The mental health of students in higher education

Council Report CR112
January 2003

Royal College of Psychiatrists
London
Due for review: 2006

Contents

Acknowledgements

The following people offered information, comment and assistance in the preparation of this report:

Ms Cris Allen, Mental Health Adviser, Royal College of Nursing

Dr Jacqueline M. Atkinson, Senior Lecturer, Department of Public Health, University of Glasgow

Ms Elsa Bell, Head, University Counselling Service, University of Oxford

Dr Peter Burke, British Association of Health Services in Higher Education

Dame Fiona Caldicott, Principal, Somerville College, Oxford

Dr Denise Coia, Chairman, Scottish Division, Royal College of Psychiatrists

Ms Jane Davies, Warneford Hospital, Oxford

Dr Peggy Frith, Deputy Director of Clinical School, University of Oxford

Dr Rob Hale, Tavistock Clinic, London

Dr Colette Halpin, Chairman, Irish Division, Royal College of Psychiatrists

Professor Keith Hawton, Centre for Suicide Research, University of Oxford

Ms Amalia Holman, Policy Adviser, Universities UK

Ms Susie Jackson, Chair, Association for University and College Counselling

Jonathan Leach, Oxford Student Mental Health Network

Dr John Lethem, Chair, British Association of Health Services in Higher Education

Dr Sheila Mann, General Medical Council

Dr Barbara Nagy, Mental Health Task Group, Royal College of General Practitioners

Dr Sinead O'Brien, Student Health Service, Trinity College, Dublin

Ms Kate Prangley, Warneford Hospital, Oxford

Ms Miranda Shaw, Warneford Hospital, Oxford

Ms Nicky Stanley, Department of Social Work and Community Health, University of Hull

Professor Chris Thompson, Head of School of Medicine, University of Southampton

Professor Andre Tylee, Institute of Psychiatry, London

Dr Rob Waller, Student Medical Practice, Leeds University

Ms Melba Wilson, Policy Director, Mind

Mr Peter Wilson, Director, Young Minds

Student Mental Health Working Group

Dr Tom Berney, Faculty of the Psychiatry of Learning Disability, Royal College of Psychiatrists

Ms Simone Black, Eating Disorders Association

Dr Ken Checinski, Faculty of Substance Misuse, Royal College of Psychiatrists

Professor Ilana Crome, Faculty of Substance Misuse, Royal College of Psychiatrists

Dr Charlotte Feinmann, Liaison Psychiatry Section, Royal College of Psychiatrists

Professor Simon Gowers, Faculty of Child and Adolescent Psychiatry, Royal College of Psychiatrists

Dr Mike Hobbs, Psychotherapy Faculty, Royal College of Psychiatrists *(Chair)*

Dr Adrian Marsden, Collegiate Trainees Committee, Royal College of Psychiatrists

Dr Tariq Mahmood, Faculty of General and Community Psychiatry Faculty, Royal College of Psychiatrists

Ms Eileen Smith, Association for University and College Counselling/Heads of University Counselling Services

Dr Robert Smyth, Collegiate Trainees Committee, Royal College of Psychiatrists

Mr Chris Walden, Parliamentary and Policy Officer, Royal College of Psychiatrists *(Secretary)*

Executive summary

Careful evaluation of the work of university counselling services and recent media attention have enhanced awareness of the mental health needs of students in higher education. There has been a progressive increase in the number of students presenting to counselling and student health services, and in the severity of their mental health problems. Drug and alcohol misuse is a serious concern.

The Government's target is for 50% of young people, aged up to 30, to have access to higher education by 2010.

Higher education institutions (HEIs) already make considerable provision for the well-being of their students. Almost all have in place sophisticated pastoral and counselling provisions, and there are numerous examples of good practice in identifying and supporting students with mental health problems. The range of resources deployed by HEIs is increasing to meet the requirements of the Special Educational Needs and Disabilities Act 2001. National Health Service (NHS) facilities, both in primary care and specialist mental health care, have a significant role in working with HEIs to address the needs of students with mental health problems. However, NHS mental health care provision for students is variable, and there are often significant obstacles to access and continuity of care. Despite their intellectual abilities and potential for advancement, students with mental health problems are a disadvantaged population. The modernisation agenda for mental health services therefore offers an opportunity to improve facilities for students.

A working party of the Royal College of Psychiatrists has investigated this complex subject and the findings are contained in this report. Although its conclusions and recommendations are set out below, readers are referred to the main body of the report for a comprehensive account of the issues.

This report reviews the nature, prevalence and causes of mental health problems in higher education students; reviews existing services; and presents recommendations for the development of strategic policy and best practice in relation to mental health promotion and the identification and treatment of mental ill health in this growing population. The recommendations will be of interest to students and HEIs, but are aimed primarily at those who commission and provide mental health services, including psychiatrists and other mental health staff.

Conclusions

1. There is evidence, particularly from the evaluation of student counselling services, that the number of higher education students presenting with symptoms of mental ill health has increased in recent years. An increase has been demonstrated in the number of students presenting with more

severe mental health problems. Mental health problems can be severely disruptive to the student's capacity to study and learn.

2. The available research evidence suggests that students report increased symptoms of mental ill health compared with age-matched controls. However, there is no empirical evidence to confirm that students are more likely to suffer diagnosable mental disorder or illness than the age-matched non-student population. It is essential to differentiate severe mental disorder/illness from less severe conditions, as their management and potential implications for continued study are likely to be different.
3. Higher education is associated with significant stressors, including the emotional demands of transition from home and school to the less structured environment of college, independent study and examinations, and financial pressures. Although stress is not pathological in itself, and indeed it may be necessary for maximal performance, such stressors may contribute to the higher rate of emotional symptoms among students.
4. The increase in numbers of students seeking help with serious mental health problems probably reflects:
    - the rapidly increasing numbers of students entering higher education
    - the progressive approximation of the characteristics of the student population to the general population, as university student populations may previously have displayed a lower incidence of mental health problems
    - the increasing willingness and choice of young people to identify, disclose and seek help for a range of emotional and mental health problems.
5. The progressive narrowing in recent years of access to mental health services, for which the focus has been to treat 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.
6. Mental health problems in students may be seriously disruptive to their education and emotional development, and sometimes to other students and the educational institution.
7. For this reason, it is appropriate for HEIs, primary health care services, secondary mental health care providers and other relevant agencies to address the issue of student mental health in a coordinated manner.

Recommendations

Recommendations are set out in a 'linear' arrangement, which is designed to reflect the stages of a student's potential mental health journey.

1. Mental health promotion should be addressed actively in each higher education institution and could include:
    - programmes to promote emotional literacy
    - education about sexual health
    - education about substance use and misuse
    - education about the causes, identification and management of mental health problems.
2. Information about mental health for students, including available services, should be publicised in student handbooks, notices, websites and targeted educational campaigns.
3. Mental health policies have been developed in most HEIs and set out clear frameworks for supporting students with mental health problems, including substance misuse. All HEIs need such policies, which should be communicated to relevant internal bodies, including the student body, in the form of written guidance on services and procedures. These policies should also be discussed with other relevant agencies, including primary health care teams and local mental health providers.
4. University counselling services are, in effect, the primary mental health care option for many students, and should be resourced accordingly.
5. Nationally agreed policies should be developed, not only to ensure continuity of mental health care between the student's home area and the university, but also to preclude conflicts between home and college NHS providers about funding. These should clarify the responsibilities of primary health care and secondary mental health care providers in both settings, university health and counselling services, and of the student.
6. Where there are large numbers of students, the local Primary Care Trust should develop a student 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 the academic year.
7. Development of a local network is required to ensure shared policies, cooperation and communications between HEI health and counselling services, primary mental health care services, secondary mental health services and other relevant agencies.
8. Identification of a mental health adviser in each HEI, likely to be the head of the counselling service or the disability officer, to whom internal and external bodies may turn for information and advice.
9. Identification of student advisers or 'champions' in the local mental health service, including the community mental health team (CMHT), in-patient unit, deliberate self-harm service, substance misuse team, eating disorder service and psychological therapy service.

10. Mental health services to promote access for students by taking into account their attitudes, developmental needs and academic timetable, and by finding ways to 'inreach' HEIs.
11. Active use of the care programme approach (CPA) to ensure effective collaboration in the student's treatment between the student, university counsellors, college and home general practitioner (GP) and mental health workers, and carers identified by the student, for example family or college officers. It must be recognised, however, that university counsellors and other HEI staff are not qualified mental health workers and cannot assume the responsibilities of care coordinators.
12. Where appropriate, if the size and needs of the student population warrant it, consideration might be given by NHS Trusts to the formation of a dedicated student mental health service (akin to a student CMHT).
13. Specific attention should be given where necessary to the accommodation needs of students with severe mental illnesses.
14. Further attention should be given by universities, mental health providers and professional bodies (including the Council for the Regulation of Healthcare Professionals) to the mental health needs of students in the medical and other health care professions.
15. Research programmes should be established collaboratively between university and NHS mental health services to examine the nature and trends of mental ill health in students and to evaluate different models of service provision. Academic departments of psychiatry have an important role in supporting research in this area.
16. Funding bodies must ensure that services that support the mental health of students are adequately resourced to meet the needs of the growing HEI student population.

Introduction

Increasing concern has been expressed about the mental health of students in higher education. Concerns have been articulated by students themselves and by the academic staff who teach them. Perhaps the most persuasive evidence of an apparent increase in mental health problems in students has been produced, however, by the counselling services and pastoral staff in colleges and universities who endeavour to assist students in difficulty, and by the staff of student health services.

In the past few years, the mental ill health of students has attracted specific media attention. Some reporting has been sensationalised and irresponsible, for example when describing the suicide of students in highly emotive and critical terms. Most media reports have been sensitive and balanced, however, drawing attention constructively to the apparent growth of emotional and psychiatric problems in the student population. These might have made it easier for students themselves to acknowledge problems such as depression and eating disorders.

A report by the Association for University and College Counselling (AUCC, 1999), entitled *Degrees of Disturbance: The New Agenda*, has been particularly influential in drawing attention to an apparent increase in levels of psychological disorder among higher education students. The report prompted the Royal College of Psychiatrists to convene a working group to consider the evidence for and implications of increasing morbidity for both higher education and mental health services. Naturally, the College also wished to review the specific responsibilities of psychiatrists for the mental health of students.

The increasing number of students presenting with mental health problems reflects the rapidly increasing access of young people to higher education and the associated growth in student numbers. It also reflects the growing rates of mental health problems among young people generally. Given the trends in the general population, it is hardly surprising that rates of psychological disturbance and psychiatric illness among students are rising. The effects are profound. They are felt by the students themselves, both subjectively and through the negative impact on their education, but also by those around them, including peers and family, and by the educational institutions that the students attend.

Moving away from home, family and childhood friends to an unfamiliar place and culture constitutes an additional challenge at an age when most students are also negotiating significant developmental changes. The cultural and language differences may be felt most keenly by students from other countries. The number of mature students is growing too, and they may face particular challenges such as combining the demands of higher education with domestic responsibilities, and managing the changing patterns of established relationships that are provoked

by exposure to new ideas and expectations. Increasing numbers of students from socio-economically disadvantaged populations, and from ethnic minority groups, are obtaining access to colleges and universities. They may have no familiarity with higher education institutions or the demands of advanced study, however, and may feel isolated from the majority of students and alienated from both the institution's culture, and the families and communities from which they come. These are potent ingredients for distress and psychiatric disturbance, but the relative lack of structure and supervision often results in these difficulties going unnoticed.

On the other hand, higher education has an important role in enabling people with established psychiatric problems to develop their personal, social and intellectual potential, and thereby to make a productive contribution to society. In certain cases, entry to higher education is an important part of a patient's recovery from psychiatric illness. Caution is needed, however, as higher education imposes significant demands on the individual and may precipitate intolerable distress and illness relapse.

The stresses of university and college life, therefore, might exacerbate pre-existing emotional and psychiatric problems in some students, and precipitate disorders in others. There is a widely held view that the pressures on students have increased in recent years as a result of financial constraints, growing competitiveness, and heightened aspirations for achievement and material security. Vulnerable students might need higher levels of support in order to achieve their potential. Academic and pastoral support from staff may be more difficult to access now, however, as a result of increasing student numbers without commensurate staff increases, the trend towards modular courses, and the demand on academic staff for research and publications. Although friends and family are still seen as the main sources of support, an increasing number of students turn to university or college counselling services. However, staff numbers in counselling services, as in other university departments, have not increased in proportion to student numbers. Therefore, services are often having to manage a growing volume of demand for counselling, and an increase in the severity of the psychological problems with which students present, with limited resources. All too often, they also experience difficulty in accessing NHS services.

Primary health care services are sometimes not organised to meet effectively the mental health needs of students in higher education, although some universities have dedicated student health services with 'in house' mental health workers. 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. Evidence suggests that many students choose not to disclose their psychiatric problems for fear of prejudicing their chances of selection for higher education. Even when their psychiatric history has been disclosed at the time of application or entry, this may not have been communicated by the college to the local GP. Later,

students who are 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.

Students and colleges may find it even more difficult to access secondary mental health services. This might be because there is no working relationship between the college or student counselling service and local mental health services. In some cases, the student's psychiatric disorder might not be perceived as severe enough to achieve the prescribed threshold for access to the local mental health service. 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 might have left college for a vacation before an appointment was available. The long waiting periods for access to specialised NHS psychological treatment services are a particular problem. For these reasons, university and college counselling services are often expected to provide specialised psychological therapies. Although a number of services have appropriately trained staff, few have sufficient resources to offer specialised treatments to all students who need them.

We must not lose sight, however, of the value of higher education for positive mental health, or of the excellent work undertaken by many universities in enabling vulnerable students to benefit from higher education. Learning in a constructive and stimulating environment can enhance self-confidence and a sense of achievement, particularly if it leads to tangible rewards such as fulfilling employment. Higher education may also promote socialisation, independence and self-reliance. For many students, college life affords their first opportunities for selective relationships. Although a potential source of anxiety, the exploration of sexuality and intimacy is important in defining the transition from adolescence to adulthood. Challenges are addressed and resolved. Identities are formed. These positive aspects of student experience are powerful factors in promoting the self-esteem, resilience and sound mental health that protects against psychiatric disorder, even in the face of later adversity.

These are important issues for the Royal College of Psychiatrists. There is widespread concern about the increased incidence of psychiatric disorder among young people, including students. The mental health of school and further education students is not to be disregarded, for it significantly influences later experience. Naturally, as a medical body, the College has a particular responsibility for addressing the mental health needs of students in the health and caring professions, including medical students. There is much that can be achieved through this exercise. Academic institutions offer valuable opportunities for collaborative research and the development and evaluation of new styles of mental health service for young people.

Epidemiology

It has been suggested that mental health problems are more common in students now than in the past. However, there are a number of difficulties in obtaining reliable rates of mental health problems among the UK student population and we have little longitudinal data to discern trends over time.

The first difficulty surrounds the definition of a student. Some studies have focused on university students, but others refer to students on vocational courses at colleges of further or higher education. Some are concerned with issues around living away from home, while others include students living at home. Reported samples differ in terms of the age of students included. Much of the comparative data refers to younger populations, aged 14–18. Such differences render comparisons between findings or aggregation of data problematic.

Second, much of the research data originates from outside the UK and so its applicability to the UK is uncertain.

A third issue concerns the definition of a mental health problem. Some studies are concerned with 'disorder' and others with 'problems'. In general, the former refers to syndromes amounting to a mental health diagnosis, whereas the latter is concerned with problematic symptoms or behaviours. There is often a difference between the two in terms of threshold (higher for disorder) and methodology (disorder implying clinical diagnosis, whereas problematic symptoms and behaviours are usually based on self-report). For example, although subjective distress may be problematic, it should not be equated with psychiatric disorder.

Finally, this is a rapidly changing field and so epidemiological data quickly become out of date. Rates of some problems seem to be changing over time (see below). Of equal importance is the substantial increase in the number of students entering higher education in the UK in recent years. This is likely to influence the epidemiology in various ways. Students in large intakes may feel less supported (see Aetiology, pp. 25–27). More significantly, opportunities for study have arisen for greater numbers of young people who were previously denied it. Although in general terms this a very positive development, it is probable (see below) that a number of these students are subject to more predisposing risk factors and more vulnerability factors than students of 20 years ago.

Although higher education students have always faced potential risk factors for mental ill health associated with being a student (and risk factors of living away from home) such as isolation, lack of peer support and examination stress, university students were until recent times a relatively healthy population. Generally, those able to take up a university place were advantaged in terms of academic ability, family background and material wealth, and the selection process might have screened out the more vulnerable candidates. As increasing numbers

of young people in Britain have been entering higher education over the past 10 years, the prevalence of many mental health problems is likely to equate to the rates in the age-matched general population.

Although there are limitations to the data, there are reasons to believe that rates of mental health problems are high, and possibly increasing. The information on the range of mental health problems affecting students comes from two main sources:

- Epidemiological studies of the prevalence of disorders in older adolescence and young adulthood, although there is no agreed age differentiating adolescence (which is a developmental stage) from adulthood.
- Studies of students in further and higher education. There is cumulative activity data from student health services (AUCC, 2002), although information from this source naturally represents only those students who attend such services, and from cross-sectional studies of university populations (e.g. Grant, 2002; Leicester University, 2002).

Prevalence of mental health problems in older adolescents and young adults

The age of students varies widely because of the increasing numbers of mature students, but many will be in their late teens and early twenties. The completeness of prevalence data varies with disorder, but Table 1 shows examples of published rates as close as possible to the target age range. However, these data derive from general population studies and cannot be equated directly to student populations. Furthermore, rates do not necessarily correlate with prevalence in early adulthood.

The data on drug and alcohol use are striking in comparison with other European countries. Wallace *et al* (1997) report that 41% of UK school leavers report lifetime use of an illegal drug, higher than any other European country, and that 78% have been intoxicated with alcohol by the time of leaving school.

There are no reliable reported rates of personality disorder among the student population. By early adulthood, however, significant numbers of students will demonstrate levels of dysfunction in their interpersonal relationships, or challenging behaviours that may disrupt their education, render them vulnerable to mental disorder or pose concerns about their suitability for their chosen career. There are epidemiological data on a number of physical or experiential factors known to increase rates of mental health problems. Thus 10% of young people are thought to have suffered sexual abuse by the age of 16 (Baker & Duncan, 1985), and 1% will have been diagnosed with epilepsy by the age of 20 (Sunder, 1997).

Research studies of students infurther and higher education

In 1999–2000, only 4.5% of the 1.6 million students in higher education declared a disability and only 0.12% declared a mental health disability (see Mental health

promotion, pp. 47–50). Clearly this is a gross underrepresentation, reflecting a continuing reluctance to declare mental health disability despite the provisions required by the Disability Discrimination Act 1985. Association of University and College Counselling data suggest that approximately 3% of university students consult their counselling service per year, and it is probable that approximately 8% in total may do so during the course of their student career. Two-thirds of those who use the counselling services are female.

There are substantial limitations to the research literature on mental health problems among student populations. Most have depended on student self-report data, in some cases complemented by use of well-validated questionnaire measures. A few studies have been methodologically sound, have attracted a large number of respondents, and (e.g. Leicester University, 2002) have been repeated. Both British and international studies have focused on mental health symptoms rather than on mental health disorders.

Epidemiological data will be addressed under the following headings:

(a) mental disorders
(b) suicide, deliberate self-harm (DSH) and suicidal ideation
(c) mental health symptoms and measures of psychopathology
(d) changes over time
(e) risk factors and protective factors.

Mental disorders

At one university in Dublin, approximately 1% of students present to the student health service with major psychiatric disorders (O'Brien, personal communication, 2002).

Schizophrenia In a survey of approximately 14 600 students registered with the Leeds Student Medical Practice, two students were recorded as having a diagnosis of schizophrenia (Mahmood, personal communication, 2002). In general, a small number of students will present with schizophrenia because adolescence and young adulthood is the age of maximum risk of onset.

Affective disorders In a study of over 3000 students at ten universities (Webb *et al*, 1996), Hospital Anxiety and Depression (HAD) questionnaire scores identified 12% of male and 15% of female students with measurable levels of depression. The University of Leicester's Student Psychological Health Project (Leicester University, 2002) surveyed more than a thousand second-year students in 1998 and 2001 using the Brief Symptom Inventory (BSI) and found in both years that 13% of undergraduates recorded scores suggesting they were moderately distressed by feelings of depression. Women scored significantly higher than men. Using the Beck Depression Inventory (BDI), 14% of students in a South African study were found to be moderately or severely depressed (Mkize *et al*, 1998).

In an earlier phase of the student survey in Leeds, 0.7% of students had a recorded diagnosis of 'recurrent depression' (Mahmood, personal communication, 2001). In this survey, between 1995 and 2000, the proportion of students being prescribed antidepressant medication was 3–5%. Clinical information from Oxford suggests that the rate of increase in GP prescribing of antidepressant medication to students has greatly exceeded the increase in antidepressant prescribing for non-students (Burke, personal communication, 2002). However, in a recent large community survey, students were found to be at significantly lower risk of depression than the whole population sample, 3.2% *v.* 7.1% (Ostler *et al*, 2001).

Anxiety disorders Webb's questionnaire survey (Webb *et al*, 1996) indicated that 17% of male and 25% of female students had scores on the HAD scale suggesting moderate to severe levels of anxiety. In the Leeds diagnostic survey, 0.3% of students had 'chronic anxiety', 0.1% had phobic disorder and 0.3% had obsessive–compulsive disorder (Mahmood, personal communication, 2001).

The Leicester University (2002) study showed 12–14% of undergraduates recorded BSI sub-scale scores suggestive of moderate obsessive–compulsive distress (trouble remembering things, trouble concentrating, difficulty making decisions, checking).

Eating disorders In a survey of Oxford students, Sell & Robson (1998) found that 10% of women reported a current eating disorder. Also in the UK, Doll *et al* (2000) found that 6% of all students (9% of female students) had a 'probable DSM–IV lifetime eating disorder.' The Leicester study found that 4% of undergraduates reported self-induced vomiting, and 2% use of laxatives and diuretics, to control weight (Leicester University, 2002). Concealed binge eating was reported in 7%. In the Leeds survey, the prevalences of anorexia nervosa and bulimia nervosa were 0.4% and 0.5%, respectively (Mahmood, personal communication, 2001).

Alcohol and substance use Data are increasingly available on the prevalence of alcohol dependence within student populations. In Oxford, Sell & Robson (1998) found that 24% of women and 40% of men were exceeding safe limits for alcohol consumption. Among medical students, half exceeded World Health Organization guidelines (Pickard *et al*, 2000). In a survey of ten British universities, Webb *et al* (1996) found that 15% of students were drinking at a hazardous level. In Cambridge, Surtees *et al* (2000) found that 10% of students consumed alcohol at levels suggestive of problem use. In Leicester (Grant, 2002), 14% male and 31% female undergraduates admitted harmful levels of alcohol consumption; but 50% and 25% respectively also admitted binge drinking at least once per week. However Mahmood (personal communication, 2001) reported that only 0.1% of students had a recorded diagnosis of alcohol dependence. This difference might be explained by the distinction between problem use and dependence, but also because the widespread acceptance or normalisation of heavy drinking in younger people results in reluctance to make a formal diagnosis.

Table 1 The prevalence of mental health problems in older adolescence and young adulthood

Problem	Prevalence (%)	Comments	Source
Affective disorders			
Bipolar disorder	1	Among those aged 14–18	Lewinsohn *et al*, 1995
Depression	0.4–8.3	Among adolescents	Birmaher *et al*, 1996
Dysthymic disorder	1.6–8.0	Among adolescents	Birmaher *et al*, 1996
Schizophrenia	1	39% of males and 23% of females who develop schizophrenia have onset before age 19	Loranger, 1984
Anxiety disorders			
General	10–20	Female > male	Pine, 1997
Phobic conditions	3.6		Craske, 1997
Obsessive–compulsive	1.9		Wallace *et al*, 1997
Social phobia	1.1		Craske, 1997
Conduct disorder			
General	14	Among those aged 12–16; male:female ratio 2.5:1	Offord *et al*, 1987
Drug and alcohol misuse			
Alcohol – men aged 16–24	12	4–8 units/day	ONS, 1998; Bridgwood, 2000
	35	>8 units/day	ONS, 1998; Bridgwood, 2000
Alcohol – women aged 16–24	17	3–6 units/day	ONS, 1998; Bridgwood, 2000
	23	>6 units/day	ONS, 1998; Bridgwood, 2000
Cannabis (last year)	26	Aged 16–24	Ramsey *et al*, 2001
Cocaine (last year)	5	Aged 16–24	Ramsey *et al*, 2001
Heroin (last year)	1	Aged 16–24	Ramsey *et al*, 2001
All class A (lifetime)	20	Aged 16–24	Ramsey *et al*, 2001
All class A (last year)	9	Aged 16–24	Ramsey *et al*, 2001
All class A (last month)	5	Aged 16–24	Ramsey *et al*, 2001
All illicit (lifetime)	50	Aged 16–24	Ramsey *et al*, 2001
All illicit (last year)	29	Aged 16–24	Ramsey *et al*, 2001
All illicit (last month)	18	Aged 16–24	Ramsey *et al*, 2001
Eating disorders			
Anorexia nervosa	0.36–0.83	Among girls	Wallace *et al*, 1997
Others	4.2	Among girls	Fairburn & Cooper, 1993; Wallace *et al*, 1997
Suicide			
Attempted	2–4	Among adolescents	Wallace *et al*, 1997
Completed – girls	0.0025	Aged 15–19	Pearce & Holmes, 1995
Completed – boys	0.0075	Aged 15–19	Pearce & Holmes, 1995
Asperger syndrome	0.36 min	Aged up to 16	Ehlers & Gillberg, 1993

ONS, Office for National Statistics.

Students who drink excessively have not been demonstrated to have higher levels of depressive or anxiety symptoms (Webb *et al*, 1996; Pickard *et al*, 2000; Grant, 2002), although this has been shown to be the case in the general population. This discrepancy might be explained by the effect of alcohol in masking mood and anxiety disorders, but Grant's study did find that

undergraduates reporting frequent binge drinking recorded higher levels of subjective concern about alcohol usage. This suggests that some students might be receptive to advice and help.

Current cannabis use was reported by 20–30% of students (Webb *et al*, 1996; Sell & Robson, 1998; Surtees *et al*, 2000). Current amphetamine use was reported by 3% of students (Sell & Robson, 1998). The majority of students who have used drugs first did so prior to entering university (Webb *et al*, 1996).

Suicide, deliberate self-harm and suicidal ideation

The most significant change in the pattern of suicides in the United Kingdom has been the marked increase in suicide in young males (Hawton, 1992). This phenomenon is not confined to the UK, as similar increases have also been reported from other developed countries such as the USA, Canada, Australia and New Zealand. Between 1980 and 1992, the suicide rate for males aged 15–24 in England and Wales increased by 81.1% (Charlton *et al*, 1992), and although the rates have declined a little in the past few years (Kelly & Bunting, 1998), they are still much higher than previously. Rates of deliberate self-harm are higher in females than males, especially in teenagers (Houston *et al*, 2001). However, suicide following attempted suicide in the young is not uncommon (Hawton *et al*, 1993). Since the great majority of university students are in their late teens and early twenties, a similar increase in the rates of suicide might be expected among students in higher education. Fortunately this is not the case, as is shown by a number of studies in the UK and other countries.

Suicide In Cambridge from 1970 to 1996, the suicide rate in students was 11.3 per 100 000 and was not significantly elevated when compared with an age-matched general population (Collins & Paykell, 2000). Although the suicide rate in Oxford University students between 1976 and 1990 appeared to be elevated, Hawton *et al* (1995*a*) demonstrated that it was no higher than the general population when open verdicts were included. Longitudinal studies of completed suicide appear to show a marked reduction in the rates of suicide in students at Oxford and Cambridge Universities over recent decades. Rates at other British universities also appear to be lower than in the general population (Hawton *et al*, 1995*a*).

In a large study in the USA, Silverman *et al* (1997) found that students were at reduced risk of suicide. The observed suicide rate was half that which would have been expected in a matched population. Similarly, a Finnish study found a significantly reduced rate of suicide among male students (Niemi & Lonnqvist, 1993). Because of the relatively low rates of suicide in male students, female students appear to be overrepresented among those who complete suicide compared with the gender ratio in the general population (30–40% *v*. 15–20%), but rates of suicide in female students are probably still lower than in the age-matched general population.

Deliberate self-harm Rates of deliberate self-harm (DSH) hospital attendances among Oxford students were found to be lower than age-matched controls, but the marked differences in social class may be one explanatory factor (Hawton, 1995*b*). A slight increase in numbers in the past decade is possibly due to the increasing numbers of students at university. Lower rates were also found among higher education students in Edinburgh (Platt, 1986). In a survey of UK students, Doll (2000) found that 2% reported 'harming themselves' and 0.2% reported 'attempting suicide' in the preceding term. The Leicester study found that 4% of undergraduates admitted a history of deliberate self-harm or dangerous risk-taking behaviour (Leicester University, 2002).

In the USA and Switzerland, 2–3% of students reported self-harm over the preceding 12 months (Rudd, 1989; Meehan *et al*, 1992; Rey Gex *et al*, 1998). Schweitzer *et al* (1995) found that 7% of Australian students reported that they had attempted to kill themselves in the 12 months before questionnaire completion.

The marked variation in reported rates of 'attempted suicide' reflects problems in terminology, for this term may be used to cover non-suicidal self-harm and other actions.

Suicidal ideation In two recent studies of UK students, the proportion reporting suicidal ideation during the past term was 7–9% (Sell & Robson, 1998; Doll, 2000). Internationally, rates of suicidal ideation among students have been much higher than those found in the UK. In the USA, between 26% and 43% reported suicidal ideation within the preceding year (Rudd, 1989; Meehan *et al*, 1992). Brenner *et al* (1999) found that 10% of students reported 'serious suicidal ideation' over the preceding 12 months. In Switzerland, 45% reported suicidal ideation in the past year (Rey Gex *et al*, 1998), and rates were as high as 61% among Australian students (Schweitzer *et al*, 1995). This marked variation in rates of suicidal ideation has not been explained.

It is not yet clear whether these worryingly high rates of suicidal ideation might be associated with the growing evidence that frequent cannabis use predisposes to anxiety, depression and suicidal ideation (Rey & Tennant, 2002).

The significance of reported suicidal ideation requires urgent elucidation. Such thoughts may reflect distress and age-consistent nihilistic ideation rather than true suicidal cognition. Certainly, there is very limited association between reported suicidal ideation and suicidal acts, but Grant (2002) reported a correlation between suicidal ideation and deliberate self-harm in a student population. Barrios *et al* (2000) consider suicide to be the end-point of a continuum that begins with suicidal ideation. They found that students who reported suicidal ideation were significantly more likely to indulge in behaviours that put them at increased risk of injury, including physical fights and driving while intoxicated.

Indicators of suicide risk Hawton *et al* (1995*a*) found a number of factors to be associated with increased risk of suicide among university students, with

relationship difficulties being the most common factor. Academic problems, worries about academic achievement, dissatisfaction with the course, sexual problems, family problems, psychiatric and personality problems, and physical illness were other contributory factors. Working fewer hours (Tyssen *et al*, 2001) has also been associated with increased risk of suicide (Barrios *et al*, 2000). No association was found with examination times (Hawton *et al*, 1995*a*; Collins & Paykel, 2000), which was an unexpected finding.

Interestingly, affiliation with organised religion appears to be a protective factor against suicide (Jensen *et al*, 1993; King *et al*, 1996).

Mental health symptoms and measures of psychopathology

In the UK, the transition into higher education is associated with an increase in measures of emotional distress (Fisher & Hood, 1987; Surtees & Miller, 1990; Rosal *et al*, 1997). Homesickness was identified in 31% of first-year residential students in Dundee (Fisher & Hood, 1988). Doll (2000) found that 30% of UK students experienced 'emotional or psychological problems' in the past term. Using well-validated instruments, Ashton & Kamali (1995) showed that second-year students suffer high levels of anxiety, depression and alcohol use. The 2001 Leicester study found that 20% undergraduates reported concerns about anxiety symptoms and 35% about feelings of sadness and depression. Seven per cent reported that psychological symptoms had adversely affected their studies.

Stewart-Brown *et al* (2000) found that UK students had poorer scores across all eight dimensions of the Short Form 36, with emotional problems being particularly evident, compared with age-matched population norms. Tyrell (1992) found that 32% of Irish students identified more than six symptoms on the 28-item General Health Questionnaire (GHQ). Using the same instrument, Baldwin *et al* (1998) found a prevalence rate for 'caseness' in a longitudinal study of Scottish nurse students of 32–55%, varying with stage and type of training. Clearly these studies were identifying emotional distress rather than serious mental health problems.

Rosal *et al* (1997) found a sustained increase in depressive symptoms among American medical students following entry into university, and this was most evident among females. In contrast to these findings, a large Australian study comparing students with non-students found no significant difference between the two groups on a measure of depression (Hong *et al*, 1993). A Canadian study failed to demonstrate that medical students were any more 'stressed' than the general population (Helmers *et al*, 1997).

Changes over time

Student counselling services in the UK report that increasing numbers of students are presenting with mental health problems of increasing severity (Association of University and College Counselling, 2002). Apart from these reports, there are few data from which to draw any firm conclusions regarding temporal changes

in mental health problems among students. The Leicester University (2002) survey of second-year undergraduates in 1998 and 2001 showed no evidence for increasing symptoms or subjective concern, except in relation to managing personal finances. Hawton *et al* (1995*b*) did not identify any increase in the rate of DSH in Oxford during 1976–1990. Davidson & Hutt (1964) found that the rate of admission of Oxford students to psychiatric hospital was three times the national average in the 1950s, but current admission rates in Oxford suggest that students are underrepresented in the in-patient population.

Risk factors and protective factors

Gender As in the general population, suicide is more common in male students than female students, both nationally and internationally (Niemi & Lonnqvist, 1993; Hawton *et al*, 1995*a*; Silverman *et al*, 1997; Collins & Paykel, 2000). However, studies of suicide have found that the female-to-male ratio was higher among students than that seen in the age-matched population. In his study of deliberate self-harm, Hawton *et al* (1995*b*) found that females presented 2.6 times more frequently than males. Suicidal ideation was found to be unrelated to gender within student populations in the USA and Australia (Rudd, 1989; Schweitzer *et al*, 1995). Pickard *et al* (2000) and Webb *et al* (1996) found similar levels of drug misuse among males and females.

Females are more likely to show increased evidence of emotional problems during the course of higher education (Fisher & Hood, 1988; Surtees & Miller, 1990). Fisher & Hood (1998) found that female students demonstrated increased levels of depression, anxiety and phobias compared with their male counterparts, but homesickness was unrelated to gender. In the UK and elsewhere, female students have been found to be more likely to demonstrate increased levels of psychological symptoms using a range of measures compared with their male colleagues (Tyrell, 1992; Hong *et al*, 1993; Rosal *et al*, 1997; Watanabe, 1999; Surtees *et al*, 2000; Grant, 2002).

Age Hawton *et al* (1995*b*) found increased rates of DSH among undergraduates relative to postgraduates. In the USA, Silverman *et al* (1997) found increased rates of suicide among those over 25 years old. Students over the age of 30 were overrepresented among referrals to a student psychiatric service (O'Mahony & O'Brien, 1980).

Socio-economic group Data are lacking regarding the influence of socio-economic group on psychiatric illness and psychological symptoms among students. Roberts *et al* (1999) demonstrated that financial problems are associated with poorer mental health in student populations. Stewart-Brown *et al* (2000) reported increased rates of financial worries among students compared with age-matched populations. Although Hawton *et al* (1995*b*) did not identify financial concerns as a frequent worry in their Oxford DSH study, others have identified such concerns as a frequent source of stress (Fisher & Hood, 1987; Tyrell, 1992).

Living arrangements and social contacts The increase in psychological symptoms following transition to higher education was found to be unrelated to whether students were residential or living with parents. Those who had previous experience of being away from parents and/or home were less likely to experience homesickness (Fisher & Hood, 1988). Those living alone reported increased rates of suicide attempts (Schweitzer *et al*, 1995). Increased frequency of participating in activities with others was found to be associated with better mental health (Reifman & Dunkel-Schetter, 1990). Interpersonal problems emerged as the most frequent precipitant of DSH in Oxford (Hawton *et al*, 1995*a*).

Ethnicity The University of Leicester study (Grant, 2002) showed that students from ethnic minorities scored significantly higher on all six sub-scales of the BSI. In a large Australian study examining suicidal ideation among students, Asian students reported increased rates of suicide attempts (Schweitzer *et al*, 1995).

Religious affiliation In the USA, Jensen *et al* (1993) found that increased 'religiosity' was associated with better mental health. There is evidence of increased suicidal ideation and behaviour among those without religious affiliation (Schweitzer *et al*, 1995; King *et al*, 1996).

International students There is some evidence of increased mental health symptoms among international students in Britain (Javed, 1989). A Scandinavian study found that foreign students were at increased risk of mental health problems (Sam & Eide, 1991). Those at greatest risk of mental health problems included single students, married students living away from their spouses, young students, female students, undergraduates and those of Asian or Arabic origin.

Course of study Those studying the arts have increased rates of DSH (Hawton *et al*, 1995*b*) and higher GHQ scores (Springett & Szulecka Lekarz, 1986; Watanabe, 1999). Surtees & Miller (1990) demonstrated high rates of psychological distress among medical students, particularly at the commencement of their course. O'Mahony & O'Brien (1980) found that medical (and dental) students were overrepresented among referrals to a student health psychiatrist. In Canada, medical students were found to be no more stressed than either other students or the general population (Helmers *et al*, 1997).

Other academic issues Examinations time was not associated with increased rates of suicide (Hawton *et al*, 1995*a*; Collins & Paykel, 2000). Although Hawton *et al* (1995*b*) did not identify an increase in DSH during exam time nor during the final year, they did find that academic issues were the second most common source of problems for students, after interpersonal concerns. Stewart-Brown et al (2000) found that study problems were a major source of emotional distress. Tyrell (1992) found that academic concerns were the most frequently reported source of stress among Irish students.

Two earlier studies did not identify lower levels of intelligence as a significant contributor to mental health problems in Oxford students (Davidson & Hutt, 1964; Kelvin *et al*, 1965). Interestingly, in a British study from the 1960s, Kelvin *et al* (1965) noted that those who obtained first class honours were at increased risk of mental health problems, as were those who dropped out of university. Hamilton & Schweitzer (2000) found that perfectionism is associated with increased suicidal ideation among students. Consequently, institutions should not assume that high academic achievers are free from mental health problems.

Conclusions

- People with major psychiatric disorders, such as major depression and schizophrenia, appear to be underrepresented in student populations, although the quality of research data is poor.
- Excessive alcohol consumption and substance misuse are very common among students. It is recognised that drug and alcohol problems in later adult life often have their roots in excessive consumption during the student years.
- Students are not at increased risk of suicide and may be at reduced risk, especially male students.
- Compared with the gender ratio observed in the age-matched general population (15–20% of those who complete suicide are female), women are overrepresented among students who complete suicide (30–40%).
- Suicide is much more frequent among students with a history of psychiatric problems.
- Students are at lower risk of self-harm than other young people.
- Annual rates of suicidal ideation are about 10–50% and indicate that there will be between 1000 and 5000 students who experience suicidal thoughts for every one student who actually completes suicide.
- An annual rate of self-harm of about 2% indicates that there will be 200 students who engage in self-harm for every one who completes suicide.
- On balance, the research literature suggests that students have increased mental health symptoms compared with age-matched controls.
- In common with findings in the general population, female students report increased rates of mental health symptoms.
- 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.
- Good social networks and peer contacts, and religious affiliation, appear protective against mental health problems.
- Further research, using evidence-based diagnostic criteria, is urgently needed. Sequential prospective studies across a range of universities will be required to provide accurate figures for rates of mental health problems, including severe mental illness, and to determine whether they change over time.

Aetiology

Entry into higher education presents the student with additional challenges at a time when the transition from adolescence into adulthood is in full swing. In addition to the usual physiological, emotional and cognitive changes associated with this developmental process, students are confronted with a number of major life events, including separation from family, friends and school peers, and having to adapt to a different structure and style of learning requiring more self-reliance, self-motivation and self-teaching. They must master the generic tasks of coping with greater individual autonomy, such as taking responsibility for their budget and finances (in some cases having to take on paid work), managing their own physical and emotional welfare, and coping with unsupervised relationships and other experiences. In addition, they have to adjust to an increasingly complex organisation where what is expected of them might not always be explicit or transparent.

Sources of stress that are more specific to students in higher education can be broadly divided into the following:

- student-related factors
- institutional factors
- governmental policies.

Student-related factors

Students with pre-existing mental health problems are entering universities in greater numbers. They often arrive without any prior warning of their needs, resulting in discontinuity of treatment and follow-up. This, added to the well-known stresses of university life (e.g. pressure for academic achievement, time management, financial constraints, social relationships, loneliness and homesickness), increase the likelihood of their breakdown.

As many as 60% of first-year students report homesickness, and of all university students they are at the greatest risk of developing mental health problems (Adalf *et al*, 2001). This can be compounded by the lack of a confiding relationship, and a subjective feeling of loneliness, which has shown to be correlated with symptoms of anxiety, depression, alcohol and drug misuse, and suicidal ideation (Curtona, 1982; Perlman & Peplau, 1984).

A larger number of students from less privileged backgrounds now attend university, are less protected from the vagaries of life and are therefore more likely to suffer mental ill health. Roberts *et al* (1999) have shown that financial problems are associated with poorer mental health in student populations.

Women, who have higher rates of psychiatric disorders in general, particularly depression and anxiety (Horwath & Weissman, 1995), now account for half or more of the university student population and show increased evidence of psychological disturbance during the transition to higher education (Fisher & Hood, 1988; Surtees *et al*, 2000; Adalf *et al*, 2001).

More students from ethnic minorities are entering universities, who might be at greater risk of developing mental health problems (Schweitzer *et al*, 1995). More international students are studying at British universities, and are more vulnerable to mental health problems (Sam & Eide, 1991).

There is an increase in use of alcohol and drugs among students in higher education, both reflecting and causing increased mental health problems.

Students tend to confide in and seek help from peers, and yet students have been shown to be poor at recognising the presence and severity of psychological symptoms in others (Malla & Shaw, 1987; Broadbridge, 1996; Sell & Robson, 1998). Some students cite stigma as a reason not to access counselling services. Peer support training may be of value in this respect; and continuing education and anti-stigma campaigns are needed to improve perceptions of mental health issues (Royal College of Psychiatrists *et al*, 2001). When students do try to access the university counselling services, these are often oversubscribed, and they might have to wait up to 2–3 weeks for an appointment, despite evidence that seeking help early is beneficial.

Individual resilience to the pressures of student life is mediated by factors internal and external to the student. Students with higher intellect, higher self-esteem, an internal locus of control and good problem-solving skills, and who have secure attachments to supportive, stable parents and communities, are better equipped to manage student life. It is likely that the increased intake of students from less privileged and more disrupted families and communities (who are less prepared to meet these pressures) will be associated with an increase in the prevalence of mental disorder.

The role of institutions in increasing student stress

At a time of increase in student numbers, staff numbers have not increased proportionately. Furthermore, with the increasing bureaucratic demands inherent to their work, academic staff have less time to fulfill their pastoral role (Grant, 2002).

The modularisation of some degrees, while providing students with increased flexibility and choice, has sometimes resulted in the loss of a stable peer group and the opportunity to maintain consistent contact with academic staff. In these circumstances, difficulties are more readily overlooked. Reductions in formal teaching time leave some students with increased free/unstructured time in their day, and they might therefore be more vulnerable to the temptations of alcohol and drugs.

Ironically, at a time of burgeoning student numbers and increasing mental health problems among students, some universities, in the name of economy, are scaling down their traditional support services including counselling. Fortunately, some universities put a premium on providing pastoral care.

The impact of governmental policies on student mental health

The introduction of tuition fees and abolition of student grants have contributed to a situation in which many students, after paying the rent and essential bills, are left with little money for other basics.

Compared with many other European Union (EU) countries, the UK is spending far less on education, which has led to curtailment of university funding, a relative shortage of teaching staff and the scaling down of support services. There is less money for research and the number of traditional part-time research jobs available to students has dropped. Students now have to compete in the open market and some are forced to work full-time to survive financially.

Although the Government is now committed to increased NHS funding, current UK health spending as a percentage of gross domestic product is less than that of other EU countries and, therefore, it is not surprising that mental health services available to students in higher education fall far short of ideal. In under-resourced NHS psychiatric facilities, students' psychiatric problems might not be perceived as severe enough to warrant access to psychiatric services (AUCC, 1999).

These multiple factors combine to create an environment in which students with pre-existing mental health problems may be at increased risk of breakdown, and those who do not have psychiatric problems on entry to higher education may become more vulnerable.

Impact of specific mental health disorders

The aphorism that 'common things are common' can lead to complacency about, and inappropriate normalisation of, conditions such as depressive disorders, anxiety disorders, substance misuse and eating disorders. There is often an assumption that these conditions are akin to rites of passage into adulthood and are inevitably transient. There may be fears about 'over-pathologising' young people and creating a cadre of 'patients' whose needs could not be met anyway. This effect may be compounded by students' fears and shame as well as a sense of quasi-invulnerability, leading to poor use of health care facilities. These effects are seen in other conditions where there is a significant psychosocial impact of seeking help, such as sexually transmitted diseases. These conditions have intrinsic distress and cause harm to the student and those around, however, as well as usually adversely affecting academic performance. They can all become chronic and may contribute significantly to suicide and other causes of premature death. A balance is needed to avoid either ignoring or inappropriately pathologising these conditions.

The chapter on epidemiology (pp. 13–24) reports prevalence data on these conditions. This chapter aims to illustrate specific features and the challenges associated with them in student populations.

Depressive disorders

Presentation

Depressive disorders are often hidden and have a complex interaction with factors such as homesickness (Fisher & Hood, 1988), forming a new peer group and strain on pre-existing relationships. Achieving student status carries with it increased pressure to succeed, which is diametrically opposed to the cognitive and emotional facets of depression. Isolation and poor academic performance may become significant features, but rarely trigger help being sought or offered unless they are extreme. Concerns about going 'mad', apprehension about medication and about psychological treatments are compounded by fear of being branded a 'failure' by friends, family and the academic institution.

Treatment

Antidepressants carry stigma for many people, although some students may seek medication too readily as a 'quick fix' (Leach, personal communication, 2002). These drugs have adverse effects (including effects on sexual function) that militate against good compliance. Medication might be offered when

psychological treatments are more appropriate, because it is easily given. Psychological treatments are time-consuming and difficult to offer consistently when students alternate between college and home. However, when used judiciously, both treatment modalities are effective.

Anxiety disorders

Presentation

Anxiety disorders are diverse, ranging from frank obsessive–compulsive disorders and specific phobias to transient, free-floating anxiety and social phobia. Pre-existing underlying disorders may be exacerbated by specific stressors such as examinations, but then entirely attributed to them. Maladaptive coping strategies, such as self-medication with alcohol and other sedative substances, can exacerbate the anxiety disorder.

Treatment

Cognitive–behavioural treatments are often indicated for anxiety disorders, but might be limited by the availability of trained staff and the need to synchronise with term times. Sedative medication is attractive to some practitioners and patients because it offers early relief. Although it is useful when there are specific, time-limited stressors, it adversely affects cognitive performance in the case of examination anxiety.

Substance misuse

Presentation

Hazardous use of drugs and alcohol is perceived by many as part of student life, but it can be as much a problem as dependent use. In contrast, academic institutions may view illicit drug use and behavioural problems associated with excess alcohol as conduct issues. This near paradox may cause students to hesitate in seeking help from anyone who they think might contact the authorities, even when they realise they have a problem. For the same reasons, friends may also hesitate in advising help. Also, few of the relevant professionals, including doctors (Crome, 1999), will have had specific training in substance misuse screening and non-specialist interventions.

Treatment

Treatment is often a lottery, despite good evidence that brief interventions are effective in reducing harmful consumption, and the increasing availability of drug and alcohol counselling agencies. The philosophy and elements of these brief interventions are encapsulated in the acronym FRAMES (Bien *et al*, 1993):

F **F**EEDBACK of personal risk or impairment
R Emphasis on personal **R**ESPONSIBILITY for change
A Clear **A**DVICE to change
M A **M**ENU of alternative change options
E Therapeutic **E**MPATHY as a counselling style
S Enhancement of patient **S**ELF-EFFICACY or optimism

Some professionals may be poorly equipped with the knowledge and skills to deal with substance misuse, but should be aware of other resources such as counselling agencies and self-help groups. Outmoded, negative attitudes may also supervene, especially when considering harm-minimising approaches (e.g. advising on less hazardous use of Ecstasy, while not ignoring the risks). Also, there needs to be awareness of students' family and cultural backgrounds when tackling substance misuse.

Eating disorders

Presentation

A spectrum of eating problems is common in young women, but eating disorders are less common and more often concealed in young men. Triggers for the development or exacerbation of eating disorders in students include academic and social pressures, the absence of course structure that allows perfectionist traits free rein, the loss of family routines and the challenge of defining an identity.

Until a firm diagnosis is made, attention should be given to the level of disturbance caused by the eating disorder to the daily life of the student. Students might be able to conceal an eating disorder because of the absence of family mealtimes and because they move between college and home. Poor self-esteem and a sense of shame are often present and might contribute to secrecy and denial, and hold a person back from seeking help. Individuals with bulimia associated with other impulsive behaviours (including substance misuse and deliberate self-harm) may utilise a range of services.

Treatment

The treatment of students with eating disorders presents a challenge because of the discontinuity of home and college services, and the discontinuity of services for adolescents and young adults. Students with established eating disorders often require a specialised treatment package, including family therapy for anorexia nervosa, that is difficult to deliver during term time. Cognitive–behavioural therapy is effective, but often difficult to access. Individual counselling and psychoeducation is valuable either as a direct treatment approach for less severe problems, or as an adjunct or interim measure in severe cases. Help, support and information are available through the Eating Disorders Association (http://www.edauk.com/).

More guidance and training are required in the recognition and diagnosis of eating disorders, both in student health services and among academic and support staff. Psychoeducation might reduce the stigma associated with eating disorders and encourage affected individuals to seek help.

Developmental disorders

Presentation

Relevant developmental conditions include conduct disorders, personality disorders and Asperger syndrome. Half of the conduct disorders seen in adolescence started in childhood and often include offences against property, absenteeism and 'reckless' behaviours. The interface between conduct and personality disorders is blurred and there is often reluctance to identify personality disorders in young adult students because of the plasticity of personality. However, clear features suggesting all types, including borderline and dissocial personality disorders, may be present. Similarly, the sustained abnormalities of social behaviour found in Asperger syndrome may not be correctly attributed, especially if comorbid depressive or anxiety disorders are to the fore. Students with Asperger syndrome may simply withdraw and, because they fail to make demands of services, be overlooked. Often difficulties are unmasked, not so much by the direct stress of university life, as by its lack of structure in comparison with a school and home that have been well regimented to suit their needs.

Personality disorders are characterised by pervasive and enduring disturbance in the individual's emotional state, attitudes, behaviours and interpersonal functions, resulting typically in marked difficulties in personal and social relationships. Insight may be very limited, particularly in dissocial presentations, so that the personality disorder may be more apparent to others than to the individual concerned. Recognition and diagnosis may be difficult, however, because the features of personality disorder may overlap with the more egocentric, eccentric and oppositional behaviours of some adolescents. Key features are the persisting disturbance of interpersonal behaviours and relationships, the association with conduct disorders, including aggression and substance misuse, and the destructive impact on the person's general functioning, including study. Of most concern are the tendencies towards seriously irresponsible and destructive interpersonal behaviours characteristic of those individuals with dissocial and borderline personality disorders.

Treatment

More than with any other group of disorders, therapeutic nihilism and a reluctance to attach potentially stigmatising labels contribute to the reluctance to diagnose and treat developmental disorders. Instead, they may be addressed piecemeal

and symptomatically. Correct diagnosis allows the start of an understanding and mastery of the problem, as well as being the passport to suitable services. The nature of developmental disorders is such that there is a tendency to hope that they will rectify themselves. Support, counselling and social skills training can be offered in addition to enhanced educational and personal guidance. However, if they are severe and impair students' personal and academic functioning, there is a responsibility to recommend further assessment and specialist treatments. The extent of such provision will be influenced by the relevant sections of the Disability Discrimination Act 1995. These students might require more specific programmes to help them develop the social and self-help skills necessary for university life as well as their postgraduate career where, for example, they will need to cope with (and utilise) groups to get full value from a syllabus. Such a programme might include didactic tuition and training as well as providing ongoing supervision and support (Powell, 2002). More specialist treatments may include cognitive–behavioural therapy.

Historically, personality disorders were regarded as largely untreatable. In recent years, however, there has been emerging evidence for the potential value of a number of psychological therapies including psychodynamic, cognitive–behavioural and cognitive–analytic therapies, and therapeutic community treatment. Again, identification and accurate diagnosis are a prerequisite of treatment, as is a non-judgemental stance from those around the individual. A degree of developmental plasticity is an important positive prognostic factor.

The special issues surrounding life as a student away from home can complicate the presentation, detection and treatment of these developmental conditions. Staff require awareness training, including details of the full range of help available. It should be clear to students and staff alike that college-linked and home-linked treatments should be coordinated.

Specific developmental disabilities

Although students in higher education are unlikely to have generalised learning disabilities, specific developmental disabilities are frequent and tend to occur in clusters. A group of disabilities that does not include a well-known entity is likely to pass unrecognised and uncompensated, unnecessarily creating difficulty for the student. Innate deficits in executive function, attention, impulse control, or the control of movement and coordination result in real underachievement, at worst turning an intelligent and hard-working student into a clumsy, ill-organised 'failure'. Furthermore, although there might be general appreciation of the problems in reading, writing and spelling that come with dyslexia, there is little comprehension of, for example, a specific auditory disability that allows a student to hear (and even repeat) instructions without having the capacity to understand them. Hard-learned strategies for coping need to be identified, supported and developed. University disability officers have a key role here.

Impact of mental disorders

Any protracted illness, physical or mental, will have an effect on a student's career within a competitive environment and the finite time scale for study. Mental disorders have far-reaching impacts that can be threefold: first, on the student; second, on the institution; and third, on the family and society.

Students

- *Impaired performance.* Symptoms of anxiety and depression with associated poor concentration can lead to delay in completing essays or assignments and underachievement in examinations.
- *Deferment of courses.* A student may take 3–6 months or more to recover from the aftermath of an acute depressive, manic or psychotic episode.
- *Dropping out of higher education.* With chronic illnesses such as schizophrenia and severe obsessive–compulsive disorder, the student might be unable to complete the course.

Institution

A student affected by a serious mental disorder (including personality disorders of borderline/dissocial type) can be a disruptive influence on other students and may place considerable pressure on the institution's staff and its support, counselling and medical systems. A small number of students with drug problems might become tempted or be pressurised to 'deal' drugs among their peers. There are often complex interactions between health and conduct issues to be addressed. Higher education institutions receive substantial central funding, which might be seen as wasted if students do not complete their studies.

Family and society

The failure to complete a course of studies is a major setback not only for the affected student, but also for the family who often have to support the student emotionally and financially, while also dealing with the loss of their aspirations for their child.

The tragedy of student suicide

Although there has been a substantial increase in the rates of suicide and attempted suicide among young people, it is reassuring to note that the rates among university students have not increased sharply (see Epidemiology, pp. 13–24). None the less, there is no room for complacency as the loss of even a single individual is tragic and every effort should be made to prevent unnecessary wastage of young lives.

Hawton *et al* (1995*a*) have recommended the following preventive strategies:

- Careful induction of students at the time of admission to university to promote awareness and social integration.
- Promotion of means of alleviating the stresses associated with academic work.
- Easy accessibility of counselling services.
- Easy accessibility of psychiatric services.
- Responsible media reporting of student suicide, as there is some evidence to suggest that sensational reporting in newspapers and television can lead to imitation by impressionable young minds.

Most universities have already introduced induction programmes, and efforts are being made to increase the accessibility of counselling and psychiatric services. The publication of new guidelines on reducing the risk of suicide by Universities UK (2002) and the release of this report will, hopefully, provide further impetus to such efforts.

Most suicides are linked to an identifiable mental disorder (including depression, substance misuse and personality disorder), and some might be prevented through early recognition and effective treatment of the underlying disorder. In particular, there are now a number of effective psychopharmacological and psychological treatments for depressive illness, and brief psychological interventions for substance misuse. The prevention of suicide in students is a major challenge to universities and associated mental health providers. There can be no better reason for active collaboration and networking between agencies.

Mental health of students of health care and related professions

The mental health of students in the caring and related professions has attracted particular concern because of their future potential impact on others. Although a doctor, nurse, social worker or teacher with psychiatric problems is much more likely to represent a risk to themselves, the spectre of potential harm to patients, clients or pupils has led to strict protocols for the management of students of these professions who develop mental health problems.

Medical education

Medical students are the most frequently studied of the health care professions. Although relatively few have serious mental illnesses, studies have shown that medical students report higher levels of psychological symptoms than the general population and that levels of distress increase progressively during the course of medical studies. Roberts *et al* (2001) found that a quarter of a large sample of US medical students suffered symptoms of mental ill health. Students perceived the need for personal health care, but 'feared reprisal from seeking help'.

Medical practice demands the highest standards of performance and conduct. The study and practice of medicine is stressful, however, and both medical students and doctors are vulnerable to mental health problems, especially anxiety, depression and substance misuse. There might be an association in some cases between stress, mental ill health, and personal or professional misconduct.

In the USA and Canada, health promotion programmes for medical students have been established to reduce the effects of stress (Wolf *&* Scurria, 1995). 'Wellness electives' have been shown to reduce stress and improve coping strategies. In London, the Royal Free and University College Medical School has developed a peer tutoring project, academic advisers meet students several times a year and clinical advisers operate walk-in surgeries to track student progress (see Mental health promotion, pp. 47–50).

Medical education involves much more than the acquisition of knowledge and skills. It involves development of ethical understanding and professional responsibility. The General Medical Council's revised framework for medical education, *Tomorrow's Doctors* (General Medical Council, 2002*a*), emphasises the acquisition and demonstration of the attitudes necessary for achievement of high standards of medical practice, including in relation to the doctor's own personal development. This implies the need for medical students and doctors to be capable of applying their knowledge and understanding to their own attitudes and behaviours.

Tomorrow's Doctors recommends that 'attitudes and behaviour that are suitable for a doctor must be developed. Students must develop qualities that are appropriate to their future responsibilities to patients, colleagues and society in general.' Then 'doctors must not allow their own health or condition to put patients and others at risk' (paragraph 2).

The ethical obligations of medical students and doctors are stated clearly in the requirement to 'recognise the duty to protect patients and others by taking action if a colleague's health, performance or conduct is putting patients at risk' (paragraph 4d).

Medical schools are responsible for emphasising to students the importance of looking after their own health, including their mental health, and must inform students about the occupational health services, including counselling, that are available to them (paragraph 59).

Because medical students who graduate are entitled to provisional registration by the General Medical Council, *Tomorrow's Doctors* states that 'only those students who are fit to practise as doctors should be allowed to complete the curriculum and gain provisional registration. Students who do not meet the necessary standards in terms of demonstrating appropriate knowledge, skills, attitudes and behaviour must be advised of alternative careers to follow' (paragraph 70).

In summary, medical graduates should be able to demonstrate:

- awareness of their personal and professional limitations
- a willingness to seek help when necessary
- awareness of the importance of their own health, and mental health, and its impact on their ability to practise as a doctor.

Mental health and medical registration

There is a balance to be struck between supporting medical students with mental health problems and safeguarding the interests of patients. The General Medical Council has published revised guidelines for universities and medical students in *Student Health and Conduct* (2002*b*). Although the safety of patients and the care of students are both important, the document states clearly that 'the safety of the public must always take priority' (paragraph 3). It also states that, because medical students achieve the right when they graduate to provisional General Medical Council registration for the practice of medicine, universities must ensure that those whose health or conduct gives serious cause for concern are provided with appropriate support but, if they remain a risk to patients, they should not be permitted to graduate with a medical degree (paragraph 12).

In the event of a medical student requiring time out from university for illness, the General Medical Council requires that the duration of training should be limited to 7 years' maximum in order not to compromise its overall quality. Students with recurrent or chronic mental health problems (perhaps particularly psychotic illness, severe eating disorder, or severe personality disorder) may

require counselling and advice regarding alternative careers. They may need to transfer to other degree programmes or to exit with an ordinary degree rather than a registrable medical qualification.

Mental health screening and nurse training

The Clothier Report, an independent inquiry into the deaths and injuries caused by children's nurse Beverly Allitt, recommended stricter criteria for selection to and progress in nurse training (Clothier *et al*, 1994). Eight of the report's 12 recommendations relate to tougher screening procedures. It endorses the advice of the Chairman of the Association of NHS Occupational Physicians, who suggested 'excessive absence through sickness, excessive use of counselling or medical facilities, or self-harming behaviour such as attempted suicide, self-laceration or eating disorder are better guides than psychological testing'. It was also stated that 'applicants who show one or more of these patterns should not be accepted for training until they have shown the ability to live an independent life without professional support and have been in stable employment for at least 2 years' (5.5.16).

These stringent criteria might make sense if the clinical picture is indicative of a severe and potentially dangerous personality disorder, but interpretation of any exclusion protocol will need to take into account the requirements of the Disability Discrimination Act 1995 as it now applies to higher education (see Policies and procedures, pp. 41–46).

Although the Royal College of Nursing supported the Clothier Report's recommendations in general, it has published health assessment advice for the profession to help address these concerns. The College acknowledges that there are limitations to health assessments, but asserts that the aim is to ensure that the applicant is fit to carry out their job without a significant risk to their own health and safety or that of the patient. The College advises that health assessments should:

- only be carried out by qualified occupational health nurses and physicians
- be careful with regard to the confidential nature of the information disclosed
- not exclude an applicant on the basis of information supplied on a questionnaire alone
- allow a clear appeals procedure and an independent second opinion.

Following an inquiry into the actions of another nurse, Amanda Jenkinson, the Bullock Report advocated that the recommendations of the Clothier Report be extended to cover all health care professions (Bullock, 1997). An appendix to the report sets out an exhaustive questionnaire which, although it could throw up false positives, has been adopted by other occupational health services.

If the consequence of disclosing a mental health problem such as an eating disorder was inevitable exclusion from training in a health profession, it could

deter individuals from seeking help from either professional agencies or self-help groups. Any attempt by the potential student to hide a significant mental health problem, however, could be viewed as a dishonesty unworthy of a responsible professional person. Most mental health problems, including personality disorders and substance misuse, are treatable if detected early and addressed constructively. Screening and risk assessment in the higher education context needs to be highly sophisticated and mindful of the interests and rights of the potential student.

Confidentiality

These expectations in relation to selection, education and registration highlight the dilemmas surrounding confidentiality in relation to health care students with mental health problems. The General Medical Council's expectations of doctors who treat medical students with serious mental illnesses are quite clear: disclosure of the student's illness may be necessary in the public interest. 'Doctors should not disclose information, without the student's consent, unless the risk posed to patients is so serious that it outweighs the student's right to privacy' (General Medical Council, 2002*b*: paragraph 5, 'Student Health and Conduct'). The student's consent for disclosure should be sought by the responsible doctor, of course; but if it is refused, the student may have to be informed that disclosure is unavoidable. University counsellors and non-medical academic staff are not bound by the General Medical Council's code, but might appropriately follow its principles. All who work with students who present with mental health problems might be encouraged to consult with colleagues about any potential overriding of confidentiality.

These stringent expectations could well discourage students with mental health problems from asking for help for fear of being prevented from continuing their studies or qualifying. This could only heighten risk to the public. Instead, mental health concerns could be seen as a good reason to seek appropriate help as early as possible. This complex issue emphasises the need for universities and health providers to make appropriate help as readily available as possible.

The Association for University and College Counselling has taken significant steps towards the negotiation of agreed, operational interpretation of confidentiality issues in universities where there are health care students.

Support for students

To support students, the General Medical Council recommends that medical schools should provide information about career structures and progression in the NHS. Students should be helped to identify their interests, strengths, weaknesses and personal circumstances so that they can consider job and career options that will be appropriate and fulfilling. In line with the Disability Discrimination Act 1995, medical schools must have regard for the well-being and welfare of students,

ensuring informed access to academic and pastoral support at all stages of training. In addition, students should be made aware of the full range of occupational health services, including counselling, available to them.

Medical schools then have a duty to advise and support medical students. They should have systems in place:

- to ensure that medical students are aware of GMC guidance on professional conduct as set out in *Duties of a Doctor* (http://www.gmc-uk/org)
- to support medical students in addressing the stresses associated with medical education
- to identify those with symptoms of stress that might be early signs of mental ill health
- to identify and address mental ill health, substance misuse or conduct problems, initially through remedial procedures wherever possible.

The General Medical Council is unequivocal about the management of students with serious mental health problems: universities with medical schools should establish robust and defensible procedures, including an appeals process, to deal with students who are causing serious concern on grounds of ill health or poor conduct. Students should be in no doubt about their own responsibilities. 'As future doctors, students should follow the guidance in *Good Medical Practice* from their first day of study, and understand the consequences if they fail to do so. In particular, students must appreciate the importance of protecting patients, even if this conflicts with their interests or those of friends or colleagues' (General Medical Council, 2002*a*: paragraph 94).

All of this confirms the need for universities and their health partners to have systems in place for identifying and assisting students with mental health problems.

Professional regulation

There is wide heterogeneity in the trainings of the different health care professions. Furthermore, the practice of health professionals is regulated by a number of different bodies that have differing lines of accountability, and differing expectations and requirements in relation to training.

In light of successive public enquiries, the Department of Health (2001*a*) has proposed an overarching Council for the Regulation of Healthcare Professionals, to which individual regulatory bodies (although not the new General Social Care Council) will be accountable. The council will be answerable to Parliament, and will coordinate the individual regulatory bodies' functions, including education and training. The Department's consultation paper proposes that the Council should promote common curricula and shared learning across the professions.

The implications of the Government's recent proposal of a Medical Education Standards Board, charged with overseeing a new system for postgraduate medical education and training, are not yet clear.

Implications for mental health services

Psychiatrists and other mental health professionals who have contact with universities, either through teaching or by providing mental health services, may be well placed to promote a culture of self-awareness in which the students' own experience can be disclosed and discussed as part of a reflective learning paradigm. Furthermore they may be able to ensure that rapid routes are in place for independent psychiatric assessment and management of students when necessary. Psychiatrists may be asked to advise about a student's capacity for continued study and, particularly in relation to health care and related subjects, the student's eventual qualification. Special attention might be paid to students with substance misuse, conduct, or personality disorders. Evidence of compliance with treatment, and insight into their condition, may be sought in addition to full recovery before the students are permitted to resume studies or to graduate.

Contemporary emphasis on clinical governance will ensure continued rigorous attention to standards of selection, training, assessment and appraisal for the health care professions. However, as specified clearly by the Special Educational Needs and Disability Act 2001, such procedures must be operated fairly and without prejudice to the interests of students with mental health disabilities. Inevitably, there will be test cases in coming years.

Recommendations

For students of health care and related professions:

- curriculum to include ethics; learning about the importance of one'sown health and behaviour, including mental health and conduct; promotion of self-awareness and awareness of peers; the duty of disclosure
- assessment of self-learning in relation to 'emotional literacy'
- psychiatrists to be aware of specific mental health issues in relation to medical and other health care students.

Policies and procedures

NHS policies and initiatives

The past 3 years have seen unprecedented policy developments within the NHS, some of which have direct relevance for students with mental health problems. The strategic policies of most direct relevance for the mental health of higher education institution students are set out in three major Department of Health documents:

- *National Service Framework for Mental Health: Modern Standards and Service Models* (Department of Health, 1999)
- *The NHS Plan: a Plan for Investment, a Plan for Reform* (Department of Health, 2000)
- *The Journey to Recovery: The Government's Vision for Mental Health Care* (Department of Health, 2001*c*).

A number of policies relating to substance misuse have been published in recent years, and these have direct relevance for young people:

- *The Substance of Young Needs*: commissioning and providing services for children and young people who use and misuse substances (Health Advisory Service, 1996)
- *The Substance of Young Needs Review* (Health Advisory Service, 2001)
- *Tackling Drugs to Build a Better Britain: The Government's 10-year Strategy for Tackling Drug Misuse* (Cabinet Office, 1998).

Detailed implementation guidance has been issued by the Department of Health for several of the service developments designed to deliver modernised mental health services in line with the National Service Framework (NSF) and NHS Plan, including crisis resolution services and early intervention services for young people with psychosis. Publication of a National Service Framework for children and young people is awaited.

The NHS Plan sets out the Government's agenda for modernisation of health services, and draws particular attention to the need for equitability and ease of access to high-quality services.

The National Service Framework sets standards and defines service models for promoting mental health and treating mental ill health. It sets out programmes to support local service delivery, and specifies high-level performance indicators. The standards defined address:

- mental health promotion and combat of discrimination (standard 1)
- access to primary care and specialist mental health services (standards 2 and 3)

- provision of responsive and effective specialist services for people with severe mental illness (standards 4 snf 5)
- services to support carers (standard 6)
- coordination of services to achieve suicide reduction (standard 7).

Standard 1 can be achieved in relation to higher education students only through collaboration in strategic and service planning between local NHS agencies (Primary Care Trusts, primary health care services, specialist mental health care services), higher education institutions and other relevant agencies, including voluntary and other non-statutory organisations. Mental health promotion, and systematic progress towards combating stigmatised discrimination against students with mental health problems, may be enabled by joint development of a student section in the local Health Improvement Plan (HImP).

Ready access to services appropriate to the needs of students with mental health concerns or problems, again, can be ensured only by active collaboration between relevant service providers, specifically university health and counselling services, primary NHS health care services, and specialist NHS mental health providers. The last have a responsibility to deliver effective treatment services for all people with severe mental health problems, including in-patient psychiatric treatment where this is necessary. The care programme approach (CPA) is central to the safe and supportive organisation of mental health services for those with the most severe problems.

The emphasis in modernising mental health services is on providing rapid, round-the-clock access to local services for people with mental health problems. This includes ready access to specialist services for those with severe mental illness. Crisis services should be available at all times for people with serious mental health problems who might otherwise require admission to hospital for psychiatric treatment. In each area, dedicated services will be developed to support and treat young people (aged 14–25 years) who present with psychotic illness. These services may be relevant for some students with more severe mental illness; but they are specifically not designed for people with 'common mental health conditions' including mild depression, anxiety states and interpersonal crises, or those with exclusive diagnoses of substance misuse or personality disorder. The responsibility for assessing and treating students with these more common problems will remain with university health and counselling services, and NHS primary care health services.

The Government's most recent paper, *The Journey to Recovery*, introduces policy for supporting the process of recovery for all those who have suffered mental illness (Department of Health, 2001*c*). It emphasises that the majority of patients have real prospects for recovery, if they are supported by appropriate services. The aim is to enable and empower people with mental health difficulties to take their full place in society. The importance of access to community resources for housing, friendship, education and work is identified. These needs are basic to the recovery of self-respect and personal effectiveness. For some, higher education

will be an important part of this recovery process. Higher education institutions are already addressing their responsibilities to students with pre-existing mental health problems, as well as those who develop problems during higher education.

The educational context

Degrees of Disturbance (AUCC, 1999) drew attention to a number of aspects of higher education that might have been influencing the level of mental health difficulty in HEIs. These included widening access, increasing financial pressures on students and the growing demands on the time of academic staff caused partly by the declining unit of resource in the sector: a decline of 37% in real terms between 1989–1990 and 1999–2000 (figures from Universities UK website).

Since the publication of that report, there have been a number of new developments. There is now more research evidence on the nature and prevalence of psychological difficulty in British students (Stanley & Manthorpe, 2002; research summary produced by the Oxford Student Mental Health Network) and more on the effectiveness of counselling interventions with students (Potter, 2002). There is also greater awareness of the extent of the problem as evidenced by, *inter alia*, the establishment by Universities UK of a steering group on student suicide, further work by the Association of Managers of Student Services in Higher Education in this area and a proliferation of conferences on related topics.

Innovations within higher education institutions in response to current trends, developments in government policy and the introduction of new legislation mean that this field is constantly changing.

Higher education institutions' responses to the mental health needs of students

In 2000, the Committee of Vice-Chancellors and Principals, now known as Universities UK, in association with the Standing Conference of Principals and the Association of Managers of Student Services in Higher Education, published *Guidelines on Student Mental Health Policies and Procedures for Higher Education* in order to guide and support higher education institutions in their strategic planning to ensure that, in relation to teaching and learning, student support and staff development, they take full account of the needs of:

- students experiencing mental health difficulties
- other students and staff who work and study with students experiencing mental health difficulties (Universities UK, 2000: p. 6).

The document was concerned not only with the support of individuals in difficulty, but also with the creation of institutional structures and cultures conducive to mental well-being. It therefore recommended that higher education institutions consider a range of functions such as teaching and learning, admissions and recruitment, and quality assurance for their possible impact on mental health. In addition, it recommended that institutions consider setting up

internal task groups to consider the implications of the guidelines for policies and procedures and that they give priority to staff development in this area.

The results of a Heads of University Counselling Services survey (AUCC, 2002) suggest that the majority of universities have taken these recommendations on board. Seventy-six per cent of respondents' universities had established internal task groups to review their policies and procedures and more than half of these have already produced their own recommendations. A few universities (Hull, Leicester, Teeside, Manchester Metropolitan) have surveyed their staff to elicit their experiences and support needs in relation to students with mental health difficulties. A number of institutions have already produced staff guidelines on responding to students in difficulty and have set up training programmes to enable their staff to implement these.

Widening participation in higher education

The Government continues to pursue its widening participation policy: the current target is for 50% of people under 30 to experience higher education by the year 2010. Under its 'Excellence Challenge' programme, it aims to encourage institutions to widen participation by admitting more students from under-represented groups. This normally means students from families where there is no tradition of going to university and those who live in postal areas considered to be underrepresented in higher education.

Increased funding has been allocated to universities to encourage widening participation and to raise the aspirations and achievement of underrepresented groups. Additional funding, such as opportunity bursaries, hardship funds and fee waiving, has already been introduced. Further changes in financial support for students are likely to follow.

Widening participation, with its welcome emphasis on hitherto disadvantaged groups, implies an increase in the number of students likely to require additional support, both educationally and emotionally. The arrival of more students, many of whom with requirements that are likely to exceed those of the 'traditional' university entrant, will inevitably increase pressure within an already heavily taxed higher education system.

Student services review

It is acknowledged that students need more than just financial support. In January 2002, Universities UK was asked by the Department for Education and Skills to review student services with the objective of identifying 'a range of effective approaches by student services in retaining students in higher education through to successful completion'. This was at the instigation of the Secretary of State for Education, who recognised the need for improved welfare and pastoral services to support a more diverse student population. The report was published in November that year (Universities UK, 2002). Students with a history of mental

health problems were one of the groups identified for which universities require more information on effective approaches to supporting and retaining students.

Extension of disabilities legislation to education

Higher education institutions are becoming increasingly aware of their social and legal obligations towards students with disabilities, including those related to mental ill health. Almost all universities now employ at least one disability officer, while a minority (14.5%) have established mental health worker posts (Heads of University Counselling Services, 2002).

From 1 September 2002, educational establishments will fall within the scope of the Special Educational Needs and Disability Act 2001 (which amends the Disability Discrimination Act 1995 to include education as Part IV of the Act). This specifies that it is unlawful to discriminate in education on grounds of disability. Admissions, enrolment, the provision of student services, which include *inter alia* services such as teaching, assessment, field trips or placements, and exclusions are all covered by Part IV of the Act. Discrimination is defined as:

- treating someone less favourably than someone else for a reason related to his/her disability and that treatment cannot be justified
- failing to make a reasonable adjustment when a disabled student is placed, or is likely to be placed, at a substantial disadvantage in comparison with a person who is not disabled.

The Disability Discrimination Act 1995 definition of disability is 'a physical or mental impairment that has a substantial and long-term adverse effect on a person's ability to carry out normal day-to-day activities'. Therefore, students with mental health conditions have new legal rights to fair treatment.

The Higher Education Statistics Agency (2000) data for 1999/2000 show 1 631 680 students (taught, research, undergraduate, postgraduate, full-time and part-time) in higher education, of whom 73 840 declared a disability (4.5%); and of these, 1960 students identified a mental health disability (0.12% of the total number of students): see http://www.hesa.ac.uk.

At the moment, numbers declaring a mental health disability are small. For example, at one large new university for entry in 2000, of 29 644 applicants to the university, only 32 disclosed mental health difficulties (0.11%), and of 9390 student acceptances, 16 students (0.17%) had a declared mental illness. This university's December 2000 Higher Education Statistics Agency return shows a total of 17 388 students registered, and of these students only 24 identified mental health difficulties (0.14%).

It is highly unlikely that these figures give an accurate representation of the extent of mental health problems in the student population. One university counselling service wrote to all students about to enter one faculty in August 2001 saying 'if you have declared a disability of ANY kind then ignore this but if you anticipate a serious difficulty on entry due to mental health issues then

please tell us as we would like to arrange support for you in the initial weeks'. There were 10 replies; all the cases were serious in the sense that a recently experienced significant mental health disturbance had interrupted study.

There is no way of predicting how student requests for 'reasonable adjustment' might develop should the perceived benefits of declaring mental health disability come to outweigh the perceived drawbacks of disclosure. As dyslexia has become more socially acceptable, the numbers declaring it as a disability – and seeking reasonable adjustments – have increased considerably. Students may become much more aware of how their global well-being affects their performance and make increasing use of mental health difficulties to plead mitigating circumstances with examination boards. It is an area in which precedents are waiting to be set.

The Association of Managers of Student Services in Higher Education document *Responding to Student Mental Health Issues: 'Duty of Care' Responsibilities for Student Services in Higher Education* poses pertinent questions about how institutions might address the needs of students with mental health difficulties in relation to pre-admission, admission, entry/induction, ongoing support or interruption of studies (AMOSSHE, 2001). A number of institutions have made suggestions about possible adaptations to examination protocols to accommodate those experiencing mental health difficulties.

Recommendations

- Those responsible for providing and managing psychological support to students in the NHS, higher education institutions and the voluntary sector need to be kept informed of and involved in discussions about relevant developments.
- Practitioners and managers should be encouraged to review their practice and provision in order to ensure that their institutions are offering an adequate level of service to the increasing number of students requiring psychological support.
- Research into the experience and support needs of students entering higher education under the widening participation initiative should be a priority.

Mental health promotion

Health promotion is the process of enabling people to increase control over, and thereby to improve, their health. Health promotion has three intertwining strands: education about illness, prevention of illness using self-help and other measures, and the promotion of healthy lifestyles. Universities have a duty of care for students, not only when mental health needs are made known at admission, but under new legislation, universities must anticipate possible needs and provide a variety of opportunities for confidential disclosure of mental health problems during the students' course of study. Once a disability has been disclosed to any member of staff, the institution is responsible for making reasonable adjustments to its provision to meet the needs of the student with disabilities unless the student refuses permission to share the information disclosed.

Health promotion aims to:

- **enable** through reducing differences in current health status and ensuring equal opportunities and resources to enable people to achieve their fullest health potential
- **advocate** through making conditions that have an impact on health, such as political, economic, social, cultural, behavioural and biological factors, favourable through advocacy for health
- **mediate** through coordinated action by all concerned, including government, health, social and economic sectors, voluntary organisations, local authorities, industry and the media.

Mental health promotion for students in higher education requires coordinated, collaborative and integrated strategy and action. The World Health Organization grouped the general subjects for health promotion as follows. From these general groupings, it is possible to propose strategies that can be used within the higher education sector.

- **Young people need access to appropriate health services**

Student health centres and counselling services need to be put in place or improved by increasing the number of personnel and the training provided for them.

- **Development of an environment conducive to health**

A student council is needed (perhaps associated with the student union) to deal with any personal, economic or cultural problems; and to work for justice and equality in services provided for students (e.g. to tackle poor housing conditions).

- **Strengthening of social networks and social support**

All universities have a 'Freshers' induction week to smooth the transition to university life, to provide information about clubs and activities and provide an

arena for social networks to form. It needs to be recognised that transition takes time, so students need ongoing opportunities to form networks and relationships. Induction sessions also give information on support services, peer-run services such as Nightline and other health promoting activities.

- **Promoting positive health behaviour and appropriate health strategies**

Clubs and associations associated with healthy lifestyles (e.g. sports clubs, entertainment clubs, religious and cultural societies) should be promoted actively. Assertiveness training, training for emotional literacy/intelligence (Goleman, 1995) and other self-help activities may also be offered. The organisation of social activities at which alcohol is not consumed is essential, particularly for ethnic minority populations (e.g. Muslim groups for whom this is not permitted). In view of the threat presented by alcohol and drug misuse, both to health and the realisation of academic potential, this should be addressed assertively with information, psychoeducational campaigns, and university policies designed to promote responsible consumption patterns.

- **Increasing knowledge and disseminating information related to health**

Information may be disseminated by lectures, student handbooks, leaflets (e.g. alcohol use, sexual health), and material on student union and university websites. Training should be provided for academic and support staff on recognising mental health problems in students, and in techniques for promoting motivation and self-esteem. These services and strategies need to be provided in a format that is usable by everybody irrespective of gender, nationality, social status, sexuality and disability.

The Government obviously has a significant part to play in health promotion, hence each education institution has to develop policy in line with current Government guidelines.

In the National Service Framework (NSF) for mental health (Department of Health, 1999), the first standard is mental health promotion to ensure that health and social services promote mental health, and reduce the discrimination and social exclusion associated with mental health problems. Mental health promotion is most effective when interventions are built on social networks and made at crucial points in people's lives. A healthy workplace can promote good mental health. Access to services, and suicide prevention, are addressed by standards 2, 3 and 7 (see previous chapter).

The NSF local implementation groups, which are coordinated by Primary Care Trusts, have a key role in areas where there are higher education institutions in promoting collaborative mental health strategies for students which involve all relevant agencies. These include HEIs, non-statutory agencies, primary health and secondary mental health care providers. A student mental health strategy can give prominence to mental health promoting activities, structures and policies. In Oxford, for example, the mental health promotion strategy incorporates specific

aims in relation to providing education on safe drinking and sexual practice, developing HEIs as healthy workplaces, supporting activities that promote the development of emotional resilience, challenging discrimination, promoting social inclusion, and signposting key services.

The Committee of Vice Chancellors and Principals (CVCP) guidelines (Universities UK, 2000) recommend that staff development must be focused on the promotion of positive attitudes to mental health, and recommend that institutions give priority to incorporating appropriate staff development sessions. The CVCP guidelines state that higher education institutions must be aware of relevant legal and duty of care issues, provide for students access to support and guidance services, and liaise between agencies. The university has a duty of care, but can only discharge this if students declare known health concerns at the time of admission (see Policies and procedures, pp. 41–46). Intake screening for mental health problems would be highly contentious. The CVCP report stresses that there must be preparatory information for students, and access to support and guidance, so that applicants can discuss support needs prior to admission with clear confidentiality procedures and protocols. The CVCP report suggests that institutions may establish a central contact point for communication with local mental health agencies and other relevant external organisations. This will usually be the university counselling service.

The promotion of the university as a healthy workplace, and the concept of the 'health promoting university', is illustrated by the universities of Lancaster and Leicester where the provision of a learning environment is viewed as the joint responsibility of the academic departments and the central health, counselling and pastoral support providers. Leicester University has undertaken a project to raise the awareness, knowledge and skills of the whole institution through the production of study support guidelines and materials to enhance mental health provision (see Current provision and models of good practice, pp. 51–56). Because of the potential impact on students of mental illness in academic staff, it is appropriate for HEIs to make occupational health provision for their staff.

Peer support programmes have an important place in promoting the nurturing environment of universities. These may involve training in recognising and responding to mental health problems for student volunteers or those with official responsibilities, such as welfare and union officers. Several examples of good practice in mental health promotion are described on university and organisational websites (see Current provision and models of good practice, pp. 51–56).

Recommendations

- Information for mental health promotion should be widely available in universities, and incorporated into student handbooks.
- Advance information should be provided for students accepted to university, to prepare them for the realities of university life, to encourage those with pre-existing mental health problems to disclose

these before admission, and to signpost sources of further information, support and advice.

- Disability policies must address the needs of students with mental health problems as well as physical disabilities.
- Student unions should sponsor campaigns of mental health promotion, in part with the aim of reducing stigma.
- Pilot educational models of mental health promotion (e.g. in relation to substance misuse) should be implemented and evaluated in universities as a matter of urgency.
- Universities should formulate policies for developing their potential as healthy workplaces and health-promoting places of learning.
- Universities and key partners, including primary health and secondary mental health providers, should develop strategic policies and collaborative frameworks for mental health promotion (student mental health networks).
- Because mental health promotion is a key standard identified by the National Service Framework for mental health, local implementation groups in areas where there are HEIs should ensure higher education representation and development of a mental health promotion strategy for students as an integral component of their work plan. This should include:
  (a) the provision of signposts to local services for students, college staff and primary care practitioners, and
  (b) guidance and training for all relevant agencies on good, collaborative practice in identifying and responding to the mental health needs of students.

Current provision and models of good practice

Most universities operate a student support network, although there is no one comprehensive model that can be held up as *the* 'model of good practice'. However, we can describe current provision and suggest the principles that form the basis of good practice in student mental health. Early intervention is important, particularly because a range of treatments have been shown to be effective.

Help-seeking behaviour

Students in difficulty do not necessarily turn to officially designated mental health services; often they look first to other, more familiar, sources of help (Grant, 2002). Some may not ask anyone for support, but may draw attention to their needs by behaviour that rouses concern in other students and staff. Students with mental health difficulties are most likely to be directed, in the first instance, to their GPs or to on-campus paramedical, counselling or disability personnel.

Current service provision

Medical and psychiatric services

Eighty-two per cent of respondents to a recent Heads of University Counselling Services (HUCS) survey (HUCS, 2002) reported their universities had on-campus medical provision where students could register with and be treated by a doctor; the remainder had nursing/health advisory cover. Some universities fund this provision, in others the cost is covered by the NHS. Not all students are registered with their university practice: some continue with home GPs, others register with different doctors in the area, some may not be registered at all. Over 45% of respondents reported that their universities had provision for on-campus psychiatric assessment, while 34.5% had provision for on-campus psychiatric treatment. Off campus, there is little specialist mental health provision for students or other young people in the age range 16–25. Adult psychiatric services may not be particularly well adapted to students' needs, and the provision of such services is patchy.

Counselling

All but two universities have counselling services, as do the vast majority of colleges of higher education. The counselling services in different HEIs are broadly similar: staff members are trained, have ongoing clinical supervision, offer mostly individual work, and use theoretical models that are systemic and developmental in emphasis. Counselling services also provide consultation to staff concerned about their students' well-being. There are some important differences between

services – in levels of funding, and in staff expertise and training. Some services now employ clinical psychologists and cognitive therapists, and a number have psychodynamic psychotherapists. They may also differ in the emphasis they place on different aspects of their work.

Work currently undertaken in counselling services includes short-term focused work (to deal with a crisis, life event or current conflict), the exploration of more complex developmental issues (which are often highlighted by the university context), and therapy for deep-seated and long-standing emotional and psychological problems. Most of the counselling provided is brief; and the provision of longer-term counselling needs always to be balanced with demand. A few have psychiatrists as part of their team, and many, but not all, have access to psychiatric consultancy. Psychiatric assessments carried out in counselling services are not entered on student medical records unless the student is referred to local NHS health services.

Disability services

Almost all universities now have one or more designated disabilities officers, who will be aware of the implication of the Special Educational Needs and Disability Act 2001 and will look at the broader issues of mental health in the university setting. Students who declare mental illness on application, or who subsequently disclose it to the institution, may well be referred to a disabilities officer. A few universities now have designated mental health workers who may be located in medical, counselling or disability services.

Academics in pastoral roles

Although the expansion of higher education has led to a dilution of the traditional personal tutorial system, most institutions still provide some kind of tutoring or guidance by academic staff. Recent research (Grant, 2002) showed that students seeking help and advice were more likely to approach tutors than any other institutional help providers. Stanley *et al* (2000) argue persuasively that HEIs should acknowledge and support personal supervisors and tutors in providing front-line, non-stigmatised sources of advice and support for students with mental health problems. Academics in these roles need training, access to consultation and information on referral routes. Other staff, e.g. residential staff, may provide support to students without the benefits of recognition, training or consultation.

Central student services

All universities provide a range of student services. The services most usually offered are accommodation, career advice, child care, counselling, disability support, financial advice, health, sport and recreation. These are usually delivered independently, and may or may not be centrally managed. In many universities,

staff of these different services would liaise, cross-refer and perhaps meet together from time to time.

Student unions

Most student unions now employ welfare advisers who offer advice on a range of issues including personal concerns. They usually have a drop-in facility. Nightline, a telephone helpline staffed by students, is active in most HEIs. Some universities also have websites devoted to mental health.

Good practice

All higher education institutions now accept a duty of care towards their students, although resource constraints and competing demands may restrict what can be provided. In the last 5 years or so, there has been increased concern about the mental health needs of students (often seen as part of the growing disability agenda) and a number of initiatives have been designed to meet them.

The CVCP guidelines list the development projects on student mental health which were funded by the Higher Education Funding Council (England) between 1996 and 1999. This organisation continues to invest in special initiatives to improve provision for students with disabilities, including those related to mental ill health. This and other research, together with the impetus provided by the publication of *Degrees of Disturbance* in 1999 and the CVCP guidelines in 2000, led to a number of universities (76%; HUCS, 2002) setting up working parties on student mental health. In 2001, the Association of Managers of Student Services in Higher Education produced a *Good Practice Guide* to help HEIs plan and develop policies, systems and structures in relation to current and prospective students experiencing mental health difficulties. This guide covers duty of care in relation to a range of procedures from admissions to interruption of studies (AMOSSHE, 2001).

Many universities have reviewed their procedures in the light of the guidance provided by the documents mentioned above. They have produced their own guidelines for staff on how best to respond to students in difficulty; and some have produced separate sets of guidelines for students. Most university counselling services were already providing training in mental health issues for staff; but the university working parties set up to implement the CVCP guidelines have often instigated further training. Useful guidance on a range of topics, including developing an institutional mental health policy, supporting students, training staff and promoting mental health can be found on the website of the Student Mental Health Network: www.studentmentalhealth.org.uk.

Given the extent of activity and awareness within counselling and other student services, it is invidious to single out any one institution for particular mention, but it might be worth drawing attention to some examples of good practice which are readily accessible.

Some examples of good practice

The University of Westminster has recognised the necessity of support for students entering university under the widening participation initiative by increasing the staff of its counselling and advisory service.

Among many examples of good practice, one distinctive model is offered by the Educational Development and Support Centre at the University of Leicester. It brings together a range of services for both students (careers, welfare and counselling services, AccessAbility centre, sick bay and student learning centre) and staff (teaching and learning unit, and counselling service). This grouping makes explicit the link between effective teaching and appropriate support for learning. It offers a holistic approach to the creation of an effective and supportive learning environment for students, which is viewed as the joint responsibility of the academic departments and the central academic and pastoral support providers. Further details can be found at www.le.ac.uk/edsc.

Another comprehensive model, at Birmingham University, is described by Rickinson & Turner in *Students' Mental Health Needs* (Stanley & Manthorpe, 2002). The authors show how academic departments and counselling, medical and psychiatric services work together to support students. The philosophy behind this approach is based on a recognition of young people's developmental needs, vulnerabilities and potential, and on a belief that 'people are integral to the system in which they function' (Stanley & Manthorpe, 2002: p. 175).

In the same volume, Lago describes the challenges and opportunities for collaboration between services in the university and the wider community, based on his work in Sheffield. Cooperation with other helpers within and outside the institution is in fact a hallmark of counselling services in HEIs. Examples of liaison and joint working can be found in the many examples of good practice outlined in Appendix 1 of the CVCP guidelines. A case study from Edinburgh University that illustrates the principles and benefits of collaborative work can be found on the HUCS website (www.hucs.org) under 'Good Practice'.

All university counselling services offer consultation to other staff, and many are represented on committees and working parties. Their knowledge of their institutions, and staff and student concerns, together with their professional expertise, are good preparation for these tasks. The vast majority (86%) offer training in mental health issues to staff. A description of one such training from the University of Hertfordshire can be found in the Good Practice section of the HUCS website. Counselling services realise that students often turn in the first instance to other students for support, and therefore make their expertise available to student-led services (e.g. Nightline) or welfare officers employed by student unions. Many (58%) offer training to students: one good example of such initiatives can be found in the description of Oxford University's peer support training, again on the HUCS website.

Hence, services aim to make their expertise available by a number of routes. In addition to personal and group counselling, consultation, staff and student

training, many run conferences, provide workshops on a range of topics (e.g. study skills, examination anxiety, confidence building) and offer guidance in leaflets and on websites. Examples of these can be accessed through www.hucs.org.

Counselling services are concerned to know what impact they are having on their users. Many seek feedback through evaluation questionnaires given to all clients at the end of counselling and some use the Clinical Outcome Routine Evaluation (CORE) system as a way of measuring the effectiveness of their work (e.g. University of Manchester and UMIST Counselling Service Evaluation Report).

Principles of good practice in student mental health

Good practice in student mental health should be based on the following principles:

- There is collaboration between HEIs, the NHS and other local agencies (including voluntary organisations) to ensure that students can access appropriate care without undue delay. Careful attention needs to be given to issues of confidentiality.
- The importance of early identification and intervention for young people at risk of developing severe mental illness (given this commonly emerges in late adolescence or early adulthood) is recognised.
- There is recognition of pressures specific to students in higher education, i.e. academic, financial difficulties, parental expectations, unstructured time, frequent transitions (geographical and emotional).
- Treatment plans are tailored to the personal and contextual needs and the academic requirements of the student.
- Practice is based on evidence, and there is ongoing research and evaluation of service provision.
- Consideration is given to the fact that late-adolescent students are likely to be struggling with issues of dependence and independence and may be ambivalent about seeking help: therefore, rapid and easy access to non-stigmatising and flexible psychiatric, medical and counselling services is provided.
- Given that students are most likely to seek help from those with whom they have most frequent contact, all HEI staff need to take some responsibility for student mental health. There is a need for training to raise general levels of mental health awareness among staff and students, so they can recognise signs of psychological disturbance and know when and where to refer for specialist help.

Recommendations

- The pastoral duties of academic staff to be recognised and supported, for example with regular training and through their appraisal process.

- The opportunities for students offered by multi-faith chaplaincies to be recognised.
- Local mental health teams and counselling and medical services in HEIs to work more closely together when jointly supporting those with severe mental health difficulties; to develop frameworks and clear protocols for cross-referral which take account of local mental health and counselling provision and expertise. Student counselling services to participate in the care programme approach (CPA) for students when necessary, although it must be recognised that student counsellors are not mental health workers and cannot fulfil the role of CPA care coordinator.
- An enabling policy to allow students to move smoothly between home and university, to ensure continuity of NHS treatment (including CPA) and without arguments about which Trust should pay.
- NHS resources organised to allow for speedy response to referral in serious cases.
- The establishment of community mental health teams (CMHTs) with special remit for those aged 16–25 years, staffed with particular responsibility for developing an understanding of student issues; or appointment of staff to generic CMHTs who have knowledge and expertise in relation to the mental health needs of students.
- An expansion of in-patient units for young people, and an extension of the upper age limit for adolescent units, so that students have access to appropriate in-patient facilities when these are required.
- Development of services for early intervention for those at risk of psychotic illness.
- Guidance to GPs and CMHTs on student mental health needs.
- Access to supported accommodation for students with serious mental health problems.
- All HEIs required to have adequately resourced counselling services.
- All HEI counselling services to have access to appropriate psychiatric consultancy.
- Counselling services to continue to develop and deliver training programmes for staff and students, drawing on other expertise from within and without their institutions.
- Research into new models of service delivery (e.g. posts of mental health workers recently established in some HEIs), students' perceptions and preferences about treatment; needs of young men and of ethnic minority students who appear more reluctant to access mental health services; incidence of student suicide and prevalence of mental health problems among university students.

Appendix 1: Counselling in higher education

By Eileen Smith (AUCC/HUCS)

All but two universities have counselling services, as do the vast majority of colleges of higher education.[1] The total (including full- and part-time) student-to-counsellor ratio in the higher education sector (both colleges and universities) is about 4650:1. In higher education colleges, the average ratio is one full-time equivalent (FTE) counsellor to 2500 FTE students: in universities, the ratio is higher and the average is one FTE counsellor for about 3500 FTE students (AUCC, 2001).[2]

Information on requirements and guidance for good practice can be found in the British Association for Counselling and Psychotherapy (BACP) *Ethical Framework for Good Practice in Counselling and Psychotherapy* (BACP, 2002*b*)[3] and the AUCC's *Guidelines for University and College Counselling Services* (AUCC, 1998).

There are some counsellors in higher education who are not members of the BACP; they would subscribe to the codes of ethics of other professional bodies such as the British Psychological Society (BPS), the UK Council for Psychotherapy (UKCP) or the British Confederation of Psychotherapists (BCP). There is a comparatively new AUCC Counselling Service Assessment and Recognition Scheme, details of which can be found on the Heads of University Counselling Services website. The scheme is too new for many services to have been through the process yet, but the documentation gives some indication of current thinking about acceptable levels of provision and practice.

There are many broad similarities between counselling services in different HEIs as well as some local variations. Similarities are in requirements for training, qualifications and supervision, in the reliance on a therapeutic (not an advice and guidance) approach, in the adoption of theoretical models which are systemic

1. A college of higher education is generally smaller then a university; it may specialise in one area, e.g. art education, or cover a broader range of subjects.
2. These figures and subsequent ones referenced to AUCC 2001 are from the AUCC survey. They refer to those institutions responding to the survey. The figures for universities are based on a larger and more representative sample than those for colleges of higher education, as about two-thirds of universities replied to the survey but only a third of the colleges.
3. The majority of university and higher education college counsellors belong to the British Association for Counselling and Psychotherapy which is responsible for ethical codes, accreditation and registration. The Association for University and College Counselling (AUCC) is a division of BACP and offers sector-specific guidelines. The Heads of University Counselling Services (HUCS) group is a special interest group of AUCC but membership is open to the Heads of Service in all universities regardless of their affiliation to any other professional body. The HUCS initiated the 1999 report *Degrees of Disturbance* and organised in 2002 a conference on student mental health.

and developmental in emphasis and in involvement with the educational context. There are also some differences – in levels of funding, in staff experience, expertise and training, in theoretical orientation and in the emphasis on different aspects of the work.

Counsellor qualifications

Recent feedback from the HUCS mailbase indicates that the vast majority of university counsellors are graduates, many with higher degrees, trained in counselling and/or psychotherapy and with a substantial amount of post-qualification experience. Counselling tends to be a second or even third occupation and it is common for counsellors to have extensive experience in other relevant fields before training in counselling; common backgrounds include lecturing and teaching, psychology, social work and nursing. Some services employ clinical psychologists and cognitive therapists; many have psychotherapists.

Regular and ongoing clinical supervision with a more experienced practitioner in a related field is a requirement for all BACP members who are practising counsellors (BACP, 2002). Continuing professional development is seen as necessary for maintaining competent practice (BACP, 2002). The BACP offers its members a scheme for further voluntary self-regulation through accreditation with BACP and registration with the UK Register of Counsellors. Some university counsellors are registered with BPS, UKCP or BCP. An AUCC survey reported that 75% of HEI counsellors are accredited or registered, 51% of those in new universities and 68% of those in old (AUCC, 2001).

(There have been questions about accreditation and why not all counsellors are accredited. Accreditation is not a qualification but an additional undertaking, one that is not yet a statutory requirement. Some counsellors may still be acquiring the necessary post-qualification experience while others who are eligible may have other priorities for continuing professional development.)

What clinical work is undertaken?

Most counselling is of individuals although many services offer group counselling as well. Work currently undertaken in counselling services is very varied. All HEI counselling services offer what one NHS document defines as counselling: 'a systematic process which gives individuals the opportunity to explore, discover and clarify ways of living more resourcefully, with a greater sense of well-being – concerned with addressing and resolving specific problems, making decisions, coping with crises, working through conflict or improving relationships with others' (Department of Health, 2001*b*), but many also offer what the NHS might be more likely to define as psychological therapy.

All services attend to the pressures on their clients caused by the demands of the student role; they are aware of the therapeutic possibilities of harnessing work on the issues thrown up by the educational context with young people's

maturational drives in order to promote development. A range of interventions is offered: from short-term focused work – perhaps to deal with a crisis, life event or current conflict – to the exploration of more complex developmental issues, and therapy for deeper seated and longstanding emotional and psychological problems.

Depression is by far the most prevalent presenting issue to counselling services in all HEIs (38% of new clients in new universities, 49% of clients in old universities) with figures for anxiety also high (23% in universities). About 5% report self-harm in every kind of institution; 6–10% report suicidal ideation; 2–5% drug or alcohol misuse. About 6% of university counselling service clients reported anorexia or bulimia (AUCC, 2001).

The majority of counselling in universities and colleges is short-term (the average number of sessions in HEIs is 4.5), although this does not necessarily imply the issues dealt with are simple and easily resolvable. A number of factors may contribute: services operate an open door policy; HEI counsellors have developed their consultation and brief work skills; adolescents tend to be wary of prolonged dependency. However, there has been an increase in the proportion of student clients in longer-term counselling in higher education colleges and new universities. Overall 13% of clients had 8–15 sessions and 7% had 16 or more (AUCC, 2001). This shift may suggest that there has been an increase in the complexity of the issues students are bringing for counselling. The proportion of clients with difficulties rated by counsellors as 'severe' has increased in HE colleges and new universities (AUCC, 2001). Although a number of services have staff appropriately trained and experienced to offer longer-term or specialised help, few have the resources to offer these interventions to all students who might benefit.

A recent HUCS survey suggested a variety of approaches to students with more severe mental health difficulties. In response to the question 'How does your service see its role in relation to severe mental health problems?' the following answers were received from university services (multiple responses were permitted):

No work	9%
Emergency sessions	49%
Short term or occasional supportive work	73%
Long term supportive work	49%
Remedial therapy in conjunction with medical treatment	51%
Other	18%

The differences indicate differences in resourcing, expertise and philosophy.

No service would undertake the diagnosis or treatment of severe mental illness but all would consider it important to be sufficiently well informed to recognise the various forms of mental illness and to know when referral to psychiatric services is necessary.

Many services seek feedback by inviting all completing clients to give a written evaluation of the service they have received and the impact that counselling has had on them. Some services use the CORE system as a way of measuring the effectiveness of their work.

Some students may be reluctant to use counselling services. There are a number of possible explanations:

- perceived stigma associated with seeking help for any psychological difficulty
- lack of information about what is available: resource constraints may lead counselling services to limit publicity
- misunderstanding about what counselling offers
- oversubscribed or underfunded services having to operate a waiting list
- preference for seeking help from those known (e.g. friends, tutors) or from more familiar help providers (e.g. GPs)
- preference for other (positive and negative) ways of dealing with problems.

Services aim to reach those reluctant to use personal counselling by training other staff and students in helping skills, and by ensuring there is a spectrum of support and information available by the provision of, for example, preventative sessions on study and examination anxiety, health information material on websites.

Links with other professionals

The establishment of links with local medical and psychiatric services for consultation and referral is seen as an essential part of the work of a counselling service in an institution of higher education (AUCC, 1998). Counsellors value ease of access to medical and psychiatric opinion, consider it important to familiarise themselves with local NHS and voluntary services and essential to refer those for whom counselling is not appropriate or sufficient alone.

Most services have some contact with local community mental health teams (HUCS, 2002). A number of services have a part-time psychiatrist either on their team or as a consultant. Counsellors tend to discuss more cases with psychiatrists than they refer for assessment or treatment.

About half of university counselling service respondents to a HUCS survey were able to access on campus psychiatric assessment for their students while one third had access to on campus psychiatric treatment. Sixty-two per cent of university counselling services reported themselves as broadly satisfied with existing arrangements for psychiatric support.

Counsellors often work in conjunction with their university's health centre doctors and nurses when dealing with students with, for example, severe depression, an eating disorder or self-harming behaviour.

Some counselling services operate within student services frameworks but all services would, when appropriate, liase with academic and halls staff, chaplains, student unions and other student support services and would be involved with them in a number of policy making and training activities.

What institutional work is undertaken?

All university counselling services see their responsibilities as wider than the provision of clinical work. The majority (86%) offer training in mental health issues to other staff (HUCS, 2002) and many (58%) to students. More training is being offered as part of institutions' response to the CVCP guidelines. All university counselling services are available for consultation to staff concerned about students' well-being and many are represented on relevant committees and working parties.

References and further information

A good place to start is the Heads of University Counselling Services website – www.hucs.org – where one can find, *inter alia*, the text of *Degrees of Disturbance*, information about the AUCC Service Recognition Scheme and the forthcoming 2002 HUCS conference ('Beautiful Minds? – Students, Mental Health and the University') and links to the websites of individual university counselling services and other relevant organisations in education and mental health.

Suggested reading (see reference list)

Bell (1996, 1997)
Lees & Vaspe (1999)
Rana (2000)
Smith (1997)
Stanley & Manthorpe (2002)

Appendix 2: Glossary of acronyms

AMOSSHE	Association of Managers of Student Services in Higher Education
AUCC	Association for University and College Counselling (a division of BACP)
BACP	British Association for Counselling and Psychotherapy
BAHSHE	British Association of Health Services in Higher Education
BCP	British Confederation of Psychotherapists
BPS	British Psychological Society
CORE	clinical outcome routine evaluation (a system of measures devised by the University of Leeds Psychological Therapies Research Centre)
CPD	continuing professional development
CVCP	Committee of Vice-Chancellors and Principals, now renamed Universities UK
FTE	full-time equivalent
HEI	higher education institution (includes universities and colleges of higher education)
HUCS	Heads of University Counselling Services (a special interest group of AUCC)
NSF	National Service Framework (strategic policies for service development, including the NSF for mental health services for adults of working age)
UKCP	United Kingdom Council for Psychotherapy
UKRC	United Kingdom Register of Counsellors

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