Chapter 18

Mental Health Services on Campus and in the NHS

This chapter examines what can be expected in a modern university in terms of prevention, early intervention and treatment of mental ill health. Some of the names and assigned role descriptions may vary between institutions. Not all help is formal. Students often informally assign carer roles onto people not necessarily officially appointed to fill them, including peers, teachers and family members. It can sometimes be hard to pinpoint whether a student is simply interacting in a healthy way and making normal use of interpersonal support, or whether they are receiving explicit support for their mental health, albeit from unofficial sources.

Jasmine, a second-year student, had moved out of halls into a flat with two friends. They noticed she had become increasingly withdrawn and asked what was wrong. She admitted to feeling constantly anxious and often unhappy without any particular trigger. After a couple more weeks of this her friends took her along to the counselling service.

She was given a prioritised assessment where it was found she had a restrictive eating disorder as well as social anxiety and low mood. With her agreement, the counselling service contacted her general practitioner (GP) and arranged referral to the national health service (NHS) eating disorders clinic. Unfortunately, things became worse before she could be seen there. She returned home and received treatment in her former home town.

Before she returned to university the following year, she was encouraged to declare a 'disability' and apply for Disabled Students' Allowance (DSA). This paid for weekly appointments with a specialist mental health mentor who encouraged her to keep appointments with the eating disorders clinic and to follow their advice. The mentor helped her with strategies for when she 'slipped up', and ways to socialise better and make sure the disorder didn't interfere with her studies.

One of the most important skills for helpers is knowing when to introduce the person to more formal support. This matters for the well-being of both helper and helped student. In fact, much of the effective work of helping with mental health difficulties involves steering paths through the myriad different options available.

For those who require more formal help, it is essential to have an idea of what is available both within the university, and beyond its walls, and for all helpers to be able to coordinate care effectively. This chapter outlines formal service provision and its recent developments, as well as progress in its integration and networking capacity. Finally, it examines some examples of projects and pilots of interventions in different UK universities that show promise.

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A Time of Change and Growth: 'Step Change', 'The University Mental Health Charter' and the Work of the World Health Organization

At the time of writing this chapter, support for student mental health is in a phase of striking expansion. In the past, the main sources of pastoral support for students were academic personal tutors, hall wardens, and chaplaincy services. Student health services, counselling services and disability services supplemented this support These have been close to being overwhelmed as student numbers have risen overall and with proportionate increases in rates of those who need support with their mental health. This was the case even before the COVID pandemic and lockdown further exacerbated the situation.

There was already a 50% increase in the demand from students for mental health and well-being services between 2010–11 and 2014–15. Several reasons for that increase were hypothesised: reduced stigma around disclosure, widening participation, reductions in NHS support and increased financial stressors, such as student loans. During this period, the number of undergraduate students recorded as declaring a mental health condition trebled from 0.4% to 1.3%, but there was still a high level of non-disclosure and low levels of help-seeking relative to known levels of need (Macaskill, 2013).

Counselling was the most consistently offered effective intervention, and positive results were also demonstrated in services offering psychodynamic therapy, structured brief therapy and integrative therapy. However, the capacity of one-to-one counselling services to offer support to large numbers of students was too limited to be appropriate as a first-line intervention for all who seek help. Waiting lists lengthened, and alternative approaches, were suggested, particularly cognitive behavioural therapy and mindfulness. These were often in online and self-help formats, although some studies reported poor uptake and high dropout rates for these (Brown, 2018).

The expansion in student mental health services has occurred in the context of growing dissatisfaction with NHS services. There has been some unease about whether student mental health services are being called upon to make up for shortfalls in the NHS. In contrast, NHS specialist services point out that the mental health needs of students are often closely entwined with the academic and social environment built up by university institutions. Universities make considerable profit out of bringing a large extra temporary population into an NHS Trust area during termtime. It may be reasonable to expect that some of the students' fees be invested in supporting their mental health.

COVID and its aftermath have created a climate of further pressure, both on GPS as service gatekeepers and referrers, and on NHS mental health provision. There are risks that without considerable extra resource, student mental health referrals may not be prioritised unless they reach emergency point. NHS waiting lists are often unrealistic in terms of the length of the course and semester dates that students work to. Vulnerable students should not be expected to be their own care co-ordinators in such a climate.

It is understandable that authorities such as governments and university governors might see the answer to student mental ill health as mobilising resource to employ more 'student counsellors'. This was indeed the response of the Scottish Government in 2018 when their Programme for Government invested £20m to provide more than 80 additional counsellors in further and higher education institutions over the subsequent four years. Such increase in counselling staff is welcome, but far from being the

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whole answer. Counsellors cannot reach out to the whole community to provide preventative interventions, nor can they prescribe or manage severe episodes of mental disorder.

This book, like The University Mental Health Charter (Hughes & Spanner, 2019), concludes that a 'whole university approach' is needed to address the dynamic and complex situation. Such an approach depends on high-quality research and integrating whole networks of response to the diverse needs of the student population – both undergraduate and graduate – and also the needs of the staff groups. Chapter 13 considers further how staff, both academic and non-academic, at all levels of seniority, can benefit from mental health support and treatment in their own right and in in their important roles as culture carriers, role models and pastoral carers within the university.

One approach to improving services is to increase the capacity of existing services. Another is to add in completely new services, either to replace current structures, or more commonly on top of current provisions. This latter approach has the benefit of plugging gaps whilst preserving – or adapting – the resource that is already in place. There is, though, a real risk of increasing confusion and difficulties in communication. Clarifying, publicising and facilitating pathways between services can be a worthwhile action in itself. It can be a risky venture to dismantle longstanding services, even if they are inadequate, but remodelling and improving them has to be done with regard to the morale and wisdom of staff involved.

Jeannette worked for more than 20 years in a university counselling service, where she was recognised as expert in the support of people with traumatic backgrounds. She provided long-term support, sometimes extending beyond the time when a student graduated or dropped out of academia, and was admired and loved by her colleagues, to whom she provided both formal and informal supervision.

After a critical review, the university decided to increase student access to counselling by limiting treatment to a norm of two sessions, with a maximum course of six sessions. Training was provided, in which the training team from a prestigious university presented compelling evidence for the benefits of the new way of working.

Jeanette had not been personally consulted in the changes, and decided to leave the service rather than adapt to a way of working that would not recognise her particular skills. She felt demoralised and deskilled by the implication that research had shown her style of counselling was not effective, but she was headhunted to work in a military trauma service. Meanwhile, many of her colleagues became uneasy without her support and supervision in the service. So many left that there was effectively a complete changeover in staff, and a period where the service was not working at full capacity and not attracting staff. No one knew whether outcomes for the new way of working were any better than before, as the measures used to assess this were not comparable with previous data.

In September 2017, a working group published new guidance for leadership in the report 'Stepchange: Mentally Healthy Universities' (Universities UK, 2020). This offers a wide perspective beyond the usual focus on counselling. The document points out the publicised increase in student suicide and highlights the duty of care of higher education institutions to their students. It urges universities to see themselves as health-promoting environments, adopting mental health as a strategic priority with a 'whole-university approach', embedding good mental health across all university activities, including

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greater investment in university mental health services, digital interventions and suicide prevention. Stepchange (Universities UK, 2020) recommends that universities collaborate with parents, schools and employers to prepare students for transitions and that they work closely with the NHS to explore how mental health services should be commissioned, co-ordinated and delivered to students.

The report's principles have provided the basis for a charter award scheme to measure, validate and appreciate excellence in this area of student well-being. As mentioned earlier in this book, The University Mental Health Charter (Hughes & Spanner, 2019) allows university applicants and their families and other funders to take this crucial aspect of university life into account when deciding on choice of university (Chapters 2 and 3). Regular reviews are required to keep services appropriate to the changing student population and the dynamics of society itself.

Social change means that treatments that were effective for one cohort of students may not continue to be so over time. For instance, the guided self-help we offered in the 1990s to students with bulimia nervosa was strikingly effective, using paperback books and minimal input from trainee psychologists. Today, such books and manuals are less effective. They fail to address social media and online influences on eating disorders. Books and print formats are less acceptable and appropriate to modern students, who expect online modules and interactive apps. Such texts appear dated in their implicit assumption that all patients are young white heterosexual women. It is primarily psychological therapies that become dated in this way, but it's also crucial to prescribe drug treatments in accordance with updated knowledge of options, interactions and adverse side effects.

Teaching and Academic Staff on the Front Line of Supporting University Mental Health

The role of academics in managing their own and their colleagues' and students' well-being, mental health, and mental disorders, is discussed further in Chapter 13. Students' mental health difficulties often arise in the academic context; the students concerned may prefer to access support from a familiar and sympathetic teacher than seek formal help. They also tend to return to trusted teachers and academics while they are on the waiting lists for services and or when they feel that services don't meet their needs. In this situation students are receiving support from unqualified academic staff, weakening appropriate boundaries and placing both academic and student at potential risk.

Chapter 13 provides further recommendations for the sort of training that could support staff's own well-being, foster more effective help for students, and build close constructive relationships between teaching staff and mental health staff to share responsibilities appropriately.

Awareness and Information on Campus and on the Internet

Any visitor to a university campus will be struck by the number of leaflets in piles, posters on toilet doors, stalls offering home baking, and awareness-raising information about mental health initiatives and help contacts. Browsing university and student websites and social media pages, also brings up a bewildering range of help options ranging from phonelines and charity websites to peer support groups. It is like being in a

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huge supermarket, wondering which foods are in fact substantial and nutritious and which are more a matter of attractive packaging. Universities can provide a great service to their members by subjecting some of these initiatives to rigorous scrutiny and investing in properly evaluated interventions whenever possible.

Mental Health Services Typically Found on University Campuses

Student Mental Health Support Services and What They Offer

- Student health service – physical AND mental health advice and input – contraception, sexual health, vaccination, travel advice, 'signposting' nurses, perhaps doctors
- Student counselling service – mental health – trained counsellors, no prescribing
- Mental health mentors – mentorship (rather than therapy) for students with a self-declared mental disorder. Funded by ringfenced government money (DSA)
- Student funding or financial services – advice, loans, emergency funding, debt management, advice on DSA (See Chapter 9)
- Disability services (including neurodiversity – attention deficit hyperactivity disorder, autism spectrum disorder, dyslexia and dyspraxia – diagnosis and adjustments to study) (See Chapter 18)
- Multifaith chaplaincy
- Student inclusion service – international students, those from different ethnic or non-traditional backgrounds, 'first gen', LBTGQ+ minority groups (See Chapters 11 & 12)
- Hall wardens, senior hall residents, security staff and administrators often find that a significant part of their work involves pastoral care.

Names and structures differ, but most UK universities offer free access to general 'disability services', specialist learning support, counselling services, mental health mentors, financial services, accommodation services and chaplaincy. They may be grouped loosely with international student support and careers service, sometimes sharing buildings, and often linking with the student union.

According to The University Mental Health Charter (Hughes & Spanner, 2019) virtually all universities report having well-documented and robust frameworks and procedures for responding to an incident or crisis affecting staff or students. Students experiencing a mental health crisis are generally referred directly to NHS services. Several institutions highlighted the effectiveness of security staff in dealing with crises. This is analogous to the role usually played by police.

In an acute mental health crisis in the wider community my experience has been that police officers show evidence of good training and display remarkable compassion and kindness to our patients. University security staff also need mental health to be part of their training and supervision.

Outside acute crises, most staff and students told Hughes and Spanner (2019) that they preferred help that was bespoke to academic pressures. NHS mental health services – particularly psychological and counselling services – involved longer waits than on campus services.

Counselling Services

In the clamour for more counselling to be made available to students it can be all too easy, to overlook the important issue of how effective the counselling actually is when

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accessed. This is yet more important as the length of contact is increasingly cut down to a maximum of six sessions or even fewer. We need to specify what is meant by 'counselling', what the 'dose' of treatment needs to be, and what outcomes have in fact been measured.

There have been laudable attempts to assess effectiveness of student counselling. These include an analysis by Murray et al. (2016), who used the respected Clinical Outcomes in Routine Evaluation (CORE) questionnaire scores to assess outcomes in 305 individuals attending a large UK university counselling service. At the end of the course of counselling, 63% of individuals showed a reliable improvement. However, these were students who completed the course. It is important to include evaluation of everyone who was referred, if the overall effectiveness of the service is to be properly evaluated.

The history of providing counselling in higher education institutions goes back more than 70 years.

In 1948, Mary Swainson began to offer personal counselling in the Postgraduate Department of Education at University College Leicester. By 1955 the College had recognised this 'psychological advisory service', though undergraduates were only offered the service if referred by their head of department.

In 1964, Audrey Newsome set up the first fully developed student counselling service at the new University of Keele.

This has been achieved in a well-designed recent study by Broglia et al. (2021) who evaluated progress of over 5000 students referred to counselling at four universities. On average, the students waited 14 days to be seen, then spent around 13 weeks in contact with services, during which they attended between four and five counselling sessions, excluding the initial assessment.

The students concerned were mostly undergraduate, female, UK white, and had not declared a 'disability'. The students received one-to-one, face-to-face in-house counselling sessions from professionally accredited therapists. Staff were trained in humanistic, psychotherapy, cognitive behavioural therapy, psychodynamic, and integrative approaches. The measures used were versions of the CORE or Counseling Center Assessment of Psychological Symptoms (CCAPS) assessment tools (Locke et al., 2011). These questionnaires are both respected validated measures.

In this study, outcome measures were completed at every visit, so it was possible to demonstrate that students who ended therapy prematurely had poorer outcomes. Even allowing for the inclusion of these students in the overall results, the change in depression scores was substantial. The combined rate for severe and moderately severe distress fell from 60% before counselling to 27% after counselling. 66% students who completed the planned number of sessions showed 'reliable improvement' – a comparable figure to previous studies' findings.

The study is important in being a first step towards developing a national dataset of student counselling outcomes, which could ensure we provide students with the most effective known treatments and speedily evaluate new ones. Examining the features of the clients carefully can also allow us to consider what works for whom. Only by using similar measures across national samples will we get big enough numbers to evaluate what works for minority groups too.

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Meanwhile it is heartening to observe that students who presented to counselling with low levels of well-being and functioning, and high levels of depression, anxiety, academic distress and trauma could be treated so effectively in so few sessions, and may leave us understanding why governments are ready to invest in more of these impressive services on campus.

Adaptations to University Counselling during COVID

At the time of writing, research is only starting to emerge on adaptations to student counselling services in lockdown, and their effectiveness. Psychological support, like academic teaching and meeting, transferred to online platforms. There were delays and obstacles while platforms worked to ensure confidentiality and access for both counsellors and their clients.

Some early studies from Italian universities describe experience that can be generalised to the post-COVID climate. One study (Savarese et al., 2020) emphasises how the use of the online mode significantly changed the professional work of the therapists. They held daily team meetings to address unfamiliar issues, including the modification of the setting and the professional reflections that this activated. However, they succeeded in providing not only individual counselling but also small groups for anxiety management and study skills.

Ierardi et al. (2022) in Milan exploited the situation to measure the effectiveness of online versus in-person counselling for university students. They identified two groups of students with comparable mental health difficulties and demographics. The first group was treated face to face just before the pandemic, the second group was treated online during lockdown. The good news is that online counselling reduced symptoms of depression, anxiety, obsessiveness–compulsiveness, and interpersonal sensitivity to a similar extent as in-person counselling. However, the online intervention was less effective in reducing 'total psychopathological distress'.

The authors observed that both therapists and students were by now well used to using technologies in their daily lives and had little problem creating a good therapeutic alliance based on empathy and listening. There did appear to be extra benefits to in-person counselling. This was associated with reduction in discomfort, anger, and somatisation (bodily symptoms of mental distress) and increase in life satisfaction. They admitted, though, that the pandemic situation itself and the resulting lockdown, might be responsible for how resistant to change these symptoms were in the second group. It would be helpful to repeat the comparison of face-to-face versus online treatment with two groups of students after lockdown. Now that people are better equipped to use technology for therapy, this could allow treatment when students are on vacation or away on placements.

Chaplaincy

All universities host chaplaincy services offering quiet spaces for reflection and prayer, and compassionate support. Students and staff have told me that they appreciate the warmth – sometimes literally on a cold winter day on campus – and informal opportunities for non-pressured, non-judgmental conversations. Others have felt wary that if they engage in this there will be an ulterior motive of 'converting them' to a religious faith. However, most chaplaincies welcome staff and students of all faiths or none, calling

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themselves 'non-denominational' and 'multi-faith'. Chaplaincies continue, as they have done for centuries, to provide listening, religious services, meditation opportunities, tea and coffee, even lunch, and low-key social events to counter loneliness. A straightforward view of the campus chaplain is as a representative of a particular faith tradition who works in a secular environment – similar to the work of chaplains in hospitals, prisons and the armed forces.

The word 'chaplain' is thought to originate in the legend of St Martin of Tours. While serving Rome as a soldier deployed in Gaul, in the third century AD, he cut his military coat in half to share it with a ragged beggar. That night Martin dreamed of Christ wearing the half-cloak he had given the beggar. The half he kept became a holy relic to which people would pray. The relic's guardian was called a 'chapelain'.

One of the earliest known instances of a chaplain in a university dates back to the year 1256, when the University of Cambridge was granted funding for two full-time chaplains to serve its students.

In contrast with the increasingly regulated and measured structures in university counselling services, the practice of chaplaincy services has always been less defined, and open to the creative responses of individual chaplains to the circumstances they find. Chaplains engage with academic departments to varying degrees depending largely on individual relationships and common points of intellectual interest, but this is often uneven and unstructured. Increasingly, they are integrating themselves with more formal university structures, providing websites and regular programmes, as well as providing services to academic and pastoral staff. Some offer meeting places, hosting for meetings on sensitive topics such as suicide reviews, supporting bereaved students, and collaborations with student services. Some student support services use chaplaincy premises to hold some of their clinics and meetings.

A profession characterised by goodwill and very flexible job descriptions may find itself called to fill gaps in other provision. This may be positive and creative but also risky and controversial. In some institutions for instance, chaplains have been approached to lead on legal responsibilities around counter terrorism. Chaplains may be assumed, rather than explicitly qualified, to have the necessary expertise in religious politics and pastoral diplomacy.

Chaplaincy can be treated as a sort of overflow service for oversubscribed professional support departments. Nolan (2021) claims that 'What began as a Christian ministry is visibly morphing into a secularised form of therapeutic service'. This is a precarious arrangement, based on an assumption of good communication and trust between all parties. Most chaplains are part time, many are volunteers, some are paid by their church or religious organisation, some by the university and others by some combination of funding. They are unlikely to have the same line-management or training opportunities as counsellors. Their job descriptions tend to specify membership of a religious organisation rather than a professional body, so they are not usually within the systems of accountability, safeguarding and quality control that university managers demand of mental health staff in student services.

This recontextualising of the campus chaplaincy – both as non-denominational spirituality and as a form of mental health care – is felt by some chaplains to pose problems of balance even as it has helped to renew attention to the office. They are happy

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for students who aren't in any world religion to they come in, have tea and meditate. But some still wish to prioritise the needs of students who identify as having specific spiritual and religious needs.

In the context of this book, it is not appropriate to debate the balance between religious and mental health input that should be expected of our university chaplains, though we need to be aware of that potential conflict. Almost by accident, chaplains may be being expected to undertake advanced mental health practice without the appropriate training, supervision and indemnities. I have been unable to find a legal view of this situation.

It is not clear what mental health training should be provided to chaplains both before and after appointment. Both recruitment criteria and provision of continuing professional development are needed, particularly where the role overlaps considerably with social work and counselling. Gloria Woodland, who directs the Associated Canadian Theological Schools Seminaries, defines the role of the chaplain as 'spiritual health practitioner'. She says it takes more than the usual clergy training – 'It's going to take interpersonal skills, as well as skills in the field of psychology, mental health, and a theological perspective.'

There are costs associated with expecting previous training or providing it for appointees. Currently, the salary for university chaplains (when they are not volunteers) is around £25 000, in comparison with £40 000+ for university counsellors. It is unlikely that religious organisations could fund chaplaincy at that level but might instead expect universities to consider taking over costs and governance arrangements. Chaplains remain accountable to their religious organisation, but those undertaking mental health work might benefit from additional membership of a professional body such as the University Mental Health Advisors Network.

Chaplaincy is particularly suited to well-being interventions rather than specific treatment for people with mental disorders. One university chaplain hosts an annual guided walk through the city's sacred places – churches, temples, synagogues and mosques. The walk follows a lunch of bread and soup and is attended by students of all faiths and none. International students are particularly welcomed.

One year, as they visited a temple, one new Hindu student was moved to tears to have found her own place of religious worship. Many of the students from the walk became 'regulars' at the Wednesday lunches hosted by the chaplaincy centre. These were continued through the Christmas vacation to support students unable to return home to their families.

University Mental Health Advisors

The role of mental health advisors (MHAs) is to assess the impact of mental health needs on academic ability and provide information about mental health issues and the services available to support them. They work alongside disability advisers, mental health mentors, well-being advisers and counsellors. MHAs normally either have a postgraduate qualification in mental health or a professional qualification, and many have extensive experience of working in the public sector. The professions represented include occupational therapy, mental health nursing, social work, psychology, counselling, psychotherapy and people with a portfolio of extensive experience of supporting people with long-term mental health conditions.

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The role involves co-ordination and case management rather than direct counselling or therapy. The job title and remit of their role may differ across each university, but typically, a MHA acts as a point of contact for the student throughout their course. Confusingly – but also conveniently – many MHAs also work as specialist autism mentors, or provide specialist one-to-one study skills and strategy support. Since 2003, there has been an overall professional association for MHAs, the University Mental Health Advisors Network. This association also functions as a campaigning body to improve services and increase the appropriate uptake of DSAs for students with mental health conditions.

Meeting the Extra Costs of a Mental Disorder at University: DSA

The DSA is a government-funded allowance designed to ensure that students who have a longer-term health condition or 'disability' are not disadvantaged in accessing their university studies. When a student discloses their mental health disorder to the university, this generally sets off the process of inviting them to apply for DSA, but a student who later decides to request help or develops their disorder later on, may of course apply.

It is an important part of the role of university mental health professionals to help steer students through the complicated pathways to help. Further details about applications and the financial context of mental health are described in Chapter 9.

For many students with mental health problems, the greatest benefit to receiving DSA is being able to access one-to-one support from a specialist mental health mentor. Counselling and some other university services often have limited, fairly short duration of contact, whilst psychotherapy and psychology services in the NHS usually have very long waiting lists. Specialist mental health mentoring, on the other hand, provides regular, flexible long-term input from a qualified mental health professional, and usually from the same individual for the length of the university course.

Mental Health Mentors

Mental health mentors (here referred to as 'mentors' but not to be confused with peer-mentors), like MHAs, work with students for the duration of their studies to help them achieve their full potential at university while also mitigating the impact their mental health condition might have on them. Unlike MHAs, mentors do deliver regular substantial face-to-face appointments typically weekly, over at least 30 weeks of the academic year. These are not strictly therapy for the disorder, but therapeutic in terms of ensuring that the consequences of the disorder are managed in the context of the student's university life.

Students who have disclosed a mental health condition or autism spectrum disorder can apply to Student Finance England, who then allocate DSA to pay for a certain number of hours of mentorship. Most mentors are paid for by the students' DSA but international students and others not eligible for DSA can often be supported by university or charitable funds – such referrals are increasing.

Mentors are qualified mental health professionals (this is one of the requirements of DSA funding) who can work with students with a range of mental health conditions, help them come to terms with their diagnosis, and help them improve their self-management competences. They can help explore the underlying causes that prevent effective study, such as perfectionism, fear of failure and anxiety. They can provide support with

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timetabling, goal setting, workload prioritisation, and managing expectations about appropriate levels of study. They will work with the student on short- and long-term targets, providing them with the tools and the mindset to achieve personal academic goals.

Jagesh had been diagnosed with bipolar I disorder after an alarming 'breakdown' in his second year at university, when he believed he had 'superpowers' and had invented a machine that would bring fortune to his family. At the time he was engaged to be married, but this was called off, and he was on bad terms with his family in India.

He was provided with a specialist mental health mentor through university funding, and was allowed to repeat second year. He had been a high-achieving student up to that point. He now had depression and was concerned that the medication he was prescribed was slowing his brain and causing weight gain.

He took a whole term to warm to his mentor, partly because she was a woman of the same age as his strict and disapproving mother, but eventually developed a trusting and appreciative attachment to her.

One simple intervention that transformed his academic recovery was for her to phone him each morning for a week to help him get up, take his medication and attend lectures. The following week he called her to confirm he was up and about, and after that he would text.

Another useful habit was the 'practice interviews' they conducted together before his appointments with the psychiatrist. Initially, Jagesh felt he should simply agree with everything his doctor said, even though he would not necessarily be able to follow the advice afterwards. With his mentor's help, he learned to courteously but firmly express his own point of view.

Eventually, they discussed rebuilding the relationship with his family. His improved grades gave him a greater confidence in taking up the communication again.

The University Mentoring Organisation (UMO) has conducted a large and detailed online survey of all students on their books between 2011 and 2019, focussing general life functioning, academic performance, and the experience of mentorship (Matthews, 2020). 90% responded very positively and endorsed the service they received as having a profound influence on all these areas of university life.

A smaller qualitative study explored the experience of mentors as well as the students they mentored (Lucas & James, 2018). Again, mentees' satisfaction levels were high. Mentors reported that in the 1-year mentorship they had developed their personal skills, had a strong relationship with their mentee and were positive about the mentoring role within the university. As with counselling, mentorship moved to online platforms during COVID lockdown and is now coping with the challenges of post-COVID mental health problems.

Students Who Flourish without Formal Support

Despite concerns about deteriorating student mental health, and even in the aftermath of COVID, remarkable numbers of young people thrive with only minimal therapeutic input, often without formal referral at all. Research described in Chapters 2 and 3 of this book examines some of the features that characterise those flourishing students, including strong peer relationships and engagement in physical activity.

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Jakob was an Australian geography student whose whole life seemed sunny. He made friends very quickly at his UK university, and whilst he was not an ambitious sportsman, he joined several 'social' sports societies and engaged in a great deal of volunteering work. He had the knack of remaining friendly with ex-girlfriends, and found a more lasting relationship with a fellow Australian in his third year.

He had a tendency to leave his academic work until the last minute, and his teachers sometimes felt he was underachieving, even 'cruising'. He surprised everyone by getting a good 2:1 degree before the couple returned to their home country to take on postgraduate studies.

Even students previously diagnosed with a formal mental health condition may flourish without formal mental health support, particularly if their needs are anticipated. Young people usually prefer to talk to friends and family and people they know rather than professionals. There are risks though that students may come to rely inappropriately on psychological support from academics and teachers at the expense of both parties. This is explored further in Chapter 13.

Jacinda was diagnosed with obsessive–compulsive disorder (OCD) and severe anxiety at age 9, so her school and family expected she might have some struggles at university. She had been discharged from child and adolescent mental health services (CAMHS) at age 15 on medication, which she continued to take, and decided to disclose her mental condition on her application. To everyone's surprise she required no formal counselling or hospital appointments. She says,

> My mental health OCD and anxiety was dealt with very well whilst at university. It did not affect my studies directly. I have heard of stories on the news of students who committed suicide after not receiving support over their mental health, which has raised questions around mental health support at some universities. I had times where I had issues surrounding OCD and anxiety. However, this was dealt with very well at the university health centre and at my local GP clinic. My medication was reviewed and I took it regularly. and whilst there were likely peaks and troughs, I cannot recall any particular cases where it deteriorated significantly.

Preventative and Early Intervention Input

Researchers have learned from the characteristics of flourishing students and designed interventions to reinforce strong peer relationships. The Oxford University peer support programme trains undergraduate and graduate peer supporters using qualified peer support trainers. They teach the skills of being a good listener, helping others feel more comfortable with social and academic relationships, helping others to manage and communicate sensitive issues, learning one's own limits in a listening situation and knowing when to refer the person being supported (Crouch et al., 2006).

Byrom (2018) examined a six-part peer-led course for mild depression, based on behavioural activation. This showed promising evidence of effectiveness in those who attended most of the sessions but attrition was relatively high with only 28% completing the six session course.

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Recent Developments at the University of Bristol

2016 launch of new Vision and Strategy to review student pastoral support. £1milliion per annum to fund new student well-being service embedded in academic schools to proactively support well-being and to identify and ensure access to specialist services when needed. Review of pastoral support in residences

2016–17 Cluster of student suicides prompted new suicide prevention and response plan (University of Bristol, 2018c)

2018–19 Pilot of *The Science of Happiness* – a first year formative rather than summative course on mental well-being, examining the science of well-being from multidisciplinary viewpoints with and supervised small groups to put principles into practice. Student who took the course in their first term, reported higher levels of well-being than those waiting to take the course in their second term

'Single session one at a time' approach (Dryden, 2019) Students are offered a single session of counselling only, albeit with the option of booking a further session after reflection. This has reduced waiting times, an aspect of care particularly appreciated by students.

Single point of access designed so that the university, not the student, manages the complexities of assessing, allocating and co-ordinating support (Ames, 2022). Students to apply for mental health support using a single online form.

E-Mental Health and Apps

Bristol, like other universities, has experimented with embedding mental health improvements into all students' curriculum using youth-friendly methods such as 'apps'. The Fika app (www.fika.community/) is specifically focused on mental 'fitness' – not mental health. The app designers have embarked on research in which participating universities map and embed their 5-minute 'emotional workout' app across the curriculum. Though they refer to it as an 'emotional' workout, in practice, there is more focus on cognitive rather than affective aspects of health. It is too early to endorse particular apps without further studies, but conducting such studies is essential and overdue.

There is a concerning abundance of apps that are readily accessible by the public without the means to quality assess or determine their appropriateness. A review of mental and physical health apps found that only 14% had been designed with input from a healthcare professional (Sedrati et al., 2016). The majority of apps for physical health had been designed for medical professionals rather than patients, but the majority of apps for mental health had been designed for direct use by clients or patients.

So far, I have not heard of any lawsuits brought against apps providing inappropriate advice, but I have seen harms. Young people with anorexia eating disorders for instance have followed advice to increase exercise and avoid 'unhealthy' food as ways to improve their mood. Potential users could benefit from having professional guidance on the appropriate use of apps. Mental health authorities might consider using a hallmark of some sort to endorse appropriate apps. It is usually relatively easy for professionals to spot harmful apps, but in order to recommend effective positive apps we need more research.

Parents, Families and Lay Carers as Mental Health Support

There is no doubt that today's students are able and willing to stay in closer contact with their parents than were previous generations, thanks to digital technology. More than ever, this makes those parents informal partners in the mental health care of students.

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A ‘cluster’ of students suicides at Bristol University triggered discussions about changing contracts about sharing information with parents. Bereaved parents took a lead in campaigning for the change. The university created a new student emergency contract procedure (Ames, 2019) that allowed students at the time of registration with the university to nominate an emergency contact in the event of serious concerns about their well-being. More than 90% students provided this consent, suggesting that students do expect people close to them to be involved in caring for them when they need help. There is now more of an onus on universities to justify any decision to not use the emergency contact, rather than a fear of ‘breaching confidentiality’ if they do make contact. The views and roles of students’ families are considered further in Chapter 4.

How Services within the University Connect with the NHS

Mental Health Services That Students and Staff May Need to Access Off Campus

NHS Services That Are Particularly Relevant to Students

- General practice (also called ‘primary care’)
- General adult outpatient services
- Adult eating disorders services
- Psychotherapy services
- Psychological therapies
- Early psychosis teams

Gaps in NHS Provision for Students

- Sheer amount of resources – to allow shorter waits, more regular appointments, longer courses of treatment and better integration of services when the student has several different disorders or where the disorder manifests in different ways.
- Developmentally appropriate services. This is not only a matter of respecting ‘transition age youth’ but also of acknowledging that the needs of intellectually and academically active students are different from those of non-academic middle-aged adults with more chronic disorders, particularly in the case of inpatient wards.
- Services for misuse of alcohol and other substances that may not (yet) reach criteria for addiction or severe chronic disorder.
- Services for ‘Borderline’ or ‘Emotionally unstable’ personality disorder, including chronic trauma services.
- Services for people with sexual difficulties, both for those who have been victims of sexual aggression and for young disturbed or confused perpetrators.

The role of in-house university mental health and counselling services is to support the short-term mental health needs of students and staff, with special acknowledgment of academic demands in a university. In contrast, NHS services are designed to support citizens’ severe and often longer-term mental health needs and support their clients towards recovery.

For most of us in the UK, access to specialist services, including NHS mental health services, is through our GP. Strictly speaking, GPs are not NHS employees but are financed by the NHS to provide primary care, and then to be ‘gatekeepers’ or ‘conduits’ where their patients require more specialist input. There has been growing concern about inadequate GP numbers for the population need, and we have already seen in Chapters 2 and 3 about the transition to university life that students do not always manage to sign up with a GP in their university city.

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GPs and Student Mental Health

Universities UK (2020) asks universities to develop regular high-level links with NHS commissioners and services, and with local authorities and the third sector, with a particular focus on the dangerous transition periods. Universities UK (2020) report that, in 2018 before COVID, about 45% of institutions had a student GP based on site and in 33% of institutions, students can access NHS mental health practitioners on site. Universities might consider hosting more primary care, secondary care and third-sector mental health provisions on campus. As GPs are the gatekeepers to most NHS services, signing up with an on-campus GP could be readily facilitated at Student Registration.

Specialist student GPs quickly become expert in the student culture of the moment. They often provide longer than usual appointment times and hold joint meetings and reviews with other services. Student medical practices develop expertise in dealing with situations common in university life, such as eating disorders, drink, drugs, relationships, procedures for coursework extensions and contacts with the best people to speak to about other matters of concern. At the moment, though, GPs are not properly appreciated or resourced for expertise in student mental health.

Funding is allocated to GPs via a formula based on the general medical services contract, weighted by deprivation and age then distributed according to number of registered patients. Additional funding is mostly based on long-term physical rather than mental conditions. Students are within an age group that is physically very healthy and unlikely to make large demands on the GP practice in terms of their physical health. However, mental conditions are becoming increasingly dominant parts of a GP caseload, especially after COVID. Practices with a high number of registered students are faced with substantial gaps in funding for their workload. This could be changed to recognise mental as well as physical disability on general practice.

IAPT and Its Relevance for Universities

Improving access to psychological therapies (IAPT) is an initiative introduced in 2008 by NHS England to improve outcomes for 'low-level' mental health difficulties. It was developed and introduced by the Labour government of the time, based on economic evaluations by Professor Lord Richard Layard, therapy guidelines from the National Institute for Health and Care Excellence (NICE) and input from the eminent clinical psychologist David M. Clark. There are over 200 IAPT services across England, making it the largest publicly funded implementation of evidence-based psychological care in the world. Patients are initially offered brief, low-cost, and low-intensity guided self-help based on principles of cognitive behavioural therapy, delivered over the telephone, via computerised cognitive behavioural therapy, in large groups or in a one-to-one format.

There is much to commend IAPT. The initiative included regular collection of standardised data. This allows critical evaluation and adjustment of the project. Saunders et al. (2020) found that outcomes were improving up to and beyond the government's 50% recovery rate target. This was linked to patients receiving more treatment sessions, delivered in a more condensed period of time, and reduced non-attendance.

In contrast, the project has been criticised for failing to appoint enough qualified therapists, resulting in high caseloads, long waiting lists (6–18 weeks after referral) and short treatment times. It has also been noted that the goals of getting people back into the

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workplace and reducing the need for antidepressant prescribing have not been achieved. In fact, both antidepressant prescribing and psychiatric disability claims have continued to rise. Most university students would be able to access specialist student counselling more conveniently and effectively than using IAPT. Timimi (2015) found that recovery rates, as a percentage of patients referred, was lower for IAPT services than for university counselling services.

Diversity of Service Provision

Universities do not all offer the same mental health services – and nor should they. Until we have better evidence about the benefits and risks of different interventions, it is healthier for different institutions to creatively set up and research services that respond to the observed needs and collaboratively incorporated demands of students and other members of each unique university. It's healthy too, that some institutions 'borrow' examples of good practice that work in other university communities, and discover whether such models work in their own environment.

The size of the institution is an important factor. Initiatives developed in Manchester may work well in other large cities where there are multiple higher education establishments and very large student populations, but may not in smaller or more rural settings. Conversely, there may be extra problems for the London universities, where the student population is spread over several different health boroughs.

Universities, like schools, have different profiles, different special areas of excellence, and attract different ranges of diverse applicants What works for one setting may not work for another, and the existence of different ambience and pace allows individuals choice – provided that they are aware of the diversity. There is an important caveat to this, however. New and un-researched services and interventions should be carefully researched in terms of outcomes and economic costs. Ineffective treatments are potentially harmful in their own right and also by dint of taking up resource that could be used effectively elsewhere.

Integrating NHS and Student Services in Greater Manchester

Greater Manchester has one of the largest student populations in the country, with around 100 000 people attending the city's five higher education institutions. Just before the COVID pandemic, it became the first place in the country to establish a dedicated centre to help support higher education students with mental health needs when higher education forged new links with the health and social care partnership.

The centre – jointly funded by all the partners – takes referrals directly from the different counselling centres, so that the student has only seek help once. Whether the student presents to the NHS mental health system, third sector or university they receive the same standard assessment, and are then directed to appropriate intensity of care. Their treatment plans take into account important demand factors such as examination periods, and the specialist experience of the centre is an extra benefit.

A university setting is ideal in providing expertise and eagerness to practise research and evaluation skills, so it is disappointing when proper evaluation is not in place from the start of any new plan. Feedback from a self-selected group of participants is not a substitute for the use of painstaking application of objective and subjective outcomes.

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Creating a New Mental Health Speciality?

This book has repeatedly emphasised how university students are disadvantaged in NHS mental health services, largely as a result of the multiple transitions they face on leaving home and CAMHS services, and continue to experience as they travel between home and university, or spend time on placements elsewhere or abroad. However, it would not be ethical for students to expect privileged queue jumping within the NHS at the expense of other patients. Moreover, it can be of concern that students present with different needs from the majority of NHS psychiatric patients, who tend to be considerably older, and in many cases more disabled by their conditions.

It has been argued elsewhere that the expertise of CAMHS clinicians may still be relevant to this group of 'transition aged youth'. Some CAMHS services in the NHS are experimenting with extending their age group up to age 25, but this doesn't necessarily solve the problem of geographical moves, and is pragmatically difficult to manage. There are legal and social differences involved in treating people under age 18 with those who are legally adults. Finally, the staff shortages in CAMHS services are already worrying. Expecting CAMHS to take on the large numbers of mentally ill individuals from age 18 to 25 is frankly unrealistic.

There are other communities whose particular mental health needs are catered for in ways which respect their needs without disadvantaging society – the armed forces have their own clinicians, with ring-fenced budgets. Older adult mental health services are a separate specialism within NHS Psychiatry, and of course there is CAMHS itself. Other specialist mental health services include eating disorders services, substance misuse services, and psychotherapy departments. Their models would have much to teach us about networking on a regional and national basis to cater for special needs groups.

Women in the perinatal period have been another group of young people for whom existing 'general adult' services have been problematic. Again, time constraints involved in pregnancy mean that many months on a waiting list fails to keep up with the need. In the same climate that has seen growing pressures on NHS staffing, the new speciality of perinatal psychiatry is flourishing.

One feature of all these relatively small specialities is the crucial role of communicating with other services around the patient. They regard managing transitions as a powerful part of the work, rather than as a mere inconvenience to the treatment. We have to protect access to confidential records, but the current scattered nature of electronic records doesn't so much protect confidentiality as fragment communication. GPs do not automatically have access to their patients' hospital records or vice versa, clinicians in different health trusts and boards cannot access previous records, and too much responsibility is placed on individuals to remember and repeat their medical and social history, even at times of mental illness.

In principle, management of transitions involves handing over care from one service to another, but in practice, students experience fluctuating transitions. They do not completely leave their home and spend all their time at university. If they become seriously mentally ill, their condition may sometimes require inpatient hospital care, more often outpatient care, and sometimes only the support of the university mental health services. Multiple handovers and handing back can interrupt the course of recovery. It can work much better if everyone involved in the individual's care remains informed and potentially available to hold planning reviews.

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Integration, communication and cohesion of different mental health services with each other and with other specialities and disciplines is crucial. In the outside world, adults are usually expected to provide their own integration of care between work, doctors, hospitals, social care and so on. This is always difficult when a person is vulnerable as a result of illness. All the more so if the illness concerned is a mental illness and the patient is still very young. However, it can be a challenge for outside agencies to manage the networking and integration for them when confidential record keeping is not shared across different services and different geographical locations.

I would strongly suggest that each university hosts forums where NHS mental health services can share with universities their experiences, methods and campaigns. Taking this further, I would strongly urge the construction of national and UK-wide specialist groups devoted to expertise in university mental health. The College of Psychiatrists of Ireland does have a Faculty of Youth and Student Psychiatry. I would urge the Royal Colleges of Psychiatrists and of GPs to create faculties of university mental health. This would recognise the specific challenges and expertise and workforce required to meet them. This expertise could then be explicitly taught as part of the medical curriculum and tested in examinations.

Practice Points

- Students and staff are provided with a large range of mental health support, many of them boasting excellent outcomes, but the multiplicity makes for confusion rather than clarity
- Counsellors, mental health advisors and mental health mentors are available without fee to most university students. These are well researched and evidenced in the treatment of mild to moderate mental illnesses and in the support of people with longer-term disorders.
- Students with a significant level of depression or one of the more severe anxiety disorders are likely to require longer courses of therapy than counselling services routinely offer.
- Chaplaincy takes many forms and is also a widely available but so far less well evidenced
- There is still much work to do in terms of dovetailing and integrating different services around a vulnerable student. The challenge is greatest when NHS as well as in-house university services are needed.
- Discussions with local NHS clinics are needed to share care appropriately and provide therapeutic continuity. Arrangements for treatment during vacations are essential.
- Integrative models such as that piloted in Greater Manchester show promise, but different universities and geographical locations may need different solutions.
- More than half of universities do not have a GP on campus. Workforce shortages make it ever more difficult for GPs to co-ordinate the care of their student patients.
- GP funding needs to be reviewed to acknowledge the extra burden of mental health care.
- The Royal College of Psychiatrists and related organisations could focus expertise in the field of university mental health by creating a new faculty of university mental health.

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