

## **Are we doing enough for students with mental health problems? Considerations for mental health professionals.**

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‘Mental health problems are hugely stigmatised...the vast majority of people with mental health problems do not want people to know because people look at you differently...even on a course like this where people are very understanding of each other and respectful of difference, it’s still one of those things you’d hope people won’t look at you differently but you can’t assume that’ **Student**

‘Already you feel uncomfortable and anxious about having to tell someone you don’t know...some very personal things about you...I am very open about my mental health problems but I would rather not have to run around telling people...having to repeat the same story and having the same confused looks.’ **Student (1)**

In its report on student mental health, The Royal College of Psychiatrists (2) reported that rates of mental ill-health symptoms are higher among students than among the general population, but that there is no evidence that students experience higher rates of mental disorders or illness.

Official statistics from the Higher Education Statistics Agency (HESA) in the UK suggest that the proportions of undergraduates declaring a mental health difficulty on entry to higher education rose from 5 in every 10,000 in 1994-5 to 30 in every 10,000 in 2004-5. If we examine figures provided by HESA in the years 2003 – 2008 we see a gradual rise in postgraduate and undergraduate students reporting mental health difficulties despite the relative stability of total student numbers. Of interest is the steady rise in those reporting an autistic spectrum disorder, usually Asperger’s syndrome. Table 1 (3). However, the few studies carried out so far into prevalence of mental health problems in universities come up with findings that do not allow us confidently to assess rates of the full range of mental ill-health problems compared with the general population.

Table 1

	Total students	Total known with disability	Mental disability	Autistic spectrum disorder
Total postgraduate 2003-4	181005	7845	280	0
Total undergraduate	676495	37700	1970	80
Total all levels	857505	45545	2250	80
Total postgraduate 2004-5	175165	8695	270	35
Total undergraduate	673775	40430	2095	260
Total all levels	848940	49125	2365	295
Total postgraduate 2005-6	184085	9410	380	55
Total undergraduate	711590	45425	2490	420
Total all levels	895675	54830	2865	475
Total postgraduate 2006-7	183320	10260	450	40
Total undergraduate	696710	47490	2695	420
Total all levels	880030	57750	3145	465
Total postgraduate 2007-8	178905	11235	595	55
Total undergraduate	705700	51275	3235	615
Total all levels	884610	62510	3830	665

Roberts *et al* (4) surveyed 360 university students in two London universities using standard measures – the General Health Questionnaire (GHQ) and the SF-36 – to assess physical and psychological functioning. Most of the indicators for physical and psychological health were markedly lower for students than for the general population (matched on age and gender). However, Monk (5) administered a questionnaire to 210 students at one university randomly selected across a range of disciplines. She found that 52% of the students had scores on the GHQ greater than 5 (i.e. were of concern of developing a treatable psychiatric disorder) compared with 30% in the general population. Humphrey *et al* (6) in a study of 468 social policy students at Newcastle University, again using the GHQ, showed that students were significantly more stressed than the general population, by comparing their scores with findings from the British Household Survey.

Waller *et al* (7), in a study focused on Leeds University, looked at records from the counselling service, university medical centre and an NHS psychiatric team, responsible for the university medical centre. All showed a rise in referral rates, with the medical centre showing the proportion of students being prescribed psychoactive drugs rising from 1.7% in 1996 to 2.8% in 2003. The number of new referrals to psychiatry (secondary care) had risen by 170% between these two years, while the number of registrations at the university medical centre had only risen by 65%.

In the US, evidence from a 13 year prospective study suggested that the severity and the frequency of mental health problems reported to counselling centres in a large midwestern university experienced a steep increase, in particular levels of anxiety, depression, suicidal intent, personality disorders and consequences of sexual assaults (8). Similar findings had already been reported by Pledge *et al* (9) in 1998 who stated that 'the level of severity of these concerns is much greater than the traditional presenting problems of adjustment and individuation.' These concerns included suicidality, substance

abuse, history of psychiatric treatment or hospitalization, depression and anxiety. In surveys carried out by Counseling Centre Directors also in the USA, Gallagher et al (10,11) reported that 89% of centres had to hospitalize a student for psychological reasons and 10% reported a student suicide. 10% of all students had 'seriously contemplated suicide'. A longitudinal study of distress in college found that although this peaked in freshman years, a subset manifested severe, chronic levels of distress (12).

Eisenberg et al (13), in a study of 2,843 students in another large midwestern public university, using a Web-based survey mode and standardised adjusted non-response measures related to depression, anxiety and suicidality, found 15.6% and 13% of undergraduates and graduates respectively screening positive for depressive or anxiety disorder, and 2.5% and 1.6% respectively having contemplated suicide in the previous 4 weeks, figures which were higher than the National Comorbidity Survey Replication data but which could be accounted by the use of screening tools. Further afield, Shaik et al (14), in a cross sectional study of 264 medical undergraduates in a Karachi University reported that stress related symptoms, including low mood, inability to concentrate, short tempers, change in sleep patterns, loneliness and fatigue had been experienced by between 55% to 82% of medical students.

Whilst we could find no specific studies looking at the outcome of students with previous mental health problems who decided to pursue academic studies., what seems clear is that students represent a vulnerable population as far as the expression of psychological problems is concerned. University life can be stressful for a whole variety of reasons, including academic pressures, relocation, relating to new peers, concerns about financial pressures (15,16,17) and having to respond to personal and familial expectations. The massive expansion of university places prior to 2003 has also brought into higher educational institutions cohort of young and older students from non-traditional backgrounds, including foreign students, who also have special needs. With funding pressures, University staff-student ratios have declined, increased pressures on staff to generate income and to carry out research has reduced the time available for pastoral duties, and modularisation of curricula have broken up stable peer groups. These difficulties can have profound implications: some students might drop out of university or show academic decline, others persevere despite their symptoms, graduate and end up in local services on leaving University. Those experiencing mental health problems could cause distress to other students, tutors, employers and clients, engage in offending behaviours, abuse alcohol or drugs, deliberate self-harm or suicide, find difficulties in asking for help, or have problems in engaging with local services whilst at University.

The College report, which is currently being reviewed and updated, suggested that better arrangements for communication and collaborative work should be undertaken between University departments and mental health services. This is a concern that has also been expressed by the Universities UK Working Group on Mental Well-being in Higher Educational Institutions (HEIs) (18,19) and the London Network of Psychiatrists working in HEIs. The following set of questions and advice has been prepared with the collaboration of these groups

in order to address the specific issues for mental health professionals whose patients are considering an entrance to a HEI.

### **What should a mental health professional be considering if his/her patient wishes to go to University?**

Deciding to enter or re-enter higher education for a person who has experienced mental health problems could be an important but difficult step. Higher degrees do increase the chances of purposeful and satisfying employment in the future, and this in turn can have a beneficial effect on mental health. However, the evidence suggests that students with prior mental health problems are especially vulnerable in the highly pressured university environment, and many do not succeed in completing their courses. On the other hand, this patient group has all the characteristics of those benefitting from focused, well coordinated care.

Mental health professionals have an important role in preparing their clients to become more resilient and anticipate any problems which might occur, thereby increasing their chances of academic success. The following are some issues that could be considered if a client is contemplating this move.

#### **1. Has the patient taken into account the likely stresses he/she is likely to face in our modern universities, particularly in the first year?**

These stresses might be due, among other reasons:

- to having to relocate to a new city at some distance from home
- to the challenges of having to meet a new group of peers
- to the modularisation of courses with changing student groups and pressures
- to the strict timetables for courses and assignments, the requirements to work with others and the anxieties around examinations.
- to financial implications of entering Higher Education

Other things to consider:

- Is the programme one that suits your patient's skills and abilities? If it is not, what are their chances of success? If they were to fail, how would this affect their well-being?
- Is the nature of the course, particularly the assessment process, going to be tolerable? It could be that some students, maybe those with Asperger's for example, might struggle with the subjective nature of essay writing or the requirement for group assignments. Discuss in particular how the choice of subject chosen to study may affect them (e.g. possible reliving unprocessed traumas, and their fear of failure, especially if they are returning to University after interrupting their studies due to illness).

- Placements: if the course requires students undergo a placement, then have the implications to home-life and employment (if they have a job) been considered? Have travel implications and time-commitment issues been considered?
- Workload: are they fully aware of the time and energy commitment required of them? Do they know how much study per week they will need to do to succeed? Do they know how much coursework they will be required to submit?
- Potential impact on family, friends and lifestyle: the commitment required is likely to demand a significant amount of the student's time. Have they considered what they will lose as a result of this?

## **2. Where will the future student be living?**

If they are living in university accommodation they may have no choice about who they live with. There may be pressures to participate in a culture of heavy drinking and possible recreational drug use. Discuss how communal living may affect them. What will they disclose to their house or flatmates? What support might they expect from them, if any? How might fellow students react to their difficulties?

## **3. Will the future student disclose their diagnosis to the University?**

If so, advice can be given regarding the support they can receive from the University Disability Service in getting the University to make reasonable adjustments, the possibility of getting a Disability Allowance, support from the University Mental Health Advisor, Counselling Service and mentors. Concerns about confidentiality could be raised, especially if the patient consents to contact between the university and local mental health services.

## **4. If the future student moves out of the catchment area:**

Give advice on registering with a new GP or if available, with the Health Centre at the University, obtain consent to send information regarding mental health needs to the new GP, as well as to University Mental Health Advisor and University Disability Service, and give indication of what support may be required from local mental health services. If possible, retain involvement in care and offer ongoing liaison and consultation to University Services and local GP and CMHT.

## **5. How will their illness affect their ability to study?**

This might depend on the presence of ongoing symptoms and here it is helpful to anticipate how these symptoms could affect the future student so that they can prepare for and manage any difficulties as best as possible. If there are relapses, discuss and agree a plan of action. If possible liaise with the Mental Health Advisor or the University Disability Service when doing this.

## **6. If the patient is taking medication:**

Discuss how this may affect their ability to focus, concentrate and summon enough energy to complete their assignments and studies, as well as participation in seminars and group activities. Beware of sudden reductions in medication which up to then have stabilised the patient sufficiently to consider starting studies. Would it be helpful for the student to have something in writing about how his/her illness and medication might affect ability to study?

## **7. The role of Student Counselling Services and the University Mental Health Advisor**

Student Counselling Services are able to offer short-term counselling for students that are experiencing distress, in particular if this associated with difficulties students are experiencing during their stay at University and in managing to complete assignments and prepare for examinations. Many counsellors have training in other fields other than supportive, one-to-one counselling, including for example cognitive behaviour approaches, Eye Movement and Desensitisation Reprogramming techniques, and diverse forms of group work. Any work that is undertaken with a patient known to mental health services would obviously benefit from communication and collaboration, as long as the student provides consent.

Mental Health Advisors usually come from a community psychiatric nurse or psychological background, and are able to see students quickly if they are experiencing a mental health crisis, give advice to the student, and act as an intermediary with local mental health services and GPs if required. They also have a role in raising awareness of mental health issues in university academic staff and mentors, home wardens, Disability Services, and so forth.

### **Summary**

Whilst students possibly represent a psychologically vulnerable population because of the stresses involved in University life, the problems faced by students who already have a mental health problem is particularly important to address, as this may create an obstacle to successful completion of academic courses, with subsequent loss of opportunities as well as the mental health support offered by satisfying employment. The suggestions made in this article are for mental health professionals who can alert and prepare their patients to the problems they are likely to face, and to bolster their attempts at an effective partnership of care with relevant university agencies.

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On behalf of

Working Group Reviewing the Royal College Report on Student Mental Health

Universities UK Working Group on Mental Wellbeing in Higher Education Institutions and

The London Network of Psychiatrists working in Higher Educational Institutions

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