

# **New Horizons in Mental Health: Points to consider from a Higher Education perspective**

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## **MENTAL HEALTH PROMOTION & EQUALITY OF OPPORTUNITY:**

- 1 Reducing stigma at an earlier age by introducing the concept of mental health into school settings, including information on activities which promote mental health and greater encouragement for young people to partake in these activities including wider promotion of mental wellbeing in the wider population. The Royal College of Psychiatrists' 2003 report into the mental health of students recommended that mental health promotion should be addressed in HE settings<sup>1</sup> – but arguably this should be rolled out in secondary or even primary schools?
- 2 One of the running themes of the National Service Framework for Mental Health 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 studies, such as that by the Royal College of Psychiatrists and Heads of University Counselling Services, indicate that years of information-giving alone is not improving the mental health of student populations. Mental health promotion should therefore move beyond information-giving and address social and cultural barriers to mental health.
- 3 When considering the focus on healthy, independent living and quality of life such ideas often seem to be very vaguely constructed, and it is therefore difficult for service providers to know what they are aiming for, and for anyone else to know when they have achieved it. It may then be helpful to look outside of mental health services and give consideration to how these things are constructed in society more generally. The most obvious point which is often raised is about employment, but there is rarely an explicit link made to education, and an explicit link to HE is even rarer.
- 4 Therefore, consideration should be given toward forging greater links with HEI's, and in supporting young people with mental health difficulties to undertake educational qualifications, at a level comparable to their peers. This might include, for example, making sure that students with mental health difficulties are routinely made aware of their entitlement to apply for the Disabled Student Allowance (DSA), as most are currently unaware of this, and are therefore missing out on important sources of support. Students with mental health difficulties would also benefit from being made aware of their rights under the Disability Discrimination Act, and be supported in negotiating with HEI's what adjustments they can expect to be made.
- 5 There could also be consideration given to the needs of students as carers. It is often assumed students will help or support someone in their family who is affected by a mental health difficulty, but for those students who are in the position of carers, there may be very little consideration given to their own needs for support.

- 6 The National Service Framework for Mental Health 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). Given that the peak age of initial onset of psychiatric disorders like schizophrenia and bi-polar disorder is between the ages of 18-30 and that other mental health difficulties are likely to be at their most acute between the ages of 16-25 (affecting between 1 in 7 and 1 in 5 people) 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, 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).

#### **EARLY INTERVENTION:**

- 7 There are over 400,000 students accepted onto undergraduate courses each year, of which the Royal College of Psychiatrists estimate from 2003 indicates 1 in 4 will experience mental health difficulties at some point during the course of their study. Early Intervention in Psychosis is an example of good practice with regard the early treatment of individuals who may be at risk of developing psychosis - but excludes young people who are at risk of developing other mental health problems including anxiety, depression, self-harm, suicidal ideation/behaviour, personality disorders and eating disorders.
- 8 Further, the RCP acknowledges that there has been a progressive narrowing in recent years of access to mental health services, for which the focus has been on treating people with severe mental illness, may have resulted in an increased tendency for students with moderate mental health problems instead to seek pastoral academic support and referral to University counselling services. Unfortunately, pressures on mental health services have coincided with increased pressures on University resources.

#### **IMPROVED CARE PATHWAYS & COMMUNICATION BETWEEN STATUTORY SERVICES, UNIVERSITIES & FAMILIES:**

- 9 Clearer care pathways, particularly when considering the transition from child to adult services. Transition from CAMHS to adult services can be particularly difficult for young people, particularly when this time corresponds with the transition from school to higher education. Therefore, improved links between CAMHS and adult services would benefit students.

- 10 The RCP report recommends that funding bodies must ensure that services which support the mental health of students are adequately resourced to meet the needs of the growing HEI student population. In addition, when considering that the seasonal influx of students can increase the local population from anywhere between 2,000 (Lampeter) to 40,000 (Manchester), during term time, it would make sense for local Health and Social Care Services to employ additional part-time staff during term time, to provide adequate cover for the transitory population of students.
- 11 The Responses and Prevention in Student Suicide report from 2007<sup>2</sup> found that not all university/college support services seemed to communicate effectively. Information sharing protocol between universities and local health services should therefore be improved and standardised. For example, some University Mental Health Advisors/Coordinators are able to refer students directly to Crisis Resolution and Home Treatment Teams, Community Mental Health Teams and/or Early Intervention in Psychosis teams – whereas other University Mental Health Advisors/Coordinators are reliant on the student's GP to make a referral. Given that students in higher education are a high risk age group for onset of serious mental illness, it would be useful to forge improved links between universities and Early Intervention services for first experiences of psychosis in particular.
- 12 The RCP recommends the development of a local network is required to ensure shared policies, cooperation and communications between HEI health and counselling services, primary and secondary mental health services and relevant agencies.
- 13 There are considerable difficulties with regard students not being permitted to be registered with two GPs. Having to see a consultant at home, when they are registered with a consultant on campus and vice versa. The RCP 2003 report acknowledged that there may be a lack of coordination between home and college GPs with failures of communication compounding the student's difficulties. Students with pre-existing psychiatric disorders sometimes arrive at college without local services having been informed of their need for support and treatment. Later, students who have been incapacitated by psychiatric disorder might be sent home to obtain treatment, but home services might not be geared to provide this in the time scale of the academic calendar.
- 14 Even when referrals are accepted, the relatively slow response of mental health services might fail the student because of the structure of the academic year. At worst, the student may have left college for a vacation before the appointment was available. Therefore, we consider that statutory mental health services who are involved with supporting/treating students with mental health difficulties should take greater responsibility for the seamless referral to mental health services in the place where the student chooses to study, and also to offer enhanced availability of mental health services to students when they return home during vacations.

- 15 The RCP recommended the active use of the Care Programme Approach to ensure effective collaboration in the student's treatment between the student, university support services, college and home GP and mental health workers, carers identified by the student and so on.
- 16 When statutory services are alerted to a student experiencing difficulties with their mental health, there can sometimes be little emphasis given to the information provided by housemates or siblings of the student, who may have a greater awareness and understanding of the lifestyle and recent changes which may be a factor affecting the student's mental health than the "nearest relative".
- 17 As regards monitoring the care for students, there is currently no mechanism for health/social services to record "student" data and therefore monitor it. Perhaps this would also be something for you to enforce with health/social care services?
- 18 RaPPS findings also indicate that a substantial proportion of student suicides occur during transitional periods, e.g. at the start or towards the end of the academic year, highlighting the earlier point acknowledging the difficulties of transitions for many students. Possible strategies could include the review of the availability of resources during these key periods (April to June, August to October); developing links between schools/ colleges with HEI's to ensure that they are made aware of their entitlements and the level of support they can expect to receive, as at times this can differ from FE. Promoting positive messages about mental well being in schools may further encourage those with emerging problems to access services.

#### **IMPROVED PROVISION OF PSYCHOLOGICAL SERVICES:**

- 19 It is understood that mental health difficulties amongst the student population is increasing in terms of numbers of students presenting with mental health difficulties and the complexity of those difficulties. Given these increases, there can be a frustration in identifying the mental health support needs of students when there are limitations to the treatment options available through statutory services. There should therefore be an improved provision of statutory, specialist mental health services for students with mental health difficulties/disabilities.
- 20 The RCP report recognised that the long waiting periods for access to specialised NHS psychological treatment services are a particular problem. For these reasons, university mental health support and counselling services are often expected to provide specialised psychological therapies and few have sufficient resources to offer treatments to all students who need them.
- 21 The RaPPS study recommends that mental health services should be made more attractive to the student population, particularly young men – as many

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students are concerned about the stigma associated with the use of University or NHS support services. Most students included in this research were young men in their early twenties. In two-thirds of the case studies, they had been diagnosed with a mental health problem at time of their death and in most cases these problems had emerged while they were students. Seeking the opinions of students regarding how services could be improved would therefore be necessary.

- 22 Although the Improving access to Psychological Therapies Programme (IAPT) is being rolled out across the country, there are considerable differences in areas where IAPT is well established, and other areas where it is in the initial stages of recruitment of staff. Currently, IAPT is available in only 35 out of 152 PCTs.<sup>3</sup> For many students, living in areas where IAPT is not available or in its infancy, the provision of psychological services is relatively poor, with waiting lists for referral to psychological services of 18 months or more in some cases. Many students have an expectation that if they see their doctor, they can be referred for counselling/psychology services relatively quickly, when in reality, this is too frequently not the case.
- 23 Whilst the IAPT programme is likely to benefit students in Higher Education as well as the rest of the population, specific issues related to engaging with the student population will need to be addressed. 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.
- 24 Although the computerised cognitive behavioural programmes of Beating the Blues and Fear Fighter are being made increasingly available, they are designed for the general population and anecdotal evidence from students who have been prescribed either programme suggests that the attractiveness and efficacy of these programmes amongst some of the student population may be relatively poor.
- 25 The RCP recommended that, where there are a large number of students, the local PCT should develop a mental health strategy in consultation with university health and counselling services. This may require a needs assessment and option appraisal for the design of NHS treatment services, including psychological therapy and substance misuse services, sensitive to the needs of students in terms of their developmental stage and the structure of their academic year.
- 26 Waiting times for consultant psychiatry appointments are frequently up to 11 weeks long; considering the University term lasts for 10 weeks, it is not unusual

for students to be offered an appointment when they are on vacation. Waiting times for the student population is a particular issue not just because term may have ended in the meantime and students may have returned home and find themselves needing to negotiate with a different health service, but also because even a few weeks out of study may prevent a student from completing the year or even their entire programme of study (in comparison to the situation for someone in employment where a few weeks absence may be, in most cases, merely inconvenient).

- 27 Research has suggested that students with depression are twice as likely to drop out of their studies.<sup>4</sup> Given that the RaPPS study also indicates that perceptions of 'failing' are strongly associated with suicidal thinking, it seems clear that prompt access to statutory mental health services for the student population is a necessity.
- 28 Once a student has been seen by a consultant psychiatrist, there may be issues with regard over reliance on medication because of the paucity of psychological treatments available. The findings of the RaPPS study also indicates that antidepressant medication still appears to be the main intervention offered by GPs. Students' friends and parents reported that a number of those who died had thought taking antidepressants was stigmatising and ineffective. We therefore consider that prompt access to specialist statutory mental health services, delivered within greater emphasis on the biopsychosocial model (as opposed to the biomedical model) may be of greater benefit to the mental health of students.
- 29 The RCP report concluded that, where appropriate, if the size and needs of the student population warranted it, consideration might be given by NHS trusts for the formation of a dedicated student mental health service (akin to a student CMHT).
- 30 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.

#### **REFERENCES:**

<sup>1</sup> <http://www.rcpsych.ac.uk/files/pdfversion/cr112.pdf>

<sup>2</sup> [http://www.rapss.org.uk/pdf/rapss\\_full.pdf](http://www.rapss.org.uk/pdf/rapss_full.pdf)

<sup>3</sup> <http://www.communitycare.co.uk/Articles/2009/08/07/112312/is-the-roll-out-of-talking-therapies-fast-enough.html>

<sup>4</sup> <http://www.mentalhealth.org.uk/information/news/?EntryId17=73561>