CR231

Mental health of higher education students

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Introduction

The purpose of this document is to review and update the previous report from the Royal College of Psychiatrists, *Mental health of students in higher education* (RCPsych, 2011). That report and its 2003 predecessor have been influential, and their contents have been drawn upon by other bodies such as MWBHE (see Appendix 2) and by many individual higher education institutions (HEIs).

In this report, we provide an update on some areas covered in the previous publications, such as the epidemiology of mental disorder in students and age-matched populations. In relation to risk, we discuss some of the issues that lead to vulnerability in students. We also highlight potential benefits, and areas that promote resilience and mental wellbeing. We 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 outline the ways in which HEIs have responded to concerns about the mental wellbeing 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 and equality legislation. Others have arisen from policies that have been proposed by bodies such as Universities UK (formerly the Committee of Vice-Chancellors and Principals).

We describe the various pathways to care that may be accessed when a student is experiencing psychological distress. Students will usually gain access to specialist psychiatric care by the normal route of referral by their GP. Others will seek alternative forms of help through counselling and other services provided by HEIs. 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 2003 report is Mental Health Advisors (MHAs) and, more recently, Mental Health Mentors. These individuals and, increasingly, teams are expected to adhere to standards of professionalism which ensure safe and effective practices within HEIs, and to undertake a range of roles. They assess how mental health difficulties affect learning, assess needs, and assist students in developing context-specific, individualised, self-management strategies. 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 HEIs and the NHS. MHAs are often also given 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, including:

- Some students, particularly international students, may be sensitive to the fear of stigmatization.

- 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 discuss how the efforts of NHS services and those provided by HEIs 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 improvement in collaborative working. There is a need to consider developing appropriate protocols for the sharing of confidential and sensitive information.

Since the publication of the previous report in 2011, the concerns highlighted in it have shown no sign of abating, and in many respects have become more pressing. The following factors reflect this point:

- The demand for university-based counselling and Mental Health Advisor services continues to rise.

- 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 HEIs which have made them less able to cope with mental disorders in students, for example 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, and this can mean that less time is available for pastoral care.

- It seems likely that pressure on public finances will exacerbate these problems in the next few years.

Environmental factors have also played their part. Traditional universities were usually based on a single campus, with most students living nearby. The majority of them 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 them progressing through courses over differing timescales. As a result, they are less likely to form stable relationships with their peers or academic staff. The tutor system, which used to play a very important role in offering personal and academic guidance to students, has been eroded in many HEIs.

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 because of a breakdown in the relationship between the student and one or other parent.

At the same time public financial support for students has decreased drastically. Student grants have largely been replaced by loans and onerous tuition fees have been introduced. Students are increasingly taking on part-time paid work to help meet their basic needs. This can detract from the time and energy available for academic study and personal development, and places them at an unfair disadvantage in relation to their more affluent peers. Students who are managing mental health difficulties can experience additional financial disadvantage as they may be less able to cope with the demands of both study and work, and are more likely to have to repeat modules or years of study.

Students who move from school to university are at a stage of transition between dependence and independence. While this is usually a positive transition, they 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 super-

vised to one in which they must take a more active role in managing time and planning their studies. Older students have to make a transition from work to an academic environment.

Of course, there are also many potential benefits to be accrued from studying at university. For example, there are new opportunities for developing friendships and pursuing intellectual, social, recreational, and sporting interests. The higher education environment also offers a wide range of easily accessible student support services that are not routinely available in earlier educational years. Even in relation to mental health issues, the university environment itself can enable students to be more able than others to benefit from psychiatric and psychological help, especially psychotherapy.

In terms of their mental health and wellbeing, the fact that students are usually bright, articulate and knowledgeable means that 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 challenges. By ensuring that the higher education environment and relationships are conducive to mental wellbeing, many difficulties can be ameliorated. Higher education may offer benefits to students with a history of mental illness or psychological difficulties by providing new sources of self-esteem and opportunities for engagement with peers and wider society. Students are at a stage in life open to a range of possible futures; if problems that arise are caught early, it may be possible to set someone on a life path that is more positive and less difficult.

We have attempted to produce a report that will be of practical help to those attempting to improve the care and treatment of mentally troubled and vulnerable students. We hope it will also assist HEIs and others 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.

1. Executive summary and recommendations

EXECUTIVE SUMMARY

This report is an update of *Mental health of students in higher education* (RCPsych, 2011), which provided guidance and recommendations for psychiatrists, the NHS, and HEIs regarding the provision of mental health support for students.

It is well recognised that students are a group with particular characteristics. This report provides an update of the areas covered in 2011; it highlights the factors that promote resilience and emotional wellbeing in the student population, also those creating vulnerability to mental disorder.

The current report refers to developments in government policy, and the recommendations and opinions of Universities UK (UUK) and student bodies; it does not attempt to address the differences in multi-agency partnerships or context in different geographical regions or UK jurisdictions. It is assumed that, throughout the UK, we need to ensure robust partnership-working across the NHS, Higher Education, Local Authorities, and other agencies, with clear pathways of care at all levels of service involved with student mental health, and a commitment to promote emotional wellbeing and resilience, and to provide early effective intervention where problems occur.

This document takes into account the increase in student numbers, and changes in student characteristics and vulnerabilities, since 2011, and acknowledges the role of financial pressures on students. It provides updates on the epidemiology, prevalence, and impact of mental disorder, including neurodevelopmental disorder, in students and age-matched populations, and the issue of student suicide. It outlines the importance of good transition of care and continuity of care between services, and the challenge of effective communication in the context of medical confidentiality.

The Covid pandemic has thrown up a new set of concerns that will have to be considered in the context of student mental health. These will apply to all students but will weigh more heavily on those who come to university with past histories of mental ill health. Such students may already find it difficult to integrate with a new social environment and to build relationships with clinicians, support staff, academic staff, and their fellow students. These difficulties will be exacerbated by the restrictions arising from Covid.

The purpose of the following recommendations is to inform work with commissioners, service providers, and partner agencies, and to improve the mental health support and treatment available. This is key to improving outcomes for students in higher education in the UK.

RECOMMENDATIONS

Recommendation 1:
NHS mental health services should provide parity of access for the student population

It is usually the case that there are waiting lists for NHS psychiatric care and that episodes of care extend over periods of months. This can create obstacles to access in students who spend part of their time at university and part in their home area or elsewhere. The following measures should be considered as ways of mitigating this problem:

Waiting lists should be managed in order to avoid detriment of care in students. If the student is on a waiting list in the university location, provision should be made to ensure that treatment starts during term time and is either delivered within the academic year or is planned to bridge gaps during vacations.

Students who are on waiting lists and then graduate or drop out of university should be referred to the equivalent service in their home area or new area of residence. They should be able to transfer a proportionate period of 'time already waited' to the home or new service rather than start at the bottom of a second waiting list.

Recommendation 2:
NHS mental health services should provide continuity of care for the student population

The fact that students often divide their time between home, university and other locations creates difficulties in providing continuity of care for those with long term mental health conditions. An additional factor is that the transition to university-based services may require transition from Child and Adolescent to Adult Mental Health Services.

If a current patient is going to university, the transition to new services should be considered well in advance of the student's start date. The home-based service should ensure that the patient is referred to services in the university location and that these services are given full information about the student prior to the student's arrival. The same procedures should apply when a student leaves university, especially if they have left because of mental ill-health.

In students with mental disorders that are unstable, severe, and enduring, consideration should be given to developing a joint care plan between home- and university-based services.

The student going to university should be advised to contact and meet the Mental Health or Disability Advisor at their intended place of study to discuss any support that may be required and to consider applying for Disabled Students' Allowance.

General practitioners (GPs) and their teams make vital contributions to the prevention of mental illness, early detection, and longer-term management. It is important that all possible efforts are made to ensure that students register with a general practice as soon as possible after arrival at university. The fact that a patient cannot be registered with more than one practice at a time can lead to discontinuities as the student moves from home to university and back again. There may, for example, be delays in the transfer of medical records and in the timely prescription of medication.

The NHS should consider how better to manage the issue of registration in students who divide their time between home and university. This should be done in a way that does not lead to financial detri-

ment in university-based general practices. One option might be the creation of a common electronic and/or patient-held medical record.

Recommendation 3:
Mental health policy in HEIs

All HEIs should have a working group that oversees the implementation of good practice in relation to student mental health. This should be chaired by a senior manager. The aims of such groups should include the following:

- Ensuring that the HEI meets its obligations under disability legislation;

- Health promotion (e.g. in relation to alcohol and drugs, and sexual victimization);

- Training of staff in recognition of mental disorder and assessment of suicide risk;

- Provision of services such as counselling, MHAs, student support and mentoring;

- Application of a 'whole university' or 'whole system' approach to student mental wellbeing;

- Liaison with NHS mental health services to develop models of integrated care.

Recommendation 4:
Integration of services

Students who are mentally troubled may come into contact both with NHS mental health services and those provided by universities, such as counselling. Outcomes will be better if these inputs are integrated and coordinated.

HEIs and local mental health services should develop a joint 'care pathway' to cover the assessment and management of the mental health conditions experienced by students. This might be a joint effort involving all HEIs in one location.

This should set out lines of communication and boundaries between services. The pathway should make it clear, to university staff and general practitioners, how to refer to general and specialist mental health services, and how to proceed and who to contact in situations such as psychiatric emergencies. The pathway should also set out arrangements for supervision, support, and joint working.

A system should be set up to resolve disputes between services in relation to where responsibility for treatment lies.

Recommendation 5:
Resource allocation

Demand for counselling and other services is substantial and seems to be growing inexorably. There are clear links between mental wellbeing and academic performance. There is growing pressure on NHS mental health services as a result of a range of factors, including increased recognition of conditions such as ADHD and autism spectrum disorders, and growing numbers of international students.

It is important to ensure that services based in both HEIs and the NHS are given sufficient resources to meet these demands.

General practice funding is partly determined by the estimated morbidity of the practice population. One consequence of this is that practices with large student populations are less well remunerated. In the long term this will create problems with recruitment and retention of staff and may even threaten the viability of these practices.

The vital contribution of these 'atypical practices' to student mental wellbeing should be recognised and some form of enhanced payment introduced. This might be utilised to allow practices to offer enhanced mental health care, thus diminishing the need to refer to mental health services.

Recommendation 6:
Improve communication with families – think student, think family!

Parents and other family members are usually the most important part of a student's network of support, especially for undergraduates. They can be an invaluable source of information in relation to assessment and diagnosis. There are of course situations where the family is the main source of the student's mental health problems, and involving them may not be appropriate.

Anyone who is involved in helping mentally troubled students should, wherever appropriate, seek the consent of the student to engage their family in the processes of assessment and treatment. Families should be given a point of contact they can use to communicate concerns about the student.

Recommendation 7:
Research

The development of existing and new services in students will only be effective if it is informed by up-to-date research. This should examine areas such as:

- Prevalence of mental disorders in students; research should distinguish between the types of disorder that require specialist mental health service input, those that require other services such as counselling, and those that can be managed by NHS primary care;

- Outcomes of treatment by mental health services, counselling, and other services;

- Relationships between mental health and academic outcomes;

- Research into the rising prevalence of mental disorders in young women;

- Research into mental disorders in minority groups.

Recommendation 8:
Covid 19

The Covid 19 pandemic is likely to have significant impacts on the mental wellbeing of students and on the capacities of NHS and support services to provide treatment and help to mentally troubled students. The NHS and HEIs should be alert to these impacts and do whatever is possible to minimise their effects and to find alternative ways of meeting the needs of students. This will include ensuring that adequate student counselling and wellbeing services are available in both the universities and the NHS to meet increased demands. There may also be longer term psychosocial impacts on this cohort of students as a result of the restrictions and economic contraction arising from Covid. A longitudinal assessment of the impact of Covid on students is underway and can be accessed here: www.covid-socialstudy.org/results.

2. Recent policy documents

Since the previous *Mental health of higher education students* College Report in 2011, concern about the mental wellbeing of students has achieved an ever-higher profile, with the publication of several reports and surveys and extensive press coverage of these. These documents have been the drivers of policy and practice, and a summary of their key points is provided below.

Student mental wellbeing in higher education: good practice guide

This important document was commissioned by Universities UK (UUK) from the Mental Wellbeing in Higher Education Working Group (UUK, 2015).

The guide states that over the previous five years the proportion of disabled students who declared a mental health condition increased from 5.9% in 2007/08 to 9.6% in 2011/12, and of the entire student population the increase was from 0.4% to 0.8%. It highlights that liaison and joint working between relevant university and NHS Services can be vital for student mental health and wellbeing. Good joint-working can enable safe transitions, ensure access to general medical and specialist mental health supports, avoid duplication, and facilitate the management of risk, and response to crises.

The guide recommends that HEIs build up relationships with external agencies so that cross referrals can be facilitated, and increased dialogue can help institutions develop their expertise. In return, external organisations can gain some understanding of institutional policies and procedures and the needs of the student body. This is of particular importance in cases where there is insufficient attention given to planning for student communities by NHS commissioning bodies, and consequent pressure on institutions to provide services to fill gaps in provision. The guide also recommends a central point within each HEI for communication with local mental health agencies and other relevant external organisations. This may be a mental health professional who can also provide advice to students and staff on a regular basis, or someone at senior management level advised by the director of student support or the equivalent.

If a close professional relationship with local mental health services can be forged, communication and liaison between NHS and higher education services and the successful progression of referrals can be significantly enhanced. In its recommendations the guide also strongly advises that robust arrangements are put in place for any student with a history of mental health difficulties who is required to undertake a period of time studying off campus, including those studying or working abroad.

Not by degrees: Improving student mental health in the UK's universities

The Institute for Public Policy Research (IPPR) was commissioned by UUK the Mental Health and Wellbeing In Higher Education (MHWBHE) Group to produce this report (Thorley C., 2017).

The report reiterates the finding from other work that rates of mental ill-health have increased in young people, and especially in young women.

A positive aspect is that it attempts to categorise the areas of concern. It identifies three problem groups:

- Those with a diagnosable clinical condition;

- Those who are mentally distressed but whose symptoms would not hit the threshold for a formal diagnosis;

- Those who score low on standard criteria of mental wellbeing (happiness, life satisfaction, feeling things done in life are worthwhile and low anxiety).

The total number of available hours of counselling varied enormously between HEIs, from a low of 19 hours to a high of 410 hours per week. The report indicates that the majority of students who access counselling services do not need or want their full quota. For example, students at the University of Dundee are entitled to up to 6 sessions, although the average number undertaken in practice is 3.8.

With regard to managing risk and responding to mental health crises, one of the most important factors reported by HEIs was having a strong relationship with local NHS mental health services. Of equal importance was training for security and accommodation staff in responding to mental health crises.

Student academic experience survey

This survey is carried out by Advance HE and the Higher Education Policy Institute and reported in 2019 (Neves J. & Hillman N., 2019).

The survey is mainly focused on students' perception of course quality but also covered mental wellbeing.

One finding of the 2017 survey was that across the UK there was almost an equal split between those who thought their courses offered good or very good value for money (35%) and poor or very poor (34%). Since 2012 there had been a steady worsening of this split (Neves J. & Hillman N., 2017).

The 2019 Student Academic Experience Survey showed improvements on these parameters, with 'good or very good' increasing from 35% to 41% between 2017 and 2019 and 'poor or very poor' falling from 34% to 29% in the same period. Scottish students are much more likely to report good value for money (63%) than English (39%), Welsh (47%), and Northern Irish (38%) students, but this may of course arise from the fact that Scottish students do not pay fees.

The changes in value-for-money perception were not accompanied by a belief on the part of students that their overall learning had increased.

Student wellbeing was defined by four criteria in the survey

- Happiness;

- Life satisfaction;

- Feeling things done in life are worthwhile;

- Low anxiety.

Between 2016 and 2019 there were falls in Life Satisfaction (16% to 14%), Life Worthwhile (22% to 17%), Happiness (21% to 18%) and Low Anxiety (21% to 16%). Lesbian, gay, bisexual, asexual and others (LGB+) score less well on all parameters.

The survey described a report by ONS on the mental wellbeing of all young people aged 20–24 in 2017/18. In this survey, 27% rated Life Satisfaction as positive, 33% thought Life Worthwhile, 33% scored positive on Happiness and 37% reported Low Anxiety.

The fact that students seem to be faring so much worse than the general population of young people, despite the advantages of student life, is a cause for concern. There is no comment on whether scores on Life Satisfaction, Life Worthwhile and Happiness in students are related to perceptions of value for money. It must be a dispiriting experience to spend three years or more of one's life on a course which seems to be poor value for money, especially if one is piling up a mountain of debt to do so.

The 2019 survey included a question on whether students would wish their parents to be informed in the event of concern about their mental wellbeing. 15% would wish their parents to be informed under any circumstances and 66% only in extreme circumstances. 18% would not wish their parents to be informed under any circumstances.

The results were based on a survey of 70,000 students. The response rate was 20% with just over 14,000 responses being collected.

Minding our future: Starting a conversation about the support of student mental health

This document was published under the aegis of Universities UK Task Group on Student Mental Health Services (UUK, 2018).

It raises a number of important issues that are discussed in the present report. These include the difficulty that students experience in obtaining access to mental health services; breakdown in continuity of care between home and university-based services; the increasing diversity of the student population; the growing prevalence of mental ill-health in young women; the low funding of general practices with large numbers of students; and the increasing number of students who declare a mental health disability.

UUK calls for student mental health to be given high priority and for coordinated input from a range of stakeholders including universities, the NHS, local authorities, schools, the voluntary sector, and businesses.

The NHS Long Term Plan

The NHS England Long Term Plan (NHS 2019) incorporated student mental health within its wider approach to services for people aged 18–25, with a commitment to deliver an integrated approach across health, social care, education, and the voluntary sector.

'NHS England is working closely with Universities UK via the Mental Health in Higher Education programme to build the capability and capacity of universities to improve student welfare services and improve access to mental health services for the student population, including focusing on suicide reduction, improving access to psychological therapies and groups of students with particular vulnerabilities.'

3. Mental disorders in students

What do we mean by mental disorder?

The first problem faced in discussing this issue is differing conceptions of mental disorder. A number of terms have come into use when this matter is addressed, such as 'mental illness', 'mental health problems', 'mental health difficulties' and 'mental health issues'.

This conceptual diversity has probably contributed 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). This has risen substantially since then. Female students are more likely to disclose than males.

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. Monk (2004), also using the GHQ, found that 52% of a cohort of students scored positive

Macaskill (2012) carried out a cross-sectional survey of undergraduates in which students were assessed at entry to university and at the mid-point of years one, two and three of their courses. The presence of mental disorder was assessed using the GHQ-28. The overall prevalence of 'psychiatric caseness' was 17.6% which is similar to the general population. Rates were higher in women and highest in the second year of study.

The fact that the reported prevalence of a problem can vary so much depending on how it is ascertained and defined creates obvious difficulties with regard to planning provision of care for those with mental disorders.

Barkham et al. (2019) argue that there is a need for greater clarity and consistency in the use of terminology and a need to draw a distinction between student wellbeing and mental disorder. It is important that research into the prevalence of impaired wellbeing and mental disorders and the outcome of services such as counselling is based on valid and reliable measures. In the absence of this, it is difficult to know what services should be provided and a risk exists that resources will be mis-applied.

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. (Cowley, 2007).

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 the responsibility 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 and cause less distress and disability. However, it is important to remember that these may still have a negative impact on a student's ability to complete their coursework on time or to revise for their examinations. Some of these conditions are self- limiting and will 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. 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 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 benefit from it. There is therefore a need to prioritise demands against the resources available to meet them.

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 (http://www.beatingtheblues. co.uk) and MoodGYM (http://www.moodgym.com.au) for people with mild and moderate depression, and FearFighter (fearfighter.com) for people with panic and phobia.

Why focus on students?

Student service managers, counsellors and MHAs 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.

In general, the prevalence of mental disorders increases with social deprivation. There is therefore a perception among some health professionals that students are privileged young people and that their demands for mental health services should therefore be lower.

Nevertheless, young adults between the ages of 18 and 25 are at peak age of developing serious mental illnesses such as schizophrenia and bipolar disorder.

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 also a higher prevalence of eating disorders in the young adult population. 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. These can be 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 mental disorders that are less severe can lead to failure on the part of students to fulfil their 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.

The transition from home to university can be a difficult period for many young people, especially those with a long-term mental health condition. 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. Financial difficulties, including the need for many to work part-time during term time to support themselves, can be another source of stress.

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. This can place students at risk of a range of mental disorders and other problems, which will be discussed in this document.

Students must anticipate going into a highly competitive work environment. They will often enter working life saddled with large debts incurred from student loans. 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 or becoming overdependent.

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.

Epidemiology of mental disorders in students

Most students falls into the age group of 17–25 years, though 32% of UK students are aged over 24 (https://www.universitiesuk.ac.uk/minding-our-future). This age span encompasses the transition from adolescence to adulthood. The high-risk period for onset of schizophrenia, bipolar disorder, as well as common mental disorders such as anxiety and depression 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. Hence university students span an age range in which a wide spectrum of mental illness is seen. 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).

In addition to illness or disability, mental-health conditions in young people have a negative impact on their development, quality of life and ability to participate fully within their communities and society as

a whole (Fisher and Cabral De Mello, 2011). Mental-health conditions are associated with behavioural health risks such as substance use, unsafe sexual behaviour, and violence, and increased risk of communicable and non-communicable diseases, injury, and all-cause mortality. Taken together, these data illustrate the significant long-term impairment, disability, disease burden and economic cost associated with mental-health conditions in young people.

Until 2011 there was a very substantial increase in the numbers of young people leaving school and going on to higher education. However, that increase has not been maintained in recent years, with the number of students in 2016/17 down 7.3% on the peak of 2010/11 As numbers rose, students from more socially and culturally diverse backgrounds entered higher education. There are more mature and part-time students, and many students from backgrounds with historically low rates of participation in higher education. The prevalences of important causal factors for mental disorder in young people in general have also shown substantial changes in the past two decades. These include increased rates of family breakdown, changes in consumption of alcohol and illegal drugs, and unemployment.

Prevalence of mental disorders in students

Bewick et al. (2008) carried out an internet-based survey of mental distress in students in four UK HEIs. 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 one month before starting university and again in the middle of the second year, using the Hospital Anxiety and Depression Scale. 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.

Eisenberg et al. (2013) described a mental health survey carried out in 26 higher education establishments in the USA. Depression and anxiety were measured using the Patient Health Questionnaire-9 (PHQ-9). Participants were questioned about suicidal thinking and plans, suicide attempts, and non-suicidal self-injury (NSSI). They were also asked about the impact of symptoms on academic performance and wider social functioning.

17.3% of students screened positive for depression and 9.8% for an anxiety disorder. 6.3% of students reported serious thoughts of suicide in the previous year, 1.6% had a plan to commit suicide, and 0.6% had made an attempt. 15% of students had engaged in NSSI in the previous year. 58% of students who had been depressed reported some impact of their symptoms on social functioning.

Women were more likely than men to be troubled with major depression and anxiety. Asian students had a higher prevalence than whites of depression but a lower prevalence of anxiety. Depression and suicidal ideation were more prevalent in black students but NSSI was lower. Hispanic students were more likely than whites to be depressed. Students with current or past financial problems were more likely to be anxious, depressed, and suicidal.

A survey carried out by YouGov UK was headlined 'One in four students suffer from mental health problems' (YouGov UK, 2016).

The main findings were that 27% of students reported some form of mental distress. This was more prevalent in women (34%) than men (19%) and more prevalent still in LGBT students (45%).

The commonest symptoms were depression (reported by 77% of those with mental health problems) and anxiety (74%). 14% of students said they had an eating disorder; 5% had a 'behavioural or developmental' problem such as attention-deficit disorder, and 5% had learning disability.

Nearly half (47%) said that their symptoms interfered with completion of some daily tasks and 4% said they could not complete even simple tasks.

Seven in ten said that work from university was one of their main sources of stress. The next biggest concern for students was finding a job after university (39%), followed by family worries (35%). Jobs and relationships (23% each) and friends (22%) accounted for the majority of the other sources of stress. Leaving university with large debts, more graduates competing for fewer jobs and having to consider undertaking post-graduate studies to have an advantage in the employment market, thereby further increasing their debts, were other possible causes of stress.

Surveys such as this are covered widely (and uncritically) in the national press, perhaps because of the opportunities they provide for attention grabbing headlines.

The main problem that arises once again in this survey is that it is difficult to know how far the results can be generalised to the student body as a whole. The sample was a large one. It appears from the YouGov website that respondents are self-selected rather than being a representative research sample. Detailed demographic data are given but no information on whether the survey sample differs in any significant way from the general run of students. Diagnoses were self-allocated.

Another concern is the utilisation of psychiatric terminology in describing and conceptualising the problem that the survey highlights. The term 'non-medical medicalisation' has been applied to the growing phenomenon of applying diagnostic terms to thoughts, feelings and behaviour which

may be distressing or problematical, but which would not lead to any form of diagnosis in a psychiatric clinic. This leads to a broadening of the spectrum of what are often described as 'mental health problems'

Expansion of the concept of mental health is probably confirmed by the fact that only 14% of students said that they had no friends suffering from a mental illness; 26% had one or two mentally ill friends; 28% put the figure at between two and five; 11% between five and 10; 3% between 10 and 20; and 2% had no fewer than 20 or more mentally ill friends.

There are various factors that might be driving this expansion. The use of the terminology of mental health and disorder may be a way of indicating that the problems that students are describing are serious ones. It gives a sense of solidity and objectivity to these problems. Second, and perhaps more important, it entails an entitlement to some form of help. Most societies recognise an obligation to help those whose problems fall within the ambit of sickness and health. This applies to a lesser degree, if at all, to non-medical problems.

There is a down-side to viewing emotional distress in terms of mental disorder. It expands the potential demand for services such as counselling and mental health services at a time when demand seems already to exceed supply. We may be raising expectations that cannot be met. In addition, the belief that one is in some sense mentally disordered might lead to the assumption that some form of expert help is required, and hence undermine the roles of active coping and non-professional support.

The study sought information on students' attitudes to mental health problems. Students were prepared to accept that mental health problems were as serious as physical problems, were open to acknowledge the need for help, and were sympathetic to sufferers. Despite this, there are still many students who keep their difficulties hidden and only ask for help when they are in crisis.

Since 1993 the NHS in England has been carrying out surveys every seven years of mental ill health in the population. The most recent was carried out in 2014 and was reported in 2016 (McManus et al., 2016) The data relating to mental disorders in young people are of major relevance to this report.

Since 1993 there has been a steady increase in the prevalence of 'common mental disorders' (CMDs) (most commonly depression and generalised anxiety disorder) in women. The levels in men have risen to a much smaller degree. In 2014, the one-week prevalence of such disorders was 20.7% in women and 13.2% in men.

This gender gap has become more pronounced since 1993, and especially in young people, to the point that the report designates young women as a high-risk group. In the 16-24 age group 26% of women compared to 9% of men reported a common mental disorder in the week preceding the survey. One in four young women reported that they had harmed themselves at some point in their lives. In 2000, the figure was much lower at 6%.

Self-harm at a young age can become established as a long-term coping mechanism. It can sometimes be imitated by friends and acquaintances. It may lead to an increased risk of suicide in later life.

12.6% of women aged 16–24 screened positive for post-traumatic stress disorder compared to only 3.6% of men. Rates in older female age cohorts were 6% or less.

There were substantial reductions in harmful and dependent drinking in young men aged 16–24 between 2000 and 2014. This reduction was less marked in women, though levels were still lower than those found in men.

One third of people of all age groups with CMDs were receiving treatments such as psychotropic medications, counselling, or psychotherapy – the highest level ever recorded. This was the result mainly of

increased use of psychotropic medication, though there were increases in the uptake of psychotherapy and counselling by people with more severe symptoms.

The prevalences of mental disorder reported are less than those found in the YouGov survey mentioned above for women (34% of YouGov female respondents reporting some form of mental distress compared to 26% young of women in the NHS survey diagnosed with a common mental disorder) and even more so for men (19% compared to 9%).

The differences in methodology between the two surveys are enormous. The NHS survey was of the general population, used representative sampling, and standardised assessments of psychiatric morbidity. The YouGov survey was confined to students and was based on self-diagnosis and self-selection. Nevertheless, it is striking that the NHS survey has produced prevalence figures that are not greatly dissimilar.

If the NHS survey is given more importance on account of its superior methodology and if we assume, in keeping with other research cited in this report, that the prevalence of mental disorder in the student population does not differ significantly from non-students, we have to assume that there is a need to focus attention on female students. This will have to embrace both prevention and treatment.

It is beyond the scope of this report to enter into a detailed discussion of the reasons for these high levels of mental distress and disorder. There are some causal factors for mental illness that bear down more heavily on young women than on men or older women.

Sexual traumatisation such as rape and childhood sexual abuse are potent causes of later psychiatric problems. These will often present with post-traumatic symptoms. Although males can be victims of this, girls and young women are at higher risk. Intimate partner violence usually involves a male perpetrator and a female victim. In support of this as a significant causal factor is the fact that many more young women than both young men and older women are screening positive for PTSD.

Deliberate self-harm is a common consequence of sexual traumatisation. The rising prevalence of this provides further support for sexual traumatisation as an important causal factor in mental disorder in young women. This is entirely in keeping with clinical experience in students referred for psychiatric treatment.

The UK Office for National Statistics crime survey in 2016 sought information from respondents on experiences of childhood abuse. 11% of women aged 16-59 gave a history of sexual abuse in childhood compared to 3% of men. 3% of women and 1% of men had experienced sexual assault by rape or penetration (including attempts) during childhood (https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/abuseduringchildhood/findingsfromtheyearendingmarch2016crimesurveyforenglandandwales).

A study of schoolgirls aged 14–17 in England, Norway, Italy, Bulgaria, and Cyprus found that more than four in ten had experienced sexual coercion. Although most of this consisted of non-physical pressure (e.g. threats to end the relationship) in many cases physical coercion was used, including rape. The highest rates of sexual coercion were found in English teenagers. In Italy 34% of boys said they had used pressure to achieve kissing, intimate touching, or intercourse and 17% said they had used force to do so. Coercive behaviour in boys and 'sexting' were both associated with regular use of pornography. (Stanley et al., 2016).

A study of anal sex in heterosexual people aged 16–18 in England was published in 2014. It used individual and group interviews of 130 participants. Anal sex often involved ambiguous consent and pressure on, or coercion of the young woman. It was often carried out in the expectation that it would be painful (Marston C & Lewis R, 2014).

A large survey carried out in the USA revealed a lifetime prevalence of rape of 22.4% in women aged 18-29. In the survey population as a whole, 21.6% of female victims had first experienced rape before their 12th birthday and 32.4% between the ages of 12 and 17 (Tjaden and Thoennes, 2006).

Research from other settings has highlighted the importance of traumatisation as an aetiological factor in mental disorder in students.

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) 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. 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 were 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.

To summarise, it is likely that many young women are arriving at university already burdened with significant histories of traumatization and that others will experience traumatizing episodes while studying.

Suicide

Key data

One indicator of mental disorder is the rate of suicide and here the data point in the opposite direction in relation to gender.

In the UK, suicide rates in 2018 were 17.2 deaths per 100,000 for men. For females, the UK rate was 5.4 deaths per 100,000, which is similar to what it has been for the last 10 years.

Rates were highest in males and females in the age group 45–49 and lowest in females aged 10–29. Despite having a low number of deaths overall, rates among the under 25s have generally increased in recent years, particularly 10 to 24-year-old females where the rate has increased significantly since 2012 to its highest level, with 3.3 deaths per 100,000 females in 2018. Across all age groups, the suicide rate was three times higher in males than females

In 2018 Scotland had the highest suicide rate in GB with 16.1 deaths per 100,000 persons.

The IPPR publication mentioned earlier in this report states that numbers of suicides in students increased by 79% (from 75 to 134) between 2007 and 2015 and that the figure for 2015 was a 'record'.

This assertion is based on data for England and Wales for the years 2001 to 2015, obtained from the Office of National Statistics. The data comprise raw numbers rather than rates and thus take no account of increases in student numbers in this time frame. The accompanying text from ONS states that the figures cannot be used to ascertain the risk of suicide in students. Numbers of suicides were highest in 2014 and 2015 but it may be too early to state that these indicate a secular trend. In students, as in the wider population, numbers of suicides were around three times higher in males than females.

Student suicide is of course a major concern and a tragedy for students, their families and all others who have any kind of relationship with the person who commits suicide. Nevertheless, the alarming headline figures in the IPPR document depend on 'cherry picking' of the data. The document does not mention the warning from ONS about using the figures to estimate suicide rates. The figure for 2007 was the lowest in all the years 2001–2015. Numbers before 2007 were considerably higher (e.g. 112

in 2004). Nevertheless, we recognise that the high figures in recent years are a cause for concern and future trends will have to be closely scrutinised.

The ONS produced a detailed report on student suicide (ONS 2018). This differed in some important respects from previous reports. In the past, data on student suicides were based on the occupation of the deceased as recorded in the death certificate. In the new report, a student is defined as someone registered at a Higher Education provider in the UK reporting to the Higher Education Statistics Agency. Students in further education or at sixth form colleges, who might have been included in previous analyses, were excluded. Analyses were based on data from students in England and Wales.

The salient points in the report were as follows:

- The rate of suicide in the 12 months ending in July 2017 was 4.7 deaths per 100,000 students. This comprised 95 deaths. Although this is a higher figure than most of the previous years studied, the numbers are small, and it is therefore difficult to identify statistically significant differences. The overall rate was unchanged since the 12 months ending July 2015.

- In the time period between the 12 months ending July 2013 and the 12 months ending July 2016, higher education students in England and Wales experienced suicide rates significantly lower than the general population (including students) of the same age.

- The suicide rate in male higher education students was significantly higher than females (6.7 vs 2.8 per 100,000). The highest rates were seen in males studying for an undergraduate degree.

- The number of suicides is lower than previous ONS estimates. The likely reason for this is the new definition of the population at risk. On average, the number of student suicides between 2001 and 2017 identified from HESA records is 28% lower than previous ONS estimates.

Student suicide rates increased with age, as is the case in the general population. The median age at death by suicide for students was 26. Students aged 20 and under had a significantly lower suicide rate than other age groups. In students aged 21–24 and 25–29 suicide rates were higher in undergraduates than postgraduates.

Suicide rates were compared between white, Black, Asian and others (includes mixed and other ethnic background). The only significant difference was a higher suicide rate in white vs. Black students.

Between 2001 and 2017 there were 406 records that linked a HE student registration with an ONS suicide record with a student code, that were not included in the analysis. This was because the death occurred after the end date recorded on the HESA record and it was believed that these were no longer students. There were 99 cases where suicide occurred within 28 days of the HE 'end date'. 109 suicides were not included where the reason for leaving university was noted as 'death'.

It certainly seems appropriate to include these deaths in producing suicide rates. The paper also states that the figures for the period ending July 2017 are likely to be an under-estimate because, in England and Wales, suicides are only certified by a Coroner after an inquest. This leads to an average delay of around five months between the death and certification as suicide.

Inclusion of these deaths resulted in an increase of 0.5 in the overall student suicide rate (from 4.7 to 5.2 in the year ending July 2017), which was not statistically significant.

On this analysis, the lowest rate of HE student suicides was in the 12 months ending July 2008 at 3.0 per 100,000. The highest rate was 5.7 per 100,000 in the 12 months ending July 2014.

Impact of suicide

Student suicide will be very distressing to those who have been in close contact with the deceased prior to death. They will sometimes feel guilty because they failed to appreciate how distressed the person was or to anticipate the suicide. Tutors may worry that they placed too much pressure on the deceased.

The suicide of a student will cause distress to flatmates for reasons that include the following:

- They may have found the body.

- They will face police questioning.

- Depending on the relationship with the person they may be called upon to go to a mortuary to identify the body.

- They may have to cope with family members coming to the flat to remove belongings.

- They will often find it impossible to carry on living in the same flat, especially if this is where the suicide occurred. In such circumstances, private landlords are sometimes unsympathetic about allowing premature termination of leases.

- In many cases, students are distressed to the point at which their academic performance suffers.

Suicide in international students creates extra requirements and potential areas that might cause distress. These can include liaison with embassies and the recruitment of interpreters to allow liaison with families.

Academic and hall warden staff may also be involved in having to break the bad news to families.

Where staff and students might want to attend the funeral, there will be a need to communicate with families to ensure that this is acceptable to them.

These issues are described in detail in an excellent account of student suicide entitled Responses and Prevention in Student Suicide (Stanley N et al., 2007). The authors recommend active outreach to students and staff who have been affected by a suicide.

It will sometimes be the case that a university experiences a cluster of suicides in a short space of time. This happened in Bristol in the 2017/18 academic year, in which 10 students in the city are thought to have died by suicide (Guardian, 2018). This can generate anger and anxiety in students and their families and demands for action to tackle the problem. It can also generate considerable anxiety in university staff with responsibilities for pastoral care about risk of more suicides,.

It is important to respond to such clustering by trying to identify risk factors that may be more prevalent in one institution than others, and attempting to mitigate these. It is also important to look for common factors in these tragic deaths. It is also the case that clusters of suicides arise by chance and in such an event the situation will more than likely return to 'normal' regardless of what action is taken.

There is evidence from the ONS survey that the 28 days after the finish of higher education is a high-risk phase. In many cases the reason for termination will have been the onset or exacerbation of a mental disorder. The distress of mental disorder will be amplified by the fact that this has led to withdrawal from

studies with consequences such as feelings of failure and uncertainties about the future. Dropout from university will likely lead to a break in continuity of existing psychiatric care, or delay in gaining access to services if the student is not already engaged with these. It may also lead to loss of informal support networks. In circumstances such as these a student may be left without support and therapy at a time of maximum vulnerability. This underlines the need for effective management of the transition from university to home or elsewhere in students suffering from mental illnesses.

A common response to suicide is to call for research into prevention and this has been given a high profile in the UK and elsewhere; see (NAASP, 2012) for an account of the US National Strategy for Suicide Prevention. One impediment to prevention is that suicide is a rare event, resulting in one death per 20,000 students per annum. It is very difficult to detect the young person who will die by suicide in the midst of the very much larger group of students who are mentally distressed and who have given thought to suicide. For the same reason, it is very difficult to assess the effectiveness of local suicide prevention initiatives.

A second problem is that suicide rates are affected by factors that operate within individuals, their networks of close relationships, their community (e.g. college or university) and wider society (e.g. quality and accessibility of mental health care, see https://www.ncbi.nlm.nih.gov/pubmed/22305767 for an example from the UK).

Covid and student mental health

The Covid epidemic has thrown up a new raft of issues that will have to be considered in the context of student mental health. These will apply to all students but will weigh more heavily on those with histories of mental ill health. Such students may already find it difficult to integrate with a new social environment and to build relationships with clinicians, support staff, academic staff, and their fellow students. These difficulties will be exacerbated by the restrictions arising from Covid. Problems may arise in the following areas:

- Increased general anxiety and/or depression amongst the student population arising from: anxiety about getting Covid; the effects of the Covid crisis on their course and their assessments; anxiety about finances because of fewer opportunities for paid work; anxiety about future career prospects; anxiety about family back home being at risk of, or ill with, Covid; anxieties about living in shared accommodation;

- Social isolation of students because of increased use of remote learning;

- Impacts of social distancing on engagement with student clubs, societies, and social events;

- Possible changes in use of alcohol from social to solitary drinking;

- A larger proportion of NHS and student support services being provided virtually rather than face-to-face, with a likely reduction in effectiveness and engagement, possibly leading to under-recognition of problems and failure to provide treatment, therapy, or support;

- Effects of Covid-19 on GP registration of students, it being even more important for HEIs to ensure that students are registered, allowing a prompt response to students who develop symptoms of Covid or who test positive;

- The international student cohort likely being reduced in the next year or two but likely to need enhanced support (both from HEIs and NHS);

- An increased need to promote physical activity in students, possibly preventing the development of Covid and ameliorating symptoms in those who do contract the illness;

- The majority of first year students having been offered places on the basis of predicted, rather than actual, exam results; some students with predicted results below their potential and others whose prediction has inflated their grades; some students being angry and disappointed at not getting on to the course of their choice and others struggling with the academic demands of their courses.

Whilst there are undoubtedly potential adverse effects of Covid-19, it is important to appreciate that the beneficial effects of going to university can far outweigh these. The vast majority of students will be at very low risk of serious illness and will benefit from the discipline of student life. The onus will be on the universities to create the best possible experience for each student. It is also incumbent on the Government, the universities, and the NHS to provide health and welfare services for students to address the increased demands arising from these new adversities.

A longitudinal assessment of the impact of Covid on students is underway and can be accessed here: www.covidsocialstudy.org/results. This study monitors the psychological response of participants during lockdown. Early results show that the 18–29 age group have experienced increases in loneliness, stress, and fear.

Specific mental disorders

Schizophrenia

Schizophrenia is a severe and disabling mental disorder. Its peak age of onset in males is in the late teens and early 20s. Women experience a later onset. Thus, many people, particularly men, who develop this condition will do so in the time that they are students.

People who suffer from this condition experience a range of symptoms that fall into two groups, positive and negative symptoms.

Positive symptoms (usually responding well to antipsychotic medication) comprise experiences that are new and abnormal and include delusional thinking, hallucinations, and disordered thought processes.

Negative symptoms (tending to be enduring and resistant to treatment) comprise a loss or diminution of normal function and include blunting of emotions, lack of motivation, lack of pleasure and impoverished thinking.

It is negative symptoms that create most of the long-term disability found in this illness.

The onset of symptoms is often insidious. There may be a prodromal phase in which the student becomes withdrawn and isolated and stops attending classes. There may be a decline in standards of personal hygiene and other areas of social competence. Concentration and motivation are also usually impaired. The student may begin using cannabis and other drugs for the first time.

The prodromal phase leads on to the development of unmistakable psychotic symptoms. The student will sometimes be paranoid and present in a very disturbed state. Behaviour may be frankly bizarre. This

can be alarming to other students in shared accommodation. In these circumstances, a rapid response from psychiatric services is of the first importance and psychiatric hospitalisation is usually required.

Outcomes are highly variable in schizophrenia and range from complete recovery to long-term chronic disability. Between these poles, many patients experience recurring episodes of illness interspersed with periods of partial recovery.

After recovery from the acute episode, the student will often wish to return to their studies. This will sometimes create a dilemma for clinicians. On the one hand, there will be a wish and duty to support students in achieving their aims. On the other, there is a need to recognise that university is demanding and stressful and that this may increase the risk of a second breakdown. This will apply especially to students who are studying away from home and who will not have the support that can be provided by families. A student with a history of schizophrenia will often find it difficult to make new friends and re-integrate into university life. Chronic negative symptoms will make it difficult for the student to meet academic demands.

The student will usually be on long-term antipsychotic medication. This can have side-effects such as sedation which further impair the ability of the student to focus on their studies.

The consequence of these factors in combination is a high dropout rate in students with schizophrenia. Although the incidence of onset is higher in this age group, the prevalence in the student population is generally low.

The student with a history of schizophrenia will benefit from intensive and coordinated input from psychiatric, primary care and student support services. There may be a need to adjust course requirements to diminish the stress that arises from study. Examples of how to do this might include:

- allowing extra time for submission of course work;

- provision of a private room to sit examinations;

- avoidance of intensive small-group activities.

Despite optimum help, the reality may be a student who experiences residual psychotic symptoms, is socially isolated, and who struggles to cope with academic demands. People with schizophrenia are at increased risk of suicide, with an estimated rate of five percent.

In circumstances such as these, the best option may be to advise the student to withdraw from university and to explore alternatives. These might include a move to a HEI in the student's home area, part-time study, and changing to a less demanding course.

Cannabis use is now well-established as a risk factor for schizophrenia especially in adolescent users and when a variant with high THC concentrations is used. In people with schizophrenia, cannabis leads to a worse prognosis with increased rates of relapse and re-hospitalisation (Volkow et al., 2017). The student with a history of schizophrenia should be strongly advised to abstain completely from cannabis and other illicit drugs.

A more recent development has been the widespread use of synthetic cannabinoid receptor antagonists (SCRAs). These have a wide range of chemical compositions and street names and are often more potent than cannabis. The most common are Spice and K2. Acute intoxication with these substances can lead to aggression, confusion, and psychotic symptoms in addition to physical symptoms. The psychotic state extends beyond the period of acute intoxication in 30% of cases and is commonly accompanied by aggression, catatonia, and self-mutilation (Taylor et al., 2018). It is likely that these substances will have similar impacts on schizophrenia to cannabis.

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 higher risk of developing this illness. In one study, 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% had DSM-IV bipolar disorder (Smith et al., 2005).

Eating disorders

The so-called 'eating disorders' are conditions of obsessive–compulsive avoidance of fatness, and pursuit of weight loss. Patients fear treatment because of the (realistic) fear that recovery will involve weight gain. In the extreme, sufferers see professionals, family, and friends as obstacles to weight loss. Social and leisure activities become irritating distractions from the business of avoiding or getting rid of calories by restricting intake, purging or compulsive exercise. Patients are preoccupied by anxiety and calorie calculations.

In the face of such interpersonal mistrust, expertise and patience are needed to build the trusting attachment that is key to recovery. The move from home to university can disrupt such attachments at a time of increased stress, making the transition a particularly vulnerable time.

Physical risks arise from starvation and purging, and include premature death. Psychosocial risks include loss of relationships, failure to develop healthy emotional regulation skills, and thus inability to enjoy the broader opportunities of university life. Students of vocational degrees, such as medicine, nursing, and teaching, may not be fully fit for professional practice whilst under the influence of their disorder. However, the personality traits which predispose people to suffer from eating disorders also predispose them to strive for achievement. Such students often continue to excel academically and even athletically to the point of dangerous exhaustion. Patients, parents, teachers, and coaches may give insufficient priority to health over academic and sporting achievements.

Most young people experience negative stress as well as exhilaration on leaving for university. People with a genetic vulnerability to eating disorders show reduced cognitive flexibility and high anxiety. Such traits are further amplified in the starved state. Subjects such as physical education, performing arts, physiotherapy and dietetics prove particularly attractive to individuals with eating disorders. Students involved in sports teams and clubs, and who attend university gyms, are also at increased risk.

Prevalence figures for the eating disorders in the student population vary with time and place, but it is likely that prevalence is increasing with growth of the overall UK student population, the increase in the proportion of female students, and a probable increase in eating disorders fuelled by cultural factors such as social media. A large US study found about 1% of girls met criteria for anorexia nervosa at some point in their teens, whilst a further 12% met criteria for other eating disorders. There is growing acknowledgement of eating disorders in boys and men (Mengeteatingdisorderstoo http://www.mengetedstoo.co.uk/). Such disorders may involve a muscular rather than thin body ideal and may be dominated by compulsive exercise.

Anorexia nervosa has an average age of onset in early to mid-adolescence with an average course of 6-7 years. Many student sufferers will have been brought to Child and Adolescent Mental Health Services (CAMHS) by their families, and then face a double transition as they reach their 18th birthday.

They move to adult services, and from school to university, often away from home, at a crucial time in treatment.

Normal weight bulimia nervosa (BN) has a similar age of onset but can be hidden for longer because there is no tell-tale visible emaciation. Students with BN are sometimes motivated by practical consequence to seek help for the first time. Away from the parental home, bingeing and purging behaviours involve expensive food bills and social embarrassment.

The Royal College of Psychiatrists report *Managing transitions when the patient has an eating disorder* (RCPsych. 2017) highlights the plight of students, emphasising that anorexia nervosa has the highest mortality rate of any psychiatric disorder.

NHS provision involves service shortages and waiting lists, even though services for people with eating disorders have expanded this century. The report *University Challenge* from the charities BEAT and Student Minds, highlights the common predicament of waiting on the list of the local ED service, then having to re-register with a new GP at university, seek referral and join the bottom of another waiting list.

Even when students manage to access treatment, there are often big gaps when they return home or are travelling during vacations while still receiving care. Since motivation is ambivalent anyway, treatment dropout is common. For patients at high physical risk, it is dangerous when there are lapses in medical monitoring.

Family-based interventions are the leading treatments for adolescent anorexia nervosa, but these are rarely practicable in the context of geographical separation, the defensive nature of eating disorders, and the respect suddenly afforded to the autonomy and confidentiality of university students in contrast with school pupils. Most students do maintain close contact with their parents and are often financially and emotionally dependent on them. The sudden cutting off of their involvement seems arbitrary, and a waste of a powerful source of potential care.

19-year-old student Averil Hart died of anorexia nervosa in 2012. In 2017 the Public Health Service Ombudsman in a Report relating to the death (*Ignoring the Alarms*) criticised inadequate coordination and planning during the vulnerable time when she was leaving home to go to university. He highlighted failures in monitoring her health and providing treatment when she then became seriously ill. He reported that, 'Sadly, these failures, and her family's subsequent fight to get answers, are not unique.' His key recommendation was for better coordination of care between NHS organisations treating people with eating disorders. The College fully agree with the recommendations from this Report and intend to publish a Position Statement shortly on what actions are needed to fully implement them.

Another concern for students with eating disorders is the notion of 'Gap Years' which are now common before, during or after a university degree. Long periods of foreign travel can involve even more dangerous transitions than moving to university, because climate and culture bring their own challenges, and foreign health systems can be difficult to access or prohibitively expensive.

Students who have already required treatment for an eating disorder benefit from meticulous advance transition planning. A young person who has been supported intensively to gain and maintain a normal weight looks deceptively healthy but may deteriorate at an alarming rate. Post transition follow-up and review by both sides can ensure that high risk patients do not fall through the gaps. It is a good principle to increase rather than decrease the intensity of support provided at the start of a university course. In a safe context, new services can offer a fresh start, new hope, and the benefits of untried therapies when old approaches have become stale.

Student Minds recommends using videolink technology to provide continuity of therapy across geographical divides. This would allow some students to stay with the services that had already supported

them from home whilst newly diagnosed students could access care from their university town during vacations. In addition there are CAMHS services that are continuing to treat people past the age of 18, with the benefit that brings in terms of them not having to transition into adult services on top of the anxiety that can be caused by accessing services in different geographical areas.

There is currently so much inequality of provision that professionals find themselves urging patients to choose their university on the basis of local services. It would be helpful for all HEIs to identify service pathways for students with eating disorders and to provide a policy statement on eating disorders support when students first apply.

Autism spectrum conditions

The prevalence of autism spectrum conditions (ASC) (autism, atypical autism, Asperger syndrome and other forms of pervasive developmental disorder) is 9.5 per 1000 in children in the UK and 9.8 per 1000 in adults living in the community (Baron-Cohen et al., 2009, Brugha et al., 2011).

The core features are social and communication difficulties, unusual interests, and repetitive or stereotyped behaviours. There may be intolerance of changes in routine. People with these conditions will sometimes become very anxious in social interactions. There may be a paucity of non-verbal communication involving both gestures and affective tone of voice.

Asperger Syndrome denotes autism spectrum conditions where there is no delay in language, cognitive development, or curiosity about the external environment. The main features are qualitative differences in social interaction and restricted patterns of interest. Speech may be verbose and lack intonation and volume may be poorly modulated. Most students with an ASC are likely to fall into this category. Rates of diagnosis are rising though it is not clear whether this is a result of increased ascertainment or a true increase in prevalence. The male to female ratio in Asperger Syndrome is around nine to one.

People with Asperger traits are often socially isolated but are not usually withdrawn in the presence of other people. Their attempts at social interaction are sometimes awkward and this may lead to rejection by others. Depression may arise from negative social experiences over many years and a sense of being different from others.

There may also be significant cognitive strengths. These can include extraordinary capacity for memorization and unusual attention to detail. Enormous amounts of information may be learned about restricted topics. Some individuals exhibit enhanced visuo-spatial skills such as drawing or ability to play a piece of music after hearing it only once.

These strengths may confer advantages in academic pursuits that depend on attributes such as these, and many such individuals can enjoy successful academic careers.

Students with Asperger's Syndrome should be advised on courses that will capitalise on their strengths and which will not lead to undue stress. In one study carried out at Cambridge University, students were asked to complete a scale known as the Autism Spectrum Quotient. (This identifies autistic traits but does not allow diagnosis as it is possible to score highly on this scale without being distressed by these traits). Scores in students overall were similar to a control group. Students who were studying sciences and mathematics scored higher than social sciences and humanities students, with mathematicians scoring highest of all. The scale was also applied to 16 winners of the UK Mathematics Olympiad (mean age 17.4 years). Their scores were similar to the mathematics students.

In the survey by Brugha et al. (2011), the Autism Spectrum Quotient (Baron-Cohen et al., 2001) was used for initial screening. This is a self-report measure and may be useful as part of diagnostic assessment.

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. An autism-spectrum disorder may not have been diagnosed before university entry.

The provision of specialist services for those with ASCs is, to say the least, patchy. Diagnosis can be of benefit to the student in several ways. It provides a framework that helps the student and academic staff to understand the difficulties that can arise from this condition. It gives the student access to Disabled Students' Allowance funding that can pay for the support of a specialist mentor. There may be a need for modifications to parts of the course if these prove stressful to the student. Diagnostic assessment may be provided by NHS mental health services, the National Autistic Society, and other charities or university disability services.

Attention deficit hyperactivity disorder (ADHD)

ADHD is a common mental health disorder that begins in childhood and frequently persists into adulthood. It is characterised by inattention, hyperactivity, and impulsivity. ADHD commonly co-occurs with other specific learning disabilities (SpLDs), neurodevelopmental disorders (e.g. dyslexia, dyspraxia, autism spectrum disorder), and mental health conditions (e.g. anxiety, depression, substance misuse, personality disorder, eating disorders). In a Swedish population database of adults with ADHD the co-morbidity of anxiety and depression was 50% in women and 35% in men and of substance use disorder 30% in women and 40% in men (Chen et al., 2018). There is no prevalence estimate for ADHD in university students in the UK. In Ireland, the reported prevalence estimate in students aligns with the 3-4% prevalence for ADHD in the general adult population (AHEAD, 2016; Asherson et al., 2016). Within institutions of higher education (HEIs), ADHD is commonly classified as a SpLD, rather than as a mental health condition (see https://www.hesa.ac.uk/collection/c17051/a/disable).

Mental health service provision for university students with ADHD is often inadequate. Waiting times for an assessment in specialist NHS services can be up to two years and more. This limits the potential for effective medical interventions and psychosocial and educational support for university students with ADHD. In the UK, ADHD in adults is generally under-diagnosed and under-treated, due to a lack of recognition, awareness, or training; age-dependent changes in the presentation of symptoms; or scepticism in the general population and professionals about the validity of ADHD as a diagnosis (Kooij et al., 2019). In the UK, ADHD is a specialist-only diagnosis with primary care providing support to specialist services through shared care protocols, e.g. NICE (2018) guidelines. These guidelines highlighted how ADHD tends to be mis- or under-diagnosed in women, and possibly also in people from Black and ethnic minority groups.

ADHD can cause problems for university students that include finding it hard to engage in self-directed study, attend classes at different times, take copious notes, complete course work and submit it on time, plan, or generally be organised (Sedgwick 2018). Under the Equality Act 2010, ADHD is classified as a disability. The Equality Act stipulates that HEIs must make reasonable adjustments to remove systemic barriers and provide extra support for disabled students, to enable them to engage fully in their programmes of study and to benefit from university life in general. The potential range of education-related problems and reasonable adjustments are listed in Table 1 (from Sedgwick, 2018).

Table 1. Potential learning problems and reasonable adjustments

Learning problems due to	Reasonable adjustment
Mind wandering (daydreaming, intrusive task-unrelated thoughts)	25-50% extra writing time in examinations
Poor working memory (requiring more time to understand complex conceptual ideas)	Separate room for writing examinations
Disorganisation and inefficiency	Academic coaching; being invigilated in an examination by a support worker familiar with ADHD
Difficulties with planning ahead, misjudging how long tasks take to perform (different conception of time)	Flexible start times for an examination
Procrastination (requiring more time to complete tasks)	10 to 20 minutes of a rest break during examinations
Forgetfulness	The ability to negotiate extensions to deadlines for assignments
Difficulty sustaining attention (especially when bored or not engaged)	Where possible, the ability to negotiate part-time study or to defer examinations
Difficulties with following long explanations	Subject-specific support (or one-to-one tutoring)
Hyper-focus on topics of self-interest to the detriment of other topics and tasks	Academic coaching

University students with ADHD can present to student support services with a range of learning problems and psychiatric co-morbidities. In the UK, and elsewhere in Europe, there is a paucity of research about the impact of ADHD on the educational outcomes of university students. A comprehensive review of the (mostly North American) literature about university students with ADHD was conducted by Sedgwick (2018), and the main findings of this review are summarised in Table 2.

Table 2. Summary of key findings about university students with ADHD

Theme	Findings
Academic, social & psychological functioning	• Poor performance in time-limited exams & overall academic achievement (i.e. classification of degree) • Lower levels of social adjustment, social skills, and self-esteem in relationships • A range of factors predict academic success including better coping strategies • A positive mental attitude/resilience and exercise may be good coping strategies
Giftedness	• Not easy to differentiate symptoms of ADHD from traits of intellectual giftedness • Twice-exceptionality (2e) describes the combination of ADHD & intellectual giftedness. 2e individuals are often misunderstood and mis- or under-diagnosed with ADHD • High IQ does not preclude the possibility of ADHD • Students who get good grades but still report ADHD symptoms are most at risk of not getting diagnosed and treated
New media technologies (NMT)	• Internet overuse (or addiction) may be a concern • NMT could precipitate or perpetuate ADHD-related behaviours (but inconclusive research) • Important to ask about NMT use during assessments for ADHD

Theme	Findings
Treatment	• Research in university students with ADHD is rare • Not clear if psychiatrists consider the unique demands of university life when prescribing medication • Academic achievement and performance increases with medical treatment • Unclear if psychological interventions improve academic functioning • Coaching is not defined as a psychological treatment, but it may be useful
Substance misuse & non-medical use of stimulants	• More likely to misuse tobacco, alcohol and other licit or illicit substances • Prevalence rates for use of 'study drugs' is from 5–35% in North American and 0.8–16% in Europe (excluding Ireland and the UK) • In Ireland and UK resilience to PCE use and low prevalence rates only reported in one study
Malingering	• Concerns about feigning ADHD to get a prescription for stimulant medication • Detection depends on the knowledge, skills and expertise of the practitioner undertaking a diagnostic assessment

Management of ADHD university students

Pharmacological treatment with stimulants (methylphenidate or lisdexamfetamine) is recommended as first-line for adults with ADHD by (NICE, 2018) 'if their symptoms are still causing significant impairment in at least one domain after environmental modifications' (1.5.15). ADHD medications are among the most effective within adult mental health as summarised in a recent network meta-analysis (Cortese et al., 2018). University students with ADHD have reported improvements in their note taking, scores on tests, writing output and completion of course work after starting ADHD medication (Advokat et al., 2011). A study from Sweden showed that young people with ADHD had better scores in standardised university entrance exams when they were taking prescribed ADHD medication compared to those patients not on ADHD medication (Lu et al., 2017). Many students prefer the flexible use of prescribed

stimulant medication with optimum doses during times of essay writing and exam preparation, and no medication between terms and on days without academic work (DeSantis et al. 2008).

A matter of central importance is that students with ADHD cannot afford to wait for a year or more for assessment and treatment in the NHS without risking academic failure or under-performance, and increased psychopathology. For these students, the misuse of caffeine products or non-prescribed stimulants may become attractive options for self-medication. Some university students seek a private ADHD assessment and initial treatment, then ask their GPs for repeat prescriptions, only to be told by some GPs that a repeat prescription cannot be done, because they have not been seen in a specialist NHS service. Students with possible ADHD should therefore be fast-tracked for an initial assessment by NHS services.

At present we do not know exactly how many university students in the UK have ADHD. Therefore, ADHD remains a hidden disability within higher education. We need to better understand how university students with ADHD adjust to life at university, the academic challenges they face, and how these are managed or overcome. The provision of rapid access to an assessment/treatment for university students with ADHD may be a challenge for clinicians working in this NHS, but such models of practice can be developed. We need to bear in mind the substantial costs that can arise from delayed treatment. Under-performance at university can have a long-term negative impact on someone's career.

Alcohol

High levels of alcohol intake have been a traditional feature of student life at university in the United Kingdom, and in other countries. Many young people start to drink more heavily when they are free of the constraints of life in the family home and when they reach an age when it becomes legal to purchase alcohol. Despite continuing high levels of alcohol consumption in the general adult population in the United Kingdom there have been sustained reductions in alcohol consumption over the last ten to fifteen years in this younger age group. The reasons behind this are not entirely clear. Two recent reports document these trends.

First, a paper in October 2018 in BMC Public Health (Ng Fat et al., 2018) looks at the data from the annual Health Survey for England from 2005–2015. A key finding is that the proportion of 16- to 24-year-olds who are current non-drinkers increased from 18% in 2005 to 29% in 2015.The increase is mainly due to an increase in those who have never drunk: from 9% to 17% over the same period. For those who were drinking, a range of improvements were also seen including a fall in drinking above recommended limits from 43% to 28%. These changes were found in many demographic sub-groups, including those in further education.

Second, a detailed report in September 2018 entitled 'Youth Drinking in Decline' was published by researchers from the University of Sheffield (Oldham et al., 2018). As well as also using the Health Survey for England data, they used data from school surveys and show that underage as well as young adult drinking has been in decline for over a decade and point to a similar trend in the other nations in the United Kingdom. Interestingly a similar trend is not always found internationally, raising the question as to why UK youth culture is moving in such a positive direction.

In both reports it is shown that those in fulltime higher education (FTE) show consistently lower consumption than those not at college or university. For example, 36% in FTE are classified as non-drinkers compared to 23% not in FTE (Ng Fat et al., 2018 Table 2).

Alcohol dependence is a condition that usually occurs after many years of heavy alcohol use. For this reason, well defined dependence is rare in young people, particularly those who have succeeded in

entering Higher Education. The main problem around alcohol in students is harmful or hazardous drinking.

Guidance in the United Kingdom on sensible drinking limits changed in 2016 from 21 UK units for a man and 14 units for a woman per week to 14 units for both men and women. It was also advised that people should have at least two days off alcohol per week and not consume more than 2–3 units of alcohol on any one occasion. These new safe levels were based on an analysis of risk undertaken on behalf of the four Chief Medical Officers in the United Kingdom.

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, both physical and sexual. 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.

There is a strong evidence base for interventions that can make a difference both to the collective population of a higher education institution and to the individual student who presents with a problem around alcohol, whether self-identified or identified through appropriate screening. The guidelines on safe drinking have a role at both levels and the technique of 'social norming' can be useful. This depends on the idea that heavy drinkers often believe that their peers are drinking the same or more than they are. Presented with evidence that they are an outlier compared to the average student, heavier drinkers tend to reduce. As well as the relative benchmark of a survey of the general student population, the student's drinking can be compared to the safe drinking guidelines issued by the UK Governments. The fact that students work within a common IT environment at their place of study has opened up opportunities to promote better health in a number of domains including health education around alcohol.

It is advisable for Colleges and HEIs to have clear alcohol policies for both staff and students. Such policies should outline actions to be taken if a student or staff member uses alcohol during the working day, and should be designed to help the student in difficulty by offering clear pathways to counselling and treatment alongside any disciplinary action and monitoring. Student unions should not offer inducements to consume alcohol e.g. reduced prices during 'happy hours'.

In the case of students of the healthcare profession, the student not only needs to have met the required educational standards but also has to be declared a fit person to practise. An active alcohol or drug problem that has come to the attention of the university or college might therefore debar the individual concerned from graduating.

Drug use and 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% said they regularly used ecstasy. Only 5% had ever used opiates and less than 1% used opiates regularly.

Since 2001 the range of psychoactive drugs available to be used recreationally has expanded greatly (Nutt, 2012). The internet, the dark web, criminal networks, and the ingenuity of chemists working for the growing market around drug experimentation gave us the phenomenon of 'legal highs', and the need for the Psychoactive Substance Act 2016 to prohibit this wide range of new drugs. We speak of these drugs, now made illegal, as Novel Psychoactive Substances (NPS) and characterise them in relation to the traditional categories of stimulant-like, psychedelic-like, depressant or with mixed effect.

Severe adverse reactions to these drugs can be idiosyncratic in nature, as with the occasional deaths from MDMA/Ecstasy. Emergency departments and liaison psychiatrists are describing psychotic reac-

tions with treatment made difficult by the fact that the nature of the substance consumed is often unknown. Occasionally clusters of adverse reactions are seen around dance events and music festivals. This has led to initiatives such as The Loop to offer drug testing at such events to determine the nature and strength of a tablet purporting to be, say, MDMA.

Additionally there has been a resurgence in interest in psychedelic drugs, such as LSD, with a number of Psychedelic Societies in existence around the country with many subscribers to the groups being students. The use of drugs in combination, both licit and illicit, is often discussed on the web forums. This resurgence is paralleled by new scientific research into the potential for psychedelic drugs to act therapeutically in psychiatric conditions, including addiction.

The problem of misuse of prescription drugs is one that has achieved growing prominence in recent years, especially regarding stimulants such as methylphenidate. Such drugs can improve attention and concentration in young people who do not have ADHD and there has been concern that use of these drugs to treat the disorder has been accompanied by widespread non-medical use. Garnier et al. (2010) in the USA 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 the 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 stimulants between the first and second years of university. The reason for use was again to improve attention and concentration. Teter et al. (2010) reported that 6% of students had used non-prescribed stimulants in the last year. There were high rates of depression in those who used 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 using drugs such as methylphenidate and modafinil to enhance performance and to 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 had used 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 to run into problems as a result of alcohol use. As with alcohol, colleges and universities should have policies in regard to how they will deal with students who run into difficulty through drugs, and where the drug is illegal the main difficulty may be criminal proceedings.

The National Union of Students published a report in 2018 – *Taking the hit: student drug use and how institutions respond* – which showed that cannabis, MDMA and 'study drugs' (e.g. methylphenidate) are the most popular drugs in descending order in a sample of over 2000 students. (This in a sample that is most likely skewed towards those most interested in the topic of drugs, so that the prevalence rates given are likely, by the authors' own admission, to be biased upwards). The report also surveys institutional policies towards dealing with drug use and seems to find them overly punitive, though in most instances counselling services exist but are poorly publicised. Stricter rules apply to student accommodation with eviction being likely in response to possession of drugs. The report calls for a less punitive approach with adequate provision of counselling and harm reduction services.

Creativity and mental disorder

The possibility of a link between creativity and mental illnesses such as schizophrenia and bipolar disorder is one that has intrigued psychiatrists for many years. MacCabe et al. (2018) carried out a large-scale case-control study, using Swedish population registries to test for an association between studying a creative subject at high school or university and later mental disorder. They found that individuals who had studied artistic subjects (visual arts; music; dance, theatre, and drama; film, radio, and TV production; fashion design) were at higher risk, with odds ratios of 1.90 for schizophrenia, 1.62 for bipolar disorder and 1.39 for unipolar depression. The association was strongest for visual arts.

It is likely that creativity rests on cognitive styles characterised by divergent thinking and the ability to form novel links between ideas. If taken to an extreme this may result in the formation of delusions and disordered thinking. The study was unable to exclude drug use as a confounding factor.

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. Socio-demographic 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.

Below are several other considerations for meeting the needs of student populations:

- Mental health disorders in the student population can 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 childhood sexual abuse, 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 HEIs 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.

4. Higher education context

Counselling in higher education

Context

The first university counselling service was believed to be established in 1962 at the University of Leicester. Other universities followed its lead, and many services have now been in existence for more than 50 years. The BACP expert division for counselling in further and higher education, the Association for Student Counselling (ASC), came into existence in 1970. It later became the Association for University and College Counselling (AUCC) and is now BACP Universities and Colleges (www.bacp.co.uk).

Almost all HEIs now have counselling services, as do the vast majority of higher education colleges. The Royal College of Psychiatrists document *Mental health of students in higher education* (2003) concluded that university counselling services were the main mental healthcare option for many students and recommended that they should be resourced accordingly.

In the last decade, university and college counselling services have experienced a large increase not only in the number of clients accessing counselling services, but also in the severity and complexity of presenting issues. HEFCE, now part of the Office for Students (OfS) cited a 42% increase between 2010/11 and 2015/16 in the number of students declaring a mental health disability on application to university. There has also been an upsurge in the number of students from non-traditional backgrounds, due to the Government's commitment to widening participation that seeks to increase the number of students from under-represented groups accessing higher education. These students may need particular support in order to reach their best academic potential, as they may face additional hurdles in the transition to HE.

There has also been a shift in perspective because of higher fees, with students now seen, and seeing themselves, as 'customers' who have rights that come with that label. This view of being 'customers' may have a legal status, as if universities and other higher education providers do not meet their obligations to undergraduate students they may be in breach of consumer law.

Many university counselling services are now BACP accredited, evidencing their good professional practice, and the BACP has produced a detailed competency framework for counsellors in HE and FE in recognition of their particular context and challenges.

Clinical work

The cornerstone of most of these services is offering counselling to individual students, alongside therapeutic and psychoeducational groups. Some services counsel staff as well as students. The most common issues students present with to counsellors are depression, anxiety, problems in relationships, and loss, often resulting in academic difficulties such as procrastination and lack of motivation. Some of these concerns are similar to those of the general population. What is different is that these difficulties can be triggered by academic requirements and other aspects of student experience and their impact on the ability to study.

Counsellors in HE are experts in working with these pressures. They are aware in particular of the challenges that being in a time of transition provokes, and the therapeutic possibilities for personal maturation, employability, and life-long awareness of supporting their own mental health that are available if counselling interventions are timely and sufficient.

An initial consultation will usually include a risk assessment to determine a student's state of mind and the urgency of their need for support and signposting. Different models of counselling support are offered, according to their university's resources and the needs of its students. Some have a single session model with the option of a later follow-up, others offer a stepped care service. Some services counsel by Skype or other video platform, which may be particularly supportive for students who are overseas, have mobility difficulties, are carers, or are on placement. Many also offer email and telephone counselling for those clients who are unable or unwilling to present in person. The offering of early morning and evening sessions enables access to clients whose placement, work, or home commitments makes it difficult for them to come during normal working hours.

There has been an increase in short-term work by counsellors of all orientations, with a focus on a personal crisis, an adverse life event, or a current issue that is impacting on the student experience and academic study. Longer-term therapeutic work, which can focus on exploration of more complex developmental issues, and deeper-seated and long-standing emotional, psychological, and mental health problems, is less available in university and college counselling services than in the past due to the pressure of increased client numbers. However, many services support and hold students with more intransigent mental health difficulties, especially when the student is struggling to contain their behaviour, is unwilling to access other internal or external services and/or there is a delay in securing psychiatric care, and when tertiary support is reduced or withdrawn. It is common that when a psychiatric crisis has reduced in intensity, mental health care is also lessened, and patients are often returned to university services for their ongoing care, including counselling, mental health, welfare and disability services, and online support.

Although a university counsellor should not diagnose or aim to treat severe mental illness, many services have specialists, including mental health advisers, who offer support to enable clients with mental health issues to manage their symptoms, working together with local mental health services on tailored care packages. However, with NHS tiers 3 and 4 services being stretched, university students who are NHS patients are frequently referred to their university's counselling service.

Risk assessment and referral, when appropriate, are an intrinsic part of the counselling work. All counselling services acknowledge the importance of being able to recognise symptoms that may indicate a mental illness, acknowledge their boundaries, and know when referral to medical and psychiatric services is necessary. This is a requirement of the BACP *Ethical Framework for the Counselling Professions* (2016) that many services adhere to, which emphasises the need to work to professional standards within the practitioner's competence ([BACP Ethical Framework for the Counselling Professions](#))

A high proportion of students who are referred to secondary or tertiary mental health services can be expected to make use of the flexible and prompt support that can be offered by university counselling services to complement the treatment received through the NHS. The establishment of links with local medical and psychiatric services for consultation and referral has always been seen as an essential part of their work. Some services have been able to access dedicated psychiatric consultancy and support. Others have regular meetings with their NHS mental health trust to discuss joint clients/patients so that they are offered a timely and appropriate service.

Services routinely evaluate the effectiveness of their counselling using outcome measures such as the Clinical Outcome in Routine Evaluation (CORE) or other scales to track changes in clients during the course of counselling as well as to assess the effectiveness of counselling.

Most services evidence the impact of their work by offering clients an anonymous evaluation questionnaire on which they can record their experience of counselling and their own estimation of its effectiveness.

Working proactively with the wider institution

The MWBHE / UUK *Student Mental Wellbeing in HE Good Practice Guide* (2015) supports a 'whole university' approach to the mental wellbeing of students. The Guide offers advice on the development of policies and procedures, raising awareness and training, legal considerations, and support and guidance structures so that all members of staff within the university, including senior management, are aware of their responsibilities to mental wellbeing.

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

All university counselling services offer consultation to university staff members concerned about students' wellbeing. This can lower staff anxiety about students and help them to judge whether or not a referral to counselling or other internal or external service 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.

Counsellors frequently offer reports on mitigating circumstances, to enable academic staff to evaluate the impact of students' mental health difficulties on their academic studies.

Training

Most counselling services run a variety of training programmes to guide staff in their work of supporting students, on subjects including supporting distressed students, suicide prevention, and stress management. Many also train and supervise students who are buddies, residence and academic peer mentors, as well as frontline staff, security and advice services, and other groups and departments that have contact with students.

Psychoeducation

Many services offer students a range of wellbeing initiatives, and workshops on, for example,

- Mindfulness;

- Procrastination;

- Examination anxiety;

- Transitions;

- Stress;

- Relationships.

These services can supply written and internet-based information about common emotional and learning difficulties. Self-help information (e.g. bibliotherapy, leaflets on issues particularly pertinent to stu-

dents, and online resources) is available for those students who prefer to access books, websites and online self-help support. Some counselling services make use of the opportunities afforded by e-technology by, for example, offering online discussion boards or providing web-based self-help programmes.

Counselling services work with student unions, societies, and other student support staff to promote mental health and attend inductions and fairs to publicise and raise awareness of their offerings.

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

Many counsellors attend wellbeing working groups and residence referral meetings to advise on the mental health care of students of concern. They collaborate closely with their institution's disability service, MHAs, international service, study skills support, academic departments, security service, widening participation unit, chaplaincy, student union, as well as other student support and welfare services.

Counselling services have frequently developed a university-wide mental health strategy and a 'whole university approach' (Caleb, 2019). They collaborate in the construction of policies and procedures such as mental health and wellbeing, fitness to study, diversity and equality, mitigation, returning to study after abeyance, and crisis intervention.

Many counsellors are invited to serve on relevant university committees and working parties. They are able to use these forums to feed back to their institutions their perspective on the impact of its practices on the student experience, and trends that need consideration.

External liaison

University counsellors are aware of their professional boundaries and the recognition of symptoms that indicate the need to refer clients on. To this end, university counselling services create relationships with internal (for example wellbeing, mental health advice and disability services) and external partners (including the GPs, local mental health trusts, as well as voluntary agencies such as Samaritans and Mind) in order to signpost effectively. This will be done in partnership with mental health services within the institution where relevant.

Counselling services aim to forge close links with their local NHS services. The response to their approaches has been varied in achieving this ambition. However, comprehensive networks had already been established in some cities which have several universities and colleges. For example, the universities and colleges in Leeds have joined up to develop a close working relationship with the local primary care trust, CMHT, and GPs; the Oxford Student Mental Health Network has built a coalition of educational establishments and NHS providers to share ideas and offer relevant training. Where counselling services have developed close relationships with their local NHS Mental Health Trust, this enables regular meetings to discuss joint patients so that there is effective and responsive collaborative care.

Professional standards

Important guidance documents include the BACP *Ethical Framework for the Counselling Professions* (2016) ([BACP Ethical Framework for the Counselling Professions](#) and the BACP *Competency Framework for Counselling in FE and HE* ([Further and higher education competences (bacp.co.uk)](#).

Most university counsellors are graduates, many with higher degrees, trained in counselling, counselling psychology and/or psychotherapy, and with a substantial amount of post-qualification experience.

Some services employ clinical and counselling psychologists as well as cognitive therapists. Regular and ongoing clinical supervision is a requirement for all BACP and UKCP members who are practicing counsellors and psychotherapists. Continuing professional development is a requirement for maintaining competent practice.

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. A large number of the university counselling services themselves have gained service accreditation with the BACP. The BACP Universities and Colleges (BACP UC) is an expert 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 wellbeing of students. The taboo about mental ill health seems to be lessening and more students are willing to seek support for their emotional difficulties. However, the increasing number of clients may challenge the quality therapeutic work that is offered unless counselling services are resourced accordingly.

Research has shown that students who have experienced counselling feel that they were positively supported, both in terms of academic achievement and their overall student experience. They were also able to develop skills that would enhance their future employability (BACP, 2012, Impact of counselling on academic outcomes: students (bacp.co.uk)).

There is an ongoing concern about the increasing mental health needs of students and what counselling services in HE are resourced to provide. It is crucial that the work of HE counselling services is safeguarded and developed so that university students will continue to enjoy their best possible experience of university life and their highest potential for academic achievement.

Mental Health Advisors

Brief history

The Mental Health Advisor role was developed as part of a HEFCE-funded project at the University of Northampton from 1997 to 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 MHAs 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, Loughborough, 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 HEIs

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 five members. UMHAN now has 235 MHAs and 15 managers registered at 127 institutions.

Some institutions have taken a different approach to mental health provision and have brought a range of health-related capabilities together to create 'health and wellbeing teams'. Others, despite not appointing a MHA, offer specialist advice through, for example, their disability or counselling services or their health centre. Universities that have Mental Health Advisers are often members of the University Mental Health Advisers Network (UMHAN) and can be found on the UMHAN website (https://www.umhan.com/pages/2-about-umhan)

Since this report was last updated in 2011, the demand for mental health support at HEIs has continued to increase, and the government has opened up the market to competition from external providers independent of university services. Regulation of these providers has followed, and between January 2016 and December 2019, all mental health advisers and specialist mental health mentors delivering DSA (Disabled Students Allowance) funded support were required to register with, and be audited on a yearly basis by, DSA QAG (Disabled Students allowances Quality Assurance Group). DSA QAG ceased to operate in December 2019, but the Department of Education (DfE) expects service providers to adhere to the key principles and standards underlying the quality assurance framework. They should only employ staff who meet the qualifications listed in the professional body matrix (see appendix). Any new service providers are required to register with the DfE. All service providers are expected to maintain registration with a relevant professional body (e.g. social work, nursing, occupational therapy, UMHAN membership). Please see the section below for more information about DSA-funded Mental Health Mentors.

Professional background and qualifications

The majority of MHAs are educated to 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, with a post graduate qualification in mental health or psychological therapy. They will also usually have had several years' experience of working within NHS mental health services or other adult mental health settings. Most are employed by the university (although there are a handful employed by the NHS). They are usually largely recognised as a team or service in their own right, but may be located with disability or counselling services.

Supervision is an essential working practice for Mental Health Advisers and Mentors due to the complexity and demands placed on these practitioners, and the need to ensure safe, effective, and accountable practice on behalf of the organization to the staff they employ and the students their staff aim to serve. In line with professional practice standards, most HEIs fund regular monthly clinical supervision for their MHAs, conducted by suitably experienced professionals. These are often clinicians working within local NHS mental health services.

Roles and responsibilities

Direct work with students

Mental health advisers specialise in assessing how a student's mental health difficulties may affect their education. They will explore these with the student, advising on strategies and interventions to enable successful progression in their studies. MHAs often facilitate practical arrangements within the education context and are therefore able to utilise context-specific networks to reduce barriers to education.

Similarly, through their active involvement and partnership working with healthcare providers, MHAs are in a position to ensure that practical support and therapeutic/medical support complement one another. 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 illness 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 and is informed by statutory service provision.

MHAs offer support to applicants and newly enrolled students with experience of mental ill health during their transition to and from university. It is easier to identify students who may benefit from MHA 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. However, some individuals choose not to disclose a history of mental disorder. While disclosing is not a requirement on application, failure to disclose can lead to crisis situations, academic underperformance, or even failure to progress if adequate support and adjustments have not been considered. More needs to be done to encourage applicants and students to disclose any mental illness, for example by making clear that to do so will not incur any sanctions in relation to undertaking their education.

If any mental illness is declared, access to an adviser will provide space for current or prospective students to consider how their difficulties may affect their education. The MHA will assess and advise on education-specific resources and reasonable adjustments which might be possible, to facilitate the same opportunities for successful progression as for those who are not experiencing their specific difficulties. In collaboration with the student, advisers can assess individual learning and teaching requirements and share these with tutors and others (e.g. residential staff) on a 'need to know' basis. This helps to ensure that tutors understand the difficulties a student might experience, and the adjustments that would promote learning and progression. Many students find this helpful, particularly if on a joint Honours course, as it can be very daunting for a student to contact each tutor individually to share personal information and negotiate adjustments without support.

Advisors can recommend adjustments in assessments 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.

MHAs provide self-help information and offer guidance and support to help students better manage their mental wellbeing, 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 and panic attacks, manage self-injury, and cope with depression. Some one-to-one support can be funded through the Disabled Students' Allowance. The adviser might suggest that the student applies for DSA and support them through the application process.

If a student's mental health is causing concern to them and/or others, the adviser can liaise with their GP (with their consent) and can support them 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 MHA role. Many students find accessing mental health services challenging, particularly if it is the first time they have required a formal mental health assessment. A MHA may be able to offer consultative support to staff to facilitate an early intervention response to emerging concerns. The adviser can act as a bridge between higher education, the 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 MHAs 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 HEIs when there are different perceptions of the urgency or seriousness of a case. For example, academic failure may not be viewed as seriously as losing a job by statutory mental health services, yet the consequences may be as significant for a student's immediate and long-term prospects. 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 HEIs, staff often require support or reassurance regarding their contact with students who are causing concern. The adviser can offer guidance, advice, and training for staff in supporting and responding to students presenting in distress, or those whose behaviour is causing concern.

Other responsibilities

MHAs 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 wellbeing 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 wellbeing alone or in collaboration with external agencies or internal services such as disability advisers, counsellors, or the students' union. They may also run therapeutic groups or facilitate support groups for students.

As many HEIs currently employ just one full- or half-time MHA post, their resources are limited, and it is often a demanding role. However, it is very rewarding when students can progress and develop the life skills and self-confidence essential to recovery and social inclusion both within and outside of the university setting.

Mental Health Mentors

Mental Health Mentors only work with students who have been awarded DSA funded support. Some are employed by HEIs and others are self-employed or work with independent non-medical support worker services. They need to be able to understand the individual student's mental health diagnosis, their lived experience, and the impact of having a mental illness on their capacity to learn and succeed on their university or college programme.

Students who are allocated specialist mental health mentoring often have a diagnosis of depression and/or anxiety, bi-polar disorder, eating disorder, personality disorders, schizophrenia, or social anxiety. Frequently, students present with co-morbid issues, which can include drug and alcohol misuse. These students are often on prescribed medication.

Specialist mental health mentoring involves assisting students to gain insight into the psychological mechanisms at play in their difficulties, and to learn to monitor and manage their mental and emotional wellbeing. They also need to become aware of the triggers that may cause them to become unwell. Mentors can support them in devising strategies and study-related skills that can lessen anxiety about their work. The relationship also provides practical learning support tailored to the student's specific needs; the regular appointments with and reliable presence of a calm and thoughtful mentor can often make the difference between the student's success or withdrawal from the course.

Quality assurance and accreditation

Mental health mentors liaise and collaborate with other specialist staff within the university, such as mental health advisers. This is to ensure that the needs of the student are considered from both community (equality) and personal (self-management) perspectives concurrently. This collaborative approach ensures that additional or different resources/arrangements within the University can be brought to bear to better reflect or support changing personal resources and circumstances.

For quality assurance mental health mentors are required to be accredited and meet quality assurance standards defined by the Department for Education. This includes mandatory qualifications and appropriate supervisory arrangements.

At the time of the writing of this Report, Scottish students are unable to access DSA funding for Mental Health Mentoring. This issue is currently being considered by the Student Awards Agency Scotland.

Disabled Students' Allowances

Any student with a diagnosed mental disorder may be eligible for the Disabled Students' Allowances (DSAs). This section highlights some of the important issues but does not claim to be exhaustive. It should also be noted that policy and practice are subject to change so students should always be advised to seek advice and support from the MHA or disability adviser at their HEI.

Grants are provided under DSA to help meet the extra course costs students can face because of a disability, including those arising from mental disorder and specific developmental disabilities such as dyslexia and autistic spectrum disorder. They are paid on top of the standard student finance package and do not have to be repaid. The amount depends on individual need and not household income. The allowances are available to eligible full-time and part-time students (including those living in the family home), although the amount awarded to part-time students depends on course intensity. Both undergraduates and postgraduates may apply.

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; enabling software, such as mindmapping applications to aid information processing and memory;

- Non-medical helper(s), e.g. mental health adviser/specialist mentor or study support tutor (particularly helpful if a student has had a long break from study because of ill health);

- Extra travel costs related to course activity 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 can be accessed to reimburse additional cost such as photocopying and printing.

Changes to funding implemented from September 2016 mean that students are expected to contribute towards the cost of purchasing a computer. Nevertheless, HEIs will sometimes recognise that some students with disabilities might not have access to savings of this amount and will consider awarding funds to aid purchase of recommended equipment. Students are advised to contact their disability team for further advice.

Further information on the application process is available at https://www.gov.uk/disabled-students-allowances-dsas. Students who receive an NHS bursary can obtain information on www.nhsbsa.nhs.uk/student-services.

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

To apply for the DSA, students should contact Student Finance. To be eligible, their condition must meet the definition of disability under the Equality Act 2010 in that it has or is likely to have a substantial and long-term negative effect on functioning. Applicants will be asked to provide medical proof of disability such as a letter from their GP or specialist. A proforma for providing medical evidence can be accessed via https://media.slc.co.uk/sfe/nysf/sfe_dsa_disability_evidence_form.pdf.

Once Student Finance 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 are likely to be most familiar with the resources available. This assessment can take place before the start of the higher education course, and this is advisable. Students who receive an NHS bursary can obtain information on nhsbsa.nhs.uk/student-services.

It is advisable for any prospective students to contact their HEIs disability team and/or mental health service even if DSA is not in place, so anticipated adjustments and support can be accounted for prior to arrival. Guidance may also be sought in applying for DSA.

Any recommendations, such as a mental health adviser or mentor, will be considered as part of the student's Study Needs Assessment and can only be supplied if the support is:

- required for study-related reasons;

- required for reasons related to their mental health difficulties;

- not already provided by another source (e.g. from the university or college);

- not provided by friends or family members of the student, due to the potential conflict of interest.

'Non-medical helper' is a term which embraces different roles, including dyslexia tutors, mentors for students with autistic spectrum conditions, and, specifically in relation to students with mental health difficulties, the most common non-medical helper recommendation is called specialist mental health mentoring. This can be delivered by University mental health advisers or mental health mentors who can be independent of the student's university.

5. Health services context

Pathways to psychiatric care

The standard route into NHS psychiatric care is referral by a GP. Some 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.

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 HEIs have a university medical service this is far more effective and straightforward than in those institutions that do not have a 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 where the student is able to access it, 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 Community Mental Health Team (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 an acute psychosis or is very disturbed there may be 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, eating disorder, Emerging Personality Disorder, Autism and ADHD services. The provision of these services varies widely from one area to another.

In general, there is limited direct access to NHS secondary care for potential patients or for 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. Second, 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, the filter provided by 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 (e.g. the student with an acute psychotic breakdown) in which direct access to secondary care can be of enormous help to troubled students. In many institutions MHAs 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 in-patient psychiatric treatment, usually on a voluntary basis, but sometimes after being detained under mental health legislation. In recent years there has been a trend away from in-patient treatment towards community-based treatment using 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 for local services to avoid involvement as they may fear, rightly or wrongly, that little can be achieved within a short time frame. 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. They 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 are made aware of the academic and social experience of the students in the populations that they serve. 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 MHAs.

Mental health service transitions

The transition from childhood through adolescence to adulthood is a crucial stage of social, personal, and emotional development. Most mental disorders have their origins in the teenage years (Jones, 2013) and many have precursors in childhood. As outlined previously in this document, the years 16–24 are a particularly critical period of vulnerability to mental illness, as well as a period of major physiological, emotional, and social change in young people's lives (Jones, 2013).

The different professional cultures of child and adolescent mental health services (CAMHS) and adult mental health services (AMHS) have contributed to differences in theory and practice, and eligibility thresholds for access by young people. The traditional age split between CAMHS and AMHS has resulted in services being described as 'weakest at the point of highest need' (McGorry, 2007). This weakness is substantiated by research findings (Singh et al., 2010). A number of risk factors for poor outcomes have been identified for young people in transition to adult services, such as becoming 'lost in the system' and having nobody to support engagement with adult services. Many papers outline the problems and pose possible solutions (Lamb et al., 2008; Singh et al., 2010; Parker et al., 2011; Social Care Institute for Excellence, 2011; Birchwood & Singh, 2013; Department of Health, 2015; NICE, 2016; RCPsych., 2017).

The issues and risks for poor outcomes are even more relevant to the transition and transfer of care with respect to students moving into adult mental health services at the same time as a move to Higher Education. Across the jurisdictions of the UK, guidance is available on ways to achieve optimum transition and transfer of care of young people requiring ongoing mental health support and intervention, and these too are applicable to the student population.

Qualitative research carried out across the UK has identified elements that are important for successful transition of care, including preparation for transition, case management, strong therapeutic relationships, joint management of care, and flexibility regarding point of transfer (NICE, 2016). An additional protective factor that promotes an effective transition is having a trusted adult who takes on the key role of transition or link worker, and is the sole point of contact for the young person during transition (Department for Education, 2003; Lamb et al., 2008; NICE, 2016). Key policies and guidance relating

to adolescent mental health specify the need for the full participation of the young person in these processes (United Nations, 1989; Department of Health, 2000; Department for Education, 2003; Lamb et al., 2008; Birchwood & Singh, 2013; Paul et al., 2013; NICE, 2016). The MindEd website (minded.org. uk) was created with a parent co-author and outlines how a parent or carer can support a young person in achieving a good transition from CAMHS to AMHS.

The key principles outlined in all these documents are supported by the NICE guidance on transitioning from child to adult services (NICE, 2016). These guidelines include involving young people, parents, and carers, ensuring that transition occurs at a developmentally appropriate time, providing continuity of support before and after transition, using a person-centred approach, and ensuring that different agencies work together. NICE recommends that good transition planning should include the designation of a named worker that the young person trusts, who will act as a link between adolescent and adult services and provide continuity of support for a minimum of six months before and after transfer. It also recommends that transition planning has a focus on building independence, makes use of peer-support groups and mentoring, and builds in support for education/training and health and wellbeing. NICE includes a recommendation for young people's passports – documentation compiled by the clinician and the young person that includes all relevant background information, diagnoses, intervention history, risk management strategies, and protective factors.

NICE also recommends that attention is paid by NHS organisations to the supporting infrastructure for transition, e.g. ensuring there is a senior executive accountable for transition strategies, and an operational-level champion supporting the process and reviewing effectiveness of the local strategy.

The transition to university will usually take place at a time when the young person is mentally well. The process of getting into university requires planning and preparation over many months. There is therefore more than adequate opportunity for health services to plan for transition of care.

These factors may not apply when transition out of university occurs because of the first-time development of a mental illness or recurrence of a long-standing disorder. Here, the student may be acutely unwell and have no prior engagement with services either at university or at home. The student who drops out of university may have a sense of failure and loss in addition to the symptoms of mental illness. Dropout may lead to loss of contact with friends and other sources of social support. As discussed in the section on student suicide, this may be a time when the student is at high risk of suicide.

It is therefore imperative that all possible steps are taken to ensure that there is no break in continuity of care between university and home. This will require active liaison between psychiatric and GP services serving the university population and those in the student's home area.

The proposals in the NHSE Long-Term Plan to develop models of service based on a 0–25 age range has the real potential to address some of the transition issues faced by students with mental health issues. It will be important to consider the additional complexities that students moving away from home to university face when developing these types of services.

General medical care of students

All higher education students, including international students, are entitled to be registered with a general practitioner in the United Kingdom. The vast majority of these will already be registered with a GP before they enrol into their chosen university. For those students who remain at their family home and commute to their university, there will be no need to re-register with a new general practice. On the other hand, for those students who move away from home to attend their chosen university, it is essential to re-register for GP services.

Students should ensure they are registered with a general practice in the locality of the university at the start of their studies. Most university health practices make active efforts to have new students fully register in the first few days or weeks of university enrolment. This provides the opportunity to screen early for pre-existing medical problems including mental illness. Sometimes students do not register initially but then register when they first develop a medical problem. This can lead to delay in diagnosis and treatment of any condition.

In most situations, the student's GP will be the primary link between NHS and higher education services. In the event of acute illness, the GP is usually the first port of call either for the student or the higher education institution (or even the student's parents). Practices used to dealing with university students are well aware of the particular issues related to the student group and have systems in place to cater for their specialist requirements. This is true in respect of the management of acute illness, and the continuity of care and follow-up of long-term medical conditions.

Apart from a few exceptions where the student health service is directly provided by the university, most primary care health services for students are provided by mainstream general practices. Many of these are former university-run student health services and most continue to have strong links with the welfare services within the university. In other cases, practices attract large student populations because they are located in close proximity to the university or college campus. Such practices may have no formal link with the higher education institution.

There is no facility for students to remain registered with their original general practice and also register with a practice in the vicinity of the university (so-called 'dual-registration'). Whilst this might appear an appropriate arrangement to promote, there are also strong arguments against it. There is good reason to assert that it would cause more fragmentation rather than better continuity of care. It could create risk in relation to prescribing if a student is receiving medications from two independent sources who are unaware of what the other is prescribing. Additionally, GP payment formulas are based on capitation. Assuming there will be no additional payment relating to patients being dual-registered, the payment is likely to be split between the two general practices. This may result in university-based practices becoming even less financially viable. It is also possible that one of the dual practices would do the lion's-share of the care whilst having to share the reimbursement with a 'silent-partner' practice.

Therefore, it is important that students are registered with a general practice within the locality of their university. Although students can spend a significant proportion of the year away from the university setting they spend more of the year based at university. Those who have moved to attend university are more likely to need the services of primary care whilst they are lodging in the university locality, not least because of the lack of 'soft supports' they would have access to living in the family home.

It is also important to have easy access to primary care during term time, to afford continuity of care and monitoring of ongoing conditions that might affect academic performance (e.g. physical conditions such as asthma and diabetes, or psychological conditions such as depression, bipolar disorder, or eating disorders). The student would remain registered with their 'university' GP practice during university recesses. The longest of these recesses would obviously be over the summer months. During these times, the student can still consult either face-to-face or by telephone, and some GP practices also have facilities for email advice. Arrangements can be made for repeat and acute prescriptions.

If necessary, students can also register as a 'Temporary Resident' for up to three months if they are residing during vacations outside the boundaries of their university-located practice. If home-based practices insist that students fully register, the student will automatically be de-registered from their university-based practice. This initiates a transfer of medical records which can take months and then needs to be done again when the student returns to university. Alternatively, some students have been

told by the family practice that if they de-register at the point of going to university they will not be allowed to re-register. Neither of these practices can be supported in the interest of the student's health!

The Student Health Association (SHA) is an association of general practitioners and primary care nurses who provide services to students, either exclusively or as part of a larger practice population. Their motto is 'Representing specialists in student healthcare'. There is an involvement and experience in the management of student mental health which is considerably greater that that provided in routine GP settings. They are more cognisant of the effects of mental disorder on academic progress and the impact of academic pressures on student mental health. In such cases, GPs often liaise directly with student counselling services, disability services, MHAs, academic staff and university support services, NHS specialist services and voluntary services.

It is very important to emphasise that most cases of mental distress and disorder 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, 2009a) and the monitoring of patients on antipsychotic medications (NICE, 2009b).

Arrangements for communication and referral between medical practices and university counselling services vary from institution to institution. Where Higher Education institutions have an identified affiliated GP practice this communication is far more effective and straightforward than for those institutions which do not have a close relationship with a single primary care provider. It is helpful if clear channels of communication are established and relevant information is shared. This will require the consent of the individual student, but most students are generally happy to give this.

One intention of the current GP Contract was to achieve improved assessment and management of chronic diseases such as coronary heart 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.

Additionally, the General Medical Services contract for GPs has a complicated capitation formula, which provides funding based on factors such as levels of deprivation, elderly patient numbers, and numbers of patients living in residential and nursing homes. This also disadvantages practices with high numbers of young patients, meaning that the 'weighted-list' on which payment is made can be significantly less than the actual practice list size. These elements of the GP Contract result in underfunding of GP practices with high numbers of students, and do not take into consideration the high demands for physical and mental health care arising from the student population. They take no account of the high turnover of the student population, which adds a significant extra burden to the primary care workload.

General practices providing for students have been recognised by the NHS as 'Practices serving Atypical Populations'. This status was declared in NHS England's *Guidance Note: GP Practices serving Atypical Populations* (NHS 2016). This document advises local commissioners to identify and support the practices that serve these populations in order that patients will continue to receive effective primary care. This has allowed some university-based general practices to obtain funding for enhanced services such as appointment of a Community Psychiatric Nurse.

What to do if a student with a mental health disorder 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 adviser, he or she may be able to advise on how to do this. MHAs 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 MHA 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. The UMHAN directory of Mental Health Advisers provides contact information (umhan.com/pages/7-mental-health-advisers).

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. They may struggle to form relationships with peers and as a result become socially isolated. They 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 is 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.

Prospective students should contact disability services at their university to enquire about support that is available. A disability officer or MHA 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 their 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:

Has the patient taken into account the likely stresses they are 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 the 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 wellbeing?

- 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's 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. possible reliving unprocessed traumas and fear of failure, especially if they are returning to university after interrupting their studies because of illness).

- Placements: if the course requires that students undergo a placement, then have the implications for home-life and employment (if they have a job) been considered? Have travel implications and time-commitment issues been considered?

- 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?

- The impact of the size and location of the preferred university on the student's mental health should also be explored by their mental health professional. Some students will be able to cope with studying at a university with more than 30,000 students in a large city such as London, while other students will not be able to do so.

- 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?

- 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 MHA, 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.

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 MHA 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.

- 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 effectively as possible. If there are relapses, discuss and agree a plan of action. If possible, liaise with the MHA or the university disability service when doing this.

- If the patient is taking medication:

  - How is the student going to manage their medication while at college, i.e. are they able to renew their prescriptions and/or take their medication without supervision?

  - Discuss how this may affect their ability to focus, concentrate, and summon enough energy to complete their assignments and studies, as well as participate 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 the possible impacts of their illness and medication on ability to study.

In summary, whilst students possibly represent a psychologically vulnerable population because of the stresses involved in university life, the problems faced by students who already have a mental health problem are particularly important to address, as this may create an obstacle to successful completion

of academic courses, with subsequent loss of opportunities as well as the mental health support offered by satisfying employment.

The suggestions made in this section are for mental health professionals who can alert and prepare their patients to the problems they are likely to face, and to bolster their attempts at an effective partnership of care with relevant university agencies.

If there are serious doubts about the prospective student's ability to cope, it might be better for them 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 their 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.

6. Collaborative working between health and higher education-based 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.

There should be an emphasis on the maintenance of a student lifestyle that enhances good mental health and gives the student resilience to better deal with the stresses and disappointments that are inevitable at some point in their time of study. To this end Universities UK have published an initiative: *Minding Our Future: Starting a conversation about the support of student mental health*. https://www.universitiesuk.ac.uk/policy-and-analysis/reports/Documents/2018/minding-our-future-starting-conversation-student-mental-health.pdf

This initiative recommends a Whole System Approach within universities in respect of student mental health and looks at ways and means to enhance collaborative working between health and higher-education-based services. For a large proportion of the student population university life will be a rewarding and life-enhancing experience. However, for some students the transition might be problematic or come at a time when there are other life factors that may be adversely affecting the student's mental health (some that may be at greater risk would include those with pre-existing psychiatric illness; those with a history of childhood trauma; those coming out as gay or lesbian; transgender students and those with a history of autistic spectrum disorder or eating disorder).

Mechanisms need to be in place for staff awareness and vigilance for students who may be developing problems, and to provide support including signposting to NHS services when these are required. On the other hand, the move from home and school to university will, for many young people, be a move to a more therapeutic environment. The transition to independent living and study can be a catalyst to a more healthy and resilient existence. This group also needs support from their university in their continued development.

One problem that arises is the 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 are 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 (e.g. GDPR). There are restrictions on the extent to which confidential clinical information can be disseminated outside the NHS. 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 MHAs 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. There are already examples of University Support Services, GP services, and NHS mental health services piloting or developing shared care arrangements. An example of an innovative, integrated

system in Greater Manchester is described in Appendix V. Other examples include Sheffield University, Huddersfield University, and the two universities in Belfast, to name just a few. This is very much work in progress!

If HEIs 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, MHAs, and NHS services under a single organisational umbrella. The downside of this is the risk that understanding of the structures and cultures of HEIs would be lost. Furthermore, it may have the effect of inappropriately 'medicalizing' lower levels of mental distress which the university support services currently deal with very effectively.

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.

Another concern expressed by university counselling and support staff relates to students diagnosed with emotionally unstable personality disorder. These individuals often engage in repeated deliberate self-harm and other self-destructive behaviours such as binge drinking and drug use. Hall wardens and other university staff are often called upon to intervene and provide support at times of crisis. These students can cause considerable anxiety because of implied or explicit risk of self-harm and suicide. University staff often feel unsupported by NHS mental health services in these situations, and left to cope with problems and manage risks that are beyond their skills and remit. These individuals are demanding and require skilled management. It is important that mental health services accept primary responsibility for this group of students.

Better networks of communication between HEIs 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. It is especially important that HEI staff are able to get rapid access to advice and assistance in psychiatric emergencies.

The Government should be actively facilitating, and providing resources to enhance and formalise, these networks of communication which at present can be ad hoc and sometimes poorly defined. HEIs should incorporate these strategies into their corporate plans and NHS Mental Health service providers should be identifying how they can fulfil these obligations within their annual business plans. Student GP services within the locality of the university or affiliated with these institutions are an obvious interface between NHS and Higher Education Services. The GP service should be actively involved with service liaison. This, of course, will require sufficient resourcing for those GPs with whom the higher education students are registered!

Principles of integrated practice

The following principles should be applied to integrated working:

1   **Strategic development of care pathways for students would ensure that services sustains local best practice.** Student populations should be regarded as an atypical population in commissioning primary care services, to ensure students' health needs are met. Stepped pathways between local mental health services and the educational

setting should be developed to assess needs and ensure students receive appropriate support at each step of the pathway. Conducting joint Strategic Needs Assessments for the geographical area would be beneficial. For more information visit: https://www.universitiesuk.ac.uk/minding-our-future

2   **It is important to establish networks between university and local mental health service providers.** This aids understanding of each other's services, good working relationships, and appropriate signposting and referral. Inductions for new healthcare staff should include establishing working relationships with University-based support networks. Some universities have been proactive in inviting local statutory and voluntary services in, to encourage local networking. Reciprocal engagement is important for asset mapping, as well as health and educational outcomes. University Mental Health Day activities are good examples of opportunities to focus attention on shared issues. The Oxford Student Mental Health Network offers information and training to HE and FE staff and students, and for health care staff. For more information visit www.unimentalhealthday.co.uk and http://www.osmhn.org.uk/

3   **It would be helpful if the key member of staff supporting the student within the HE institution identified themselves and their role and responsibilities to external healthcare providers.** Universities are large organisations with staff who have differing roles, responsibilities, and job titles between institutions. Regular opportunities to update on changes are important.

4   **For students managing long term mental health conditions it can be helpful if the person providing their primary source of support within the university is invited to attend CPA (Care Programme Approach) reviews and/or discharge planning meetings.** This will enable joined-up working and ensure the impact of treatment on educational progress is considered. They can also make it clear that HE based services complement but do not replace statutory mental health care. Frequency and purpose of CPA reviews should take into account transitions commonly associated with student courses (e.g. placements abroad or moving out of Higher Education/locale).

5   **Communication policies based on shared legitimate interests, and boundaries of confidentiality, need to be agreed from both parties and communicated clearly to students,** so they feel more comfortable about liaison and can build trusting relationships.

6   **When managing waiting lists it is recommended that mental health care providers take account of the academic calendar.** Students are at a disadvantage to the general population in that first appointments may fall during an exam period or when they have returned home for vacation.

7   **Continuity of care during transition to university needs careful consideration.** Ideally the patient and their needs should be flagged up to NHS services prior to the student arriving at university. Referral is often dependent upon the person registering with a GP, which causes delays in allocation of healthcare. Referral to the university-based mental health service in the summer before the prospective student starts can lead to support during the transition and on arrival, and support and advice about applying for Disabled Students Allowances.

8   **It is important to reduce students' repetition of their situation to different services, and promote services having a shared understanding of the student's issues and needs.** The development of a 'student passport' would be helpful in this regard.

9   **Students should be encouraged to register as a temporary patient if initially reluctant to register with university-based GP practices.** Understandably many students are reluctant to move away from known and trusted sources of support. However, this causes problems with access to crisis and other mental health services, and to prescriptions for maintenance medications. A shared care arrangement between GP practices would be the ideal working forward, to enable continuity of care. Unfortunately issues such as funding arrangements and who would have overall clinical responsibility still need to be addressed before this becomes possible.

10 **MH care services inside and outside universities should work together to ensure students are not financially disadvantaged if they need to suspend studies or repeat a year of study due to ill health.** They need to ensure they write to the students finance body, quoting the student's customer service number, to explain the nature of the mental health difficulty and why this impacts on their ability to progress with their studies. Student finance request evidence of Compelling Personal Reasons (CPR) before they will consider providing additional funding for future study.

The challenges of moving out of university education

Students may leave or take a break from higher education due to: successful completion of study; lack of fitness to study or practise procedures mandated by their university; withdrawal or suspension of study due to ill health; and the need of time for recovery.

Universities offer a supportive space for personal development for people living with enduring mental health conditions. Moving away from that network of support, the flexibility that academic settings often provide, and their identity as a student can be daunting.

Successful completion of study

The workplace can offer exciting opportunities, but a very different environment and expectations. The financial implications of leaving study can also cause concern. In higher education financial support is offered via student loans and grants, and universities often offer bursaries and hardship funds for those from low-income households. These offer a non-stigmatising source of funding, and financial stability that is often lacking for people with enduring mental ill health outside of the education system. Although some students are eligible for benefits (and some receive them during their studies), the assessments for these can be stressful and uncertain. Anxiety about sustaining regular working hours and losing benefits can add to the fear of progression into the workplace and contribute to a deterioration in mental health.

To aid transition from university, it is advisable that university support services and external health care professionals involved in the treatment and care of final year students ensure that they are aware of financial and employment supports that are available following completion of studies.

This information might include:

- Citizens Advice and Community Law services can advise and support students in negotiating financial support and benefits to which they are entitled. Some universities invite these organisations on campus to supplement their own financial guidance services.

- University careers services offer students and graduates support to develop employability skills.

- Disability confident employers. There is a link to a regularly updated list of these employers across the UK on the .gov web page.

- The Equality Act (2010) requires employers to make reasonable adjustments to enable disabled employees to perform their roles. This might include earlier or later start times and time off to attend medical or therapy appointments.

- Access to Work, who offer advice, practical support, and grants to fund adaptations not covered by employers, such as taxis to get to and from work if unable to use public transport, or funding for a support service during absence.

- MIND & Rethink also provide advice and information about seeking employment.

- Jobcentre Plus schemes and Disability Employment Advisers at job centres in Great Britain, and Jobs and Benefits offices in Northern Ireland, also offer advice and support if a mental health condition is disclosed.

Fitness to study or practise

The majority of universities have frameworks and procedures to assist their appropriate action where the health and/or behaviour of a student give rise to serious concern. This may include risk of harm to self or others, or behaviour that is a significant cause of distress or disruption to others (UUK, 2015). Relevant professional or regulatory bodies will have their own procedures for students regarding fitness to practise.

The initial stages flag up concerns and can lead to offers of support and monitoring of the individual concerned. The final stage can mean a student is required to suspend their studies, or in extreme cases withdraw from study with encouragement to access treatment and support to overcome their difficulties. When the individual is recovered and feels ready to return to study or practice they may be required to provide evidence of fitness to do so, and they would be advised to engage with the university mental health or counselling service to support transition back to university.

Suspension of study

Students who decide to suspend their studies voluntarily (known as intercalation) due to ill health can be supported in making the decision by a mental health adviser, academic advice service, or course leader. 'Return to study' policies and procedures can then support the student's transition back to University. This allows for a managed and supportive return. The student is likely to be expected to engage with relevant support services, especially if they do not have external support in place. The rationale for this is to enable successful academic progression and avoid the financial costs to the student of repeated suspension and return to study.

It is essential that any health professional involved in the treatment of a student taking a break from study due to ill health supports their client by providing a letter to evidence the 'compelling personal reasons' (CPR) that led to the break and/or failure to progress with study. This should be submitted to the relevant student finance body quoting the finance customer reference number. This will enable the individual to access funding for further study in the future if they wish to do so.

Whatever the reason for the student transitioning out of education, continuity of care is again important, as outlined in the section above. The university and any external agencies involved in supporting the student at that time should work together to ensure that current health and care needs are communicated and transferred if the student is moving away from their university location.

7. International students

International students in HE

Universities and other HEIs in the UK provide an international environment, with students and staff from a wide range of national, cultural, ethnic, and religious backgrounds. International recruitment of students is driven by the pressure to improve funding, the opportunity to provide educational opportunities not available elsewhere, and by an understanding of the value of an international experience for all students, including UK students. There is a strong international market in student recruitment, with existing 'competitors' such as the USA, Canada and Australia now joined by European countries developing courses taught in English, as well as by countries in Asia and the Middle East, and particularly China, where costs may be lower and factors such as immigration less challenging.

Key facts and figures

In 2017/18 19% of all students in the UK came from other countries: 6% from EU countries and 13% from countries outside the EU (HESA, 2019, [Where do HE students come from? | HESA](#)). A large number of non-UK domiciled students study at postgraduate level, where they form 42% of all students on full time postgraduate courses. China sends overwhelmingly the most students to the UK, with nearly a third of non-UK domiciled students coming from there. The number of students from China is greater than the total number of the next three sending countries together, which are the USA, India, and Malaysia (HESA 2019, [Where do HE students come from? | HESA](#)). Numbers can be subject to political influences, both in the sending and the receiving country. For instance, the numbers of students from India has declined recently, partly following negative reactions in India to a perception that the UK is less welcoming to international students. These figures are broad trends; at some institutions, the proportion of international students at undergraduate and postgraduate level combined exceeds 50%.

International students and mental health

The term 'international student' is itself a wide umbrella term, meaning only that a student has travelled from outside the UK to study. As with any generalisation, it is incumbent on all working in the field to be mindful of the danger of moving from generalisations to stereotypes, based on assumptions or limited knowledge.

It is impossible to be knowledgeable of the complexity of the cultures represented in this student population, including the complexity of cultural attitudes to both physical and mental health. At the same time, it is important to be aware of the struggles an international student may have as they adjust to living and studying in the UK, with the possible impact on their mental health. This can be challenging for practitioners working with students, with limited time to provide an effective and sensitive response.

The move to the UK to study will always be a complex and demanding experience for an international student, whether a young person undertaking their first degree or a mature student undertaking postgraduate or professional education. Some of their challenges will be shared by all students, for instance developmental issues such as separation and independence, identity formation, new relationships forming and breaking, as well as the academic pressure of more advanced study.

Some concerns will be more particular to international students. Compared to UK students, their familiar reference points and 'anchors' are likely to be less accessible. These may include friends, family, familiar faces and places. In the home environment students will be used to functioning confidently, managing their environment and relationships, understanding how life works. Suddenly they can find themselves in a new environment where this is no longer the case, where they can feel unexpectedly de-skilled even in simple day to day activities. The impact of these changes is what is often termed 'culture shock'. Where things go badly wrong, for example unexpected financial struggles, difficulties in finding friendships, or academic failure, the psychological consequences can be severe. Students may also be reluctant to share difficulty with family and friends. While this may be true of UK students too, the possible loss of face or stigma of failure may accentuate the tendency for international students to hide difficulties. Although electronic communication such as Skype can make it easier to stay in contact with home, it can be tempting for students feeling lonely to isolate themselves further by relying on on-line relationships at the expense of face-to-face contact.

The expense of travel means that students may not be able to travel home more than once a year, if that. When other students can go home at weekends and vacations, these periods can be particularly lonely for students whose family and friends are far away.

Other specific concerns for international students can include studying effectively in a less familiar language, and adjusting to an unfamiliar study culture with new and different expectations. The high cost of study as well as possible family expectations may also increase the pressure. A student may have come to the UK to study having been a high achieving student in their previous study environment, and find the change of academic approach disconcerting. The UK system places emphasis on extended periods of self-organised study, a critical assessment of sources, and active class participation, all of which are to an extent culturally specific. It can be difficult for a student, used to a system with different emphases, to work out what is required to succeed academically in the new context, especially if feedback is not easy to interpret or, at worst, if it is delayed or scant.

Seeking help

Seeking help from a mental health professional, whether a psychiatrist, counsellor, or psychotherapist, may present additional barriers, particularly if the student is from a society where mental health difficulties carry a particularly strong stigma. While all societies have traditions of help giving and help seeking, turning to a stranger for help may feel unacceptable. The 'distributed' care system which exists in most universities can be confusing, with perhaps lack of clarity of the role of teacher, personal tutor, counsellor, MHA, and international student adviser. In addition, the system of accessing external specialist support through a GP (a culturally specific term in itself) may also be opaque as international students will often not 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 different expectations of medical services.

For example, the availability of or threshold for medication can vary from country to country. A UK psychiatrist or GP may come under pressure to continue prescription of medications they consider unwarranted, or to provide medication not approved in the UK. The way mental health conditions such as depression or anxiety are described is also culturally determined, and some students will describe emotional distress with physical symptoms such as headache, insomnia or gastrointestinal problems. It may be helpful to see what is considered as 'somatisation' simply as a different conceptualisation, and certainly unhelpful to see it as an 'avoidance'.

Mental health and stigma

The stigma of mental health difficulties exists in all societies. In some it may be more overt, which can inhibit students from seeking help. It is possible that where such stigma exists strongly, enabling a young person with mental health difficulties to study abroad represents on face value a "win-win" option. The stigma is distanced and replaced by the status of international study. Also, a student themselves may feel that moving abroad to study provides the opportunity for a 'fresh start'. Unfortunately, study abroad is unlikely to be a solution in either case and can indeed exacerbate an existing vulnerability or illness.

A student who develops a severe mental illness may have to suspend or leave studies and return home. The need to return home and/or suspend studies is likely to affect a student's immigration status significantly, and loss of leave to remain can greatly increase their stress levels. Psychiatric services may be less well funded in low- and middle-income countries and some medications may not be available. If continuation or maintenance medication is required, recommendations for this should take account of what is 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.

Conclusion

Institutions and health providers share a desire to support their student populations and help them to succeed, whatever their social or cultural background. It is incumbent on HEIs and health providers to work together to make the support available comprehensible, transparent, and accessible for all students, including international students, with sensitivity to their varying needs.

Useful links

Universities UK International www.universitiesuk/international

UUKi is the international arm of Universities UK, representing UK universities and acting in their collective interests globally. UUKi actively promotes universities abroad, providing information for and about them, and creating new opportunities for the sector.

UKCISA www.ukcisa.org.uk

UKCISA, the UK Council for International Student Affairs, provides advice for international students in the UK and universities, colleges and students' unions who support them.

8. 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 many reasons why these students are of particular interest to health services. One is that they are the NHS professionals of the future and the health service has a strong interest in ensuring that they continue through to the completion of their studies and training.

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 their chosen profession.

In 2015 a survey was carried out of mental disorder in UK medical students. The population was recruited from readers of the journal *Student BMJ* and seems not have involved representative sampling. Of 1122 respondents, 30% said that they had received treatment for a mental health condition in the course of their medical studies and approximately 15% said that they had contemplated suicide. A major concern was that 80% of those reporting problems said that the support they received was poor or only moderately adequate. (BMJ, 2015).

A further concern was the sense of stigma about mental disorder conveyed to students by their clinical teachers. This led to a belief on the part of students that it would be detrimental to their career progress to admit to the presence of a mental health problem and to seek help.

The GMC document *Professional behaviour and fitness to practise: guidance for medical schools and their students* (GMC, 2016) provides detailed information on what is expected of medical students. It sets out factors 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. Early warning signs include poor attendance and failure to engage with studies.

It states that mental or physical ill health can affect fitness to practise. It emphasizes the need for pastoral care to be provided separately from assessments of academic progress. It also points out that students have an obligation to seek and accept help for any condition that may impair performance, and that failure on the part of a student to meet this obligation may be as important as the impairing condition itself in determining fitness to practise. The GMC requires that any concerns about fitness to practise are addressed before a student is allowed to graduate. A doctor who has any clinical responsibility for a student should play no part in assessment of fitness to practise.

The option of referral to the medical school's occupational health provider should always be considered.

For nursing and midwifery students the equivalent document is the *Nursing and Midwifery Council: The Code* (The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates - The Nursing and Midwifery Council (nmc.org.uk))

In 2013, the UK General Medical Council and Medical Schools Council issued a document, *Supporting medical students with mental health conditions*, since updated (GMC, 2015). This recommended that

medical schools work to tackle stigma against mental illness and to provide a supportive environment for students. It emphasized the importance of clinical care being provided by clinicians who were independent of the medical school. It acknowledged the pressures faced by medical students from workload and the stress of encountering patients who are seriously ill. It pointed out that there is evidence suggesting that medical students are more vulnerable than others to conditions such as depression and anxiety. The document recommended that staff receive training in the identification of mental disorder in students.

It is important to counter the possibility that students might be reluctant to declare a problem because they believe that this will damage their future career prospects or that it will lead automatically to formal assessments of fitness to practise. That is why the GMC expects that medical schools will inform students that mental disorders are common and expected and that appropriate help will be given. A reciprocal obligation is that students will be open and honest about health problems. Students should be made aware that the use of illegal psychoactive substances will always lead to assessment of fitness to practise.

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. Those 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 wellbeing.

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, in many 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. As with a doctor who is providing treatment, 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, they 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 their 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.

A 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: good practice in handling patient information* (GMC, 2009: par. 36–39).

The GMC document *Welcomed and valued: supporting disabled learners in medical education and training* (GMC, 2018) sets out the obligations of medical schools and organizations involved in post-graduate training of doctors and offers suggestions on how disabled medical students and doctors might be supported.

The GMC document *Caring for doctors, caring for patients* (GMC, 2019) was produced in response to concern about the mental wellbeing of doctors. There is now considerable evidence to support this concern. To give one example, the 2018 National Training Survey reported that 25% of doctors in training and 20% of trainers in the NHS scored high or very high on a measure of burnout (the Copenhagen Burnout Inventory).

The report covers the problems of medical students as well as doctors. As part of applying to the GMC for provisional registration, medical graduates have to declare any health problems that might have an impact on fitness to practise. The commonest problems are those arising from mental ill-health. The numbers of medical graduates reporting depression, anxiety and stress have risen in the past four years and comprised 8% of all medical graduates in 2018.

Medical students report the same stresses and concerns as other students. There are also concerns that are specific to medical and other healthcare students. These include coping with patients who are sick or dying and witnessing serious untoward incidents. Medical students face higher financial pressures as a result of the longer duration of the medical undergraduate course. Shorter vacation times lead to reduced opportunity for paid work.

The report makes some recommendations that might improve matters. These include student-led peer support and mentoring, and training in personal wellbeing as part of the curriculum. Medical students

also benefit from well-organised placements and a sense of belonging. Medical schools should actively seek feedback from students and aim to meet their needs. They should have mechanisms for students to raise concerns about issues such as bullying and undermining. Confidential advice and support should be available to students. The report suggests moving to pass/fail assessment, at least in some subject areas. Finally, the report recommends monitoring of student wellbeing and having this as a standard indicator of medical school performance.

A paper from the USA points out that medical students have higher rates of depression than age-matched cohorts and that rates of depression seem to increase as students advance through the course (Rosenthal and Okie, 2005). Suicidal thinking was highly prevalent and was found in one study to affect 11.2% of US medical students in the previous year (Dyrbye et al., 2008). It is important to deal with this problem not just because of its effects on students. Doctors also experience high rates of depression and suicide and it may be that these are problems that become established in medical school.

The GMC describes the usual approach to mental disorders in medical students e.g. education, reduction of stigma, and improving access to mental health services. These approaches are reactive and offer help for problems once they have arisen. It is important also to consider and, where possible, mitigate the adverse effects of medical education on the wellbeing of students.

Slavin et al. (2014) suggest that we should not regard mental distress as an inevitable consequence of being a medical student. There is also a need to look at the role of the medical school curriculum as a cause of mental distress. It has been shown for example that marking systems that involve dividing students into three or more grades are associated with higher levels of stress and emotional exhaustion than pass/fail grading. Also, problem-based learning seems to cause less distress than traditional teaching.

They describe changes made in one US medical school with the aim of preventing depression and other symptoms. These included changes to grading, increased elective time, reduced formal teaching time, establishment of 'learning communities', and teaching in mindfulness and resilience. Students enrolled after the institution of these changes experienced fewer depression and anxiety symptoms and increased community cohesion.

It follows from this that medical schools should give consideration to the structure of the curriculum and how this might impact on the wellbeing of students. There is no justification for imposing mental distress on students unless there is an educational need that cannot otherwise be met.

The GMC does touch on this matter in *Caring for doctors, Caring for patients* when it suggests moving to pass/fail marking, at least in some subjects. The research from the USA indicates that a broader re-consideration of the medical curriculum might be of help to students.

Appendix I: An account of the work of one university psychiatrist

Dr Leonard Fagin
Consultant Psychiatrist to Student Counselling Service
London Metropolitan University (LMU) 2006 to 2009;
University of the Arts 2009-2011;
University College London 2013-present

Amy, aged 22, is a Master's student coming up to her final dissertation. She referred herself to Student Psychological Services saying she had suicidal thoughts and scored high on the PHQ9. She claims she has never felt confident about her academic performance, despite very good marks in her A levels and a 2:1 in her undergraduate degree. She compares herself unfavourably to the other students in her course and has fallen behind on some of her assignments. She has started to cut her arms to obtain relief, something she had not done since her teens. She has also resorted to alcohol, and occasional use of alprazolam, which she obtained on the internet, as well as MDMA and cannabis. Recently she has been haunted by suicidal thoughts, especially in the evenings, which affect her sleep, it taking up to two hours before she can doze off. She has not confided her worries to friends or family. She has held back on acting on her suicidal ideation, thinking of the impact on her mother, who suffers from depression, and her two younger siblings.

How come so many of these bright students are contemplating suicide?

This is a question often asked by educationalists and clinical practitioners based in higher educational establishments, finding it difficult to make sense of this rising phenomenon in young people with potentially hopeful careers and futures. Having worked in three university settings in London over the past 11 years I have witnessed changes which lead me to be concerned about the trends, not only in the demand for services to support students to help them complete their academic aspirations, but also in the nature of student mental health problems.

All my assignments as a psychiatrist consisted of joining teams of qualified and experienced counsellors, psychotherapists, MHAs and, in the case of UCL, other psychiatrists. We offered assessments and brief interventions to students who referred themselves or were referred by others (such as tutors, friends, general practitioners mental health services). Over the years, students have increasingly sought help from these services, rising in the case of UCL, to up to 100 referrals per week on average during the academic year (Catherine McAteer, personal communication, 2018). As a result, waiting times have increased, prompting teams to have to adopt measures to screen the degree of urgency, to explore brief interventions, groups, workshops, or online therapies as alternatives to more prolonged one-to-one psychological treatments, and to tighten up liaison with general practice, mental health, and other therapeutic organizations which are also experiencing increasing demand.

During our weekly multidisciplinary discussions, where we present the results of our assessments and discuss problematic presentations, it is striking to note how often suicidality is mentioned by students. In fact, on their psychological services registration form over 26% state that they are having suicidal thoughts. More worryingly and tragically, we have had students commit suicide. Are we witnessing an epidemic of suicidality in this population? When we analysed possible contributing factors several issues were highlighted, but it was not possible to pinpoint single or more frequent triggers. International students, under pressure to perform academically by family or government granting agencies, and who were not achieving these expectations, were particularly vulnerable. Students who decided to defer or interrupt their studies because of academic or other demands, and who were not in contact

with supportive agencies during the hiatus, were also susceptible to suicidality. Previous mental health problems often re-surfaced in the pressure-cooker atmosphere of the university, especially for students tasked with complicated assignments, with the prospect of failure in exams and not being able to achieve the desired degrees. Students who had previous contact with mental health services back home often found themselves unsupported by statutory services when they moved to university, either because local services were difficult to access or because previous services had not made appropriate links to ensure that the student was seen by practitioners and offered support during the academic year. Students often mentioned in their assessments talking to other students who were suicidal or had accessed social media to explore ways in which they could commit suicide. Financial pressures, the prospect of having to pay off loans, and bleak employment prospects post-university, may also have contributed, as well as isolation and accommodation problems. Relationship problems and loneliness were also regularly mentioned. The use of alcohol and recreational drugs (and recently increasing use of alprazolam – Xanax) possibly also lowered the threshold of acting on suicidal ideation. The loss of pastoral care by tutors was also mentioned, blamed on the expansion of student numbers. Needless to say, this has had an impact on all of us trying to respond in a helpful manner, and discussing it in our multidisciplinary meetings in a frank and open manner allowed us to share the emotional load and gain some understanding and perspective on the issues.

The spectrum of psychological and psychiatric problems presenting to Student Psychological Services is wide and not too different from requests arriving at local Community Mental Health Teams. It no longer surprises us to find students with moderate to severe anxiety and depressive symptoms, frank psychotic phenomena, ADHD and Autistic Spectrum Disorders, or very disturbed young people with personality disorders arising from poor early parenting or abusive backgrounds. The difference from patients referred to CMHTs is that many students often seek help and have the reflective capacity to benefit from interventions. The problem, as in other helping agencies, is to have in place the right degree of experienced resources to respond to these demands with some expediency, and an established point of contact with services outside the university that can offer specialist help when required. It is important to bear in mind that university health services are not replacing traditional NHS mental health facilities, but in my view many students do present with conditions that could benefit from an assessment by a psychiatrist and a prompt referral to CMHTs when this is required.

Gathering and recording of basic reliable demographic and contact data are essential in this process, especially if referral to other services is the outcome. Particularly important are details of general practitioners 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 currently being taken or has been taken in the past. We have experienced problems when students are being treated closer to home, return back during term breaks, and need ongoing support from their local GPs as well their university GPs, with many practices not supporting dual registration.

Emotional dysregulation in young people is to be expected, partly as many are still in the process of maturation, with doubts about their strengths and capabilities, not helped by real uncertainties about what the future holds in terms of careers and employment. What I have come to realise is that the experience of emotional dysregulation is catching, and affects not only the students we see, but also those they are in close connection with, including ourselves as practitioners. I am also aware that during adolescence and young adulthood emotional dysregulation is not only understandable but perhaps a necessary phase, allowing students to explore and learn about their frailties and vulnerabilities, if opportunities for reflection are offered.

When I first see a student who has been referred to Student Psychological Services, usually presenting with high levels of disconnected emotions, I am mindful of two things. One is that I have to be ready not to be rocked into the maelstrom, tightening up my virtual seatbelt for the ride. The other thing is staying

with it, accepting it, waiting for the storm to subside until somehow the student gains perspective. My role is not as an assuager, I simply am an accompanist, stating by that my interest in being connected to them, and that these situations can be handled, eventually. In this I am also communicating that I am exploring with them their own internal sources of strength and resilience and not assuming that they are just simple feathers in the wind. This is not to dismiss the need to explore other underlying factors, such as depression and anxiety, which may require targeted interventions.

Recent studies in the BMJ poured cold water on the value of risk assessments leading to stratification in suicide prevention (Large et al., 2017). However, they do conclude, as so many other authors have pointed out, that those presenting with a mental health problem require a thorough and sympathetic assessment with the aim of negotiating an individualised treatment plan, and that those acknowledging suicidal thoughts or behaviours should be offered evidence-based therapies for the treatable problems associated with suicide, such as substance misuse disorder and depression. They also remind us that the overwhelming majority of people who might be viewed as at high risk of suicide will not die by suicide, and about half of all suicides will occur among people who would be viewed as low risk. These suggestions for assessments are being followed assiduously by our clinical practitioners, but usually it falls on the psychiatrists in the team to become involved and to give advice or put in place measures to minimise risk. It has been helpful to provide contact information for services available out of hours (such as the Samaritans); print out cards offering suggestions to students on what they can do if they are overwhelmed by suicidal feelings; link up with local GPs, Community Mental Health Teams and Accident and Emergency services; discuss responses with tutors and warden supervisors; and offer emergency slots for those deemed to be requiring urgent assessments.

So how could I have responded to Amy's difficulties? I am mindful that Student Psychological Services in universities have limitations on what can be offered, as they do not have the comprehensive resources to respond to psychiatric emergencies. However, I do believe these services often offer a first port of call for students in distress, and that they do have a role in hopefully preventing bad outcomes or in directing students to services where help can be obtained.

Amy had filled in her registration form on-line giving a brief account of her difficulties and her expectations of the help that she was seeking. That helped the triage team to allocate the assessment to the most suitable practitioner in the team. Her high score on PHQ9, her suicidal ideation, and use of alcohol and drugs led the triage clinician to allocate her to me.

I needed to give Amy a chance to express in her own words her difficulties, to understand when she first experienced them and whether she could identify any triggering factors. I would also ask her to tell me the nature of her suicidal thoughts, when they arise, how far had she gone into imagining not only how she would act on them, but also to let her tell me what stopped her from carrying them out. I would acknowledge the positive step she made in requesting help and disclosing her innermost worries. I would enquire whether she was living in Halls, or a shared flat, or with her family, and if she had confided her distress with friends or flat mates. I would listen carefully to occasions when she did not feel so burdened, whether she had developed strategies to manage them, exploring her own strengths and reflections. I would also ask her if she had thought what specific help she was seeking by coming to Student Psychological Services. After taking a personal and family history focusing on her early memories and relationships, I would explore the nature of her affective disturbance and exclude any other factors which could trigger off an impulsive act. This approach often manages to contain worries for students, particularly if followed by practical suggestions of where they can obtain assistance, day or night, but also acknowledging that they have internal strengths and resources which they often believe have failed them. Obviously there are instances when more immediate action needs to be implemented, and a letter and a phone call to the Local CMHT or a visit to the A&E Department may be required when there is a serious risk of self-harm and deterioration.

Appendix II: Mental Wellbeing in Higher Education Working Group

The Mental Wellbeing in Higher Education Working Group (MWBHE) is an Expert Network, made up of representatives of specialist mental health and wellbeing organisations within the HE sector, to guide and advise on issues relating to mental health and wellbeing in HEIs.

MWBHE brings relevant issues and trends to the attention of the HE community and works with representative bodies on strategic issues of importance to the mental wellbeing of HE students and staff. It also educates and informs those involved in service provision, particularly in areas of strategy and good practice. It comprises representatives from significant bodies in the field of student mental wellbeing, and sector experts as required.

The MWBHE working group is now hosted by Advance HE.

Aims

- To promote research and collaboration between the different sectors, agencies, and professional groups with responsibility for mental wellbeing in HE;

- To educate and guide on effective and evidence-based practice;

- To be a reference point for government bodies, managers in the NHS, the voluntary sector, and educational institutions and practitioners, in respect of mental wellbeing in HE;

- To influence policy on issues related to mental wellbeing in HE;

- To offer guidance on effective practice.

MWBHE aims and objectives link with the core aims of the membership institutions.

Publications

Student mental wellbeing in higher education: good practice guide (UUK, 2015).

By taking account of current student requirements and the increasing diversity of higher education provision emerging across the UK's four nations, the MWBHE/UUK 2015 guidance highlights the following areas for consideration in developing institutional policies and procedures:

- National and international policy developments;

- Duty of care and legal considerations;

- Access to support, advice, and guidance;

- Provision of training, development opportunities, and information dissemination;

- Demand for institutional services versus external statutory services;

- Liaison between internal and external, voluntary, and statutory agencies.

Each institution is different; therefore their use of this guidance will depend on their size, setting, student cohort, resources available, and the particular challenges the institution may face.

MWBHE Bibliography of Research

This bibliography of research on issues concerning student mental health and wellbeing has been compiled in order to bring together the literature relevant to the development of student service provision in UK higher education.

In order to make the resource more useful and manageable, the references have been grouped by key topic into seven sections that address:

- Policy development and practice at institutional level;

- Student services practice and development;

- Help seeking;

- Influencing factors and impact on academic learning;

- Student diversity, including gender, gender identity, social class, ethnicity, and age;

- International students;

- Self-harm, suicide, and eating disorders;

- Alcohol and substance abuse.

Conferences

MWBHE joins with Universities UK to run yearly conferences on the issue of student mental health and wellbeing. See the MWBHE website for further details.

Appendix III: UUK's mental health in higher education work

Universities UK established a proactive programme of work to develop and implement a 'whole university' approach to mental health in December 2016. The programme ensures that wellbeing and mental health are a strategic priority for universities.

UUK established The Mental Health in Higher Education advisory group which convenes students, university leadership and professional services, research and clinical expertise, mental health leadership, third sector organisations, government departments, bodies, and regulators to provide strategic exchange and direction for mental health in higher education.

Not by degrees

A narrative review was commissioned from the Institute for Public Policy Research (IPPR), published as *Not by degrees: Improving student mental health in the UK's universities*, receiving widespread coverage. The main findings of the review were that over the past 10 years there has been a fivefold increase in the proportion of students who disclose a mental health condition to their institutions, that 94% of universities noted an increase in demand for counselling services, and that there was significant variation in the ways in which universities design their strategic response. Recommendations included that HE leadership should see mental health as a priority, the adoption of a 'whole university' approach, and better links with NHS services.

Stepchange: mentally healthy universities

Stepchange: mentally healthy universities, the refreshed Stepchange framework, was published in May 2020 following an evaluation of three university pilot schemes at the University of Cardiff, University of York, and University of West England. The whole university framework calls on universities to adopt mental health as a strategic priority, to see it as foundational to all aspects of university life, for all students and all staff. The framework was co-developed with Student Minds' University Mental Health Charter and provides a shared framework for change.

The framework includes the case for action by university leaders to make mental health a strategic priority, to create healthy settings where students and staff can thrive. The whole university approach is formed of four domains, with an increased focus on staff mental health and wellbeing: Learn, Support, Live, and Work. Five cross-cutting themes are also established as being key to embedding the approach: Leadership, Co-production, Information, Inclusivity, Research, and Innovation. As with the previous version of Stepchange, the importance of transitions into, through and out of university are highlighted along with the importance of working with the NHS to improve access to and coordination of care.

UUK and the Child Outcomes Research Consortium (CORC) have also developed a self-assessment tool to encourage universities to plan and implement a whole university approach. Each section reflects the structure of the *Stepchange: mentally healthy universities* framework and includes sets of questions for university leaders and teams.

Minding our future

In May 2018 UUK's Student Mental Health Services Task Group, chaired by Paul Jenkins, CEO Portman and Tavistock Trust, published Minding our future: starting a conversation about the support of student mental health (UUK, 2018) so that all students can access the care they need. The publication called for a 'place-based' approach, which involves responding to the needs of a local student population with NHS, universities, and colleges working in partnership with local authorities, schools, businesses, and the third sector. Examples of such approaches to care for students are starting to appear in Greater Manchester, Bristol, and North London.

Guidance on preventing student suicide

Although new data published by the ONS showed that there is a significantly lower rate of student suicide among university students in England and Wales compared with the general population, universities see this as a priority area. In September 2018, UUK and Papyrus launched new guidance to help prevent student suicides within higher education. Aimed at university leaders, the document includes advice on developing a strategy focused specifically on suicide prevention, covering the following areas:

- Steps to prevent student suicide;

- Intervening when students get into difficulties;

- Best practice for responding to student suicides;

- Case studies on approaches to suicide prevention through partnership working;

- Checklist highlighting steps university leaders can take to make their communities safer.

Additionally, UUK is working with students, parents and carers, legal and health experts, and government to produce guidance regarding disclosure and consent.

On-going work

UUK is a partner in an OfS Mental Health Challenge Competition funded project led by UWE Bristol. The Student Mental Health Partnerships Project brings together five regional partnerships which are being developed between universities and local NHS services. UUK's role is to convene a National Learning Collaborative of all the project partners and share learning with the wider sector, to support the implementation of the commitment to student mental health in the NHS long term plan, and embed co-production of service design and delivery with students and practitioners.

Of note

The student mental health research network UK Research and Innovation (UKRI) announced the launch of eight new mental health research networks. One of them is concentrating specifically on student mental health in higher education research. Led by the Institute of Psychiatry, Psychology and Neuroscience, King's College London and working with researchers with a range of expertise, practitioners, and other key stakeholders across the higher education sector, their aim is to improve what we know about student mental health.

Government initiatives

UUK has responded to the government's *Transforming children and young people's mental health provision: a green paper* (Department of Health, 2017) Welcoming the development of a new national strategic partnership with government, third sector, professional bodies, students, colleges, and employers focused on improving the mental health of 16–25-year-olds by encouraging more coordinated action, experimentation, and robust evaluation. However, the strategic partnership was not mentioned in the government's response to the consultation.

Appendix IV: Healthy Universities

In addressing mental health it is important to appreciate that health is a multi-faceted concept and that mental, physical, social, spiritual, and societal wellbeing are inextricably linked. Furthermore, whilst good services are essential for students and staff experiencing mental health problems, it is important to remember that this service provision takes place within a wider institutional context. The organisational and social environments of universities are, in many ways, unique: for many students, this is perhaps one time when learning, leisure, accommodation, social life, medical care, counselling, and social support all co-exist in one place. However, in many universities the proportion of students commuting to university has increased greatly over recent years. It is therefore important that universities acknowledge and understand the diversity of their student population and the different experiences, pressures, and needs. If services are to be effective and people are to thrive, there needs to be a broader commitment to developing as a healthy and health-enhancing organisation.

The UK Healthy Universities Network, which has a membership of around 60 UK HEIs, has adopted the following ambitious and wide-ranging vision:

'A Healthy University adopts a holistic understanding of health; takes a whole university approach; and aspires to create a learning environment and organisational culture that enhances the health, wellbeing and sustainability of its community and enables people to achieve their full potential.' (UK Healthy Universities Network)

Healthy Universities is one application of the healthy settings approach, which moves beyond the delivery of targeted health promotion programmes in organisational and place-based settings, to consider how the contexts in which people live their lives can themselves support wellbeing by embedding health into their ethos, structures, and processes. As Dooris, Wills & Newton (2014: p7) comment:

'The rationale for the settings approach is based on the recognition that health is largely determined by people's environmental, economic, social, organizational and cultural circumstances. In addition to operating at a societal level, these influences operate in and through settings of everyday life, directly and indirectly influencing health. It follows that effective health promotion requires us to focus on the places in which people live their lives.'

The settings approach has a number of characteristics (Dooris, 2006; Dooris, Wills & Newton, 2014; Suárez-Reyes & Van den Broucke, 2016). First, it represents a shift of focus towards a salutogenic view concerned not only with illness, but with wellbeing and what makes people flourish – fostering health potentials inherent in the social and institutional settings of everyday life (Kickbusch, 2003). Second, it adopts an ecological model, appreciating that health is holistic, multi-dimensional, and determined by a complex interaction of personal, social, behavioural, and environmental factors. Third, it views settings as dynamic complex systems, acknowledging interconnectedness and synergy between different components, different groups of people, and with wider society, and advocating a 'whole system' perspective. Fourth, it adopts a comprehensive holistic change focus, drawing on learning from organisation and community development, and using multiple, interconnected interventions to integrate health. Fifth, it appreciates that most settings – including universities – do not have health as their main mission or raison d'être, and that it is therefore essential to advocate for health in terms of impact on or outflow from core business.

The Healthy Universities approach thus aims to make HEIs more health-enhancing places. It recognises that student, staff, environmental, and societal wellbeing are essentially inter-connected, and also appreciates that health underpins the success of HEIs, providing a foundational resource that supports its performance and productivity. Reflecting the wider healthy settings perspective, it is commonly understood to comprise three focus areas (Dooris et al., 2016):

Creating healthy and supportive learning, working, and living environments: for example, through providing appropriate health-related services supported by policy; incorporating health and sustainability criteria into building and campus design; ensuring that learning and social spaces are comfortable and conducive to wellbeing; co-ordinating assessment deadlines so that they do not aggregate and cause unnecessary stress; and prioritising management styles and staff/student relationships that are respectful and compassionate.

Increasing the profile of health and sustainability in the university's routine life and core business of learning and research: for example, focusing not only on 'health' courses, but also working to ensure that multiple disciplines – whether architecture, urban planning or human resource management – stimulate students to graduate fired up to become change agents for health and wellbeing; designing and implementing targeted and universal health improvement interventions and programmes; and exploring opportunities to build skills and capacities supportive of personal and community health.

Connecting with and contributing to the wellbeing, resilience, and sustainability of the wider community: for example, through developing a university's corporate social responsibility and civic engagement roles; through local leadership for health; through student and staff volunteering; and through socially engaged research and learning.

Higher education offers enormous potential to influence positively the health and wellbeing of students, staff, and the wider community through education, research, knowledge exchange, and institutional practice. Conversely, investment for health within the sector also contributes to core priorities such as retention, achievement, performance, and reputation. Through focusing on their corporate social and environmental responsibility, and their potential to 'future-shape' students (and, indeed, staff) as local and global citizens, Healthy Universities can also contribute to institutional and societal productivity and sustainability. This was highlighted in research commissioned by the Higher Education Academy and supported by the Department of Health (Dooris & Doherty, 2010a, 2010b). 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)

This research demonstrated a rapid increase in interest in the Healthy Universities approach, a finding supported by a 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 (Dooris, 2006). Such an approach has significant added value, offering 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.

A more recent research project funded by Advance HE (Dooris, Powell & Farrier, 2018) explored the perspectives and understandings of vice-chancellors and members of national networks regarding leadership for a whole university approach to health, wellbeing, and sustainability. This concluded that effective, authentic, and credible senior-level leadership is a pre-requisite for the successful implementation of a Healthy University initiative. Alongside a number of challenges, including the large-scale and complex nature of universities, respondents identified opportunities to secure such leadership

– including finding appropriate 'windows of opportunity'; advocating for health to be a named responsibility within a senior leader's role; aligning Healthy Universities' work with core priorities and strategic planning cycles; using the increased profile of issues such as mental health as a catalyst to wider senior-level buy-in; and employing charters and strategies as engagement drivers.

Importantly, this whole system perspective long advocated by the UK Healthy Universities Network has increasingly been adopted and endorsed by national bodies and reflected in publications. For example, Universities UK's *Student mental wellbeing in higher education: good practice guide* (UUK, 2015) explicitly acknowledges the pioneering work on Healthy Universities carried out by the University of Central Lancashire, whilst its *Stepchange Framework for Mental Health* (UUK, 2017) was informed by the UK Healthy Universities Network's framework and calls for a whole university approach involving community, learning, living, and support components – within a wider whole system approach that connects an individual university with its local health and social care system, and locates its work within the broader policy context.

The Healthy Universities approach offers a process and strategic and operational framework for universities to connect activities, programmes, and services, and to embed health and wellbeing into their whole system – their policies, procedures, staff training, curriculum, services, communications, and campaigns. Within this framework, there are a range of specific measures that can be taken to promote mental wellbeing. Some of these focus explicitly on mental health – for example: anti-stigma campaigns; mindfulness; buddying and mentoring for new students; social media awareness campaigns; debt advice; and support for problem gambling. However, the approach also helps institutions to understand the links between mental health and other issues, thereby adopting a more holistic perspective. Examples include: fostering strong relationships with the Students' Union and external partners to tackle cultures of heavy alcohol use; facilitating physical activity, healthier eating, and other supportive behaviours as means of promoting positive mental wellbeing; considering the impact of curriculum assessment design and timetabling on students' experience; encouraging social connectedness within student accommodation; and addressing relationship consent, sexual harassment, violence, and hate crime by developing a whole system commitment to 'changing the culture' (Universities UK, 2016).

For those institutions wanting to find out more about, or be supported in implementing, the Healthy Universities approach, the UK Healthy Universities Network has a comprehensive website and toolkit, comprising case studies, guidance packages, and a self-review tool. An online questionnaire provides a mechanism for universities to catalyse cross-institution collaboration, and to review their progress in embedding a whole system approach to health and wellbeing within their core business and culture (Dooris et al., 2016). The UK Network is now part of a growing worldwide movement and a recent research report includes institutional case studies from the UK and other countries (Dooris, Powell & Farrier, 2018). Its vision and conditions of membership reflect a commitment to the aspirations and calls to action set out in the Okanagan International Charter for Health Promoting Universities and Colleges (2015), which highlights the pivotal role played by higher education, contending that:

'Health promoting universities and colleges transform the health and sustainability of our current and future societies, strengthen communities and contribute to the wellbeing of people, places and the planet.'

Appendix V: Greater Manchester Universities Student Mental Health Service – A trailblazer

Greater Manchester is the first place in the country to establish a dedicated centre to help support higher education students with mental health needs, thanks to a pioneering partnership between the region's four universities (Manchester, Manchester Metropolitan, Salford, and Bolton), the Royal Northern College of Music, and the Greater Manchester Health and Social Care Partnership (GMHSCP), the body that oversees the area's £6 billion devolved health and social care budget.

The aim of the service is to provide treatment and support to students with significant mental health difficulties, and so enable them to fulfil their university ambitions and experience, building on the existing wellbeing service provision. Students with pre-existing mental health problems or those whose mental health problems emerge whilst at university will be supported to succeed, manage their mental health problems, and be able to access the right support at the right time, including specialist treatment for mental illness.

To enable this service, we have secured an innovative partnership between the universities in Greater Manchester, the NHS, and Third Sector, endorsed by the Mayor, Andy Burnham. We are hoping to augment this alliance further by working with organisations from private industry; this opportunity will undoubtedly benefit all involved as we work together to build the whole ecosystem to support student mental health, our future workforce, economy, and community. This co-funded model has seen an initial investment of £1.6m over a 2-year pilot period, to be evaluated from a clinical and health economics perspective. The service is also part of a national learning collaborative, working with Universities UK to enable sharing, learning, and co-development of a standardised and holistic mental health and wellbeing outcomes framework. The service started with the 2019/20 university academic year.

The transition to university can be difficult, with many young people living away from home, family, and friends for the very first time. This can be made even more challenging when a student is dealing with significant mental health issues alongside the everyday challenges of being a student.

The Greater Manchester Universities Student Mental Health Service is designed to enable students to access mental health services quickly and easily, and also helps to inform and develop best practice, with its aspiration to lead the way in mental health provision on campus, both nationally and globally. This is being done through the creation of the 'Hub', one team that connected with the pre-existing student wellbeing provision already delivering an IAPT model of psychological intervention.

The new Service is hosted by Greater Manchester Mental Health NHS Foundation Trust (GMMH), a key provider of specialist and community mental health services across the city, and particularly across the university locations. This enhances existing university provision through the creation of the 'Hub team' and its specialist mental health workforce that includes nurses, psychologists, psychiatrists, and our voluntary and community sector partners, offering one trusted assessment through a single entry-point for all referrals. The Hub provides specialist assessment, diagnostic triage, and evidence-based interventions, including creative arts. The team works across three university sites to ensure locally delivered care to all students. When more highly specialised care might be needed, the Hub team links directly with NHS specialist services, many delivered by GMMH NHS Foundation Trust, and the team provides the care navigation for all students that previously remained a gap for our universities. Our vision is to develop self-referral and we work closely with students and our primary care colleagues, through our governance structures, to continue to review and develop this service based on need and our data.

Care continues for the students both within and outside term time, facilitated by digital technology. The Hub team manages up to 600 referrals per year for students studying at a Greater Manchester university, who are referred or self-referred into the wellbeing services. Whether students are registered with a local GP or not, if they are a student of one of the Greater Manchester universities they can access this service. There is an information sharing agreement within Greater Manchester Health and Social Care Partnership which supports the service and the GMMH NHS Foundation Trust electronic care record system is used, with a vision to develop the student e-passport.

With 103,000 students, Greater Manchester has the largest student campus in Europe. Over the last 5 years 94% of universities in the UK have reported a significant rise in students accessing support for mental health difficulties with depression and anxiety disorders being the most common. The number of students dropping out before completing their degrees has trebled in recent years, but evidence shows that graduates enjoy better wellbeing than non-graduates, hence it is vitally important to support students to graduate. In Greater Manchester, approximately 10% of the student population have accessed mental health and wellbeing support over the last year, but those with severe illness and high-risk presentations need enhanced treatment and support and with the increasing demand, existing services require further development in a holistic way.

The first 12 month Evaluation report is now complete and provides compelling evidence to develop the service further particularly given the impact of the covid 19 pandemic . Amongst a number of whole system findings , the service reported a 19% reduction in emergency presentations to A and E and a 19% reduction in referrals to community mental health teams . Based on these outcomes , the pilot has been extended by a further year so that evaluation and further development can continue based on the initial data.

Our vision is to create a whole system service from prevention to prescription to support students for their whole university career and equip them with the toolkit to stay well into the workplace so that they can achieve their maximum potential. The greatest wealth of our students is their health and we believe that the foundation for this is good mental health.

The Greater Manchester Universities Student Mental Health Service opened its doors in September 2019.

Professor Sandeep Ranote FRCPsych.

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