student minds

A summary of the Report to HEFCE:

"Understanding Provision for Students with Mental Health Problems and Intensive Support Needs"

www.hefce.ac.uk/pubs/rereports/Year/2015/mh/Title,104768,en.html

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Rationale for this summary

In 2014 the Higher Education Founding Council for England (HEFCE) commissioned a report to update the Council's understanding of institutional support provision for students with mental health problems and other impairments with high cost or intensive support needs. In July 2015, The Institute for Employment Studies published an extensive report, based on a literature review and case studies completed at 12 Higher Education Institutions and Further Education Colleges across England.

This document provides a summary[1] of the report, written by Nicola Byrom for Student Minds. Student Minds has summarised the report to provide a concise overview for students and other interested stakeholders; while we support much of the report, neither the original report nor the summary presented here represents the views of Student Minds. The summary reflects the language used in the original report, and as such, does not accord with Student Minds' policies or mental health messaging.

Overview

Higher education (HE) is covered by the Equality Act 2010, and disability is one of the specific protected characteristics. A person has a disability for the purposes of the Act if he or she has a physical or mental impairment and the impairment has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities. However, the Disabled Students' Allowance guidance does note that:

'Sometimes a student's disability does not substantially affect their normal day-to-day activities but does have a substantial effect on their ability to study. In the context of DSA 'day-to-day activities' includes education.'

Under the Equality Act 2010 it is unlawful for Higher Education Institutions (HEIs) and Further Education Colleges (FECs) to discriminate against disabled students by treating them less favourably when offering places and providing services.

Demand for support 2
Disclosure 3
Funding 4
Service provision 6
Policies and Strategies 7
The role of wider University Services 9
Working with External Agencies 13
Effectiveness of Provision 15

[1] Our summary is just that – a summary. As the original report is 180 pages, we have done our best to capture everything, but must acknowledge that we will have missed details here and there!

Demand for support

All institutions recognised that there had been a rapid increase in demand for support from students with mental health problems. Increasing demand for support is a recurrent theme throughout the report:

- UCAS reports the numbers of UK accepted applicants declaring a disability increased from 23,772 in 2008-9 to 34,625 in 2013-4.
    - 187,620 students with a self-declared disability in England – that is 9.6% of all students.
    - The number of students receiving the DSA has increased, from 36,000 in 2007/8 to 56,600 in 2012/3.
- Students claiming DSA perform above the sector average in terms of degree attainment and progressing to graduate employment or further study.
    - Students with a declared disability not in receipt of DSA perform below the sector average across all outcomes.
    - Only 45.5% of disabled students are in receipt of a disabled students' allowance.
- The total number of students on advisers' case-loads had increased.
- Waiting times/ lists for some key services such as counselling had increased.
- Staff input (staff days) devoted to students with mental health problems and/ or complex needs had increased, although this tended to be noted by citing examples.
- Increased complexity of cases:

'Whereas traditionally the university counselling services would have been around transition, homesickness, relationships, developing a sense of identity outside your primary caregivers. Now it's severe and enduring mental health problems that we are seeing as our most common presenting concern.'

- A shift away from students accessing services due to the break-up of relationships, transition or homesickness. Students are now more likely to present with anxiety, depression or low mood.
- Increasing numbers of students are at high risk of harming themselves, or in the most serious of cases are suicidal.
- Students with support needs of this nature experience fluctuations or 'flare-ups' in their health and so may need to access services more frequently.
- Greater incidence of comorbidity of mental health problems alongside other impairments and challenges.

The report considers where the increase in demand arises from:

- Institutions have grown in size, with increasing numbers of students.
- A more open culture concerning mental health makes it easier to ask for help.
- Diagnostic procedures have improved, producing more reliable diagnoses at an early stage in a student's life.
- Better quality of care and treatment may mean that individuals who would not previously have attended HEI are now studying at HE.
    - It was viewed as very positive that people were transitioning to HE who may not have done so in the past, whilst at the same time there was recognition of the impact of taking vulnerable people away from personal support networks and into a situation of intense academic pressure.
- Shortcomings in external statutory mental health provision, including barriers to referral and long NHS waiting lists, may mean HEIs are bearing the load as this provision recedes.

- Support in school is better in terms of improved awareness of mental health and access to counselling. This was thought to have enhanced students' knowledge that there is access to support.
- Intensified individual pressures exerted on students which were exacerbating mental health problems:
  - Finding the money to continue into higher or postgraduate education was a struggle for some students, and increasing fees, although not necessarily dissuading people from entering HE, may be inciting fresh anxieties once studying.
  - Increasing pressure to succeed, whether in terms of family expectations or finding employment post-study.
- Recent student cohorts were less prepared in terms of their resilience to make the transition into HE.
- Increased body and image awareness coupled with decreased social interaction was felt to stem from the advent of social media.
- The dangers of very accessible and unpredictable legal highs, as well as the impact of incidences following overconsumption of alcohol.

Disclosure

Across all institutions, the proportion of students who declared a mental health problem was 1.4% in 2012/3. While an increase on previous years, this is understood to reflect only a small proportion of the number of students experiencing mental health problems. Encouraging disclosure and early disclosure is important so that institutions can plan provision effectively. Late disclosure can cause difficulties for institutions' ability to plan effectively, and can impact on students' academic performance and retention. Disclosure of a disability on the UCAS form is separated from the admissions process, and is used to start an early dialogue with the student before they start to identify support needs and put in place a tailored package of support. Despite this, there is still considerable anxiety amongst students that if they declare a disability or mental health problem at the application stage, it may act against them.

Disclosure is challenging. A student experiencing distress, or perceived by others to be mentally unwell, is faced with multiple decisions:

- Whether or not they identify as having a mental health problem;
- Whether they see themselves as disabled and choose to disclose.

Even if a student does consider themselves to have a mental health problem, they may choose not to identify as such, due to:

- Fear of stigma and pathologisation.
  - Such fears can be intensified for students on professional programmes, where questions of fitness to practice come in to play.
- Not identifying with the term "disabled".
  - While many disabled people find the social model of disability empowering, people with mental health problems may feel that it does not apply to them (Beresford, P. et al, 2010) or that, by saying they are disabled, they may be perceived to be, somehow, 'overclaiming'.

There are steps that institutions can take to address under-disclosure:

- Awareness raising initiatives, (e.g. University Mental Health Advisers' recent 'I chose to disclose' campaign).
- Providing clarity about who will have access to the information and the likely consequences of disclosure.

- Offering opportunities to talk to other students either informally or in the context of a peer mentoring scheme.
    - In a survey of 1,442 students, 75% had disclosed a mental health problem to a friend.
- Increasing the visibility of disabled staff and participation of alumni with stories of positive experiences may help to normalise disclosure.

Some of this work might start before admission, for example:

- Ensuring that staff are available during open days to talk to potential students, offering advice about transitioning to HE.
- Increasing efforts to highlight mental health during open days.
- Using positive and welcoming language throughout the admissions process.
    - Considering this importance, some interviewees noted there was much work to be done pre-admission, including staff feeling confident in using the right language.

As some candidates are fearful that disclosure might affect their application, there is also an emphasis placed on disclosure at offer of a place as well as multiple opportunities to disclose across the student lifecycle. Disclosure can be further facilitated by an active approach, including:

- Drawing on attendance monitoring data to highlight where students' presence at seminars or lectures was dropping, as a highly effective way of identifying students who may need support.
- A strong personal tutoring system.

Finally it should be noted that, for some students, however supportive the environment, the advantages of non-disclosure may simply outweigh any perceived benefits gained through disclosing a disability. The beneficial impacts of '*keeping one's work-ready reputation intact*' (in the face of the stigmatising attitudes of others) and maintaining a positive self-image are issues which have, in the view of Venville, A. et al (2013), been understated. They conclude that, '*if the goal is to increase course completion rates and workforce participation for all students with mental illness, then the receipt of educational supports ought not to be dependent upon disclosure*'.

Funding

HEIs use two main funding sources to support student with mental health difficulties:

- **Mainstream disability funding**: from an annual non-ring fenced disability allocation, including the institution's central funds (from student fee income) and funding from HEFCE (including the Student Opportunity (SO) disability allocation).
    - The SO disability allocation is not ring-fenced and becomes part of an institution's central funds, which are then distributed across the institution, based on operating costs and targets.
- The **Disabled Students' Allowance** (DSA) supports eligible students' individual needs, and tends to focus on the provision of specialist mentor support, provided either by in-house mentors or by an external agency. The DSA covers education costs only, including help with travel costs to and from the institution, and other disability related living costs are covered by the local authority in which the student is ordinarily resident.

HEIs need to draw on central funding as the DSA and SO disability allocation does not cover the full direct costs of providing support. Indications were that for every £1 received in the SO disability allocation, institutions needed to top this up by between £2 and £5.

HEIs reported challenges in accurately estimating budgets year to year as it is difficult to precisely gauge future demand, needing to respond to student needs and put in place tailored support as needs arose.

Future changes to funding

In April 2014, the Government proposed changes for the DSA, to ensure '*the limited public funding available for DSAs is targeted in the best way and to achieve value for money, whilst ensuring those most in need get the help they require*'. The Government is looking to rebalance responsibilities between government funding and institutional support, with:

- HEIs providing a greater level of support, as part of their duties to provide reasonable adjustments under the Equality Act, including:
    - General changes to course delivery
    - Information provision
    - Encouraging greater independence across the entire student body
- Government focusing support on more specialist provision for those with greater needs, that the institution may not be able to meet through reasonable adjustments (e.g. for higher specification computers and specialist non-medical help). This will not include the additional costs of specialist accommodation.

Alongside increasing demands for their services, the case study institutions were also very concerned about the proposed changes to DSA. There was a perceived lack of clear guidance as to what the changes would involve, and concerns that the guidance seemed to change over time. Both factors made it difficult for institutions to plan for the future, and for disability advisers to work with prospective students without giving an inaccurate impression of what support might be available to them.

One institution, in planning strategically for the changes, had identified that:

- Its students drew down £8.5 million in DSA funding (in total).
- Just over £6,000 DSA funding per student who received it.

Interviewees at this institution said that they could not get close to plugging even a quarter of that gap with core institutional funding. It was unknown how big a gap they might have to fill as some support would still be funded.

Potential impacts of changes to DSA may go beyond an institution and could affect the sector as a whole. The changes could lead to further 'ghettoisation' of HE, with high-profile, research-intensive institutions becoming less inclusive, and demand from disabled students clustering around a smaller number of 'beacons' of good practice.

Interviewees differed in their perspectives on the impact that such changes might have upon how institutions approach metal health, with reflections that:

- The pressures to meet increasingly stringent medical evidence criteria to receive funding from a dwindling pot of money could push the sector back towards the medical model of disability, and hamper moves among many institutions towards the adoption of the social model of disability.
- In the longer term, the changes may help the sector move away from the medical model of disability as the focus may shift away from support towards resilience and building a greater understanding among students of what they can do for themselves.
    - One interviewee felt that there was currently an emphasis on '*disabling students to get support*', for example with GPs erring on the side of agreeing that an impairment has been in place for 12 months, even though things may – as often happens in mental health – be fluctuating or improving, and that the assessment for DSA did not help the student to build a picture of what they can do.

Service provision

Mental Health / Disability Advisers

The main point of contact arranging provision was a mental health or disability adviser(s), working with students pre-admission and once they have enrolled and arrived on campus. This may include:

- Signposting students to a range of internal or external support;
- Providing assistance applying for DSA and facilitating support being put in place when students are successful in their applications;
- Liaising and coordinating to put learning support arrangements in place;
- Matching students to mentors;
- Providing advice, guidance and individualised ‘human support’;
- Being the point of contact if a student is experiencing a mental health crisis;
- Raising mental health issues amongst students and staff as well as breaking down myths and stigmas.

Mentors

Following receipt of DSA, specialist mentors were arranged. While the exact nature of mentor support would vary from student to student, the support was intended to aid students to go through their course, including support with:

- Research;
- Proof-reading;
- Issues with lecturers or tutors;
- A broader focus on guiding the student through their course.

Counselling Service

All institutions provided a counselling service. Counselling was generally short-term and finite (four to seven sessions). If students required support beyond that they would be referred to appropriate statutory services. Counselling staff at some institutions were also involved in wider wellbeing activities such as mindfulness and building resilience. Institutions tended to offer a mix of:

- Drop in sessions;
- Bookable appointments;
- Self-help resources;
- Group sessions focused on wellbeing issues.

Crisis response

Institutions outlined distinct processes and policies for when a student presents in a crisis situation:

- Certain key people are a first port of call and always contactable,
- Where incidences occur within student accommodation, accommodation services may be involved.
- Members of staff will follow student at risk procedures, with a first priority of ‘stabilising’ a student through the most appropriate means and depending on the student’s context.
- Staff will put in place appropriate provision and refer to external agencies – including the emergency services – if necessary.

Certain institutions emphasised this role was separate to any medical processes, as diagnoses and delivery of care in any crisis situation fell under the remit of the NHS. Therefore, involvement of Early Intervention in Psychosis or Community Crisis Teams may be required. One institution further noted the heavy impact on fellow students and staff of crisis situations, for which they had a Trauma Response Team which extended to managing the mental health impact on others.

Reflections

Even when informed by a social model perspective, student services are typically delivered on the basis of individual models and understandings of mental health. An alternative perspective suggests that individual mental health problems may have their roots in social circumstances and experience of trauma. Anyone can be either giver or receiver of support or, indeed, both at once. Such a social model repositions mental health as a social construct, not a purely individual concern. The report reflects that there are a range of ways of understanding mental health problems, madness and distress.

Policies and Strategies

There has been an increase from 28% to 52% of institutions (58 included in Universities UK survey) with mental health policies in place, and an increase from 53% to 81% with specialist student mental health posts[2].

In developing policy and strategic approaches to supporting disabled students and those with mental health problems and/or complex support needs, in particular, there appeared to be a number of decisions facing institutions. These largely related to:

- Drawing boundaries around the provision;
- Managing expectations around the role and responsibilities of the institution;
- Who can be supported;
- The nature and extent of support that can be provided.

A strong focus on the equality duty in the approach to supporting students with mental health problems and complex needs could lead to two further outcomes:

- Some institutions tended to place emphasis on students providing evidence of a long-term mental health problem to access support, setting boundaries around who can and cannot access support, and thus tended towards the medical model of disability (in line with the Disabled Students' Allowance process).

'this [disability] unit works under the principle of the Equality Act, so that we're an evidence-based service, so that you come to us with evidence of your long term condition, it falls under the Equality Act, and then that's when we put the reasonable adjustments in place and work. It's not 'I feel a bit sad today' so people come here and we work with them. They need to have a diagnosed clinical depression or a diagnosed anxiety condition, and then we engage in working with them.'

- Other HEIs embraced a more flexible approach and sought to offer all students, whether in receipt of DSA or not, the same (or similar) support package:

'the university works with the Equality Act definition of disability – if someone's behaviours or collection of symptoms, or a medical opinion, points to this conclusion, then we define them as in need of support. The funding body may not agree with this definition, but the university will supply support even when DSA won't, or where they are waiting for a decision from DSA.'

However, a key factor in deciding who to support, or to prioritise with support, was often receipt of DSA funding/ provision. This aligns with the Equality Act, and is, therefore, the legislative driver for action and so need would be determined by long-term condition. More troubling groups were students ineligible for DSA funding, particularly:

- International students, who are outside of the scope of student funding;
- Those studying at a distance;
- Those whose eligibility was borderline;

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[2] The UK Healthy Universities Network has developed an online toolkit, to promote a holistic approach, encompassing wellbeing in all its aspects. It includes a section on Developing a Holistic and Joined-Up Approach to Mental Wellbeing.

- Those who did not want to apply for DSA funding, gather the required medical evidence and undertake a needs assessment.

Provision of support for these groups varies between institutions:

- In one institution students who were not eligible for DSA funding received a similar package of individual support to the students in receipt of DSA funding, but at a significant cost to the HEI.
- In another only those with DSA support (backed up by the relevant medical evidence) could be supported in a tailored and individualised way.

More generally, determining need caused institutions some degree of challenge, for instance, determining:

- What would be deemed mental health problems.
- What could be regarded as general difficulties in making the transition to HEI life, which involved independent living, independent and self-directed study, leaving behind family and friends, and making new friends.

Policy development

In terms of policy development, publicity and implementation, several factors were identified:

- Policies and strategies are being developed against a backdrop of increasing demand for support.
- There is a commonly expressed desire to improve provision, and a tendency to regard support services as a work in progress rather than a finished article.
- Many institutions had recently restructured their provision of support moving towards:
    - A holistic approach to provide support across the whole of the student journey;
    - A physical centralisation of student support to provide a 'one-stop-shop' for ease of student access and visibility, and to improve communication and dialogue within the service.
- Responsibility for the formulation of such policies tended to lie with the HEI or college's senior management team with input from those responsible for student experience and academic affairs.
- Some institutions involved students in developing mental health provision.
    - The New Economics Foundation has proposed a 'wellbeing led approach to quality in higher education'.
    - Although student-led organisations are influential at a national level, there are few examples of students co-producing institutional mental health policy.
    - This reflects the findings of a recent review of student engagement more generally.
- In many institutions there were a number of policies rather than one overarching or focused policy.
    - This perhaps reflects the multiple drivers behind the approach to student support, the rapidly changing context, in particular increasing demand for support for mental health problems, and the complexity of needs encountered.
- Policies around reasonable adjustments can be challenging as among some institutions there was a feeling that more and more students are seeking adjustments, particularly around assessments, and thus claiming mitigating circumstances.
    - This may reflect genuine need but could relate to social anxiety or higher student expectations brought about by increased tuition fees.
    - There were concerns that constantly flexing deadlines ultimately would not help students learn to manage their conditions.
- The visibility of policies varied.

  - In a number of instances there was a concern that most staff and students would be unaware of the detail of these policies and thus be unable to implement or deliver them, meaning that policies may have little influence in guiding practice.

The role of wider University Services

There was general agreement that the ethos and commitment to equality and inclusiveness was, and should be, shared by all faculties, departments and schools (professional services and academic services). There was a recognition that the formal provision of support for disabled students sits within a wider range of invaluable and more informal support including that provided by: Students' Unions, Chaplaincy, residential wardens within HEI managed accommodation, and academic and pastoral staff.

Academic staff

Learning and wellbeing are closely linked. A recent study found that, of the students attending one university counselling service, 92% identified themselves as having problems with their academic work. Of those students, interviewed on conclusion of counselling, 67% considered that it had been important in enabling them to address those issues.

Socially supportive and inclusive teaching environments are important for the success and wellbeing of all students. These can be created by:

- Providing appropriate support to students, which may be dependent on enabling other students to be supportive and on gaining appropriate support oneself;
- Inclusive approaches designed to ensure the integration of all students, which can be facilitated through warm-up activities, small group activities and work in pairs;
- Eliciting sufficient information from students to ensure that their needs can be met whilst not breaching confidentiality;
- Creating a safe environment which is important for all students.

'It is important to recognise that for some people, some of the time, their mental state creates a barrier that impedes effective learning'.

If institutions aim to reduce the most obvious barriers for those students with a diagnosed condition, such as severe anxiety or depression, they may also reduce many more small impediments that are felt across the student population but are never revealed. While students with mental health problems have a right to reasonable adjustments, in comparison with other groups of students who fall under disability legislation, little has been written about the challenges of providing these.

Institutions recognised the vital role that academic staff played in supporting students. They could provide a safe space to talk and resolve 'low-grade stuff' without the need for referral. Thus, student support teams needed to build relationships with staff as well as students. Using these informal sources of support essentially expands the reach and capacity of the support service, and enables a wider range of entry/ access points. Teaching staff can fulfil the following roles:

- Communication:
  - Academic staff can act as a 'first point of contact' within the department, enabling staff to 'signpost' students to further sources of information, advice and guidance within the HEI.
  - A tutor can act as a 'bridge,' introducing a student to a member of staff in central support services, a peer supporter or a service provided by the Students' Union.
- Education:
  - The role of teacher was clearly the primary educational role.
  - Some staff welcomed support from central support services as they recognised this would make it easier to do their job.

    - Others questioned the extent to which the university sought to respond to individual students' requests and suggested that, if a student could not cope, then perhaps they should not be admitted, or that they should be encouraged to go home.

- Guidance:
    - Academic staff referred to the challenge of determining an appropriate departmental response to students' talk of exam anxiety or 'stress' and logistical challenges relating to assignments, including small group work and presentations.
        - In these situations the academic acted as a 'detective', weighing up the available evidence.
        - This time consuming activity was clearly not an exact science.
    - It was not uncommon for students experiencing mental health problems to have doubts about seeking help from central support services, perceiving this as a sign of weakness. Academic staff spoke about their role in normalising the services offered by central support services by breaking down myths surrounding mental health problems and explaining the HEI position with respect to confidentiality, a particular issue where students on professional courses were concerned.

Training for Academic Staff

All HEIs referred to staff development which was offered to:

- Raise awareness;
- Increase confidence;
- Enable academic staff to make reasonable adjustments;
- Encourage commitment to inclusive teaching, learning and assessment.

In most instances, staff development was voluntary. Even where there was an expectation that staff participated in disability and mental health related training, there was no guarantee that those who might benefit most would sign up. Publicising training and engaging staff, many of whom had competing demands on their time, was a challenge even where training was a requirement. However, a number of HEIs described an increased need for or interest in training:

- More requests for input on supporting students with ASD and mental health problems.
    - '*I don't think academic staff are comfortable talking about mental health. I hear the phrase frequently: "I'm out of my depth with this one"*.'
- Numbers of academics participating in Mental Health First Aid courses had increased.

Learning Support Plans

Learning Support Plans (LSP, or the equivalent terminology) were the written documents prepared for students in receipt of DSA to explain their health and learning needs, outline their requirements and the academic reasonable adjustments to ensure parity of learning experience and outcome. Typically LSPs were written by a member of staff outside the department and then passed on to departments to implement. There was some disagreement, both within and between HEIs, about this approach:

- Some academic staff felt that the system worked well;
- Others felt that they would like to be more involved in the planning process.

A potentially effective strategy was the use of a named member of departmental or faculty staff with responsibility for disability who would act as an intermediary, helping to explain in pedagogical terms the sort of reasonable adjustments that their colleagues could make. Sessional tutors appeared to have least awareness about LSPs. Their limited hours and different contractual arrangements potentially limited their access to students and to information about them.

Mechanisms for monitoring or evaluating the effectiveness of LSPs, and who received and used them, were not obvious. More than one academic expressed some frustration at the lack of transparency and evidence available about student progress during, or following, specific interventions outlined in LSPs.

Reasonable adjustments and inclusive teaching

Although reasonable adjustments and inclusive teaching were often discussed separately, there is a clear connection between the two. Whilst no one claimed inclusive teaching would totally remove the need for reasonable adjustments within an academic context, there were examples – based on experience, ideas from staff development courses, and pedagogic literature – that suggested inclusive teaching and learning will, in the future, be an important lever for change. Reasonable adjustments fell in to three broad categories, relating to:

- General teaching and learning approaches:
    - Although there was general awareness of the legal requirement to make reasonable adjustments, academic tutors were either unclear about or surprised at the nature of changes that they might need to make for students with a mental health problem or those who may have a complex disability.
    - The needs of individual students with mental health problems were not always known at the start of their degree and may emerge gradually, often in response to approaches which demanded greater independence in learning than had been the case at school.
- Programme specific requirements including fieldtrips and placements:
    - Mental health support staff played an important role for courses involving placements or fieldtrips, supporting academic departments by providing practical suggestions and helping to disseminate expertise developed in other departments within the same HEI.
- Issues associated with assessment:
    - The number of requests for reasonable adjustment or consideration of mitigating circumstances across the student population had risen.
    - This was an area of challenge for students without a LSP due to the variety and potential inconsistency of evidence provided to support claims for how their circumstances had impacted negatively on their learning.
    - Some HEIs had produced guidelines to help academic staff develop inclusive assessments and avoid, or at least reduce, the need for reasonable adjustments.
    - Overall there was a lack of consistency across departments within the same HEI and certainly between the HEIs.

Accommodation teams

Student housing staff played a significant role in supporting students with mental health problems and/ or complex needs. They were involved in:

- Allocating, providing and supporting HEI accommodation;
- Supporting students in some independent housing;
- Advising on how to deal with private sector landlords.

There was growing recognition that housing staff and hall wardens were well placed to work with a student's housemates to help them understand and resolve complex issues or to host activities to reduce isolation or publicise other services. Despite the contribution of housing staff and hall wardens there was some evidence, from a recent review of mental health services at one HEI, that residential wardens are not sufficiently integrated into support structures and that their knowledge and skills are underutilised.

Most housing offices attempted to identify and accommodate the needs of students with specific requirements, including:

- Allocating a room in a quiet block;
- Allocating the same room that they had in a previous year (one they are familiar with and confident about);
- Providing short-term/ short-notice emergency accommodation (in case a student needs to be moved);
- Letting specific students know in advance of fire drills or building works;
- Personal Emergency Egress Plans (PEEPS) may provide a useful source of information and stimulus for discussion within departments as well as accommodation, or Health and Safety staff development.

Chaplaincy staff

"The Chaplaincy is an important but sometimes overlooked participant in the overall network for students with emotional, psychological and mental health difficulties."

Chaplains were not mentioned much. Where they were discussed, however, their role was clearly pivotal, providing:

- A first point of contact and opening channels of communication with other services;
- Face-to-face support, in the more informal context of a coffee and a chat;
- Long-term support;
- Facilitating disclosure.

Peer Support

Students reported signposting their friends to HEI services and, in some cases, substituting for support services. There was increasing evidence of pressures on housemates and other peers. In terms of formal peer support, there was some evidence of cross-fertilisation of peer support initiatives between institutions (with good ideas being shared); although generally awareness of what was going on elsewhere was limited. There was surprisingly little mention of peer support schemes (and no mention of Peer Assisted Learning).

Students' Unions

'If we have someone who is at risk of harming themselves and may be in a violent relationship we can get them safe accommodation, security fully aware, (mental health adviser) seeing them, money in place – all within an hour or so'.

That kind of response is impressive but is, '*reliant on people's good will*' and their willingness to '*go over and above'*.

There were sometimes contradictions in the student-led initiatives. For example, student societies are working hard to address mental health problems, and related issues linked to alcohol. At the same time, bars in the local area may be offering deals to societies which encourage heavy drinking, for example, offering back to a student sports club all bar takings from a club night once those reach a certain level.

There was considerable variation in the way students were involved in the development of policy and in its communication, as well as in the development, delivery and evaluation of support services.

- In several HEIs, partnerships with students were embedded at the highest level, and bolstered by resourcing of the Students' Union, including the appointment of paid staff who ensured continuity and support for annually-elected sabbatical officers.
- In one HEI, there appeared at the time of our visit to be a breakdown in the relationship between the institution and the union to the extent that union officers were advising students not to use institutional services.

- Between those two extremes, there was variation in the degree to which union officers perceived their work to be valued by the institution as a whole.

Working with External Agencies

'*University wellbeing services, however excellent, cannot replace the specialised care that the NHS provides for students with mental illnesses*' (UUK, 2015, p3).

However, student counselling services are '*providing considerable relief from a potential additional burden on primary health care*'. Thought needs to be given to how primary care-based psychological therapies can be provided within higher education institutions. Connell, J. et al (2007) compared students attending counselling services at 11 universities with a similar non-student population receiving primary care services and found that university counselling services deliver a service to people who closely resemble NHS primary care service users in terms of severity and the risks that they pose to themselves.

Developing relationships with external agencies

All case study institutions were working with external agencies, such as GP practices, NHS mental health services and voluntary organisations, and this was felt to be an important part of the support picture.

- Some institutions were more strategic and proactive in their approach with external agencies and, thus, arguably more successful in sustaining linkages.
- Many relied on pragmatic or ad-hoc individual relationships (often at an operational rather than management level) which were at the mercy of staff changes on both sides.

Developing and maintaining relationships with external agencies could be challenging:

- Requiring time, a hidden cost.
- HEIs needed to be proactive in networking: '*These people aren't queuing up to come and talk to us*'.
- Teams in the NHS are constantly changing which can make communication and liaison very difficult at a personal level.
- There can be difficulties dealing with external agencies when trying to transfer care from students' homes to university, particularly around information sharing and data protection, but also around timing, and around students coming to university coinciding with moving from children's to adult mental health teams.

Some HEIs stressed that they were keen to develop relationships with other external agencies, but felt they needed to map what services there are outside of the HEI as a starting point.

Boundaries between HEIs and NHS provision

Most HEIs stressed that they are education providers and that they do not have the professional expertise to deal with what are often complex mental health problems or disability support needs. HEIs often saw their role as providing a short-term intervention plus reasonable adjustments. There was a view that longer-term and continued support should be provided by DSA, and support for wider issues should be provided by the NHS. Attitudes around this boundary differed:

- Some feel the boundary is clear:
    - '*It's really crucial [to be clear] about where our boundaries need to be, and if we're not able to do something*'.
    - '*We're not a medical service, we cannot provide medical support to students. We can only provide support that will help them while they're on a course, directly for their education, and we're very clear about that. So, our aim is to offer students choices about where they can go and seek additional support.*'

- '*We shouldn't be replacing the NHS, we shouldn't be medicalising and making it clinical. We should be helping students manage barriers and helping the university to understand those barriers.*'

- Some staff stressed that they felt that HEIs have a responsibility for young people on university courses:
  - '*The university has a duty of care, and a legal and moral responsibility for disability, equality and social justice. We need to be ensuring equity of opportunity and provision. We need to be aware of the impact of learning on emotional well-being and vice versa.*'
  - '*Taking vulnerable people away from their personal support networks and then giving them a massive amount of academic pressure is 'a potent cocktail."*'
  - '*Rather than ask 'What's wrong with someone?' we ask 'What's missing, what skills haven't they got or haven't they learned ...and how can that be taught'? How can they be helped to cope? And even if you are functioning at the highest level of mental health those skills can be really helpful and useful anyway. And the other question I'm also asking is 'What's right with you? What psychological strengths that can be developed and fostered'? If we can identify those strengths and get them working, that allows the whole community of the university to flourish.*'

Challenges arising from limited NHS provision

There was an awareness that mental health services provided by the state (via local health and social care services, or voluntary services) had been negatively affected by the national austerity measures and that this wider mental health provision may no longer be adequate. HEIs are providing 'holding' support to students whilst they were awaiting support/treatment either through DSA or from external services. Institutions reported that as NHS services are dwindling there are slower response times and frequently there is nowhere or no services for students to be referred on to. Institutions felt the problem was exacerbated by a lack of understanding of HEIs and colleges' remit and priorities, and of the pressures on students. There was also a feeling that staff in NHS and third sector services felt that HEIs should look after their own students, and that students' problems were not serious enough. Institutions were worried this could result in students not being given priority in accessing services and were concerned about a lack of recognition in the NHS about the needs and circumstances of student mental health:

- *'Sometimes we get left with the students but we're non clinical. We know exactly where our limit cuts…..and can't keep managing a risk'*.
- '…*I think that there is a tendency for GPs to refer to counselling services people who may well have gone through IAPT services were they not students.*'
- '*GPs refer a number of students back to college services*…'
- *'...it may be fine to wait 12/15 weeks under certain circumstances, but if you're working with someone who is a young person who doesn't have a lot of life skills, is away from home for the first time, that can be calamitous. And I think also they don't factor in the fact that you're dealing with a lot of adolescent volatility which may mean that things become very quickly overwhelming*'.
- '*There is somehow the belief that we're a therapeutic community and one of the discussions I've had repeatedly over the years with psychiatric units, with psychiatric teams is, would you have discharged this individual to a bedsit in the centre of the city? And if their answer is no, then why have they discharged them in exactly the same way to the university?*'

These concerns are also recognised by GPs. One GP noted:

'Mental health is a big part of the workload and I think what we have identified in recent times is that the NHS systems that follow on from general practice are struggling to meet the needs of students. Historically, the bulk of the workload went through our local community mental health team but with changes that have taken place in mental health structures over the last decade, we now have the first tier – primary mental health – which is accessed through a single point of access

telephone number. Realistically they can usually do an initial assessment within a week or so (usually by telephone) but one to one help may be 12 to 14 weeks away. And that's for a young adult who, if they lose three or four weeks out of their academic year, will struggle not to slip back a year if they've got problems. It might be that their appointment comes up and they're at the other end of the country. If they miss that appointment they are back to square one. It's frustrating'.

There were some criticisms within institutions that statutory services could lack awareness of student life – the pressures involved, the academic calendar and independent living arrangements (rather than living in supportive family environments).

Students can also face hostility at some external GP practices, with reception staff thinking students are not entitled to their services; this may particularly be the case with international students. This in turn can lead to a breakdown in carefully crafted relationships with students. Practice staff can sometimes seem unclear as to students' rights to access NHS services, and students can find the whole process intimidating and bureaucratic, especially if they are new to accessing medical services.

Effectiveness of Provision

Although services interviewed reflected that they were currently coping well, more than one institution described support services as being 'victims of their own success' – the more students were aware of the support that was available, the more students came forward to access their services. Some HEIs had inadequate staffing to deal with the demand, and their students experienced long waiting lists.

Bureaucracy

Bureaucratic processes were seen to be frustrating.

'We're technically not meant to register students unless they can evidence a condition that's either lasted for, or is likely to last twelve months. So that leaves a lot of students somewhere in the middle of those two systems'.

More and more detailed evidence is being asked for to back up funding requests from support staff, particularly when funding costs often had to be met by the HEI.

'We have spent a lot of time on getting the medical evidence for mental health right, but it's constantly changing and we get a lot of applications refused.'

Interviewees were concerned about the efficiency of some recommendations made by the DSA, for example, interviewees felt that a lot of study skills support could be perfectly well delivered in groups, but DSA assessments would always recommend one-to-one support rather than a more general recommendation that the institution provides the student with appropriate study skills support.

Outcome monitoring

The monitoring of effectiveness of interventions appeared to be a weak area, and tended to be based on anecdotal evidence (based on student feedback captured via various means), and there was little clear evidence of systematic evaluation or monitoring of support services. There was a general agreement that measuring effectiveness and providing robust evidence was challenging. It was often impossible to identify whether an intervention or other external factors have brought about an improvement in a student's situation. There was an agreement that measures did need to be put in place to try to assess what works best (and when) and what was failing to achieve appropriate outcomes, in order to help in prioritising resources.