continue with their studies. This usually occurs in the case of students who are seriously unwell and clearly not coping with the demands of studying, and who are unlikely to complete their course. Clinicians need to be aware of disability legislation when offering advice on fitness to study or fitness to practise.

The transition from home to university can be a difficult period for many young people. Despite the apparent gregariousness of student life, many students find it hard to adapt and to make new friends. As a result they can become isolated and may suffer in silence or drop out without seeking help. Mature students in particular may find themselves very isolated within the institutional environment, even if they remain in their own homes. Financial difficulties, including the need for many to work part-time during term time to support themselves, are another source of stress for an increasing proportion of the student population.

Mental disorders create a substantial economic burden on our society. Students with unrecognised and untreated mental illnesses are likely to increase these costs in a number of ways. There will be a loss of return on the public investment in higher education. Drop out from education will lead to diminished earning capacity and an increased risk of dependence on state benefits.

In the university environment, particularly where students live in institutional residential accommodation, there can be significant peer pressure to misuse alcohol and drugs. Students who do so can exacerbate existing health problems. There is evidence that early brief intervention can have long-term benefits in turning someone away from a path leading to alcohol misuse and dependence.

The student group is one whose education and experience have often fostered capacities for reflection and introspection. They are more likely to seek some form of counselling or psychotherapy and have a greater chance of benefiting from it. They are generally less enthusiastic about psychotropic medication and less tolerant of medication side-effects such as drowsiness, poor concentration and sexual dysfunction. It is important that service provision is designed with these factors in mind to maximise the acceptability and effectiveness of treatment.

Students must anticipate going into a highly competitive work environment. The expansion in higher education that has taken place over the past 20 years means that possession of a degree on its own is no guarantee of a job. There is pressure on students to gain good honours degrees and in addition to show evidence of attainment in other areas such as university societies and sports clubs, or participation in voluntary activities. Students who have experienced mental health difficulties may be at an added disadvantage when applying for jobs if they have taken longer to complete their courses because of deferrals of coursework or breaks from study to recover their health.

A further factor is that students often live in close proximity to other young people, for example in halls of residence or shared flats. Disturbed behaviour (such as repeated self-harm) on the part of one young person can cause considerable distress and disruption to fellow students and to staff in halls of residence. Students who are mentally unwell can also place excessive or inappropriate demands on academic staff, for example by academic underperformance, becoming overdependent or making vexatious complaints.

The epidemiology of mental disorders in students in higher education

Students in higher education represent a unique group in which to describe the epidemiology of mental illness. They broadly fall into the age group of 17–25 years. This age span encompasses the transition from adolescence to adulthood. The high-risk period for onset of schizophrenia and bipolar disorder in late adolescence and early adulthood coincides with entering higher education. Some in this age group are affected by long-term conditions with onset in adolescence, such as anorexia nervosa. Others are among the youngest to develop illnesses related to substance misuse. As such, university students span an age range in which a wide spectrum of mental illness is seen and pose specific problems with regard to epidemiology. In the USA, it has been estimated that mental disorders account for nearly a half of the disease burden for young adults (World Health Organization, 2008), and most lifetime mental disorders have first onset by age 24 years (Kessler *et al*, 2005).

Whereas the priority for clinical services is to ascertain the incidence and prevalence of major mental illness, broader concepts of mental disorder, such as conditions that are loosely described as 'stress' or 'distress', may have more relevance for those involved in university counselling services. Such concepts represent the milder end of the symptom spectrum and they are universally more prevalent across college campuses. One key question in this area relates to how the epidemiology of mental disorders in students may be different to that of non-students matched for age, gender and social class. Epidemiologists have historically ignored university students as a distinct group. Clinicians and those in health service research are primarily interested in prevalence by age rather than by occupation. Nevertheless, research into student mental disorder is made easier by the fact that researchers have easy access to the populations on the campuses on which they work. A second question arises from the enormous changes that have taken place in the student population in the UK in the past 20 years or so.

There has been a very substantial increase in the numbers of young people leaving school and going on to higher education. As opportunities for study have arisen for greater numbers of young people who were previously denied it, students from more socially and culturally diverse backgrounds may be entering higher education. The demographics of the student population have also changed, with many more mature and part-time students, and many students from backgrounds with historically low rates of participation in higher education. The prevalence of important causal factors for mental disorder in young people in general has also shown substantial changes in the past two decades. These include increased rates of family breakdown, consumption of alcohol and illegal drugs, and unemployment. One consequence of all of this is that epidemiological studies conducted in the past cannot be generalised to the present population of students and hence may form a poor basis for planning the provision of services.

Another significant change is the growing number of international students studying at UK universities. In consequence, studies of the prevalence of mental disorder in students in other countries are increasingly of direct relevance to psychiatric practice in the UK. The epidemiology of mental disorder in students was considered at length in the previous report on the mental health of students (Royal College of Psychiatrists, 2003). The next section will be confined to a review of some recent studies and discussion of general issues around epidemiological research in students.

Prevalence of mental disorders in students

Bewick *et al* (2008) carried out an internet-based survey of mental distress in students in four UK higher education institutions. Students were assessed using the Clinical Outcomes in Routine Evaluation 10-item measure (CORE-10). This was done as part of a study of alcohol use in students. The researchers found that 29% of students described clinical levels of psychological distress. In 8%, this was moderate to severe or severe.

The move from home to university is associated with an increase in reporting of psychiatric symptoms. Cooke *et al* (2006) conducted a study of students in their first year at a British university using a standard assessment of psychiatric morbidity. Scores increased after students began their studies, with anxiety symptoms being particularly prominent. Symptom scores fluctuated in the course of the first year but did not return to pre-university levels.

Andrews & Wilding (2004) assessed a group of UK undergraduates 1 month before starting university and again in the middle of the second year, using the Hospital Anxiety and Depression Scale. Students were also assessed in the second year with respect to stressful or threatening experiences. By the second assessment, 9% of previously symptom-free students had developed depression and 20% were troubled with anxiety at a clinically significant level. Of those previously anxious or depressed, 36% had recovered.

In the USA, the National College Health Assessment reported that one in three undergraduates had at least one episode in the previous year of 'feeling so depressed it was difficult to function' and one in ten described 'seriously considering attempting suicide' (American College Health Association, 2008). Rates of participation in treatment were low. Of those diagnosed with depression, only 24% were receiving professional help. In another survey of a large cohort in the USA, 6% of undergraduates and 4%

of postgraduates reported significant thoughts of suicide in the previous year (Drum *et al*, 2009).

Blanco *et al* (2008) used data obtained in the USA from the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) to compare the prevalence of psychiatric disorders, substance misuse and treatment-seeking in young people aged 19–25 who attended college and their peers who did not attend college. Around half of young people in the USA are enrolled in college on a full- or part-time basis. The overall rates of psychiatric disorders were no different when students were compared with non-students. Psychiatric diagnoses were made using DSM-IV criteria. The most prevalent disorders in students were alcohol use disorders (20.37%) followed by personality disorders (17.68%). In non-students, personality disorders were most prevalent (21.55%) followed by nicotine dependence (20.66%). Alcohol problems were significantly more prevalent in students, whereas drug misuse and nicotine dependence were less prevalent. Mental health treatment rates were low for all disorders. Young people with mood disorders were most likely to have received treatment. The lowest rates of treatment were for alcohol and drug problems.

Specific disorders

Some research has focused on specific disorders and examples of this follow.

Schizophrenia

Schizophrenia is a major mental illness found across the world with an approximate lifetime risk of between 0.7 and 1.3% of the population. The annual incidence of schizophrenia is approximately 1 in 10 000. The peak age at onset is between late adolescence and early adulthood and as such students may represent a high-risk group. It must be noted that low social class and professional achievement may be associated with schizophrenia and thus it may occur less frequently in a student population. Indeed, many people who are diagnosed with schizophrenia may be unable to commence or complete a university course. In a survey of approximately 14 600 students registered with the Leeds Student Medical Practice, only two were recorded as having a diagnosis of schizophrenia (Mahmood, personal communication, 2002, quoted in Royal College of Psychiatrists, 2003).

Depression

The estimated prevalence of any depressive or anxiety disorder was 15.6% for undergraduates and 13.0% for graduate students in an internet-based survey in the USA (Eisenberg *et al*, 2007). A study in Lebanon found that the prevalence of depression in medical students was as high as 28% (Mehanna & Richa, 2006). A further study from Pakistan indicated that the prevalence of depression in female medical students was 19.5%; 43.7% of this cohort also reported anxiety (Rab *et al*, 2008).

Bipolar disorder

Bipolar disorder usually begins in adolescence or early adulthood (commonly with an episode of depression) but the correct diagnosis is often delayed for up to 10 years. Recent epidemiological data suggest that exceptional intellectual ability may be associated with bipolar disorder, placing the

student population at high risk of developing this illness. Individuals with excellent school performance had a fourfold increased risk of developing bipolar disorder compared with those with average grades (MacCabe *et al*, 2010). Students presenting with an episode of depression should be carefully assessed for the possibility of a primary bipolar illness. In a study of students with depression consecutively referred to a psychiatric clinic serving the Edinburgh Student Health Service, Smith and colleagues found that 16.1% of those referred had DSM-IV bipolar disorder (Smith *et al*, 2005).

Eating disorders

Eating disorders such as anorexia nervosa and bulimia nervosa are widely recognised in the student population. The high occurrence of these illnesses in higher socioeconomic groups and the peak age at onset in adolescence make undergraduate students particularly vulnerable (McClelland & Crisp, 2001). There may be small-scale 'micro-cultures' within higher education where students are at particular risk of eating disorders. These include ballet schools and some sports teams and clubs.

Studies of the prevalence of eating disorders in students in different countries have highlighted interesting variations. A Spanish study found a total prevalence of eating disorders in a college student population to be 6.4% (Lameiras Fernández *et al*, 2002). A Mexican study showed eating disorders to have a prevalence of 0.49% in 1995 (0.14% for bulimia nervosa and 0.35% for eating disorders not otherwise specified) and 1.15% in 2002 (0.24% for bulimia and 0.91% for eating disorders not otherwise specified) (Mancilla-Diaz *et al*, 2007). No cases of anorexia nervosa were found at either time point. A Turkish study of students in a rural location found 2.20% to have an eating disorder based on the Structured Clinical Interview for DSM-IV Axis I disorders (Kugu *et al*, 2006). Of these students, 1.57% were found to have bulimia nervosa and 0.31% were found to have binge eating disorder. Again, there were no cases of anorexia nervosa. Of the 21 students with an eating disorder, 18 were female.

Autism-spectrum disorders

Students with autism-spectrum disorders can present to student support services with a range of problems. Many of these arise from the difficulties that they have with social interaction and coping with change. The leading symptoms can include depression, suicidality, anxiety and obsessive–compulsive features. The condition may also come to attention as a result of behaviour that is disruptive or socially inappropriate in other ways. An autism-spectrum disorder may not have been diagnosed before university entry. Diagnosis can be of benefit to the student in a number of ways. It provides a framework that helps the student and academic staff to understand the difficulties that can arise from this condition, and gives the student access to specialist services such as those provided by the National Autistic Society.

Alcohol

High levels of alcohol intake have been a traditional feature of student life in the UK and elsewhere. Many young people start to drink more heavily when they are free of the constraints of life in the family home. Alcohol dependence is a condition that usually occurs after many years of heavy

alcohol use. For this reason, frank dependence is rare in young people. The main problem in students is harmful or hazardous drinking. In a Newcastle study, only 11% of the students did not drink alcohol (Webb *et al*, 1996). Among those who did, 61% of the men and 48% of the women exceeded 'sensible' limits (21 units per week for men and 14 for women). Hazardous drinking (≥51 units per week for men, ≥36 for women) was reported by 15% of those who drank alcohol, whereas binge drinking was declared by 28%. This pattern was confirmed in a study of undergraduates in Aberdeen (MacCall *et al*, 2001), where 50% of men and 34% of women exceeded sensible drinking limits, 11.5% of men and 5.2% of women were drinking at hazardous levels and 9.4% of students reported no alcohol use.

The Harvard School of Public Health College Alcohol Study surveyed students at a representative sample of colleges on four occasions between 1993 and 2001; more than 50 000 students in 120 colleges took part. Among those who drank alcohol, 48% reported that getting drunk was an important reason for consuming alcohol, 23% were drinking 10 or more times in the course of a month and 29% reported being intoxicated 3 or more times in a month (Wechsler & Nelson, 2008). Caldeira *et al* (2009) identified high levels of problematic use of alcohol and marijuana in a cohort of undergraduates in the USA. A further concern was that only a small minority of these students recognised that there was a problem or sought professional help.

These high levels of alcohol use are a concern in themselves. They render students vulnerable to ill health and academic underperformance and place them at risk of accidental harm and assault. There is also the risk that heavy drinking is the precursor of a longer-term pattern of hazardous drinking, with the consequent risk of dependence.

Krebs *et al* (2009*a*) found that 20% of US women undergraduates had experienced some form of sexual assault in the time that they had been at college or university. In most cases, the victim had voluntarily consumed alcohol before the assault. Women who consume more alcohol and who get drunk more often are more likely to be victims of sexual assault. Mohler-Kuo *et al* (2004), using data from the Harvard School of Public Health College Alcohol Study, found that 4.7% women reported being raped. Nearly three-quarters (72%) of these victims experienced rape while intoxicated with alcohol. The risk of rape while intoxicated was higher in women who were aged under 21, were White, resided in sorority houses, used illicit drugs, drank heavily in high school and attended colleges with high rates of heavy episodic drinking. Reed *et al* (2009), in an online survey of students, found that all forms of substance misuse were associated with physical victimisation in men and with sexual victimisation in women. Substance use was common in the perpetrators of both types of violence.

Drug misuse

MacCall *et al* (2001) surveyed recreational drug use in undergraduates in Aberdeen. The most commonly used drug was cannabis – 22% had used it once or twice, 23% had used it more than once or twice and 17% were using it regularly. Regular use of other drugs was rare: 3.7% of undergraduates said that they used amphetamines regularly and 3% stated that they regularly used ecstasy. Only 5% had ever used opiates and less than 1% used opiates regularly.

The problem of misuse of prescription drugs is one that has achieved growing prominence in recent years. The UK, the USA and Canada have some of the highest prescribing rates in the world for medications for

attention-deficit hyperactivity disorder (ADHD), such as methylphenidate. In these countries and in most others there have been substantial increases in prescribing for ADHD over the past decade (Singh, 2008). Such drugs can improve attention and concentration in young people who do not have the disorder and there is concern that use of these drugs to treat ADHD has been accompanied by widespread non-medical use.

Garnier *et al* (2010) found that over a third of students prescribed any form of medication had given some of this to another person at least once. The most common drugs shared in this way were stimulants prescribed for ADHD. DeSantis *et al* (2009), in a study carried out in the USA, found that 55% of students admitted to use of non-prescribed ADHD medications. Most took these drugs to enhance academic performance and obtained them from friends. Use of stimulants was more common in senior undergraduates. Rabiner *et al* (2010) found that just over 5% of undergraduates began using ADHD stimulants between the first and second years of university. The reason for use was, again, to improve attention and performance. Teter *et al* (2010) reported that 6% of students had used non-prescribed ADHD stimulants in the previous year. There were high rates of depression in those who used such stimulants regularly. It is worth noting that in using stimulants in this way students may only be following the example set by their teachers and supervisors. Many academics have admitted to using drugs such as methylphenidate and modafinil to enhance performance and overcome fatigue, and some are openly supportive of this (Tysome, 2007). An informal poll of academics reported in the journal *Nature* found that one in five admitted to using performance-enhancing drugs (Maher, 2008).

Another area of growing concern is the use of performance-enhancing substances in students who are engaged in athletics. Buckman *et al* (2009) carried out a survey of male college athletes in the USA. Out of a sample of 274 students who completed anonymous questionnaires, 73 admitted to using performance-enhancing substances such as hormones, stimulants and nutritional supplements. Athletes who used such substances were more likely to use illegal as well as off-label prescription drugs and run into problems as a result of alcohol use.

Risk factors for mental disorders

One risk factor for mental disorder that may be of rising importance in the UK is financial poverty. In the study by Andrews & Wilding (2004) discussed earlier, after adjusting for pre-entry symptoms, financial difficulties made a significant independent contribution to depression. Relationship difficulties independently predicted anxiety. Depression and financial difficulties in the middle of the second year predicted a decrease in exam performance from the first to second year. Financial and other difficulties seem to increase British students' levels of anxiety and depression. Financial difficulties and depression can in turn affect academic performance. However, university life may also have a beneficial effect for some students with pre-existing conditions.

In 2006, Norvilitis *et al* surveyed 448 college students in the USA using the Depression, Anxiety and Stress Scale (DASS). They found that higher debt levels were significantly related to higher stress, with debt representing 30% of an average student's yearly income. Adams & Moore (2007) conducted a survey of financial circumstances in a large cohort of US college students. Men and women with higher-risk credit behaviour and debts were more likely to exhibit high-risk health behaviours such as drink-

driving, unsafe sex and use of stimulant drugs. They were less likely to be physically active, had a higher body mass index and were more likely to report symptoms of depression.

On the other hand, Cooke *et al* (2004) found no significant relationship between third-year UK students' levels of anticipated debt and mental well-being. Ross *et al* (2006) examined the relationships between student debt, mental health (assessed by the GHQ) and academic performance in a cohort of UK medical students. There was no direct correlation between debt, class ranking or GHQ score. A subgroup of 125 students (37.7% of the cohort) who said that worrying about money affected their studies, had higher debts and were ranked lower in their classes. Overall, students who scored as 'cases' on the GHQ had lower levels of debt and lower class ranking.

The relationship between money worries and poor mental health was also found in a study by Jessop *et al* (2005) that assessed 187 British and Finnish students using the 36-item Short Form Health Survey (SF-36). Higher 'financial concern' scores, but not actual amounts of current debt, were significantly associated with lower mental health scores.

Roberts *et al* (1999) carried out a survey of 360 students at British universities in which they examined the relationships between financial circumstances and physical and mental well-being. Poorer mental health was related to longer working hours outside the university and difficulty in paying bills. Students who had considered abandoning their studies for financial reasons had poorer mental health, lower levels of social functioning and vitality, and poorer physical health. They also reported heavy smoking. High levels of debt may lead to psychological distress either by raising the possibility of withdrawing from university for financial reasons or by necessitating a high level of paid work in addition to academic study.

The relationship between physical exercise and psychological well-being was examined in a cohort of Canadian students coming to the end of the first year of their studies (Bray & Kwan, 2006). Those students who engaged in physical activity defined as vigorous (61%) scored higher on measures of psychological well-being and were less likely to consult a doctor for symptoms of physical ill health than their less active peers.

Armstrong & Oomen-Early (2009) compared college athletes with non-athletes to test whether there were differences in self-esteem, social connectedness and depression. The setting was a small private university in the USA. Just fewer than half the sample qualified as 'athletes' by way of participation in a university athletics team. Athletes are sometimes thought to be subject to pressures arising from competitiveness and the demands of training. They may also be exposed to a culture in which high levels of alcohol use are the norm (Neal & Fromme, 2007). Overall, a third of the sample was found to be experiencing clinically significant depressive symptoms, with depression being more common in women. Depression was related inversely to self-esteem and social connectedness. It was less prevalent in athletes but this was attributable to the higher levels of self-esteem and social connectedness in this group. These factors also correlated with the amount of training undertaken by athletes, suggesting that physical activity itself may provide some protection against depression.

Lack of social support as a risk factor for mental disorder in students in the USA was analysed by Hefner & Eisenberg (2009). They obtained data by means of an internet-based survey. Students with demographic characteristics that differentiated them from most other students (e.g. minority race or ethnicity, international status, low socioeconomic status) were at greater risk of social isolation. Students who lacked social support

experienced higher rates of psychiatric symptoms, including a sixfold higher prevalence of depressive symptoms.

An internet-based survey was also used by Gollust *et al* (2008) to study the prevalence and correlates of self-injury in undergraduates and postgraduates attending a public university in the USA: 7% of students reported some form of self-injury in the previous 4 weeks. Rates were similar for men and women. Self-injury was associated with depressive and anxiety symptoms, cigarette smoking, suicidal thoughts, symptoms of eating disorders and, in the case of men, growing up in a low socioeconomic status household. Only a quarter of students who self-harmed had sought professional help in the previous year, although half of this group perceived that they had a need for help.

An association between cigarette smoking and psychiatric morbidity in students was highlighted by Heiligenstein & Smith (2006). Compared with those who did not smoke, those who smoked heavily (more than ten cigarettes per day), but not those who smoked lightly, reported substantially poorer well-being, greater symptom burden and more functional disability.

Trauma and mental disorder in students

One issue that was not highlighted in the previous report on student mental health (Royal College of Psychiatrists, 2003) was the contribution of traumatisation to the development of mental disorders in students. Recent research from a range of settings points to the importance of this issue.

Sun *et al* (2008) studied childhood sexual abuse in relation to psychiatric morbidity by means of a questionnaire survey of a large cohort of Chinese students. They revealed that 11.5% of female students and 7% of male students had experienced sexual abuse involving physical contact in childhood. Psychiatric morbidity was assessed using the Symptom Checklist-90 (SCL-90). Students who had experienced sexual abuse showed increased scores on scales measuring somatisation, obsessive–compulsive disorder, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation and psychoticism, in comparison with those who had not experienced sexual abuse in childhood. Total scores on SCL-90 correlated with severity of abuse.

In another study in China, Yan *et al* (2009) found that over half of a student cohort had experienced physical and emotional abuse before the age of 16. This group was also assessed by the SCL-90. Those who had been abused showed increased scores across a range of psychiatric morbidity.

Jumaian (2001) examined the prevalence of childhood sexual abuse in a group of male undergraduates aged 18–20 in Jordan. Twenty-seven per cent reported experience of sexual abuse before the age of 14 years; this was associated with higher levels of psychiatric morbidity.

Young *et al* (2007) surveyed a cohort of undergraduate students in the USA and obtained a history of childhood sexual abuse in over 40% of females and 30% of males. Higher levels of psychiatric morbidity were reported by both male and female victims when compared with non-victims.

Undergraduate women seem to be at high risk of sexual assault. It has been suggested that one reason for this is that they have regular interactions with young men in social situations in which alcohol or drugs are consumed by both perpetrators and victims. Women in the first and second years of higher education seem to be at higher risk than older students (White & Smith, 2001). Krebs *et al* (2009*b*) divided sexual assault into two types. In

the first, the victim is physically forced into a sexual act. In the second, she is incapacitated by being intoxicated with drugs or alcohol. The substance may be taken voluntarily or administered surreptitiously by the perpetrator. It is well known that sexual assault in childhood or adolescence is associated with a higher risk of sexual assault in adult life (van der Kolk, 1989). This study was based on an online survey of over 5000 women undergraduates. The researchers found that experience of physically forced sexual assault before starting college was associated with a substantially increased risk (nearly sevenfold) of forcible assault while at college. Incapacitated assault before starting college was similarly associated with a higher risk of incapacitated assault as a student. Use of marijuana and getting drunk increased the risk of incapacitated assault but not forcible assault. It was further revealed that 16.5% of women students had been threatened or humiliated and 5.7% had been physically hurt by an intimate partner. In some of these women, forced sexual assault was a repeated event.

McCauley *et al* (2009) carried out a survey of 1980 women students aged 18–34 years. In 11.3% of the sample a lifetime history of rape was reported. As in the Krebs *et al* study, incapacitated rape, but not forcible rape, was associated with drug use and binge drinking. Messman-Moore *et al* (2005) found that the presence of symptoms of post-traumatic stress disorder (PTSD) was associated with an increased risk of rape. They suggested that one reason why women with a history of sexual abuse or assault may be at risk is because they use alcohol or drugs as a way of alleviating the distress caused by PTSD symptoms.

Amar & Gennaro (2005) studied the prevalence of violence perpetrated by intimate partners in a cohort of college women aged 18–25 years in the USA and the relationship between this and psychiatric morbidity. 'Violence' embraced psychological abuse, intimidation, threats and coercion as well as physical violence. Seventy per cent of the sample was Black, although there was no difference in race between victims and non-victims of violence. Psychiatric morbidity was assessed by the SCL-90. Some form of violence had been experienced by 48% of the cohort and of these, a third reported physical injury. In 13% of those reporting physical injury, this was described as 'severe'. Scores on the SCL-90 were higher in victims of violence compared with non-victims and higher still in those who had been subject to multiple forms of violence.

Stepakoff (1998) surveyed a cohort of female undergraduate students. Participants completed self-report measures of sexual victimisation, hopelessness, suicidal ideation and suicidal behaviour. Adult sexual victimisation predicted current hopelessness and suicidal ideation. Both childhood sexual abuse and adult sexual victimisation predicted suicidal behaviour. One in four victims of rape, in contrast to approximately one in 20 women who had not been victims, had engaged in a suicidal act.

Changes over time

As mentioned earlier, there is a widespread perception that levels of disturbance exhibited by clients at student counselling services have increased in recent decades. This has been noted both in the UK and the USA. This observation raises a number of important questions. The first is whether the prevalence of psychiatric disorders is increasing or whether there is a change in the numbers of students seeking help from counselling and other services. If the latter, the question then arises as to whether this

change is specific to students or is one that is also apparent in the general population. This points to a need for systematic investigation of these questions.

Hunt & Eisenberg (2010) have reviewed epidemiological data in relation to the changing prevalence of mental disorders in adolescents and young adults in the USA, the UK and The Netherlands. They concluded that there has been at most a moderate increase in the overall prevalence of mental disorders in this age group. Concern about increased psychological disturbance in students is not a new one. This was examined in the USA by Reifler (1971) who compared reports from the periods 1920–1937 with those from 1960–1966. His conclusion was that there had been no increase in the prevalence or severity of psychological disturbance in students.

Schwartz (2006) was able to examine changes in the prevalence and severity of mental disorders between the 1992/1993 and 2001/2002 academic years in relation to one university counselling service in the USA. This service assessed all clients using the Personality Assessment Inventory (PAI) and scores of Global Assessment of Functioning (GAF) assigned by counsellors. Undergraduate women were overrepresented in the client population and postgraduate women even more so. (Higher levels of female participation in counselling have been also found in middle-income countries such as Brazil (Coelho de Oliveira *et al*, 2008).)The numbers of students seen by the service remained stable over the time frame studied. Between 9 and 10% of the population at risk made contact with the service. There was no increase in levels of disturbance as assessed by overall scores on the PAI. Scores on a subscale relating to suicidality also showed no increase. Scores on the GAF indicated deterioration but this was small in magnitude and did not reach statistical significance. The most striking finding was a fivefold increase in psychotropic medication use by the client population. This increased from 3–4% in 1992/1993 to 23% in 2001/2002. Schwartz suggested that this is probably attributable to the increased general acceptability of psychotropic medication use and the lower risks and side-effect burden of newer medications such as selective serotonin reuptake inhibitor (SSRI) antidepressants.

There is a relative dearth of systematic studies of changing morbidity in students over time. At the same time the perception of increased morbidity by university counselling and mental health personnel is striking. Writing from an American perspective, Hunt & Eisenberg (2010) suggested that there may be reasons other than an increased prevalence or severity of mental disorder that could explain increased demands on services. The first is evidence from the National Comorbidity Survey Replication (NCS-R) carried out in 2002. The survey demonstrated a substantial increase in help seeking between the early 1990s and the early 2000s. The rates of engagement in treatment increased from 25 to 41% of the NCS-R respondents who met criteria for a mental disorder in the previous year. The perceived increase in demand for services in the student population may be a result of an increased willingness of people in general to seek help for psychiatric illnesses and other forms of emotional distress. Young people tend to have more positive attitudes to mental healthcare than older adults so this trend may be particularly pronounced in the student population. University counsellors report an increase in severity of presenting disorders as well as an increased prevalence. However, the NCS-R showed no evidence of increased levels of mental disorder in young people between the early 1990s and the early 2000s.

Conclusions

When considering the epidemiology of mental health problems in UK students in higher education, it is important to pay attention both to subclinical distress and to diagnoses of major mental illness. Sociodemographic factors associated with symptoms include gender, social class, ethnicity and nationality. In view of the increasing social and cultural diversity of UK students, it is possible that there will be a rise in symptom reporting and diagnosable conditions. The high levels of excessive and hazardous alcohol use that have been found in UK universities may place students at risk of other mental disorders.

Below are several further considerations for the planning of university health services.

- Psychiatric disturbance is widely prevalent in the student population and this may have a significant impact on academic performance.
- In common with findings in the general population, female students report increased rates of mental health symptoms. The impacts of sexual victimisation and abuse perpetrated by intimate partners may contribute to this. There is a need for health promotion efforts to focus on both would-be perpetrators and potential victims to tackle this problem.
- Financial pressures and academic concerns are consistently identified as important contributors to mental health symptoms.
- International students may be more vulnerable to mental health problems than UK-born students.
- Good social networks and peer contacts, as well as religious affiliation, appear to have a protective influence against mental health problems.
- Further research, using evidence-based diagnostic criteria and assessments of severity, is urgently needed. Sequential prospective studies across a range of academic institutions will be required to provide accurate estimates of the incidence and prevalence of mental disorders and to determine whether these are changing over time. These should focus not only on diagnosable mental illnesses but also on psychological distress that may not meet standard diagnostic criteria. It is important that these cover a range of universities, colleges and higher education institutions to reflect the increased diversity of the student population. One development that may assist this process is the use of internet-based survey methods. Nearly all students now have a university or college email address. Campus-wide email systems have already been used to recruit cohorts of students. Students seem to be willing to participate in online surveys and response rates have been highly satisfactory (Bewick *et al*, 2008).
- Several studies have highlighted the low rates of treatment uptake by students with mental health issues. There is a need to identify the social, cultural and demographic correlates of treatment access and to consider what steps could be taken to ameliorate this problem.

Higher education context

There has been a significant development in mental health provision in higher education over the past decade or so. The Heads of University Counselling Services (HUCS) report *Degrees of Disturbance: The New Agenda* (Heads of University Counselling Services, 1999) was very influential in alerting higher education institutions to the increasing levels of psychological disturbance among students. In September 2002, the Special Educational Needs and Disability Act 2001 (SENDA) extended the 1995 Disability Discrimination Act (DDA) to include education, and placed a legal responsibility on education providers to students with disabilities, including those with severe or enduring mental disorders. The requirement for institutions to meet their legal obligations has provided a further stimulus to the development of specialist services for these students.

The Equality Act 2010 is now replacing the majority of equality legislation, including the DDA. On 5 April 2011, the new public sector Equality Duty came into force. The Equality Duty replaces the three previous duties on race, disability and gender, bringing them together into a single duty (for more information see www.skill.org.uk, a website of the National Bureau for Students with Disabilities).

At the national level, Universities UK and GuildHE supported the establishment of the MWBHE working group in 2003 (the remit and activities of the group are detailed in Appendix 1). The group's activities include surveying higher education institutions to monitor developments in mental health provision across the higher education sector. Surveys undertaken in 2003 (Grant, 2006) and 2008 (Grant, 2011) have shown significant developments over this period. The number of responding institutions (96 in 2008) with mental health policies in place has increased from 26 to 54%, with a further 29% of the 2008 respondents reporting that their policy was 'in development'. Most institutions (87% of survey respondents) provide guidance and training for their academic and administrative staff to help them spot signs of a student who is having difficulties that may indicate an underlying mental health problem, and then refer the student appropriately. Staff are also made aware of ways of helping students by making appropriate adjustments for students to the teaching and learning environments and to the various methods of assessment. Procedures to provide support for temporary withdrawal from, and return to, study are also in place in most institutions and allow students to take time out to recover their health.

New approaches to student induction in many higher education institutions have left the traditional 'freshers week' behind. It is now generally thought to be more effective if induction and orientation activities are spread throughout the first year, providing ongoing guidance and information to aid transition. 'Buddy' systems can provide mentoring and support. This sometimes takes the form of schemes in which senior

undergraduates act as 'parents' for those newly arrived. Another important source of support is the personal tutor system. The 2008 MWBHE survey showed that about 80% of responding institutions had a personal tutor system in place. However, in institutions with deteriorating staff:student ratios, providing responsive and available personal advice at a departmental level can be challenging. The majority (71%) of the respondents to the 2008 MWBHE survey rated their overall institutional provision as good or very good and for a further 25% it was adequate. However, 4% felt that their provision was poor or non-existent. Survey comments suggested that ratings largely reflected the quality of what was provided; many mentioned increasing pressure on their resources in terms, primarily, of student demand, but also institutional demand on specialist staff for training, guidance and health promotion events (Grant, 2011).

Legislative and policy framework

This section summarises the key legislative background pertaining to the widening access to higher education and to institutional responses to the increasing burden of mental health difficulties encountered in higher education. This is reviewed in association with emergent governmental reports and policy documents. The responses of higher education institutions to the legislation and governmental reports are evaluated. The resultant strategic development and organisational framework of student service departments in higher education to support students with mental health problems is also reviewed. The time frame concentrates primarily on developments since the DDA came into force in 1995. The legal definition of disability in the Act is that 'a person has a disability … if he has a physical or mental impairment which has a substantial and long-term adverse effect on his ability to carry out normal day-to-day activities' (Part 1, Section 1).

The legal definition of 'student services' in the Act is quite general. In practice, student services may comprise disability services and counselling services and may include a general practice. In larger institutions, there may be more specialised personnel such as a mental health advisor, staff to advise on financial and accommodation matters and, in some institutions, in-house psychiatric provision.

Government policies

Since the Robbins Report was produced in the 1960s (Lord Robbins, 1963), recommending a huge expansion in the number of students admitted to higher education, there have been a number of key reports, inquiries and legislative changes that have changed the landscape within higher education, leading to a population of students that has changed in terms of their demographic characteristics, mental health status and disability. In the 1960s, the student population was not representative of the population as a whole, nor is it today, but there is now a more substantial overlap.

The legal framework broadly embraces the legislation pertaining to disability, discrimination and equality, data protection and human rights. Related and intertwined with the legislation are key government reports, NHS and higher education strategies as well as an understanding of duty of care issues, liability for negligence, and the duty to promote equality.

Along with changes in governmental policy and key legislation over this period, the characteristics of the student population have changed dramatically. With increasingly inclusive strategies – widening participation in its broadest sense – the student population has embraced diversity, and students from sectors of society that did not commonly participate in higher education have been increasingly admitted. Institutions have been required by legislation to admit students that would not have been admitted in former times, and encouraged to do so with financial incentives.

The concept of widening access to higher education emanated from a number of sources, and was enshrined in the National Committee of Inquiry into Higher Education (1997) publication commonly known as the Dearing Report, which is in fact a series of reports into the future of higher education in the UK. The Dearing Report was commissioned by the government, and was the largest review of higher education in the UK since the Robbins Report in the 1960s. It noted that over the previous 20 years the number of students in higher education had doubled, but the amount of funding per student had fallen by 20%. Concerns about quality assurance as a result of this shortfall were noted, and the report recommended that financial incentives should be offered to higher education institutions that could demonstrate a commitment to widening participation, and to those with a participation strategy. This extra funding was to help meet the increased need for support services arising from a more diverse population, with higher levels of disability. The government decision in 2010 to allow universities to charge higher fees for tuition has raised some concerns about the possibility that this will deter potential students from less affluent backgrounds from applying. As a result of the Dearing Report, at the point of entry to higher education there is now a greater number of students who fall within the category of disability. The report also noted that the number of international students has been increasing over many years, with the attendant increase in mental health difficulties that are characteristic of this population.

The consequent widening participation has been welcomed in many ways by the higher education sector and the public as a whole, notwithstanding the challenges posed by students with mental health problems and disability in the higher education environment. Nevertheless, there is an additional financial burden attached to providing appropriate support to these students and the amount of work involved has not always been accompanied by a commensurate increase in funding. In the present uncertain politico-economic climate, with the financial cuts that are threatening to fall upon the public sector, higher education faces a larger challenge than ever before in maintaining support services, and the gulf between need and supply may widen further. Some student service departments have already faced cuts and others face uncertain times ahead.

Widening participation was driven by a number of aspirations. An 'inclusive' approach to higher education was seen as an important ideal in itself. Other drivers included the predicted changes in the labour market, with an expected increase in jobs that required higher education qualifications.

The government pledged to provide an increase in financial benefits to higher education institutions that showed that they were engaging in widening participation. Widening participation strategies were developed, such as the Excellence Challenge programme, which began in 2001 and was implemented by a consortium comprising the National Foundation for Educational Research, the London School of Economics and Political Science

and the Institute for Fiscal Studies, supporting and encouraging students from underrepresented groups to be admitted to higher education through a wide variety of means and incentives. The challenge of widening participation has included an aim of the government to recruit half of the 18–30 age group into higher education by 2010. Through promoting the mental health of all students there is an ethos that higher education should be able to provide a healthy environment that is supportive of its most vulnerable members.

One result of widening participation is that there is evidence to suggest that non-traditional entrants to higher education may make greater demands on support services. Meltzer *et al* (2000) showed an increased incidence of mental disorders among children from working class families, those with less educated parents, larger families, lone parents and those experiencing poverty. Additionally, Smith & Naylor (2001) made a clear link between lower socioeconomic status and dropping out.

Legislative developments

The legislative and governmental policy drivers for widening access from the 1990s to date included the DDA 1995 (followed by linked legislation), various equality legislation, NHS strategies for mental health, and funding council disability initiatives, especially the Higher Education Founding Council for England (HEFCE) from the mid-1990s. Key guidance and strategies, responding to governmental directives, emerged in higher education. A number of reports were published by various bodies within higher education institutions in response to the widening access and its consequences, looking at the challenges that they were facing and suggestions of how to address them.

Disability Discrimination Act 1995

The DDA 1995, a civil rights law, is an Act of Parliament of the UK. It ushered in major changes for higher education, among which was a requirement to respond to mental health problems in students, for example by making adjustments in the study environment to compensate for disabilities. The Act laid down that there is a duty of care incumbent on higher education, with the potential for legal redress if 'reasonable adjustments' are not actually made. In addition to reasonable adjustments, the DDA stipulates that there is a positive duty to promote the equality of students and staff with disabilities. However, there was a lack of indicative funding allocated to higher education from the government to meet the new requirements.

The DDA provided an impetus for positive changes of policy. Before it came into force, institutions could, and did, choose not to recruit or retain students (and staff) with mental health problems. The DDA required that universities must develop a comprehensive programme to meet the needs of people who have a disability. In chapter 2 of the Act it is clearly set out that it is unlawful for the body responsible for a higher education institution to discriminate against a person with a disability, in terms of admissions, the terms of any offers of admission, or by refusing or deliberately omitting to accept an application for admission. The ethos of the DDA departed from a passive approach enshrined in the Sex Discrimination Act 1975 and the Race Relations Act 1976. These two acts were based on the concepts of direct and indirect discrimination, whereas DDA used the tenet of 'reasonable

adjustment' as an active approach to combat discrimination. There has been a raft of amending legislation to the DDA, as well as associated legislation, which has further contributed to an increased number of students with disabilities in university environments.

Special Educational Needs and Disability Act 2001

The first major amending legislation was the Special Educational Needs and Disability Act 2001, commonly referred to as SENDA, which inserted new provisions in Part 4 of the Disability Discrimination Act 1995 in connection with disability discrimination. It asserted that, in relation to admission, students with a disability should not be substantially disadvantaged in comparison with those who do not have a disability. However, the DDA is more likely to protect students with moderate mental health difficulties than those with severe difficulties because of the exceptions within the Act. If the adjustment required to accommodate the student's disability is too expensive for the university, or too disruptive for the effective learning of other students, then it will not be considered 'reasonable'. Adjustments that are adjudicated as reasonable also need to be anticipated in advance when the higher education establishment has been made aware of a disability through a disclosure. It was intended that SENDA would be an adjunct to the DDA, which had legislated to prevent the unfair treatment of individuals, in the provision of goods and services, unless justification could be proved. Later, SENDA was superseded by the Disability Discrimination Act 2005. However, SENDA may have had less positive impact on disability arising from mental disorders than disability in general.

Simultaneous to SENDA, the government published *Improving Life Chances of Disabled People* (Prime Minister's Strategy Unit, 2001), which sought active help for people with disabilities and gave impetus to amendments to the DDA. The 2005 amendment introduced the Disability Equality Duty, requiring the public sector to promote equality of opportunity for people with disabilities and to address inequality through developing a scheme, action plan and targets.

The Disability Discrimination Act 1995 (Amendment) Regulations 2003 and the Disability Discrimination Act 2005 which came into force in 2006, extended the requirement that reasonable adjustments should be made to students with disabilities to a notion that there should be a positive duty to promote the equality of students and staff with disabilities. There have been no legal rulings subsequent to the introduction of the concepts of 'reasonable adjustments' and of a 'positive duty to promote equality'. The majority of claims arising out of a failure of higher education institutions to make adjustments have been settled out of court. A failure of an institution to follow its own procedures, or acting in an arbitrary manner, could lead to a student seeking a judicial review, which, although not easily obtainable, may rule that the institution is liable and compensation may be due. Current legislation is based on the principle that the educational disadvantage is not an inevitable result of disabilities or health conditions, but stems also from attitudinal and environmental barriers in higher education institutions.

Equality Act 2006

The Equality Act 2006 transferred the rights of the former Disability Rights Commission, which had been inaugurated in 1999, to the Equality and Human Rights Commission (EHRC), a non-departmental government

body. The EHRC combines the functions of the former Disability Rights Commission, the Commission for Racial Equality and the Equal Opportunities Commission. Since 2007, this body has had responsibility for enforcing the Disability Equality Duty and has powers to issue guidance on all equality enactments including disability. There is recognition of the need for guidance on the nature of the Disability Equality Duty. The enhancement of the quality of provision for students with disabilities is a shared responsibility of all staff in an institution, not just those with a remit for disability or learning support. Arrangements should be in place to ensure effective communication and partnerships between staff and to ensure that students' entitlements are met. The Disability Equality Duty requires institutions to develop a Disability Equality Scheme, with a key element being the involvement of students who have a disability. Each institution should have a Single Equality Strategy that explains its approach to promoting equality in general (rather than solely in relation to disability), its action plan, and how stakeholders have been involved. Institutions can contact the Equality Challenge Unit (www.ecu.ac.uk) for support in meeting the Disability Equality Duty. The Equality Act 2006 is a precursor to a proposed Single Equality Act, whose aim is to supersede and harmonise all the equality enactments and to provide comparable protection against threats to equality, including disability.

As a result of the various legislative developments in relation to equality, higher education institutions, under Part 4 of the Disability Discrimination Act 2005, are required to be active in encouraging applicants to disclose a disability. It is important for the institutions to create a culture that facilitates disclosure of a disability. Such disclosure is not a legal requirement, but is encouraged.

Equality Act 2010

The new Equality Act of 2010 made a number of changes to disability law. The definition of disability was changed very slightly and is stated as follows:

> 'A person (P) has a disability if –
>
> P has a physical or mental impairment, and
>
> the impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities'. (Part 6)

The Act has strengthened the requirements for reasonable adjustments. 'Substantial disadvantage' is defined as 'more than minor or trivial'. The Act offers protection from indirect discrimination. It provides protection for people who have had a disability which may recur. It outlaws the practice of employers asking job applicants about their health or disability before short-listing or offering them a job. This could mean that it will not be possible to enquire about students' health history when offering placements.

Responding to disability

Established in 1997, the Quality Assurance Agency for Higher Education (QAA) audits and reviews higher education. Under their Code of Practice, higher education institutions are required to show active change in relation to disability. In the *Code of Practice for the Assurance of Academic Quality and Standards in Higher Education*, first published in 2001, with the second edition published in 2010 (Quality Assurance Agency for Higher Education,

2010), Section 3 (Disabled Students) states that students with disabilities are an integral part of the academic community with a general entitlement to the provision of education in a manner that meets their individual requirements. Accessible and appropriate provision is not optional, but a core element. The QAA found in the evidence of the 129 institutional audit reports published between 2003 and 2006 that, overall, institutions have engaged with the guidance on students with disabilities contained in the Code of Practice, and are also aware of the need to comply with legal requirements in relation to students with disabilities (Quality Assurance Agency for Higher Education, 2006).

In terms of figures, the Open University (2006) published a comparison of the number of students with a declared disability: in 1998/1999, 289 students had a declared mental health disability and by 2003/2004 this figure had risen to 1065, a rise of 269%. In terms of all single disabilities, this is a figure many times higher than the proportionate rise in other disabilities.

Arising out of the emergent legal framework, the structure and function of student counselling and disability services was also transforming in the 1990s and the first decade of this century, largely bolstering the support that students could receive if they had a disability, including mental health problems. However, not all services increased in size. Some universities did not increase provision. In services where the provision was increased, the demands became increasingly onerous. Over the past decade in particular, many students are increasingly prepared to disclose a disability and have expectations that the university will support them.

In *Degrees of Disturbance – The New Agenda*, published by the Heads of University Counselling Services in 1999, the impact of increasing levels of psychological disturbance as a result of widening access to higher education was examined. The working group who produced this report had noted that there was an observed increase in the number of students who were presenting to counselling services or coming into conflict with their institutions. The report recommended national coordination, the development of mental health policies and building on existing good practice as a keystone to moving forward.

The Committee of Vice Chancellors and Principals (CVCP; superseded by Universities UK) responded to the need for higher education establishments to meet their duty of care responsibilities and produced *Guidelines on Mental Health Policies and Procedures for Higher Education* (Committee of Vice Chancellors and Principals, 2000). This report was the result of a collaboration between the CVCP, the Standing Conference of Principals (SCOP), the Association of Managers of Student Services in Higher Education (AMOSSHE) and various external agencies. As a result of these guidelines, many higher education establishments that had not already developed a mental health policy set up working groups to do so. These guidelines emphasised the legal and duty of care issues, access to support and guidance services, the importance of interagency working and the need to provide training.

One of the guides published by AMOSSHE, *Responding to Student Mental Health Issues: Duty of Care Responsibilities for Students in Higher Education Good Practice Guide* (2001), the need for special examination arrangements, practical guidelines and examples of institutional practice are set out.

The Learning and Skills Act 2000 acknowledged that higher education owed a duty of care to students with special educational needs, including equality of opportunity for the needs of persons with intellectual disabilities,

and provision of assessments for young people in education in transition from school to post-16 learning. The duty of care issue in general became a cause for concern in higher education and the boundaries of what counted as 'reasonable' became increasingly questioned.

In the previous report on the mental health of students, the Royal College of Psychiatrists (2003) recommended that higher education institutions should respond to the increase in demand of mental health services through mental health promotion, the development of mental health policies and a focus on risk assessment. The report highlighted the increasing numbers of students in general, the increasing numbers of mature students and the narrowing of access to mental health services for the student population. It recommended local networks to develop shared policies between colleges, primary care services, mental health services and other relevant agencies.

The MWBHE working group set out to benchmark current provision and to evaluate the impact and effectiveness of recent guidance and legislation. The group organised conferences and carried out sector-wide postal surveys of its members in 2003 and 2008. Its main aims are to promote collaboration between professional groups responsible for mental well-being in higher education, to be a reference point for government bodies, the NHS and educational institutions, and to influence policy on issues related to mental well-being in higher education. Membership includes wide representation from higher education and the Royal College of Psychiatrists, and links have been made with, among others, the National Disability Team, the Social Exclusion Unit and Young Minds. The group produced a *Framework for the Development of Policies and Procedures* (Universities UK/GuildHE Working Group for the Promotion of Mental Well-Being in Higher Education, 2006) to support higher education institutions in the development of mental health policies and procedures, broadly in light of widening participation and changes in disability legislation.

The problem of student suicide was taken up by Universities UK and SCOP (2002), in a report entitled *Reducing the Risk of Student Suicide*. This was in response to the increasing demand on student services by students with mental health problems, and recognition of a duty of care of higher education. In *Transitions: Young Adults with Troubled Lives*, published by the Social Exclusion Unit in November 2005, it was noted that 20% of 16- to 24-year-olds had a mental health problem, mostly anxiety and depression. Suicide was noted to be a cause of a quarter of all deaths in this age group. Suicide attempts had increased by 170% between 1985 and 2005.

Mentoring for mental health problems that have an impact on the academic performance of students is one strategy that has been widely taken on by disability services in higher education. The costs of this may be met by the Disabled Students' Allowance and are refunded to higher education by local education authorities. International students are disadvantaged in this respect in that they are not eligible for this funding.

Conclusions

The outcome of this legislation and the various report recommendations over the years is that in many higher education institutions mental health policies have been established. There have been varied responses to the increase in demand on services. It is difficult to summarise the scale and the scope of the impact that the legislation, with its demands and ramifications, has had

on higher education. This chapter has provided only an outline of the main issues.

There has been a general increase in liaison between higher education counselling services, primary care health services and locality mental health teams, although the extent and success of such partnerships has been widely variable. There is a continued need to build bridges between higher education and mental health services, at a locality level but also with commissioning bodies, primarily the primary care trusts in England and Wales and NHS boards in Scotland. Difficulties that preclude effective partnership working include different planning cycles, bureaucracy and the relative size of the organisations involved. Plans for the creation of specialised student community mental health teams (CMHTs), optimistically suggested in the early part of this century, seem out of reach in the present economic climate.

Counselling in higher education

History

The first university counselling service was established some 60 years ago at the University of Leicester. Others followed and many services (and the Association for University and College Counselling (AUCC), www.aucc.uk.com) have now been in existence for more than 40 years. Now almost all universities have counselling services as do the vast majority of higher education colleges. The 2003 Royal College of Psychiatrists report concluded that university counselling services are, in effect, the primary mental healthcare option for many students and recommended that they should be resourced accordingly. Since the publication of that report, those services have continued to be major providers of mental health services for students in higher education. A recent HUCS survey (P. Hunt, personal communication, 2010) indicated that across the UK approximately 4% of university students are seen by counsellors each year for a wide range of emotional and psychological difficulties.

Since the mid-1990s, counsellors have been noticing an increase in the severity of the difficulties students are presenting with. Their concerns led to the publication of *Degrees of Disturbance: The New Agenda* (Rana *et al*, 1999) and the hosting of a national conference, 'Beautiful Minds? Students, Mental Health and the University' in 2002 (www.beautifulminds.info). After the success of this conference, HUCS (www.hucs.org) was responsible for taking the lead in bringing together the different professional, government and student groups concerned with mental health in higher education; this led to the establishment of the MWBHE in 2003.

Work of university counselling services

Counsellors working in higher education are distinguished by their understanding of the connections between psychological and academic difficulties, their knowledge of the educational context and their integration with the wider institution. They strive to be accessible and inclusive. It is usual for them to offer:

- consultation, risk assessment and referral when appropriate
- a range of therapeutic work to students and to staff

- consultation to staff concerned about students
- training (including suicide awareness) for students and staff
- workshops for students and staff
- written materials to guide students and staff in their response to students in distress
- online information about how to help with study and mental health difficulties
- collaboration with others with responsibility for mental well-being within their own organisations
- contributions to institutional policy-making on mental health matters
- liaison with local NHS providers.

Many make considerable use of the opportunities afforded by e-technology by, for example, establishing online discussion boards or providing online multimedia programmes such as CALM (Campaign Against Living Miserably, www.thecalmzone.net). Services routinely evaluate the effectiveness of their counselling; many use the Clinical Outcome in Routine Evaluation (CORE) scale to track changes in clients during the course of counselling.

Clinical work

Most counselling is of individuals, although many services offer group counselling as well. Many services see staff as well as students. The most common issues students bring to counsellors are depression, anxiety, problems in relationships, loss and worries about their academic progress (data from AUCC annual surveys, see www.aucc.uk.com/survey.php). Many of these concerns are similar to those of the general population; what is different is the way these difficulties can be triggered by academic requirements and can interfere with the ability to study. Counsellors attend to the pressures on their clients caused by the demands of the student role and the impact of the educational cycle. They are aware of the therapeutic possibilities of harnessing work on the issues thrown up by the educational context in order to promote development and maturation.

A range of interventions are offered. An initial consultation will usually include risk assessment. Short-term work, perhaps in the form of brief focal therapy, can help to deal with a personal crisis, adverse life event or current conflict. Longer-term therapeutic work can focus on exploration of more complex developmental issues, and deeper-seated and long-standing emotional, psychological and mental health problems. Whereas a number of services have staff appropriately trained and experienced to offer longer-term, specialised help, few have the resources to offer open-ended psychotherapy to all students who might benefit.

The model of counselling offered by higher education services follows the paradigm described by the Department of Health.

> 'Counselling is a systematic process which gives individuals the opportunity to explore, discover and clarify ways of living more resourcefully, with a greater sense of well being. [It] may be concerned with addressing and resolving specific problems, making decisions, coping with crises, working through conflict, or improving relationships with others.' (Department of Health, 2001, p. 9)

Most also offer psychological therapy consistent with the National Institute for Health and Clinical Excellence (NICE) guidelines for depression (NICE, 2009*a*), namely CBT, short-term psychodynamic therapy and interpersonal therapy.

Many services have been innovative in developing new approaches in response to the increase in disturbance in students who consult them. Examples of these include Westminster University's mental health mentoring scheme, Manchester Metropolitan University's work on personality organisation, Reading University's scheme for people with Asperger syndrome and the School of Oriental and African Studies' exploration of new approaches to outreach (see Appendix 6 for an example of one psychiatrist's work on one of the schemes).

No service would undertake the diagnosis or treatment of severe mental illness but all would consider it important to be sufficiently well informed to recognise the various forms of mental illness and to know when referral to medical and psychiatric services is necessary. The establishment of links with local medical and psychiatric services for consultation and referral has always been seen as an essential part of the work of a counselling service in an institution of higher education (Association for University and College Counselling, 2010). Many services have been able to access psychiatric consultancy and support, often by referring to the 2003 College report to argue their case. Appendix 1 gives examples of a variety of ways in which this can be organised.

Many students who are referred to secondary or tertiary mental health services make use of the additional, often more frequent, support that can be offered by university counselling services to complement the treatment received through the NHS.

Working with the wider institution

Consultation

All university counselling services are available for consultation to staff concerned about students' well-being. This can lower staff anxiety about students and help them judge whether or not a referral to counselling is appropriate. Provision of support and advice by the counselling service often enables academic staff to continue helping students without overstepping the boundaries of their roles.

Training

Most counselling services run a variety of training programmes to support staff in their work of supporting students. Examples of these are the 10-week programme offered at the University of Hertfordshire and training of student mentors in peer support at Oxford University (see Appendix 6 for more details).

Psychoeducation

Many services offer students a range of workshops on, for example, procrastination, examination anxiety, transitions, stress and relationships. They can supply written and internet-based information about common emotional and learning difficulties. Services often work with student unions and other student support staff to promote mental health.

Liaison, collaboration and contribution to policy-making within the higher education institution

When appropriate, services liaise with academic and halls of residence staff, mental health advisors, international student advisors, chaplains, student unions and other student support services. Appendix 2 contains an example of this from Nottingham University where a GP, mental health advisor and counselling service worked together to support a vulnerable student.

Many services have developed a university-wide mental health strategy (see the example from Sheffield University in Appendix 2). Many counsellors are called upon to serve on relevant university committees and working parties. They have been active in the preparation of institutional mental health policies. They frequently feed back to their institutions their perspective on the impact of its practices on the student experience.

Collaboration with the NHS

Counselling services have been active in trying to forge links with local NHS services, often using the 2003 College report as a rationale for doing so (see the Cambridge University entry in Appendix 1). The response to their approaches has been varied. Comprehensive networks had already been established in two cities which have more than one university. The University of Leeds has developed a close working relationship with the local primary care trust, CMHT, GPs and other universities in the area, and the Oxford Student Mental Health Network has built a coalition of educational establishments and NHS providers to share ideas and offer relevant training (both described in more detail in Appendix 1).

Professional standards

Important guidance documents are *Ethical Framework for Good Practice in Counselling and Psychotherapy* from the British Association for Counselling and Psychotherapy[1] (2010) and AUCC *Guidelines for University and College Counselling Services* (Association for University and College Counselling, 2010).

The vast majority of university counsellors are graduates, many with higher degrees, trained in counselling and/or psychotherapy and with a substantial amount of post-qualification experience. Counselling tends to be a second or even third occupation and it is common for counsellors to have extensive experience in other relevant fields before training in counselling/psychotherapy. Common backgrounds include lecturing and teaching, psychology, social work and nursing. Some services employ clinical and counselling psychologists and cognitive therapists. Regular and ongoing consultation with a more experienced practitioner in a related field is a requirement for all BACP members who are practising counsellors. Continuing professional development is a requirement for maintaining competent practice (British Association for Counselling and Psychotherapy, 2010).

1 The majority of university and college counsellors belong to the British Association for Counselling and Psychotherapy (BACP) which is responsible for ethical codes, accreditation and registration. The Association for University and College Counselling (AUCC) is a division of BACP and offers sector-specific guidelines. There are some counsellors in higher education who are not members of BACP; they would subscribe to the Codes of Ethics of other professional bodies such as the British Psychological Society, UK Council for Psychotherapy or British Psychoanalytic Council.

Conclusions

Counselling services make an important and multifaceted contribution to the well-being of students. However, many services are already overstretched and under-resourced; all are concerned about the possible impact of the impending funding cuts on what they can provide. It is hoped that their work can be safeguarded and developed.

Mental health advisors

Brief history

The mental health advisor role was developed as part of a HEFCE-funded project at the University of Northampton in 1997–2000. The role was selected as an example of good practice, and the Universities UK publication *Student Services: Effective Approaches to Retaining Students in Higher Education* (Thomas *et al*, 2002) recommended the establishment of mental health advisors in all institutions. The need to manage and respond to the often complex needs of students with mental health difficulties caused growing concern at that time, and many counselling and disability services felt ill equipped to meet the growing demand. Nottingham, Leicester, Hull and Lancaster universities also undertook HEFCE-funded project work, the outcomes of which were disseminated across the sector (see, for example, Grant & Woolfson, 2001; Grant, 2002; Stanley & Manthorpe, 2002). Other universities such as Nottingham Trent and Coventry also recognised a need for specialist support for students experiencing mental health difficulties, and differing models of mental health support began emerging between 1999 and 2002. The support offered by Nottingham Trent University was cited as a model of good practice in the *Mental Health and Social Exclusion* report (Office of the Deputy Prime Minster, 2004). Many universities have found that there is a need for services to expand to meet increasing demand and have appointed additional staff.

The University Mental Health Advisors Network (UMHAN) was formed in 2001 with just 5 members and now has 95. The 58 respondents to the 2003 MWBHE survey (Grant, 2006) reported that 53% of the institutions surveyed employed a mental health advisor. By 2008, around 80% of responding institutions had at least one advisor. This change indicates a rapidly growing network of specialist mental health posts in the higher education sector and a perception that the role is effective in meeting needs (Grant, 2011).

Some institutions have taken a different approach to mental health provision and have brought a range of health-related provision together to create 'health and well-being teams'. Others, despite not appointing a mental health advisor, offer specialist advice through, for example, their disability or counselling services or their health centre.

Professional background and qualifications

The majority of specialist advisors are educated to a degree level and have a professional qualification in fields such as psychiatric nursing, occupational therapy and social work or are graduate members of the British Psychological Society. They will also usually have had several years' experience of working within NHS mental health services or other mental health settings. The

majority are employed by the university (although there are a handful employed by the NHS), and most are located within disability or counselling services or within a multidisciplinary student services unit. In line with professional practice standards, most universities fund regular monthly clinical supervision for their mental health advisors, with suitably experienced professionals. These are often clinicians working within local NHS mental health services.

Role and responsibilities

Direct work with students

Mental health advisors specialise in assessing how a student's mental health difficulties may affect their learning. They will explore these with the student, advising on strategies and interventions to reduce barriers to learning and enable successful progression in their studies. Some students will enter university with prior experience of mental ill health and established networks of support within secondary care. Some have a history of mental disorder but arrive at university with no support in place, and others become mentally ill for the first time after starting at university. Advisors work with all three groups of students, and their support complements statutory service provision.

Mental health advisors offer support to applicants and newly enrolled students with experience of mental ill health during their transition to university. It is easier to identify students who may benefit from mental health advisor support if they formally disclose a mental health difficulty on application or enrolment or if they are supported in contacting higher education services by current healthcare professionals. Some individuals choose not to disclose a history of mental disorder. This can lead to crisis situations and academic underperformance or even failure to progress if adequate support and adjustments have not been considered.

An advisor will offer a space for current or prospective students to consider how their difficulties may affect their learning, and will assess and advise on reasonable adjustments which might be possible to arrange to provide the best opportunity for successful progression. In collaboration with the student, advisors can complete individual learning and teaching recommendation forms or equivalent, to be shared with tutors on a 'need to know' basis. These help to ensure that tutors have an understanding of the difficulties a student might experience, and the adjustments that would promote learning and progression. Many students find this helpful, particularly if on a combined honours course as it can be a very daunting prospect to contact each tutor individually to share personal information and negotiate adjustments without support. The advisor might suggest that the student applies for Disabled Students' Allowance and support them through the application process (see pp. 48–49).

Advisors can recommend adjustments in examinations such as extra time to compensate for difficulties in managing poor concentration and specific seating arrangements for students troubled with anxiety. Adjustments are discussed and recommended on an individual basis depending on each student's difficulties. Advisors can recommend and support access to other university services such as counselling, extra library support and assistance, accommodation services, financial services, education and careers services, residential provision and academic advice.

Mental health advisors provide self-help information and offer guidance and support to help students better manage their mental well-being, drawing on a variety of techniques and interventions depending on their particular skills and experience. This one-to-one support can provide students with the tools to overcome anxiety, panic attacks, manage self-injury and cope with depression. If a student's mental health is causing concern to the student and/or others, the advisor can liaise with the student's GP (with the consent of the student) and can support students in accessing local mental health services. If consent is not forthcoming and the student presents as a risk to themselves or others then procedures for breaching confidentiality will be followed. These will usually include discussion with the student and consulting with a senior member of staff and/or clinical supervisor.

Liaison

Liaison with NHS services is an important part of the role. Many students find accessing mental health services challenging, particularly if it is the first time they have required a formal mental health assessment. The advisor can act as a bridge between higher education and NHS and other providers outside the higher education sector, often playing a key role in coordinating a network of support services and acting as a central focus for external agencies wishing to share information or consider support plans for students. When appropriate, they will be active in sharing issues of concern with GPs and statutory services involved in a student's treatment, particularly when supporting the student in accessing services.

As the majority of mental health advisors are not employed by the NHS, they do not have access to medical records of any kind. Sometimes it is necessary to assess and manage risk in liaison with local mental health services and GPs. Accessing NHS support can be particularly challenging for higher education institutions when there are different perceptions of the urgency or seriousness of a case. Frustrations can arise when a student's behaviour is seriously affecting others on campus, but from the health professional perspective their ill health is not considered to be serious enough to warrant urgent action.

Within higher education institutions, staff often require support or reassurance regarding their contact with students who are causing concern. The advisor can offer guidance, advice and training for staff in relation to supporting and responding to students presenting in distress or those whose behaviour is causing concern.

Other responsibilities

Mental health advisors are often involved in developing and delivering staff training as outlined above. They contribute to policy development and policy reviews to ensure that potential reverberations for student mental well-being are fully considered. They may also be expected to take the lead with mental health promotion within the university, researching and developing materials to promote mental well-being alone or in collaboration with external agencies or internal services such as disability advisors, counsellors or the student union. They may also run therapeutic groups or facilitate support groups for students.

As most universities currently have just one full- or half-time mental health advisor post, their resources are limited and it is often a demanding role. However, it is very rewarding when students are able to progress and

develop the life skills and self-confidence essential to recovery and social inclusion both within and outside of the university setting.

Disabled Students' Allowance

Any student with a diagnosed mental disorder may be eligible for the Disabled Students' Allowance (DSA). These are grants to help meet the extra course costs students can face as a result of a disability, including those arising from mental disorder and specific intellectual disabilities such as dyslexia. They are paid on top of the standard student finance package and do not have to be repaid. The amount does not depend on household income. The allowances can help pay for:

- specialist equipment, e.g. computer to work from home during periods of ill health or because of difficulties using shared IT areas, digital voice recorder to record lectures to compensate for concentration difficulties, computer with enabling software for dyslexia or visual impairment;
- non-medical helper(s), e.g. mental health advisor or learning support tutor (particularly helpful if a student has had a long break from study because of ill health);
- extra travel costs that can cover costs arising from the disability, e.g. having to commute rather than live close to university to remain with known health professionals/care package or use of taxis due to severe anxiety using public transport;
- general allowance, e.g. photocopying.

The allowance is available to eligible full-time and part-time students (including those living in the family home), although part-time students must be studying at least 50% of a full-time course. Both undergraduates and postgraduates may apply. To apply for the DSA, students should contact Student Finance or the NHS Business Services Authority if receiving an NHS bursary. Applicants will be asked to provide medical proof of disability such as a letter from their GP or specialist. Once Student Finance or the NHS Business Services Authority have confirmed eligibility for DSA, they will ask the applicant to have an assessment of course-related needs with one of the National Network of Assessment Centres. They should provide information about the Centre nearest to the student's home, although it is worth checking whether the university the applicant is, or will be, attending has its own independent assessment centre as they will be most familiar with the resources available. This assessment can take place before the start of the higher education course, and this is advisable. However, agreement must be obtained by Student Finance or NHS Business Services Authority to fund this assessment. A standard letter of guidance for doctors providing reports has been produced by the University of Northampton in Appendix 7. For more information, consult the booklet *Bridging the Gap: A Guide to the Disabled Students' Allowances (DSAs) in Higher Education* from the Student Finance website (www.direct.gov.uk/en/DisabledPeople/EducationAndTraining/HigherEducation/DG_10034898). Students who receive an NHS bursary can obtain information on www.nhsbsa.nhs.uk/Students.

In Scotland, academic funding is arranged by the Student Awards Agency for Scotland (www.student-support-saas.gov.uk). Welsh students should consult www.studentfinancewales.co.uk and those in Northern Ireland can check www.studentfinanceni.co.uk.

Healthy Universities

The social environment of higher education institutions is unique in many important ways that are relevant to the emergence, detection and treatment of mental disorders in students. This is perhaps one time in a person's life in which work, leisure, accommodation, social life, medical care, counselling and social support are all provided in a single environment. Furthermore, this environment is one that has research and development as one of its core functions. This provides opportunities to develop and evaluate new possibilities for the prevention and treatment of mental disorders that may be difficult to achieve elsewhere. For example, Andersson *et al* (2009) described a system established in a Swedish university in which all new first-year students were assessed in terms of alcohol intake. Students who were drinking at hazardous levels were offered a programme of therapy aimed at ameliorating this. This intervention was associated with positive changes in terms of alcohol use, stress and mental symptoms in comparison to high-risk freshmen at a control university. These improvements were sustained 1 year later. (For a review of alcohol reduction strategies in students, see Larimer & Cronce, 2007.)

The Healthy Universities initiative (www.healthyuniversities.ac.uk) has adopted a more ambitious rationale in relation to student health. The university or college is seen not only as a place of education but also as a resource for promoting health and well-being in students, staff and the wider community. It can do this in two ways. The first is through various programmes of health promotion. The second is by imparting knowledge and skills that will help students to attain better health. The higher education funding councils and the Department of Health are supporting work that focuses on promoting student and staff well-being and many institutions are now part of the Healthy Universities network. The MWBHE group has published guidelines on mental health promotion (www.mwbhe.com/publications-resources).

Notwithstanding how good the services provided for students (or indeed staff) with mental disorders are, they will find it difficult to thrive unless the physical and educational environments are conducive to well-being, reflection and recovery. Individual services need to be set in the context of a healthy organisation to have the greatest impact. This is one where, for example, learning and social spaces are comfortable, tutors are approachable and assessments are aligned with the curriculum and are spread out evenly to avoid unnecessary simultaneous deadlines.

Higher education offers enormous potential to positively influence the health and well-being of students, staff and the wider community through education, research, knowledge exchange and institutional practice. Investment for health within the sector also contributes to core agendas such as staff and student recruitment and retention, and hence institutional and societal productivity and sustainability. This was highlighted in the research commissioned by the Health Sciences and Practice Subject Centre and supported by the Department of Health (Dooris & Doherty, 2009). The report of this research opened with a quotation from Professor Richard Parish, Chief Executive, of the Royal Society for Public Health:

> '[Healthy Universities matters not only because] it's important for staff and students now – but because these are the people who are going to become the leaders of industry, our public services, our universities and our voluntary organisations in the future. So, it helps to set the tone

> and establish a climate within which they are going to be more receptive to these ideas when those students find themselves in positions of influence in due course.' (Dooris & Doherty, 2009, p. ii)

The research revealed the extent and range of activity taking place within higher education institutions and demonstrated a rapid increase in interest in the Healthy Universities approach. This finding was supported by the responses to the recent MWBHE survey: of the 84 institutions that answered the relevant question, 20% already considered themselves to be 'health promoting institutions', and a further 27% were 'working towards' this status (Grant, 2011). This points to a growing appreciation of the need for a comprehensive whole-system approach that can map and understand interrelationships, interactions and synergies within higher education settings, with regard to different groups of the population, different components of the system and different health issues. Such a system-based approach has significant added value. It offers the potential to address health in a coherent and coordinated way and to forge connections to both health-related and academic targets within higher education.

It has long been appreciated that settings such as schools and workplaces enable health promotion programmes concerned with encouraging individual health to be implemented. However, the settings-based approach moves beyond this view of health promotion in a setting to one that recognises that the places and contexts in which people live their lives are themselves crucially important in determining health and well-being. The rationale for the settings approach is based on the known influence of environmental factors on health and well-being. It follows that effective health improvement requires investment in the social systems in which people spend their time and live their lives. As Dooris & Hunter (2007: p. 108) have argued:

> 'If public health and health promotion represent a mediating strategy between people and their environments, synthesising personal choice and social responsibility in health, then this has important implications for the management and organisational dynamics within a social system or health setting regardless of whether it is a school, hospital, university, prison or workplace. In this way, health promotion can be viewed as an intervention in social and organisational systems to improve health'.

There are also specific measures that higher education institutions can take in terms of promoting mental well-being. An obvious one is to tackle the culture of heavy alcohol use and binge drinking that is such a prevalent part of student life in the UK. The bars in student unions have traditionally been a source of cheap alcohol for students. Use of alcohol may be boosted by drinks promotions, 'happy hours' and other inducements to drink. At the very least student unions should not exacerbate problem drinking and instead should have policies that mitigate the effects of alcohol misuse. These policies might address matters such as pricing, sales of 'alcopops' and other high-alcohol beverages and serving drinks to customers who are obviously intoxicated. Unions and other student bodies should make efforts to promote alcohol-free activities and events.

Sources of help for the student in distress and ways of gaining access to these should be widely publicised. Efforts to promote integration of the new student into university or college life should be developed as far as possible. These include the allocation of a 'buddy' or 'parents' (roles usually taken on by more senior students) to provide mentoring and support.

Improving health and well-being for all will lead to enhanced retention of students and higher academic performance. Some universities started on this systemic route more than 10 years ago, others are only just preparing for such an initiative and will need help and support drawn from across institutions, including counselling and health professionals, human resources staff and staff development units as well as the academics and learning support staff.

Pathways to psychiatric care

NHS PATHWAY

The standard route into NHS psychiatric care is by referral by a GP. In some cases general practices within the UK employ counsellors or psychologists. Only a minority of practices have any formal arrangements for the delivery of more intensive psychological therapies such as CBT, although this should change with the IAPT initiative in England and Wales and comparable efforts in Scotland such as Doing Well by People with Depression (2003–2006).

If the GP feels that a student's mental disorder cannot be effectively managed within primary care, the student will sometimes be directed to the counselling service within their academic institution. Arrangements for referral and communication between medical practices and counselling services vary from institution to institution. Where higher education institutions have a university medical service (see pp. 53–55) this is far more effective and straightforward than in those institutions that do not have this close relationship with a single primary care provider. In such cases there may be no facility for GPs to make formal referrals to counselling services and no reporting back to GPs in the course of, or at the end of, counselling. It is helpful if clear channels of communication are established and relevant information is shared. Students are generally happy to consent to this.

The GP may also make a referral to the local secondary care CMHT. These teams are multidisciplinary and can provide a range of interventions such as psychiatric assessment, expert pharmacological management, occupational therapy and more formal treatments, for example CBT. In the case of a student who has acute psychosis or is acutely disturbed there may other options such as referral to early intervention for psychosis teams or intensive home treatment teams.

Where appropriate, individuals can be referred by CMHTs to specialised tertiary services such as psychotherapy, drug and alcohol services and eating disorder services. The provision of these services varies widely from one area to another.

In general, there is limited access to NHS secondary care directly to potential patients or to non-NHS referrers such as counsellors and other university staff, and there are good reasons why this should not be overridden. The first is that the GP can coordinate and provide continuity of care for patients as they proceed through the system. The GP remains responsible for prescribing rather than this responsibility being dispersed across a range of specialist services. This means that there is less risk of drugs being prescribed that have adverse interactions. Finally, GP referral is a major factor in promoting efficient use of secondary and tertiary services.

In countries in which there is direct access to specialist services, healthcare costs are generally much higher and resource utilisation less efficient.

There are nevertheless some specific situations in which direct access to secondary care can be of enormous help to troubled students. In many institutions mental health advisors and counsellors have developed good links with early intervention and crisis assessment and treatment teams and direct referrals to these have proved very beneficial to students.

In rare cases, students will require care within in-patient psychiatric settings either on a voluntary basis or as a consequence of being detained under the Mental Health Act. In recent years there has been a trend away from in-patient treatment towards community-based treatment within the newly developed services such as crisis resolution teams, home treatment teams and early intervention for psychosis teams.

It is important that services are tailored to the time constraints of student life. Because a student may not be staying in the area for a long period of time there is a temptation by local services to avoid involvement as they may fear, rightly or wrongly, that little can be achieved within a short timeframe. There are often long waiting lists, especially for services such as clinical psychology. A student may come to the top of the waiting list towards the end of an academic year. He or she will usually then return to their home area or go elsewhere for the summer vacation and be unable to attend. Appointment letters or questionnaires may go astray as a result of changes of mailing address. The consequence is that the student may be dropped from the waiting list and then has to be re-referred and start the whole process again.

It is important that higher education institution personnel have some insight into how the NHS services work and the pressures and constraints that exist in the health service. It is equally important that NHS personnel have a better understanding of the systems and structures of higher education. In recent years NHS psychiatric services have come under increasing pressure to focus their resources on patients with severe and enduring mental illnesses such as schizophrenia and bipolar disorder. In some cases, there has been a corresponding decline in the availability of services to those with less severe conditions such as mild to moderate depression, and the burden of caring for students with these conditions may fall on counsellors and mental health advisors.

General medical care of students

It is very important to emphasise the major role that primary care plays in the management of mental disorders in the general population. Most mental disorders are managed at the level of primary care without referral to specialist services. This role is reflected in the NICE guidelines for diagnosis and management of depression (for example, in the stepped-care model of care; NICE, 2009*a*) and the monitoring of patients on antipsychotic medications (NICE, 2009*b*).

In GP practices with a significant cohort of students on their patient lists, there is an involvement and experience in the management of mental disorders which is considerably greater than that provided in routine GP settings. In such cases, GPs often liaise directly with student counselling services, disability services, mental health advisors, academic staff and support services. The general practice often exercises a pastoral and advocacy role as well as the core clinical role.

All students should register with a GP when they first come to a university or college and, in fact, most do so in the first weeks following matriculation. Most university health practices make active efforts to have new students fully registered in the first few days following enrolment and screen for pre-existing medical conditions, including mental illnesses. Sometimes students register with a university GP only when they first develop a medical problem, which may be a mental disorder. General practitioners are usually involved in the care of patients with the full spectrum of mental illnesses, whether this is at first presentation or with ongoing care. In the vast majority of cases, higher education institution services will involve the student's GP as the primary link with NHS services. Furthermore, in crisis situations the GP is often the first port of call either by the student or the higher education institution (or even the student's parents). Practices used to dealing with students and higher education institutions are well aware of the particular issues related to the student group and have systems in place to cater for their specialist requirements.

In the past, many universities were direct providers of primary care health services to students. Although these services were funded by the NHS, the university employed clinical staff such as doctors and nurses. This model has now been largely abandoned and primary care services are nearly always provided by mainstream general practices. In some cases these are former student health services which retain links to the higher education institution and the majority of whose patients are current or former students, university/college staff and their families. They may also, for example, have contracts to provide non-NHS services such as medical certificates and opinions on fitness to study abroad. In other cases, practices attract large student populations because they are located in close proximity to a university or college campus. Such practices may have no formal link with the higher education institution and primary care services for students are provided as for non-students.

This diversity of provision was confirmed by a recent survey carried out by AMOSSHE (L. Foley, 2010, personal communication). Of the 57 institutions which responded to the survey, only 2 were direct providers of medical services. Thirty had a service-level agreement with a general practice on or near to the campus for provision of services to students. Twenty-three stated that they had a local practice that provided treatment to the majority of students but that there was no formal contract with the practice. In the other two institutions there was no arrangement or understanding of any sort with a primary care provider.

One intention of the current GP contract was to achieve improved assessment and management of chronic diseases such as coronary heart disease, kidney disease and diabetes. This was taken forward under the auspices of the Quality and Outcomes Framework (QOF). A substantial proportion of the income of GPs is now achieved by attaining adequate performance against a range of targets for specific diseases. The diseases targeted by the QOF have a low prevalence in young people in general and in students in particular. As a result, practices with a high number of students and few patients over the age of 25 have been unable to attain income levels that are comparable to that of the average GP. This could lead to disincentives to GPs becoming involved in the care of students. At the very least what is likely to happen is fewer and fewer trained clinical staff being available to provide primary care services including support and treatment for mental illnesses to more and more students. Unless this situation is remedied the future of student health services will be uncertain

and is potentially precarious. There is a risk that the expertise in dealing with mental health difficulties that has been developed in some practices will be diminished or lost.

Collaborative working between health and higher education institution services

There is overlap in the problems that people present with to NHS psychiatric teams and higher education institution services (e.g. Connell *et al*, 2007). It seems self-evident that care could be improved if these two sectors worked in closer collaboration with each other. For some students, integrated collaborative working is well established; some examples of these are described in Appendix 1.

A possible option would be to create a single pathway of care in which NHS and the relevant higher education institution staff work together in a fully integrated service. This would allow all who are involved to see students who are most appropriate to their skills and training. It would also allow easy referral of students from one professional to another. However, such integration may be difficult to achieve when there is separate management of the different elements of mental health provision. There are often other barriers to joint working.

One of these is the existing configuration of psychiatric services. An integrated service could probably only arise if there was a designated CMHT which took all referrals from the student population of each higher education institution. In most psychiatric services, provision of care is sectorised by geographical location or GP population. The establishment of dedicated student psychiatric services would require considerable reorganisation of services. It might also cut across important working relationships that psychiatric services have with GPs and social work departments.

A second problem arises from constraints on exchange of clinical information. National Health Service clinical records are created and retained in well-established organisational and legal frameworks. Administration and monitoring of case notes is undertaken by trained clinical records professionals. There are clear standards in relation to retention, storage and disposal of case notes. Case records are covered by data protection legislation which sets out criteria and procedures for patient access. There are restrictions on the extent to which confidential clinical information can be disseminated outwith the health service. Any clinician who does convey such information to a non-NHS provider of care will remain accountable for any breach of confidentiality that might arise from this. Similarly, counsellors and mental health advisors maintain case notes and confidentiality in line with professional guidelines and data protection legislation. Service-level agreements could be negotiated between services and disclosure forms designed and agreed by university/college and NHS staff to enable liaison and information exchange where appropriate. This would require the explicit, written consent of the student.

If higher education institutions had contracts with the NHS for the provision of counselling and mental health support rather than being direct providers themselves, it might be possible to bring counselling, mental health advisors and NHS services under a single organisational umbrella. The downside of this is the risk that the level of understanding of the structures and cultures of higher education institutions, the context-specific training,

the understanding of learning processes and ready access to professional help would be lost.

If complete integration is an unattainable goal, it is desirable that relations between student services and NHS services are formalised in some way. This would be particularly valuable in some of the more extreme cases involving, for example, students who experience depression and are at risk of suicide or those with an eating disorder who are becoming dangerously underweight. In such cases, it would be helpful to have procedures to follow and for higher education institution staff to know whom to contact in the NHS for advice and assistance. Most higher education services make it clear to their clients that in circumstances where there is a serious risk to self or others confidentiality may have to be breached.

Better networks of communication between higher education institutions and the NHS can ensure that psychiatric services are readily available to those who are in need and can facilitate access to the expertise of NHS staff for advice, supervision, support and teaching about psychiatric conditions.

What to do if a psychiatric patient is moving to university

In many cases young people with serious mental health problems are able to enter higher education. This may involve a move to a new location. In such circumstances, there is obviously a need to ensure continuity of care. If the student is on long-term maintenance medication, it is essential that arrangements are made for continued prescription of this. The 'home' mental health team should make every effort to ascertain the service or services that would be appropriate for the patient and to make a referral before the student starts at university. Most CMHTs serve defined populations which may be based on primary care lists or on geographical location. If the university or college has a mental health or disability advisor, he or she may be able to advise on how to do this. Mental health advisors can also help in other ways. They may be able to arrange a visit to the university so that they can meet the student before the start of the academic year, and ensure that they receive appropriate services and preparation for study. They would also be able to advise on the student's eligibility for DSA. Referral to a mental health advisor will obviously require the consent of the student. National Health Service personnel can play a very important role by encouraging prospective students to make early contact with their chosen university or college, and agreeing to allow them to provide relevant background information to the key higher education support staff.

A successful application to university or college by a young person with a history of mental illness will usually be viewed in a spirit of optimism and hope. It may be seen as the opening of a new chapter in life and a break with a recent past dominated by illness and disability. A student may decide not to disclose a history of mental disorder because of a wish to move on and leave the past behind. In many cases, optimism and hope will be fully justified. In others, it is important that these feelings are tempered by realism about the young person's capacities to adjust to a new life and to cope with the demands of higher education. This is especially the case with illnesses such as schizophrenia, in which there may be enduring disabilities in areas such as motivation, emotional expression and ability to relate to others. This applies even more so if there are residual positive symptoms, such as delusional thinking. In cases such as these, university may not be a happy experience for the young person. He or she may struggle to form relationships with peers and as a result become socially isolated. He or she may find it difficult to cope with the kinds of interactions that arise in the context of small-group teaching, such as giving presentations to fellow students. Concentration may be impaired as a result of medication and this can combine with diminished motivation to make it difficult to meet the academic demands of the course. A person who is studying far from home

will have to cope with all of this without the informal support of family and friends. It is very easy for a reclusive or underperforming student to become socially isolated and for problems to drag on and grow worse over periods of months before any help is obtained.

Another group that may have difficulties in adjusting to student life are those with autism-spectrum disorders. Such students often find it difficult to be in settings such as large lecture theatres and may do better in subjects or modules with smaller numbers of students. Subjects that require more independent study and less group work also present fewer problems, so it is well worth advising prospective students to investigate such issues by speaking with admissions tutors before making final decisions about applying for courses. Private sector accommodation can prove more restful than halls of residence which tend to be noisy. Some students find that they are distracted and distressed by the noise and movement of others around them and require a digital voice recorder or note taker to compensate for poor concentration. A student with an autism-spectrum disorder will often benefit from an individual room for examinations. Specialist equipment and support or mentoring can be paid for by the DSA. The National Autistic Society is sometimes able to provide this to help students to settle in to university and to negotiate relationships and social situations. Prospective students should contact disability services at their university to enquire about support that is available. A disability officer or mental health advisor should be able to offer an assessment of learning and teaching needs and then make recommendations and arrange adjustments to help the student. It is often helpful to liaise with academic staff so that they understand the difficulties that the student may experience.

It is important to make a careful assessment of the prospective student's capacities to cope with the demands of higher education. This should include assessment of factors such as motivation and concentration and ability to relate to others. It is important to ascertain the degree to which the person has insight into his/her illness. If maintenance medication is required, it is essential that the prospective student has enough insight to make arrangements to obtain this and to adhere to treatment recommendations.

The following summarises the issues that should be considered if a patient is contemplating higher education.

1 Has the patient taken into account the likely stresses he/she is likely to face at university, particularly in the first year? These stresses might arise from:

- having to relocate to a new city at some distance from home
- the challenges of having to meet a new group of peers
- the modularisation of courses with changing student groups and pressures
- the strict timetables for courses and assignments, the requirements to work with others and the anxieties around examinations
- financial implications of entering higher education.

Other things to consider:

- Is the programme one that suits your patient's skills and abilities? If it is not, what are their chances of success? If they were to fail, how would this affect their well-being?

- Is the nature of the course, particularly the assessment process, going to be tolerable? It could be that some students, for example those with Asperger syndrome, might struggle with the subjective nature of essay writing or the requirement for group assignments. Discuss in particular how the choice of subject chosen to study may affect them (e.g. fear of failure, especially if they are returning to university after interrupting their studies because of illness).
- Workload: are they fully aware of the time and energy commitment required of them? Do they know how much study per week they will need to do to succeed? Do they know how much coursework they will be required to submit?
- Potential impact on family, friends and lifestyle: the commitment required is likely to demand a significant amount of the student's time. Have they considered what they will lose as a result of this?

2 Where will the future student be living? If they are living in university accommodation they may have no choice about who they live with. There may be pressures to participate in a culture of heavy drinking and possible recreational drug use. Discuss how communal living may affect the patient. What will they disclose to their house or flatmates? What support might they expect from them, if any? How might fellow students react to their difficulties?

3 Will the future student disclose their diagnosis to the university? If so, advice can be given regarding the support that they can receive from the university disability service in getting the university to make reasonable adjustments, the possibility of getting a DSA, support from the university's mental health advisor, counselling service and mentors. Concerns about confidentiality could be raised, especially if the patient consents to contact between the university and local mental health services.

4 If the future student moves out of the catchment area:

- give advice on registering with a new GP or, if available, with the health centre at the university;
- obtain consent to send information regarding mental health needs to the new GP, as well as to the university mental health advisor and university disability service, and give indication of what support may be required from local mental health services;
- if possible, retain involvement in care and offer ongoing liaison and consultation to university services and local GP and CMHT.

5 How will the person's illness affect their ability to study? This might depend on the presence of ongoing symptoms and here it is helpful to anticipate how these symptoms could affect the future student so that they can prepare for and manage any difficulties as best as possible. If there are relapses, discuss and agree a plan of action. If possible, liaise with the mental health advisor or the university disability service when doing this.

6 If the patient is taking medication:

- discuss how this may affect their ability to focus, concentrate and summon enough energy to complete their assignments and studies, as well as participation in seminars and group activities;

- beware of sudden reductions in medication which up to then have stabilised the patient sufficiently to consider starting studies;
- consider whether it would be helpful for the student to have something in writing about how his/her illness and medication might affect their ability to study.

If there are serious doubts about the prospective student's ability to cope, it might be better for him or her to 'test the water' before moving away from a supportive home environment and embarking on a demanding degree course. This could avoid the dashing of high expectations by the inability to meet the demands of studying or by psychiatric relapse. For example, the student could assess his or her capacities to cope with higher education by studying at a lower level (e.g. access to a higher education course), undertaking a non-degree college course, studying part-time or attending a higher education institution within commuting distance of home.

Mental health issues faced by international students

A detailed report on the mental health of international students was recently published by the charity Young Minds (Young Minds, 2006). In this section, we summarise the findings of this report.

Universities and other higher education institutions are under enormous pressure to improve funding by the recruitment of international students. Higher education in the UK is energetically marketed and competes for students with institutions in countries such as the USA, Australia and Canada. International students come from a wide range of cultural, ethnic and religious backgrounds, and it is important to be aware of the challenges they face in adjusting to living and studying in the UK when considering their mental well-being.

International students face all of the stresses of other students such as adjustment to the academic environment and moving out of the family home. In many cases they have to do this without weekend or vacation access to the usual support structures of family, friends and home. It is usually expensive for international students to return home and many do so only once per year or even less often.

The system of teaching in the UK may be unfamiliar to international students and this can increase the difficulties of transition. Over 75% of international students are self-financing or are dependent on their families. Attendance at a UK university entails a considerable financial sacrifice for the student or his/her family. This can increase the pressure to succeed and the consequent fear of failure. Many students come to the UK with high expectations of success and prestige when they return to their home countries. For such students the prospect of failure can be very threatening.

Although some international students are well provided for financially, many have limited funding, and may be less able than their fellow students to afford satisfactory accommodation. Some even have to economise on food. Finding part-time work to help supplement their income can be particularly challenging if they do not have a high level of English language skills. International students are sometimes criticised for forming in-groups and not mixing with the wider student body, but it is easy to underestimate the difficulties involved in engaging with a new and unfamiliar social milieu. Some international students find it difficult to become involved with student organisations or even find that such organisations do not welcome them. A further problem for some international students is the fact that alcohol plays a large role in social activities in the UK student population. If a student's cultural or religious background prohibits or discourages the use of alcohol, this can create a significant barrier to full participation in a range of social and sporting activities with fellow students.

International students' attitudes to, and expectations of, mental health services will reflect the diversity of experience that they bring from their home countries. At one end of the spectrum, students from the USA will often come to the UK on multiple medications for depression, ADHD and other psychiatric diagnoses. The threshold for medication use in such conditions in the USA tends to be lower than in European countries (Zito *et al*, 2008). A UK psychiatrist or GP will often come under considerable pressure to support continued prescription of these medications even if he/she doubts the wisdom of this. Students from North America may also have extensive experience of counselling and therapy and expect that this will be easily accessible. On the other hand, in other cultures there is sometimes a high level of stigmatisation associated with mental illness. Students may be reluctant to admit to mental distress and to seek help. In some cases, psychological problems will lead to 'somatisation', that is the expression of psychological distress in the form of physical symptoms such as headaches, insomnia and gastrointestinal symptoms.

International students will not usually be familiar with the workings of UK mental health services. They may not have a clear understanding of the various roles of psychiatrists, psychologists, counsellors, community psychiatric nurses and others. They may also have misapprehensions about how to gain access to treatment.

With regard to social relationships, international students are most likely to associate with students from their own country. Failing this, they tend to make friendships with other international students. They are least likely to associate with local students.

There are four broad ways of relating to a majority culture:

- assimilation: the person becomes as much like the majority culture as possible
- integration: adjustment to the majority culture and adoption of some of its aspects while retaining the attitudes and behaviour of the student's culture of origin
- traditional approach: the student retains primary identification with his/her original culture and rejects the majority culture
- marginalisation: the student becomes socially isolated, rejecting both original and new cultures.

There is some evidence that students do best with integration or the traditional approach. Those who attempt to assimilate fully seem to do less well and those who become marginalised do worst of all.

Students whose first language is not English can be at a disadvantage in relation to others. If English language proficiency is inadequate, this can lead to a range of problems. The most obvious of these is a detrimental effect on academic performance. Students may find it difficult to understand lectures, take notes and complete assignments such as essays. They may underperform in examinations. They can find it difficult to speak up in tutorials or to ask questions. A poor grasp of English can also make it hard for students to integrate into the host culture and to engage in social interactions.

Vacations can create problems for students who are unable to return home. The Christmas vacation may be especially difficult. There may be deadlines for examinations or course work. The international student may be faced with cold, wintry weather and short days for the first time in his/

her life. In some cases, university accommodation will have to be vacated. Support services such as counselling may close down or operate at a lower level of provision. Students who need to take a break from studies to recover their health may be unable to afford to do this because of financial pressures. This often increases mental distress. They may also face difficulties in renewing their visas when they wish to return to the UK, and this can provide a disincentive to take time out to recover fully.

A student who develops a severe mental illness may have to drop out of university and return home. Psychiatric services are often poorly funded in low- and middle-income countries and the more expensive psychotropic drugs may not be available. If continuation or maintenance medication is required, recommendations for this should take account of what will be available in the student's home country.

Clinicians and counsellors should be aware of the possible impacts of some psychiatric diagnoses when students return to their home countries. In countries such as the USA, where healthcare is largely funded by private insurance, a diagnosis of schizophrenia or other severe mental illness may lead to increased insurance premiums or difficulty in obtaining health insurance at all. In traditional cultures, diagnoses such as substance misuse or problems arising from sexual identity or preference may lead to stigmatisation of young people. This is not to propose that diagnoses should be withheld when this might be detrimental to the student but to suggest that psychiatric diagnoses should be made with circumspection, especially if there is any uncertainty, and with awareness of the potential harm that can be caused.

Most higher education institutions employ international student advisors to help these students manage the many challenges they encounter when studying in an unfamiliar environment. Further information is available from the UK Council for International Student Affairs (www.ukcisa.org.uk).

Medical and other healthcare students with mental disorder

Medical and other healthcare students are prone to the same risks and problems as other students. There are a number of reasons why these students are of particular interest to health services. One is that they are the NHS professionals of the future and the NHS naturally has an interest in ensuring that its workforce is able to practise safely and competently.

There is a further concern that arises from the fact that these students come into contact with vulnerable patients. The existence of a mental disorder may lead to risk to patients, both now and, even more so, when the student graduates and enters his or her chosen profession. The GMC document *Medical Students: Professional Behaviour and Fitness to Practise* (General Medical Council, 2009*a*) provides detailed information on what is expected of medical students. It sets out criteria that should raise concern about fitness to practise, describes how medical schools should try to detect such problems at an early stage and how they should deal with students who are thought to represent significant risks to patient safety. For nursing and midwifery students the equivalent document is *Guidance on Conduct for Nursing and Midwifery Students* (Nursing and Midwifery Council, 2009).

Medical and other healthcare students are expected not only to achieve factual knowledge and technical competence, but to develop and demonstrate conduct that is responsible and informed by the highest ethical principles. This assigns responsibilities to healthcare students which do not apply to other students. Those who are responsible for the education of healthcare professionals are required to ensure that students not only acquire the requisite knowledge and skills but also that their conduct meets acceptable standards. This process of assurance may involve assessment of psychiatric well-being.

Medical students are expected to be aware that their own poor health may put patients and colleagues at risk. They are expected to seek medical or occupational health advice, or both, if there is a concern about their health. They should also be aware that they may not be able accurately to assess their own health and be willing to be referred for treatment, and to engage in any recommended treatment programmes if advised to do so. It is expected that they will be registered with a GP.

Although patient safety is generally seen as the paramount concern, the rights of the student as set out in disability discrimination legislation must also be considered. It is important also to be aware that fear of being suspended or excluded from the course may deter a student who experiences problems from seeking help. This could lead to a significant and perhaps remediable problem being undetected and untreated, bringing

unnecessary suffering to the student and posing significant risk to patients in the longer term.

Medical students are also enjoined to take steps (e.g. informing a senior member of medical staff) to prevent harm to patients that might arise from the behaviour or ill health of a colleague. They are expected to demonstrate maturity, respect for others and the ability to work as a member of a team.

The GMC expects that medical schools will have in place systems of pastoral care, mentoring and support. The hope is that this will allow problems to be detected and dealt with, at least in some cases, before the question of fitness to practise is raised. These systems should allow students to express concerns in an atmosphere that is supportive and confidential. However, students should be made aware from the start that the obligation to confidentiality is constrained by the need to protect patients from any harm that might arise from the problems of students. In such circumstances, a mentor or tutor may be obliged to inform the medical school of any matter of concern.

If fitness to practise becomes an issue, the student should be given opportunities to correct the underlying problems. Any doctor who is involved with the student in a supportive or mentoring role should not also be involved in the formal investigation of concerns about fitness to practise or in decisions that might affect the student's professional future. If it is found that impaired fitness to practise is arising from ill health, the medical school may impose conditions on the student that include appropriate medical supervision.

There are a number of issues that can arise when students of medicine and nursing or other healthcare professions become mentally unwell. The most important are maintenance of confidentiality and avoidance of conflict of interest. Medical students and others face a risk of loss of confidentiality if they are treated by a psychiatric service which is associated with their place of study such as medical school or school of nursing. There is a risk that the student/patient will encounter fellow students who are in the hospital in the course of their teaching. This can create considerable embarrassment for the student and also for his/her peers and can delay the process of recovery and social reintegration. Some psychiatric services have set up reciprocal arrangements with neighbouring services to accommodate patients such as this and this is often the ideal outcome. Where this is not possible for geographical or other reasons, every effort should be made to maintain confidentiality. If a medical or healthcare student is being seen as an out-patient, he/she should be seen whenever possible in an off-site clinic such as a GP health centre. If in-patient care is required, efforts should be made to avoid contact with other students and to avoid discussion of the student's symptoms and problems in the presence of his/her peers. Another measure that has been used to maintain confidentiality is to set up a 'safe haven' or 'hidden patient' arrangement by which access to the psychiatric records of healthcare students is restricted. This can apply both to cases that are open and to those that have been closed. The disadvantage of this is that such records may not be accessible out of hours and this could lead to detriment of care. Some NHS psychiatric services have removed safe haven arrangements for this reason.

Conflict of interest can arise when healthcare students experience mental disorders which raise questions about their fitness to practise in their chosen profession. A psychiatrist may be called upon to assist with the decision about whether a student should be allowed to continue on a course

or to graduate. Psychiatrists and other health professionals who contribute to the assessment of a student's fitness to study should not also take on the role of responsible clinician. This especially applies when psychiatrists are looking after undergraduate medical students or postgraduate doctors registered for degrees at the same university where the doctor is employed either as a staff member or in an honorary capacity.

A further conflict of interest can arise when a psychiatrist, counsellor or other practitioner is providing treatment to a healthcare student and there is concern about the impact of a mental disorder on the student's ability to practise. The usual requirement to respect patient confidentiality may have to be balanced against the duty of care to third parties such as the patients that this person may be responsible for in the future. The permission of the student should always be sought before any disclosure is made. If this permission is not granted, the clinician will have to decide whether risk to patients overrides the obligation of confidentiality. Guidance for doctors on disclosure of confidential information in the public interest is available in the GMC document *Confidentiality* (General Medical Council, 2009*b*: par. 36–39).

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Appendix 1
Examples of collaboration between the NHS and higher education institutions

University of Leeds

A unique relationship exists between universities in Leeds and Leeds Primary Care Trust. The Trust has a senior health improvement specialist for students, who coordinates liaison with universities. As a result, the *Leeds Student Health Needs Assessment*, which makes a series of recommendations regarding student mental health, was published in 2006. The Trust provides a focused learning and self-help clinic to the university which offers a drop-in and one-to-one advice and guidance using cognitive–behavioural principles. This is offered one afternoon per week at the student counselling centre.

There is now a Leeds student mental health group which has representatives from the three universities, student unions, Leeds Primary Care Trust and the community mental health team (CMHT). This group is chaired by the head of the student counselling centre at the University of Leeds and is developing the liaison between NHS services and universities, and providing an opportunity to establish working relationships, referral agreements and good practice guidelines.

There is also a close relationship between Leeds University and local GPs, particularly the Leeds student medical practice, which has over 30 000 student registrations. In addition to health services, the student medical practice is available for consultation, referral and training; it also provides relevant documentation for students.

For further information about responses to student mental health needs in Leeds see, the *Leeds Student Health Needs Assessment* on www.leeds.nhs.uk (search for student) or see Humphrys (2009).

Oxford Student Mental Health Network (OSMHN)

Since 2000, there has been an active partnership between Oxford Brookes University, the University of Oxford, Oxford and Cherwell Valley College, Oxford City Primary Care Trust and Oxfordshire and Buckinghamshire Mental Healthcare NHS Foundation Trust to improve communication about, and

understanding of, students' mental health needs within the local education and healthcare sectors. This is achieved through:

- steering group meetings each term attended by representatives of the network partners
- active linking with key working groups, committees and teams in local mental health services with individual steering group members taking responsibility for particular teams and sectors.
- publication of a regular *Network Newsletter*
- maintaining and developing the Oxford Student Mental Health Network website which provides up-to-date information on mental health matters, resources and current research
- delivering cross-institution regular training on student mental health matters – recent trainings that have had attendees from all of the represented institutions have included 'Managing out of hours crises' and 'Mental health problems in male students'.

  For further information, go to www.osmhn.org.uk

Cambridge and Anglia Ruskin universities: network to promote liaison between universities and the NHS

Cambridge and Anglia Ruskin universities have established a network of relevant and interested university and NHS personnel to promote liaison and communication between the NHS and the universities. The process of setting up the network involved gathering university support by including an item on the university senior management committees' agenda and using contacts to involve key NHS personnel. A conference was organised to raise awareness among the universities and the NHS; high-profile speakers were invited and the aim was to discuss the implications of the Royal College of Psychiatrists' 2003 report on student mental health. Invitations were sent out to GPs, psychiatrists, community mental health workers, counsellors and therapists working with GPs, the NHS and universities, university senior administrators, tutors, nurses, chaplains and bursars. Following on from this, a network was formed of relevant and interested NHS and university personnel to consider the local provision of mental health services for students in the light of the College report and to investigate ways of improving the coordination of mental healthcare for students by strengthening liaison between services. The initial priorities of the network were: health promotion, continuity of care, identification of mental health advisors in universities, identification of student mental health advisors in local mental health services, collaboration in students' treatment and issues of confidentiality. Several useful meetings were held but it proved difficult for NHS partners to sustain their commitment given the pressures of other work.

The main components of the service are:

- 24-hour confidential service for students, Linkline (www.linkline.org.uk)
- clear emphasis on holistic student health (encompassing mental health) in primary care through a very well-used web resource, www.camstudenthealth.co.uk

- Association of Student Practices in Cambridge (www.camstudenthealth.co.uk/pages/single/practices)
- thriving university counselling service, with excellent annual reports (www.counselling.cam.ac.uk)
- student union approach (www.cam.ac.uk/staffstudents/studenthandbook/welfare/healthcare.html)
- multiagency committee on student health, a committee of Cambridge University college nurses, and others
- secondary mental health services (www.cpft.nhs.uk).

University of East London

The University of East London has developed a framework to provide students with emotional or mental health difficulties with a pathway to care via a multidisciplinary and professional care team. The core of the service provision includes a triage approach to assessing students' health difficulties and referring them appropriately according to an evidence-based approach. The team also operates a critical incident duty system to respond to acute student mental health episodes that may involve risk to self and/or others. The team has developed formal external partnerships with local community and statutory services. As an example, one important partnership is with the Newham Improving Access to Psychological Therapies service which provides cognitive–behavioural therapy directly to University of East London students. These local partnerships are now crucial to the model and have dramatically increased the service provision to students while offering them more choice in their pathway to care.

University of Bath

The university has a well-developed mental health policy with a focus on student welfare. This includes an intranet site ('mindmatters') that has advice about common mental health problems. As well as counsellors, the university has employed a mental health worker and commissions sessional input from a consultant psychiatrist who runs clinics in the university alongside the mental health worker. The psychiatrist is able to take referrals for undergraduate and postgraduate students who may not meet eligibility criteria for secondary care mental health services. The psychiatrist also works in the local CMHT so that there is close liaison with those services. The mental health worker has also developed close links with the specialist eating disorder service and local early intervention team.

Appendix 2
Internal liaison within higher education institutions

Nottingham University

In 2007, we appointed a mental health advisor. This was the culmination of our work in response to the Royal College of Psychiatrists' report on student mental health (Royal College of Psychiatrists, 2003). We recognised that, although there were many areas of good practice in the university, there were also some gaps. A steering group was formed including the head of student services, head of the university counselling service, GP from the university health service with responsibility for university liaison, and the disability coordinator. We aimed to shape a new role which was complementary to each of the services listed but which did not overlap with existing provision. We agreed that an individual with a psychiatric social work background or mental health nursing background would best suit our needs, and that this person should be under the line management of the head of student services.

University of Sheffield: a collaborative student mental health strategy

Two years ago a student mental health strategy was adopted at the University of Sheffield, based on a framework drawn from the Royal College of Psychiatrists' 2003 report. We set out from the beginning to manage this on a collaborative basis, bringing in all the major internal contributors to student mental health provision. Our aim in doing this was to create a coherent approach to student mental health in the institution and to avoid splits between contributors. Our strategy leadership group includes: the head of student health and well-being, the head of counselling, the head of our disability and dyslexia support service, the lead GP on mental health from our in-house medical practice, the head of our student support and guidance service (which includes a critical support team) and the students' union welfare officer. The group meets every 6 weeks or so. The benefits of this approach have been:

- greater coherence in approach and a single, unified strategy
- increased service integration and multidisciplinary working

- opportunities to discuss and take action on emerging mental health issues
- improved relationships and better communication between services.

As a result, the strategy has delivered:

- a publication for staff, *Helping Students with Mental Health Difficulties*
- jointly delivered staff training events throughout the year
- shared, multiservice training and continuing professional development
- cross-service supervision and case discussion arrangements
- joint care pathway between services for non-psychotic mental health issues
- joint referral and communications protocol between our health, counselling and disability services
- creation of a new mental health advisor role (based in the disability team but with a wide remit) as the result of cross-service discussion and agreement
- appointment of a disability outreach worker whose role is to help bridge the transition between school and university for potential students.

Appendix 3
Different models of psychiatric provision

A range of very varied arrangements are described here, from one university which employs a psychiatrist for several sessions a week, to others which have found ways of accessing local NHS psychiatric services.

King's College London

We have a consultant psychiatrist/psychoanalyst who is a permanent member of the counselling team here at King's College London. He works 8/11 of an NHS contract. His input into clinical counselling team meetings is invaluable as is the fact that he has a very significant case-load of very disturbed students (last year, for example, he saw 125 students). The psychiatrist handles any referrals to community mental health teams (CMHTs) and liaises with external GPs when necessary. We also have a good relationship and regular meetings with our medical centre staff, who value highly the ability to refer easily to a psychiatrist.

Goldsmiths College, London

We have established a very good relationship with a psychiatrist at our local CMHT. He now has a remit to see virtually all Goldsmiths students who are referred to the CMHT so that he has built up a real awareness of the issues students face and has a sound understanding of the particular mental health issues among this group of patients. This link means that we can give students sound information about what to expect when they have a psychiatric assessment at the CMHT.

Queen Mary, University of London

At Queen Mary, University of London, the 2003 report (Royal College of Psychiatrists, 2003) has added weight to our bid for extra funds for psychiatric support and has allowed us to recruit two new consultant psychiatrists to the team. They are employed by the local trust and have their work with us written into their job plan. This means that clinical

governance, continuing professional development, etc., are all covered by the trust and the university reimburses it monthly for the hours it provides. We run a total of 60 half-day clinics each year, concentrated mostly during term-time but with some also during university vacations.

Through the Queen Mary University/East London NHS Foundation Trust Liaison Group (a group which developed out of a working group on student mental health in 2003) reciprocal arrangements for medical student psychiatric admissions between East London Foundation Trust and Camden and Islington NHS Foundation Trust have been established since 2007, for students from Queen Mary University, University College Hospital and the Royal Free Hospital.

Oxford University

University of Oxford Student Counselling Service employs a consultant psychiatrist (0.2 whole time equivalent). The main duties of this post are:

- to act as medical consultant to the team
- to assess students (referred by counsellors) in whom a mental illness might be developing
- to liaise with and advise NHS primary care practitioners on treatment options, including appropriate medication
- to play a key role in managing service interface with NHS secondary and tertiary services
- where requested, to advise academic and support staff on the appropriate management of students with mental health problems
- to contribute to strategic thinking on the university's mental health policies.

A key benefit in this role results from the fact that the psychiatrist is a full member of the counselling service team, attending weekly staff meetings and all training and staff development events.

Brunel University

The mental health support coordinator and the head of the counselling service meet monthly with a care programme approach lead within the NHS mental health trust to discuss shared students who are in-patients and out-patients with the trust. This is only relevant to students who live on or near the campus and are under Hillingdon Mental Health Services, but it has been invaluable in terms of helping us find out how the trust works and what the statutory responsibilities are.

Warwick University

At Warwick we have just been given by the primary care trust a designated community psychiatric nurse to work alongside our mental health coordinators. The nurse will also work in the community part-time, but we

see this as a step forward as she has easy access to psychiatrists and other NHS provision.

Leeds University

The Student Counselling Centre retains a consultant psychiatrist on a sessional basis. The psychiatrist meets with the counselling team two or three times a term to discuss patients and talk about appropriate community and NHS referral sources for clients. Initial assessment and referral to psychiatric services are provided by the student's GP. The psychiatrist is also available for telephone consultation when needed. The Centre has also developed useful working relationships with the local early intervention service for young people (ASPIRE). This service offers assessment and ongoing support for young people who show signs of developing psychosis between the ages of 14–35 years. The Centre works closely with the local crisis resolution team when dealing with students experiencing acute, severe or complex mental health problems, who are presenting with significant risk of harm to self or others, and who may require admission to hospital.

Liverpool University

In the past 5 years we have established a student mental health advisory service which has grown from 1 day per week in March 2003 to become a full-time service in September 2005. Our mental health advisor has made links with community-based mental health workers, crisis resolution team and the early intervention team as a key part of her role. We have a student mental health advisory group which meets three times a year to address student mental health issues within the university as well as looking at how we can develop links in the city. The group has made contact with key senior staff in the NHS to investigate encouraging the development of NHS services that meet the needs of students.

Glyndŵr University

A direct referral pathway has been set up with the First Access Mental Health Team in Wrexham. This enables existing clients to be referred to psychological therapies for secondary care support. The First Access team has offered to come into the university to offer talks and sessions on mental health days. We do not have direct access to a psychiatrist but we do have a line of communication with the CMHT and with the Llwyn y Groes psychiatric unit within which the psychiatrists are based.

Staffordshire University

We have had good contact with the crisis resolution service and particularly with the early intervention service for psychosis, with whom we now meet once per term.

Appendix 4
An account of the work of a university psychiatrist

By Dr Leonard Fagin, Consultant Psychiatrist to Student Counselling Service, London Metropolitan University, October 2006 to February 2009

I joined the student counselling service at London Metropolitan University at the beginning of October 2006, offering a maximum of 2 half days a week. The role of the consultant psychiatrist in this service is to offer psychiatric expertise in the management of students with mental health problems that present to the service for help. Following initial assessments by one of the counsellors, or during the course of their interventions, any students raising concern are discussed at the weekly team meeting, where suitability for a psychiatric assessment is looked into. Part of my initial contribution was to try to refine the criteria for psychiatric assessments, a process that is ongoing.

Gathering and collection of basic reliable demographic and contact data is essential in this process, particularly if referral to other services is required. Particularly important are details of general practitioners (GPs) and any other mental health services that may be involved, the results and findings of previous assessments and interventions that have been tried, as well as medication that is being taken or has been taken in the past.

Once a decision to see the student has been agreed, I have made arrangements to see students at both university campuses. At the moment there is no waiting time, and students are seen within 1 week or earlier. I usually see students for an hour, and then immediately dictate my findings onto a history template that I have prepared. Reports are then typed and distributed via email to the counsellor concerned, and when appropriate, the GP or other services likely to be involved. The assessments are usually also followed up by feedback with the counsellor concerned, either one to one or in team meetings, when a strategy is discussed and agreed. I have on some occasions also had to communicate directly with GPs or psychiatric services when this is relevant or urgent, to secure follow-on appointments or to discuss issues such as medication. I have participated actively in team meetings on both clinical and management matters. During the course of team meetings I have also contributed my views regarding other students seen and discussed by counsellors, but who do not necessarily require psychiatric assessments. I have also contributed a training session for counsellors on personality disorders, and facilitated two away-days for the counselling team, reviewing the role of the service and producing a report to help in the recruitment and induction of a new manager to the service.

I have also been involved in assessing a student with particular problems and a disability who had made a number of complaints about the university, and prepared a report, attended court, and then provided a needs assessment based on the student's diagnosis.

I have seen a wide variety of students, many of them presenting with frank psychiatric pathologies. As can be seen by the breakdown in Table 1, the wide distribution of diagnostic categories, even in a small sample such as this, is probably indicative of the variety and degree of pathology prevalent in the student body of London Metropolitan University, and confirms the assumptions made by the university about the need for adequate and prompt psychiatric assessments and referrals to appropriate services when required. I have been impressed, however, by the amount of experience possessed by the small number of staff in the counselling service and elsewhere in the university that can offer help to these students, but believe that this matter needs further research and development.

I have also had the opportunity of having very helpful regular meetings with the manager of the counselling service regarding many issues relating to the service as a whole. I have also met with the disability advisor, the acting head for disabilities and dyslexia, and the lead university chaplain, to discuss liaison opportunities.

Since joining the university I have made efforts to raise the profile of student mental health in a number of contexts outside the university. I have organised and now chair the London Network of Psychiatrists involved in the London Student Mental Health Psychiatric Network. I sit on a working party of the Royal College of Psychiatrists who reviewed the current report. I am also the College representative on the Universities UK/GuildHE Committee on the Promotion of Mental Well-Being in Higher Education Institutions (MWBHE). The Committee has organised a conference on fitness to practise where I facilitated one of their workshops. At another conference organised by the Committee in April 2009 I gave a keynote address on facts about student mental health in the UK.

I am enjoying my work with the student counselling service and believe that there are a number of developments which promise to improve access to mental healthcare and support for those students that require it, especially working jointly with the newly appointed mental health advisor, whom I also supervise.

The breakdown according to gender indicates a similar ratio to that observed for mental health disorders in the general population, that is roughly 2:1 female to male ratio. Male students with mental health problems tend to be younger than female students, and this would have to be compared with the age ratios across all students in London Metropolitan University to see whether this is of significance.

I have used the ICD-10 as this is the classification system currently most used in the UK. The most frequent categories of mental disorder are affective disorders, representing one in five of all diagnoses (many of which are accompanied by anxiety disorders); some of these conditions are severe enough to warrant active treatment under supervision. These are followed by a variety of personality disorders, the most frequent of which is emotionally unstable personality, borderline type – about one in six of all diagnoses. Both these disorders are likely to affect the academic performance of students but those with personality disorders may also affect other students or academic staff. A variety of anxiety disorders, approximately 10% of all disorders, were also present. I have been struck by the numbers of students with frank psychotic symptoms, all of them requiring intervention

Table 1 Analysis of results (up to June 2008)

Students seen since 9 Oct 2006,[a] *n*	55
Men, *n* (%)	16 (29)
Women, *n* (%)	39 (71)
Average age, years	
Men	25
Women	29
Diagnostic breakdown, *n* (%)	
Psychotic disorders	6 (9)
Affective disorders	13 (19)
Anxiety disorders	9 (12)
Mixed anxiety–depressive disorders	3 (4)
Phobic disorders	2 (3)
Obsessive–compulsive disorders	2 (3)
Somatisation disorder	2 (3)
Autism-spectrum disorder	6 (9)
Gender identity disorder	1 (1)
Substance use disorders	5 (7)
Personality disorders	11 (16)
Post-traumatic stress disorders	1 (1)
Attention-deficit hyperactivity disorder	1 (1)
Eating disorders	4 (6)
No diagnosis	4 (6)
Total number of diagnoses	70 (100)

a. Female:male ratio 2.2:1.

from psychiatric services, although at least four of these were not known to local psychiatric services. Also striking was the number of those with autism-spectrum disorders, exclusively Asperger syndrome, who, despite their disability, were enrolled in courses often requiring interaction with other students and whose disability may have gone unrecognised by previous educational establishments. The other area of concern is the number of students presenting with a variety of substance use disorders, approximately one in ten.

Many students were either not registered with a local GP or were very unclear about their registration with GP or mental health services. Having said that, most of these students also continued, and wished to continue, to see a counsellor from our own student counselling service in order to provide liaison and support, as well as psychological interventions.

Appendix 5
University general practice – University of Sheffield health service

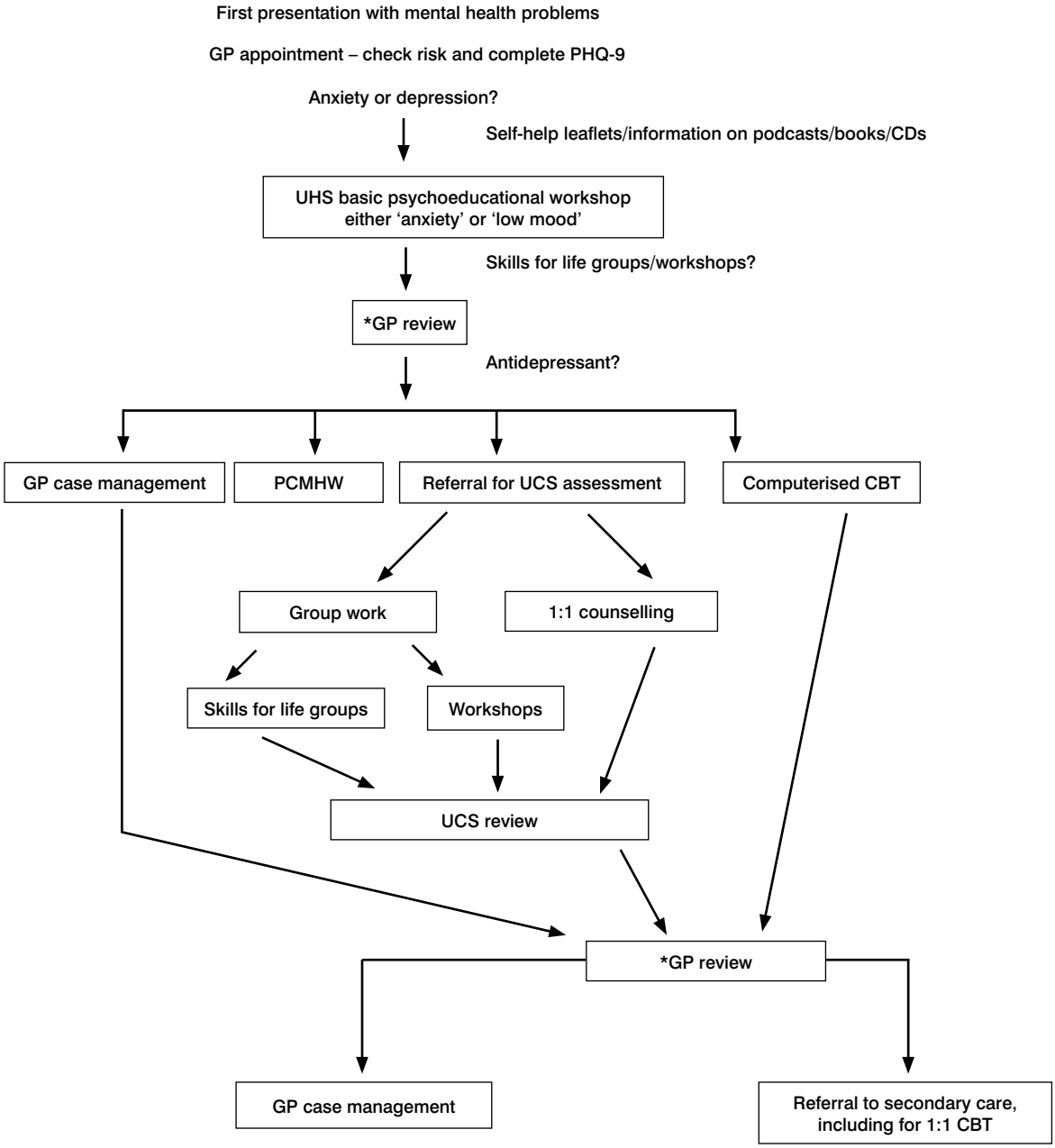
The University of Sheffield aims to be proactive with regard to mental health. The university health service, university counselling service and the disability and dyslexia support service are all represented in the University Mental Health Strategy Group (see also Appendix 2).

Within the university health service there is a lead GP for mental health, who oversees the provision of care for students with mental health difficulties. All students are asked to complete a health questionnaire before they come to university and any declaring a current or past history of a mental health difficulty including an eating disorder are offered a one-to-one interview with a doctor during our intro week. The aim of this session is to ensure that the student is aware of the range of support available as well as to assess current need at the time of transition. The university health service has worked with the counselling service to devise a care pathway for the management of anxiety and depression using a stepped care model (Fig. 1).

Self-help books are available on prescription and CDs with information on sleep disorder and exam-related anxiety can be purchased from the health service. Workshops on managing low mood and stress and anxiety are run by the primary mental health worker (funded by the primary care trust). These complement group sessions on relaxation, assertiveness, exam stress and confidence building held by the counselling service. The health service has invested Quality and Outcomes Framework (QOF) monies in the provision of cognitive–behavioural therapy (CBT). This is offered to students with obsessive–compulsive disorder, phobias, habit disorders and post-traumatic stress disorder, allowing these patients to be seen reasonably promptly within the familiar setting of the practice. The health service also has an eating disorders clinic which provides nurse-led, guided self-help based on CBT principles for students with mild to moderate eating disorders. The clinic liaises closely with the local voluntary sector and the NHS specialist eating disorders service. In addition to the QOF-funded CBT and eating disorders clinic, the practice has a high-level Improving Access to Psychological Therapies worker 1 day a week.

The university health service is actively involved in health promotion and takes part in healthy campus weeks providing clinical staff at the student union as well as literature on mental health promotion and alcohol-related issues.

Providing effective mental health services for a list size of 23 000 is an ongoing challenge within the current financial climate, but if as a result of accessing these services students are enabled to manage their difficulties and fulfil their academic potential, the benefits are likely to be lifelong.



CBT, cognitive–behavioural therapy; GP, general practitioner; PCMHW, primary care mental health worker; PHQ-9, 9-item Patient Health Questionnaire; UCS, university counselling service; UHS, university health service.
*GP review to include: (i) risk assessment; (ii) scores, PHQ-9; (iii) self-reported narrative of onset and course of problems.

Fig. 1 University health service and university counselling service care pathways for depression and anxiety disorders (drawn up by Dr Alison James, Sheffield University Health Service).

Appendix 6
Initiatives from counselling services

Manchester Metropolitan University: Personality in Education

Personality in Education was a day programme run in partnership with Manchester Metropolitan University, University of Manchester and Therapeutic Community Services North. The programme was run over 16 weeks. It was aimed at students who had a history of complex and enduring emotional, relationship and behavioural difficulties. Students also had a history of expressing difficult emotions through impulsive, aggressive or self-harming behaviours, including alcohol or illicit drug use as a way of dealing with powerful emotions. Students were able to self-refer to the programme, which began with an intensive weekend session and continued with weekly sessions.

The programme aimed to provide a safe environment in order that participants could find healthier ways of dealing with distressing feelings. All aspects of the programme – social therapy groups and formal therapy groups – provided a setting in which therapists and students worked alongside each other to explore various aspects of a student's experience. Through exploring and understanding their relationships, the students had the opportunity to build on strengths and find new ways to manage difficult feelings and experiences. In this way they could develop greater self-esteem and better-quality relationships.

Reading University: students with Asperger syndrome

We have an integrated support scheme for students with Asperger syndrome. We run an assessment clinic for students without a diagnosis who may have been identified by counsellors, study advisors or the mental health advisor. The assessment is led by a specialist working in the psychology department. Once diagnosed, the student can access social and academic mentoring through the disability office and receive skills training from the counselling team. If they come into university with a diagnosis, they will be assigned to the Asperger syndrome group for support and monitoring. We have regular team meetings of staff supporting students with Asperger syndrome through their degrees. These are attended by representatives from all areas involved

– counselling, disability, study advice, mental health advisor, GP, consultant, and careers advice – to make sure that students are supported through their degree in a coordinated way. Students normally have one key worker, who may be from any specialism, to maintain contact with others and field relevant information. During vacation and on graduation the careers service assists students with Asperger syndrome with creating a CV, practising interview skills and finding their way into work.

School of Oriental and African Studies, University of London: outreach programme

We are going to be piloting a well-being service in the near future. It is intended to provide a means of engaging students who are causing concern in a substantial way but who are not themselves accessing support services. It will bring together counsellors, the mental health advisor, learning advisors and the students union. We are also hoping to involve faculty student support staff. Students who have raised concern (e.g. we have had students in the past who have written disturbing material in their exam transcripts) but who have not engaged with any of the support structures offered will be contacted by someone as part of the well-being service to see whether we can engage them better. The intention is that it will be both more proactive and more informal than current structures allow. Once contacted, it will be up to the student to decide how much of the available support they wish to access. It will be clearly separated from any disciplinary procedures.

University of Westminster: Mentoring for Mental Health Programme

The Mentoring for Mental Health Programme will soon be entering its 6th year. What began as an independently funded initiative between disability services and the counselling and advice service has proved so beneficial to students with long-term mental health problems that it has been recognised by the institution and become embedded within university systems. Dropping out, falling behind, social isolation, acute anxiety, mental breakdown – these are some of the difficulties faced by students with long-term mental health problems. The mentoring programme sets out to support such students, offering them help to negotiate university life.

The continued increase in numbers of students accessing this support since the programme's inception shows that students with long-term mental health problems are now more confident of receiving appropriate support and less worried that they will be stigmatised. This has implications for the university in terms of retention. The programme deals with a wide range of sometimes severe mental health problems, including schizophrenia, bipolar disorder, eating disorders, self-harm, suicide attempts and borderline personality disorder. Mentors have offered support on family matters, helped students to settle in and make friends, enabled them to contain their anxieties and advised on completing forms, and liaised with academic staff, disability advisors and tutors. They have helped students to manage their workloads and referred them for counselling or specialist psychological treatment.

The Westminster mentoring programme is different because it utilises staff from the existing counselling service instead of recruiting external mental health advisors. Thus the mentors are already familiar with the university environment and with the particular issues faced by Westminster University students. Other advantages are that, as trained counsellors, mentors have the experience and knowledge to spot the warning signs when a student is on the verge of a psychological crisis. The programme is proactive and preventative. It enables students to become more autonomous in relation to their academic career and leave or suspend their studies with dignity if this is the right course of action for them. Above all, it offers a lifeline before students start to flounder and supports them throughout their time at university, not just at crisis points.

Work on improving the programme is ongoing and most recently a revision of recording and referral methods has taken place to ensure that information is passed on to relevant parties to enable students to receive the most appropriate help.

Oxford University: Peer Support Programme

The service trains in the region of 250 students each year in basic listening and support skills. This is a 30-hour training at the end of which students can advertise themselves as part of the Peer Support Panel in their college or department providing they continue to attend fortnightly monitoring/ supervision groups with their trainer (who is also a qualified counsellor). As well as cross-college trainings, a specific training is offered each year as a special study module in the 4th year at the graduate medical school and as an intensive, pre-course training to a cohort of Master of Business Administration (MBA) students in the Saïd Business School, University of Oxford. A modified training is delivered before the beginning of the academic year for graduate students who have a defined welfare role such as junior deans in colleges. About 4% of the students who use the counselling service have been referred by peer supporters, who also refer to medical services within and attached to colleges. For further information see www.admin.ox.ac.uk/shw/peers.shtml

University of Hertfordshire: tutor training programme

The University of Hertfordshire counselling service has developed an intensive 10-week course for personal tutors and other interested staff with a view to raising awareness of the psychological factors affecting teaching and learning. The first 'taught' half of a session covers issues such as managing the boundaries around the role of personal tutor, transitions, exam and learning difficulties, creating helpful interactions with students, recognising risk, and breaking bad news. The second half comprises presentations from course members about current issues in their work, with the aim of integrating theory with practice. The course is part of the professional academic development programme at the university and can be taken for credit. It has helped members of staff in their interactions with individual students and has also led to their devising supportive structures within their departments. For more information contact counselling.centre@herts.ac.uk

University of Ulster: suicide awareness training

Within student support, two members of staff are trained to deliver applied suicide intervention skills training (ASIST). A programme of delivering this training to staff and those who work to provide one-to-one support to students with disabilities (note-takers, study skills coaches, campus assistants, etc.) has been running at the university over the past 2 years. Feedback from the training to date has been very positive, although it can often be difficult to get participants to commit to the required 2 days.

University of Teeside: exercise and mental health

We were the first UK university to develop 'Lightening Your Load', where we recognised the significant contribution physical and recreational activity can make in maintaining positive mental health. The Lightening Your Load programme was developed with the express intention of building on this important link. Our staff are trained to provide appropriate advice and guidance on what is available in a professional and sensitive manner. We are linked with the sport and recreational team and offer a combination of counselling and physical/recreational activity. Some of our goals are to:

- promote a sense of well-being for the body and mind
- encourage exercise, physical activity and recreation as a form of self-help
- help raise confidence, self-esteem and energy levels
- promote a sense of belonging and participation in the life of the university.

This year we have extended this further and piloted our first group with 'adventure therapy'. This involves taking a group of students away for a day of outdoor activities with our mental health advisor, sport and recreational staff and a counsellor.

Leeds Trinity and All Saints College: exercise and mental health

During the academic year 2006/2007 the counselling service at Leeds Trinity and All Saints College established links with the university sports centre to encourage clients with mental health issues to engage in physical activity as an additional means of managing some of their symptoms. We recognised that although enabling students to access the facilities at a reduced cost via our referral route was useful, some students needed more input to maximise the potential benefits that physical activity could offer them. Some found it hard to continue with their exercise programmes because of low motivation or feelings of self-consciousness when exercising alone.

This year, the service liaised with the sports development officer and the sports centre manager to find a volunteer who could be trained to offer an 'exercise buddy' service to students with mental health issues wanting to engage in regular exercise. One of the counsellors provided some training

to the volunteer and then students from the service were offered the option of working with the volunteer as a way of support with their exercise plans, following their initial assessments with the sports centre. This system has worked effectively and several students have benefited from the extra support during the initial stages of their exercise plans. They commented that without the 'buddy' they probably would not have had enough motivation to get going with their exercise regime. These students have subsequently been able to continue with exercise independently and have reported improvements in their self-esteem and overall mood levels. Indeed, one person commented that she had been able to reduce her medication as a result of engaging regularly in exercise.

Appendix 7
Northampton Assessment Centre form

Northampton Assessment Centre

University of Northampton
Student Centre, Park Campus
Boughton Green Road
Northampton, NN2 7AQ

Phone: 01604 892668
Fax: 01604 892667
E-mail: NAC@northampton.ac.uk
Web: www.northampton.ac.uk/nac

Student name: .....

Address: .....

..... Telephone number: .....

Course/Year: .....

Date: 2009

Dear

The University of Northampton supports students in their application for Disabled Students' Allowances. The student's funding authority determines whether an award will be made. To support the student's application for Disabled Students' Allowances, the funding authority requires sufficient medical evidence from a health professional as part of this process.

The medical evidence should be a description of the following information:

- diagnosis of conditions(s)
- effect the disability may have on learning/attendance at university
- any impact on day-to-day activities
- impact on likely course-related activities, for eample presentations, group work, placements and field trips, general communication with others

Please state whether the condition affects any of the following:

- concentration, motivation
- short-term/long-term memory
- ability to travel on public transport
- reading/writing for long periods
- use of IT equipment

The above are suggestions of the kind of evidence funding authorities require to support applications for Disabled Students' Allowances. Medical evidence letters can be given to the student for approval and forwarded to:

.....

Student Finance or NHS Grants Unit as appropriate depending on course .....

.....

nnac national network of assessment centres

DISABLED STUDENT ALLOWANCES DSA-QAG QUALITY ASSURANCE

matrix

Appendix 8
Universities UK/GuildHE Working Group for the Promotion of Mental Well-Being in Higher Education

History

The issue of mental well-being has risen in prominence over the past few years, partly because of changes in disability legislation, concern over social exclusion and developments in NHS policy. Within both higher education and the NHS there has been a number of high-profile reports and conferences including the Royal College of Psychiatrists' report on the mental health of students (2003), the Universities UK and the Standing Conference of Principals (SCOP) report on reducing the risk of student suicide (Universities UK & Standing Conference on Principals, 2002) and the Heads of University Counselling Services Beautiful Minds conference in 2002. In spring 2003, representatives from a number of professional organisations came together to form a group that could take the issues forward and act as a focal point for future developments. Universities UK and SCOP (as GuildHE was then called) agreed to the establishment of the group as a committee within their structures, and, later that year, the Working Group for the Promotion of Mental Well-Being in Higher Education (MWBHE) held its first formal meeting. The group is constituted as a self-financing working group of Universities UK and GuildHE. It reports to the Universities UK Student Experience Policy Committee and the GuildHE Council.

Membership

The MWBHE group maintains regular contact with nominated policy officers and advisors from Universities UK and GuildHE. It includes representatives from the student body, the Royal College of Psychiatrists, the British Association of Health Services in Higher Education, the Association of Managers of Student Services in Higher Education, the Association for University and College Counselling, Heads of University Counselling Services, the Higher Education Academy and the University Mental Health Advisors Network. The Department for Business, Innovation and Skills and the Department of Health are invited to send observers.

AIMS

The aims of the MWBHE group are to:

- promote collaboration between the different sectors, agencies and professional groups with responsibility for mental well-being in higher education
- be a reference point for government bodies, managers in the NHS and educational institutions and practitioners in respect of mental well-being in higher education
- influence policy on issues related to mental well-being in higher education.

PRINCIPLES

Some of the key principles the group follows are:

- mental well-being calls for collaborative work and 'a whole-institution approach'
- higher education can promote personal and social development
- mental health is important for all members of a university
- mental well-being depends on a complex interplay of internal and external factors
- attention to the range of student experience is vital
- staff and student concerns are interrelated and interdependent.

ACHIEVEMENTS TO DATE

RESEARCH

One of the first tasks undertaken by the working group was a survey of current practice in Universities UK/SCOP member institutions. A questionnaire on mental health policy and practice was sent out in autumn 2003 to all higher education institutions in the UK. The purpose was threefold: to provide a benchmark of current provision; to evaluate the impact and effectiveness of recent guidance documents, funding initiatives, legislation and government policies; and to guide the future work of the working group. A report on this project (Grant, 2006) has been published and sent to all UK higher education institutions.

The survey was repeated in 2008. Its findings have been reported at a number of conferences. A full report will be circulated to all higher education institutions and put on the MWBHE website.

CONFERENCES AND SEMINARS

February 2004	Mental Well-Being in Higher Education: Policy and Practice, Universities UK, London

May 2005	Joined-up Practice: Towards NHS/Higher Education Collaboration in Promoting Mental Well-Being, Universities UK, London
November 2006	Mental Well-Being and Learning: Exploring the Connections, Universities UK joint conference with the Higher Education Academy, London
February 2007	Responses and Prevention in Student Suicide (RaPSS, www.rapss.org.uk), dissemination event for the RaPSS project, Universities UK, London
February 2008	Fitness to Practise Seminar, Universities UK, London
April 2009	Mental Well-Being in Higher Education: Current Challenges, Universities UK, London

Guidelines

Guidelines on preparing institutional mental health policies as well as guidelines on good practice in mental health promotion have been prepared and circulated to higher education institutions.

Website

The group has established its own website: www.mwbhe.com

Consultation

- An email consultation group has been established to improve communication and consultation with other organisations in the field.
- The group has consulted to Young Minds on the preparation of a document offering guidance to higher education institutions: *Higher Education Institutions and International Students' Mental Health*.
- The group was represented on the steering group for the RaPSS research.
- Members of the group served on the Royal College of Psychiatrists' working groups on the mental health of students, both the 2003 group and the one that prepared the current report.

Links

Links have been established with Universities Scotland, the Social Exclusion Task Force, the Equality Challenge Unit, Young Minds and the National Institute for Adult Continuing Education.

CURRENT PROJECTS

- The group is currently revising the CVCP *Guidelines on Student Mental Health Policies and Procedures for Higher Education*, first published in 2000.
- It is contributing to the Healthy Universities initiative.
- Another conference is being planned.

The MWBHE group welcomes contributions from others on any issue concerning the mental well-being of students and staff in higher education. For further information about its work, contact the Chair, Dr Annie Grant (annie.grant@uea.ac.uk).

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College Reports have been approved by a meeting of the Central Policy Coordination Committee and constitute College policy until they are revised or withdrawn.

For full details of reports available and how to obtain them, contact the Book Sales Assistant at the Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG (tel. 020 7235 2351, fax 020 7245 1231).

The Royal College of Psychiatrists is a charity registered in England and Wales (228636) and in Scotland (SC038369).