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Building Resilience for the Future:

City of Glasgow College Conference on Mental Health

Conference Notes

Mark Ames – Director of Student Services at University of Bristol

The first step in approaching the issues surrounding MH is trying to understand what impedes students in their education and MH.

Trends we're seeing – always been there in the student population. We are now seeing a greater proportion of people being open about their MH (a positive). Students are also being better supported to achieve their academic potential. On the other hand, we are seeing a greater prevalence of social isolation and anxiety/depression. However more people are reporting their MH issues and more are prepared to admit their MH issues when given the opportunity.

Because of this increase in talking about MH, academics are sometimes feeling out of their depth due to number of people coming forward. The fact that Universities are now attracting a more diverse student population is both a blessing and a curse as there is a much richer cultural diversity however with that more complex MH issues can arise.

We thought 'what are we doing' in a selection of areas:

University-wide - We established a student counselling service. We also have our own health service (GPs, nurses etc.) and disability services. We also put a focus on sport, exercise and health. We discovered that the participation in these groups helps build relationships. Drawing from this, the more relationships students build the lower the chances of feeling isolated. 68% engaged in physical activity lead by this division after the first year of analysis. There was a significant change from the darker times of 3 years ago.

Looking at ways the student union can take a lead in developing peer-led approaches also helped us, which feeds into the next focus: Report and Support. We set up a website where people could seek support and also information/advice in relation to sexual misconduct. We then reviewed what we do for suicide prevention and, in light of the previous years' difficulties, what we can do to support the people left behind afterwards.

Residences - We implemented a high profile residential-life service. We can now spot earlier on where people are falling behind to provide the support that they need at a stage which will benefit them proactively instead of reactively.

Faculties and schools - We looked to support people in their transition into HE and then help build communities from this. There was a big step-up in promoting information about self-support and confidence in coming forwards with MH issues to get help. Peer-led support was also focused upon to make sure people are in contact with people (face-to-face contact) and also so we can identify earlier if someone is falling behind either in relation to their MH or academic progress.

External partnerships - Having access to services and advice in specialist areas e.g. substance abuse. This is because we know that the specialist care and support needs to be delivered by that specialist. University of Bristol are now involved in a country-wide project dealing with how Universities can work with NHS and specialist MH services to improve further in both curriculum and student support in the academic environment.

UUK strategy - Took each area and identified 'what are we doing in each of these areas?' then 'what are the gaps'? – What should we do better/do more of? Whole institutional approach is appropriate. Student MH and Wellbeing sometimes thought of as a 'send them away and fix it' mentality (where people suffering are removed from their usual setting and scrutinised or overwhelmed with questions etc.) not as it should be – create the environment which promotes and supports good MH.

We need to also think about staff. They are also just as impacted by changes in MH and having a staff strategy is equally important. They need support too!

Vice Chancellor set up taskforce to tackle key moments during university time. Having separate staff and student strategies is important as they need different types of support. If there was one singular strategy for both staff and students it would be more likely to be very student-support heavy and this must be avoided.

What pivotal things need to be done as a next step? The Senior Leadership Team of every institution need to recognise that MH is a key priority – Do you want to be in a reactive mode where you just deal with what has already happened or do you want to create the environment where MH is supported beforehand?

A great thing that we've started is students can opt in at point of registration to have University of Bristol contact their emergency contact if they are concerns in relation to MH. This means that the support can also be offered by people who the students know themselves as well as professionals that University of Bristol can guide them to/provide themselves.

Mrs Pauline Hanesworth - Head of Learning and Teaching SRUC

MH issues are increasing rapidly year-on-year. Second most disclosed disability.

UK students report significantly lower levels of wellbeing than the general population.

We can see a correlation between MH Issues and drop outs. Increasingly students are more likely to turn to their lecturers than turn to the support services.

We need to look at the curriculum as everyone is exposed to it not just the people who come forward, which usually is the minority of those who are experiencing MH issues. Education has a large impact on MH. Learning does require a certain level of discomfort/stress but there is a point where it tips over from productive pressure to detrimental issues.

Make it visible and explicit. Where does the lecturer's role fit? They need to provide an environment of promoting good MH and wellbeing not be a counsellor.

Ask staff directly where would MH and Wellbeing fit in your subject and curriculum. We know a key pressure point is assessment and there is a need to stop bunching in exams. Having assessments all close together can often cause a disproportionate spike in student and staff stress levels and therefore a spike in MH Issues.

Academics need to better understand when to set deadlines too. Stop midnight deadlines or ones immediately after breaks away (e.g. Christmas).

Not having rest periods in study is not conducive to a high retention of knowledge as it has been shown that the increase of cortisone can have adverse effects on the prefrontal cortex and hippocampus regions of the brain – the areas which help us retain and then apply knowledge.

Conduct practices which help people join in work with other people and encourage people to voice their concerns e.g. peer working and support. Using this as a core teaching method it helped people have better MH across the board.

Connect – Group based learning, peer to peer.

Be active – How can the students move and be active? Also need to look at how we assess the subjects - not just written exams but also proactive assessment.

Take notice – identify stories from the news and see how the students' personal experiences mirror this and then tie that back into the curriculum. And notice other people who need that help. How does what they're learning connect them to the world instead of taking them out of it.

Keep learning - get student to take charge of their learning and increase awareness that helps them become independent learners – Higher Education Academy QAA "Compendium of Effective Practice in Directed Independent Learning".

Give – give back to the wider community.

What advice would you give to staff about implementing MH in the curriculum? – Staff can become overwhelmed too but we need to look at what we are currently improving and then making those small changes continuously helps make it much more manageable.

Kate Haining – PhD Student from University of Glasgow – Using E-Mental Health to Detect Emerging Psychosis

Approx. 1.1 Billion people are living with mental health and substance abuse disorders.

More generally MH is a leading cost in support nationally and 15-24 is worse age band with 75% of mental health disorders emerging in this age band. £94 Billion cost per year in MH related causes. Transition from adolescence to adulthood is the main area of difficulty.

There are many barriers but the main ones are the stigma associated with having a mental illness, continued underfunding of services and then difficulty accessing those services – long waiting lists, income and cultural inequalities. MH interventions online is a scalable and accessible support for many people.

The yellow (Basic Symptoms) and orange (Attenuated Psychotic Symptoms) stages are at risk of developing psychosis. BLIPS (Brief Limited Intermittent Psychotic Symptoms) part spans the gap between 'at risk' and 'diagnosable' and only last less than a week and therefore cannot be diagnosed but are intense for that time period. These resolve without treatment. We need to protect these people early to prevent or aid if they do break into a full psychotic disorder.

We were asked to look into different brain markers that could signpost psychosis and grown our knowledge on this. Participants followed for 3 years and have 7 appointments in this time period. Youth Mental Risk and Resilience Study (YouR-Study) is an MRC-funded project that aims to develop a biomarker for psychosis-prediction. There is a website for the YouR-Study where there are several stages to screen participants. There were 180 participants meeting CHR criteria, of which 25 met FEP Criteria, 40 had affective disorders/substance abuse and then 50 control participants.

Online screening tool. Website. 25 questions. Recruited Glasgow and Edinburgh colleges, Universities, GPs, NHS. www.your-study.org.uk.

3500 completed questionnaires. 500 invited in for interview.

We have done cognitive testing. We also subject them to a brain mapping session. We measure neuro-oscillations (MEG).

MRIs look at different chemicals in brain while looking at different images and tasks.

We can look at the different areas of brain for high and low actively and draw from this study to look at these areas and sign post where these changes are.

Hope to recruit 850 participants to undergo face to face assessments at London and Glasgow sites.

We're also looking into getting people into the system straight away instead of the years that clinical support can take. Possible ways to improve the current online-screening platform: incorporate known risk-factors for emerging psychosis, perform online cognitive testing, and obtain speech samples to detect thought disorder /semantic anomalies.

How do you think the results of the research can be rolled out? – We need to improve the format to be rolled out. These need to be improved through continued study. Also collating our ideas with others to improve across the board. We need to add cognitive factors, environment factors to the questionnaires. Often people know they have a problem themselves but are reluctant to step forward but we see that changing slightly.

Prof Susan Powell and Zulfi Jiva

We developed a 60 question survey. Mostly year 1 university students completing it and more females answered questions than other genders (2507 female/1162 male/14 transgender or other) and females are more likely to come forward. 42% (n=1426) of the students were not registered with local GPs.

Food = a lot of people cannot prepare their own food. Only 56% (n=2227) respondents prepare their own food. 11% (n=371) eat 5 or more portions of fruit and vegetables per day. This need to be addressed.

Drink = a great number were getting drunk on a regular basis. 23% (n=792) of males and 50% (n=1700) of females were drinking wanting to get drunk. 42% (n=1,434) couldn't remember night before with 54% (n=1,847) not aware of support available.

Drugs = 30% (n=1027) taken drugs in last year – mainly alcohol, cannabis and cocaine.

Mental health – we saw more females report with issues. Many students don't seek support as they feel like they should be able to cope with it but they can't and this stigma needs to change.

We also need to find more effective ways to analyse MH and wellbeing and on a more frequent basis. This could also be achieved by designing interventions: student consultations and developing a surveillance system rather than a snap shot.

Manchester has a very large student population and this means the MH issues are much more prevalent. There is a significant increase in student coming into the MH services but people are struggling to keep on top of the MH support so we need to support the people giving the support.

Universities have provided up to £650,000 to help. In total around £1.6 million to help the greater Manchester areas. We are now looking for industry funding.

The aim of the service is to provide proactive mental health assessment, support and interventions from experienced mental health professionals to students to enable them to fulfil their university ambitions and experience.

This pilot is scheduled for 2 years. We are looking at around 500-600 students but this will be continuously reviewed to see if a greater provision is needed.

Set up a service provision on the high street for main three universities whereas University of Bolton gets one or two days and then Salford get two or three.

We are also providing group therapy for students. We have different people involved and but with industry funding we can increase these numbers.

Also because of the waiting times this is a problem as students might be missing appointments because of study or going home.

We all have mental health – there is a need to help males discuss their mental health. Having this open discourse will most definitely improve in the numbers of males disclosing their mental health and therefore get more support.

Q & A

Has there been thought towards the transition from high schools to Unis/colleges? Early prevention is key here. It is important to provide support across all ages. A lot of young people are unable to articulate their mental health.

MH for students for whom English isn't their first language is difficult. Although there is a certain level of English required for University, they are less able to articulate the support they need. We have to use external providers to combat this.

One of the most impactful changes for staff was the introduction of the student supports services. It relieved the pressure of students coming to academics all the time.

Recruitment of minority staff. In Bristol they worked closely with local community to target publicity on vacancy roles. They were clear that they were actively seeking to diversify staff profile. They are trying to combat the stigma that counselling, as a career, is only for female and/or middle class.

In the college application it includes mental health under Disability due to Funding Council reporting. Although this is not the only way to report. Many colleges and Universities have in-year self-referral with counsellors on staff. Mark Ames from Bristol said that we risk medicalising or therapising what is a normal thing. Transition to a new city, new course, new work, new social circles etc. would have an effect on anyone. They invite students to let them know if they are anxious

about coming to university and then if needed a residence hall advisor can contact them.