

Understanding provision for students with mental health problems and intensive support needs

Report to HEFCE by the Institute for Employment Studies (IES) and Researching Equity, Access and Partnership (REAP)

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REAP is an externally funded research group based in Lancaster University's Department of Educational Research, which explores the factors contributing to exclusion from learning as well as looking at the ways in which barriers to participation can be removed. It works closely with the Centre for Social Justice and Wellbeing in Education, and HERE@Lancaster (the Centre for Higher Education Research and Evaluation).

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Executive Summary

This report presents the findings of a research project undertaken for the Higher Education Funding Council for England (HEFCE) to update its understanding of institutional support provision for students with mental health problems and other impairments with high cost or intensive support needs. In particular, the research explored:

- how HE providers fund and provide support for students with severe mental health problems and impairments where intensive or multi-agency support is required;
- the split of provision between in-house support services and external support agencies;
- how HE providers balance factors in making decisions over the nature and extent of support offered with limited funding, and the impact on students; and
- what the key pressure points and challenges for HE providers are.

The study involved a review of recent literature concerning the ways in which support for students with mental health problems and other impairments is organised, and case study visits to 12 higher education institutions (HEIs) and further education colleges (FECs) across England undertaken between October 2014 and February 2015. Case study institutions were selected to ensure a spread across different types of institution.

The research was primarily qualitative, with the core of the research consisting of context specific in-depth interviews with a range of staff, at all levels and across different roles, to explore what institutions do and why, and the challenges faced.

Policies and strategies

There appeared to be a number of key drivers underpinning the institutional focus on supporting disabled students:

- Moral responsibility and a duty of care for students.
- Legal responsibility to meet the duties of the Equality Act.
- Business case to attract and retain students.

While these seemed to be present in all case studies, to varying degrees depending on their histories, mission and values, the underlying approach was expressed around ensuring that every student who can access higher education academically gets an equal opportunity to succeed, and that offer decisions were separated from information about support needs.

Institutions reported that policies and strategies were being developed against a backdrop of increasing demand for support, particularly from students with mental health problems. There was also a commonly expressed desire to improve provision, and thus a tendency to regard support services as work in progress rather than a finished article.

Responsibility for the formulation of policies for supporting disabled students tended to lie with the institution's senior management team, with input from those responsible for student experience and academic affairs. The senior level input ensured buy-in at the highest level of the institution, and helped student support services to lever sufficient funds to implement their policies and approaches. Institutions recognised that policies needed to be regularly reviewed and updated to ensure they keep up with the legal framework and influence of external factors, such as changes to NHS provision/eligibility, and government policy on student support.

In developing policy and strategic approaches to supporting disabled students, institutions appeared to face a number of decisions, including: who to support, or prioritise with support; where HE responsibility ends; and the extent to which they can be proactive rather than reactive.

Many institutions had recently restructured their provision of support, often as part of a wider restructuring of the whole institution. This has tended to be part of the drive towards taking a more student-centred approach, reducing bureaucracy and reducing administrative costs, whilst freeing up resources for more value-added activity. Two common features of the restructurings emerged: a holistic approach to provide support across the whole of the student journey; and a physical centralisation of student support to provide a 'one-stop-shop' for ease of student access and visibility, and improve communication and dialogue within the service.

There was recognition that the provision of support for disabled students is a shared responsibility, and that formal support sits within a wider range of more informal support including that provided by: academic staff; pastoral staff; Students' Unions; Chaplaincy; and residential wardens within HEI-managed accommodation.

Demand for support and how it is provided

There was an overwhelming consensus that demand for mental health provision was rising: there were increasing numbers disclosing pre-arrival; increasing needs emerging while students were at university; and increasing complexity of problems and comorbidity of mental health problems alongside other impairments. By contrast, numbers of students with other impairments with high cost or intensive support needs were felt to have been fairly stable, although as accessibility and support improved there was an anticipation that numbers would increase over time.

There were felt to be a number of drivers behind this increase in demand for support for mental health problems, including: a more open culture in society concerning mental health; changes in healthcare leading to more reliable diagnoses at much earlier stages of students' lives, and better quality treatment allowing students to access HE who would not have been able to do so in the past; institutions developing a reputation for supporting students; and greater financial and academic pressures on students leading to problems emerging during studies.

In terms of the provision of support, student support services (under various auspices) was the main hub, with disability or mental health advisers undertaking a range of support activities, including: pre-admission activity with applicants and more general outreach activities; induction support and awareness raising for new students; triaging of new students; specialist responsive tailored support; crisis prevention and management; and wider well-being activity.

One crucial strand of formal support provided was assistance with applying for Disabled Students' Allowance (DSA), and then facilitating the support being put in place when students are successful in their applications. DSA-funded support for students with mental health problems tended to be focused on specialist mentor support, provided either by in-house mentors or by an external agency. For students with other impairments, DSA-funded support could include other non-medical helper support, and assistive technology.

Where students were in receipt of DSA, or had a recognised disability or mental health problem, advisers would facilitate the implementation of learning support adjustments, such as classes being held in accessible rooms or timetabled at certain times of the day, adjustments to assessment arrangements including deadline extensions or taking exams in a small room, and special accommodations regarding placements or fieldtrips. Learning support adjustments were often developed in collaboration with the student and academic staff.

All institutions provided access to a counselling service, with a broader remit than that of mental health mentors in that it would cater for the needs of a wider spectrum of students, but narrower in that the focus is simply on the provision of counselling. Counselling was generally short-term and finite, with a course typically consisting of

four to seven sessions, and if students required support beyond that they would be referred to appropriate statutory services. In addition, counselling staff at some institutions were also involved in wider wellbeing activities such as mindfulness and building resilience.

Role of wider university services

Academic staff were seen to have a key role in supporting students with mental health problems or other impairments, although departmental responses varied both across and within institutions. In addition to having an involvement in pre-entry activities and monitoring attendance, academic staff may fulfil a number of roles around communication, education and guidance.

In some institutions there were members of staff with a specific remit to work with disabled students, either academic staff with additional responsibilities, or disability advisers assigned to and located in particular departments or faculties.

Wider institutional services were also reported to have a role in providing support to students with mental health problems and complex needs. Estates departments were instrumental in improving physical accessibility, generally, as buildings were maintained and updated, and, specifically, for particular students in adapting accommodation or teaching buildings. Accommodation teams played a significant role in supporting students, for example ensuring students with mental health problems are placed in quiet accommodation blocks and that hall wardens are alert to any particular needs. Libraries could support disabled students through practical assistance with finding and carrying books, and creating quiet spaces to help reduce stress. Chaplaincy staff played a role as a first point of contact and provider of informal support, and may be particularly helpful for international students. Finally, Students' Unions and local Student Minds also played an active role in supporting students through buddy initiatives and wellbeing campaigns, and may have involvement in the development of institutional policies and strategies.

Working 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. Building networks and links allowed for signposting, and facilitating access, to more specialist and expert support for students. They also allowed both parties (external agencies and institutions) to understand more about the working environments of the other. This could be beneficial as 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).

Some institutions were more strategic and proactive in their approach with external agencies and, thus, arguably more successful in sustaining linkages. Yet 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. Having the time to make contacts and sustain these could be particularly challenging for busy university staff when time with students is often at a premium. The time invested was a hidden cost. Other challenges involved developing linkages across broad geographies, trying to support students' transitions from home to study location (and transfer of support provider) and stepping in to 'hold' students whilst they waited to access the NHS provision they needed.

Funding issues

The two main funding sources for students with mental health problems/intensive support needs were: the Disabled Students' Allowance (DSA); and an institution's central funds (of which the majority is student fee income, but also includes funding from HEFCE including the Student Opportunity (SO) disability allocation). In 2014/15 the SO disability allocations varied from £10,000 up to £400,000 per institution. 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. Central funding, most of which comes from fees, was generally used to fund wider student support provision including disability services and counselling, whereas DSA funding supports eligible students' individual needs.

Institutions reported the challenges involved in accurately estimating budgets year to year. They found it difficult to precisely gauge future demand; not just the numbers of students requiring support but the nature of their individual needs and thus resources required, which varied considerably from year to year. Institutions often had to be reactive, responding to student needs and putting in place tailored support as needs arose. It was also difficult for institutions to disaggregate costs and thus spending for different types of support provided or the different types of impairment requiring support (eg mental health problems) due to: the holistic nature of support provided; the overlapping nature of conditions (comorbidity); and the proactive and wider nature of wellbeing support provided (aimed at wider student populations rather than individuals).

Institutions mentioned needing to draw more and more from their central funding (ie mostly student fee income), as the DSA funding and their SO disability allocation was by no means covering the full direct costs of providing support to the disabled student population (let alone covering the often hidden costs of the involvement of wider staff, training and supporting volunteers, and making available appropriate space to support students). Indications were that for every £1 received in SO disability allocation, institutions needed to top this up by between £2 and £5.

To date institutions have supplemented the SO disability allocation using income from student fees to provide the required services, although the provision of counselling services often had to be limited as demand far exceeded supply. Institutions feel they are just about keeping up with demand, but there was a recognition that much more could be done with additional funding. However, there were shared concerns about the future and whether, with the increasing levels of demand for support services, the scale of topping up from central funds could continue to rise and be sufficient to meet all needs.

Effectiveness of provision

With rising number of students accessing support services, there were clearly challenges in meeting demand, but most institutions focused on understanding and meeting needs appropriately. They predominantly thought they were offering excellent support, but some recognised that aspects of provision could be improved. Institutions placed particular attention on the transition period helping students prepare for and adjust to university life; and also worked to make their services accessible and reduce the stigma attached to seeking help.

Late disclosure was a major challenge to effective provision and so institutions made great efforts to reach out to students pre-enrolment to enable support to be put in place as early as possible. Other challenges related to universities' estates or locations which could be difficult to adapt appropriately because of location or listed building status, inadequate staffing to deal with demand (which could be unpredictable), pressures on external services (significant budget cuts), and institutional bureaucracy.

The monitoring of effectiveness 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. Some institutions were using the Clinical Outcomes Routine Evaluation (CORE) approach to measure the effectiveness of counselling interventions, while others looked at differential outcomes of disabled and non-disabled students such as achieved grades, National Satisfaction Survey scores, retention, appeals and complaints, and graduate destinations.

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.

Impacts of external pressures

Alongside increasing demands for their services, the case study institutions were also very concerned about the proposed changes to DSA. Some interviewees reported that they felt the DSA assessment process had been tightening already, with applications being turned down that would have been accepted in the past, and applications taking much longer.

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.

The delay in the implementation of the changes was welcome, although the original timetable was felt to be unrealistic if institutions were to adapt to them while maintaining the number or proportion of disabled students in higher education. The new timetable was still felt to be tight to fully prepare for the changes.

Most interviewees felt that the mentoring support provided for students with mental health problems, and non-medical helper support for those with complex or intensive needs, would still be funded through the DSA. However, the removal of lower band support may adversely affect students if they received it alongside the higher band support. Students with mobility problems or those with autism spectrum disorders were highlighted as those who could potentially be affected by this.

The uncertainty around the guidance on the DSA changes meant that most institutions found it difficult to estimate the financial impact on them, although all knew they would need to draw more on student fee income to support students with mental health problems and other disabilities.

There were some concerns raised that the changes could lead to situations where students with disabilities were discriminated against. If the support available was reduced then fewer disabled students may choose to apply, or increased numbers may choose not to disclose an impairment for fear of potential discrimination, which would make it more difficult for institutions to plan levels of support.

However, thoughts on the potential impacts of the changes were not all negative. Some interviewees felt that the changes would help promote more inclusive curricula over the longer term, enabling more generic rather than individualistic solutions, and that DSA funding may have been part of the reason why institutions had not made more efforts to develop inclusive curricula.

Issues and challenges

There was a widespread concern that the recent rise in demand from students with mental health problems would continue, and that this rise in demand would lead to institutions facing a number of key challenges.

- **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. However, there is a recognition that students may be anxious about declaring a disability or mental health problem as they feel it may act against them, and it was felt these anxieties may increase as a result of the DSA changes.
- **Developing inclusive curricula** can help institutions provide more support using fewer resources, which was seen as particularly important in light of the proposed changes to DSA and the growing demands from students. While most case study institutions are starting to address this, they still had a way to go before they could describe their provision as fully inclusive, and could benefit from sharing practice or testing different approaches.
- **Introducing proactive measures** to reduce demand for support, such as wellbeing and resilience initiatives, can also assist in making limited resources stretch further. Again, this is an area where different models or initiatives could be rigorously tested to assess their outcomes and find out what can best make a difference.
- **Improving internal relationships** between academics and support staff, and generally across the institution, can improve the holistic nature of support. Disability awareness training for academic staff may also be effective.
- **Developing external partnerships** can benefit both the university and external partners, and although partnership working requires an investment of time and resources, the costs may be more than outweighed by savings in other support areas.

Institutions were not seeing the same level of increases in the numbers of students with complex physical or sensory impairments and so there was less concern about supporting them in the future, although with finite resources increases in one area might put pressures on resources overall, and individual cases could present particular challenges.

1 Introduction

The Institute for Employment Studies (IES), in partnership with Researching Equity, Access and Partnership (REAP) at Lancaster University, were commissioned by the Higher Education Funding Council for England (HEFCE) to improve their understanding of how higher education institutions (HEIs) and further education colleges (FECs) in England provide and fund support for UK-domiciled¹ students with:

- moderate, severe or sporadic mental health problems, and
- impairments where intensive or multi-agency support is required.

A separate study, conducted by York Consulting explored support arrangements for students with Specific Learning Difficulties (SpLD).

1.1 Research context

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 DSAs ‘day-to-day activities’ includes education.’²

Under the Equality Act 2010 it is unlawful for HEIs and FECs to discriminate against disabled students by treating them less favourably when offering places and providing services. Under the Act, HEIs and FECs must make ‘reasonable adjustments’ so that disabled students are not significantly disadvantaged compared with other students who are not disabled. Reasonable adjustments do not necessarily have a cost

¹ This will include full-time and part-time, and both undergraduate and postgraduate students

² Outline of DSA Guidance for Practitioners, Student Loans Company
www.practitioners.slc.co.uk/media/847636/guidance_document_-_second_draft_for_publication_16.10.2014.doc

implication, they can include providing extra time for assignments or providing course materials in advance.

In England there are two key funds to support disabled students: mainstream disability funding from HEFCE; and individual funding from the Government (via Student Finance England) in the form of the Disabled Students' Allowance (DSA). However, institutions may also provide individual level support from other funding sources such as Access to Learning Funds or central funding (including fee income).

- **Mainstream disability funding:** this comes in the form of an annual non-ring fenced disability allocation (now part of the Student Opportunity allocation). The widening access and improving provision for disabled students allocation reflects the proportion of students that each institution recruits who are in receipt of DSA, and there is a minimum level of funding for all institutions. The funding goes to institutions rather than individual students and contributes towards the institution's cost of their support provision for disability students. The allocation for 2014/15 was £15.2 million for the sector.
- **Disabled Students' Allowance:** HE students living in England with a disability, long-term health condition, mental health condition or specific learning difficulty can apply for a Disabled Students' Allowance (DSA) from the Student Loans Company. These cover 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. Students are encouraged to apply before starting their course (UCAS recommends at least six months before the start date, as the process can take up to three months). The allowances are non-repayable grants paid via Student Finance England to support the purchase of specialist equipment such as computer software, provision of non-medical personal support (including one-to-one tuition), more general support such as Braille paper, and the extra travel costs to attend university or college. The amount received depends on level of study (undergraduate or postgraduate), mode of study/intensity of course, and assessment of need. Students must prove eligibility by: providing a letter from their doctor or specialist or diagnostic assessment from a psychologist or specialist teacher; and then have to undergo a DSA Needs Assessment. These are a formal part of the process and are undertaken by approved external agencies. The DSA Needs Assessment: explores the nature of the disability and the impact on the educational experience; identifies the student's needs in relation to their course; and makes tailored recommendations about technology, strategies and support requirements. Once approved, the DSA amount is paid either to the student or the organisation providing the service or equipment.

In April 2014 a number of changes were proposed for DSA support for 2015/16 onwards, and these proposals form part of the Government's agenda to improve efficiency in the HE sector – taking account of changes in technology and course

delivery, changes in equality legislation, and pressures to reduce public spending. The aim is 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, which can include general changes to course delivery, information provision and encouraging greater independence across the entire student body; and Government focusing support on more specialist provision for those with greater needs, that the institution may not be able to meet through reasonable adjustments (eg for higher specification computers and specialist non-medical help), but this will not include the additional costs of specialist accommodation. In addition, the definition of disability used in DSA assessments will align with that provided by the Equality Act 2010 and those making needs assessments and providing support will need to be registered.

HEFCE is reviewing the provision and support for disabled students in the HE sector as part of the Government’s proposed changes to the DSA. This research forms part of the process by providing HEFCE with evidence to support future policy and help to identify various models of practice for the sector.

The last review of the provision and support for disabled students was commissioned by HEFCE in 2008/09. This³ found that:

- There was some form of dedicated support service provided for disabled students across institutions in general and disability services were becoming quite well established (although core staff numbers were relatively small). There was variation in the degree to which disability was felt to be embedded throughout the institution (in thinking and action) but institutions were aware and committed to the principals of disability equality in HE.
- Institutions claimed to provide support for all types of impairments. However, the largest group catered for were students with dyslexia, and students with these specific impairments attracted a great deal of attention. The group most often cited as not having their needs met sufficiently were students with mental health problems (followed by students with hearing impairments). In terms of mental health, institutions noted how the way in which the *‘unpredictable and high risk nature of ‘crisis’ events makes adequate resourcing extremely difficult’*.

³Harrison, M., Hemingway, L., Sheldon, A., Pawson, R. and Barnes, C. (2009). Evaluation of Provision and Support for Disabled Students in Higher Education, HEFCE

- Institutions faced a number of constraints and challenges in supporting disabled students in the areas of: assessment and disclosure; continuity of funding; difficulties in providing for physical access needs; (practical and attitudinal) problems in teaching and learning; gaps in staff training; and uncertain support from central management and external agencies. Poor information flows and communication could also delay support and information needed to be provided to all students rather than tightly focused on those with visible support needs.
- Mainstream disability funding was important to HEIs, and they used their allocation to: provide general dedicated disability services; technical assistance and equipment; improvements to campus accessibility; provide individual support services (such as personal assistants); staff training; and supplementing DSA for individual students. Also, they found that the mainstream funding could stimulate or leverage additional resources. HEIs varied in their methods for allocating the funding, but many channelled the funds to a central support service or to disability services. There appeared to be little monitoring of spending. The majority of HEIs spent considerably more on supporting disabled students than their mainstream disability funding allocation, with some able to supplement HEFCE funding with other external sources and others providing support from their own budgets.
- Students in receipt of or applying for DSA were able to access a range of services including support and guidance at the early stages and some form of financial support in the event of DSA delays. Access to Learning Funds were often cited as substitute funding. Part-time and international students were a concern as they lacked support through the DSA funding stream.
- There had been major shifts towards engagement with disability in recent years, but there was no particular overall pattern to suggest that best practice was to be found predominantly or disproportionately within any particular types of institutions.
- The study concluded by characterising three mutually reinforcing stages of development within HE: firstly placing emphasis on responding to physical impairments through improved access and reducing barriers; secondly focusing on responding to less visible and multiple impairments and enhancing support and systems for all students through better teaching delivery, improved communications, improving assessment and curriculum delivery and staff training; and thirdly, adopting Equality Impact Assessments to embed disability issues in a generic way across core activities and central management processes.

Since the 2008/09 research the HE system in England has undergone significant change, particularly with regard to the increases to tuition fees introduced in 2012 and the consequent reductions to HEFCE grants which affects central funding for supporting disabled students. More recently, the Government has announced the lifting of the cap on the number of students that HE providers are able to recruit from 2015/16 as well as

changes to the support provided to disabled students through the Disabled Students' Allowance also from 2015/16.

In addition, since 2009, the evidence base has grown particularly in regard to HE attainment and outcomes for disabled students. This evidence shows that overall the number of students declaring themselves disabled has increased following successes in widening participation. This has increased both demand among disabled students and levels of disclosure and there have been some significant shifts in the most commonly reported impairments. Some of the key findings are:

- Mental health and social/communicative impairments (such as autism) have doubled since 2008/09, impacting quite significantly on institutional services and support structures.
- UCAS reports the numbers of UK accepted applicants declaring a disability increased from 23,772 in 2008-09 to 34,625 in 2013-14⁴
- The numbers of students receiving DSA increased from 36,000 in 2007/08 to 56,600 in 2012/13⁵.
- Higher Education Statistics Agency (HESA) data showed increases in the number of disabled students studying at postgraduate level (PGT and PGR) and that the mode of study (full or part time) is broadly similar to that of PG students who are not disabled.
- Disabled entrants are more likely than non-disabled entrants to no longer be in HE after their first year of study⁶.
- Disabled students are less satisfied in five out of seven question categories of the National Student Survey⁷.
- The HEFCE report 'HE and beyond'⁸ shows that students claiming DSA perform above the sector average in terms of degree attainment and progressing to graduate employment or further study. However, students with a declared disability not in receipt of DSA perform below the sector average across all outcomes.

⁴ See www.ucas.com/data-analysis/data-resources/data-tables/disability

⁵ Source: Student Loans Company (SLC)

⁶ Source: HESA UKPIs 2010-11 <http://www.hesa.ac.uk/content/view/2379/#dsa>

⁷ National Student Survey: Findings and trends 2006 to 2010 (HEFCE, 2011) <http://www.hefce.ac.uk/pubs/year/2011/201111/>

⁸ 'HE and Beyond' (HEFCE, 2013) <http://www.hefce.ac.uk/pubs/year/2013/201315>

- The latest Equality Challenge Report (2014)⁹ asserts that there were 187,620 students with a self-declared disability in England accounting for 9.6 per cent of the student body, that there were a higher proportion of undergraduate students with a disability than found for postgraduates, and substantial differences by subject of study (highest levels among those studying creative arts and design disciplines). The report also notes that just 46.5 per cent of disabled students were in receipt of a Disabled Students' Allowance.

1.2 Research aims

HEFCE were therefore looking to update their understanding of the provision of support for disabled students in the context of the changes outlined above but this new research has a strong focus on the **strategic responses** of institutions to their support for disabled students at all levels and modes of study. It sought to understand the interplay of the investments made from different sources of institutions' income, including the HEFCE grant; and identify the key challenges for institutions in providing services.

Support for disabled students involves a broad range of issues. However, this research had a very specific focus on increasing understanding of how HE providers support students with **severe mental health problems or complex multiple impairments** and the way in which HE providers determine how to deploy the resource available to them, including HEFCE grant funding.

The key questions for this research were:

- How do HE providers fund and provide support for students with severe mental health problems or impairments where intensive or multi-agency support is required?
- How do HE providers provide and fund support for students with sporadic or moderate mental health problems?
- What is the split of provision between in-house support services, such as student counselling, and external support agencies?
- What is the nature of the technical interface between HE providers and external support agencies, such as mental health trusts and GP practices and how do the relationships operate when a multi-agency approach across geographical regions is required?

⁹ Neave, S (2014) Equality in Higher Education: Statistical Report 201, Part 2: Students, ECU http://www.ecu.ac.uk/wp-content/uploads/2014/11/ECU_HE-stats-report_student_v19.pdf

- How do HE providers balance factors in making difficult decisions over the nature and extent of support offered with limited funding and the impact on students of those decisions?
- Is the balance of the funding provided through the Disabled Students' Allowance optimal?
- What are the key pressure points/challenges for HE providers?

1.3 Methodology

The study involved a review of recent literature, and case study visits to 12 HEIs/FECs across England undertaken between October 2014 and February 2015.

1.3.1 Literature review

To set the empirical research from the case studies in context, and to provide an update to the previous HEFCE research on institutional support for students with disabilities, a review of relevant literature was undertaken. The literature review focused mainly on UK literature but included international perspectives where relevant, and was guided by the following objectives:

- To provide continuity with, and complement, existing HEFCE disability research; by focusing on general disability-related evidence published since 2008-09, with a particular concentration on issues which relate to mental health (MH).
- To include discussion of recent publications by the Equality Challenge Unit (ECU), the Higher Education Academy (HEA), Universities UK (UUK), and Student Minds, along with recommendations from our Steering Group, in order to contextualise issues identified in our empirical research.
- To provide a context for themes explored in the case studies, looking at issues relating to the experience of students with mental health and/or intensive support needs across the student life cycle.
- To identify, within UK and international literature, policy and practice, potential solutions and examples of good practice, which complement or expand on examples raised by the case study universities in this research.

In addition, a range of useful resources were collected during the literature review, and these are presented in Appendix 1.

1.3.2 Case study selection

The selection of the case study institutions was based on the following factors:

- The proportion of total students within the institution with mental health problems (categorised as high, medium or low proportion based on the range across all English institutions).
- The proportion of students with mental health problems who were in receipt of DSA (again categorised as high, medium or low proportion based on the range across all English institutions).
- Trends since 2008/09 in numbers of students with mental health problems (again high, medium or low growth based on the range across all English institutions).

All English HEIs were assigned to a cell in the resulting matrix. A number of other secondary factors were then taken into consideration to make the final selection in order to ensure a spread of different institution types: broad geography (north, mid, south); location (city, campus, single-site, multiple locations); type of institution (generalist, specialist, FEC); average tariff required for entry (high, medium, low); and size (large, medium, small). In addition, HEFCE and the research teams were careful to ensure that institutions were only selected to participate in one of the studies; the IES/REAP study focusing on mental health and impairments requiring intensive support; or the York Consulting study focusing on SpLD.

1.3.3 Case study approach

The research was primarily qualitative, with the core of the research consisting of a mix of four slim and eight expanded case studies involving a large number of context specific in-depth interviews with a range of staff including: senior managers (eg Registrar, Pro Vice Chancellor, Director of Student Support); managers of disability services/student support services; learning support staff; specialist mental health staff; counselling staff; staff from library services and estates; and heads of academic departments to understand what they do and why and the challenges faced. In a number of case studies, interviews and focus groups were also conducted with student representatives and disabled students to understand the experience of (or lack of) support. Also, where possible, representatives from external support agencies were interviewed to gather their perspectives on the issues.

Slim case studies involved a minimum of five staff whereas expanded case studies involved more than 12 interviews. Thus, expanded case studies allowed a more in-depth investigation of the issues in those institutions that appeared to be exhibiting good or innovative practice identified from the quantitative data analysis.

Across the case studies a total of 165 individuals participated in in-depth interviews/discussions. This included 23 students (or student representatives).

The research was not designed to be an audit of provision but a frank and open exploration of the challenges faced and the resulting decisions made and practices adopted within institutions to support students with moderate to severe mental health problems and/or physical impairments where intensive or multi-agency support is required. To allow for these discussions to be open, interviews were in the main face-to-face and were either one-to-one, paired interviews or small focus groups (depending on interviewees' preferences).

A qualitative approach ensured that the greatest possible diversity of viewpoints and key HE characteristics would be reflected. However, it should be noted that, unlike large scale survey research, findings from qualitative research cannot: be interpreted as being statistically representative of all HEIs and colleges in England; or be used to describe the numbers and proportions of institutions or staff displaying particular characteristics. Instead qualitative research provides depth of insight. It gives a detailed understanding of how and why institutions made decisions and took actions around supporting disabled students – specifically students with mental health problems or complex support needs –rather than the incidence of these practices.

The shortlisted case studies were sent an invitation to participate in the research from the HEFCE Chief Executive. This letter (sent in September 2014) set out what the research involved, introduced the research team and asked for a named contact. The research team then followed up and worked closely with the institution liaison to identify the most relevant individuals to speak with, and to arrange the interviews and group discussions at the most convenient times for interviewees and arrange for suitable venues. Slim case studies involved visits of one to two days, and expanded case studies involved two to three days of visits. A topic guide was developed in partnership with HEFCE colleagues and was used flexibly with individual participants based on their role in the institution and their experience. With interviewees' permission, the discussions were recorded in order to supplement the notes made by the lead researcher for each case study.

Analysis of the case study findings used a content analysis technique against a framework of themes developed during workshop sessions among the research team. Findings were organised and summarised using these themes with anonymised quotes provided to illustrate and illuminate key points.

The case study findings were also combined with analysis of quantitative information provided by HEFCE analysts. These data were drawn from across the sector to understand the changing size and shape of population of disabled students which will impact on the nature of demand for support services.

A list of contacts from some of the case study institutions from which good practice examples have been presented in the report is included in Appendix 2.

1.3.4 Report structure

This research report therefore brings together findings from the quantitative information and from across the 12 case study investigations. It also takes account of feedback from the research steering group on emerging findings from visits with three early case studies.

- Chapter 2 presents a review of recent literature around institutional provision for students with mental health problems and other disabilities.
- Chapter 3 provides analysis of data on disabled students, gathered from various sources.
- Chapter 4 explores the policies and strategies adopted by institutions and provides further understanding of the strategic responses of HEIs and colleges to providing support for students with moderate, severe, or sporadic mental health problems and/or disabilities where intensive or multi-agency support is required.
- Chapter 5 looks in detail at the demands on institutions, how this has been changing and the factors driving the change. It then describes how they provide support for the sub-group of students with mental health problems and/or intensive support needs.
- Chapter 6 draws on the views of staff and students to examine how support is provided through academic departments, wider institutional services and the role played by students themselves.
- Chapter 7 explores the interface between institutions' support services and external agencies, to understand where these working relationships exist and how well they are working.
- Chapter 8 looks at the costs and funding aspects of providing support to understand how support is funded, the balance and sufficiency of funding sources, and the implications of (future) funding shortfalls.
- Chapter 9 examines the perceived effectiveness of support, in terms of meeting the needs of students with mental health problems and/or intensive support needs and identifying interventions that were particularly effective in assuring students were able to stay healthy and successfully complete their studies. However, it also explores how well institutions are able to measure effectiveness and, thus, truly assess their impact.

- Chapter 10 brings together views on the impact of recent, and also up-coming, sector changes and other external pressures on the nature and level of support they can provide.
- Chapter 11 draws the report to a close by identifying a number of key challenges that institutions are currently facing, or are likely to face, in developing their provision to support students with mental health problems and other impairments with intensive support needs, and gives examples of the approaches adopted in some of the case study institutions.

2 Literature review

2.1 Introduction and background

HEFCE's last funded research on disability was six years ago (Harrison, M. et al, 2009), and combined a review of the literature with empirical research. It gathered information on the ways in which higher education and further education institutions in England and Wales organised disability support for all students, and how a complex and changing context impacted on expenditure. It built on earlier research to consider the extent of progress towards improved practices, concluding that, though the '*climate of thinking about disability*' in HE had been '*transformed*' over the last ten to fifteen years, significant further work was needed (p135). The two research projects commissioned by HEFCE in 2014 look at the nature, level and cost of institutional provision of specific groups of students with a disability. One looks at students with specific learning difficulties¹⁰ and the other, this study, focuses on students with severe to moderate mental health conditions and/or intensive support needs.

The rationale for a joint focus on students with mental health conditions and students with intensive support needs is that both groups raise complex and challenging issues for institutions, relating both to how they are defined and to how they are supported. Providing reasonable adjustments for these groups of students may involve additional time, effort and resources – over and above those required by other disabled students – and may involve the coordination of multiple institutional and external services.

Whilst '*mental health problems*' has some coherence, as a category, '*intensive support needs*' could refer to students with widely divergent issues that may have physical and/or mental health dimensions. For example, a student with sensory and physical impairments who uses a signer, and has a physical impairment requiring adaptations to buildings, or a student with a diagnosis of bipolar disorder who also has a specific learning disability. Whether support needs are intensive may derive not only from the characteristics of the student but also from the context. A student may require additional assistance for a specific period of their course, for instance during a

¹⁰ Support for higher education students with specific learning difficulties (HEFCE 2015), <http://www.hefce.ac.uk/pubs/rereports/Year/2015/spld/>

placement or a year abroad. Both '*groups*' of student are considered in our empirical research but – as there is scant identifiable literature on intensive support needs per se – this review takes mental health problems as its primary focus.

Like the previous HEFCE study (Harrison, M. et al, 2009), this research has combined empirical research – comprising analysis of HESA data on participation rates of disabled students, and institutional case studies – with a review of the literature, to set that research in context. Our literature review has been guided by the following objectives:

- To provide continuity with, and complement, existing HEFCE disability research; by focusing on general disability-related evidence published since 2008-09, with a particular concentration on issues which relate to mental health (MH).
- To include discussion of recent publications by the Equality Challenge Unit (ECU), the Higher Education Academy (HEA), Universities UK (UUK), and Student Minds, along with recommendations from our Steering Group, in order to contextualise issues identified in our empirical research.
- To provide a context for themes explored in the case studies, looking at issues relating to the experience of students with mental health and/or intensive support needs across the student life cycle.
- To identify, within UK and international literature, policy and practice, potential solutions and examples of good practice, which complement or expand on examples raised by the case study universities in this research.

The review is aimed at a policy and practitioner audience. It draws on diverse categories of writing including: academic books and peer reviewed articles; commissioned reports based on empirical research and/or research syntheses; publications from lobby groups and outputs from relevant websites. Material has been selected for its relevance to issues raised within the case studies drawing on previous knowledge of the field, recommendations from the steering group and additional searches for examples of good practice.

The review focuses primarily on UK literature but, where relevant, includes references to policy, practice and perspectives from elsewhere. Many of the sources referred to are shaping, or have the potential to shape, higher education policy and practices; and to influence the perspectives of staff who work within the higher education sector as well as the health, social care and third sector practitioners with whom they collaborate. This broad, and increasingly accessible, range of sources has the potential to shape, too, the views and expectations of students and their families; along with the schools or colleges who prepare and support them to access, participate and progress within, higher education.

Finally, the review has identified some literature that may be unfamiliar to some HE staff and students. It draws on debates that are taking place in the broader higher education and mental health sectors, to shed new light upon the issues and potential future directions for support.

2.1.1 Structure

The chapter is organised thematically, under four main headings:

- The first relates to students with mental health problems and intensive support needs
- The second examines the rights, responsibilities and responsiveness of institutions and the staff who work within them, covering:
 - National policy and networks
 - Institutional policy, practice and partnerships
 - Student services and academic departmental support
- The third theme considers aspects of the student journey, including:
 - Transitions into, through and out of higher education
 - The teaching and learning context
 - Wider aspects of the student experience
- The fourth theme explores some academic literature that offers critiques of current trends, and considers challenges and ways forward

2.1.2 Note on terminology

Mental health is a contested field. Language, which varies across disciplines, interest groups and countries, is evolving fast. *Mental illness* and *mental disorder* are generally associated with individual understandings of mental health difficulties. Terms such as *mental health difficulties*, *problems* or *issues* and *mental distress* are associated with more social understandings (the idea that mental health problems can result from difficult, and sometimes, traumatising experiences). Some people understand their experiences as *madness* – a term which harks back to a time before unusual experiences, such as hearing voices, began to be located within a ‘*health*’ or ‘*medical*’ framework. As with the reclaiming of words such as *queer*, the reclaiming of the language of madness aims to challenge stigma associated with the term, and to open up a space for thinking differently (Church, K., 2015 – see Critiques of current trends).

There is considerable variation in terminology used in the literature. Many of the reports reviewed here expand in some detail on that issue. They may do so in order to explain why a particular term is used, as language varies across time, geographical space and between diverse sectors. Another reason for discussing terminology is to defend the use of a particular, contested, term. Scarffe, P. (2013) for example, uses the Higher Education Statistical Agency's descriptor, *mental health condition* but indicates the limitations of the term, given that everyone has a mental health condition.

2.2 Students with mental health problems and complex needs

Chapter 3 goes on to provide a breakdown of the best available data on the numbers of students with mental health problems within UK universities, including those in receipt of Disabled Students' Allowance (DSA). Here, the main messages from the literature regarding the nature and extent of the issues facing students with MH problems, and some of the factors which may influence whether or not they disclose, are summarised.

2.2.1 Student with mental health problems

One in four adults experience MH difficulties at some point in their lives (ECU, 2014a). A number of significant reports have recently been published with a focus on the mental wellbeing of students: Duggan, C. and Byrne, M. (2014); Royal College of Psychiatrists (RCP, 2011); World Health Organisation, (WHO, 2013); Equality Challenge Unit (ECU, 2014a); Mental Wellbeing in Higher Education Working Group (UUK, 2015). These draw on recent studies, to summarise what is known about prevalence. The academic literature includes studies on the mental wellbeing of particular groups of students, for example, international students (Lloyd, M. et al, 2011; Soorenian, A. 2013) and postgraduate students (Wisker, G. 2011). It also includes studies which look at the mental health correlates of socio-economic status (Ibrahim, A.K. et al, 2013).

There are studies and reports with a disciplinary focus, some prompted by concerns that levels of mental ill-health are raised in particular professions and related fields of study. The General Medical Council has produced a useful good practice guide to supporting medical student with mental health problems (Grant, A. et al, 2013; and RCP, 2011). Other examples include: health and social care professions, such as nursing (Nolan, P. and Smojkis, M. 2003), social work (Collins, S. et al, 2010) and psychology (Craig, N. 2010); law students (Field, R. and Duffy, J. 2012); trainee teachers (Huyton, J. and Sanders, L. 2011); students of veterinary medicine (Cardwell, J. M. et al, 2013) and students of the performing arts (CDD, 2014). For further discussion of discipline issues and guidance generated by relevant professional bodies see Houghton, A. and Anderson, J. (forthcoming).

Literature of this type encompasses both small case studies and larger scale surveys, and complements the statistical information in chapter 2. In drawing conclusions it is important to take account of the particular context of the study, including the definitions used to describe students' mental health conditions. It may relate to a distinct '*problem*' issue, an institution and a particular student population over a specific time period – for example, a study of deliberate self-harm amongst Oxford university students in the period 1993-2005 (Mahadevan, S. et al, 2010).

2.2.2 Multiple identities

It is through research – and, in particular, research that adopts a narrative approach (Grant, A. et al, 2013) – that it is possible to make sense of students' multiple and changing identities and bring an intersectional lens to bear upon their experiences. The literature exploring equality issues highlights the importance of recognising students' multiple identities (Morgan, H. and Houghton, A. 2011) and how prejudices – such as racism, sexism, classism and homophobia – can compound one another (Burke, P. 2012). In a mental health context, it is important to bear in mind that discriminatory and stigmatising attitudes impact not only on people experiencing distress, but may also have been a cause of that distress in the first place (Tew, J. 2005). What is clear is that any mental health policy, or set of guidelines relating to students with intensive support needs, has to link closely with other policies within a higher education setting, in order that a holistic response can be provided (RCP, 2011; WHO, 2013). That is also essential, given that some students who present with mental health problems may not qualify for specialist support, either due to the way in which *disability* is defined, or for other reasons that are discussed below. Such students nonetheless have a significant impact on institutions and increase the pressures they are under.

2.2.3 Issues around disclosure

A student experiencing distress, or perceived by others to be mentally unwell, is faced with multiple decisions. The first relates to whether or not they identify as having a MH problem in the first place; the second to whether they see themselves as disabled and choose to disclose (Spandler, H. et al, 2015). Some students, considered by others to be mentally unwell, may understand their issues in other terms. They may, for example, see what are commonly labelled symptoms – such as hearing voices, or self-harming behaviour – as a coping mechanism (Romme, M. and Escher, S. 2013; Cresswell, M. 2005, McAllister, M. 2003). Even if a student does consider themselves to have a mental health problem, they may choose not to identify as such, out of a fear of stigma and pathologisation (Student Minds, 2014; Martin, J. 2014). Such fears can be intensified for students on professional programmes, where questions of fitness to practice come in to play (Shrewsbury, D. 2015; Stanley, N. et al, 2007).

Secondly, even if a student considers themselves to have a MH problem and is willing to be open about that, they may simply not identify as '*disabled*'. While many disabled

people find the social model of disability empowering, people with MH problems may – due to its associations with physical impairment – 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’ (Spandler, H. and Anderson, J. 2015). The literature suggests that Deaf students who use British Sign Language, or students with dyslexia or those with chronic health conditions such as asthma or diabetes may not find the label and subsequent categorisation helpful either (Coare, P. et al, 2007; Riddell, S. and Weedon, E. 2014). Finally, as with mental health problems, the literature suggests that fear of stigma and discrimination may be a significant disincentive to identifying as disabled (Markoulakis, R. and Kirsh, B. 2013; Quinn, N. et al, 2009; Fuller, M. et al, 2004).

Linking back to the discussion about multiple identities, above, it is important to be aware that a student may identify in different ways in different contexts and for different purposes. For example, they may identify as disabled in order to access Disabled Students’ Allowance (DSA) or adjustments to examinations. They may discard the label in other contexts, especially as they move into the workplace, either because they see no benefits in it, or because they fear discrimination there (ECU, 2014b).

2.2.4 Institutional responses

ECU figures point to under-disclosure at an institutional level (ECU, 2014a; HM Government, 2011). The literature suggests a number of steps that institutions can take to address that. Firstly, awareness raising initiatives, such as the University Mental Health Advisers’ recent ‘*I chose to disclose*’ campaign (2015) and initiatives linked to the ‘*Time to Change*’ anti-stigma campaign, may be helpful in allaying fears. Despite widespread support there have been critiques of the fundamental assumptions underpinning stigma busting campaigns (Cooke, A. and Harper, D. 2013). Secondly, the likelihood of a disclosure is increased when students are clear about who will have access to the information and know about the likely consequences (ECU, 2014a). Thirdly, students’ fears about disclosure may be allayed by opportunities to talk to other students (Rosenthal, J. M. and Okie, S. 2005), either informally or in the context of a peer mentoring scheme. In a survey of 1,442 students, 75 per cent had disclosed a MH problem to a friend (ECU, 2014a p4). Fourthly, the visibility of disabled staff and participation of alumni with stories of positive experiences may help to normalise disclosure. For students of health and social care, the active involvement of patients, service users and carers in teaching may provide additional helpful role models (Basset, T. et al, 2006). Research in Scotland’s FECs (ECU, 2013) recommended a similar series of practical strategies to encourage and support disclosure, including: raising awareness and understanding of MH problems; taking action to create a culture of acceptance; publicising support and relevant policies; and providing multiple opportunities throughout the student lifecycle.

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'* (p11).

2.3 Rights and responsibilities: questions of responsiveness

2.3.1 National policy and networks

The Disability Discrimination Act (1995) provided a definition of disability, and outlined the rights of disabled people and institutional responsibilities, including the provision of *'reasonable adjustments'*. Since then, UK legislation has outlined further responsibilities relating to education (Special Educational Needs and Disability Act (SENDA), 2001), has brought disability together with other equality agendas via the Equality Act (2010) and has introduced additional requirements for a proactive response, under the Public Sector Equality Duty.

Recent reports, summarised below, address this legislative context and provide a choice of routes into recent and current debates around student mental health. Underpinning recent legislation the following reports offer explicit support for the social model of disability, and signal some of the debates associated with different disability models and how these influence both policy and practice. The following articles and reports offer more detailed discussion and consideration of these debates: Martin, N. (2012) summarises the different models; Duggan, C. and Byrne, M. (2014) provide an international comparison of attitudes towards disability models; Oliver, M. (2013) reviews the changes in attitude towards the social model; Beckett, A. E. and Campbell, T. (2015) show examples of how the social model is an oppositional device; and Beresford, P. et al. (2010) offer examples of how models are informed by the experience of people using mental health services.

- **Student Mental Wellbeing in Higher Education (UUK, 2015)** – provides a comprehensive overview of the international and national UK legislative and policy context within which mental health services to students are provided. It also provides an overview of developments within a higher education context, recent sector-wide surveys and has clickable links to relevant organisations and initiatives.
- **Understanding adjustments: supporting staff and students who are experiencing mental health difficulties (ECU, 2014a)** reports on staff and student surveys on the

current experiences of disclosing a MH problem within higher education. The report draws on practical examples from across the sector and offers recommendations including recognition of the resources required for encouraging disclosure and creating an inclusive learning and working environment.

- **Grand Challenges (Student Minds, 2014)** – draws on a two-stage project in which both students and staff were invited to identify key challenges in student mental health and then to rank, in order of priority, all those that had been suggested. The report identifies Ten Grand Challenges for student mental health and, drawing on direct quotes from respondents, explains why these are important.
- **The Mental Health of Students in Higher Education (Royal College of Psychiatrists, 2011)** – updates a previous Royal College of Psychiatrists document (2003), taking into account a changing context. It includes recommendations for psychiatrists and NHS services, higher education institutions and all sectors and has a number of appendices with examples that can be drawn upon. It provides an overview of the legislation and policy.

There are multiple organisations involved in developing policy and practice relating to student mental health and disability. These have diverse origins and areas of focus. For example:

- The UK National Healthy Universities Network, which has a broad membership of universities and interested individuals, has a broad focus on health and wellbeing, encompassing both physical and mental health.
- The Universities UK Mental Wellbeing in Higher Education committee aims to promote collaboration between the different sectors, agencies and professional groups with responsibility for mental wellbeing in HE and to influence policy.
- Diverse networks are concerned with the professional development of groups of staff. Some - like the University Mental Health Adviser's Network (UMHAN) and the British Association of Counsellors and Psychotherapy, Universities and Colleges division (BACP- UC) - are mental health specific. Others take a broader focus: the National Association of Disability Practitioners (NADP) and the Student Health Association (SHA).
- There are a number of student focused networks, including those led by students: NUS Scotland's Think Positive Campaign, Student Minds, Students Against Depression and the Student Nightline association that has, for many years, provided student-led support.

A number of these student-led initiatives have recently come together, with other organisations concerned with the mental health of young people, under the auspices of the Alliance for Student-Led Wellbeing. It remains the case, however, that there is

currently no single organisation resourced sufficiently to coordinate activity and interest groups related to student mental health across the UK higher education sector.

2.3.2 Institutional policy, practice and partnerships

It is clear, from recent reports and the burgeoning literature, that student mental health is an issue being accorded importance within UK universities. Universities UK conducted surveys of UK higher education institutions in 2003 and 2008 (Grant, A. nd). Of the 58 institutions that responded in both years, the proportion with mental health policies in place increased from 28 per cent to 52 per cent and the proportion with specialist student mental health posts increased from 53 per cent to 81 per cent. Whilst 68 per cent of those are located in disability or counselling services, 20 per cent are located within general student services provision (ibid). There is some evidence that the location of mental health services within disability services is off-putting for some students with mental health problems (Quinn, N. et al, 2009), pointing to the need for careful and thought through whole institution responses.

There is guidance available to university managers tasked with developing such policy in the area of student mental health. Of the reports referenced above in Section 2.3.1, the Universities UK good practice guide (2015) is key. It builds on earlier work (Grant, A. 2005; Crouch, R. and Scarffe, P. nd) to outline what institutions might include in a comprehensive student mental health framework, along with detailed information relating to duty of care and the legal context. The UK Healthy Universities Network has developed an online toolkit, to promote an holistic approach, encompassing wellbeing in all its aspects (Health Universities (no date); see also Holt, M. et al, 2015). It includes a section on Developing a Holistic and Joined-Up Approach to Mental Wellbeing, which addresses both staff and student mental wellbeing, highlighting the links between them. An earlier HEFCE-funded project resulted in publication of an online Student Mental Health Manual, which has a section on '*developing a student mental health policy*' (Ferguson, 2002). There are also accounts available of how particular universities have developed whole system approaches (Marshall, L. and Morris, C. 2011).

One area where good communication across the institution is essential is in the assessment of risk. This is a question of culture, as well as one of following procedures. In a study of 16 higher education institutions, conducted under the auspices of AMOSHE, Barden, N. (2014) found that, in some places, although no-one was in overall '*charge*', there was a general sense of hierarchy and '*a sufficient level of risk would trigger an upward discussion*'.

One of the ways to encourage different parts of the higher education system to work together on wellbeing is through redefining what is meant by some other overarching goals, quality enhancement for example. The New Economics Foundation has proposed a '*wellbeing led approach to quality in higher education*' (Steuer, N. and Marks, N.

2008). Although less developed in a UK context, the notion of curriculum infusion also has the potential to engage staff with responsibility for broader issues – in that case curriculum development – in student mental health-related issues (Olson, T.A. and Riley, J. B. 2009). Student engagement is another area that would seem to have close links with our concerns in this report. 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 (Trowler, V. and Trowler, P. 2010).

There are good reasons for developing close working relationships between student services and academic departments, not least that learning and wellbeing are so closely linked (Wallace, P. 2013; Topham, P. and Moller, N. 2011). A recent study (McKenzie, K. et al, 2015) found that, of the students attending one university counselling service, 92 per cent identified themselves as having problems with their academic work. Of those students, interviewed on conclusion of counselling, 67 per cent considered that it had been important in enabling them to address those issues.

If there is a rationale for different parts of an individual higher education institution to work together, so too is there a need for well-developed external partnerships. The recent report by Universities UK makes the point that *'university wellbeing services, however excellent, cannot replace the specialised care that the NHS provides for students with mental illnesses'* (UUK, 2015, p3), pointing out that universities are academic, not therapeutic institutions. The report contains a helpful section on working with the NHS and a useful overview of the external specialist services with whom universities and other providers of higher education may need to liaise.

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. They concluded that, as student counselling services are *'providing considerable relief from a potential additional burden on primary health care'* (p55), thought needs to be given to how primary care-based psychological therapies can be provided within higher education institutions (See also Ashworth, S. 2009).

There is frequent mention, in recent articles, of funding cuts to statutory and third sector mental health services (Knapp, M. 2013; Price, C. 2014), and the potential impact of financial constraints on universities. Student Mental Health Advisers identified inadequate NHS mental health services, and slow referral pathways, as the top two Grand Challenges in student mental health (Student Minds, 2014).

An appendix to the most recent Royal College of Psychiatrists (RCP) report on student mental health (RCP, 2011) offers general guidance with a range of specific examples of collaboration between the NHS and higher education institutions. The RCP publication also includes a checklist, aimed at General Practitioners, outlining practical suggestions

for supporting a 'psychiatric patient' planning on moving to another part of the country for their higher education studies.

One of the recommendations of the Breaking the Silence Report (NUS Scotland, 2011) was that universities should embed themselves more proactively within community networks of mental health support services, with a view to mutual learning and the sharing of resources. It was also suggested that higher education institutions consider the creation of '*arms-length*' community-based mental health support for students.

The next section moves from considering the ways in which institutions respond to student mental health concerns in general, to the specific points in the student journey when a response may be needed.

2.4 The student journey

Transition is an ongoing process, relating to all stages of the student journey and to diverse aspects of the higher education experience. For Tomaskevski, K. (2001), transition concerns students' rights: to, in and through education. Experiences of transition are influenced by policies and practices relating to admissions, induction, and progression through the programme, as well as into employment or further study. Originally developed to encourage strategies for widening participation in higher education, the student life cycle framework (HEFCE, 2001) aims to prompt discussion around the student journey, and the services provided by staff concerned with particular stages of it. It might be used, for example: to facilitate discussion between outreach staff and the disability service (Wray, M. and Houghton, A. 2007); to guide decisions about targeted or integrated activities for disabled students during induction (Action on Access, 2009); or to prompt exploration of the role of, and potential for collaboration between, disability and mental health and university careers services, regarding future careers and ongoing education (ECU, 2014b).

2.4.1 Transition into higher education

There are a range of stressors associated with the move to higher education. Younger students in particular may be coping with living away from home and having to look after themselves for the first time, with fears about what lies ahead, and with the loss of both emotional and practical support from friends and family. There is some evidence that older students, more likely to remain in their own homes, have better developed coping skills (McLafferty et al, 2012). However, for them, there may be other kinds of pressure. They may find themselves more isolated within the institutional environment (RCP, 2011); unable to take advantage of social networking opportunities, or have childcare or parental care and other responsibilities. Financial pressures may be greater than for younger students and increase the likelihood that they will be juggling study with a part-time job. Even where they are in a position to engage socially, they may feel that the types of opportunity on offer are not geared up to them (NUS Scotland, 2010)

and, like one respondent in Russell's study, feel 'detached from the social circle of university life' (Russell, 2008, p117). There is evidence from the Russell study that mature students may also find it harder, because of limited time, to explore and to locate sources of support. All of the above issues are likely to be exacerbated for mature students with moderate to severe mental health problems.

The '*What works?*' report – funded and supported by the Paul Hamlyn Foundation, HEFCE, the HEA and Action on Access – explored the first year transition with respect to retention and identified a sense of belonging as important for all students (Thomas, L. 2012). This project added to an existing body of UK and international literature on the first year experience, for example, the UK First Year Experience (Gibson, S. 2012; Yorke, M. and Longden, B. 2008), in the US Tinto, V.(2006) and in Australia (Krause, K. and Armitage, L. 2013).

For students with MH problems and students with intensive support needs, disruption to personal and professional support networks, such as occurs for those who move away from home, may impact particularly adversely on wellbeing and a sense of belonging. The loss of a positive relationship with a family GP, or a primary or secondary mental health practitioner, can for example be significant (RCP, 2011). The Royal College of Psychiatrists report provides a comprehensive list of considerations for '*home*' practitioners, striving to support a student with mental health problems who is going away to university (RCP, 2011 p58-9).

This report also identifies international students as a group faced with specific challenges, and provides a range of useful examples to illustrate the implications for induction, as well as other stages of the student journey. In addition to the challenges of a mental health problem, international students may be faced with concerns about immigration, funding and expectations from home (Lloyd, M. et al, 2011). Moreover, they may be faced with alien cultural understandings about mental health, accompanied by unfamiliar service responses. Attitudes towards medication and the role of counselling differ considerably from one country to another. Types of medication available, and the levels prescribed, may also vary. The RCP report suggests that there are four student responses to studying abroad:

- assimilation, where the student tries to fit in with the majority culture;
- integration, involving adoption of some of the culture but retaining some of their own;
- a traditional approach, where the student retains their own culture and rejects the majority culture;
- marginalisation, where the student experiences isolation resulting from their rejection of both their own and the majority culture (RCP, 2011 p62).

Drawing on evidence from the charity 'Young Minds' (2006) it appears that international students with MH problems who integrate or adopt a traditional approach do better than students who try to assimilate and those who experience marginalisation. The aforementioned need to provide all students with a sense of belonging (Thomas, L. 2012), has implications for the induction of international students, pointing to the need to provide academic and support staff with an opportunity to explore the issues. A University of Nottingham report (2011) includes some useful scenarios and questions for discussion.

Much of the disability research considers disabled students as an undifferentiated category; however, students with autism are noted for having intensive support needs especially at times of change and transition (Cooper, A. 2013). Based on multiple detailed interviews with eight students with Asperger syndrome, Madriaga, M. et al (2008) offer a detailed insight into their experiences and offer practical advice for how to enable transition for this group of students. There have been two recent developments for this group, Firstly, the Department for Education (DfE) has funded the Autism Education Trust (2013-15) to provide training to enable staff in schools, colleges and higher education to ease the transition from school into further and higher education. Secondly, as part of their Access Agreement, (a statement required by the Office for Fair Access, if institutions charge £9,000 fees), some universities have developed pre-degree activities such as summer schools, to ease transition for students with autism, something recommended in the HM Government (2014) update report, '*Think Autism*'.

2.4.2 Transition through higher education

There are suggestions in the literature that the transition to second year can be a particularly difficult time for students (Macaskill, A. 2013) and an unrecognised stress point, compared with the transition to first year, when university support initiatives are more likely to be in place. At the beginning of the second year, students may be moving out of halls of residence (generally prioritised for first years) and into shared living arrangements, which may bring additional challenges for some students with mental health and intensive support needs. Academic pressures can mount too, at this stage, where marks begin to count towards a student's final degree.

As students move through higher education there is evidence that assessment and examinations are associated with stress (El Ansari, W. et al, 2011 and Scarffe, P. 2007). Some institutions address these concerns by providing revision and stress workshops and through other approaches such as mindfulness sessions. These may be embedded within the curriculum or delivered in separate sessions, outside a formal programme of study (Conley, C.S. et al., 2013).

Periods of work-based learning can also be particularly challenging for students with moderate to severe mental health needs. The Geography Discipline Network, as part of

HEFCE's *Improving Provision for Disabled Students Funding Programme*, generated a series of practical guides for students with different 'impairments', including students with mental health problems. The guides looked at particular issues for students on fieldwork placements who are away from their usual support structures, faced with unfamiliar (social and/or physical) challenges which may involve living communally and/or working in groups (Birnie, J. and Grant, A. 2001). Due to their age and perceived experience, mature students on work placements linked to professional programmes can experience increased pressure resulting from being given roles and responsibilities beyond their current stage of learning, (Keogh et al, 2009).

2.4.3 Transition out of higher education

Less explored in the literature, the transition out to employment or further study is possibly as important as the transition into higher education. This final phase is associated with equal uncertainties: for example, a return home for international students, and, for the majority of students, worries about future employment within a challenging job market (NUS Scotland, 2010) which may be intensified for older students, who may have less flexibility about where they can work due to family responsibilities. Worries about employment can, in turn, raise the stakes around exams and course assessment which, as noted earlier, are a particular cause of stress.

A recent ECU report '*Supporting disabled students' transitions from higher education into employment: what works?*' (ECU, 2014b) draws on 2012/13 Destination of Leavers from Higher Education (DLHE) data and a survey of 1,574 disabled students/graduates and 100 non-disabled students/graduates. The ECU report shows how full time employment rates are lower for disabled than for non-disabled students and confirms variation between different groups of people. The graduates most likely to be unemployed are those who typically have intensive support needs. For instance, the unemployment rate for students with social communication/autistic spectrum disorders (22 per cent) compares unfavourably with that for non-disabled graduates (6 per cent) (ECU, 2014b, p.3). The ECU report explores the experiences of specific groups of disabled students, as they moved out of HE, and draws out the implications in terms of institutional provision including the careers service.

There is, moreover, ample evidence from the literature of particular employment related issues for students with mental health problems who graduate from professional degrees, relating to fitness for practice issues (Chew-Graham, C. et al., 2003; Stanley, N. et al., 2010).

The review has considered the ways in which institutional policy influences student support services within a higher education context, and how these need to take account of different phases of the student journey. Key for students at all stages is the departmental context, and the learning and teaching that goes on there.

2.4.4 Teaching and learning

There may well be students with mental health problems and/or intensive support needs in any given teaching and learning situation. In thinking about how such needs are responded to, there is much to draw from recent thinking about inclusive teaching and learning that responds to the requirements of all students, and can do much to reduce the need for reasonable adjustments for those with specific needs (Hocking, C. 2010). Socially supportive and inclusive teaching environments are important for the success and wellbeing of all students and, in his book on 'Improving mental health through social support', Leach, J. (2014) provides some pointers to how these can be created: firstly, providing appropriate support to students, which may be dependent on enabling other students to be supportive and on gaining appropriate support oneself; secondly, 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; thirdly, eliciting sufficient information from students to ensure that their needs can be met whilst not breaching confidentiality; and fourthly, creating a safe environment which is important for all students. This could relate to managing challenging behaviour but also to setting and keeping appropriate boundaries to ensure learning is not disrupted.

In a Canadian context, the '*Well-being in Learning Environments*' project at Simon Fraser University (SFU, no date) has collated resources for creating a positive classroom environment, including simple ideas about how an educator can establish a supportive tone, by sharing some of their own educational ups and downs; along with encouragement for students to discuss what they find challenging, what they can contribute and what support they feel they need.

The UK Higher Education Academy has championed this inclusivity agenda, producing a number of toolkits to enable institutions to assess inclusivity (May, H. and Bridger, K. 2010). It has produced general guidance about inclusive curriculum design, complemented by a series of discipline-based resources (Morgan, H. and Houghton, A. 2011). To help embed inclusive practices and encourage collaboration between different sections of universities, the HEA has worked with 16 higher education institutions on a change programme, intended to provide examples for other institutions seeking to engage with the inclusivity agenda (Wray, M. 2013). Several disciplines have also produced guides to encourage inclusive practices for students with a range of impairments including mental health; many of these suggestions are transferable to other disciplines. For example, Craig, N. and Zinckiewicz, L. (2010) *Psychology Handbook*, and Geography and a recent series of discipline specific guides discussing strategies for equality and diversity published by the HEA (2015) that look at Art and Design, Classics, Education, Physical Sciences and Social Work.

Inclusive practice is one key starting point (Gavira, R. L. and Moriña, A. 2015). Another is to consider the specific needs of students with mental health problems. As Birnie and

Grant state, '*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 (Birnie, J. and Grant, A. 2001, p2).

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. The recent Equality Challenge Unit report is one attempt to address that (ECU, 2015a) and provides examples from a range of UK higher education institutions. The Scottish Association for Mental Health has also produced a useful brief guide – making reasonable adjustments for students with mental health problems – which considers issues linked to class hours or structures, physical environment and working practices (SAMH, 2012), which suggests an holistic approach similar to that used by Schreuer, N. and Sachs, D. (2014) in their research regarding the physical, human and academic accommodation services (PHAAS).

One additional resource is the Higher Education Support Toolkit, produced by Boston University's Center for Psychiatric Rehabilitation (Legere, L. et al, 2009). It uses the US term, '*accommodation*' which means the same as '*reasonable adjustment*' in the UK. It includes a student self-assessment checklist and a list of accommodations and strategies that can be adopted in the classroom, by both students and by institutions.

A final area for consideration is the way in which teaching about mental health can support the mental health of students. Interestingly, Laidlaw, A. et al (2015) report no overall difference between students with MH problems studying mental health as part of their degree and those who were not in terms of how they understood their MH problems. However, there are opportunities for students learning about mental health to support their own wellbeing.

Whilst this might be assumed to take place primarily in health and social care disciplines, the '*curriculum infusion*' approach (Olson, T. A. and Riley, J. B. 2009) would argue that it can be built in to teaching in other areas. What is specific to education for health and social care is the direct involvement of people with lived experience of mental health problems, in developing student understanding. In 2014-15 the Health Care Professional Council (HCPC) made it a statutory requirement to involve service users and carers in programmes of study (HCPC, 2014) and other regulatory bodies require it too. Although motivated by a need to develop students' understanding and skills, the impact on their own wellbeing should not be underestimated. At the University of Brighton, for example, students were both encouraged to focus on their own self-care and introduced to a model for understanding and dealing with the emotional distress of others through the input of people with experience of using health and social care services (Jeeawock, M. and Morris, C. 2011).

More radically, Krznaric, R. (2007) goes so far as to suggest that all students should complete a foundation year in human awareness which would include one strand on the art of living, covering *'what really matters to individuals in their lives and futures, their emotional needs and personal well-being. The core topics are precisely those that are not traditional subjects of study but have been of concern to human beings throughout history and across cultures. These topics include: love, ambition, suffering and loneliness, time, freedom, purpose, creativity, fear, death, work, being good, variety and simplicity, and sensation'* (2007, p2). Although such an approach would be resisted by many, it does link to concerns about graduate skills and employability and might do something to challenge what has been perceived by some as an overly therapeutic culture within UK higher education institutions. Such an approach points, too, to the need to situate discussion of student mental health in relation to their broader experience whilst at university.

2.4.5 Wider aspects of the students' experience

The experience of a student with mental health problems or intensive support needs is determined not only by the support services on offer and the context within which their learning takes place – discussed in this chapter to date. A whole range of other individuals and broader institutional initiatives can impact on a student's wellbeing and ability to cope: from porters, through library and catering staff to residential wardens and administrators; from parents, through friends to casual acquaintances (ECU, 2014a).

Before moving onto the institutional responses, a word about the influence of parents and family networks. Although there is some evidence outlining the negative impact of *'helicopter parents'* on the psychological well-being of young students (LeMoyné, T. and Buchanan, T. 2011; Schiffrin, H. H. et al, 2014) and concern expressed about parent attempts to interfere in support arrangements when some students move to university, family members can also be invaluable in the provision of support. Social media makes long-distance support – via email and Facebook for example – more feasible, and there are of course many students who still live at home. In a recent research project funded by the Leverhulme Trust (Lewis, J. et al, 2014), thirty pairs of students and parents were interviewed. The study concluded that in addition to wider social and political changes there have been rapid and diverse changes in how family members communicated. Of note in thinking about where students get support from, Lewis et al found that the majority of students in their study were dependent on their parents financially and also tended to see them as a significant source of emotional support (via email, phone and Skype).

Family relationships are, of course, a key source of support for mature students too, who are more likely than younger students to be in established relationships, and to continue to live at home. The process of learning itself can cause students to radically reassess their lives and understandings (Green Lister, P. 2003), however, in some instances this may lead to the breakdown of established sources of support. Moreover,

there are a significant number of students – particularly women – who are lone parents. They may be particularly at risk of mental health problems (Cooper, C. et al, 2008), which can be exacerbated by financial and other pressures associated with studying at university. It is not hard to see how international students – whether younger or mature – may be particularly impacted by the disruption to family relationships, and consequent loss of support, associated with study at a UK higher education institution.

2.4.6 Adopting a holistic response

A recent UUK report suggests that there is a need to *'help students to capitalise on the positive mental health benefits of higher education while identifying and providing appropriate support to those who are more vulnerable to its pressures'* (2014, p. 9). Most institutions recognise this need which may explain the increased interest in developing activities to respond to what Stanford University described as a *'silent epidemic'* (Stanford University, 2008, p.7). The US report refers to research since 2000 which demonstrates increased emotional difficulties, risky behaviour and suicide attempts, where students struggle to cope with life as a student (see Stanford University, 2008, p. 7). They propose a holistic and longitudinal response that is also recommended by the Healthy Universities Framework which asserts that a Healthy University is one that:

'Aspires to create a learning environment and organisational culture that enhances the health, well-being and sustainability of its community and enables people to achieve their full potential' (Healthy Universities, 2010).

An online self-review process allows institutions to consider: leadership and governance; service provision; facilities and the environment; communication, information and marketing; and academic, personal, social and professional development. To support institutions to develop and promote health and wellbeing, the Framework includes a series of guidance packages, of particular relevance to students with MH problems, including *'Developing a holistic approach to mental wellbeing'* and *'Enhancing the student experience and performance'*.

Research by Holt, M. et al, (2015) explores 423 students' experiences from eleven universities participating in the UK Healthy Universities Network that include practical suggestions from students. Although it is not explicitly focused on the views of students with MH problems, this research and the Healthy Universities Framework provide ideas for a more holistic and inclusive approach.

Social support is crucial for the wellbeing of all students, including students experiencing mental health difficulties (Leach, J. 2014, RCP, 2011). Leach provides a useful list of *'what social supporters can do in educational settings'*, based on the five key elements of social support: friendship; emotional support; constructing meaning; offering advice; and giving practical assistance. As he points out, some of these elements may be more appropriate to one role than another. Teaching staff, whilst they

can't be friends, can be friendly, offer emotional and practical support as well as assistance in constructing meaning around certain issues. Specialist supporters, such as counsellors and mental health staff, are well placed to offer emotional support and help in constructing meaning.

There is limited research into the support provided by non-teaching staff (Leach, J. 2014); though college wardens are clearly significant, and non-teaching staff can help identify students at risk of suicide (Stanley, N. and Manthorpe, J. 2002). Leach cites a librarian who explains that students approach her as if she were '*an aunt or neighbour, I am sure that students prefer that ordinariness*' (2014, p112). As libraries and other aspects of university life become more mechanised, such encounters may become increasingly rare. Case studies in this report confirm the importance of these wider services and contributions, including those made by Chaplaincy staff and students' unions.

There is considerable evidence from the literature of the part that students play in supporting one another (ECU, 2014a; Turner, A. P. et al, 2007) – reflected in the recent '*Look after your mate*' campaign by Student Minds. The opinions of friends may be sought, both on mental health problems per se, and on appropriate courses of action (Laidlaw, A. et al, 2015). There can be challenges in ensuring that such initiatives are appropriate to the needs of students of all ages and not just the majority age of that institution. Moreover, as Leach, J. (2014) points out, friendships are sustained by reciprocity, so where mental health difficulties place limits on people's ability to offer something in return, that can result in isolation. This points to the need for more formal mentoring and peer support initiatives.

Peer support, Leach suggests, can encompass all five elements of the social support referred to above. Students in higher education institutions often find their networks of support have been disrupted through the move to university. Even for those students who stay living in the family home, disrupted relationships may be a factor, as friends from school move away to distant universities (Leach, J. 2014) or in the case of mature students the time available for maintaining friendships and relationships is reduced. Regardless of age some students find studying in higher education can also create social distance, where friends and family have not themselves been to university. Loss of social support can of course be intensified for international students. In the summer of 2010, Equally Connected facilitated a group of international students at Heriot Watt University in Edinburgh to make a short film about the challenges of leaving home, to live and study in a new country, and the strategies they employed to ensure their wellbeing. The film can be viewed online (see the list of useful resources in Appendix 1).

Peer support initiatives are one example of formalised student-led support. Students' Unions, and their activities, are another. The majority of students' unions are actively concerned with mental health promotion, in some cases supported by the work of a sabbatical officer. Groups such as Nightline, that have existed for many years, have

been joined by other student-led initiatives, sometimes affiliated to national networks such as Student Minds. Their work on identifying *Ten Grand Challenges* in student mental health has been taken up by individual students' unions, which also build activities around initiatives such as World Mental Health Day and University Mental Health Day.

There are some challenges for students' unions seeking to engage with students with mental health problems, however, including: communication; a lack of connection; and continuity (Pinkney, E. 2011). Pinkney suggests that a desire for independence and the annual rotation of student leaders can result in passionate Students' Union officers lacking the name or contact details of their university's mental health adviser and possibly vice versa. He argues that a concerted effort is required to go beyond partisanship in order to maximise potential for collaboration and avoid inefficiency and wasted effort for all concerned.

There is growing evidence of the positive impact of physical activity on mental health, and recent research has extended that to student populations (Tyson, P. et al, 2010; Hawker, C. L. 2012). A recent partnership – between Student Minds, British Universities and Colleges Sport and Sport in Mind – is working with student sports societies to raise awareness about mental health. The project will involve the development of a guidance and policy pack for the HE sports sector and a mental health training programme tailored to staff who work in university sport. It is planned that, having developed their own understanding and skills, staff will then cascade those down to university clubs and sports teams. For students not actively engaged in sport, and perhaps for women in particular, initiatives such as the Student Minds '*Love your Body*' campaign may be helpful in developing confidence and in combating the impact of stigma. Other approaches to the development of social support, such as participatory arts (Margrove, K. L. 2015) are discussed in the literature.

This all returns to the issue of a whole university approach to student mental health. Whilst the majority of the literature drawn on here pertains to the UK, useful frameworks have been developed elsewhere. For example, Washburn, C. et al (2013) identify seven key components of a systemic approach, which are: institutional structures, policies and practices; a supportive, inclusive climate and community; mental health awareness; a community capacity to respond to early indications of concern; self-management competencies and coping skills on the part of students; accessible mental health services; and a capacity to respond to crises. The framework for post-secondary student mental health relates these, respectively to: all students; students with concerns about coping; and students with mental health concerns.

2.5 Critiques, challenges and ways forward

This final section of the review moves on from considering policy and practice as it currently plays out within an institutional context, to present some critiques and challenges of accepted ways of framing student mental health, and then points to some ways forward.

Reports on student mental health over recent years have built incrementally on previous work; sometimes very explicitly, as in the case of the 2011 update to the Royal College of Psychiatrists earlier guidance on student mental health (2003). This encourages continuity in the discussion, signals continued interest in the issues, and a recognition that the context is still changing. There is now a broad understanding of key issues surrounding prevalence, impact on individuals, implications for institutions and responses in a UK context. There is a striking degree of consensus over potential ways forward, as evidenced in the earlier sections of this chapter and reflected in the data that was collected from case study institutions. Much of the guidance produced to date is invaluable; particularly that which stresses holistic, whole institutional approaches (UUK, 2015).

Though much of what has been written has been framed, broadly, in the social model of disability, there are surprisingly few references to recent academic writing and thinking in the field of disability studies. One reason for that may lie in the divide that has traditionally existed within universities between academics researching disability studies, on the one hand, and disability services delivering support to students on the other (Oslund, C. M. 2014). Although both disability studies and disability services are grounded in the social model of disability, they have developed separately. The work divide between academics and support staff reflects a divide that already existed within universities when the fields emerged (*ibid*).

The situation is even more complex when it comes to mental health, which has arguably been marginalised within disability studies and has no unifying field of study of its own. As new mental health groups coalesce - around notions of madness, trauma and distress - this is starting to change. In this penultimate section of the chapter, a few ideas are highlighted that, whilst they influence thinking in the broader fields of disability studies and mental health, have not yet been discussed in a higher education (student mental health) context.

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 (Tew, J. et al., 2012) and experience of trauma (Dillon et al, 2012). A new body of theory is developing under the umbrella of Mad Studies (LeFrançois, B. A. et al, 2013). This decentres the idea of a well practitioner who gives, and an ill service user who receives, emphasising that anyone can suffer distress; that

anyone can be either giver or receiver or, indeed, both at once. It repositions mental health as a social construct, not a purely individual concern. Current academic debates are therefore accompanied by the idea that there is no one fixed body of knowledge, instead there are a range of ways of understanding mental health problems, madness and distress. This raises practical implications for practitioners working in student services, as it emphasises the need to focus on meaning making, for example, the sense that a person makes for themselves of unusual experiences such as hearing voices (Romme, M. et al, 2009).

The language, of *'madness'* may be unfamiliar – alienating even – to some concerned with student mental health in the UK. It is, however, intended to provoke. Church believes that the term *'mad'*, makes you *'STOP...and say... "WHAT?" And in that interruption, that space of sudden confusion, we can invoke a strand of human experience and history that pre-dates and challenges psychiatric dominance. We can seize an opening into "something otherwise"'* (Church, K. 2015, p261). This *'something otherwise'* may be a space that would feel welcoming to students who conceptualise their experience as difference rather than as disability; indeed this is proving to be popular for some students in Canada (Reid, J. and Poole, J. 2013). Moreover, for students who are studying in health and social care, philosophy or sociology, it may align more closely – than more traditional models - with their academic learning (Church, K. 2012).

Linked to the above, and in contrast to the dominance of thinking around stigma in the student mental health literature, there is a growing body of thinking around sanism. Sanism is a term – analogous to sexism and racism – that is used to describe prejudice and discrimination against people perceived to be *'mentally ill'* (Perlin, M. 2000). It is argued that sanism offers an analytical lens to understand and examine how discrimination against people with mental illness is exacerbated by other forms of oppression relating to age, ethnicity, race, sex and social class (Morrow, M. and Weisser, J. 2013). According to Morrow and Weisser, sanism implies, *'the valuing of rational thinking and socially acceptable forms of behavior, and the subsequent ostracization and/or punishment of people who do not or cannot conform'* (ibid, p31). It is not hard to see how this concept might be of relevance in a context, such as a university, where rationality is arguably even more valorised than in some other settings (Price, M. 2013); and where the pressure to conform may increase in line with rising student numbers.

Finally, Ecclestone and colleagues (Ecclestone, K. 2007; Ecclestone, K. et al, 2005) have critiqued the dominant idea and call for universal support in the current education and HE system. They suggest that across the UK education system there is increasing use of labels associated with emotional vulnerability and an image of *'diminished selves'* that operates as a powerful cultural narrative and is propagated by the media. In Ecclestone's view, the increased numbers of students experiencing MH problems is partly explained by these new ways of framing the problems of life. She warns that educators, committed to social justice, need to consider whether privileging emotional needs may result in diminished educational aspirations. However, it is important to

note that Ecclestone does not suggest that taking account of students' needs is unimportant, nor does she deny that some students need therapeutic interventions. What she does suggest is that, *'if "emotional safe spaces" end up as "education" for those labelled as vulnerable, the erosion of universal educational goals rooted in high aspirations and optimism about human potential will create very insidious forms of inequality'* (2007, p467).

This section has highlighted some developing ideas that are little, if at all, reflected in mainstream reports and which currently sit a little to one side of much debate around student mental health. One possible reason for that is that there are linguistic gulfs to be bridged. There was a time when terms such as mental illness and disorder were predominant in discussions around student mental health. It required a shift to begin to think and talk in terms of mental health problems or conditions or difficulties. For some, terms such as madness and distress may seem a step too far; and terminology varies not only between individuals and fields of study and interest groups, but also between nations. Yet it is perhaps only through a determined effort to get beyond initial reactions to, and preconceptions about, language that institutions can begin to forge the necessary alliances to develop their thinking and practice in new ways.

That word, alliances, brings the discussion back to an issue raised earlier. This review of the literature has revealed a broad range of organisations and groups with an interest and involvement in the field of student mental health. As discussed, ideas are developed and then drawn upon in subsequent publications and reports but opportunities for dialogue between different networks and groups of stakeholders can be rare. That is, in part, a product of a number of poorly-resourced organisations already stretched to their capacity. As cuts impact on the mental health sector as a whole, new groupings and alliances are being formed, both within the health and social care sector (Psychologists against Austerity for example) and within the higher education sector (The Alliance for Student-Led Wellbeing). In recent years, considerable progress in raising awareness and enhancing support for students experiencing mental health problems has been achieved. Creating opportunities for dialogue – within and between disciplines, institutions and sectors, with students themselves and with broader mental health service user and survivor groups – is arguably key to ensuring that progress can, in challenging times, be maintained and built upon.

3 Data analysis

HEFCE researchers provided the project team with data on student numbers by disability for all HEIs and for nine FECs with at least 1,000 HE students on their rolls. These data are from the HESA student record and are based on students' own self-assessment of disability. As such the data only show the numbers of students who disclose a problem to their HEI, and the prevalence of mental health problems among HE students is likely to be higher than the figures presented here.

Across all institutions, the proportion of students who declared a mental health problem was 1.4 per cent in 2012/13, or 1.3 per cent if the Open University (OU) is excluded (Table 3.1). Students with Specific Learning Difficulties (SpLD) accounted for 5.7 per cent of all students, while those with multiple impairments accounted for 1.1 per cent, and those with other disabilities or impairments accounted for 3.6 per cent. Thus 88 per cent of students did not report a disability in 2012/13, and students with mental health problems accounted for around 12 per cent of all students who reported a disability.

Table 3.1: Students with declared mental health problems as a proportion of all students, 2012/13 (%)

	Mean	Min	Max	N=
Specialist HEIs including OU	2.14	0.0	4.6	39
Specialist HEIs excluding OU	1.90	0.0	4.6	38
HEIs with high average tariff scores	1.34	0.4	2.4	30
HEIs with medium average tariff scores	1.12	0.0	4.0	30
HEIs with low average tariff scores	1.19	0.6	2.1	30
FECs	1.61	0.9	3.1	9
Total including OU	1.38	0.0	4.6	138
Total excluding OU	1.27	0.0	4.6	137

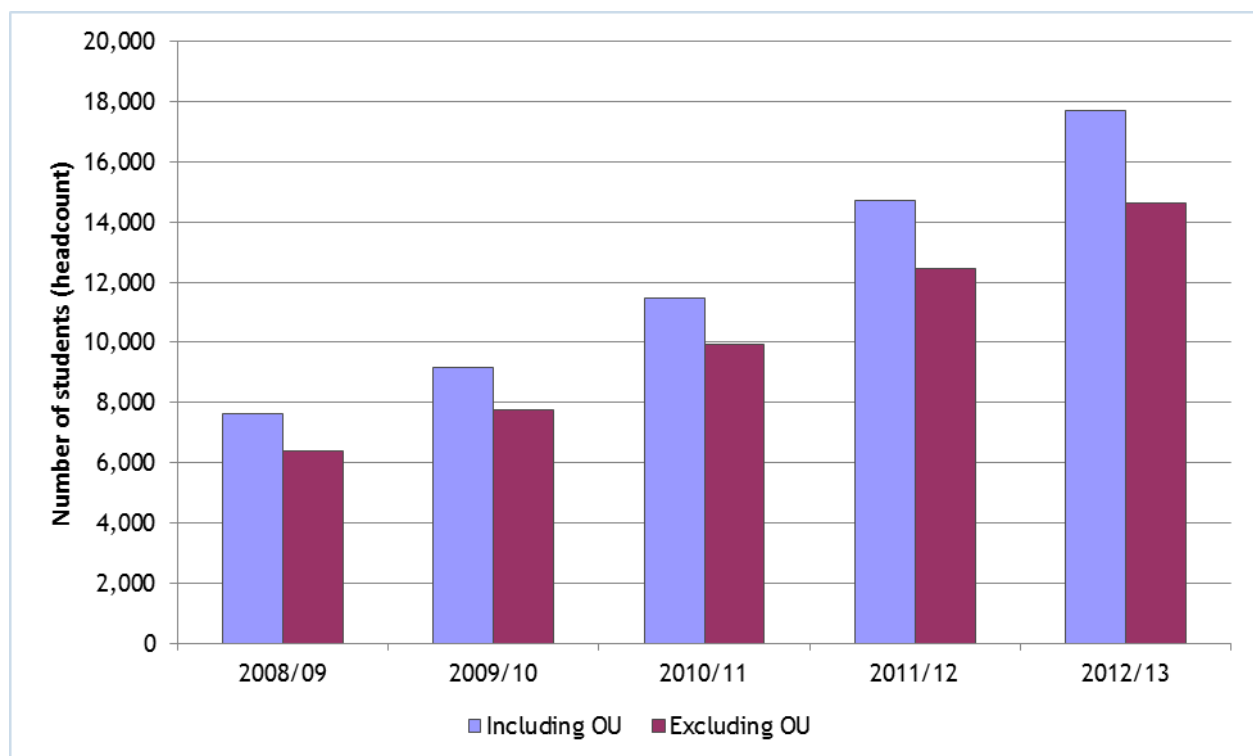
Source: HEFCE

There was some variation by type of institution, with the highest proportions on average found among specialist HEIs (2.1 per cent including the OU, 1.9 per cent excluding the OU), and the lowest found among general HEIs with medium or low average tariff scores (1.1 per cent and 1.2 per cent respectively). Some institutions had

no students who declared a mental health problem, while in one specialist HEI nearly five per cent of students had a declared mental health problem.

The number of HE students declaring a mental health problem has increased dramatically over the last few years, as shown in Figure 3.1. Across all institutions the number of students with a declared mental health problem increased from just under 8,000 in 2008/09 to nearly 18,000 in 2012/13, an increase of 132 per cent. If the OU is excluded, numbers increased from around 6,400 to 14,600, or 129 per cent.

Figure 3.1: Number of students with declared mental health problems



Source: HEFCE

Table 3.2 shows the change in numbers of students with declared mental health problems by type of institution, and shows that the largest increases on average were among FE colleges, at 168 per cent, followed by HEIs with high average tariff scores, at 157 per cent, while the smallest increases were among HEIs with low average tariff scores, at 104 per cent.

Table 3.2: Percentage change in numbers of students with declared mental health problems, 2008/09-2012/13

	Mean	Min	Max	N=
Specialist HEIs including OU	140.0	-50	700	39
Specialist HEIs excluding OU	123.4	-50	700	38
HEIs with high average tariff scores	157.1	-1	496	30
HEIs with medium average tariff scores	122.0	-100	392	30
HEIs with low average tariff scores	104.4	22	523	30
FECs	168.2	35	2,667	9
Total including OU	131.7	-100	2,667	138
Total excluding OU	128.5	-100	2,667	137

Source: HEFCE

Around one third of all students with a declared mental health problem are in receipt of Disabled Students' Allowance (DSA). Table 3.3 shows that the proportion across all institutions, including the OU, is 33 per cent, while if the OU is excluded the proportion is slightly higher, at 37 per cent. Across specialist HEIs and FE colleges there were some institutions in which no students with mental health problems received DSA, although in some specialist HEIs all students with a declared mental health problem received DSA. On average, HEIs with medium or low tariff scores had higher proportion of students with mental health problems in receipt of DSA than did HEIs with high average tariff scores.

Table 3.3: Proportion of students with declared mental health problem in receipt of DSA, 2012/13 (%)

	Mean	Min	Max	N=
Specialist HEIs including OU	23.8	0	100	38
Specialist HEIs excluding OU	38.5	0	100	37
HEIs with high average tariff scores	30.1	13	47	30
HEIs with medium average tariff scores	40.3	17	73	29
HEIs with low average tariff scores	39.6	24	58	30
FECs	42.6	0	77	9
Total including OU	33.1	0	100	136
Total excluding OU	36.5	0	100	135

Note: no data available for two institutions which had no students with a declared mental health problem

Source: HEFCE

4 Policies and strategies

4.1 Introduction

This chapter explores the policies and strategies adopted by institutions to meet the demand for supporting disabled students, specifically students with mental health problems, intensive support needs, or both. It provides further understanding of the strategic responses of HEIs and colleges to providing support for this sub-group of disabled students, and of the factors taken into account when making decisions about the nature and extent of support offered. It also looks at the context for policy-making around supporting disabled students, and students with mental health problems, in particular: how policy and strategy is developed and who has responsibility for, and who can contribute to, this process; the issues facing institutions and the coverage of policies; and the concerns institutions have about future decisions.

4.2 Institutional policy context

The 12 case study institutions chosen represented a range of sizes, subject portfolio (including several specialist institutions) and histories – as noted above in Chapter 1. All these aspects had a bearing on their approach to supporting disabled students. There were a number of pre-1992 institutions with a vision and overarching strategy based on generating world-class research and being a world leading university but they also had values around inclusiveness and providing effective and efficient services to students. There were also a number of post-1992 institutions with a tradition and, historically, a strong focus on widening participation, access and increasing diversity, although some were looking to build a more global brand. In addition there were specialist institutions which have recruited students on the basis of a specialist talent or interest, thus enhancing their national/international reputation which have tended to attract a higher proportion of students with mental health problems (see Chapter 3). However, all the case study institutions were dealing with a rise, in many cases a rapid one, in the numbers of students with mental health problems, some with severe mental health problems, and with more complex support needs.

4.2.1 Drivers

There appeared to be a number of key drivers underpinning the institutional focus on supporting disabled students: a moral responsibility, and a duty of care, for students; a legal responsibility to meet the duties of the Equality Act; and a business case to provide a satisfactory service to retain students and attract new students (and linked to perceptions of risk). These seemed to be present in all case studies, to varying degrees depending on their histories, mission and values.

Among many of the case studies visited there was strong sense of the duty of care and a legal and moral responsibility for disability equality underpinning their actions and approaches – that all students, who are able to study regardless of their backgrounds, circumstances or characteristics, should be able to access higher education and enjoy and complete their studies.

‘The university has a duty of care, and a legal and moral responsibility for disability equality and social justice. We need to ensure equity of opportunity and provision. We need to be aware of the impact of learning on emotional well-being and vice versa’.

‘[widening participation] is part of our ethos and remit. We have a clear view that we are here for the public good, and there’s an awful lot of what we do that we will put within the public good banner’.

This was often expressed in terms of: reaching out to all students and feeling pleased to be able to support students with complex needs to come to the HEI and succeed in their studies; working to provide high quality and consistent support; and creating a network of support to ensure that no student ‘slipped through’ this net. The duty of care driver tended to be associated with an inclusive or widening participation ethos and with activities underpinned by the social model of disability (which is at odds with the medical model of disability used in DSA assessment).

The influence of the legal responsibility ensured that offer decisions regarding offering a potential student a place were separated from support needs. There were strong views expressed by the institutions visited that no disabled student would be discriminated against when applying for a place, although it was recognised that students may feel that they may be discriminated against and so may not disclose a pre-existing condition.

‘Those people who come to us with a known mental health diagnosis, then there's clearly policies around that, that it should not be taken into account during the admissions process.’

Disclosure of a disability on the UCAS form is, then, 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. Disability (and costs to support the student) does therefore not feature in decisions about whether to

offer a place or not. Indeed, there was evidence from some institutions that support measures, such as alterations to accommodation, may be initiated in advance of confirmation that a student will, in fact, be registering.

However, 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 led some institutions towards labelling and medicalising behaviours and issues as a mental health problem in order to access funding and thus support. It also led to solutions centred on making reasonable adjustments as defined under the Act, setting boundaries around what support could be received, rather than promoting flexible and widespread solutions.

'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, the drive to support the needs of disabled students also came from concerns around maintaining or increasing a specific market position or niche, or, more commonly, maintaining and increasing student satisfaction across the entire student body.

'We are aware that a high proportion of students with disabilities come to [institution]. We know that if we provide a generic support that will meet many needs, and then you add on the individual needs. And we recognise that, in terms of their market position, it is a good position to be in; that we have a relatively niche group of individuals who are choosing to come to [university] disproportionately... reputationally we are perceived to be one of the best, and that's why they come to [institution]'

Falling student satisfaction levels could impact upon the institution's ability to attract and retain students – arguably their core business. Student satisfaction is measured with the annual National Student Survey, the results of which are available to

prospective students and other stakeholders and can influence decisions, expectations and recruitment. Satisfaction or lack of satisfaction is also evidenced by retention figures. This was often expressed by interviewees along the lines of *'if we don't do these things, our students will drop out'*. The business focus around support services for students was in one case accompanied by a shift in the language used within student support to discussions around risk awareness, assessing risk and risk management, and about having enough resource to manage the risk. Interviewees at this institution noted how they used their risk assessment to leverage additional funds from the HEI for student support services:

'it is acknowledged at the top to be a key area and we have to provide appropriate support. If I was to go to the VC at any stage and say 'I don't think we are doing this', this is something they would have to address.'

4.2.2 Increasing demand

There has been a rise in the number of students in higher education with mental health problems (*'demand has gone through the roof'*), as evidenced by the statistics in the earlier chapter. However, the insights from the case study institutions show other patterns beneath this overall growth.

Institutions reported a rise in the number of individuals disclosing mental health problems upon application, in the numbers disclosing later into their studies and in the numbers of students experiencing crisis situations. They also reported a rise in the number diagnosed with more severe mental health conditions such as personality disorders and bipolar disorder.

They had also seen a rise in the numbers of students with social and communication impairments such as Asperger syndrome or other autism spectrum disorders. There was a perception that whilst demand for support for students with physical disabilities had tended to remain stable, it was likely to grow over time with the improved accessibility and support offered in the HE sector.

Lastly, institutions were seeing an increase in students with more complex support needs, and with both mental and physical disabilities. These individuals often required support from more than one specialist or resource, and additional involvement with their teaching departments. Their needs may be subject to fluctuations and 'flare-ups' requiring an immediate response, and they may need to use the institutions' mental health provision/services more frequently.

'It's not just the numbers, a student who arrived with us, autistic and visual impairment and mental health and psychotic under section from the university...their needs changed in the last three weeks, to go from three hours to 30 hours a week'

In addition, the more complex cases could impact on other students and take more resource to manage or involve a wider set of services from across the institution (see below in section 6.3).

In some instances it was difficult for institutions to provide firm numbers on service usage to evidence rising demand and more complex demand requirements, but they were able to show: how the total number of students on advisers' case-loads had increased; how waiting times/lists for some key services such as counselling had increased; and how 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. These measures were often used to make a business case for increased resources, particularly to gain more support-focused staff. For example at one institution there was a commitment to increase paid counselling staff by 0.4 full-time equivalent for every 1,000 increase in student numbers. Indeed, all institutions reported an increase in staff to support disabled students in recent years.

There were concerns that the real extent of demand is still largely hidden. With greater visibility of services, increased efforts to encourage students to take responsibility and seek support (particularly DSA funded provision) and greater success in supporting students, more students would potentially come forward and demand would continue to rise. This could put pressure on stretched resources and put institutions at risk of failing to provide an adequate service:

'if we become a mecca, attract a lot of students with severe needs, the pot of money required will be getting out of hand. But it is not a sum that is currently a problem'

'I've seen an increase in high level of need - dual diagnosis, autism, substance misuse and mental health. I came in 18 years ago and I don't think we'd been good at responding to mental health needs, as we get better we are recruiting and supporting better, where they would have dropped out they aren't ... we are getting an obvious success rate'

4.2.3 Desire for improvement

Supporting the health and wellbeing of all students and staff, and disabled students in particular, was seen as important in all case study institutions, and key to enhancing the student experience.

The importance was reflected in the positioning of disability support services as a key professional service, alongside other critical student facing/value-added services, and falling under the responsibility of a key member of the senior management team such as the Registrar or Pro VC (although in some cases this was a relatively recent move). Indeed, clear direction and support in all cases was provided by the institution's senior management team including the VC. The importance was also reflected in the increasing level of resources allocated to disability support services.

‘we are doing everything we can to be inclusive... we have a real commitment to be inclusive here, and that extends right to the top to the Vice Chancellor’.

However, the work of supporting disabled students appeared to be under regular review, with some institutions visited still embedding very new structures of support. There was a common desire to improve provision, and, thus, a tendency to regard support services as work in progress rather than a finished article.

‘The service is only a year old, so we are still embedding our new approaches. It’s the result of the audit and review the university did ... so we only have the picture for one full year.’

There was also a recognition that policies and procedures need to be regularly reviewed and updated to ensure they keep up with the legal framework and changed context/influence of external factors (such as changes to NHS provision/eligibility, and government policy on student support), to ensure they are useful and useable:

‘So we need to look at these policies and just see whether they actually are fit for purpose, because often something at policy level is difficult to operationalize because of the unique nature of all institutions sometimes it doesn’t always fit.’

4.2.4 Significant investment in estates

Many of the institutions participating in the research had recently been able to invest significantly in their capital estate. This investment had vastly improved the physical accessibility of their campuses. Investing in new buildings had provided the opportunity to plan access effectively and to be forward thinking about future access requirements and incorporate new technologies and materials. Considerable attention and expense had been given to designing appropriate and flexible learning and accommodation buildings and ‘spaces’ and also to thinking about the connecting spaces and landscaping. This included having a number of adapted/adaptable rooms (eg rooms that are larger than average to accommodate equipment and to allow manoeuvrability, adapted bathrooms, ceilings reinforced to support hoists, and adjoining rooms for live-in carers) to enable disabled students to live on campus for the duration of their course. It also included offering a variety of types of accommodation to meet a range of needs, beyond physical access and support needs. However, institutions reported that there remained some challenges around the position of some campuses, planning restrictions, and the age of existing buildings, many of which have listed status. Further discussion of estates provision is presented below in section 6.3.2.

4.3 Formulation of policy/policies

4.3.1 Policy development

Responsibility for the formulation of policies for supporting disabled students, and students with mental health support needs, tended to lie with the HEI or college's senior management team with input from those responsible for student experience and academic affairs. So policies tended to be developed by a group with a shared responsibility rather than by one individual. In a few institutions, input was sought from outside of the HEI and their mental health policy was developed in consultation with academic and support staff in a number of other HEIs or external agencies. In most institutions, the lead for student support services, which as noted above, tended to be a member of the senior management team, had responsibility for putting the strategy into operation which included distribution of resources and working with appropriate academic staff and other professional services (such as estates and library services). The senior level input ensured buy-in at the highest level of the institution, and enabled student support services to lever sufficient funds to implement their policies and approaches. However, there were indications that wider input might be required/appreciated to ensure policy accurately reflected the constantly changing challenges faced 'on the ground' and to acknowledge the key role that staff and peers can play in supporting students (ie a shared responsibility).

Some institutions reported how they involved students in developing mental health provision, which may indirectly influence policy development. For example, one institution has an advisory group of students who help to develop the service and discuss what the service might offer, another involved the Students' Union in consultation around provision, and one had a student experience sub-committee which scrutinised the work of student support services. Involving wider input from both students and staff was felt to be important and there were some criticisms levelled at policy makers that they are too removed from the realities of student needs:

'At the moment it does feel as though there are people making decisions who are perhaps a bit divorced from the kinds of issues that the students are experiencing' [Law lecturer]

Good practice example:

The University of Leeds have a particularly active 'Mind Matters' student group, and the university has been a leader nationally in encouraging the involvement of students in addressing issues to do with mental health. Indeed the student Mental Wealth Project (now part of Student Minds) began at Leeds.

4.3.2 Raft of interconnected policies, guidelines and procedures

In many institutions there were a number of policies rather than one overarching or focused policy covering the provision of support for disabled students and specifically students with mental health problems or students with complex support needs. 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. HEIs and colleges may not feel able to codify practice in a formal policy, and much of the feedback gathered indicated how decisions were made flexibly, on a case by case basis, and prioritised by need. However, in many institutions there appeared to be a standard offering, which tended to apply to high demand services such as counselling which needed to be rationed to some extent (see below), although this standard was not rigidly enforced, and could be flexed on a case by case basis.

One institution had a specific student mental health policy which was developed in 2007, and was recognised to be in need of updating. The policy set out several broad principles which were consistent with the requirements of the Equality Act. These principles included: provision of an inclusive strategy which aims to be responsive and proactive; having a coherent institutional approach; and creating a supportive environment enabling students with mental health problems to realise their full academic potential. A key aspect of the policy is the boundary it sets, making it clear where the HEI's responsibility ends. It expresses full recognition that the HEI *'is not a mental health facility nor is it a therapeutic community'* but that, first and foremost, it is a provider of higher education. The policy also stresses that supporting students is a shared responsibility, shared by staff, students and the individual (the individual has a responsibility to seek appropriate support, and take appropriate steps to manage their condition); and that a student's capacity to study is key. When mental health problems interfere with this capacity, either for the student themselves or the learning of others, action needs to be taken. This indicates that mental health policies and action can overlap with disciplinary action and policies.

Another institution also had a student mental health policy. This set out three overarching categories of mental health problems and how these linked to different levels of support provided. The policy covers both staff and students and notes that although staff are required to exercise a duty of care and respect confidentiality, *'no one member of staff should take sole responsibility for addressing a student's mental health difficulties'* due to individual limitations in terms of skills, experience and available time. The policy also outlines a number of aspects as good practice: providing emotional support through a buddy system; that identification of needs should not involve diagnosis or labelling as it is *'not necessary in order to determine what might assist the student. A student's first experience of higher education might be the only time they have been able to put labels aside and concentrate on their academic potential'*; the importance of flexibility, for example, to help students deal with fluctuating health; the coordination

of support; and taking care with terminology so as to not insult a student's intelligence and capabilities.

For other institutions with no specific mental health policy, a key policy (or 'start point') was the Equality and Diversity policy which sets out institutions' legal responsibility:

Under the Equality Act 2010 (or the Disability Discrimination Act 1995 in Northern Ireland), it is unlawful for universities and colleges to discriminate against students with disabilities by treating them less favourably when offering places and providing services. They have a legal requirement to make 'reasonable adjustments' so that students with disabilities are not put at a substantial disadvantage [Equality Act 2010]

These policies tended to outline the specific the groups covered and could provide a framework for action. They generally do not mention mental health specifically but reference disability in general. General statements such as student charters tended to signal students' responsibilities for their own actions and informing institutions about relevant information.

Another related policy was the Admissions Policy. This makes it clear that admission decisions are not influenced by whether the student lives with a mental health problem or physical disability and thus has additional support needs, and works to ensure that admission is based on academic performance alone, whilst ensuring compliance with the Equality Act. However, it is interesting to note that in many cases the Admissions Policy makes explicit reference to the fact that the institution cannot guarantee to meet the needs of every applicant with a disability:

'The University recognises that disabled students are an integral part of the academic community, and makes every effort to meet the needs of applicants with disabilities. It cannot, however, guarantee to meet those needs in every case'.

This was also noted by an interviewee explaining how the HEI tries to make all the adjustments it can but where on-site medical services are needed, or when students want to enrol on particular courses that are inaccessible, or have a specific competence standard typical of some professional courses, adjustments may not always be possible: *'Our policy is to accommodate anybody that we can, but we do have cases [where we cannot] and they are the students that make a decision to go elsewhere'*. This highlights a potential tension – an offer of a place could be made (it would be discriminatory to refuse to offer a place on the basis of a student's disability) but a student might not be able to take it up because the HEI or college cannot make the adjustments and accommodations required. There was no evidence to date that a student had not been accommodated and HEIs and colleges cited numerous examples of how they provided extensive, unique and resource intensive support packages to enable individuals to study with them. However, in one instance interviewees described how a student who

had not disclosed a disability in advance could not be accommodated in that academic year:

‘We had a case, it was probably four or five years ago, where we had a student who arrived without declaring in advance ... who needed very complex support, including care. In the end, I think we negotiated with the student to say, look, you’re going to have to defer.’

In addition, there were a number of other policies and procedures covering assessment and the reasonable adjustments that could and should be made, and in what circumstances. This would include exam policies and, commonly, mitigating circumstances policies. There were also policies and procedures covering behaviours such as students at risk, disciplinary procedures, attendance policy, fitness to practice and fitness to study (which can allow a student to intercalate). These indicate how strategy is operationalised down to departments, schools etc. as they provide clear guidelines for staff so they know when to step in, what actions they should take (eg referral to student support) and to try to ensure a consistent approach is adopted across the institution. It was acknowledged that a key concern of staff was knowing when to act.

These policies and procedures can also help protect students, helping to deal with situations appropriately and assess behaviours (‘of concern’) in context before formal disciplinary procedures are implemented, and often helping them to remain with the HEI/college. For example a fitness to study policy/attendance policy could involve allowing students to take time off to seek external support, or allowing them to intermit or intercalate if their studies are being affected and they are missing too much; and then putting in place a plan to assess when they are ready to return and helping them phase their return:

‘It’s relatively new. It’s something we’ve been doing in practice but we put it down into the regulations now. It’s where a student is clearly missing too much or is too ill to attend, is not going to submit, is going to fail. We can force an intermission in those circumstances. It’s in the students’ interest - they’re not racking up more fees, they’re given time out to go and seek the medical assistance that they need and we manage their condition when they get back.

Fitness to practice was used particularly with professional/vocational programmes of study such as teaching, social work and nursing, often where students come into close contact with vulnerable adults or children. Here a student’s suitability to practice in a particular profession is assessed, and consideration may be given to whether the student displays the required personal and professional qualities required. One HEI described how they had a responsibility to ensure that students could meet the requirements of relevant professional bodies attached to the individual courses, and would not want to raise false expectations. Another noted how early disclosure was important in assessing fitness to practice:

‘we encourage people to tell us, we ask in a more direct way, for those courses where there are professional requirements, and also where there are a complexity of disability and the fit and competence to complete the programme. It is not a blanket approach but it is more sophisticated to make the right decision for the student and programme’.

However, 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 rather than a mental health problem, or reflect higher student expectations brought about by increased tuition fees (the student as customer mind-set). There appears to be a fine line between creating and embedding an inclusive curriculum and assessment regime and making individual plans for all students and/or letting students dictate their own deadlines. There were also concerns that constantly flexing deadlines ultimately would not help students learn to manage their conditions.

Other related documents included the Student Charter, also known as the Respect Charter or the Partnership at some case study institutions, setting out what students can expect to receive and this would include high quality support services. As indicated above, the setting and managing of student expectations may be particularly important in an age of student as consumer and increasing focus/importance on the student experience.

There were also a number of other documents and procedures that were tailored to institutional staff, setting out how to provide support, measure progress and deal with crisis situations. These documents, or key parts, could be circulated to wider stakeholders involved in the holistic support process so they would be aware of what they should do (although there were issues here around confidentiality and the detail that could be provided). These materials included the Individual Learning Plan, the Support Plan, the Crisis Plan for those students deemed to be most at risk, and the Return to Study Plan for those students who have had a period of hospitalisation or had a period of intercalation. Students were often heavily involved in the development of these tailored action plans.

Thus between them, the policies set out the commitment to inclusivity and encouraging diversity and dealt with: the groups and populations of students of interest; when and in what circumstances a student might be contacted by the HEI to discuss support needs; dealing with disclosure and confidentiality of information; what support students could expect; clarifying responsibilities of the HEI/college, academic departments and central services; and when action could be triggered.

4.3.3 Promotion and review

The visibility and publicity of policies varied. Some institutions published their relevant policies on their website alongside a wealth of other materials but these

tended not to be accessible in all formats and to meet all needs. One institution had an easily navigable website, with clear graphics, where all information could be found in one place under a 'Student Support' tag.

Example of good practice in promoting support online: University of the Arts London

The University of the Arts London website was particularly clear and easy to navigate, including an amalgamation of all services that students might wish to access under 'Student Support'. In addition it was noted that along with written information, there were videos which also informed students about mental health and general health issues, and which were presented with subtitles and in British Sign Language.

Not all institutions' websites made information available in this range of accessible formats to meet all needs.

Awareness among staff that the institution had policies tended to be high in some institutions (eg 97 per cent of staff in one university were aware of the Equality & Diversity policy), but 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. Staff may also be unaware of the full range and interconnected nature of policies related to supporting disabled students and those with mental health problems.

One HEI sought to overcome these issues with a Staff Communication strategy, which included a staff guide which gave an overview of policy and key contacts for staff should they have any concerns about a student. There was also a disability adviser 'linked' to each college/school, and this adviser also attended team meetings to update staff on new documents and strategies.

4.4 Organisation of structures for support

The detailed aspects of how institutions respond to demand and provide support for students with mental health problems and/or complex support needs is addressed in the next chapter, whereas this section provides an overview of how their support was organised.

Good practice example:

The University of Leeds recently carried out a consultation on the future provision of support for the emotional, psychological and mental health needs of students. The review was prompted by an increase in the numbers and needs of students over recent years and increasing pressures on NHS and other community based services. It was conducted by a seven member team including: a Faculty Dean, a Faculty Pro-Dean for student education, the Director of Student Opportunity, an external consultant, the Deputy University Secretary, the Head of Commercial Services and the Leeds University Student Union Welfare Officer. A range of individuals and groups were consulted during the process including representatives from the Student Union.

The consultation concluded that the university lacked an ‘integrating model of student mental wellbeing’ which could create a conceptual framework to inform interventions, and that there were different understandings of the University’s responsibilities under its Duty of Care to students and staff’. It was felt that a well-articulated set of principles and obligations would facilitate discussion when difficult and complex cases were under consideration and could be linked to the recent ‘Time for Change’ pledge signed by the University and Students’ Union together.

The new structures and processes put in place were felt to represent a step in the right direction but the university recognises there is more to do.

4.4.1 Recent restructuring

A key thing to note is how many of the case study institutions had recently restructured their provision of support, and this was often part of a wider restructuring of the whole institution. This has tended to be part of the drive towards taking a more student-centred approach, reducing bureaucracy and reducing administrative costs, whilst freeing up resources for more value-added activity. However, it also implies a recognition that previous approaches were no longer effective or viable in responding to the numbers and diversity of needs. This reiterates the theme identified earlier that student support is regarded as ‘*work in progress*’ and needs to be reviewed and updated to remain effective.

4.4.2 Holistic service and network of support

Reorganisation also appeared to be driven by the desire to provide support across the whole of the student journey, to recognise the complexity of students’ lives, and to encompass the whole experience not just academic engagement/study support/teaching in classrooms, and to provide joined up services:

‘to have an integrated oversight of the student journey’ or to ‘provide an equitable experience for all students - from the moment they apply, all through their studies, to the day they graduate’.

‘There is a strong emphasis on the whole experience from teaching in the classroom and student support...the emphasis on the whole transition from point of application to arrival on campus, and support and incorporation of disabled students’

‘our business and student services plan has something to say about the whole student experience....it is about maximising student opportunities and engaging the whole student body rather than just attending, it is about supporting achievement’

Reorganisation was therefore about bringing together support for different aspects of student life including teaching and learning, health and well-being, housing and library services.

This holistic approach was a common theme and saw support for students with mental health problems, and disabled students more generally, situated alongside (in terms of organisational administration and also often physical location) other student facing services, for example, admissions services and the Chaplaincy and, thus, often part of the largest professional service within the institution. There was a sense that services have not always joined up well in the past and students who were unsure of the services that were available or appropriate for them may seek support from the wrong source. Similarly, staff, who can act as the first point of contact for students, may also be unsure of what support is available and most appropriate. It was hoped that the holistic approach would allow for greater visibility/signposting of support and greater access, with multiple entry points. For example one institution had a form that anyone in their institution could complete that ensured that a student was signposted to the most appropriate service.

One institution had implemented a pilot programme linking disability support with careers support to enhance the employability of disabled students.

Example of sustained provision across the student lifecycle: De Montfort University

De Montfort University is delivering a project called ‘DMU Thrive’, comprising of an education and employability pathway from pre-entry to graduation. This ensures disabled students or students with a mental health difficulty are connected to wider university resources that they may be less likely to access such as the careers advice, and that they are provided with a service tailored to their needs. More widely the project provides day-to-day support such as help with CVs and interviews as well as finance, welfare and specialist mental health and disability support. Students are engaged throughout their lifecycle, right from pre-entry discussions around whether the course is right and it is the right time to enter HE, through to graduation.

The joining up of provision has also taken place within student support services to bring together support for different conditions/problems and create better links between support for disabled students, mental health and wellbeing. This has seen a move away from a specialist ‘silo’ approach to one that brings together a network of

professionals. Indeed, interviewees frequently used the term 'network' and spoke about ensuring individuals would not 'slip through the net'. This counters the idea of '*this is my patch*'. The service may still have specialists and require specialist resources (eg specialists in dyslexia and dyspraxia, autism spectrum disorders, mental health advisers, counsellors and wellbeing practitioners such as alcohol awareness workers), and services for disabled students may be differentiated from services for students with mental health problems, but there is a careful use of job-titles and sharing of responsibilities to enable seamless support. Many interviewees hoped that by bringing all student support services together it would: enable more personal links to be made at faculty level through clear communication routes; create a more seamless experience of support for students; enable support staff to help each other and address the problem that the demand for specialisms can be unbalanced (for example 17 students with hearing impairment, compared with 2,500 with specific learning disability in one institution); and also create opportunities for people from across the range of support provision to discuss complex cases and how services can interface to best support that student.

As noted above, institutions reported that they were seeing more complex cases, students with multiple disabilities (eg students on the autism spectrum with mental health problems), and the networked approach helped them to react quickly. There was, however, a tension or challenge with joined-up services in terms of confidentiality and the degree to which support workers and staff can share information about individual students.

With an integrated and joined up service, interviewees described how students needed an initial consultation or triage in order for staff to decide the most appropriate referral or staff member to work with the individual, and indeed the level of priority or 'risk':

'so staff can make appropriate referrals and students go to the right place and the journey will be better - not going from pillar to post'.

It becomes the responsibility of the student support team to decide who is the most appropriate support worker rather than the student's decision about which service to try to access. From the triage (or needs assessment for those disclosing during the application/admissions process) and individual plan can be drawn up and resources deployed appropriately.

4.4.3 Centralisation and rebranding

Alongside a restructuring and refocusing of the service, there was often a trend towards rebranding and relabeling of services for disabled students – relabeling of the service itself and the job titles of those within the service. This often saw the use of more inclusive terms such as wellbeing or student affairs, to make the service(s) appear more accessible and less off-putting and stigmatising for students. This was seen as particularly important to those seeking help with mental health problems, as students

may not see their problem as a disability nor identify themselves as disabled, particularly when their mental health problems may be intermittent. It was felt that this type of rebranding would reposition the service as one available to all students rather than targeted towards specific students. This change has been partly attributed to the growth in numbers of students with support needs, the increased awareness of the social model of disability beginning to influence institutional practices, and the recognition that students may be happier with a *'wellbeing'* rather than a *'disability'* centre label.

At the same time, there has been a trend towards physical centralisation of student support to provide a *'one-stop-shop'* for ease of student access and visibility, and co-location of the range of services in order to improve communication and dialogue within the service: *'it is important to see the connection, pan university, that it is run centrally for consistency, expertise, to bring together services to personalise responses'*. This co-location of services in one large professional services department included, for example, disability services, health and wellbeing services, counselling, Chaplaincy, advice for international students, and complaints. Yet general support for learning skills, such as essay writing etc. was more often located within the library services. However, for institutions with multiple campuses, centralisation of services was itself a challenge, and there was a need to ensure provision across all sites, with some satellite offices/spaces to deliver services in other sites often staffed for just a few hours a week.

One institution had adjusted their service to be both holistic and centralised:

Example of good practice in holistic and centralised support: Bath Spa

The university has a holistic and centralised student support department providing support with mental health, counselling, disability matters, and dyslexia support as well as learning support, peer mentoring, financial support, and health and wellbeing. Everything is housed within the one department and location so it easy for students to move between different specialists and forms of support (although if they have multiple needs they will have a lead worker aligned to their priority needs as too many individuals for a student to deal with can be confusing). The central service also helps to ensure that no stigma is attached to visiting *'student support'*.

4.4.4 Support viewed as a shared responsibility

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). Indeed, 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 (support for students from students and peer led support); Chaplaincy (this tended not to be faith specific); residential wardens within HEI managed accommodation; and academic and pastoral staff. For example one institution noted the important role of the

Chaplaincy in promoting a culture of good mental health and counselling individual students (see section 6.3.4 for a discussion of the types of services Chaplaincies offered).

All case study institutions recognised the vital role that academic staff played in supporting students, in terms of: monitoring behaviour and spotting early warning signs; acting as the first point of contact for students; signposting students to support and encouraging disclosure in order to access support, as well as making adjustments (section 5.2 discusses in depth the roles academic staff play). They could also 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. Also, in several institutions staff worked alongside volunteer trainee counsellors – those studying on university-provided courses – in order to increase their counselling capacity whilst at the same time providing these individuals with real placement experiences.

Individuals also had a critical role to play in many institutions, both in driving forward change and championing provision within institutions, but also in building networks across the sector and with external agencies. Indeed, policy and structural changes can depend on individuals and can be derailed by the departure of key champions. These are often individuals with a long history of supporting disabled students either in higher or further education contexts (in different institutions) or in the NHS. In another HEI, staff turnover was proving to be a difficulty in maintaining timely and effective services. The discussions with interviewees also reflected the importance of a strong and accessible student support team – a group who are well integrated, connected and cooperative, and genuinely motivated and committed, who have students' '*best interests at heart*'. It was notable at one institution, which had a team of long-serving staff, that staff morale was high, with staff being able to offer support to each other in what are often stressful jobs.

4.5 Policy issues

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, and addressing key questions around who can be supported and the nature and extent of support that can be provided.

4.5.1 Drawing boundaries - who is supported.

A key factor in deciding who to support, or to prioritise with support, was often receipt of DSA funding/provision, and, thus, who was able to provide evidence of a long-term mental health condition or other disability/impairment. This aligns with the Equality Act, and is, therefore, the legislative driver for action and so need would be determined by long-term condition. Here support could involve facilitating the DSA application, matching assessed needs to suitable provision and arranging appropriate services. Therefore students in receipt of DSA funding/or likely to receive funding, appeared to attract the greatest response from institutions, including on-going counselling and mentoring support.

However, most institutions were also providing additional support: to top-up and pay for DSA services where the DSA allocation falls short/runs out, which was a common occurrence for students with sensory impairments (acknowledged to be a group with high cost support needs); to fill in whilst assessments were made and individuals were waiting for funding to be granted; where the full recommendation from the needs assessment was not funded by the DSA; and when short-term interventions were required during pressured or crisis situations.

More troubling groups were students ineligible for DSA funding (failing to meet the criteria or respond to the increasingly stringent medical criteria), particularly: international students, who are outside of the scope of student funding; those studying at a distance; those whose eligibility was borderline; and those who did not want to apply for DSA funding, gather the required medical evidence and undertake a needs assessment. Institutions found it difficult to assess the requirements of these students and therefore had differing approaches to whether they could access support. For example, 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. One other tended to offer more informal support and signposting to local external services for students without the DSA funding and diagnoses in place, as they found it much harder to ascertain whether these students needed specialist support:

‘we will look at providing them with someone to come and talk to, and having the options and choices about where they might wish to seek further support’

There was a common theme that the institution should not have to take the place of DSA provision and, thus, students who were likely to be awarded DSA funding had a responsibility to apply for funding. This was a particularly strong focus at one institution. This meant that part of the work of student services was to encourage and support individuals in their claims – whether this was during the application process and prior to arrival or whilst on their course.

Institutions highlighted the resource implications associated with providing holistic and less medical approaches to supporting international students with mental health problems. Interviewees acknowledged that this group could have severe and often undocumented/un-evidenced needs due to: the two way communication and cultural barriers associated with discussion and disclosure of mental health problems; lack of communication about treatments followed prior to their arrival in the UK; isolation from former support networks; and lack of awareness resulting from UK HEI staff not being aware about the needs of students from different cultures or how mental health problems are responded to elsewhere.

There appeared to be a commitment in many institutions to support international students with mental health problems or other disabilities, with this support funded via general income streams. Institutions reported how, in some cases of high support needs, the support costs could far outweigh the income gained from the higher fees gained from international students, although this was offset by the fact that a lot of international students required very little support. There were also concerns among some institutions that with the push to extend the global reach of UK HE, this group of students could grow fast and place an even greater strain on resources. A related subgroup of international students were those studying at a distance, in satellite campuses. This group were mentioned by a couple of institutions, who felt that service level agreements were required to set out what support was practical but also what was expected from franchising partners to ensure student service provision was of a comparable quality to that provided in the main site. One institution noted how online counselling could prove effective in these situations.

Institutions often saw their role as providing a short-term intervention plus reasonable adjustments. The latter was often viewed as part of the move to a more inclusive curriculum, generally made by academic staff with student support or by individual departments themselves footing the bill in meeting the additional support needs of non-DSA funded students. In this way students were offered support which enabled them to stay part of the HEI or institution community and fulfil their learning potential. 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.

Determining need caused institutions some degree of challenge, and there were discussions in the interviews around what would be deemed mental health problems and 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. Both were issues that could require action, but differing responses and prioritisation of responses. The former (mental health problems) may require targeted and prioritised support and linkage with external agencies, whereas the latter (difficulties making the transition) may require proactive and widespread/general initiatives to help students develop strategies for independent living and resilience. However those with mental health

problems could also face additional difficulties making the transition. As a surgery nurse noted:

‘They don’t know what medication they are taking. They are given a prescription by the doctor and they take it to reception. They don’t know how to look after themselves. They are very vulnerable. They lose all the usual support networks - family, friends etc. They are thrown into a flat with six or eight people they have no idea about and they are expected to just get on with it’

Indeed, in one institution there was a strong feeling expressed by the on-campus GP surgery that students were seeking medical help inappropriately; either in situations where they were clearly coping, or alternatively in relation to day-to-day support needs which could better be met elsewhere. GP staff felt that health and wellbeing lectures to new students during the first term, covering basic wellbeing, mental health and physical health, and, particularly, the importance of getting into a regular sleeping routine were important as it was felt some of the issues students were coming to the surgery for were driven by a lack of sleep and a lack of a normal routine.

4.5.2 Drawing boundaries - where HEI responsibility ends

Institutions were clear that their role was to provide a range of support and advice services, and provide appropriate referrals and signposts to other services but not to replace the statutory /professional services available through the NHS. The roles of the NHS and the university support services were seen as distinct (though complementary). Within some institutions, support for mental health problems and complex support needs was perceived as primarily about helping with academic management and integration with the student community: offering short-term support focused around managing the impact that a student’s condition has on their studies (or longer-term support supported by DSA funding); and providing short-term support to help people deal with difficult life events and not treatment of their condition. Serious conditions would either have an on-going management plan supported by external agencies, or should be referred to external services; although clearly many students would have their needs met by the support available within the university without the need for referral to outside agencies.

‘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’.

Other institutions took a wider perspective, taking a view that support could also involve helping students to be more aware of their own skills and resources and to take (some) responsibility for their own wellbeing and accessing relevant support:

‘My view of mental health, I hold the traditional psychology continuum view of it which is 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’

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. 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’.

This caused an additional challenge for institutions that felt unable to influence the wider landscape. They clearly saw themselves as providers of HE and not a ‘therapeutic community’ or the ‘5th emergency service’ which they felt was a perception held by wider stakeholders and some students. They were troubled by the potential failure of external services to support their students’ wider needs. This challenge had two potential outcomes: the need to manage students’ expectations; and the requirement to step in and provide ‘holding support’.

Interviewees talked about the balance between raising awareness of and improving access to the institution’s support service, whilst also managing students’ expectations of what they could receive and taking responsibility for their own mental wellbeing.

Discussions also highlighted how institutions were providing ‘holding’ support to students whilst they were awaiting support/treatment either through DSA or from external services. For example, one institution would offer students a package of four

to five counselling sessions whilst the students was awaiting an external appointment, but in reality this could be a much longer intervention as waiting lists for external appointments could take much longer. So HEIs can act as a stop-gap to support students prior to them accessing NHS support, particularly impacting upon the counselling services HEIs provide. 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. For example, feedback suggested that in some areas services for students with Asperger syndrome or ADHD were 'purely diagnostic'. 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:

'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'.

4.5.3 Categorising need and making appropriate responses

The feedback gathered, particularly from a senior management/strategic level, suggests that currently institutions feel they are meeting the needs of their students, deciding on the extent and nature of support that can be provided flexibly and on a case by case basis, using a mix of DSA funded support and wider support services. So the strategic issue currently facing institutions is not really who to support, but who to see first and how to respond to their needs. There are concerns that with increasing demands (in terms of student numbers and individuals' expectations) coupled with the retraction of external support services, there may need to be some rationing of support in the future as HEI funds are not unlimited; and difficult decisions may need to be made about who can be supported.

At present, institutions face the challenge of designing appropriate responses for those disclosing later in their student journey. There was no indication that HEIs or colleges took a different approach to students depending on when they disclosed a need or sought support (ie no cut-off date for access to support). It appeared that the same strategies and staff were used to support students who disclosed at application stage compared to those who disclosed during their studies, although the referral or entry point could differ (with academic and pastoral staff playing a key role in on-course/later disclosure, contacting the student support team with their concerns about a particular student or working to encourage students to self-refer). However, institutions clearly preferred to have as much information as possible before the student commenced their studies so they could put in place appropriate support across the institution including working with estates, accommodation, library services, timetabling services and academic staff and be aware of the likely resource implications.

Students in crisis situations (which were felt to be on the increase, whether with known conditions or undisclosed problems) tended to require a different approach and an urgent and intensive response, generally involving speedy referral to the named case worker or a senior/experienced member of support staff and swift/close liaison with external agencies such as the emergency services and mental health response teams. In general HEI and college support services were provided during office hours and during term-time and an initial response to a crisis situation outside of these times should involve the appropriate emergency service. Wardens in accommodations and student peer support systems come into play at those points too.

Categorisation of need was therefore important, rather than timing of disclosure; with need identified where possible through the collection of information before or during application or the initial triage session with support services. Institutions could then balance the level and/or speed of intervention to the need. Indeed, some institutions had a risk register or equivalent and prioritised students on this basis. This could be used to fast-track high risk students to access counselling services, which appeared to be in greatest demand and could have lengthy waiting lists, or to appointments with support service staff to develop appropriate plans to react in critical situations, and to make onward referrals to external agencies such as the Early Intervention in Psychosis Team or Community Crisis Team.

Other institutions categorised students based on the level of support required, ie continuous and multiple support requirements versus short-term, intermittent requirements: psychiatric diagnosis rather than emotional distress; reactive mental health problems because of the stresses of being a student; severe and enduring mental health problems including psychotic disorders rather than more common mental health problems such as anxiety and depression; obsessive-compulsive disorders, rather than stress caused by a period of change, transition or loss.

‘We prioritise people with high risk cause, complex presentations, or if there’s something like a third year and they will be coming up to finals and they’re leaving. So we’ve got a range of factors which we think about in terms of allocating. I do the allocations once a week.’

‘if you have that ongoing support, those will be the students that we are really pushing towards DSA, to be accessing the specialist support and probably to be accessing GP support as well... Students with short-term stress, we do have extenuating circumstances procedures, extensions. So they are more likely to go down that route than to come to us looking for ongoing levels of support’.

One institution had a more sophisticated conceptualisation of mental health problems. They had developed a quadrant model based on severity of condition on one axis, and level of functioning on another.

‘we do try to balance the level of intervention to the particular need so we wouldn’t automatically go down the line of saying immediately you need this

massive package of care and support in place. But it is difficult because if they do potentially need that you have to go through Student Finance England or the NHS if it's an NHS funded course. It's a very long-winded process you can't easily react and put in quite a lot when you need to and then take it away again. You either have the package or you don't.'

Institutions therefore tended to offer a mix of drop in sessions and bookable appointments and lower risk students or those with short-term intermittent requirements could be provided with self-help resources whilst waiting for appointments (as well as those who would not or could not access counselling services) or group sessions focused on wellbeing issues. One institution, for example, has a computer-based self-management system called 'Calm' with five modules on depression, anxiety, stress, insomnia and drugs and alcohol. It also runs a number of groups advising on insomnia or procrastination as part of its wider proactive wellbeing initiatives. These students could also access the standard package of counselling which tended to involve a set number of sessions; in one institution it was one 90 minute session, while others offered 60 minute sessions in packages of four sessions up to eight sessions.

Several institutions reported how the demand for counselling was high and growing, leading them to offer-time limited counselling. One institution noted:

'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'

Institutions reported that although counselling was in high demand, the standard number of sessions was driven by staff experiences of the optimal use of the service, and that with higher numbers of sessions students tended not to turn up to the last few appointments which was a waste of resource. However, the standard package was not rigidly enforced and could be increased for individuals if necessary.

4.5.4 Proactive responses

There appeared to be three interpretations of proactivity:

- Early engagement with students: this involved reaching out to students before application to support their choices, encouraging early disclosure (pre or during application) and accessing DSA, if appropriate, and enabling appropriate packages to be put in place before the student starts.
- Promotion of wider wellbeing: this involved health promotion and wellbeing activities covering a range of topics and helping students deal with key student pressures.

- Thinking more generally about inclusivity within the teaching and learning context, including at the stage of course design, and making wider changes and adaptations to learning and living spaces, and course design, in addition to more specific and tailored support.

Many institutions placed emphasis on encouraging students to disclose and seek support at an early stage in their student journey, preferably before or during application, as this enables institutions to plan and properly resource support. Disclosure could be encouraged by the medical services linked to the HEI, by academic staff, and by staff in feeder institutions. It was felt that lecturers who have a visible disability or are open about their own experiences can particularly encourage disclosure from students. Encouraging disclosure was often about helping students overcome the myth that declaring a disability would damage their chances of being accepted on a course. However, there was an acknowledgement that still only a relatively small proportion of students disclose their mental health problem before arriving at the HEI. In one institution, a survey of students found only a small proportion of those having a diagnosed mental health problem had disclosed this to the HEI before arriving.

Institutions worked at early engagement including pre-admission outreach by having a student support presence at open days. A staff member may be present, or they may provide a slide pack or hand-outs so that those involved in the open days feel confident that they are using the right language. This was felt to raise awareness of support available in the HEI but also support available generally in HE, and to indicate the importance of disclosure and of seeking support as early on as possible. Early engagement with students (pre-application) could help them decide whether the HEI would be 'right' for them:

'We're very active in trying to encourage students that have complex disabilities, high needs students, to actually contact us, and we offer a site visit so they can meet accommodation, they can visit their director of student experience from the school, meet our disability advisor and ask any questions they've got, and we can start planning the provision that's required for them before they actually get here. So the practice is I think a positive one, we try and engage very early on with prospective students, and they may come and they may go somewhere else. If they come here, it means we've got the heads up to try and get things in place before they actually arrive on day one'.

There was agreement that waiting to engage with students with declared disabilities once an offer of a place has been made could be too late but a larger concern was lack of preparation, waiting too long and allowing a crisis situation to develop.

'Stuff gets put in place when there's a crisis. What we need is the same lower level response earlier on ... Keeping the door open, that understanding, that making it easy for them to access help needs to be a lot earlier than what it is. We wait too long until it becomes a major problem I think and, by then, you're

already at risk that they've missed a lot of their course. Maybe they've seriously overspent. Maybe they have got into drugs or drinks ... You're not too far down the path but you've then got to start dealing with all the consequences of what's happened'

'If we know they're coming we can plan, but it's a disaster if they get here and arrive this weekend and have a psychotic breakdown ... So it's really important, we think, that vulnerable students are identified in advance.'

Some (but not all) institutions were therefore consciously taking a more proactive approach to supporting disabled students, linking support for mental health problems and conditions with wider strands of wellbeing activity and public health. This was to try to prevent crisis situations (*'The best intervention is before it happens'*), ensure more intensive and medical support could be appropriately directed – and as part of a holistic response for students.

Good practice example:

The University of Lincoln were taking a proactive approach and enshrined this in their Equality and Diversity Report:

'This year we have had a particular focus on advancing the equality and diversity agenda through embedding and linking it as an integral aspect of other initiatives and work streams, such as our wellbeing agenda, the continued development of our respect charter campaign and our drive for greater levels of engagement of staff and students in everything we do. ... Our people are diverse, and we have acknowledged this by proactively linking our work strands of wellbeing and diversity to help to promote greater awareness about issues in relation to mental health and caring responsibilities'.

They described how they are working to increase their ability to intervene at an early stage, thereby reducing the number of students who get into crisis situations. This included: a Mental Health campaign run by the Student Union; a free 8 week Mindfulness course previously aimed at staff, but now available to students; and a monthly programme of health promotion campaigns covering topics such as disordered eating, bowel and prostate cancer, mental health, winter disorders and SAD, the importance of sleep, personal resilience, and responsible drinking.

Other proactive responses (termed preventative rather than remedial work in one institution) included:

- Providing a space/activity for quiet, relaxation and interaction (one example given was a knitting afternoon once a week).
- A scheme which enabled students to join an exercise programme in conjunction with counselling.
- Disability awareness training for academic staff to improve understanding among staff of the impact of various conditions, particularly mental health problems, on

learning. This was recognised as an on-going process as turnover of staff can be high.

- Activities around de-stigmatising mental health problems in both student and staff communities.
- Wellbeing support providing help with preparation for university and institution life, coping with leaving home and independent living, initiatives that can build readiness and resilience which can prevent some individuals developing mental health problems during their student journey. Examples here included a healthy eating programme encouraging students to eat together to build peer support groups, eat well and save money.

4.6 Looking to the future

Looking to the future, interviewees raised concerns around the impact of the DSA changes particularly on students from low income backgrounds, the demands placed upon the institution itself, and their abilities to respond. One university is being proactive in their response to the changes to DSA. They have set up a DSA Working Group, chaired by a Pro VC to look at the various ways the changes could impact on the HEI, the threats and opportunities, and what the HEI can do to mitigate any negative effects. They are finding this acts as a useful forum to staff to share their concerns. Across the institutions there was a lack of clarity about the nature and the likely effect of the DSA changes. For example staff were concerned that non-medical support for those with mental health problems (such as mentoring) may be cut or reduced.

5 Demand for support and how it is provided

5.1 Introduction

This chapter draws on the views of institutional staff regarding the demand for support and how it is provided by looking at: the changing pattern of student demand for services including the various drivers of demand; the various types of support services available and different organisational structures involved in providing support in different institutions; formal provision of support including that funded through Disabled Students' Allowance (DSA) and institutions' increasing emphasis on the promotion of disclosure and student support services.

5.2 Demand for support

Across the universities and colleges interviewed, there was an overwhelming consensus that both the number and proportion of students declaring mental health problems has risen. Operational staff noted that mounting caseloads were making it challenging to keep pace with demand. Even where there was a lower reported proportion of students with mental health problems, staff raised concerns that this was due to a lack of appropriate monitoring data and lower rates of disclosure, rather than a smaller proportion of students with such needs (as before suggesting a large latent demand). Furthermore, interviewees explained that the needs of students are becoming more complex, as highlighted in the previous chapter. There has been a shift away from students accessing services due to the break-up of relationships, transition or homesickness, and they are now more likely to present with anxiety, depression or low mood. Additionally, increasing numbers of students are at high risk of harming themselves, or in the most serious of cases are suicidal. Growth in the complexity of cases may mean that students with support needs of this nature experience fluctuations or 'flare-ups' in their health and so may need to access services more frequently.

Alongside this are greater incidents of comorbidity of mental health problems alongside other impairments, and greater incidents of students experiencing multiple challenges where their mental health problems are coinciding with other needs such as the personal responsibilities of mature students, the impact of leaving care,

transitioning or having been bullied. Likewise, the numbers of students who require intensive support has escalated, including those with sensory impairments or students with Asperger syndrome.

Increasing numbers have manifested across the student lifecycle. Firstly, interviewees noted greater numbers of students were arriving with diagnoses already in place. In particular, these included anxiety, low mood, depression or other (long-standing) conditions of a 'more severe' nature such as bipolar disorder or schizophrenia, where students have been prescribed medication. Secondly, it was also indicated there were growing numbers who went through the diagnosis process whilst in higher education (HE). Trends were perhaps more inconsistent between schools or faculties at some institutions. For example, interviewees outlined greater expansion of students with mental health problems in disciplines such as psychology, the creative arts and drama, nursing and mental health nursing.

The changing profile of student cohorts has thus led to students needing and seeking help from a greater multiplicity of services, or placing greater demands on existing ones. Support required from the mental health mentor has doubled at one institution, and there has been a 54 per cent increase in referrals to the counselling service over the past 12 months at another: *'it's just getting more and more'*.

Contrastingly, this picture has not been mirrored by similar growth in students with multiple disabilities requiring multi-agency support, where numbers were felt to be small and to have remained stable. As accessibility and support on campus was improving, there was some anticipation that ensuing numbers would therefore increase over time.

5.3 Drivers of demand

Although institutions have been growing in size, interviewees noted that the surge in demand cannot be explained by rising student numbers alone – although institutions with rapidly internationalising cohorts were experiencing larger numbers of such students requiring disability or mental health support. Several factors driving the nature of demand for institutional provision were therefore considered.

5.3.1 Change in culture

A strong consensus existed amongst staff at the case study institutions that, up to a certain point, societally there was a more open culture concerning mental health. It was felt individuals in the population were more widely encouraged to discuss mental health, so interviewees concluded this led to a greater willingness amongst the student community to seek formal and informal help, discuss their difficulties and diagnose conditions. Campaigns – both physical campaigns eg posters, and those using social media – were thought to raise the topic in a public forum, imbuing it with greater

prominence and contributing to reducing the stigma around mental health. However, some interviewees were careful to note that despite apparent increasing openness, certain students may still be reluctant to engage with the issue. Some may reject the mental illness label or question why they are being referred from counselling to a disability service as they do not consider themselves to be disabled. Additionally there may be particular trepidation amongst certain groups of international students, potentially experiencing exacerbated anxiety and pressure to achieve. They may be at greater risk of not disclosing a mental health issue or a difficulty in coping with academic/student life, and may conceivably feel more isolated than domestic students due to distance, time zones, the requirement to adapt to another language or culture, and for some overcome stigma associated with mental health problems which in some cultures is even greater than within our own. Therefore, interviewees contended there was still a lot of work to be done around normalising mental health problems.

‘I think that we have got a very high number of Chinese students and, I think, they have a lot of anxiety about asking for support and receiving support, so sometimes a student will come in and they’ve actually been referred by their academic advisor or by a tutor, but they’re very reluctant to take the course or to make any kind of formal acknowledgement of wanting support, so that number should be higher than it is, really because our suspicion is, actually, a lot of international students aren’t coming to [us], that we could be supporting.’

‘There are increasing numbers of pressures and we do have a good reputation also amongst younger generations and there is less stigma - but people are worried about having diagnoses ... The more severe forms: bi-polar, personality disorders, because of how they [are] seen, that label stays with you. There are students who don’t want to get the label, in case they get labelled in the workplace.’

One institution reported how they had introduced initiatives to attempt to normalise some of the transition issues incoming students may face.

Example of normalising transition issues: University of Lincoln

Staff at the University of Lincoln discussed the importance of ‘normalising’ certain issues such as initial homesickness, loneliness and attachment issues. One initiative offered sessions for international students which explained how feeling homesick was normal, and suggested strategies to draw on their own resources to get through this initial difficulty. Interviewees explained such strategies were valuable for all students, and that it was important not to pathologise emotions immediately. Proactive strategies were viewed as ‘the best intervention’, and interviewees suggested that HEIs should do more to facilitate students’ self-awareness around their skills and resilience. Developing and fostering psychological strengths was perceived as a preventative strategy that would be valuable for all students.

‘If we can identify those strengths and get them working, that allows the whole community of the university to flourish’

5.3.2 Changes in the healthcare sector

Increased disclosures of disabilities or mental health needs were also connected to changes in the healthcare sector, both positive and negative. Diagnostic procedures were felt, by some, to have improved, producing more reliable diagnoses at much earlier stages of students' lives. Better quality of care and treatment may also mean that individuals who would not previously have attended HEI are now studying in HE. Additionally, experience of having engaged with mental health services – such as those provided in primary care – prior to HE may lead students to arrive with higher expectations of the level or nature of help they will receive. Alternatively, shortcomings in external statutory mental health provision, including barriers to referral and high NHS waiting lists, may mean HEIs are bearing the load as this provision recedes.

‘The big change I’ve seen is it feels like an increase in demand. There have been huge drives in the health care system to shift work out of secondary care and in to primary care and, at the bottom line, primary care hasn’t got any bigger. Primary care funding is something like eight per cent of the NHS budget and that has slipped back from much higher figures in the past.’

5.3.3 Success of widening participation

Alongside these two drivers which may partly explain increasing rates of diagnosis or disclosure, interviewees noted further factors which may influence the demographic profile of cohorts. Both factors were seen as having encouraged more people to view HE as a viable option. Firstly, 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. In addition, institutional engagement with widening participation has impacted on the profile of students now enrolling. It was viewed as very positive that people were transitioning to HE that 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.

5.3.4 Institutional factors

Whilst the above may be considered to apply across the HE sector, some institutional and disciplinary specificities were thought to influence the proportions of students with mental health problems on different courses and at different establishments. Firstly, some interviewees explained that their institutional reputation played a key role. For example, students with recognised mental health problems may feel more inclined to apply to an institution seen as inclusive, small or friendly, with a more community feel or situated in a peaceful location. However in contrast, the same features of a campus may be potentially limiting the number of students with multiple, complex physical disabilities, for whom accommodation or teaching spaces may not be

accessible. Alternatively, the nature of certain courses, disciplines and modes of assessment was felt to coincide with higher proportions of students with declared mental health problems or other difficulties. Particular examples included music technology, computer games and modelling which had high numbers of students with autistic spectrum disorder, and psychology which had high proportions of students with mental health problems. It was therefore felt that an institutional offer with higher proportions of humanities or creative courses or with more coursework than exams may increase the proportion of students with a declared disability or mental health problem.

Furthermore, institutional initiatives to engage students were felt to have increased disclosure, such as the promotion of the benefits of earlier disclosure during the admissions process. Efforts were also made to promote student support services. Examples included rebranding student support under the wider and more inclusive rubrics of wellbeing or student life, promotion at open days and university events and the relocation of the service into a more prominent location so as to increase footfall (and therefore demand).

5.3.5 Greater pressures on students

Lastly, interviewees discussed a wide range of intensified individual pressures exerted on students which were exacerbating mental health problems. Some of these coalesced around finance. 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. This additionally translated into increasing pressure to succeed, whether in terms of family expectations or finding employment post-study. Furthermore, pressure to succeed was said to be particularly exacerbated at some more selective institutions in recent times, particularly as students adjust to their transition or compare their attainment to fellow students. Such concerns were somewhat tempered for some interviewees who contended that recent cohorts were less prepared in terms of their resilience to make the transition into HE. Identity issues formed a further pressure point that was raised. Increased body and image awareness coupled with decreased social interaction, was felt to stem from the advent of social media. Finally, there was some discussion of the dangers of very accessible and unpredictable legal highs, as well as the impact of incidences following overconsumption of alcohol.

5.4 Organisation of support

Student support services (under various auspices) were the main hub for facilitating what help students were provided with. There were variations in organisational structure, with some services being notably distinct, demonstrably separate and only allowing for signposting between services. Others had more collective, overlapping and holistic forms, linking mental health, counselling, disability matters, dyslexia and

learning support, peer mentoring, financial support or health and wellbeing. Stigma surrounding a visit to student support was said to be reduced in the latter, more integrative structure. Furthermore, there was variation in how institutions arranged their support. Some offered a single, centralised service (with smaller hubs at other campuses or locations), others a consistent distribution of services across multiple locations and, some, individualised disability and wellbeing services linked to particular faculties.

The lexicon of how support was provided had been reconfigured in certain institutions, such as renaming the service as a Wellbeing Centre or as part of Student Life. There was some consensus that this encouraged more students to seek help by removing some negative associations, despite the fact the majority of work was with students with mental health problems. Exemplifying this more positive and inclusive language, one service heavily focused around 'inclusion', incorporating responsibility for education, employment and health promotion.

The main point of contact arranging provision within this service 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, applications for DSA funding, liaising and coordinating to put learning support arrangements in place and matching students to mentors. In short, triaging support from all the different pools of expertise necessary. Alongside this are more informal responsibilities for providing advice, guidance and individualised 'human support', and they may be the point of contact if a student is experiencing a mental health crisis. In some institutions with more expansive provision, advisers had specialist knowledge and expertise, so would be connected particularly to specific learning difficulties, disability support, mental health or autistic spectrum disorder. Furthermore, in particular proactive institutions the mental health/disability adviser's role may include raising mental health issues amongst students and staff as well as breaking down myths and stigmas. However, there was a general consensus that their role was focused on supporting students to study and find strategies to manage, and that they were not providing a therapeutic service:

'It's about raising concessions for examinations, regular meetings with departments in terms of advising departments around the particular disability, the impact of the disability on staff training, attending case conferences where the student may be in particular academic difficulties, arranging support with external agencies or internal staff, monitoring that support to make sure that students are attending and that they're engaging with departments, are keeping up with academic work, managing expectations from parents, and in this particular situation, liaising with the [institutions]'

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

Mirroring the complexity and diversity of the support needs of students, many interviewees noted support had, at some level, to be responsive and tailored to individual demand. Mental health problems may be short-lived or acute, peak at certain times of year or be longer term and deep-seated. Students felt to be particularly at risk may need to be fast-tracked and if necessary get through to their adviser straight away. There may also be seasonal peaks according to the academic cycle, notably around the first term or exam periods. In addition, students may have high levels of expectation and demand for help initially, which may somewhat dissipate some months later. There may also be differences within the student body. For example, postgraduate students are often more solitary and their needs not always as visible. Therefore student support staff were required to draw on different options within provision at different points – and in different ways – in order to support the student in the best and most appropriate fashion.

‘We try and react for the individual needs. One thing we do doesn’t necessarily work for everyone.’

‘For me if you consider what is available outside the university, social care or NHS, they wouldn’t receive same kind or level of support or expertise, we have a responsive service. We get to know the lecturer and we can be flexible.’

One institution had clear processes for tailoring support to individuals and prioritising support for those felt to be most at risk.

Example of good practice in tailoring provision: Bath Spa

The university recognises that the causes of mental health problems are varied: they can include abuse; rape; academic stress; bereavement; home-sickness; identity issues; body image issues; and relationship problems. These can lead to short-lived, acute episodes that can peak at certain times of the year; or longer term problems or deep seated issues that students have always had and are living with. Thus the university offers a range of provision that can be tailored to the individual. They respond to individuals on a case by case basis. Student Support triage an individual, they would then be assigned to an appropriate lead specialist who would coordinate their provision. This would include matching students to advisers; and if the student could receive DSA, would involve matching them to DSA support workers; and also monitoring progress. A student’s case or need can be categorised as high (‘student of concern’ who is flagged as such on student records), medium or low priority depending on the risk posed to themselves or others; and this can change over time. High priority students are fast tracked, and can get through to their coordinator straight away in emergency or crisis situations. These high risk students also have a care plan which sets out what to do in an emergency. This is helpful to wider university staff such as security staff who would deal with ambulances coming onto campus, and first aiders and residential advisors who provide out-of-hours support.

Occasionally interviewees explained there were key groups responsible for making decisions about what support in particular should be provided. Several examples were outlined. In one institution there were Disability Support Groups which met prior to student enrolment to identify potential changes or pre-existing structures students may

need once in HE, and Student At-Risk groups which looked into changing or erratic behaviour and considered the best way of supporting students and managing risk. Somewhat more informally there were cases of weekly opportunities for staff across services to assemble, and discuss complex cases, including how the different services can interface to support that person well.

5.4.1 Tailored and long-term support via the Disabled Students' Allowance

One crucial strand of formal support provided across the institutions was assistance with applying for Disabled Students' Allowance (DSA) where students may be eligible. Application was seen as of the utmost importance across HEIs, with Student Support and the Students' Union strongly encouraging students to apply at the earliest possible stage. Assessments are carried out by independent assessors considering a variety of issues, from physical disabilities to mental health and dyslexia, often supported by medical evidence. Choice is available in terms of where students wish to undertake the assessment – it may be through a centre housed within the institution they are applying to, another local centre or alternatively one closer to a student's home. Where students are successful in their DSA application, support staff can use the recommendations to arrange reasonable adjustments as well as make arrangements related to DSA-funded assistance. The most pertinent information can then be shared with schools or departments to allow them to deliver the most inclusive learning. Some concerns were raised about the support package remaining static for three years, which may mean students are less likely to challenge their need for the support as time goes on.

It was noted that it was rare for assessments to be especially directive about support needs. Interviewees noted equitable collaboration across academic and estates staff was important in developing the most appropriate individual learning plan. Furthermore, student involvement in the process was said to contribute to its success. This helped to ensure that responses were as appropriate as possible and information was comprehensive about requirements and expectations:

'The importance of a dialogue with the institution what the university could offer, and what the student needs, don't always match.'

'It's in discussion with the student as well... we should make that clear, we do discuss the support and give them the option rather than us saying you've got to do counselling or you've got to do this.'

However, it was noted that international students are ineligible to receive DSA, so are reliant on institutions' equity strategies to access any support. Although demand is (currently) at a lower level than that from UK-domiciled students, when crisis situations arise they can be notably more complicated.

Following receipt of DSA, a mainstay of formal provision for students with mental health problems or complex physical impairments was the arrangement of non-medical helper support, which the student support services put in place. Specialist mentors were recommended specifically to help students who have been awarded DSA, including those with mental health problems and sensory impairments. 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 very practical advice – and provide assistance complementary to any counselling, external or medical support. Particular examples of help may include support with research, proof-reading, any issues with lecturers or tutors, or a broader focus on guiding the student through their course. Interviewees generally noted that students were recommended one hour of contact per week during term time, but examples were also cited of students receiving more or less support. Arranging this can present difficulties, for example where students are more likely to be off-campus – such as PGCE students – or if they persistently do not turn up.

Employment conditions of non-medical helpers varied. Some were employed by the institution and so delivery was provided in-house, whilst other institutions outsourced the service to external agencies, using freelance staff. It was noted that as the number of students requiring support at any one time fluctuates, staff may be employed on an ‘annualised hours’ basis and requested according to the institution’s needs.

5.4.2 Counselling

All institutions interviewed provided their students with access to a counselling service, with a broader remit than that of mental health mentors in the sense that it would cater for the needs of a wider spectrum of students, but narrower in the sense that the focus is simply on the provision of counselling. Counsellors could provide support to students with mild to moderate mental health problems and to those not in receipt of DSA. Counselling was delivered by a mix of British Association for Counselling or Psychotherapy (BACP) accredited counsellors, those in the process of gaining accreditation, and some volunteer student counsellors on their work placements. This mix of staff was used responsively according to severity of condition, and in one instance where waiting lists had grown following staff sickness short-term locum practitioners had been drafted in.

A range of counselling formats was offered, including person-centred counselling, rapid eye movement desensitisation and cognitive behavioural therapy (CBT) or similar support. In one case specialist CBT practitioners were being employed with funding from the NHS, to reduce pressure on the counselling service. Some issues of boundaries around counselling were discussed. Some interviewees noted students may not necessarily receive support if they were being counselled elsewhere, whilst others explained their provision was complementary to other referrals, for example from GPs. Several institutions relayed that they had experienced challenges particularly in terms

of increasing male participation in counselling, which was traditionally lower than that of female students.

The number of sessions in any one course of counselling commonly ranged from between four to seven sessions, sometimes extending up to 12 in certain circumstances. However at the lowest end one institution offers a single 90-minute session, deemed sufficient to move students through a crisis situation as well as keeping waiting lists down. Comparably shorter spans of provision were viewed as inadequate in the eyes of Students' Union sabbatical officers at the institutions where this was provided. However, student support staff noted that their provision was more responsive than that of external agencies, known to have long waiting lists, and this was having a positive impact on student retention.

'Four [sessions] seemed the right number; after four, students seem to fizzle out and you wouldn't have that final important concluding session'

Institutional approaches also varied according to whether courses of counselling were seen as finite or ongoing. On the one hand, some institutions offered fixed-term provision, potentially as a 'stop-gap' after which, if necessary, statutory or charitable provision should step in (although one institution noted there was flexibility if waiting lists were long). On the other, 'repeat blocks' were offered to students as and when necessary. One interviewee noted that due to the increasing demand being placed on the service, they had been forced to move from an open-ended to a time-limited delivery model.

Counselling services were publicised widely around campuses, through postcards, online resources and in student diaries. Some institutions (and counselling services) required students to refer themselves to the service (for which they may use an online portal, telephone call or attend in person to book an initial meeting). This may follow on from signposting via course or personal tutors, who may notice that students are struggling and recommend they try counselling; others may instead allow referrals from disability or mental health advisors or tutors, although this was still contingent on the consent of students. Additionally, some counselling services offered more integrated, broader provision, reaching out to wider tranches of the student body. This may be through groups and sessions concerning mindfulness, assertiveness, confidence, resilience, managing stress or sleep hygiene. Activities of this nature were felt to come under the umbrella of wellbeing and so were viewed as more inclusive, although one institution noted it lacked the resource to run groups like this.

One institution had a system of informal support, provided by university staff based in faculties, that ran alongside the formal counselling and gave students an alternative space in which to be heard.

Example of good practice in informal support: The University of Greenwich

The ‘Listening Ears’ project at the University of Greenwich was highly valued and seen to provide quality support much more quickly than other services such as counselling or statutory provision. It is run by a voluntary network of university staff, who are not trained counsellors but act as contacts that students and staff can access to discuss any issues they are facing, and develop strategies to work through concerns. The interaction is private, unless someone requests that a particular issue is passed on to a tutor, department or university office.

5.4.3 Adjustments

Finally in terms of formal, ‘core’ provision from HEIs, where students had a (persistent) recognised disability or mental health problem (sometime this had to have been diagnosed), learning support adjustments were put in place. As with counselling, many were not contingent on students being in receipt of DSA. Such arrangements were often developed in collaboration with students as well as with various support and academic staff. One approach included flexibility with deadlines for assessment as part of the wider institutional formal policy of mitigating evidence or extenuating circumstances, with some institutions being comparably more open to requests around adjustments. However, others were reticent about using extensions without careful consideration.

‘One of the things we try and do is to avoid students relying on things like extensions all the time. They can of course have them if they have a valid reason, but we’re trying to help students develop as independent adults who are aiming to go out to work, and to work to deadlines and function. So, it’s not always in their interest. If they’re too ill to submit, they’re too ill to be here, and they need to take time out. If they’re OK, they need to be trying to manage their condition - with our help - and submit to deadlines.’

An expansive range of additional adjustments used to ‘*level the playing field*’ were listed by interviewees. For examinations, students may be able to take them in smaller rooms, have rest breaks or not have more than a certain amount in one day. They may also have additional time, an adaptation felt to be crucial in the narrative of one international student who felt the extra 15 minutes they had to read the questions was helpful for them.

Example of good practice concerning exam provision: The University of Leeds

Interviewees noted there was a particularly well-publicised policy relating to exam access arrangements, made on the basis of evidence. Alternative provision may involve allowing students to take the exam in a small room, have rest breaks, have no more than a certain number of exams on one day or not be in a room with a computer. There is additionally wider support which interviewees felt students may feel more comfortable accessing as it is devoid of connotations relating to mental health. For example, the Students' Union arranging a drop-in when students are revising for exams, where students can sit on bean bags, relax and watch a film.

Timetabling adjustments were also made, for example to accommodate transport issues or where medication may mean students function better at certain times of the day, or to ensure accessible rooms were available. Furthermore, if students find giving presentations to a group challenging, they may present first, or last, or be allowed to submit an assessment in an alternative format, as agreed with academic staff. Greater support may also be given with group work.

'If it's something fairly standard, for want of a better way of putting it, then they [disability adviser] can probably just recommend that. If it's something a bit more unusual then they probably need to meet with the course team and discuss that ... Standard things might include things like adjustments to exams, for instance. We make a huge number of adjustments to exams so that could be communicated that way. In terms of something a bit more unusual, I suppose that would happen where a student's disability was one which didn't so commonly present. It may be also things like if you've got a hearing impaired student or a visually impaired student where they may need to know certain things. If you were using a sign language interpreter or something like that then you probably need to speak to the academics concerned so they understand how to use that facility, so those sorts of things really.'

More high-cost and complex adjustments were often contingent on DSA funding, so eligibility (or a lack thereof) shapes some of the available learning support adjustments that students are provided with. Such support includes note takers for example where students have cerebral palsy or visual impairments, BSL signers, transcriptions, studio or lab support and intensive mobility support. There were some limited incidences of this support being subsidised by institutions where DSA was not, or had not yet been, granted – including loaning of chairs or voice recorders – but there were limits on what could be stored and maintained.

5.4.4 Crisis responses

Finally, 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, and where incidences occur within student accommodation, accommodation services may be involved. These 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 then 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.

In one institution, a team was established to ensure there was out-of-hours cover for crisis situations:

Example of good practice in crisis situations: The University of Derby

The University of Derby has established a Critical Incident Response Team, designed to deal with crisis situations out of hours and to provide a more immediate and coordinated response. This team worked collaboratively with the wider university, the Students' Union, Chaplaincy and halls of residence to ensure a holistic approach. There are staff trained in trauma therapy who will provide support to fellow students following a crisis incident, using rewind techniques and cognitive behavioural therapy for anyone who may have witnessed an incident or be affected. Particular attention was paid to certain times of year, including anniversaries of incidents and deadlines for exams.

5.5 Promotion of disclosure and student support services

All institutions emphasised the importance of encouraging early disclosure, as it enabled them to contact students, identify what support had previously been received and so understand needs and offer appropriate responses. If students arrive with complex difficulties having not declared during the application process, institutions may find it hard to make adjustments or provide suitable accommodation. Given this importance, many institutions emphasised the work taking place to encourage students to disclose during the application process. They could then inform students of support available, signpost them to appropriate services or agencies and allow students support services to make direct contact to discuss specific requirements.

There was said to be no difference in approach according to whether students declare earlier or later in their lifecycle. Support is not differentiated, and can be arranged at a later point, and there was evidence of post-enrolment disclosure documentation to support this. Nonetheless, interviewees contended that provision can be more effective when institutions know in advance, and this can mitigate the impact of waiting times and delays, both in terms of learning support arrangements and DSA applications. Therefore, there were many ways in which disclosure was encouraged. For example, staff were available during open days to talk to potential students, offering advice

about transitioning to HE. Increased efforts to highlight mental health during such days was seen as an effective mechanism to alert students and help build relationships from the start. Positive and welcoming language throughout the admissions process was additionally felt to be a key point of success. Considering this importance, some interviewees noted there was much work to be done pre-admission, including staff feeling confident in using the right language.

Where students disclose during the admissions process, student support personnel have the opportunity to evaluate that information and prioritise actions for each student prior to them arriving. Students disclosing pre-entry – either through UCAS or through HEIs' own early disclosure forms – may be contacted by an appropriate adviser, who could thus share relevant information, and discuss any learning support adjustments. This often takes place collaboratively through discussions with the student and perhaps academic or other professional services staff. Support and estates teams can then arrange adjustments before a student arrives, or, where this is not possible, will be able to inform them in a timely manner about any particular difficulties. Part of the process may also include inviting the student to visit the campus to see the campus and accommodation or teaching spaces.

'[That] shapes our work and is part of our culture, so earliest opportunity, open days, standard advice, individual appointments, workshops about preparing university life, making the transition into university [part of a] combined service. Transitional experiences, what they need to do pre uni life, all their skills, and gaps for and action plan for individual.'

Regardless of the emphasis on early disclosure, interviewees were well aware that some candidates were fearful this would affect their application, or may be unwilling to engaging with services at that point. So, emphasis was similarly placed on disclosure at offer of a place, and it was clear there were multiple opportunities to disclose across the student lifecycle. Posters and leaflets about student support services are distributed at Freshers' Fairs, put on stalls in common areas and during publicity events, left at teaching sites and put within halls of residence. Likewise, disability or mental health advisers may have a very high profile at induction, conveying the message that disclosing impairment is not stigmatised and that help is available. Online promotion was a further key channel for increasing access to health information. For example, this included wellbeing blogs and a website synthesising all of an institution's wellbeing initiatives. Particular good practice was demonstrated through an especially clear and navigable website with subtitles and BSL translated video information. Where websites were user-unfriendly, there were concerns this could be impacting on delivery and staff were convinced of the need to make more use of social media interfaces to maximise student engagement.

'You've got to do it based on what the student feels that they need. But the same joined-up approach. Keeping the door open, that understanding, that

making it easy for them to access help needs to be a lot earlier than what it is. We wait too long until it becomes a major problem.'

Disclosure was further facilitated through both formal and informal means. An active approach was evidenced where some institutions drew on attendance monitoring data to highlight where students' presence at seminars or lectures was dropping. There was consensus that this was a highly effective way of identifying students who may need support. However elsewhere it was noted that the personal tutoring system has been strengthened as an alternative to more formalised responses to non-attendance.

More informally, students might hear about support through word of mouth through fellow students, or changes in their behaviour may alert tutors, friends or flatmates that they might need support. Friends and tutors may thus be aware of particular issues, and could encourage students to self-refer to student support services or counselling and highlight their concerns with the appropriate services. One HEI has a webpage which directs students and staff as to what to do if they have concerns about a student, with appropriate points of contact both in and outside of academic hours. It was further noted that students with mental health problems may access services at particular pressure points, for example during a disciplinary process or where they are facing personal risks such as running out of money.

'What we're trying to do is focus on encouraging the intervention. We have what we call an early intervention form which any member of staff across the university can fill in to say they think a student has a particular need. They don't need to know our structures internally, they don't need to know which team you need to refer it to; they just need to know there is an issue and then that will be picked up centrally and dealt with by the appropriate team.'

Staff were aware of the potential link with greater success and retention for students who disclosed and were keen to encourage this wherever possible. Issues surrounding confidentiality of non-disclosure can pose a barrier to institutions, for example where high levels of specialist support would require proper coordination of provision between counselling, academic or support services as well as liaison with external agencies and statutory healthcare providers. Furthermore, helping eligible students to access DSA will allow them to receive crucial financial help. The importance of facilitating continuous disclosure was underlined where, for example, some students come initially to discuss dyslexia and later disclose mental health problems that they did not want to discuss in an email or in a form. In another institution, a survey of students undertaken by the Students' Union around mental wellbeing issues found that of those respondents who had been diagnosed with a mental health problem, only 10 per cent had disclosed this prior to enrolling.

'Obviously, all the way through, as they become a student, it might be through a course tutor or another professional member of staff, and there are multiple opportunities to discuss.'

‘We do a very hard sell on students who are struggling and say you need to be accessing support. There are very few who won’t go down, once you explain why... With what’s on offer with the DSA, why wouldn’t you be taking it?’

Whilst the above can be considered in some ways reactive, evidence was also found of proactive interventions to alleviate some of the tensions present throughout the transition to HE. For example, this included a one-day, pre-entry study skills intervention (including a high proportion of disabled students), and a wraparound intervention *‘demystifying support, removing that remedial sense. This is about ensuring success’*. Elsewhere a preventative approach centralised the importance of collaboration, both with other individuals and academic staff. Alternatively, some institutions were piloting residential summer schools for students with Asperger syndrome and mental health problems so that they can experience life away from home, on campus, before the start of term – although some institutions noted they lacked the resources for this. Hard-to-reach groups were actively sought, in particular efforts were made to promote the counselling service to male students who were accessing it less frequently. Elsewhere, it was noted that there was only sporadic preventative support activity.

6 Wider HEI contexts/services

6.1 Introduction

This chapter draws on the views of staff and students to examine three broad aspects of institution provision: firstly, how support is provided through departments and in an academic context; secondly, the role of broader institutional services (including the library, human resources, estates and accommodation and Chaplaincy) in the provision of support; and thirdly, the role played by students themselves and by students' unions in supporting students with mental health problems and/or complex needs.

6.2 Departments and the academic context

There was a diversity of approaches within the case study Higher Education Institutions (HEIs) with respect to who provided support and how it was organised within the academic department or faculty. This reflected wider organisational structures; for example, pastoral and academic issues may be the responsibility of a member of academic staff working in the student's department, or provided as part of an institution-wide tutorial system. Similarly, in some institutions, disability officers with responsibility for communicating learner support plans were based within faculties whereas in others they worked in a disability office and advised students from a range of faculties. Comments indicated that academic staff generally felt positive about central support services (those aimed at disabled students and, more specifically, at students with mental health problems).

Terminology varied, reflecting diverse organisational structures. Central Support Services is used here, as an umbrella term, to refer to a spectrum of support services including disability office, mental health team, counselling, medical services and general wellbeing team. The term 'programme' here refers to a particular degree, and module is used for a course within a degree. Academics worked within a 'department' that was located with other departments within a faculty. HEIs typically had several faculties.

6.2.1 Departmental context and issues

Departmental responses varied across and within HEIs. These variations depended on the departmental culture which, in turn, was influenced by: the student profile

including number and range of students' needs (perceived to be increasing); the subject matter and whether the programme had professional accreditation; and the departmental history, for instance whether there had been recent organisational change or critical incidents, eg a student death.

In one HEI, a member of staff, based in a Students' Union, identified three types of department: 'spot on' – those that provide appropriate support but know their limitations and where to refer students on to; 'in house' – those that try and do everything themselves; and 'uninterested' – those that respond only to the most tangible of student concerns ('a broken leg, a broken arm or a car accident'). That is, of course, a generalisation. Departments have to be distinguished from individual academics, who may fall in to one or all of those categories. Of one student, an advice centre worker said:

'he was ready to quit so many times. His department were ready to quit on him so many times. But he had a very responsive and understanding personal tutor'.

There was evidence of departmental staff, academics (including Teaching Fellows and Graduate Teaching Assistants) and administrators needing and obtaining support in their roles. This was obtained informally, through colleagues; provided by staff who supported students – mental health advisors and counsellors, for instance – or, in the case of major incidents, designated staff belonging to a crisis team. Support for departmental staff was felt to be important, given the range of roles they undertook.

6.2.2 Staff Roles/functions/tasks

Academics working in departments undertook a number of different tasks that related to their teaching and learner support roles of responsibility. Members of staff with teaching responsibilities were identified as a key source of support because of their regular, and in some cases prolonged, contact with students. Some of the tasks they fulfilled overlapped with central support services; others were discrete and delivered by academic staff only, in the context of the department. Staff tasks covered formal responsibilities that were publicised to students as a service offered by the department as well as informal support that fluctuated according to student need. The level and nature of support provided by teaching staff was influenced by their awareness of, and ease in dealing with, students with mental health problems or students with complex disabilities whose sensory or physical requirements were unfamiliar. Support was also shaped by prior experience (both personal and professional), their discipline and/or profession, and access to educational development and training. The tasks teaching staff carried out enabled them to fulfil the following roles:

- Communication: first point of contact, signaller, signposter and bridge
- Education: teacher, role model and assessor

■ Guidance: detective and myth buster

Teaching staff were often involved in attendance monitoring which could involve them drawing upon each of these roles depending on the situation. The combination of roles fulfilled by any given member of academic staff appeared to depend on their formal and informal working relationship with central support services. Some would refer or direct students to access central support services; others would pass students onto departmental administrative staff or a named individual within the department who either had experience or a particular interest in working with disabled students. The nature of the referral depended on the organisational structure and physical proximity of central support staff to the departments; this was particularly noticeable in split sites.

Communication roles

There were a number of formal systems through which students would be assigned to academic staff who could act as a 'first point of contact' within the department. Academic tutorial systems provided a named contact within the students' department (or in some HEIs in another department) with whom the student could discuss academic and pastoral concerns. In this role they might also become the 'first point of contact' for a student's friends, parents or peers living in the same accommodation. This role enabled academic staff to 'signpost' students to further sources of information, advice and guidance within the HEI.

A further communication role was that of a 'bridge' whereby the tutor would move beyond signposting but might introduce a student to a member of staff in central support services, a peer supporter or a service provided by the Students' Union. The role of 'bridge' also worked the other way, whereby staff from the disability office or mental health team would contact academic staff with information to pass on. Some institutions had formal channels of communication; others would approach the individual academic directly. In the absence of a formal tutorial system, the role of tutor might be carried out not by a named academic but by academic staff responsible for a programme or module. In some HEIs there was a named individual who was based in central support services who fulfilled a similar set of communication roles. However, unless they happened to have personal experience of teaching in the relevant academic department they would be less able, without liaison, to tailor their support to the demands of a specific programme. There was no direct evidence of academic staff involvement in direct communication with external stakeholders. However, academic staff were expected to interpret the guidance received regarding reasonable adjustments, and for students with an interpreter or mentor may have needed to respond to communication from the student via a third person.

The communication role could also work the other way, with students communicating concerns to academic staff and adjustments being made as a result, as the following example shows:

Example of good practice in collaboration between academic staff and the student voice: Bath Spa

Academic staff and students noted that during the academic year it could be difficult for some students to hear about the subject matter of a few of the texts on the English degree programme which had challenging content (eg sexual assault).

Following discussions with members of the mental health society, students flagged the issue to the English Student Rep as they were concerned it could be a trigger for emotional distress. As a result, the English Student Rep arranged a meeting between themselves, a student representative from the mental health society, the Student Support Manager, English Lecturers and the Head of English, so that students could voice their concerns and make suggestions for how things could be improved, and specifically how these texts could be dealt with in classrooms.

Students valued the opportunity they had to collaborate with academics in this way, and there was a discussion of extending this practice across other departments. Students felt their voice was heard in making reasonable adjustments: *'They respect our views and they do listen'*

Education roles

The role of teacher was clearly the primary educational role. The manner in which academic staff understood their teaching role shaped their attitude towards learner support plans, reasonable adjustments and inclusive teaching and learning. Some academic staff welcomed support from central support services as they recognised this would make it easier to do their job. Others, however, 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. These questions emerged within the wider context of discussions around the purpose of HE and were more likely to be raised by staff at HEIs with higher entry grades. In HEIs with a widening participation mission and diverse student profile there was greater emphasis on student retention and the important role to be played by academics in helping students to remain and complete their studies.

Central support service staff and students stressed the importance of academic staff remaining in class where wellbeing-related activities – such as time management, revision and mindfulness – were delivered by guest speakers, as part of the curriculum. In this way academics were perceived to be acting as a role model,

endorsing and adding value to the input. There were also examples of academic staff providing revision tips via social media or contributing to HEIs' wellbeing initiatives.

Although academic tutors were described as sympathetic, reference was made to situations when, based on their professional judgement, they would need to make unpopular decisions. The role of assessor was typical of programmes which included a fitness-to-practice component, or where safeguarding issues had been raised, either relating to the student or the people they came into contact with on a placement.

Guidance roles

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. For instance, academic staff explained that it was not always easy to detect the point at which the unavoidable stress associated with a number of imminent deadlines tipped a student over in to an inability to cope. The hidden challenges facing students with complex disabilities was also difficult to assess and may not always be picked up within the department, especially where difficulties may have been raised with an external source of support who may be unaware of who or where to raise the matter. The guidance required would depend on the student and whether the stress was judged to be impacting on their mental health or the challenge restricting a student's capacity to engage with the course. Working out how best to respond to students was therefore far from straightforward.

Another common guidance role for academic staff was that of 'myth buster'. Whereas seeking advice and guidance from within their department was seen by students as part of day-to-day experience, 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. The latter was a particular issue where students on professional courses were concerned. Dispelling myths appeared to be a key role at the pre-entry and recruitment stages as well as a necessary pre-requisite to enabling students to access the range of central support services. The guidance role for students with more complex disabilities was less clear as their support tended to be organised by central support services. As experience of students with more complex disabilities tends to be more limited and given the ever-changing nature of support services within HEIs it is not clear how, or if, academics are able to draw on previous experience to inform their future interaction with students.

Attendance monitoring

Attendance monitoring was an activity which could involve academic staff in trying to detect reasons for absence, signposting students to other sources of support if problems were detected and dispelling the myth that it did not matter if you did not attend a lecture. The process of attendance monitoring was prioritised in some departments; more relaxed in others. The diversity of responses between departments even within the same HEI was raised as a cause for concern, probably because attendance monitoring was perceived as key to ensuring that students are safe and well, and an initial indicator of where support was needed. It was suggested that effective attendance monitoring was linked to a more hands-on approach by staff and that in turn led to a greater willingness of students to come forward for help. One HEI outlined reasons for poor attendance monitoring, which included sessional tutors with short hours and limited student contact and poor use of electronic registers.

Departmental and faculty disability representatives/officers

In some HEIs there were members of staff with a specific remit to work with disabled students, which included students with mental health problems and those with complex or multiple disabilities. Sometimes they were academics with an additional responsibility; at other times they were part of the HEI disability team but located within the department or faculty or assigned to work with a particular set of departments. As described above, their job was to take on a formal 'bridging' role between academic staff within the department and the range of staff working within central support services. In some instances they also helped to develop and facilitate communication about learner support plans, and might work with the student to ensure that reasonable adjustments outlined in their plan were implemented (see 5.2.5 for a further discussion on Learner Support Plans). The Wellbeing Manager in one HEI stressed that success was often dependent on:

'having that open and real conversation with us is really helpful. Going back a few years, a BEd profoundly deaf student, the wall went up [and the dept said] "we can't do that", but we worked through it ... if we took another student on that course, because it has been really successful although we had some challenges, things would be different'.

This change in view seemed to have been achieved by central services working closely with the department.

Departmental staff with specific responsibility for disability or central support staff assigned to departments were likely to be involved in the meetings and discussions about arrangements for students with more complex disabilities. For instance, they may contribute to meetings with estates to discuss the implication for room bookings and student participation arising from the location of a specialised accessible toileting

and changing room. Alternatively, they may be responsible for organising educational development for teaching staff about to work for the first time with a student who had a British Sign Language interpreter.

The model of support and communication between departments and central support services depended on how other services were provided in the HEI and, from the accounts given, there were advantages and disadvantages with each approach. The key message – from whatever model – was the need for someone to understand the departmental culture, understand how central support services are organised and be able to liaise effectively with both sets of colleagues and the students to manage expectations. Due to the changing circumstances in provision and sometimes the student's needs it was noted that it was 'difficult to manage expectations'. Despite this, a personal commitment and interest in this work is likely to increase a staff member's willingness to engage in training and thus become a source of information on the topic.

6.2.3 Staff development

All HEIs referred to staff development which was offered to: raise awareness; increase confidence; enable academic staff to make reasonable adjustments; and encourage commitment to inclusive teaching, learning and assessment. There were three broad types of staff development¹¹:

- training that was open to and attended by staff from across the HEI and designed to support students from a particular disability group, for example, students with mental health problems or students using an interpreter;
- educational development which focused on curriculum considerations, including those that directly related to students with mental health problems or the technology issues associated for a student using a screen reader; and
- institution-wide awareness campaigns, targeted at disability such as International Disability Day, or mental health awareness via the annual 'It's Time to Change' campaign, or wider equality and diversity or wellbeing campaigns.

There was variation in the range of provision and the section of the HEI responsible for identifying need, planning, delivering and evaluating the effectiveness of staff development initiatives.

¹¹UUK (2015) offers an alternative categorisation of three levels of staff development with practical ideas for each level. Whole institution – level 1, role specific – level 2, mental health professionals and other specialist advisers – level 3
www.universitiesuk.ac.uk/highereducation/Documents/2015/StudentMentalWellbeingInHE.pdf pp33-35

In most instances, staff development was voluntary, except where staff had a specific disability responsibility and had to attend annual disability training to ensure currency. Otherwise, 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. At one HEI the focus for staff development, and topics to be covered, were identified by looking at the profile of students within each department. This proactive approach was intended to offer relevant and timely training that would equip staff to make reasonable adjustments and adopt more inclusive approaches tailored to their student cohort. (see Chapter 8 for a discussion on effectiveness). One HEI emphasised the importance of an ongoing cycle of training which included sessions on safe talk, suicidal thoughts, and sign language awareness, and, to highlight there is a role for everyone, they talked about a course which examines:

‘multi-agency support and uses real cases to highlight that staff are one part of the jigsaw and enable them to realise that a little bit of disclosure might be the final piece of the jigsaw ... a very powerful piece of training’.

Publicising training and engaging staff, many of whom had competing demands on their time, was a challenge even where training was a requirement. One HEI described recent changes to their global email system which restricted their capacity to communicate staff development opportunities by email. At another HEI students and staff referred to the introduction of ‘talking’ noticeboards, which could broadcast information in an accessible format for everyone. This inclusive approach had arisen in response to a student suggestion and had been used to publicise mental health workshops or key messages which were part of their general disability awareness-raising and mental health promotion campaigns.

A number of HEIs described an increased need for or interest in training. This had led to more requests for input on supporting students with ASD and mental health problems in particular. As one academic explained:

‘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”.’

At another HEI, the numbers of academics participating in Mental Health First Aid courses had rapidly increased, with all places already taken for the current academic year. The lack of supervision and support for academic staff involved in supporting students was mentioned by one senior academic, although there was evidence in one institution of that being provided by the Equality and Diversity officer.

There was less evidence of how institutions integrated the inclusivity agenda into their educational development provision. There were numerous comments which suggested that HEIs recognised that the inclusivity agenda was likely to be part of the longer term

solution, despite the challenge of convincing some academics of its benefits. (See also 6.2.6 inclusive teaching for further discussion).

In addition to describing the content and the purpose of staff development activities, some HEIs outlined ways of harnessing national campaigns such as the Mental Health Foundation's 'It's good to talk' initiative, and HEI-specific activities involving students, to raise awareness. These general awareness-raising campaigns had been designed to encourage colleagues, including academic staff, to recognise the need and potential benefits of participating in more structured staff development courses. Often cross-institutional teams organised awareness-raising campaigns which brought together both staff and students from diverse disciplines and settings.

At one HEI there appeared to be a balance between a proactive and reactive approach to training. They offered a range of disability related courses which were well attended. One course examined multi-agency support and used real cases to highlight how disclosure on the part of a student may be the final piece in a jigsaw, enabling a whole spectrum of support to be put in place. It was described, by an attendee, as very powerful. There was reference to an Equality Festival, which helped to celebrate diversity and tackled stigma, and to the appointment of an equality and diversity officer with the flexibility to respond to localised issues within a department or specific groups of students. Holistic and embedded approaches drew on the diverse skills and expertise of staff in different roles, helping to combat the 'us and them' mentality that can emerge where services develop separately. This had the potential to redress the concerns of some central support service staff who felt that their expertise went unrecognised by some academic colleagues.

6.2.4 Pre-entry activities: admissions and recruitment

A range of staff in a number of the HEIs reported increased involvement of academic staff in pre-entry activities such as open days. Increased academic staff involvement was clearly linked to HEIs' proactive approach to encouraging early student disclosure and helping students to make informed decisions about where and what to study. Academic staff participated in open days, contributed to fitness to practice discussions before, during and after open days, and integrated topics such as disclosure into open day talks. Disability support staff from one university provided academic staff with slides which could be used to talk about such issues. That proved helpful in allaying fears about using the wrong language which, it was felt, may in the past have prevented mental health problems from being addressed in open days.

Academic staff also invited external stakeholders to join them in interviews. Where used, these proactive approaches became part of a holistic approach advocated by HEIs that some believed would help to reduce the number of students signing up for courses to which they were not suited. One HEI described how academic departments record their competence standards centrally, together with details relating to fitness to

practice, which informs central support and admissions staff and is helpful when decisions are being made. Generally there was a widespread commitment in the HEIs we spoke to about considering:

‘how we can make adjustment to start with, a learning adjustment, transition of adjustments to help make the students more independent’.

However, as one Wellbeing Manager pointed out sometimes the student’s impairment meant they would always need an adjustment, so terms like independence need to be used with care as they might mean different things to different departments and students. Ultimately:

‘independence means different things, so for a deaf student we can’t put strategies in place, disability isn’t going to change’.

6.2.5 Learner Support Plans (LSP)

Learner Support Plans (LSP, or the equivalent terminology) were the written documents prepared for students in receipt of Disabled Students’ Allowance (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 prepared by staff located in central support services, with a member of the Disability Office being the most common person to collate the evidence. Usually they included general and learner-specific information, advice, guidance and requirements that academic staff were responsible for implementing (see earlier discussion on support services for their content and development). This section covers aspects of the LSP processes or procedures that were raised with respect to the departmental context.

As noted, in the majority of HEIs, 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 the extent to which this approach is desirable. Some academic staff felt that the system worked well; others that they would like to be more involved in the planning process. The number and range of staff involved in developing plans varied. 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. This approach appears to have gone some way to addressing a concern raised at another HEI about the clarity of the content and expectations within LSPs.

Ensuring that everyone with a teaching responsibility was aware of the disabled students in their group, and the individual adjustments that they would be required to make for them, tended to be achieved through informal communication. 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. One HEI explicitly referred to improved efficiency in communicating about LSPs, which were now available electronically. Although technology can increase access to information, it brings challenges too with respect to confidentiality.

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.

6.2.6 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

Reasonable adjustments fell in to three broad categories, relating to: general teaching and learning approaches, eg lectures and seminars; programme specific requirements including fieldtrips and placements; and issues associated with assessment eg coursework deadlines, feedback and examinations. Challenges associated with reasonable adjustments related to awareness, time and staff attitude.

General teaching and learning

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. Some adjustments, such as making lecture materials available prior to a lecture, were already in place for other groups of students. Other strategies were considered to be part of good teaching, such as giving students an opportunity to contribute without being singled out. There was a sense that 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.

The sample of academic staff spoken to does not permit a detailed discussion of discipline-specific requirements relating to students with complex disabilities or

students with mental health difficulties. These have however been discussed within the wider literature, for example:

- Geography as part of a previous HEFCE programme 'Improving Provision for Disabled Students Funding Programme' (Gravestock, P. and Healey, M. 2001),
- Psychology as part of work undertaken by the Higher Education Academy (Craig, N. and Zinckiewicz, L. 2010),
- Social Work (Anderson, J. and Sapey, B. 2012), and
- a series of subject-focused inclusive curriculum design guides (Morgan, H. and Houghton, A. 2011) (See also Chapter 2 literature review)

Fieldtrips and placements

Collaboration between central support services and departments was often vital for the successful resolution of challenges relating to placements. As one student advisor explained:

'we went out to the placement, there was a mentor at the placement, what [the student] preferred was to immerse in deaf culture, good lip reading, and identifying themselves with deaf culture ... we had to make them aware [of placement requirements], how we can embrace that they needed to do that to pass the placement, getting that balance right and they are working in a mainstream school with hearing unit. There are times when a disability won't change so we have to work with them to recognise this'.

The cost and time implication of this type of intensive work was noted, see DSA and funding for faculties.

There was evidence that mental health support staff played an important role for courses involving placements or fieldtrips. They would support academic departments by providing practical suggestions based on their own previous experience, and helping to disseminate expertise developed in other departments within the same HEI. So, for example, where placements were mandatory they would negotiate with the department to offer an HEI placement rather than one with an external organisation; or recommend the use of a link tutor to serve as a '*go between*' to the department and external placement supervisor, to ensure everyone is clear about expectations of the student as well as any reasonable adjustments.

Changes in the learning environment, such as those experienced on a fieldtrip were described as problematic because they threw up unexpected issues: for example, dirty knives and forks presenting problems for a student with OCD; or issues arising from the lack of control associated with being physically away from home. Collaboration between the mental health team and academic staff was reported as most effective.

Mental health support workers would alert academic tutors to the issues and ensure that they were involved in generating solutions which did not place the student at an academic disadvantage. In turn, academic staff identified the academic demands of a particular degree programme.

Assessment and mitigating circumstances

There was evidence that the number of requests for reasonable adjustment or consideration of mitigating circumstances across the student population had risen; one HEI estimated 10 per cent in the past few years, while other institutions suggested it was much higher. 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. Mitigating circumstances, together with broader questions about assessment deadlines, and the existence or position of alternative assessment underpinned concerns about reasonable adjustments and raised questions about parity and equity. Several HEIs also noted that it was important when making reasonable adjustments not to detract from or dilute the academic quality. 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. For example, discretion was often given to academic staff to grant extensions, and although it was easier once staff knew the students, these situations needed to be handled carefully, and not simply in response to students feeling pressured and asking for more time so they could submit a better assignment.

The diversity of response to reasonable adjustments and taking mitigating circumstances into account is the inevitable outcome of a devolved process. It may become more of an issue in the future, however, where the number of students with a LSP declines and where access to reasonable adjustments may depend on an individual student's capacity to make a case for breaks or an alternative venue for their examinations. Assessing the impact on performance in order to determine appropriate reasonable adjustments is complicated and some HEIs reported that it was already a logistical challenge to find rooms and supervision for exams and ensure there were appropriate alternative arrangements in place.

6.3 Wider HEI services

6.3.1 Introduction

This section focuses on the role of wider institutional services in providing support to students with mental health problems and complex needs. These cover services which may work closely with but were separate from central student services or the academic department. There was quite a lot of evidence of joined up approaches, liaison between

services and a commitment to holistic approaches, though this did not always amount to what might be described as an institutional approach. Despite this, collaboration between services was seen as important, so that *'little things might not become bigger things'* and, at one HEI, an Early Intervention form had been devised so that any member of staff across the HEI can raise concerns (see Section 5.5 for further details).

6.3.2 Estates

Comments relating to the physical estate tended to focus on adaptations and institutional responses for students with multiple and complex needs rather than on changes for students with mental health problems. Few HEIs have made specific adjustments for students with mental health problems to date, though one indicated that they would be able to do so.

Older premises, listed buildings for example, were described as presenting challenges in meeting the needs of students with multiple and complex needs whilst new builds were reported as offering opportunities to address the needs of students in an integrated way. At a number of institutions there was a clear and obvious commitment to planning and thinking about accessibility prior to commencement of any new building project; this was clearly facilitated by good relationships between estates staff and central support services. At another HEI, care was taken to ensure that any new builds or refurbishments took account of both physical accessibility issues and sensory considerations, for example lighting and paint colours which can have particular importance for students with a visual impairment or a student struggling with mental health problems.

Two institutions reported that they subscribed to DisabledGo, an organisation working in partnership with local authorities, universities, colleges, NHS Trusts and private organisations to provide pan-disability assessments or audits of locations, publishing the findings online so individuals may find out whether a particular venue is suited to their individual needs. This could allow any current or prospective student, as well as employees or visitors, to gain an independent insight into the physicality of the institution; one institution felt it was important to be as transparent as possible about access issues. The other mentioned that through working with DisabledGo, they had closed the inaccessible main front entrance to one building in place of an alternative accessible entrance, which ensured that all visitors entered through the same entrance and thus enhanced inclusivity.

Many HEIs have made adjustments to meet the needs of individual students who have declared a disability. This represented an additional cost for institutions, as adaptations were not covered by DSA. An example was given of recent adjustments to a room for a student with a form of chronic fatigue syndrome. These were extensive and expensive, though involved some give and take; including some compromise on the part of the

student who would have preferred to live in a different accommodation block. Adaptations to meet individual needs were described as time-consuming and complex and often included staff from across the HEI and in some instances external agencies who offered advice about specific requirements. Sometimes work would need to commence at a point where it was not even clear that the student would take up a place, or resulted in a delayed start to ensure facilities were in place. However, investment to improve or adapt accommodation for a current or incoming student would not only benefit that student but improve the overall estate making the institution more suitable for students with similar requirements in the future.

Generally HEIs reported that it was easier to meet the needs of continuing students or those who disclosed and discussed their requirements early. Some adaptations for students with multiple and complex needs were quick and easy to achieve, such as installing the right type of fire alarm system, providing an electric socket next to a bed so a deaf student can have a vibrating pillow, putting mirrors at different heights, having wash basins that can be lowered/raised. Other adaptations can be challenging and require extensive work. It was noted that building work itself can cause issues for disabled students, and that people experiencing mental health problems may be particularly affected by disruption and noise.

Library

Libraries, as repositories of information, were referred to as a potential source of information for both staff and students. When discussed, there was an understanding that students with mental health problems and some students with particular physical or sensory impairments may benefit from some or all of the following: provision of an external collection point for the return of library books; support to find books; and some flexibility regarding loan period fines and penalties. Training for library staff highlighted the benefits of: creating quiet spaces that enabled library staff to respond well to students who may be distressed; the advantage of ensuring that a designated member of staff was available to liaise with central support services; and the importance of library staff being aware of their potential role in mental health promotion.

Imagination can be applied to the design of library spaces and services. There needs to be an understanding that, for every student who perceives the library as a haven, there is another who finds its environment oppressive and anxiety-provoking or logistically a challenge to physically negotiate. The automation of systems for checking out books may be helpful for students who experience social anxiety, but alienating for students with physical restrictions or those who find comfort in basic human contact. Extended 24 hour opening hours may be facilitative for a student whose sleeping patterns are disrupted, but anxiety-producing for another who struggles with perfectionism and feelings of guilt when not working. The impact of changes such as these needs careful consideration.

6.3.3 Accommodation/housing team

Accommodation issues figure large in the lives of all students, and can be of particular importance in determining wellbeing. 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 but also in supporting students in some independent housing and advising on how to deal with private sector landlords.

In some HEIs housing staff worked closely with central support services and Students' Unions that had traditionally been considered to be a first line source of support. However, 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. For example, one HEI was planning informal gatherings after the Christmas break which was identified as a difficult time for some students. Another HEI appointed resident tutors (postgraduates who take on the role in exchange for free accommodation) to respond to out-of-hours incidents. If necessary, they could call security staff, (who followed emergency protocol); alternatively they managed the situation until student support took over. These resident tutors received training on first aid, student support and security and provided sessions on daily living skills, which other HEIs reported can be a source of anxiety for many students. Cooking and living skills featured in one HEI's summer school for students with Asperger syndrome as a way of preventing problems in the future. 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. One housing worker characterised what they offered as *'housing with support, not supported housing'*. Overall there was little evidence that mental health needs were explicitly asked about. Measures that might cater for the needs of a student experiencing mental health problems could include: 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. Although there was no reference to Personal Emergency Egress Plans (PEEPS), it is possible that these may provide a useful source of information and stimulus for discussion within departments as well as accommodation, or Health and Safety staff development.

6.3.4 Chaplaincy

At one HEI a recent consultation on mental health services concluded that *'the Chaplaincy is an important but sometimes overlooked participant in the overall network for students with emotional, psychological and mental health difficulties'*. Chaplains played a valued role in the support of international students and, in addition to ongoing support, which can be crucial at times of crisis such as in the face of a student death.

Across the case studies, Chaplains were not mentioned much. Where they were discussed, however, their role was clearly pivotal. Chaplaincy staff played a role as a first point of contact and opened channels of communication by introducing students to other services. They provided face-to-face support, not as counsellors but in the more informal context of a coffee and a chat; either in multi-faith Chaplaincy buildings or when working collaboratively in halls of residence or other locations. Sometimes their interaction with students developed into significant long-term support (a service which has hidden costs); and through simply 'being there', in an unhurried way, Chaplains played an often unrecognised role in facilitating disclosure. Chaplains linked in with existing projects and services specific to students with mental health needs. They also helped students to engage in non-mental health specific activities such as regular fair trade lunches or mindfulness activities.

The way in which wider HEI services can interconnect was exemplified by one Chaplain who spoke of their links with other 'pastoral service managers' including housing. They spoke of how hall wardens flagged up students who were struggling, financially (for example, while waiting for a disability grant to come through) or in other ways. The Chaplaincy provided £20 Sainsbury's vouchers or support of other kinds. This example illustrated how they contributed to a more extensive safety net, in which different services played a complementary role.

There was evidence that Chaplaincy services provide support on a very human level, in institutions that can feel bureaucratic and distancing. For example, in one HEI, the Chaplain had a dog, and a student would come and take it for a walk. The trust established enabled that student to access support through their GP and, in the student's view, was pivotal in enabling their success at the HEI. In another case, a student used the Chaplaincy as a kind of safe haven, spending up to 20 hours a week there, sitting and just 'being'. This kind of accepting environment can enable students to communicate about issues such as homesickness or sexuality; and can make the Chaplaincy an invaluable partner for other services wishing to engage with students.

6.3.5 Human resource/staff wellbeing

A number of staff mentioned the stress experienced by those who work with students with ongoing mental health problems or students whose support needs involve a lot of hidden demands. It was perhaps surprising that this was not raised more often. At

some institutions there were informal networks of staff who offer support and guidance to their colleagues, and in other HEIs, more regular formal arrangements where support staff could ‘unload’ at the end of the week. In some HEIs colleagues across the institution were able to make conscious use of some of the facilities in place for students to support staff. In one HEI the Equality and Diversity officer would seek out staff with support responsibilities for students with intensive or complex needs and ‘check out if they are ok’. This was a personal response rather than a formal requirement of the role but it suggests that individuals can be identified to look out for their colleagues in a similar way to the Student Minds campaign ‘*Look After Your Mate*’¹². Where there is a tragic circumstance – a student death or suicide for example – immediate support is offered in advance of human resource systems coming in to play. One member of the counselling team also pointed out that they might need to step in to help staff who were suffering with mental health problems themselves.

6.4 Student voice

6.4.1 Introduction

This section draws on the views of students, Students’ Union officers and paid staff, as they relate to support services, student-led initiatives and student engagement in decision making and institutional provision.

6.4.2 Student views on support

Feedback on departments

Students generally felt their departments were responsive to their needs. Indeed, one postgraduate student, who had studied elsewhere in Europe, expressed that they had been ‘astonished’ by the level of support from their department and the joined up nature of services. Their perception was that UK HEIs offered more than is available in other countries. More problematic, for them and for other students, was the question of access to information:

‘You don’t find out about it until you hit rock bottom ... I didn’t know that this support can go to this extent and help me on this level.’

¹²<http://www.studentminds.org.uk/look-after-your-mate.html>

Central support services

There was some evidence that, in general, students identified more readily with the term wellbeing than with disability or mental health. This potentially influenced how they responded to general advice and the extent to which they would apply for DSA or seek specific help from the mental health team. However, all of the students interviewed, who had made use of mental health support services – some of which are co-located with broader disability services – had found them to be helpful and responsive. Although there was no systematic or regular/explicit feedback on these services, students' views obtained via student surveys or individual feedback were used to inform service development and in some instances Students' Union officers discussed issues with individual services or as part of their membership of HEI committees.

Counselling and medical services

All of the HEIs provided a counselling service; typically offering four to six sessions, with referral on to external agencies in some cases. Student feedback was largely positive. Where there were negative comments, those tended to be about the short term nature of the services as here:

'I was only offered three (sessions). That's all they could give me, so what's the point? The reason I'm in this situation isn't because of something that a quick chat will resolve'

In one instance, the Students' Union disabled students officer actively discouraged students from using the counselling service, due to what were perceived to be excessive waiting times. As discussed earlier, although counselling services did limit the number of sessions available there were instances where they had extended the number of sessions whilst a student was waiting to access external counselling.

There was not much mention, by students, of the medical services on offer. However, there was evidence – from medical staff in at least one HEI – that the medical practice was well used by students for support not only in relation to strictly health-related issues but also to problems in day-to-day living. At another HEI staff suggested that: *'some students don't want to go and access medical support because they don't want it on their record'*. Whereas students with complex support needs may not have that choice, for some students with low level mental health issues it may be useful to monitor usage of the online resources or websites HEIs provide. Although take up was not discussed, given the reported increase in the number of students with low level mental health problems, understanding how, if at all, this source of information is used may help HEIs to review their services.

External services

NHS services were perceived as overly medicalised by some students, summed up in this comment: *'It's ... here's your antidepressants, off you go'*. Moreover, a number of references were made – by students and their representatives – to the lack of understanding, within NHS and third sector services, of the very particular needs of students:

'You get on the waiting list, you get to Christmas, get your appointment, you're at home, you miss it'.

Interestingly, HEIs did not mention any involvement with national activity around student transitions, such as the current Student Minds campaign¹³.

Lack of effective service provision may result not only from misaligned systems but also from ignorance and prejudice. One sabbatical officer commented that the external perception of students is that:

'It is a doss ... you've got a good life compared to other members of the community'.

Negative perceptions are sometimes fed by local press:

'They see students ... make a load of rubbish ... make a load of noise ... disappear ... leave things a ghost town ... and so you are fighting those prejudices as well'.

One student commented, tellingly, that *'sometimes [it] feels like the only person interested in your survival is your university'*.

Some external agencies might be more than willing to help of course. There was clear evidence of help for students with complex disabilities, especially those with physical needs which often involved time-consuming liaison between health, social care and the university. The cost of this type of help was in excess of DSA and often subsidised by the HEI.

Lack of information posed another barrier. One student representative expressed concern about their HEI's and Students' Union's lack of information and awareness about what is available locally, which they believed impacted on student choice. In their view, there was an urgent need for both the HEI and the Students' Union to address the information gap by mapping out where links with third sector organisations exist and how they can be built upon, which accords with a recommendation in the recent UUK report on student wellbeing (UUK, 2015).

¹³ <http://www.studentminds.org.uk/transitions-campaign.html>

6.4.3 Student-led initiatives

Organised student-run services clearly have an important role to play. Inevitably in smaller HEIs these were limited due to capacity issues. There were, however, examples of collaborative cross-institution initiatives in which individual students and Students' Unions played an active role in delivering sessions and publicising events.

Peer support or pressure?

Student Minds has been running a national '*Look after Your Mate*' campaign¹⁴ and although that was not mentioned, students and student representatives made reference to other students as a major source of support. They reported signposting their friends to HEI services and, in some cases, substituting for support services. That role can take a toll however. There was increasing evidence of pressures on housemates and other peers, resulting – in the view of one student advice centre worker – in more disputes and other strains within households.

In the words of one lecturer, students '*put pressure on each other – not necessarily deliberately, but because they are competing all the time*'. According to research from the Equality Challenge Unit, students disclose more easily to peers than to HEI employees¹⁵. However, students suggested that for some there was a fear of negative reactions from peers that may inhibit sharing with them too. For one postgraduate student, experiencing severe exam phobia, other students were perceived to lack empathy and understanding; a fact which they attributed to their youth and inexperience.

In one Students' Union a buddy service had been set up for students who experienced intermittent periods of stress (linked for example to exams or homesickness). Buddies received training from staff in the psychology department and supervision from the counselling service. A similar scheme in another HEI provided first year students with 'buddies and angels'. There was some evidence of cross-fertilisation between institutions (with good ideas being shared); although generally awareness of what was going on elsewhere was limited. For example, there was surprisingly little mention of peer support schemes (and no mention of Peer Assisted Learning), though these may, of course, have been in place in departments other than those consulted.

¹⁴ <http://www.studentminds.org.uk/look-after-your-mate.html>

¹⁵ Equality in higher education: statistical report 2014, Equality Challenge Unit

Enhancing provision

Students' Unions frequently acted as a bridge in to other services. As one union officer said:

'If we have someone who is at risk at 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, she continued '*reliant on people's good will*' and their willingness to '*go over and above*'.

One lecturer commented on the increase in student-run activity over recent years, and students and their representatives described a broad range of services. In addition to buddy systems, most HEIs have a nightline service; described, by one student with whom we spoke, as a key aspect of overall mental health provision. It was advertised frequently throughout the year, and particularly during exam periods, on the student portal.

At one HEI, a student alcohol worker had been appointed, based within the Students' Union. Although a positive development, a member of staff based in a Students' Union commented, with some frustration, that academic cycles are not taken in to account when this type of post is being considered. Often, by the time a worker has been appointed they have missed the introductory welcome week for new students and, by the time the next intake arrives – the funding having run out – that worker has already left. An academic year, as she stressed with reference to an alcohol support worker, is very short:

'You're not going to see a reduction in binge drinking amongst young people in that small a timescale when they're not here for Easter, they're not here for Summer and they're not here for Christmas.'

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; through, for example, offering back to a student sports club all bar takings from a club night once those reach a certain level.

6.4.4 Student engagement in decision making and provision

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. Some staff and students suggested there was limited involvement; others described student involvement that was highly embedded. Some variation is of course to be expected, given that consultation was

with individual students (who may not have been active in student politics) and with Students' Union officers and staff.

Example of good practice in student engagement: The University of Leeds

Students and staff at the university have worked together to create 'The Partnership', outlining what students and staff can expect from each other, what staff can expect from students, what students can expect from staff and what staff and students may expect from their peers.

This was seen as a valuable agreement in the eyes of students, who noted that this meant there should be student representation at every university committee, for example during discussions of the shape of the institution's mental health services and discussing the mental health review.

In addition, the Students' Union's new strategic plan has been informed by research with several thousand students who were asked to share their feelings and experiences in order to inform the more strategic work of the union.

At one HEI whilst there was evidence of consultation, the sabbatical officer was less certain about the effectiveness of the Students' Union in bringing about change when taking issues through the committee system. At another the sabbatical officer said '*I don't think there's been anything of major significance that we've not been consulted on*'. They explained, based on information from 'other sabbatical friends', that in other institutions that is not always the case. Moreover, there was a sense in this HEI that staff were genuinely committed to wellbeing issues; addressing them not just as '*a tick box exercise*', but going '*above and beyond what they have to do*'. In one HEI a '*you said ... we did ...*' system of feedback ensured that students had a sense that what they said 'counted'. At the same HEI there was evidence of a student suggestion relating to the needs of disabled students having been implemented.

In several HEIs, partnership 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. In that institution Students' Union services, and those provided centrally by the HEI, seemed to exist in competition.

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. The importance of the relationship between the institution and the Students' Union was underlined by one union officer's comment that, although students were anxious about the changes to DSA, that was to some degree allayed by their sense that their HEI was addressing the changes well, including students in all relevant working groups.

Mechanisms for consultation were not only established in relation to Students' Unions. For example, at one HEI, the student mental health advisor held regular forums with students around mental health. At another they were active members of a cross-university working party that was developing an annual programme of events that tackled a wide range of wellbeing activities including targeted events for specific groups of students.

Finally, student engagement was bolstered in some institutions by the use of paid advice centre staff to support student sabbatical officers – freeing them from dealing with day-to-day enquiries and enabling their roles to have more impact. Conversely, student intern posts were used elsewhere to support paid staff, freeing them up for direct support work with students. Involvement of students not only in the design but also in the communication of policies was evident in some HEIs and has been identified as an important approach¹⁶.

¹⁶Equality in higher education: statistical report 2014, Equality Challenge Unit

7 Working with external agencies

7.1 Introduction

This chapter draws on interviews with institutional staff to look at the various ways that they are working with external support agencies including: working with on and off-campus GP practices; working with NHS and statutory services including NHS mental health services, Improving Access to Psychological Therapies (IAPT), community mental health teams etc.; and involvement of local and national organisations including the police and specialist services. At the end of the chapter some good practice examples are provided of institutions working well with external agencies.

7.2 The importance of external agencies

There was evidence across all the institutions in the study that they are working closely with external agencies in both the statutory and voluntary sectors, although some are more strategic in their approach, some more proactive, and some more successful in sustaining these networks and relationships. External agencies are seen as a vital component of the picture. *'We get a good level of service from virtually all external services'*.

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. *'It's really crucial [to be clear] about where our boundaries need to be, and if we're not able to do something'*. Other staff talked about *'a clear dividing line between our responsibility as education provider and responsibility of social care to provide that care'*. However, some staff also 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'.

Another interviewee agreed that HE needed to take responsibility for the impact of learning on some students:

‘Taking vulnerable people away from their personal support networks and then giving them a massive amount of academic pressure is ‘a potent cocktail’’.

There was also general agreement that it was part of the responsibility of the HEI to ‘signpost’ students to the appropriate services:

‘Whilst we’re obviously not professional services, we will see and have contact with [external agencies] to help liaise and signpost where possible, because obviously we want to make sure that support is appropriate to them’.

Some HEIs also described external agencies as a ‘core stream’ of the support package offered:

‘We do a lot of work pre-entry. We will work with the occupational therapists, we work with doctors, both at home and in the university to make sure that beds are in place, any other adaptation as the university can do, or if Social Services have their individual pieces of equipment, then that they’re in place so the student can access those’.

Students would also be signposted to one of the several organisations with which the HEI had a close relationship. This was particularly the case for students not in receipt of DSA as much provision was reliant on this funding. Nevertheless, the specialist expertise offered by these external agencies was seen as highly valuable for those receiving DSA as well.

Networking with external agencies was also regarded as valuable because it helped the HEIs understand the changes in local services. However, it was generally felt that HEIs needed to be proactive: *‘These people aren’t queuing up to come and talk to us’*. It was suggested that this was because *‘many services are also under intensive pressure’*.

A number of interviewees also sought to point out that external agencies are often involved in working with the HEI in more complex ways. They may act as part of the students’ courses, so for instance an (external) occupational therapist interviewed reported that she was:

‘linked with the University. I have a number of students who are on placement and I have a service user who is planning on starting a history degree’.

This dual relationship appears to be helpful in building relationships and mutual understanding about the working environments of the university and the external provider.

The importance of individual contacts was also stressed by a large majority of the HEIs in the study. Many relationships were described as ‘pragmatic’ or ‘ad hoc’ rather than strategic, and as heavily reliant on individual energy and goodwill on both sides. Thus, in at least one case, the mental health advisers and the health adviser were more able to talk about working with partners than the more senior managers who were

interviewed. However, some interviewees also noted that teams in the NHS are constantly changing which can make communication and liaison very difficult at a personal level.

The overall picture was, therefore, one where the importance of good working relationships with external agencies, and the need to make students aware of the expertise that could be accessed through these agencies, was stressed. However, some HEIs faced a more challenging environment when establishing these relationships, and all were very aware of the financial pressures that were shaping the response of many of both the statutory and voluntary sector agencies to their overtures.

7.3 Challenges of working with external agencies

The majority of HEIs in the study mentioned time as being a particular challenge in sustaining relationships with external support services. Making contacts and sustaining them was time consuming for staff and the time invested was, in effect, a hidden cost. Whilst most often described as time well spent, some staff felt the immediate pressures of their work did not allow for the time needed to start and sustain these networks. In addition, where HEIs were dealing with both FE and HE students, it was felt the issues facing the students differed, and, thus, so too did the networks and external agencies with whom the institution needed to work, making for twice the time/work.

A number of HEIs mentioned that 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 MH teams:

'The main difficulties in that area are around a student having offers from several institutions, so if we contact the case workers from the student's home area they can often be reluctant to let us have additional information, in terms of data protection, confidentiality etc., so that can present some barriers; we don't always have access to all the information we need, and in any case the student might actually never come here. They may go to another institution.'

Non-campus based HEIs also faced particular challenges. They may not have an on-site health centre and students may be spread across a wide area of a city, both in their places of study and in residences. Making links with all GP practices, NHS Trusts, and other support services that students might access, may not therefore be a viable option for small teams of specialist workers already spreading themselves across a number of teaching sites.

It should also be noted that this is not a one way street, with HEIs making demands on local services:

‘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. Now I think the main criteria for that is probably that they get seen quicker through the counselling service, which is good in the sense that if you’re waiting 12/15 weeks for an appointment that’s more or less half an academic year which a student could drop out unnecessarily’.

A number of other HEIs also noted that the waiting time to access services can be too long, in which case the college often provides interim support:

‘There are long waiting lists for accessing MH services. GPs refer a number of students back to college services. We are having to hold these students because they can’t access the local services [9 month waiting list]’.

These are examples of where HEIs are helping take some of the load from local providers.

Negative relationships and responses were rare, with only few examples cited by the HEIs in the study. One interviewee pointed out that students can be discriminated against by external agencies who feel that the HEI should look after its own, and that students are undeserving. There was the danger that students are sometimes treated as a homogeneous group; outsiders can think:

“‘This is the student lifestyle” - when actually there are all kinds of students. Like mature students, or students who care or have dependents. Or international students. That’s not reflected in the response of some agencies’.

Students can also face hostility at some external GPs 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.

7.4 Examples of working with external agencies

7.4.1 General Practices and GPs

Relationships with GP practices varied significantly across the study. Geographic location was one key element in determining the success of this relationship. Institutions with multiple sites spread across major cities faced significant challenges in establishing working relationships with all the GPs and health centres with whom their students were registered (or not), many of which had different practices and pressures on waiting lists etc, whilst institutions with campus based GP surgeries were well placed to build good working relationships. This was not always the case however. In

one instance, staff described significant tensions with working with the GP surgery on campus which had led to a number of formal complaints. In another the inconsistency of response from campus based GPs was noted, with some GPs knowing more about mental health, and being more comfortable in addressing mental health issues, than others. One HEI described the local GP practice as providing 'core support', and staff from the practice were present at the HEI's enrolment day. HEI staff were highly positive about the support provided from this practice, including their knowledge around health and wellbeing needs of students. Throughout the year, the Student Support Manager liaises with the practice to see how things are progressing.

Support staff in many of the HEIs proactively worked to encourage students to register with their local GP, although many students (if they have left a family home to go to HEI) will have their own GP at home. With MH students, staff in one instance also encouraged GPs (with the student permission) to liaise with the student's home GP to facilitate continuity of care. However, it was also noted that even students with enduring mental health problems often fail to register with a HEI GP.

One interviewee described the institution as having good links with the local psychiatric service through 'LIFT' (Least Intervention First Time). This service offers a wide range of support through GP surgeries to anyone with common emotional, communication and mental health problems. The LIFT psychology services range from self-help therapies, to psycho-educational courses and one-to-one support, and means that they offer services in a tiered approach where the most commonly helpful support strategies are recommended first.

Most interviewees recognised that GPs '*were squeezed*' with one HEI describing the on-campus surgery as 'generally overwhelmed'. This may be because, as one academic member of staff pointed out, the requirement on students to provide medical evidence – in order to obtain reasonable adjustments (eg extensions for assignments) – can add to the pressures on GP services and inadvertently medicalise what, in fact, are more social issues. Consequently, waiting lists were often cited as a major problem:

'There's a bit of batting back and forth; we suggest they (the students) go to the GP and they send them back to us as they have long waiting lists and often what we can offer is quicker. Waiting lists are a major challenge, particularly when students are in crisis.'

At another institution stringent efforts had been made to make changes to the day to day operation of the surgery to facilitate accessibility – for example, the offer of on-the-day appointments, longer appointment times (increased from 10 to 15 minutes) and extended opening hours of 7am until 7pm five days a week. Reception staff had been well trained and systems were in place – for example a code system for common issues – so that students were not having to articulate complex problems at the reception desk.

7.4.2 NHS and statutory services

Again, HEI staff interviewed were all very conscious that the NHS in their area was working against a backdrop of significant cuts across all its services, with large student numbers in their area making additional demands on top of those of the local community. This latter issue is of particular note where students may be a significant percentage of the overall population during term time. These cuts in NHS provision externally mean HEIs are acting to 'hold' students in the interim. For example, some staff described such long waiting lists for counselling under the NHS in their area, that:

'students are being referred by their GPs back to the university counselling service as they know they will be seen more quickly'.

HEIs felt that, as they were unable to provide the level of support some students needed, they were left with *'no option but to keep pushing'*.

Some students interviewed also had severe concerns and criticisms about the wider health system and external agencies. They described how the NHS system can fail when a student transfers to a new area to study – they can be discharged from one service and not picked up by another service (due to waiting lists etc¹⁷). Again there was the awareness that the NHS tend to refer individuals back to their HEIs for support.

However, one HEI interviewed was more proactive: if a student was already being supported by a community mental health team or a psychiatric team, the student services would encourage the student to speak with this team about their *'intent to come and study'* and initiate arrangements for putting in place the transition to the new team in the HEI's area.

More than one HEI counselling service described *'very close links with the NHS'*, working closely with, for example, the Early Intervention in Psychosis organisation and with IAPT services and the local Urgent Response Service. Even with these close relationships it is possible for situations to unravel:

'In the unlikely event that a student is sectioned, there have been some examples of the student being discharged from the hospital, sent back to their university accommodation, and the University not being made aware'.

There was agreement, from many respondents, that where a student is in receipt of external services, links are generally good. Relationships with NHS mental health

¹⁷ This issue is the focus of the national Student Minds transition campaign
<http://www.studentminds.org.uk/transitions-campaign.html>

teams were often strongest, as HEIs were more likely to draw on these services than others. One HEI, for example, described links with the community MH team as *'good'*, although *'stronger at case load level than strategic'*. Another HEI was striving to make links with social work teams and Community Mental Health Teams (CMHTs) to cross-refer and to have easier routes. They have found that these relationships tended to be more ad hoc than having dedicated liaison personnel.

Students at one institution were fortunate enough to be able to access a local Trust's Personality Disorder Clinical Network:

'Students with personality disorders can be hard to manage because of their unstable emotional wellbeing and the 'trial and error' nature of medication, so this is very welcome'.

The service offers a four week assessment and then, if the person is judged suitable, two years of support. Whilst understanding the need for services to be targeted to those who are ready to make use of them, it was pointed out that it can be very stressful for students, waiting for the assessment period to be over and a decision to be reached:

'If they don't engage, they get nothing and we get back that person who is feeling rejected'.

International students pose particular issues in relation to the NHS. They often come with an expectation that the NHS *'won't deliver'*, or may not realise that they can access NHS services, or know how to access them. There can be issues with treatments students are receiving before they arrive in the UK that are endorsed in other countries but not available here, so sometimes students will seek out alternative medical remedies which are a concern to the HEI.

More generally, there was a concern expressed by some staff and students alike that the NHS lacks understanding of students' needs:

'There is a general lack of understanding about students from the NHS, about things like term times and the fact that you get on the waiting list, you get to Christmas, get your appointment, you're at home, you miss it'.

The NHS was criticised for not tailoring services to people's circumstances, including not factoring in adolescent volatility, something for which a very brief intervention can solve the issue:

'..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'.

One interviewee also said there seemed to be a lack of recognition in the NHS about the needs and circumstances of students regarding mental health – NHS mental health provision is predicated on people living with their family and having that support at home. There is a lack of strategic understanding about student living, and so student mental health issues are a low priority in the NHS.

‘I said it before but I will keep on coming back to this: 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?’

When students are in immediate crisis, HEIs will refer students to the local crisis team (variously named, including Urgent Response Service), who respond to emergencies with students, including when students are at risk of harming themselves or others. If an advisor has serious concerns about a student, they will get in touch with the service team:

‘We can refer them to the Urgent Response service if we receive a student who’s at risk or sometimes I’ll just contact them for advice if the student appears to be unwilling or unable to make that contact themselves’.

Students at some institutions were also signposted to the crisis teams as part of the provision put in place for students in crisis outside of HEI hours. One HEI reported that it can be a fairly regular occurrence that students get admitted to the local hospital having taken an overdose – they had six students who overdosed one week in July, but only two of these were students that the student support services were aware of. However, again, interviewees noted that the crisis teams are under huge pressure, with many resources being cut, so there is little capacity to cope with additional student referrals.

The NHS also offer other specialist services, including sexual health clinics, the cancer services, the personality disorder service and occupational therapy services. Students may also be signposted to the eating disorders service. However some interviewees report that these are *‘surprisingly, not well-used by students’* as they felt that students often preferred to discuss issues such as anorexia or more general disordered eating with a member of staff from the HEI counselling service. Some of these services are also provided on campus, but there was inconclusive evidence that this is encouraging students to access the services more readily. However, they do provide a source of information and support for HEI counselling staff or advisers who are not experts in particular fields.

Some institutions had an in-house specialist for alcohol and drug abuse, and effective relationships with the alcohol and crime reduction initiatives, and drug support

agencies. In one HEI, an alcohol worker was paid for by local health funding and located within the Students' Union so where students were fearful of the stigma of attending services off campus, *'outreach workers will come here and build the links'*. In another, an NHS-funded alcohol nurse had recently been appointed:

Example of proactive provision concerning alcohol: The University of Leeds

Alongside discussion of the complex relationship between mental health and alcohol, interviewees discussed the recent appointment of an NHS-funded alcohol nurse as well as other preventative initiatives. This is an example of collaborative work which supports the agenda of the university and NHS trust. For example, the students' union has introduced water bars so that students would not be put off getting a drink of water by large queues at the main bar.

7.4.3 Police

HEIs also work with the police service and public protection. This was broadly described by one interviewee as *'the University works in conjunction with the Lincolnshire Police to ensure a safe environment for all staff and students'*. However, the contact with the police may also be with regard to particular issues impacting on the mental health and wellbeing of students, such as the sale of 'legal highs', or with regard to individual students who are at risk of harming themselves or others.

7.4.4 Provision of mentoring services

Mentoring support was seen by most HEIs as key to students being able to continue their studies and succeed in negotiating both the academic and social aspects of university life. Mentoring provided students with a range of strategies and skills to help them survive and prosper at university.

Some HEIs used external agencies to provide DSA funded services such as mentors. Two HEIs in the study worked with Randstad Student Support who are employed to provide the mentors to support students with MH problems, whilst additional agencies were also used by other HEIs. One HEI described a proactive relationship where they vetted all mentors, and whilst this is costly in time, using Randstad Student Support, in practice, saves them money as they make the DSA applications for students. Most agencies employ trained specialist mentors, who have a background in social work or mental health, and therefore have the confidence of the HEIs to provide appropriate types and levels of mentoring support.

Some agencies will seek consent from the student to be able to share information with the HEI, and the agency can then give them monthly updates – session logs, goals set, resources used etc. – to the HEI support worker or adviser who works with that student.

In another institution, the HEI employed their own health mentors who were listed as the providers for mentoring in the DSA support. They only used an external agency in this regard if there was an unclear recommendation or a particular logistical problem which could not be solved. Relationships with private external agencies were seen to take longer to foster, and issues arose with the HEI having to chase up 'inaccurate/ not entirely appropriate' recommendations for particular students. Because of the nature of MH and physical disability conditions, the needs of the students fluctuated and often changed from the point of their initial assessment, which could create a disjuncture between the assessment centre recommendation, and what the HEI felt was appropriate for the student. The delays in receiving recommendations were also seen to be particularly problematic for students living with an autistic spectrum condition where it was seen as important to access support services as soon as possible.

7.4.5 Other external services

All institutions in the study worked with a range of non-statutory and voluntary organisations which provided a range of services to students. These might include mentoring support (as described above), interpreting support, or specific support for a variety of problems that students were facing. HEI staff recognised they did not have the resources or expertise to support students in a complex range of health and personal wellbeing issues, so were able to draw on these specialist services as a way of meeting student need.

However, one interviewee noted:

'External agencies don't have the resources to meet all the current needs. In an ideal situation we would work together rather than compartmentalise ... We don't offer any advice to partners about students or HE - it would be good to give them something back.'

Some HEIs found it challenging to make and sustain such links. Time and competing demands were mentioned as reasons for not being able to pursue some of the links and maintain the working relationships. In one case study, despite low levels of external resources being drawn upon, the 'desire' has been there.

Others stressed that they were keen to develop such relationships, but felt they needed to map what services there are outside of the HEI as a starting point. Knowledge was often invested in particular individuals and when they left the HEI, their knowledge and contacts were lost. Some Students' Unions were also very keen to map out their relationships with third sector organisations and '*where we talk to them, where we both talk to them as the university and the union, and what exactly our relationships are*'. This was felt to be important in increasing choice for students – '*at the moment, if they don't want to receive a service through the university, there is little knowledge of what else is out there*'.

Others, however, had strong links built over time with a range of organisations, which offered individual information and support for students. It was felt that the high proportions of disclosed disabilities or difficulties at some HEIs meant they had fostered very good relationships with many external organisations. The expertise that external agencies provided was also felt to be a crucial resource for staff, *'who should not be put in a position that they are not qualified to deal with'*.

Most HEIs included information about various local and national organisations on their web pages to signpost students to appropriate services. Examples of such organisations include:

- BEAT – the beating eating disorders support organisation (and others eg Somerset & Wessex Eating Disorders Association) which supports students at a monthly drop-in on campus. A large number of the MH students that health advisers see are exhibiting an eating disorder.
- Bipolar UK – an organisation that's very proactive in working with HEIs across the UK. They help students get a range of support, including peer support groups.
- CALM (Campaign Against Living Miserably) – specifically for young men, who are three times more likely than women to commit suicide.
- Citizen's Advice Bureau – used for many different reasons, sometimes legal, other times students with mental health issues which impact on financial behaviours.
- National Autistic Society which provides mentors and links into social activities, or in-class assistance.
- Rape Crisis services eg Somerset & Avon Rape & Sexual Abuse Support (SARSAS) – these organisations offer a specialist support service for women and girls who have experienced any form of sexual violence, at any point in their lives. This include: rape, sexual assault, sexual abuse, incest, sexual domestic violence, trafficking and sexual exploitation, female genital mutilation, ritual abuse, forced marriage, crimes in the name of honour, sexual intimidation, coercion or harassment, whether physical or verbal.
- Samaritans – there were several references to closer links with the Samaritans who staff would refer students to and whose services were publicised. This reflected the view that *'people's problems aren't 9-5'* and potentially extended the time when students had access to someone to talk to and was especially important outside 'working hours'. In one institution a formal partnership with the Samaritans had been put in place to provide out of hours support similar to student run nightline services. This demonstrated the institution's proactive approach. It also illustrated how external services, although not a direct cost to the HEI, did incur staff time and represented a hidden cost.

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- Sirona Care & Health is an independent, not-for-profit organisation (based in Bath but serving a wider geographical area) providing publicly funded health and social care services that support people to achieve their goals and full potential. It has the council – Bath & North East Somerset – as its partner. It offers free advice and support for adults with mental health needs and a short term psychological therapy service.
 - Students Against Depression and the local MIND organisation.
 - Terence Higgins Trust – who work with students who are struggling with their gender identity.

Many HEIs also used their websites very effectively to promote a health and well-being agenda to all students and increase access to information. One HEI has launched a month by month programme of health promotion campaigns including events on disordered eating, bowel cancer, mental health, winter disorder SAD, the importance of sleep, personal resilience, prostate cancer awareness, and being drinkwise.

Finally, some HEIs in the study have also developed relationships with national bodies related to MH provision in HE: Mental Wellbeing in Higher Education (funded by HEIs UK); Heads of University Counselling Services; University Mental Health Advisors Network; and Student Health Association (broader than mental health but concerned with mental health too). Students' Unions also had links with Student Minds and the Alliance for student led wellbeing.

Example of Good Practice: Working with External Agencies

Leicester Mental Health steering group

The Leicester Mental Health Steering Group is an external partnership with De Montfort and Leicester University, the City Council, the NHS, GP practices, and the police.

The aim of the Group is to improve mental health provision by working collaboratively and understanding good practice. It's a platform for pushing issues of student mental health up the agenda, particularly with health service commissioners, but also within the university itself. The Group meets quarterly, but uses email exchanges at other times, and a commitment has been made by all partners to move forward together.

One direct output of the Group can be seen in the Council's Joint Specific Needs Assessment for Mental Health where there is a section on student needs, which recommends, among other things, that commissioners develop strategic level contact with student welfare services to develop an integrated approach to student mental health.

Having community partners around the table makes the university aware of what provision is available locally: it acts as a focus for discussing and disseminating information about

the wide range of voluntary provision that is available, so staff can ensure students are referred on to appropriate services. It also helps community partners understand students and their needs, including the fact they are often a transient population. The Group also works closely with the Students' Union, to ensure the student voice is heard.

The Group is beneficial to all concerned. Each partner understands more clearly the work practices and challenges of the other; student needs are better understood and therefore more likely to be met; crisis situations are managed in a more timely way; it gives the university services a level of priority and buy-in internally that otherwise they might not have; and students are not going to A&E so much for crisis situations which benefits NHS colleagues.

8 Funding issues

8.1 Introduction

This chapter explores issues around the funding of support for students with mental health problems and those with high cost needs. It looks at the levels and sources of funding for supporting students including the Disabled Students' Allowance (DSA), the Student Opportunity allocation and institutions' central core funding and the interplay of the investment from these different sources of institutions' income. It then looks at the perceived sufficiency of funding, and how decisions are made to deploy resources.

8.2 Sources of funding

Support for students with mental health problems and/or those with high cost support needs was generally funded through two main sources: the Disabled Students' Allowance; and the institution's core funds which includes the Student Opportunity disability allocation, and Student Opportunity allocation for widening access.

It is worth making a distinction between these two sources of income as they are accessed and used very differently. The DSA follows the student rather than coming directly to the institution, and, at least in part, pays for the long-term specialist support required by particular students. Students apply for the DSA themselves, although often with prompting and support from student support services (eg disability advisers) as outlined in earlier chapters. Indeed, institutions felt it was important that eligible students should seek to access the funds they were entitled to rather than rely on the support of the institution, and put staff time into supporting their applications. Some staff were concerned about the application process which was felt to be more onerous and requiring more evidence than in the past. Students then receive an award based on the results of an independent assessment. In theory, students are free to spend their award where they see fit to access relevant provision, but in practice students would be guided by disability advisers to either use the institution's own mentors, or those of the institution's recommended agency.

One issue raised about DSA funding was that it led to a very individual approach rather than a whole institution approach, and institutions might have two or more

students in a particular lecture or class who were each getting note-taking support funded by DSA. The arrangements for the funding meant that it was difficult for the institution to try to consolidate the support. The only way around that was for the students to negotiate a private arrangement to share.

In contrast, student support provision (eg disability services and counselling) were generally funded through the institution's core funding. While the HEFCE Student Opportunity disability allocation was commonly cited as one part of funding to support these services, the cost of the services was far greater than the amounts received in the disability allocation, with the remaining funding coming from Student Opportunity widening access or retention funding, and institution's fee income – one interviewee described it as *'using funding from non-disabled students to support disabled students'*. Indeed, HEIs reported that there was a need to use increasing amounts of core funding as the Student Opportunity disability allocation did *'not even come close to'* covering the full costs of providing support to the disabled student population and often the DSA award (which has a cap) did not cover the full cost of supporting the assessed needs of individual disabled students. There were concerns about the shortfall of funding when assessed against known costs of staffing of disability services but institutions acknowledged that real costs went beyond this as a much wider range of staff (and their time) were involved in supporting students (see Chapter 6). Costs also included freeing up space (finding suitable space was often challenging) and the purchase of equipment. Even using unpaid volunteers had a cost implication, as they would need supervision by trained staff and administrators.

Figures on Student Opportunity funding allocations provided by HEFCE allow some descriptive analysis of amounts received by universities and large FE colleges in their disability allocations. The element of Student Opportunity funding for widening access and improving provision for disabled students reflects institutions' success in recruiting and retaining disabled students. The allocations are made pro rata on the basis of weighted student full time equivalents (FTEs) from the previous year, with institutions assigned to one of four weighting bands according to the proportion of its students who receive the Disabled Students' Allowance. Institutions receive a minimum flat rate of £10,000 even if they have no students in receipt of DSA.

In terms of Student Opportunity disability allocation funding, in 2014/15 a total of £14,473,000 was distributed, similar to the amount distributed in 2013/14, but up on the £12,422,000 distributed in 2012/13. As a proportion of total Student Opportunity funding the disability allocation increased from 3.8 per cent in 2012/13 to 4.9 per cent in 2013/14, before falling back slightly in 2014/15 to 4.6 per cent¹⁸.

¹⁸ The provisional figure for 2015/16 is £20 million, so there will be an uplift on the 2014/15 figure.

Table 8.1 presents breakdowns of the 2014/15 disability allocation by type of institution. There was little variation in the average (mean) allocation between general HEIs, although those with medium average tariff scores received the most on average, at £154,300, and those with low average tariff scores received the least on average, at £121,600. Specialist HEIs (excluding the Open University) received on average £39,200, but there was significant variation here with many institutions receiving the minimum of £10,000 and a few receiving more than £100,000.

Table 8.1 Student Opportunity disability allocation 2014/15 by institution type

	Mean	Median	Lower quartile	Upper quartile	Min.	Max.	N=
Specialist HEIs (excluding OU)	39,240	22,150	11,140	41,850	10,000	295,050	38
HEIs with high average tariff scores	148,660	137,730	83,740	229,330	41,190	287,040	30
HEIs with medium average tariff scores	154,310	130,190	88,120	224,590	42,420	310,380	30
HEIs with low average tariff scores	121,560	104,190	69,950	159,880	24,900	402,840	30
FECs	26,800	17,900	11,860	47,140	10,000	56,880	9

Source: HEFCE

To illustrate the difference between the amount of Student Opportunity disability funding received and the total expenditure on disability services, some of the institutions were able to provide detailed figures on the real cost of student support services including counselling in relation to their SO disability allocation. The SO disability allocation as a proportion of the total expenditure on disability and counselling ranged from 30 per cent down to 15 per cent. An alternative way of looking at it is that for every £1 of Student Opportunity disability funding institutions received, they were investing a further £2.30-£5.45 of funding from fee income or other sources.

The Student Opportunity disability allocation funding is not ring-fenced for disability services, and some interviewees referred to funding for disability services as 'origin blind', with all resources collected into one pot and then funding being distributed across the institution, apportioning resources based on operating costs and targets. In general institutions appeared to support the lack of ring-fencing as they felt it could restrict rather than enhance their provision. However this did mean that disaggregating the funding streams for a particular service would be extremely difficult. As one interviewee said:

'the Opportunity Funds do not go into a box somewhere and get drawn on, it provides part of our central resource which is looked on as a whole. The work of supporting students goes right across the university in all sorts of different respects so it is right that we do that'.

Institutions also described other sources of funding they could draw upon. These included funding from other university budgets such as estates and building maintenance, and project work and charities.

As noted below, institutions could draw on capital allocations, health and safety or maintenance budgets to make physical adaptations for students to learning spaces or accommodation or to provide equipment.

Some institutions also drew in support from local organisations, charities and alumni donations.

‘we work extremely hard to make sure the students are getting everything that they can from the various funding resources that we have, and we only go to our senior managers when we have exhausted every other prospect. We’ll help, apply to charities ... Our students get a lot of money from the Snowdon Trust. We’ll help students to make sure they’re getting the best from their DSA. So it’s only going to senior managers when there’s no other opportunity ... The Snowdon Trust have helped us when students ... their DSA has run out, or if they’re an international student they don’t get DSA. It’s, I think, £2,500 maximum award, which can be quite significant a piece of equipment, or for tuition.’

These donations were welcomed but often short-term which could be problematic given university timescales, and needing to get support in place before students start. One institution also talked about the possibility of reducing students bursaries in order to top up their student services funding.

8.3 Budget determination/forecasting costs

Budgets for student support services were generally developed through the main annual budget agreement processes. It was commonly a two-stage process with the disability manager or person in a similar role putting forward a case for the budget level to their line manager, eg Director of Student Services (generally a member of the senior management team), and then the budget going up to the senior management team or executive board. One institution described this as an annual ‘*conversation*’ where a departmental review process is undertaken in order to set priorities, requirements going forward are discussed, and cases are made for additional resources. Decisions are then taken by the senior management. Once the budget is set it is then up to the department how to spend/allocate it, although staff costs are the single highest cost.

As noted in Chapter 4, the drivers for supporting disabled students were a mix of social, legal and business responsibilities, and so in deciding and negotiating their budgets student support services managers are seeking to balance these obligations with available resources, for students with all types of impairments and disabilities. There was little mention of negotiations and conversations resulting in choices being

made over prioritising support for students with one type of impairment over another. Rather support was looked at in totality, with flexibility built in to adjust to the changing demands from each year's intake. Institutions also reported seeking to reduce administrative costs wherever possible to allow for more resource to be directed towards student-facing, value-added activity.

At present, however, the level of funding was felt to be sufficient and in general institutions felt they were able to leverage the funds they needed to provide the required services (as they tended not to be requesting a huge expansion in their budget).

'We are not aware we've ever said we haven't got the funding, the head of student support is very committed to have the support, always makes a case. A pot of money is available each year, we all know if we need to tap into that funding.'

Indeed, one institution noted how the work of student support services was well received, and as part of student experience was an aspect of university life that was appreciated and seen by all:

'Always felt that student support is in a particular place in that the needs will be recognised over and above any other considerations going on ... not talking massive investment ... other services don't have that level of leverage.'

However, it was emphasised that much more could be done and more provision put in place if there was additional funding.

There was a feeling in some institutions that the process of annual budget setting was more reactive than proactive. At its simplest it could involve rolling forward the previous year's budget with little assessment of need but generally involved a review of the previous year's provision including any shortfalls/challenges and an assessment of likely need for the year ahead.

For example, one institution reported that they look at level of demand in the spring each year, in terms of how busy counsellors and disability advisers are, and set that against projected student numbers for the following academic year. This institution also used an externally provided service to test and benchmark the level of professional resource in their student support services compared to other institutions. They explained how in the previous year they had looked at their capacity for counselling and due to building waiting lists, put in place measures to increase staff in the following year's budget. They also noted how, although demand for support was increasing, it was still difficult to precisely gauge demand as individual needs could vary significantly from year to year. Despite increased efforts to encourage students to disclose before they start, students were still disclosing needs during their studies or developing problems whilst on course (and this is especially the case with mental

health problems). It was, therefore, difficult to make assumptions about level of need based on numbers of students with disclosed needs, and total student numbers. It was also difficult to make simple assumptions about end support requirements linked to condition:

‘Individual cases can be very resource intensive, and can come out the blue ... one case took up two staff for a fortnight’.

The challenge in determining accurate budgets meant that institutions could run out of funds during the year and have to make a case to increase their budget and draw on university central funds, or look to alternative sources such as charities. To date, institutions have successfully been able to secure additional funding.

8.3.1 Contingency funds

Some institutions reported having a special pot of money set aside to support specific cases of disabled students. This appeared to be a type of contingency fund which could top up or form part of the annual student support services budget to try and deal with variable circumstances/situations that could be difficult to plan for in advance.

In some cases these budgets were used to help support individual students known to have high cost needs. In other cases these budgets were for physical adaptations to accommodation and buildings, adaptations which could be tailored to a particular individual but likely to have a wider usage and benefit.

One institution reported a disabled student fund (£100,000 per year) for situations where DSA support is not sufficient to meet the support needs of a particular student or to support those who were not eligible for DSA, although it was noted that sometimes support for just one student may use up a significant chunk of the budget, for example supporting students with sensory impairments. Another institution reported having a ‘generous’ disability fund to support students or for training, equipment or resources across the university. The fund would roll over if it was not all spent in a particular year so was growing, and could pay for non-medical support significantly above the DSA.

In terms of budgets for physical adaptations, another institution reported having a capital allocation of £100,000 each year as a starting point, but that they would spend more if need to make adaptations for students.

‘There’s a capital allocation each year, and it varies from year to year but in essence it’s £100K. We start with £100K. We might have to spend more than that each year, for example, if you get five students in wheelchairs all need adaptations in one year, then that’s never going to cover it. But we start with that as a baseline. Some years we’ll have to spend more than that’.

This institution gave one example of a student joining in 2014 where significant adjustments had to be made in terms of accommodating a powered wheelchair, installing hoists in the bathroom and bedroom, and connecting the accommodation to an adjoining room for the student's live-in carer, which all cost more than £50,000. But as a result of this and other adjustments in the past the institution is *'now able to say we have a fully accessible campus'*. The budget also allows them to be somewhat proactive about improving the estate:

'if there's an excess in the budget that we've not used for a particular adaptation, we can then look at some part of the estate where we think a new ramp in there ... we've got the list of schemes that we'd like to do, because we've asked people to identify, in your areas, an adaptation to the estate that would make it more inclusive.'

Another institution reported drawing on building maintenance, and health and safety budgets to fund alterations to the estate for students with a disability, with different types of support being sourced from each budget. For example, vibrating pillows and centurion alarm devices are sourced from the health and safety budget, but where kitchen adaptations were made this was from the maintenance budget. The budgets had, to date, been sufficient as large-cost adaptations had been one-off things and reasonably spread out rather than regular large-scale requirements:

'I have budgets, but I do have the remit to go to my boss and say, we need this. So, if I can make a good case ... so far, we've done everything. We haven't said, we can't do this. BUT I have no idea what I might need to do to change the estate. There may be nothing, there may be plenty, but I have no idea and there's no way that I can plan for it.'

8.3.2 Monitoring and assessing costs

Case study institutions reported difficulty in splitting out the costs of support by the type of student supported, and so found it very challenging to estimate costs of supporting students with mental health problems, or those with complex support needs.

In many cases the disability support team were working with students with all types of disabilities and so could not separate out the costs of supporting students with mental health problems from the costs of supporting students with physical impairments or specific learning difficulties. Even in institutions with separate mental health teams, costs tended to be looked at in the totality for disability support rather than by team. In addition, many of the costs of supporting disabled students arose in other parts of the institution outside of the disability support unit, for example in faculties/departments, in estates and accommodation, or in the exam office. One interviewee responded that the exam office in their institution employed one person full-time on the administration of special arrangements for exams for disabled students.

Other wider and less direct costs associated with supporting disabled students included: space/working environment '*space is a problem, it can be difficult finding enough appropriate space*'; making adjustment to buildings; and providing specialist equipment (over and above the costs covered by DSA). Some interviewees even noted that making reasonable adjustments had a cost to someone; for example extended exam periods required paying an invigilator for more hours, allowing longer deadlines for assessments has an impact on marking etc.

One institution reported that they were part of pilot by UUK to help them understand what they are spending their money on, and were currently waiting for the results of this project:

'actually identifying what you are spending your money on is not straight forward ...we are an institution that was run very heavily on central control in the past, and we are trying to loosen the levels of central control and that means we have to understand where we spend money. We don't have a full course costing mechanism for instance ... cost of space etc.'

8.3.3 Supporting international students or those not in receipt of DSA

All case study institutions were committed to providing support for international students with mental health problems or any other high cost support needs, as part of their duties under the Equality Act. Some interviewees at a strategic level said that the institutions would pay for a similar package of support to that provided by DSA for international students, although when talking to disability advisers they often reported that international students received a reduced package, for example 10 mentoring sessions over a year rather than the 30 that DSA typically funded.

In one institution there was mention of an International Students fund which could be used to support international students, and possibly those who were studying part time but below the eligibility criteria of 25 per cent of full-time equivalent, to some extent. One interviewee gave an example:

'I saw an international student a few days ago, really struggling at taking notes in class, severe dermatitis really struggling, for that we funded a digital recorder. We wouldn't be able to fund the whole support package but we would look at every situation individually.'

Staff at another institution reported that if someone was rejected for DSA but the institution felt they needed support, they would fund up to 50 per cent of DSA level.

9 Effectiveness of support

9.1 Introduction

This chapter draws on the views of institutional staff regarding the effectiveness of the support which their institution provides by looking at: the support they currently provide and also their perception of how well they would cope with increasing demand in the future; how they measure the effectiveness of their support provision; and finally, some good practice examples of monitoring effectiveness.

9.2 Perceived to be effective

During this research, interviewees in the HEIs were asked to reflect on effectiveness in relation to two main areas. Firstly, were they effective in delivering services to all students who needed them, and if numbers continued to rise, whether they thought they would continue to be so in the future. Secondly, they were asked to reflect on how effective their current services and interventions were in ensuring that students were able to stay healthy and successfully complete their studies.

Interviewees predominantly thought they were offering excellent support to all the students who were in need of their services. *'We do our very best, we don't want to fail anyone'*. Whilst there was a strong commitment to supporting students from the staff interviews, there was recognition from some that aspects of provision could be improved. Only one institution expressed concerns about its overall service, but described recent changes as meaning it was *'getting there'*.

With rising numbers of students accessing support services, there were clearly challenges in meeting the current levels of demand, but most staff felt they were meeting the needs in appropriate ways, either internally, or through links with external agencies. The overall view was, therefore, that they were currently coping well – meeting the levels of demand, and providing an effective service. HEIs were able to put in place support for those with known requirements, but were also able to respond to emerging requirements and crisis situations, dealing with students on a case-by-case basis.

9.3 Challenges to effective provision

9.3.1 Late disclosure

All the case study institutions made information available to students before they enrolled, during induction and throughout the year, for example in the form of presentations at induction sessions and in departments, via emails, the use of posters and leaflets, and on websites. They were therefore confident that all students were being made aware of the support that was available. Indeed, 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. (This might well be reflected in the rise in student numbers we are seeing in the statistics).

In line with the recognition that being able to arrange support as early as possible was highly important, one HEI had made efforts to ensure students felt able to declare their disability during the HEI's pre-screening process, and this was thought to be 'particularly effective'...

'It's about giving people information as early as possible. One of the worst case scenarios is for them to receive an offer of a place and then find that actually this building, or these other aspects that we could have said but didn't, [are unsuitable] and they actually have to reject the place on that basis'.

There were examples of institutions increasingly offering bespoke services to each student, especially for students with high-cost complex needs. Adaptations were considered with the very specific needs of each student in mind:

'I think it's just the plans we put together, we try and be comprehensive. The personal plans... are exactly that.... It's the time that we spend making sure we do everything we can do.'

However, there were examples of students who – despite all the information provided – had not found out about relevant services until some way into their course. One student commented that the process of accessing the support needed was not always straightforward, and the student and their parents would have welcomed more detailed direction in how to set about getting the level of resources he needed.

9.3.2 Transition issues

In most instances, transition issues were felt to be a major factor in meeting the needs of eligible students, and so this year one HEI is piloting a residential summer school for students with Asperger syndrome and/or mental health problems, so they can experience life away from home on campus before they arrive at the start of term. If this is successful, it will be expanded in future years. One student interviewed thought

that this would have been *'too daunting'* for him to consider, but that it might work for others. Other institutions offered similar support in the early weeks of term, including one HEI offering a 'buddies' scheme for new disabled students, and another offering 'settling in' support. This latter support was a two to three day induction programme for disabled students, helping them to move in early and settle into accommodation, meeting continuing students, meeting their personal tutor, registering early, seeing lecture areas and meeting advisors. *'They get a chance to get used to being here, to settle in and try things out before everyone arrives'*. This programme had involved 70 students this academic year.

9.3.3 Accessibility

All the HEIs in the study were working to make their services more accessible, and to reduce the stigma attached to seeking specific help. In some instances, staff reflected on the language issues surrounding disability, and whether some students were happy using labels such as dyslexia as a disability, or intermittent mental health problems as a disability or health issue. One staff member stressed the importance of not pathologising normal processes such as homesickness. Therefore, some HEIs were moving away from what they saw as off-putting labels such as 'disability', and offering a more holistic package of support with labels such as 'wellbeing'. Students interviewed at one institution were clearly happier with a 'wellbeing' rather than a 'disability' centre label, and felt it had made the service easier to use.

There was agreement in other institutions that centralising the service, and being mindful of labels and job-titles made the service more accessible:

'The service will be relocating in the next couple of years which will continue this centralisation drive, and provide more space for support activities, which can be problematic'.

Others were bringing services together to ensure students could access all their support needs in one place, and looking at the location of their services and making changes as appropriate:

'There are changes afoot with a view to improving things... we're in a funny little corner of the campus here, as a unit, and not particularly easy to find, I think, for new students, and we are moving into a co-located, refurbished building with the student life centre for next term. I think it's going to be much better in terms of accessing the location.'

When students were not in receipt of DSA, for example international students, some HEIs were striving to put in place alternative ways in which these students could access support, such as equipment loan services. One HEI also had an International Student Disability Fund which students could access under the HEI's duties under the Equality Act. Only one HEI appeared to be applying a completely equitable model for

all students: in this case all students received the same level of support, regardless of their DSA status, with core HEI funding used to meet the shortfall.

At both department and managerial level, interviewees were generally positive about the effectiveness of their ability to support all eligible students, although it was acknowledged that there were significant challenges to meeting the needs of all such students.

9.3.4 Estate issues including campus location

Campus location was seen to be a challenge faced by some HEIs in providing effective support to all eligible students. In one instance the HEI campus was situated outside of the main town, and much of the campus consisted of Grade I listed buildings which were often not wheelchair accessible and which could not be easily changed. The geographical layout of the campus can present a hindrance; campus spaces were seen to hold the potential for exclusion, although one interviewee suggested that, in practice, things were just seen to take a little longer. Another HEI faced restrictions of the estate in terms of listed building status and city-centre location, which limited the adjustments around accessibility that the HEI was able to make. This impacted not only on main teaching and lecture rooms, but also on workshops and studios.

Two further HEIs in the study who had grappled with this problem had been able to develop new buildings, and in one case a new campus, which helped to solve this particular issue, and made it possible to ensure physical accessibility to all buildings. Some issues, however, remained to be resolved, including refuge spaces and out-of-office hours use of workshops.

9.3.5 Staffing levels

Some HEIs had inadequate staffing to deal with the demand, and their students experienced long waiting lists. Pressures on external services within the NHS also put additional pressures on HEI services as they sought to 'hold' students whilst they waited for external support to be provided. In one instance at least, staff turnover was proving to be a difficulty in maintaining timely and effective services. It was notable at one institution, which had a team of long-serving staff, that staff morale was high, and student feedback excellent. Staff at this institution were able to support each other and had strong, long-established relationships with a wide range of external partners in the community.

9.3.6 Institutional bureaucracy - need for evidence

Bureaucratic processes were seen to be frustrating. Bureaucracy surrounding the 'mitigating evidence' process, for example, was seen by one advisor to be detrimental

to those students living with anxiety disorders; this was linked to the advisor role of ‘putting in anticipatory adjustments’:

‘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’.

In one instance, advisors mentioned a very recent trend in decisions being made at senior management level, creating uncertainty and potential changes to standard heuristics for requesting adjustment provision:

‘The trend, certainly recently, has been for some of that power to be taken away from us, so although we’re seeing students and we’ll come up with a package, the decision’s no longer ours. It’s going elsewhere in the university and that makes it harder to tailor packages for the students’.

It was suggested that this was possibly in response to increased numbers of students requesting mental health and disability provision: 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.

This links to another concern that was expressed: with increasing demands, a changing student population, and cuts in DSA, HEIs may need to become more strategic and less flexible about the support they provide.

9.4 Measuring effectiveness

There was general agreement that measuring effectiveness and providing robust evidence is challenging, as it is often impossible to identify whether the intervention or other external factors have brought about a bettering of the students’ situation. However, there was also agreement that measures need to be put in place to try to assess what works best.

Overall, the measuring, monitoring and reporting of the effectiveness of the service appeared to be a weak area. Measurements of success were often ad hoc and heavily reliant on feedback from students. HEIs made reference to a range of ways in which they measured their effectiveness, including some or all of the following: forums (student feedback); annual surveys and surveys used by the students union; external consultants undertaking reviews; student satisfaction forms completed when students had used any of the services; or informal feedback from students. In most cases, the use of feedback forms was erratic at best, mainly due to admin overload, and at worst provided no useful way to improve the service.

‘Forms, when they are used, go back to Head of Service but there’s no feedback loop to staff on the sharp end’.

None of these methods suggested a systematic assessment of what was working well and what was failing to achieve appropriate outcomes, or indeed, the identification of what those outcomes might be.

In one instance very few staff outside of the senior team knew if or how monitoring was being undertaken, or received any feedback about their own work or that happening in the department. Academic staff were equally unaware of what monitoring was taking place and were not asked to comment on a student's progress during or following an intervention, even when students had agreed to disclose their condition to the course leader or where a personal learning plan existed.

Staff in another HEI, however, described the importance of responding to student feedback. There was an advisory group of students who helped to develop the service and discuss what the service might offer, for example, the Wellbeing Centre opening until 7pm once a week. Staff then used the website and posters to complete the feedback 'loop', and were able to report:

“‘You said, we did’”. Also ‘drop-in’ sessions for all services had been bought into the same time frame at the students’ suggestion, which has proved very effective in making the service more accessible’.

Another HEI involved students in welfare issues and provision through regular scheduled meetings between the Student Union sabbatical team and the Wellbeing team.

Counselling service staff more commonly used the Clinical Outcomes Routine Evaluation (CORE) form to measure the effectiveness of their interventions. This form was used to assess changes in the student and how they felt. One form was used at the outset of the counselling, and another in the last session. One Senior Counsellor noted:

‘This has posed some challenges as not all students return for their final session as they are feeling better, so there is discussion about whether it could be used in the penultimate session instead. But when both are completed, 80 per cent of students show improvement’.

Another HEI measured whether the services provided have been effective in helping the student to reach her/ his potential. In this instance, the focus of mental health and disability support was on making sure students are able to properly engage with their education, so one system of measurement of success is based on grades:

‘[I’ve] just done the analysis of our graduates last year: 76 per cent of students across the piece got a 2:1 or a first, but actually, from the cohort that are declared as specific learning difficulty, 80 per cent got 2:1s or firsts. So, we feel that the support that we’ve put in place is actually delivering outcomes we’re looking for, which is high-achieving students.’

There was work to do on tracking students, particularly those with intermittent mental health problems, those on modular courses, and those on courses that use sessional tutors (external specialists who come in to teach one or a few classes) and so lack the continuity of a regular tutor. In these instances, staff collected feedback from service users through Survey Monkey, or were able to retrieve information from databases to track students and measure the effectiveness of interventions more effectively. Some HEIs were making good use of electronic registers to monitor students' attendance and, where problems were spotted, to intervene and offer further support.

Others were keen to do more, but time was proving a challenge:

'We're a small team, although we sound big ... We've got a large number of students, and I think one of the big things for us will be we'd like to do more monitoring. We try to do as much as we possibly can, but it would be much more in our interests, I think, if we monitor students. We were talking this morning about attendance monitoring, and that's often where we find students with complex disabilities in particular; one of the benefits of having the [liaison officers in departments] is they're out there and in faculties, so they can spot if students aren't attending. If a student's not getting into lectures at the time they're supposed to, or not engaging with the learning environment.'

Only one senior interviewee addressed the question of how effectiveness was measured by referring to Key Performance Indicators (KPIs). These were: National Student Survey (NSS) scores and variation between disabled and non-disabled student scores, and comments offered as part of the NSS; retention; attainment; appeals and complaints ie learning from what goes wrong (see Good Practice Example below). These KPIs were reviewed annually, and fed into the annual report. Results were also fed back through Boards of Study. Patterns were also sought in looking at complaints and appeals, so these could be addressed with particular departments or staff. In addition, quantitative data was obtained from the CRM system and qualitative data from specific feedback when it was sought.

Feedback of such information to appropriate committees was also seen as important, as it could make a difference to management decisions regarding spending or staffing, and therefore have a direct impact on how the service is developed and delivered:

'There are three main university committees: Learning Teaching and Enhancement; Quality and Standards; and Academic Board. Reports on attainment, retention and destination go to the Learning, Teaching and Enhancement Committee, whilst general quality and diversity reports go to the Academic Board, the Executive Board and the Governors'.

9.5 Good practice in effective monitoring

There was little information available as to how HEIs were monitoring or measuring the effectiveness of their provision for disabled students, including those with mental health support needs. However this does not mean HEIs are not monitoring their support services or measuring their success in relation to these students, rather, that we have yet to develop a full picture of the ways in which this is being done.

9.5.1 Annual reporting on monitoring, and the setting of targets for future years

All HEIs are required to publish an annual report that indicates their progress to date on disability issues. Some of these are far more detailed than others and set clear targets for improvement; others make broad reference to disability issues but offer no real insight into the progress of the institution against any possible targets. In one instance, no reference was made to disability at all in the Annual Report.

There is also a marked difference regarding the accessibility of Annual Reports or Diversity Reports on the websites, with some easily accessible whilst others are buried under layers of 'pages' which require a determined effort to find them. This is an area which could be significantly improved both to ensure disability issues are kept at the forefront of planning, and that students are aware of the level of pro-activity with regard to the services they will receive.

One example of good practice, where the HEI set out to provide '*Consistent and appropriate service standards and processes, and a means to monitor and ensure a high quality service delivery*' did exist, where the HEI was using formal measures to monitor their practice, and examples that illustrate this from the university's Annual Report are given below.

Example of Good Practice: Monitoring the effectiveness of support, University of the Arts London

Key Performance Indicator - eliminate the differential in National Student Survey (NSS) satisfaction rates between disabled (excluding dyslexic) students and non-Disabled students by 2015

Disabled Student Satisfaction increased by 3 per cent between 2011/12 and 2012/13. Seventy three per cent of disabled students and students with dyslexia, report that they are satisfied overall, compared to 74 per cent of students with no declared disability.

Retention

Students with a specific learning difficulty were retained at a higher rate than other disabled students (+10 per cent) or those with no declared disability (+3 per cent).

Graduate destinations

Fifteen per cent of disabled students graduating in 2011/12 reported being unemployed compared to 12 per cent of graduates with no declared disability. The previous year's data indicated that 20 per cent of disabled graduates were unemployed (compared to 12 per cent of graduates with no declared disability). Therefore, there was a narrowing of the differential between 2010/11 and 2011/12.

Student appeals and complaints

Disabled students represented 38 per cent of those making appeals in 2013, indicating that they were over-represented by around 20 per cent. This is a slight decrease in comparison with the previous year, when disabled students were over-represented in appeals by 21 per cent.

Disabled students represented 28 per cent of those making formal complaints in 2013, indicating that they were over-represented by 10 per cent in comparison to their profile within the student cohort. One student complaint related to disability equality.

[From Equality and Diversity Framework, Annual Progress Report 2014, UAL Diversity Team, May 2014 - <http://www.arts.ac.uk/media/arts/about-ual/diversity/UAL-Equality-and-Diversity-Progress-Report-2014.pdf>]

Pro-activity in looking at the current situations and identifying key measurable changes to improve the success of interventions is key; another example of this was where a HEI was working to increase their ability to intervene at an early stage, thereby reducing the number of students who get into crisis situations. A proactive approach in one case study institution was seen in the Mental Health campaign being run by the Students' Union, and the Mindfulness course, an eight week free course previously available only to staff, but now being made available to students also.

10 Impacts of external pressures

10.1 Introduction

This chapter reports views on key impacts affecting the provision of support for students with mental health problems and other impairments, focusing on the impact of the proposed changes to DSA but also considering other impacts and challenges raised by staff at the case study institutions.

10.2 Recent changes in practice around DSA assessments

Some interviewees mentioned that they had seen changes to how DSA applications were being assessed. The DSA guidance states 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 DSAs ‘day-to-day activities’ includes education.’

However, some interviewees noted that there had been an apparent shift in emphasis in how impairments are viewed away from the impact they have solely on academic functioning, and towards the impact they have on wider day-to-day activities. Advisers in one institution reported that in the previous six months increasing numbers of applications for DSA had been denied, whereas before they would have been accepted, and more detailed evidence was increasingly being required:

‘I have noticed the change in DSA, in that whereas before, they seemed to award their support, based on the basis of a long-term condition and that had an impact on academic functioning and now they’re only accepting evidence where it’s very, very clear that it has an impact on ability to carry out day-to-day activities ... So, normally, we would have been working with students where there’s clearly an impact on their academic functioning where we’re having to ask and advise students for much more complex information, particularly to get their DSA packages in place. So that has caused a delay, I think, and students applying and then it being rejected and applying and having to get more evidence. Yes, so there definitely has been a change there.’

Staff at other institutions also commented on the long and complicated application process to get DSA, and reported a sense of assessments being much more rigorous:

‘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.’

Concerns were also raised about the quality and consistency of assessments. Some interviewees felt that there were inconsistencies in how medical evidence was being interpreted, and one said that anecdotally they had heard about instances of evidence of an autism spectrum disorder not being accepted as being a disability. Another issue reported was around how assessment centres make recommendations for support, with a feeling that they were too mechanistic in prescribing standard solutions rather than doing a proper evaluation of what the needs are. One example was that 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.

Looking forward there was a worry that, with assessments already inconsistent, changes to DSA would put needs assessors under greater pressure to make even more sophisticated judgements without the appropriate background, knowledge or understanding of specific course requirements, which could make increasingly difficult situations even worse.

10.3 Impact of the proposed changes to Disabled Students’ Allowance

Interviewees at all levels within the case study institutions, from senior managers to disability advisers, raised potential issues around the impact of the proposed changes to DSA.

10.3.1 Unclear guidance

The issue of a lack of clear guidance as to what the changes would involve, and what would, and would not, be funded after the changes, was raised across most case study institutions. Some staff voiced confusion about what is ‘safe’ and what support will no longer be funded via DSA:

‘Until the changes occur we won’t really know what the university will need to do. Things are vague at the moment and there are no guidelines...it is difficult to know what will happen so we don’t know how to prepare’.

‘They’re saying it’s for institutions to work out how to interpret and apply the Equality Act, but at the same time they’re saying we will only fund things through the DSA where all the adjustments that you would anticipate having been made have been made. So on the one hand they’re saying it’s for the institutions, on the other hand they’re saying but we won’t fund things unless

you've done what you should have done, which they haven't told us what that is. It's all very vague.'

There was also a concern that the guidance was changing over time, and that institutions had begun planning for one implementation, only for the goalposts to be moved without a proper announcement or clarity about the changes to the proposals. Interviewees at one institution reported that several new strategies for responding to the DSA changes were in the pipeline as a result of the uncertainties, rather than having one clear vision of the route they wanted to take, and that it was too early to tell how the changes would impact on the institution:

'A lot of things are up in the air about the split between what the DSA can do and what the universities will have to do'.

The uncertainty made it difficult for disability advisers to work with prospective students, as they would not want to give a false impression to students of what support might be available if that support was no longer available in the future. They felt they needed definitive answers about the changes to be able to do their work effectively. Advisers were also worried that students might fall into the gap between provision that used to be funded under DSA but that institutions had not yet introduced or could not afford to implement.

Staff also expressed concern about the lack of clarity and potential ambiguity of trying to define levels.

'In a report just out from HEFCE it talks about trying to define levels. That's going to be difficult to do ... With MH, it's looking at levels of diagnosis, who will do this? We deal with SFE but we will need to know what evidence they will accept.'

Notwithstanding the concerns about the lack of clear guidance, there was a feeling among many interviewees that the mentoring support for students with mental health problems would continue to be funded through DSA, and so the changes would not impact as heavily on these students as perhaps they would on students with other types of impairments:

'I think it's reassuring that the Band 4 specialists appear to remain and be funded by DSA, which would include our mental health advisor under current guidance'.

However it was noted that students with mental health problems may be adversely affected by other aspects of the changes, for example the withdrawal of funding for computer equipment if they had concentration or anxiety issues, or variable energy levels and motivation.

10.3.2 Timetable for reforms

Many interviewees felt that the timetable for the implementation of the reforms was not long enough for them to plan properly, particularly when coupled with the lack of clear guidance:

‘I think the way they’ve done it is clumsy and is not giving us enough time to consider how to do these things. We’ve only got draft guidance for the next academic year now, well there are budget cycles within universities and we need to be bidding for budget for the next academic year to take into account the change in the following academic year, we need to do that in the next few weeks and we’ve only got draft guidance at the moment.’

Although the revised timetable with some of the changes pushed back until September 2016 was described as a *‘welcome delay’*, the original timetable was felt to be *‘nonsensical’* if the aim of spreading the financial burden for support onto institutions, while at the same time maintaining, if not increasing, the proportion of disabled students in the system, is to be achieved. One interviewee felt that there needed to be more lead time over a number of years, where the funding is commensurately reduced and institutions incrementally picked up the financial burden, to successfully achieve both aims. But in general there was relief that the changes had been delayed by at least a year, to give institutions a fighting chance of being ready for the changes:

‘Thank goodness they’ve put it back a year because I don’t think [our responses] could be ready for September, but this gives us, this academic year, to scope, and put the IT infrastructure there, ready, and the next 12 months to prepare staff and anticipate the arrival of our students’

10.3.3 Impacts of removal of Band 1 and 2 support

Although most interviewees felt that the mentoring support provided for students with mental health problems would continue to be funded through DSA, the withdrawal of the lower band support could have a negative impact. It was noted above that institutions were seeing increasing cases of comorbidity of mental health problems with other impairments such as specific learning difficulties or autism spectrum disorders, and so there were increasing instances where students with mental health problems were also receiving lower band support such as note-taking. Some respondents felt that this could have a knock-on effect on students’ mental wellbeing, and the difficulties of not having practical support could build up and reduce what mentors are able to do – mentors will spend more time providing practical support for students rather than mentoring them and helping to build up their resilience and strategies for coping. The withdrawal of note-taking or other practical support for these students could also increase their anxiety and exacerbate their mental health problems:

‘I fear for a lot of the students that I see now. The preventative value of the support is really important. The non-medical support makes a huge difference and it keeps them well, and the anxiety, the worry, the paranoia, all the symptoms the students talk about is going to go through the roof.’

It was felt that students with mobility problems could be particularly hard hit if they received lower band support for assistance with carrying books and equipment around campus, or practical support in labs or studios. Also students with Asperger syndrome or autism spectrum disorders were viewed as a group that could be particularly adversely affected by the removal of lower band support as many received this type of support as part of their DSA package to meet often complex needs. There were concerns that the removal of this support for both of these groups might result in increased stress or anxiety for students, and cause, or worsen, mental health problems.

The removal of lower band support could also put more pressure on academic staff and lab or studio technicians. In some cases the support provided by lower band assistants was quite specialised, with some specialist institutions mentioning Level 2 technical assistants who were skilled in operating particular pieces of equipment and machinery, such as electric cutters, and it was felt it would be difficult for these institutions to just replace this specialised support.

In terms of responding to the removal of this support, many institutions reported that they would have a pool of university-employed staff who would be able to assist those students most in need, but would also work to create strategies for students to develop over their academic career to be able to cope without support and assistance:

‘My hope would be that we would have a smaller band of note-takers who would work with students where there was a specific disability, so we could be talking about students where they just can't take any notes at all, and whether that's students with physical disabilities, but I would say most of that would be down to students with visual or hearing and sensory impairments, but again, it's trying to empower the students so that again they don't necessarily need that. Maybe in the first year having the note taking support, and then looking at coping strategies as they go through the three or four years of their course, so that they can build on that, on those note taking experiences.’

One institution mentioned that given the complex needs of students with autism spectrum disorders they were looking into appointing someone internally for specialised support work for these types of impairment. It was recognised that generic note-taking might be appropriate for most students, but some needed notes taken in a specific way, with particular colours used or particularly styles of note-taking which required a more specialist input.

10.3.4 Potential discrimination

Interviewees at a number of institutions suggested that the changes to DSA could lead to situations where students with disabilities were discriminated against, either indirectly or directly. There were concerns about publicising current levels of support and then not being able to deliver that when the changes are introduced. Institutions would have to start down-selling the offer of support which could lead to students deciding not to apply to, or accept an offer from, a particular university, or even not to apply to higher education at all:

‘The impact might be on the applicant in that when they’re told what the provision is, it may not meet their requirements anymore. Whatever the university makes of this reasonable adjustment ... it may not be bespoke enough.’

‘So if a student thinks the university is going to go, whew, I’m not having those that are going to cost us a lot of money they’re going to... whether that’s imagined discrimination or actual discrimination, I think there’s a real concern that it may force disability back under the radar. Now, I’d hope that that wouldn’t happen in the world that we live in but I’m not naïve enough to think that isn’t going to happen.’

One interviewee went so far as to wonder if the changes could impact on how institutions make admissions decisions:

‘I am just worried that we’ll end up with indirect discrimination because if you’ve got 10 places on a course and you’ve got 15 students and they’ve all got the same grades, do you take the five that are going to cost you a fortune? I’m really, really worried that we’ll end up with discrimination ... We know that disabled people are under-represented, on the whole, in the workforce and that’s because, invariably, they’re underrepresented in higher education and so we’re just building on that bias. So, I have serious concerns about it.’

There were also concerns that the changes could lead to a reduction in students disclosing a disability or mental health problem during the application stage for fear of potential discrimination, and so to institutions finding it more difficult to plan levels of support for the needs of incoming students:

‘I think it’ll make students think twice about disclosing, so the student won’t disclose that they have a disability. I mean, there are obvious disabilities ... but if a student doesn’t interview then there may be people who say, I’m not going to say that I have a disability because there are rumblings out there that I won’t get this type of support, and then when they get there they’re going to say, ‘oh, and actually, I need all this sort of support’. Now, my hope is that that doesn’t happen, but I think where students are worried about disability ... I mean, it happens already that students don’t disclose at other universities. I’ve certainly heard at universities that students will say, and we’ve got students here who, no matter how positive I think [university] is about recruitment, they

will say, ‘I was worried about disclosing, because I know it's going to have an impact on me, on my being accepted’

Some interviewees said that they thought their institutions would continue to recruit students with disabilities successfully, but the lack of support might result in higher proportions of them dropping out of their courses than in the past, which was not fair on the students, particularly given the financial costs of higher education for students. Also if more students were not disclosing mental health problems there could be detrimental impacts on their learning, achievement and retention.

10.3.5 Impact of charges for IT equipment

Some interviewees said that removing computer equipment from DSA could be quite problematic for their students. Because a large number of students were from widening participation backgrounds or low income backgrounds they could be disproportionately affected. Even a £200 charge might be beyond the purse of some students.

‘I think for our students the removal of funding for computer equipment is probably quite problematic in the sense that there’s this idea that students can afford their own computer equipment. I think given that our students largely come from widening participation backgrounds, I think that this is a very big open question as to whether that’s true ... It’s a huge generalisation, obviously, but a lot of our students come from low income backgrounds, the money they get is not enough to live on as it is, they have to take on part-time work just to meet their basic living costs so those sorts of things are going to be difficult.’

It seemed to some interviewees that computer equipment had become ubiquitous for any type of impairment, but sometimes it was very specialist for a particularly type of impairment eg a special mouse or screen-reader software, or for specific courses eg design packages.

As with the removal of lower band support, some interviewees worried that students having to meet the costs of equipment themselves could lead to additional stress, with an impact on mental wellbeing. Many students were already working to support themselves, and financial pressures of studying were already having an impact on anxiety and mental health, and so the DSA equipment changes were likely to make this situation worse.

10.3.6 Increase in anxiety/breakdown in trust

While the withdrawal of particular types of support, or increase in equipment costs, could increase stress and anxiety for particular students, there were concerns that the changes could impact on the overall ‘atmosphere’ around disability support in higher education and cause anxiety and unhappiness among students, as well as increasing their worries about whether they would get ‘marginal’ but necessary support.

There was concern that there could be a breakdown of communication and trust between students and mental health/disability advisers who may be seen as failing to make a strong enough case for students to get things that were previously standard before the changes.

10.3.7 Impact on costs for university

As a result of the uncertainty around the guidance on the changes, most institutions found it difficult to estimate with any certainty what the financial impact on them would be, although all knew that they would need to draw on more core funds to support students with mental health problems and other disabilities.

One institution, in planning strategically for the changes, had identified that its students drew down £8.5 million in DSA funding, although this was across all students claiming DSA, including students with specific learning difficulties, and was for all types of support funded through DSA. This worked out at just over £6,000 of DSA funding per student who received it. Interviewees at this institution said that they could not get close to plugging a gap that big with core institutional funding, or even a quarter of that, but it was unknown how big a gap they might have to fill as some support would still be funded, and how much of that gap would be plugged through reasonable adjustments, generic support and inclusive curricula changes.

Another institution had looked into the implications of the removal of Band 1 and 2 support and had estimated that after mainstreaming measures such as lecture notes or outlines in advance (which it was felt would be sufficient in terms of support for many students), the cost to the institution to support students who needed some extra help was in the order of £75,000 in the initial years, and may reduce as the institution makes the transition to be fully inclusive. It was felt that a sum of this magnitude could be funded from the access agreement or other alternative sources such as alumni donations.

However, interviewees in another institution were concerned that the increased costs to the institution of delivering non-medical support to students would make it harder to provide an equitable and appropriate service to all students. And interviewees in another gave an example of a further area where they would have to replace DSA funding with their own financial contribution: part of their DSA requirement for a student with acute anxiety/OCD/ depression was for them to have a studio and so DSA paid the difference in cost between the standard accommodation and the studio. From 2015/16 it was felt this would no longer be the case and the university will have to pay the difference.

10.3.8 Sector-wide impacts

A number of interviewees mentioned potential impacts that went beyond their own institutions and could affect the sector as a whole. Some felt that 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, in a similar way to the clustering of research funding around a few research-intensive institutions. While this might be an opportunity for these 'beacon' institutions, who may start getting disabled students who might otherwise have gone to higher tariff universities applying to them, it was seen as negative for the sector and society as a whole if some institutions became less inclusive in terms of disabled students:

'I think that's to the detriment of the HEI system nationally. I think [disabled students] bring a richness with them, just as people of all different types of diversity do. And I actually think the other students and the staff will benefit from an appropriate proportion of disabled students.'

Some interviewees were concerned 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. However, as mentioned below, other interviewees felt the changes could promote inclusivity and that DSA had hampered efforts to develop inclusive curricula.

Also, if the changes led to a reduction in the proportion of students attending higher education, and an increase in numbers drawing on social security benefits, then the savings from DSA could be eaten up by an increased benefit bill and lead to no net saving to the exchequer.

'The Government loses because they're not coming to HEI, they're on benefits. They're not therefore going to get the jobs they aspire for them to get into. We lose as an institution in terms of our diversity. And actually there's more unintended consequences, and the only thing they've gained is some money off their bottom line here, but the costs have gone up over there in terms of social security.'

10.3.9 Potential positive impacts from the changes

Thoughts on the potential impacts of the changes among interviewees were not all negative, and many saw opportunities as well as threats.

The main positive potential impact was the promotion of more inclusive curricula over the longer term; some respondents said that DSA funding may have been part of the reason that institutions had not made more effort to develop inclusive curricula. The changes may therefore be helpful, but this view was tempered somewhat by the

timetable for the changes and a feeling that they are being introduced too quickly, and that institutions would need for more time to fully implement internal changes to the way they work.

Some interviewees said that a lot of the lower band support could be delivered through inclusive curricula measures such as lecture capture and lecture notes in advance. Interviewees at one institution said that they were exploring the potential of support being delivered through a buddy system, whereby third year students would support first year students on their course/programme. Another measure was study skills support being delivered through group sessions delivered by HEI staff, rather than the current system of individual study skills support funded via DSA. Provision of assistive technology software on all library computers was also mentioned along with training in how to use it being provided by library staff.

In addition to technical and personal support solutions, interviewees mentioned the need to address the design of teaching and assessment to promote inclusion and meet the needs of many students including those with disabilities. One mentioned a need to focus assessment away from exams:

‘We also need to look at, starting right from the very beginning of the curriculum, the design and assessment. So, we are very heavily reliant on exams [here] and that's been increasing year on year. But it's probably the worst thing you can do for someone with any kind of individual needs is make them sit in an eight hour exam, because they have to get up and walk around every five minutes. That's not good. So we want to redesign and relook at that.’

It was noted that getting academic staff on board will be a challenge. Interviewees at one institution mentioned the importance of ensuring that lecturers understood why changes such as lecture capture were being introduced and to give guidance on when and how it will be used – that it is about improving the student experience for disabled students, with potential ripple effect benefits for other students, and not about spying on colleagues.

However, there was recognition that technical and generic adjustments can only go so far towards supporting students, and did not fully reduce anxiety amongst disabled students, and so there would still be a need for some form of personal support available for some students and in some circumstances.

Another potentially positive impact cited by interviewees was around raising the profile of disability support within institutions, and a more strategic approach to the planning of support. With institutions having more responsibility for funding support, rather than just drawing down external funds, there was more of a focus on what was provided to which students, and for disability support services to have increased leverage as they will be responsible for meeting more of the support needs of students.

In some institutions proactive strategies were being developed in response to the changes in DSA. One described how they had set up a DSA working group, chaired by the Pro-Vice Chancellor for teaching, and with Students' Union disability and welfare officers involved in different sub-groups, to look at the various ways the changes could impact on the institution, the threats and opportunities they posed, and what the institution could do to mitigate the negative effect. Another described how they had initiated a programme to look at what they needed to do across the institution strategically in all of the areas that would be affected by the DSA changes, and in particular to encourage a culture that looks in more depth at anticipatory adjustments to course and curriculum design, and to get every member of staff in the institution to understand how they need to start changing their practice to think about the needs of disabled students.

Some interviewees felt that over 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. Furthermore, what support the student then receives is very prescriptive and is never reviewed to assess if the student still requires it in subsequent years of their HE experience, and there is also the risk that this system sets people up to fail when that level of support is not replicated when students leave HE and enter employment.

Finally, there were some views that the changes around assistive technology were not problematic as it seemed laptops were being recommended for each and every student who applied for DSA and, with most students having laptops already, there was a lot of deadweight:

'I think the ones where we do need to go is the assisted technology, that students do not need a laptop anymore.'

10.4 Other impacts and challenges

Some interviewees acknowledged the positive impact that technological developments were having on how institutions could support students with mental health problems and other impairments. In addition to lecture capture technology and virtual learning environments replacing the need for a lot of note-taking support, institutions mentioned alternative methods of delivery in terms of online and blended learning courses, being able to keep in touch more easily with students if they were not engaging with their course for health reasons, and software programmes which can be used to improve techniques for keeping calm which can be used in the build-up to

exams. However, several interviewees were keen to point out that technological solutions on their own were not the answer to support students with mental health problems, and that they could not replace one-to-one ongoing support.

There were concerns mentioned by interviewees in some institutions that increasing numbers of international students arriving as a result of institutions extending their global reach may place additional pressure on institutional funds at the same time as they are having to cover the shortfall in DSA funding.

Finally, the difficulties around making adaptations to listed buildings was raised as a challenge, not only in terms of access to buildings but also understanding behavioural needs of disabled students and how the physical space is utilised.

11 Conclusion and issues

In this final chapter a number of key concluding themes are drawn out from the research. Five key challenges facing HE institutions are highlighted, with examples of good or shareable practice with regard to the challenges presented.

11.1 Demand for support

All institutions recognised that there had been a rapid increase in demand for support from students with mental health problems, as the quantitative data in Chapter 3 confirmed. There was also a widespread feeling that demand was likely to continue to rise as opposed to plateauing in the near future, as the key trends driving the recent increase were also likely to continue.

There was also a general consensus that students are presenting with more complex mental health disorders than in the past, with greater incidences of personality disorders, bipolar disorder, psychosis, and also comorbidity of mental health problems alongside other disabilities or impairments.

Furthermore, funding issues in general (higher debt, living costs, costs of materials on some courses) were having a detrimental effect on the mental health of students during their studies. Academic pressures could also exacerbate students' mental wellbeing.

There was less concern about students with complex physical or sensory disabilities, as demand for support from students with these impairments was not seen to be rising in the same way as demand from students with mental health problems, and there was a feeling that university staff, including academics, understood the impact of physical and sensory impairments on students' study and general university life and so it was easier to support these students. While individual cases could present particular challenges, it was difficult to plan for these as numbers of students with physical or sensory disabilities could vary with each intake.

11.2 Encouraging (early) disclosure

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.

However late disclosure can cause difficulties for institutions in not being able to plan support provision effectively, and difficulties for students in not having support packages up and running when they start HE which may have consequences for their academic performance and retention, and their mental or physical health. As an example, one institution mentioned a situation where a student with complex support needs had not declared pre-entry, and the extent and nature of the support needs meant that the institution was not able to put a required package in place for that academic year and so an agreement was reached that the student would defer for a year.

In terms of encouraging and providing opportunities for disclosure, one institution felt that few students would fall through the net given the varied ways in which students could disclose a problem, or potential problems could be spotted by university staff.

Example of good practice in identifying students who may need support: The University of Durham

It was noted that due to the multiple opportunities for students themselves to disclose a mental health problem or other disability, and for academic staff, professional services staff and other students to identify when a student may need support, it was difficult for students to ‘fall through the net’. The collegiate system at Durham generally allows more opportunities for any issues to be picked up, including where catering or cleaning staff within colleges may notice changes in behaviour and so share concerns with college student support staff. This system was additionally felt to engender a greater level of pastoral support compared with that available in many other institutions. In addition the high degree of peer support amongst students was noted, and students who may need support could be identified through a variety of formal and informal structures. For example, this might be through the junior common rooms, through social activities or through the welfare officer.

Another made a concerted effort to engage with new students during Freshers’ Week to raise awareness of the support that is available.

Example of good practice in proactive interventions and peer mentoring: Bath Spa

At Bath Spa University there has been a concerted effort by the Students’ Union to proactively engage with new students during Freshers’ Week, as this can be a pressure point for students and some find it a particularly challenging time. They operate a Freshers’ ‘Angel’ and ‘Buddy’ system during the moving in week; these individuals provide opportunities for new students to ask questions and raise issues, and they in turn give honest opinions and help people make friends. Buddies and Angels are highly visible around campus, wearing orange t-shirts, and are safe and easily-accessible first ports of call as part of a chain of support. They receive training to deal with common issues that may arise, including river safety, first aid, what to do in situations of alcohol poisoning or sexual assault. In this way Student Union Reps and student peers act as a ‘friendly face’

and another bridge to more formal support, although there was a recognition that sometimes students just want a safe space to talk and a listening ear. The University therefore also has a wider peer mentoring scheme (operated by Student Support) which matches trained student volunteers with new first year students (within course groups) to provide informal support, and help them adapt to university life beyond the first few weeks, and to signpost to further support if required.

A third institution had introduced an early intervention form system, so that any member of staff, academic or non-academic, who had concerns about a particular student could complete a single form which would then be directed to the most appropriate support team. In this way the staff member did not need to know about how support was organised, just that their concerns would be acted upon appropriately.

11.3 Development of inclusive curricula

With finite resources, the proposed changes to DSA, and as the numbers of students with mental health problems or complex needs grow, institutions will start to face difficult decisions about who they can support and in what ways they can be supported. The development of inclusive ways of working should, therefore, be a priority for all universities, particularly considering the growing awareness of the benefits to all students in adopting an inclusive approach.

While most of the institutions in the study spoke about this as something they are addressing, current policy documents generally emphasised an individualised response for reasonable adjustments to be made, and institutions felt that they still had a long way to go before they could describe their provision as fully inclusive.

One institution described how they had implemented a programme to look at the development of an inclusive culture, driven in part by the proposed DSA changes.

Example of good practice in developing inclusive curricula: De Montfort University

De Montfort University has embarked on a **Disability Enhancement Programme**, looking strategically at the proposed DSA changes to plan for transition when the changes come in, and putting in place provision to avoid the need for some non-medical help. Provision of enhanced infrastructure to support lecture capture, improved access to assistive software, as well as a focus on course/curriculum and assessment design are areas where anticipatory action is being undertaken.

‘The Disability Enhancement Programme, what we’re trying to do through that is trying to encourage a culture that looks in more depth at anticipatory adjustments and course design, curriculum design, that sort of thing. That already happens to a degree but I think we’re looking to try to give that a shot in the arm’

The Programme involves a number of elements: a) developing an accredited DSA Assessment Centre ; b) lecture capture; c) completion of equality checklists when designing courses to provide a concerted focus on inclusivity; d) careful design of messages when recruiting students, to promote the message that the university is inclusive; e) considering the university estate to improve accommodation generally(eg providing some designated quiet blocks in anticipation of the needs of autistic students, and other disabilities). In this way the university is aiming to move from base practice to good practice, and trying to promote the university as good practice with regard to disability support.

As this will be a common challenge faced across the sector, there may be potential for funding to be put into supporting new ways of working to rigorously test different approaches that could then be rolled out more widely.

11.4 Proactive measures to reduce demand for support

A number of institutions had introduced measures aimed at reducing the demand for support from students with mental health problems, through building students' resilience and ability to deal with issues themselves.

A number of institutions highlighted examples of these kinds of proactive preventative measures.

Example of proactive approaches to promoting wellbeing: De Montfort University

Staff at the institution were involved with a number of proactive approaches aimed at prevention and developing resilience and strategies amongst the student body. There were various ways in which this was exemplified:

- The creation of a **Mental Health Inclusion Team**, with priorities relating to education, employment and promotion.
- Workshops on mindfulness, preventing stress and sleep hygiene.
- Working with staff to reduce the stigma around mental health, an example of which being the mindfulness sessions that are open to both students and staff.
- Using student peer mentors for example regarding alcohol or drug use.
- A 'Fridge Raiders' scheme to assist students to prepare themselves for meeting their full potential by giving advice about healthy eating, helping with identifying those not eating properly as it may be a sign of more deep seated needs, and encouraging students to eat together to build peer support and also save money.

Example of sustained provision across the student lifecycle: The University of Derby

The university is running a new 'Love Your Mind' campaign, which is embedded across the whole institution. The campaign seeks to raise student understanding and awareness of their own wellbeing and mental health and of the links between their mental wellbeing and academic performance. Taking a proactive approach, the initiative highlights the importance of mental health for all students and outlines practical steps students can take to improve their own wellbeing and experience. Workshops are delivered as part of academic programmes, focused on improving wellbeing, performance and university experience. The campaign also runs roadshows across the campus, there are posters and leaflets identifying steps students can take to improve their mental health, webinars across the year and a bibliotherapy section is available in the library.

Another institution spoke about taking the health and wellbeing of its staff and students seriously, with clear direction and support from the senior management team. During this academic year, a monthly programme of health promotion campaigns was launched, which included a range of events focused on issues such as disordered eating, bowel and prostate cancer, mental health, winter disorders and SAD, the importance of sleep, personal resilience, and responsible drinking.

There is widespread potential for institutions to do more to build on these approaches and ultimately save time and resources.

Again this could be an area where some funding could be provided to explore different models and review differential outcomes to identify what type of initiatives can make a significant difference.

11.5 Improving internal relationships

Institutions could do more to develop better a dialogue with academic colleagues regarding support for students with mental health problems and other disabilities.

There was often a big disparity between the understanding and knowledge of most academics and staff from the disability support teams. This was highlighted regarding discussions about reasonable adjustments and Learning Support Arrangements.

It was also mentioned that academic staff could be resistant to the implementation of inclusive curricula initiatives. Concerns among academics that lecture capture could be used for performance management, or that producing materials in advance would lead to empty classes and lectures, were reported.

Two case study institutions had particular approaches to improve relationships between teaching staff and disability support services, one with disability advisers based in faculties, and the other giving academic staff a disability liaison role:

Example of support for academic staff: De Montfort University

Faculty Disability Officers (FDOs) at De Montfort University are based in the faculty buildings and provide information, advice and guidance to academic colleagues to ensure that they are aware of the relevant learning and teaching support recommendations for disabled students. FDOs also work to ensure that disabled students are aware of, and know how to access disability support in their faculty; faculties are very different in how courses are taught and assessed, hence the need for separate FDOs.

Because FDOs are based in private offices within faculty buildings, they are well known to academic staff and also more accessible. For example, if a tutor has concerns about a student in their class they can take the student along to the FDO directly, rather than having to signpost or refer to the central disability team located within Student Support. FDOs also report to tutors regularly about the students they are supporting, including passing information to tutors about learning support arrangements for particular students and giving advice to tutors about implementing any adjustments, or more general advice if tutors have concerns about any students.

Example of support for academic staff: Durham University

Each academic department at Durham University has a Departmental Disability Representative (DDR), a member of teaching or administrative staff who is an identifiable point of contact for disability advice and support for students and academic staff. A key part of their role is ensuring that information from Disability Services is passed on to tutors; disability advisers provide a report with recommendations for adjustments for each disabled student, and the DDRs will meet with the student, and sometimes the tutor as well, to talk through the adjustments. DDRs are available to help tutors with any concerns they may have about students, and are likely to know the best option, for example suggesting the student goes along to counselling, or arranging for counselling to come and pick the student up in more serious situations. DDRs may also advise other students about how one of their peers may behave in their class if the behaviour may cause concern.

DDRs would report back to the disability advisers if they became aware of any issues with a student, for example if they were not attending classes or not submitting work.

DDRs would also encourage tutors to make teaching as accessible as possible through adopting inclusive curricula methods such as putting materials on the virtual learning environment before classes and recording of lectures. DDRs receive annual disability awareness training and will try to cascade the key messages out to other teaching staff.

Another institution had put effort into working across the university to extend the support network for students, including pre-entry support:

Example of extending the support network: The University of Derby

The University of Derby was involved in supporting and contributing to a number of initiatives, in line with collaboration with the wider university. Much of this activity was aimed at extending the network of people students can talk to, improving socialisation so students could build their own support networks and increasing the number of points of contact. A number of examples were noted.

- The 'Get Ahead' wider university project was a structural way of offering support activities to students who have disclosed. This is a two-day pre-entry event open to any student who has a disability, long-term health condition, specific learning difficulty, an autistic spectrum disorder or mental health condition. This initiative allows students to familiarise themselves with the university, enrol early, set up their support and begin socialising in their new environment.
- The ASD Summer School, to aid preparation and orientation, provides bespoke events and sessions for students with autism and has a particular emphasis on social integration. One feature of this summer school is the creation of links between university support and existing support networks to provide continuity and ensure the effective transition of support.
- The Chaplaincy hosts a weekly Fair Trade lunch which creates a space that enables students to access sources of support and feel less isolated.
- Staff at the Chaplaincy also build one-to-one relationships more informally, over a coffee and chat, in order to open up channels of communication. Where a student does disclose or reveal a difficulty the Chaplaincy is then connected to other services and can direct students to where to seek help.

More training, or better training, for teaching staff in disability awareness may also be appropriate. The University of the Arts London described how a restructuring of their student support function placed support teams in each college and had a focus on staff development:

Example of support for academic staff: University of the Arts London

In the summer of 2013, a major restructuring of student support was put in place for the beginning of the 2013/14 academic year, involving additional investment of £350k. A new, single Cross-University Disability Service was established. The Service identifies adjustments and provides support, so that disabled and dyslexic students can achieve to the maximum of their potential. At the same time, new Academic Support teams were established in each college, working with a new central facilitating team, focused on enabling all students to become confident and competent independent learners. A Disability Equality staff development programme has also been established, and sessions have been undertaken with colleagues exploring inclusive policy and practice. To date 350 colleagues from a range of roles have attended this staff development.

The Equality and Diversity Forum was also being proactive in engaging both staff and students in debates about mental health issues:

‘Creativity and Mental Wealth - Marking National University Mental Health and Wellbeing Day, the Forum debated the relationship between mental health and creativity, the idea of the ‘mad artist’ and whether mental health conditions enhance or hinder creativity.’

[From Equality and Diversity Framework, Annual Progress Report 2014, UAL Diversity Team, May 2014 - <http://www.arts.ac.uk/media/arts/about-ual/diversity/UAL-Equality-and-Diversity-Progress-Report-2014.pdf>]

11.6 Developing external partnerships

Partnership working is crucial and all institutions were working with external agencies to some extent. When it worked it well was clear how it benefitted both the university and the community. However, partnership working does use resources and these need to be factored into the costs of the services, which may be difficult under increasing financial pressures, but the costs may be more than outweighed by savings in other support areas.

One institution described how having a community mental health nurse coming into counselling improved the service available for students and benefitted both parties;

Example of external services co-locating within the institution: Durham University

The local Early Intervention for Psychosis service is co-located within the counselling service in Durham University. The Community Mental Health nurse comes in one afternoon a week and also makes appointments on campus at other times, sharing an electronic diary with the university counsellors to facilitate appointments. Using counselling rooms is a less stigmatised environment than hospital, and counselling staff can see if students are not turning up and try to track them, and check that they’re okay.

The relationship works very well and has benefits for both partners. From the university’s perspective it has improved the service for students: in particular having the service co-located on campus has reduced level of non-attendance which has always been a key challenge and, if students don’t attend, then counselling staff can be proactive in getting in touch with the student to investigate any reasons behind them not turning up; it also allows for immediate referrals and makes it possible to track students more quickly and more easily. In addition, college staff can act as translators for international students.

From the Community Mental Health team’s perspective, students make up a large proportion of their potential patients - 30 per cent of residential beds are taken by students and people in the university age range are in the ‘at risk’ group - so co-location gives them easier access to their target groups. Referrals of students can be immediate because of the co-location, and once the Community Mental Health team picks someone up, they see them for three years, which fortuitously coincides with the duration of most undergraduate degrees.

One further advantage of the relationship is when dealing with the transition from child to adult mental health services for new students. NHS staff are often more willing to share information with other NHS colleagues than with outside organisations, and so the Community Mental Health nurse can liaise on the university's behalf, with patient consent, with the services in the student's home location to smooth the transition.

Another institution described how they worked together with other HE institutions and the NHS across the city:

Example of good practice in working with external agencies: University of Leeds

Through the Leeds Student Health and Wellbeing Partnership, the University of Leeds is well networked with other academic institutions (all three HEIs, FE colleges and specialist colleges), representatives from the student unions, local commissioning groups and key professionals across the city. It enables higher education institutions to talk with one voice and is based on the rationale that - contrary to some assumptions - many students are not fleeting residents. They may stay from undergraduate through postgraduate study and beyond.

The existence of this network helps to address the problem that NHS services are not well aligned with academic cycles (students may have left for the holidays by the time they reach the front of NHS waiting lists). It enables a positive initiative to be piloted within one institution and then rolled out elsewhere. This can be 'pretty powerful', not just in terms of mental health but also, for example, in campaigns around alcohol (an alcohol worker was recently funded by the CCG).

It has helped Leeds to put forward cases for change which it would have been difficult to make individually. For example, in relation to the alcohol campaign, it has been possible to measure the impact on casualty services. *'This is important, because it avoids the situation where a change in one area simply shifts the demand to another point in the system'*.

Primary care workers have offered psychological services within Leeds Student Medical Practice, and most recently there has been Better Care (<http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/>) funding for three wellbeing workers at the medical practice (who will provide support in relation to anxiety, wellbeing etc) to complement and broaden the mental health services for students already offered by the University. Leeds West Clinical Commissioning group has also produced a guide, in conjunction with both local universities, to staying healthy while at university.

<http://www.leedswestccg.nhs.uk/content/uploads/2014/08/Happy-healthy-and-safe-while-studying-in-Leeds.pdf>

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Appendix 1 - Additional guidance materials and resources

This appendix presents some useful links and resources concerning institutional provision for students with mental health problems. The resources that follow approach the topic from diverse positions. They have been selected with a view to further highlighting issues explored in our review of the literature and offer practical resources.

Reports

Recent reports on student mental health include:

- Student mental wellbeing in higher education: good practice guide - <http://www.universitiesuk.ac.uk/highereducation/Pages/StudentMentalWellbeingGuide.aspx#.VYlevPLViko>
- Understanding adjustments: supporting staff and students who are experiencing mental health difficulties - <http://www.ecu.ac.uk/publications/understanding-adjustments-mental-health/>
- The mental health of students in higher education - <http://www.rcpsych.ac.uk/publications/collegereports/cr/cr166.aspx>
- Grand Challenges in Student Mental Health - <http://www.studentminds.org.uk/grand-challenges.html>

The following publications may also be of interest:

British Psychological Society Reports:

Students with mental health problems may be having unusual experiences that are difficult to understand, and/or have fluctuating mental health issues. Two recent reports by the British Psychological Association may assist staff or students seeking better to understand such experiences:

- Understanding Psychosis and Schizophrenia: Why people sometimes hear voices, believe things that others find strange, or appear out of touch with reality, and what can help - <http://shop.bps.org.uk/understanding-psychosis-and-schizophrenia.html>

- **Understanding Bipolar Disorder: Why some people experience extreme mood states, and what can help** - <http://shop.bps.org.uk/understanding-bipolar-disorder.html>

Towards a social model of madness and distress? Exploring what service users say:

This Joseph Rowntree Foundation report explores mental health service users' views about social approaches to madness and mental distress and their relationship with the social model of disability. It provides an invaluable introduction to issues which may affect the decision to disclose.

<http://www.jrf.org.uk/sites/files/jrf/mental-health-service-models-full.pdf>

Toolkits and online resources

Action on Access Disability Guides:

This list of resources provides a series of guides and advice relating to the broader issues of disability, it includes targeted information and checklists that may support staff with a range of responsibilities, for instance marketing, library services, facilities.

<http://actiononaccess.org/resources/publications>

Developing an Holistic and Joined Up Approach to Mental Wellbeing:

This online resource - part of the Healthy Universities Toolkit, developed by the UK national Healthy Universities Network - aims to promote a whole university approach to addressing wellbeing issues in their broadest sense.

<http://www.healthyuniversities.ac.uk/toolkit/guidance-package-subsite.php?subSite=6>

The Disability Archive UK:

The aim of the Disability Archive UK is to provide disabled people, students and scholars with an interest in disability and related fields, access to the writings of those disability activists, writers and allies whose work may no longer be easily accessible in the public domain. It is hoped that the documents available via the Archive will help to inform current and future debates on disability and related issues.

<http://disability-studies.leeds.ac.uk/library/>

Higher Education Support Toolkit: Assisting Students with Psychiatric Disabilities:

This US resource aims to assist students to clarify the issues that the barriers to academic success and satisfaction, and to address them.

<http://cpr.bu.edu/wp-content/uploads/2011/09/Higher-Education-Support-Toolkit.pdf>

Mental health: A university crisis:

Mental health issues have become a growing concern for both students and academics. This Guardian series aims to uncover what it describes as 'a hidden side to university life'. It is worth reading, both for the articles and the comments upon them, as it can help highlight the diverse attitudes to mental health which staff and students may encounter.

<http://www.theguardian.com/education/series/mental-health-a-university-crisis>

Post-Secondary Student Mental Health: Guide to a Systemic Approach

The framework presented in this Canadian guide outlines a systemic approach to the creation of campus communities that foster mental well-being and learning.

http://www.cacuss.ca/current_projects_mental_health_report.htm

Mental Health in Higher Education hub:

This resource aims to enhance networking and the sharing of approaches to learning and teaching about mental health across the disciplines in UK higher education:

www.mhhehub.ning.com

Its membership includes educators, students, student support staff and users of mental health services. The MHHEHUB has collated a collection of student mental health links, including some student blogs which may help raise awareness of the lived experience of students with mental health problems: <http://bundlr.com/b/student-mental-health>

Videos

Animated Minds:

A series of short animated documentaries that use real testimonies from people with experience of different forms of mental distress. A single aim underpins all the films: to help dispel myths and misconceptions about 'mental illness' by giving a voice to those who experience these various difficulties first hand.

<http://animatedminds.com/>

Being a student is mental: normalising mental health issues:

Based on the results of a project carried out for Aimhigher Sussex, this video explores the relationship between mental health problems and progression to Higher Education, and how those providing outreach activities can make them accessible and relevant to students with mental health issues.

<https://www.youtube.com/watch?v=bpOQJIFFrxo>

Equally Connected:

In the summer of 2010 a group of international students at Heriot-Watt University in Edinburgh made this short film about the challenges of leaving home, to live and study in a new country, and the strategies they employed to ensure their wellbeing.

<https://www.youtube.com/watch?v=lGz6wih3TLs>

Tony's Story: towards a mental health promoting University:

This video shares the story of one mature student with mental health problems, raising issues that Higher Education Institutions need to address if they are to deliver environments that promote wellbeing and success.

<http://www.birmingham.ac.uk/research/activity/social-policy/ceimh/film-resources/tonys-story.aspx>

University Mental Health and Wellbeing Day - 'I Chose to Disclose':

The Support Services & Student Union at Aberystwyth University asked staff and students how they would respond if someone disclosed a mental health difficulty to them. See how they reacted:

https://www.youtube.com/watch?v=mJL0_Ot5vsQ

Websites

The Alliance for Student-Led Wellbeing comprises organisations that aim to raise awareness about the importance of good mental health, reduce the stigma associated with anxiety and depression, and provide practical and emotional support to university and college students, working alongside campus and public services.

The website contains links to a range of other useful sites including Student Minds, Mental Wellbeing in Higher Education, the University Mental Health Advisers Network and Nightline.

<http://alliancestudentwellbeing.weebly.com/>

Appendix 2 - List of institutional contacts

Below is a list of institutional contacts at the case study institutions from which we have used examples of good practice.

Table A List of institution contacts

Name	Job role	Institution	Telephone	Email
Sara Gallagher	Student Support Manager	Bath Spa University	01225 876543 or 875521	s.gallagher@bathspa.ac.uk
Phil Scarffe	Head of Student Welfare	De Montfort University	0116 250 6048	pscarffe@dmu.ac.uk
Joanne Jones	Student Wellbeing Service Manager	University of Derby	01332 591314	j.jones@derby.ac.uk
Mr Sam Dale	Deputy Academic Registrar	University of Durham	0191 334 6120	deacademic.registrar@durham.ac.uk
Lynne Spence	Head of Student Centre Service	University of Greenwich	020 8331 8587	l.t.spencer@gre.ac.uk
Christopher Warrington	Head of Student Support	University of Leeds	0113 34 34075	c.j.warrington@adm.leeds.ac.uk
Jacqueline Mayer	Head of Student Services	University of Lincoln	01522 88 6425	JMayer@lincoln.ac.uk
Mark Crawley	Dean of Students and Director of Widening Participation and Progression	University of the Arts London	020 7514 8852	m.crawley@arts.ac.uk