Higher Education Institutions' Support For Students With Mental Health Difficulties

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The inclusion of people with mental health difficulties in education or any other meaningful activity has been recognised for many years as a major determinant of mental health, as well as economic and social status, through the development of skills and confidence, self-worth and empowerment, and employment opportunities and social networks. This has been reflected in the UK in governmental policies such as the National Service Framework for Mental Health and the National Social Inclusion Programme, and concurrently in approaches which have aimed to use or develop communities' "social capital."

The influence of these policies will be considered in relation to Higher Education Institutions (HEIs) and their provision of support to people experiencing mental health difficulties. The term "institution" or "institutional" refers to individual Universities at times and how the sector is organised more generally at others.

1.1 The National Service Framework for Mental Health (NSF)

The NSF required organisations to combat discrimination against individuals and groups with mental health difficulties and promote their social inclusion (standard 1), improve access to assessment and treatment (standard 2), develop action plans for employment, education, training or other occupations in care plans (standard 5) and develop early intervention and suicide prevention strategies (standard 7)[1].

Given that the peak age of initial onset of psychiatric disorders like schizophrenia and bi-polar disorder is between the ages of 18-30, that other mental health difficulties are likely to be at their most acute between the ages of 16-25[19], and affect 1 in 7 people in any given week[9], there ought to have been some emphasis on the development of Health and Social services for people within these age ranges. More importantly, as approximately 43% of people between these peak age ranges are in some form of Higher Education[20], there ought to have been some congruence between the Health and Education sectors to target services specifically for students in Higher Education.

Two areas given further attention here are regarded as traditional approaches to student mental health – access to treatment (standards 2 and 7) and mental health promotion (standard 1).

1.1.1 Access to treatment and psychological therapies

Mental health professionals not employed within the University often use a medical or psychological model which is largely or primarily about treating and managing a condition. With a similar focus on individuals, University-based therapeutic and counselling approaches help students explore their feelings and the causes of these. Both approaches have an anticipation that people will become empowered to take the steps that will alter both the circumstances within their sphere of influence and the way they feel about themselves and their lives. These traditional approaches define students' mental health difficulties as ones to be resolved on an individual basis through medication and/or talking therapy and are relevant to the mental health

needs of students in terms of improving access to treatment (standard 2). With a focus on individuals, there is little or no focus on social or organisational structures or barriers within which students are expected to fit.

Access to NHS-provided therapeutic support may be developed and improved with the roll-out of services through the current "Improving Access To Psychological Therapies" (IAPT) programme[2], although the specific issues related to engaging with the student population will need to addressed. For example, access to therapeutic services (NHS- or University-based) or equivalent support groups, is influenced by a number of factors; both personal preference and the severity of a student's mental health difficulties, the cost (financial and emotional) involved in attending, loss of motivation, lack of conviction and self-esteem to engage, the length of sessions, cultural appropriateness, the student's resources (while studying full-time), immediate stressors, the fluctuating course of mental health problems, legal and administrative concerns as well as being deemed ready for counselling or therapy.

There is also considerable variation nationally in students' access to specialist teams such as Crisis Resolution Teams or Psychosis Intervention and Early Recovery Teams (standard 7). Some HEIs are ensuring good referral links to and from such services, while other services in HEIs see this as being the sole responsibility of primary care, while some of these teams themselves will not accept referrals from HEIs or engage with student services.

While the issues faced by students in accessing therapy and specialist teams will be discussed in more detail in another UMHAN paper, it is important to note, for the purposes of this paper, that it is not given sufficient priority within these models that, for a student in Higher Education, being supported in a way which enables them to complete their course is every bit as significant to their long term prospects – a priority which is relevant to Standards 1, 5, and 7 of the NSF.

Services whose objectives focus on individuals and enabling them to fit in with organisational structures are not designed to address the complex issues associated with social exclusion - standard 1 of the NSF (for further information, see section 1.2). Therefore, as the disability legislation (Disability Discrimination Act and Disability Equality Duty) extends the rights of people with mental health difficulties, these health and therapeutic services will need to ensure this is incorporated into their approach and their engagement with different communities. Likewise, HEIs will need to ensure the rights of people with mental health difficulties are incorporated in the kinds of provision their academic and support services make. This would necessitate development of more practical approaches which engage with the legal and policy requirements, tailored to the educational experience, rather than on broader issues typically addressed through counselling or medical intervention.

1.1.2 Mental health promotion

One of the running themes of the NSF is mental health promotion. There are examples of local campaigns which ensure quality of information and awareness-raising in relation to mental health, although this has tended to be dominated by the provision of information, materials/self-help information, or leaflets on general mental health issues alone (for example, campaigns to raise awareness around specific issues such as Eating Disorders Awareness Week or World Mental Health Day).

Various reports, such as that by the Royal College of Psychiatrists[9] and Heads of University Counselling Services, indicate that years of information-giving alone is not improving the mental health of student populations.

An alternative approach – the Health Promoting University[12] - is one which seeks to mainstream mental health promotion in the setting in which the promotion is to be undertaken. The concept of Health Promoting Universities based on the "National Healthy Schools Programme" has been gaining interest across the sector. This approach offers a structure in which to enable and embed sustainable changes within the University to maintain/promote the healthy lifestyles of students (and staff, although staff issues will not be considered here). This approach necessitates the evaluation of organizational practices, the general environment, the availability of support, lifestyle, attitudes and social inclusion.

In relation to mental health difficulties, there is some evidence already available which may inform such a structured approach, such as the work of the Royal College of Psychiatrists' report on student mental health which identifies particular risk factors, the Responses And Prevention of Student Suicide report[16], UUK Guidance on mental health promotion[15], and the feedback from University counselling services on the "emotional atmosphere" of each institution. Academic assessment practices (see section 2.2.1), suicide prevention strategies, identification of factors related to the development of mental health difficulties within the student population, and the development of supportive networks are likely to be key areas to be developed in a Health Promoting University strategy[15], as well as the inclusion of mental health under other topics such as exercise, nutrition, etc (and vice versa).

Some developments made in the context of a Health Promoting University may also be considered as reasonable adjustments as required by the Disability Equality Duty and Disability Discrimination Act (see section 2.3) or in terms of delivering effective services under contract law (see section 2.2). However, the idea of a University as being healthy place in which to work, study, and live has often been initiated at a grass roots level without a strong strategic lead or co-ordination.

1.2 Social Exclusion Unit/National Social Inclusion Programme

People with mental health difficulties experience discrimination in all areas of life and are often denied ordinary opportunities, resulting in social exclusion. As a group they face a series of interconnecting problems around poverty, discrimination, unemployment, low skills, bad housing and poor health. The government's Social Exclusion Unit[10] and National Social Inclusion Programme[8] both consider the strategic and environmental changes required to help change societal attitudes and remove barriers, so that the society enables those with mental health difficulties to lead a full life in the community.

Education has been promoted as one path to social inclusion, being perceived as a valued and socially acceptable vocation in itself, aswell as an environment which enables people with mental health difficulties to construct a socially acceptable identity, and enable them to contribute to, and be a productive member of, society. Higher Education also has the added potential to offer a challenge to negative stereotypes of low achievement levels commonly associated with people with mental health difficulties.

Enabling access to Higher Education also has the potential to improve health and wellbeing and, for those who have existing mental health difficulties or developed them while studying at this level, can be a means to recovery through, for example, providing involvement in a meaningful activity, conferring positive attributes, building structure and skills, and improving employment and financial prospects Higher Education has the potential to have a positive effect on a person's self-esteem and lifetime opportunities and this should be every bit as true for people with mental health difficulties (or those vulnerable to developing them) as it is for everyone else.[17]

Education can also be structured in a way which counteracts some of the disabling effects of mental health difficulties. In recognition of the disparity of qualifications between people with mental health difficulties and the wider population, the National Mental Health Development Unit (previously the National Institute for Mental Health for England) and National Institute for Adult Continuing Education (NIACE) have been developing strategies to increase the qualification levels of people with mental health difficulties in Further Education[3, 18].

Given that the long-stated aim of government policy to increase the social inclusion of people with mental health difficulties, as shown in the Social Exclusion Unit report and by the current investment in IAPT services, it is disappointing that the Higher Education sector and Department for Business, Innovation, and Skills (previously the Department for Innovation, Universities and Skills) has little strategy with regard to the social inclusion of people with mental health difficulties. This lack of strategy is also surprising given the government's oft-stated view that the UK needs to plan for a future high-skilled economy in which there will be very few jobs available for unskilled workers. Where attention has been paid locally to the issue of mental health difficulties in HE, the focus is largely dominated by crisis management, improving liaison with statutory services, and ensuring access to psychological therapy.

Some organisations, such as the National Union of Students (NUS) and Association of Managers of Student Services in Higher Education (AMOSSHE) are acknowledging some of the contributory factors to mental health difficulties from within the HE context[13]. For example, changes to the Higher Education system (such as higher staff:student ratios and reduced time to manage pastoral and support roles), financial anxieties, social group and identity changes, loss of existing support networks, poor standards of accommodation, increased availability and use of alcohol and drugs, inadequate support within Universities and among community mental health services, the "image problem" of Higher Education only being for particular sections of society, loss of benefits, and low confidence prior to, and during study.

In the absence of a strategy to address student mental health, Higher Education may be structured in ways which have a propensity to exclude people with mental health difficulties from full participation and self-fulfilment. For example, through potentially disabling course structures, inflexible assessment methods, complicated administrative processes and bureaucracy, lack of recognition of student achievement (other than degree classification) to boost self-esteem, etc. Sections 1.3.1 and section 2 consider further examples of inclusivity.

Over the next few years, as the government moves towards increasing the employment rates of people with mental health difficulties, this will inevitably mean a greater push for people with mental health difficulties to study to levels which make them employable in a highly skilled economy. Furthermore, with increased investment in psychological therapies with the intention of increasing the employment rates amongst people with mental health difficulties it will be reasonable to assume that this will lead to a greater number of people with mental health difficulties going on to study at Higher Education level.

Another consideration for such a strategy is the development of transition arrangements from HE into employment, as it is not uncommon for students with mental health difficulties to lose motivation because they see little prospect of securing employment at the end of their course. This ought to be reflected in the services offered by University-based Careers Advisors, and also for such services to be aware of resources local to the students' intended destination which may be relevant to achieving this goal.

In the absence of sector-wide strategy for addressing the prevalence of, and negative impact of, wide-scale psychological and practical barriers to studying means that individual institutions are at risk of perpetuating social exclusion.

1.3 Social Capital

Inclusion, care in the community, and mental health promotion is reliant on community involvement. The formal and informal social networks which support people and share knowledge and resources – the "social capital" - is an integral part of mental health policy[5]. Social capital is viewed as a determinant of health and wellbeing of individuals and communities, and is given as much importance as economic capital. However, the potential social capital within Higher Education has has not been included in any national strategy (such as the National Social Inclusion Programme's "Communities of Influence" programme[8]).

There is a huge potential for NSIP, the HE sector, individual HEIs and communities to review and use their social capital to the benefit of individuals and society at large. Indeed, some of the core values of Higher Education communities - inspiring and enabling individuals to develop their capabilities to the highest levels, serving the needs of the community, a sense of belonging to a democratic and civilized society, co-operative endeavour between tutor and student - are important bases for personal development, confidence-building, improving self-worth and are congruent with the principles of social inclusion and recovery.

. Increasingly, the numbers - and cost - of leave of absences and withdrawals from studying, the widening demographic of student cohorts, and the internationalisation of Higher Education, have highlighted the need to reflect on and develop strategies that are orientated towards student activities which support the learning process. Three areas given further attention here are Student Experience strategies, training, and peer support. Given that Student Finance England[11] recently reported that significant numbers of people who withdraw or fail to repay their loans to SFE cite mental health difficulties as their reason for this, it will be important that mental health is considered a key element within these areas.

For HEIs, the benefit of ensuring inclusion is that, as ever more people with mental health difficulties enter into Higher Education and are effectively supported in doing so, then they, in turn, will be more sympathetic to the principles of Higher Education in the future. Given the large numbers of people with mental health difficulties who could benefit from, or are currently in, Higher Education, they represent a powerful student voice.

1.3.1 The Student Experience

Currently, some institutions are developing strategies in relation to the "student experience" [14] (which may include an element of student mental health) or are working towards the development of their status as a Health Promoting University (which would necessitate consideration of student mental health).

As stated previously in relation to Health Promoting Universities (see section 1.1.2) there is huge scope for developing the HE environment to promote positive mental and physical health which would clearly contribute to a better student experience, but this often takes place at a grass-roots level and lacks strategic lead and co-ordination. Within Student Experience strategies there is often little attention paid to the experiences of people with mental health difficulties in accessing and progressing through their course, as this group is often viewed as a minority. Given that significant numbers of people who do not complete their course state mental health difficulties as their reason[11], this would seem a significant oversight in any Student Experience strategy or retention and progression policy. The figures obtainable from Student Finance England are also likely to be an underestimation, due to the under-disclosing of mental health problems.

Currently in relation to the "student experience", education policies focus on the idea of the student as a customer and institutions which adopt this perspective will give increasingly less regard to the notion of their institution as a community. De-personalising the relationship between students and Universities by focussing on educational provision as a consumer product is likely to negatively impact on the social capital of institutions in assisting all students through Higher Education.

1.3.2 Training

With regards to all pastoral and support services, including those which have a therapeutic emphasis such as counselling, students with mental health difficulties may falsely assume that this person or service has specialist knowledge in the field of mental health. The student is therefore likely to divulge information which that person feels ill equipped to cope with, or does not have an understanding of social exclusion, or does not have the relevant knowledge to ensure compliance with the institution's obligations. This is potentially extremely damaging to both the student and the member of staff and points to the importance of being explicit to students at the outset of contact the boundaries of any supporting role (see section 2.2 for further information).

Training has often been viewed as a standard way of ensuring specialist mental health expertise is dispersed amongst other services. While some generic training is useful, training needs to be tailored to the specific needs of the group to whom the training is being provided. Any form of training which is undertaken must have, as

one of its aims, breaking down misconceptions and prejudices about mental health, and giving people confidence in their abilities in this area.

Training many different staff groups, and ensuring training to new members of staff within those groups, is inherently going to be costly, both for the target audience (in terms of time out from their role) and also to the trainer. Relying on outside agencies or consultants to provide training would add to this cost, and would not necessarily be specific to students, nor specific to the institution itself. Furthermore, the development of policy, procedure and practice within the institution to ensure compliance with legislation and prevent the emergence of mental health difficulties, and ensure early intervention and adequate support, will still need to be undertaken on a day-by-day and on a long-term strategic basis.

1.3.3 Peer support

Some institutions utilise peer support as part of its social capital as a means of decreasing stress, developing a sense of belonging, helping navigate University systems, someone to talk to about anxieties about leaving home, etc. This approach may mitigate against the onset of mental health difficulties and make students more effective at concentrating their mental energies on studying. This approach also has the merit that it is not reliant on disclosure of particular mental health needs and is likely to be beneficial to all students. The take-up of this support is likely to be greater if only one of the stated aims is to prevent the onset of mental health problems. Such support could be targeted at those students who are thought to be at particular risk of isolation, developing mental health difficulties, or at potentially higher risk of suicide, such as international students, young men, Asian women, and gay, lesbian and bisexual students.

2 Institutional influences on the development of support for students with mental health difficulties

There is an expectation that public bodies would play an active role in delivering all of these objectives and Universities should be developing initiatives in response to these national policies. While local initiatives and policies make some headway in attempting to address concerns within each institution, there remains inconsistency of approach across the country and between each institution, which is clearly an inequitable situation.

At present, there remains a need for the sector to consider further what an effective, national plan would look like with regards to the issue of student mental health. Individual HEIs may currently not identify some of their responsibilities and subsequent support mechanisms as contributing to existing national polices, and merely see these as legal frameworks in which they operate or even policies which are irrelevant to education.

Some of these responsibilities will be considered here, and have already been used as drivers to develop some localised institutional support for students with mental health difficulties.

2.1 Fair Access

Most HEIs now have Access Agreements to try to attract students to their courses who would not ordinarily consider applying, and will target publications, prospectuses, outreach work and financial help at certain groups of students, such as students from low socio-economic backgrounds, students with disabilities, and looked after children.

However, these Widening Participation approaches aimed at improving access to education for people from specific target groups, such as people from low socio-economic backgrounds, cannot be entirely successful without explicitly recognising and incorporating in to policy the fact that these groups will include an above average number of people with mental health difficulties. Similarly, strategies with regards to students who have been under the care of their Local Authority ought to recognise that a large proportion of such people will have unmet mental health needs. Finally, mental health is an important factor for many of the under-represented ethnic groups, and in fact, any group in society where there has been some degree of social exclusion.

Essentially, mental health must be included as an integral, mainstream element of any strategy to improve access to HE, and individual institutions are going to struggle to defend themselves against charges of prejudice if they do not engage with the issue of student mental health on a strategic level nor spend little money on trying to attract people with mental health difficulties.

The Cabinet Office's Public Service Agreements (PSA)[7] play a role in galvanising public service delivery and driving major improvements in outcomes. PSAs set out the government's highest priorities and are shared across its departments. Since 2007, PSA 16 has aimed to increase the proportion of socially excluded adults in settled accommodation and employment, education, or training, and people with severe mental health problems are highlighted as a key demographic. Unfortunately, Public Service Agreements do not appear to attempt to engage with HE, and vice versa.

2.2 Contract, negligence and duty of care

University contracts carry an implied term that they will supply their services with reasonable care and skill. Educational professionals owe a common law duty of care to students in the performance of their professional duties, and this extends to welfare and disability responsibilities. Universities often imply in their descriptions of the role of personal tutors or other pastoral roles that their staff are competent to perform welfare functions[6].

However, it is widely acknowledged that most staff are not trained for ongoing support, therapeutic interventions, or risk assessment in mental health, and probably lack the requisite skills. It unreasonable to expect all staff to possess knowledge of areas which do not normally come within their sphere. ie. The functions of those services, and the knowledge and skills required to perform them well, are not specific to mental health difficulties. Nor will people performing their role necessarily view their actions within the wider context of policy or be fully conversant in the relevant law (most importantly, the Disability Discrimination Act and Mental Health Act).

Nevertheless, the more aware that these people are that their role can be crucial to students' mental wellbeing, the more effective they are likely to be. It will be important for institutions to realise the different levels of expertise, functions and limitations of those individuals and services. Universities will need to ensure that staff have proper awareness of the duty of care and the need to report concerns or to act in response to emerging concerns or crises. An increasing number of institutions have developed student mental health policies to try to meet this requirement, or have a rolling programme of training (see section 1.3.2).

For students who are developing, or those identified with, mental health difficulties, it would be appropriate that they are referred for adequate assessment and risk management by somebody who is able to do so. What would subsequently happen would depend upon such factors as the nature and magnitude of the risks involved, the severity of the potential harm, compliance with legislation, and would almost certainly involve extensive liaison within the University and externally to minimise the risks identified. "Risk management" in this context can involve mental health risk assessment, as well as general risk assessment in terms of successful strategies and arrangements for students, informed by specialist knowledge.

2.2.1 Stress and mental health

There is another implied contractual term that institutions will not make academic life unduly stressful for students, and it would appear that institutions that have not explicitly acknowledged the psychological dimension to their courses may be not fulfilling their contractual obligations[6]. The decisions that a HEI makes over potentially stress-inducing structures, such as student workloads, spread of deadlines, learning methods, availability of tutors or other learning resources, etc, should therefore be at the forefront of Student Experience strategies, student satisfaction surveys, or complaints procedure reviews. Overly stressful courses or underperforming pastoral care could open institutions to criticism, especially if a student does not achieve their educational goals.

Mental health difficulties can adversely affect a student's capacity to cope with stressful demands and, given the large numbers of students with mental health difficulties in HE, this issue is not one which can be avoided. Institutions should therefore be evaluating their operation, as well as the performance of pastoral care duties, in this context.

It is also highly likely that flexibility of assessment patterns and types, course structures, and other academic functions would need to be considered. For example, allowing a student to start at a slow pace and then building up to the usual pace of studying can allow them to gain confidence and rediscover lost skills. This would also be relevant to students who have been unwell while studying. Many people with mental health difficulties spend a number of years out of employment and education and may not wish to "waste time" by taking longer to complete a course than they need so may therefore prefer to study at a faster pace. Of course these kinds of reviews would also form part of the anticipatory adjustments required under the Disability Discrimination Act and Disability Equality Duty (see section 2.3) and will necessitate individual institutions' as well as the sector-wide consideration.

2.3 Disability Discrimination (DDA) and Disability Equality Duty (DED)

Institutions have a duty under the DDA to make "reasonable adjustments" to take into account the needs of students with a disability; these can be reactive adjustments - responding to an individual student's needs - and anticipatory adjustments – anticipating that student cohorts will contain people with disabilities and making adjustments prior to any individual disclosure[4].

There still exists the idea that mental health difficulties are not covered by this law, or that if a student's difficulties are stabilised using medication, or if a student is undergoing therapy, that a University does not need to consider the students' educational needs. The DDA would not take into account the effect of any medication, so a student who has a mental health difficulty which is well controlled by medication is still likely to be covered by the Act. Someone undergoing therapy is likely to still experience difficulties during this process and they are therefore also still covered by the Act. A person who has had a condition which is likely to re-occur is also covered by the Act, so there still may be a legal requirement pertaining to students who have had mental health difficulties in the past.

It is worth noting that a survey on the Disability Rights Commission (now Equalities and Human Rights Commission) website found that 52% of people who would qualify for protection under the DDA did not consider themselves disabled. This is likely to be particularly applicable to students with mental health difficulties. Indeed, many students who have the most common forms of mental health difficulties such as depression and anxiety do not even recognise the label of "mental health difficulties" as applying to their condition. There will also be students who have mental health difficulties who do not meet the legal definition, but are nevertheless disabled within the specific context of undertaking a HE course, or some particular aspect of a course (such as examinations).

For these reasons it is sensible for institutions to adopt wider criteria than the Act requires. AMOSSHE usefully identifies a criteria of a student "whose mental health difficulty, be it a long term mental illness, an emerging mental health problem, or a temporary, but debilitating, condition or reaction, that may inhibit their ability to participate fully in Higher Education without appropriate support."[13]

The DDA was amended in 2005, to place a Disability Equality Duty on all public bodies. The two most important requirements of relevance to this document are that institutions are required to:

- Promote equality of opportunity between disabled persons and other persons.
- Take steps to take account of disabled persons' disabilities, even when that involves treating disabled persons' more favourably than other persons.

The DED brings into focus the idea of anticipatory adjustments. As it is inevitable that, at some time, cohorts will contain people with mental health difficulties, and that this can potentially affect many of the institution's functions, policies and procedures, making anticipatory adjustments should be actively considered in any Disability Equality Scheme. Making anticipatory adjustments would also go some way to ameliorate the potential detrimental effects on a student's health of negotiating reactive adjustments, which can often be a stressful process. However, it is questionable whether mental health difficulties are given the priority they deserve in

existing Disability Equality Plans. This is surprising given that mental health difficulties are the leading cause of disability amongst young people, and that at any time one in seven people will have a diagnosable mental health difficulty.

Mental health difficulties should therefore be considered from the outset when designing courses and services provided by an institution. A way to fulfil this duty in respect of support for students with mental health difficulties would be for an institution to use as a starting point the question of what is required of students with mental health difficulties when completing a HE course, and subsequently comparing this to what is required of non-disabled students. An approach which uses as a starting point, what is required of students in general, and then considers adjustments, runs the very serious risk that students with mental health difficulties will continue to be disadvantaged.

Equality Impact Assessments may be another useful tool in this context to eliminate policies and procedures that discriminate against people with mental health difficulties. The process of identifying and reviewing policies and procedures needs to be an ongoing process because it is impossible to anticipate every policy which may have a detrimental effect on students with mental health difficulties.

2.3.1 Disability services

As noted earlier, people with mental health difficulties would have extended rights under the DDA, although the relation of this to individual students with mental health difficulties is complicated by the fact that there is no legal definition of what constitutes a mental health difficulty. Alterations to the DDA mean there is no longer a requirement for a mental health difficulty to be clinically well recognised in order for it to be considered a disability. Institutions must therefore ensure they are in a position to assess this and the subsequent reasonable adjustments.

With working knowledge of the DDA and DED, and working within a social model of disability, University-based disability services are in some congruence with the national policies and legal requirements in relation to students with mental health difficulties. Some disability services have begun to set up support specific to students with mental health difficulties, and it will be important that there is expertise within the service, and that the service is not merely an extension of a generic disability model. This is highlighted by the fact that students with apparently similar mental health difficulties can be affected in very different ways, and an adjustment which would be helpful for one student may be less helpful, or even counter-productive, for another.

It will also be important that students are made aware of such specialist support so they are confident in discussing the range of issues affecting them. Such a service should enable access to itself by appealing to how students with mental health difficulties view themselves, which may not be as a disabled person. It would also be essential that mental health support is given sufficient backing and resourcing for it to address the issues previously noted.

The stigma associated with mental health difficulties currently means that only a fraction of potentially eligible students would currently request reasonable adjustments. This is likely to be leading to a lot of wasted talent, and to many intelligent students achieving far less than they could. A final element of the DDA is

the monitoring of adjustments and ensuring they are effective. If the amount of reactive adjustments being made is high, or is increasing, this should be an indicator that strategic consideration needs to be given to the particular area affected to ensure that the provision made by the University are as inclusive as they could be. This may be useful in unlocking certain funds to develop more strategic, inclusive arrangements with regards to mental health difficulties such as the Disability Premium Fund.

Institutions which are serious about improving student retention and progression cannot afford to ignore the issue of making adjustments for students experiencing mental health difficulties. As the stigma breaks down, students with mental health difficulties are likely to become far more vociferous in demanding their rights. It will be essential that institutions have developed their model of disability/mental health to encompass the specific needs of students with mental health difficulties and ensure there is adequate knowledge-base and assessment skills to address the vast range of difficulties, diagnoses and areas that will need to be addressed through reactive and anticipatory adjustments. Currently, many HEIs may not be in a robust position to defend themselves against the potentially large number and range of legal challenges which it is reasonable to foresee will start to come from students with mental health difficulties. In this regard it is worth noting that the provision of specialist workers to support students with mental health difficulties will be important, but this is only one small part in demonstrating legal compliance.

2.3.2 Disability funding

Adherence to models of disability which rely on medicalisation of mental health difficulties, and direct support solely towards those students who are already disabled by their mental health difficulties, will mean that the only people who can use such services are those who may already have experienced significant problems on their course, and perhaps may already be considering taking a leave of absence or withdrawing. Similarly, adhering to a funding/resourcing model which provides such services to those already experiencing significant problems means that there is limited prospect of using practical support mechanisms in a preventative way to improve the retention and results of students with mental health difficulties, and prevent their social exclusion.

The disability model has some value in its current form in assisting those students who have already developed mental health difficulties, but it is not effective for those whose difficulties are developing, intermittent or of a short-term nature (including severely disabling disorders such as some psychoses). Providing support and resources primarily on the basis of the duration of the difficulties or how adequately they can be described by medical services is inappropriate because of the complexity of mental health difficulties. Such an approach is not congruent with many HEIs objectives in improving educational outcomes for students, and would need to be a major consideration for individual HEIs as well as the sector as a whole.

2.3.3 Disabled Students' Allowance (DSA)

Students with mental health difficulties may also be eligible for funding for support from the Disabled Students' Allowance. The provision of human support or technological aids needs to be skilfully introduced to students, as they may not even

view themselves as having mental health difficulties, let alone being a disabled student. Furthermore, using the DSA mechanism for students with mental health difficulties must based on careful assessment of their situation. For example, equipment and other resources which makes it easier for students to withdraw from activities should only be provided if, without them, the student is not going to be able to get their work done; if it merely allows them to avoid something they find difficult, this can be re-inforce the avoidance and therefore disabled the student further.

Being able to advise on the use of the DSA and drawing the distinction between enabling and disabling support as a DSA Needs Assessor can, in practice, be very difficult and it is only by having a good knowledge of mental health difficulties and working in partnership with the student that the correct conclusions can be drawn. The process of jointly reaching the most effective conclusions in DSA needs assessments also requires expertise in making specific recommendations, based on the idea of entitlement, the DDA, and duty of care considerations, which might are likely to include being very conscious of the fact that recommendations or adjustments may also have the potential to disable a student further or worsen their mental health.

2.4 Disclosure and the Data Protection Act (DPA)

Disclosing a mental health condition to a HEI is an elective process for most, as there is no requirement for students to disclose. Students may be required to disclose as part of an Occupational Health screening for certain courses which lead to registration with a professional body, such as nursing or teaching, the purpose of which is to assess whether there is a medical reason why someone cannot do the job or if the student presents a risk to others (such as children or vulnerable adults). In both cases, if a student's mental health difficulty is likely to cause an adverse effect on their ability to work or study, then the employer (in the case of placements or professional courses) or the institution (in the case of disclosures to the University) must consider any reasonable adjustments that would reduce these, in line with the DDA.

As more students (and trainees/employees) become aware of their rights and subsequent benefits to disclosing, then institutions/employers will need to increasingly reflect on the need for anticipatory adjustments. Of course, anticipatory adjustments ought to be considered in light of the significant numbers of students/employees who experience mental health difficulties. Making such adjustments may mean that some students have less cause to disclose, as their needs in each particular context are adequately met. However, it is currently questionable as to how much attention or priority is given to mental health difficulties in any Disability Equality Scheme (see section 2.3) and only a tiny minority of people will disclose a mental health difficulty to a HEI.

The effects of a lack of disclosure and a lack of anticipatory adjustments often means that large numbers of students with mental health difficulties are currently experiencing ongoing problems with their courses and are potentially underachieving. For example, anxiety in busy places (such as change-overs between lectures or during exams) or panic attacks during stressful times (such as on arrival at University or during exams) are common and affect someone's access to, or performance on, their course. With few anticipatory adjustments being made, students are currently

solely reliant on disclosure as a means of having their needs within the HE environment assessed and met. Disclosing can be a significant hurdle as the position assumed by people with mental health difficulties is that they will experience prejudice and discrimination subsequent to doing so. As the Social Exclusion Unit and many mental health organisations such as the Sainsbury's Centre for Mental Health, Mind, Re:Think and Mental Health Foundation note, discrimination and prejudice can often be more disabling than the mental health conditions themselves.

One of these prejudicial attitudes is the view that students' mental health difficulties should be dealt with privately, usually by specialist services, so that the student can then "fit in" with existing organisational and societal structures. This kind of response to a disclosure can lead to a lack of consideration of the issues which the student faces (and has probably just declared) and the connection between the concept of reasonable adjustments to students' mental health difficulties is not made. This can often be counterproductive in terms of the student-institution relationship as well as leaving the institution open to criticism that reasonable adjustments have not been considered.

Given that people with mental health difficulties often lack confidence and struggle to challenge this attitude and often lack knowledge of their rights, and that young people do not necessarily fully understand their own conditions, and what adjustments could be made, this has historically meant that their needs – as a large cross-section of the institution's community - have remained hidden. Furthermore, as the issue of student mental health difficulties/reasonable adjustments remains hidden, this leads to a lack of uptake of support which is specific to the HE context, including those support services which aim to improve social inclusion or intervene early to improve student mental health or aid recovery.

The issue of student mental health must therefore be something which is given extensive consideration in any strategies which monitor the disclosure rates or the numbers of students with disabilities at University or within each HEI. Given the disparity between the numbers of students disclosing mental health difficulties, and the numbers of students with mental health difficulties, the issue of disclosure ought to be a central component in the monitoring side of Disability Equality Schemes.

Institutions already have access to a wide range of sources for information about student mental health difficulties – application forms, CVs, personal tutor and pastoral contact, Impaired Performance/Special Circumstances letters – which may act as useful sources of information with regards to actual disclosure rates and subsequent reactive/anticipatory adjustments.

3 What are the key parameters that define effective support?

Higher Education operates in a context of citizenship, rights and government regulation. The policies and legal obligations outlined above draw attention to the role of Higher Education in furthering social inclusion, and the opportunities for improving or maintaining a HE context conducive to effective studying. It seems inevitable that in the next few years institutions are going to be asked to give serious attention to the issues facing students with mental health difficulties, especially given that the Equalities and Human Rights Commission have indicated that they are going to be looking very closely in the future at outcomes for various groups in HE. Without

taking steps to address the needs of students with mental health difficulties, in strategic and practical terms, institutions are likely to come under increasing criticism and litigation.

Currently, students with mental health difficulties are not served well by an assumption that a generic disability model will lead to their needs being addressed; nor should it be expected that a HEIs social capital would automatically absorb the context-specific needs of students; nor should it be expected that students' needs will be resolved using counselling and therapeutic services; nor are they served well by an assumption that stable mental health will, of itself, lead to educational achievement.

It should be apparent that the needs of people with mental health difficulties are very diverse, and the responsibilities of HEIs owed to them go beyond what traditional counselling, therapeutic and disability approaches are designed to deal with. Instead, there needs to be a more sophisticated model for understanding the needs of people with mental health difficulties within the HE context. Employing specialist Mental Health Advisors, the quantity reflecting the size of the institution, who have extensive professional expertise in the field of mental health will be essential in ensuring that the institution can assess, advise and plan a range of practical support strategies aimed specifically at meeting the needs that students have as a direct result of having mental health difficulties. The Mental Health Advisors, or Mental Health Support Team, would also take a lead role in shaping and implementing an institution's approach to meeting the needs of students with mental health difficulties on a strategic level.

The development of such roles and subsequent recommendations regarding the provision of support, improving services, developing strategies, updating polices, and making reasonable adjustments, should be supported by commitment across the whole institution on the basis that it will benefit a large number of students. It would also be important to recognise that some initiatives would not necessarily be expensive or complicated to implement. An institution which does not employ such specialists to actively consider how the fundamentals of Higher Education affect students with mental health difficulties may be open to criticism that it is not serving its student body, its staff, or its funders as well as it might.

Ignoring the issues outlined above, and failing to support someone in a specific capacity to address them, is consistently going to cost the sector a considerable amount because of poor retention rates, poor prestige, and poor results than could have otherwise been achieved. Conversely, since mental health difficulties affect such a large proportion of the student population and can no longer be seen as a marginal issue, addressing their needs is likely to contribute to an improvement in academic performance and retention rates, as it allows the harnessing of students' true potential and removes unnecessary and discriminatory barriers from this happening.

The variation between HEIs as regards to their level of engagement with the needs of students with mental health difficulties and their commitment to people employed as Mental Health Advisors seems to be influenced by the views and attitudes of line managers and existing services, some of whom may have little expertise in the field. Whilst individuals may have different opinions about what constitutes effective

support and how to provide it, a student's experience can differ significantly as a result of the different attitudes of existing support services, senior managers, academics, funding providers and gaps between different sectors. This is clearly inequitable.

While there is room for some variation in how local initiatives will attempt to address the issues, the following parameters have been identified by the University Mental Health Advisors Network as being the most relevant in the level of responsibility of, and the approach taken by, an institution and their Mental Health Advisors. These parameters are also ones which the institution must support a Mental Health Advisor in addressing to adequately support students:

- A culture must be encouraged in which people with mental health difficulties studying at Higher Education level becomes a mainstream notion.
- The rights of students with mental health difficulties must be promoted as a more mainstream notion to ensure the context-specific needs of students are effectively supported.
- Institutions must recognise, and adapt their strategies and polices so that they are congruent with external factors related to mental health. This would inevitably mean developing systems and procedures to demonstrate an ongoing commitment to remove the barriers to the full participation of people with mental health difficulties in Higher Education.
- Institutions must ensure they are in a position to advocate to, and liaise with relevant bodies, to promote the rights and interests of students with mental health difficulties to ensure there is a comprehensive and holistic response to student emotional and mental distress.
- Student mental health difficulties should not be viewed as individualised and/or pathologised problems. This is not an accurate or empowering perspective for students or institutions.
- Institutions must ensure that there is an enabling framework for staff and students to accept their responsibilities. Not doing so will create an inefficient and inequitable approach.
- Opportunities for improving the quality of all aspects of the student experience, based on a student mental health perspective, must be developed; mental health is everyone's business.
- Policies and procedures must be revised so that they relate to, and are inclusive of the needs of, people with mental health difficulties.
- Mental health promotion strategies must move beyond information-giving and address social and cultural barriers to mental health.
- Institutions must give priority to resourcing ongoing support for students with mental health difficulties which focus on empowering them to undertake their course successfully, as well as promoting the uptake of specific funding mechanisms such as the Disabled Students Allowance.
- Institutions must ensure that the assessment of student mental health needs, and subsequent interventions, takes into account the personal, psychological and practical situations which students find themselves in. Indiscriminate provision of support may be unrealistic and build up undue dependency.
- Services and approaches need to be re-oriented to being about prevention and early intervention, as well as crisis and relapse management. This approach would aim to prevent social exclusion in the first place as well as improved educational and health outcomes from early intervention.

- Consideration must also be given to the involvement of, relationship with, significant others in students' lives and their needs (e.g. housemates, parents, etc).
- Institutions must finally develop their existing support services and facilities so that they aim to meet the specific and distinctive needs of students with mental health difficulties. Services which are generic in their approach to mental health difficulties will not meet the specific needs of the community they aim to serve.

Senior management, including Vice Chancellors, ought to be prepared to take student mental health seriously and require all staff within the institution to do likewise. This requires them to do more than take a passing interest in initiatives related to mental health, and become pro-actively involved in bringing about their implementation. This would necessitate action both within the institution and externally.

Externally it would almost certainly involve advocating at a national level for closer cooperation between the Department for Business, Innovation and Skills and the Department of Health. Locally it would include advocating to regional/local services for developments in line with the National Service Framework and National Social Inclusion Programme to take into the account the needs of students and lead to a partnership approach with HEIs. Internally, academic departments should be encouraged to refocus their thinking in ways that recognise the centrality of mental health issues to the student experience and the very strong links there are between student mental health and issues such as results and retention. At all levels, there must be an emphasis on the rights of students with mental health difficulties.

Adapting to the issues associated with student mental health will greatly improve services to the whole student body, will bring economic and intellectual benefits to students and institutions, and thereby society at large.

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