



Australian University Students and Mental Health: Viewpoints from the literature

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With more than 1.3 million students currently attending Australian universities and an estimated 20% of these experiencing a mental illness it is time this issue received more focused attention. Despite a number of initiatives being conducted there is a still lack of research that provides a comprehensive overview on the mental health of Australian university students which considers the policy landscape designed to support student learning. This research attempts to help fill that gap by providing a purposeful audit of the relevant literature. Specific material examined includes peer reviewed journal articles published within the past five years, the Australian Disability Discrimination Act 1992 (DDA), Bradley Review of Australian Higher Education (2008), and presentations from six keynote speakers at the 2017 Inaugural Australasian Mental Health and Higher Education Conference (IAMHHEC). Findings reveal that, despite student mental health being a widely recognised global concern, well developed policies still need to be developed to guide future approaches. What is known is good mental health is necessary for students to reach their full potential and universities are well positioned with expertise, structural and human assets to make a positive difference. Policies and action demand attention with a unified strategic approach across the Australian and international higher education sector essential.

Key terms: University students, mental health, Australia, policy.



Introduction

This paper is a purposeful audit of literature and reports that address student mental health in the higher education sector in Australia. The structure of the review is informed by Cooper's Taxonomy as described by Randolph (2009). It begins by establishing the global context for student mental health in higher education, the reasoning behind the review, and clarifies the audience for whom this audit is prepared; then, identifies how the mental health of young people in Australia and higher education students are reported in the literature; provides an outline of how the Australian government and university policies respond to this issue; discusses the parameters for choosing literature for the review and the methodological organisation; and lastly, summaries the trends evident in the literature to highlight lead mental health and wellbeing initiatives being undertaken in various Australian universities. The substantive collection of literature presented in this paper comprise an overview of current information on the mental health of Australian university students and the policy landscape that supports their learning endeavors. Peer reviewed journals published within the last five years, along with the Australian Disability Discrimination Act 1992 (DDA), the Bradley Review of Australian Higher Education (2008), and presentations from six keynote speakers at the 2017 Inaugural Australasian Mental Health and Higher Education Conference (IAMHHEC) hosted by James Cook University, inform content.

Global perspective

At the global level, mental health is a priority for the health agenda (World Health Organisation, 2017). People experience mental health difficulties due to their inability to effectively respond to the stressors of life, making it difficult for them to function effectively and constructively. Mental health disorders and mental ill health, named for example as depression, anxiety, schizophrenia and dementia, and disorders from alcohol and substance abuse, together constitute an estimated 13% of the global burden of disease and outstrip both cardiovascular disease and cancer (Collins et al., 2011). The damage caused by mental ill health to all sectors of humanity is now formally recognised, alongside communicable diseases, as being significant and requiring responsive action (World Health Organisation, 2017). Depressive disorders account for two-thirds of the global mental ill health burden (Collins et al., 2011) with the World Health Organisation (2017) recognizing depression as the single largest contributor to global disability and the major contributor to suicide.



There is emerging acknowledgment of the link between the stress of modern life and mental ill-health (Abbott, 2012). Worldwide, mental ill health is currently being identified as the number one health issue facing young people aged 10 to 24 presenting with the highest prevalence of mental health difficulties and disorders, with suicide the leading cause of death for 15-24 year olds. Since 1997 surveys of US college students indicate that rates of depression have doubled and the incidence of suicide has tripled (Gewin, 2012). A survey of 28,000 students in 51 US postsecondary institutions revealed that 45% of respondents felt “things are hopeless,” 50% felt “overwhelmed by anxiety”, 30% were feeling “so depressed it was difficult to function,” and 7% had seriously considered suicide in the previous 12 months (Kirsh et al., 2016). Other studies from around the world report similar trends of increasing levels of mental ill health in higher education students (Goozee, 2016; Kirsh et al., 2016; Laidlaw, McLellan, & Ozakinci, 2016; Levecque, Anseel, De Beuckelaer, Van der Heyden, & Gisle, 2017; Macaskill, 2013; Nami, Nami, & Eishani, 2013; Quinn, Wilson, MacIntyre, & Tinklin, 2009; Sarmiento, 2015; Tinklin, Riddell, & Wilson, 2005).

In Australia the situation is no different (Orygen, 2017) with particularly disturbing figures coming out of indigenous populations. Dudgeon (2017) in her IAMHHEC keynote address, *Aboriginal and Torres Strait Islander mental health: Implications for Universities* reminded the audience that in 2015 the overall Aboriginal suicide rate was twice that of other Australians and that self-harm among young “Indigenous people aged 15-24 is also high at 5.2 times the rate for other young people” (p. 3). Dudgeon highlighted the dramatic increase of suicide and self-harm over the past 30 years with young Aboriginal people (17-23) years of age most at risk.

Neither are students of Australian higher education institutions exempt from the malaise of mental ill health and stress induced disorders, with the literature reporting they are even more likely to incur issues with mental health than those in the general population (Stallman & Shochet, 2009). Typically, undergraduate students are in their late teens or early twenties, the age when the vast majority of mental health disorders manifest (Gewin, 2012; Martin, 2010; Norton & Brett, 2011; Perre, Wilson, Smith-Merry, & Murphy, 2016). The added stress of high fees and performance commitments may cause and/or compound pre-existing stress in university students. Mental ill health is also associated with high risk behaviours like excessive alcohol consumption, illicit drug use and unprotected sexual activity (Sarmiento, 2015).



In the higher education sector, multiple barriers challenge students who are experiencing mental health difficulties which negatively affects successful course completion (Orygen, 2017). For these students, successful integration and engagement with student life is disrupted by fluctuations in thinking and concentration, lower levels of academic confidence, mood variability, motivation spikes, the negative effects of medication and difficulty with social relationships (Venville et al., 2016). Additional barriers reported by students in this study include discrimination, unstable housing, financial stress and not knowing how, when or where to access available educational adjustments or supports. Accessing support is compounded by the stigma and devalued identity attached to mental ill health (Laidlaw et al., 2016; Perre et al., 2016; Quinn et al., 2009). Afraid to be identified as ‘mentally unfit’ students are loath to seek help and only 10% of US students and 4% of students in the UK are estimated to seek treatment (Gewin, 2012). In addition, students with mental ill health may find symptoms difficult to recognize as they expect to feel pressured from study commitments (Gewin, 2012), consequently, symptoms remain undiagnosed and untreated. With mental ill health largely a hidden disability, it presents unique issues for students and the (possible) inability to identify and advocate for their rights and actively seek meaningful support. These students may therefore receive less care than their peers with physical disabilities (Venville et al., 2016).

Why explore literature about Australian university student mental ill health?

As already reported, university students experience higher rates of depression than the general public (Bore, Pittolo, Kirby, Dluzewska, & Marlin, 2016). To promote positive outcomes at personal social, economic and political levels, responses to the gravity of mental ill health in young people studying at university must be exemplary. Mental ill health creates emotional and financial costs to students and considerable cost to the wider community through lost investment from course non-completion and downstream costs to the mental health sector from non-intervention at an early stage (Orygen, 2017). To set the context for how Australian universities respond, this paper explores literature addressing government policy, the mental health of Australians generally and the mental health of young people and university students. Despite the Australian Government Department of Health funding various programs to support the mental health of young people aged between 12 and 25; like *Headspace*, (<https://www.headspace.org.au/>), and *Batyr@uni programs* (<http://www.batyr.com.au/university-programs/>) there is no (known) policy that responds to mental health across the higher



education sector. Hence, response to university students' mental illness occurs at the discretion of each tertiary institution.

Higher education sector, policy makers and interested parties

This aim of this paper is to inform the Australian higher education sector, government policy makers and interested parties, of the complexities of student mental health and to detail how the issue of mental health and wellbeing is addressed. The compounding issues implicated in university students' mental health at the global level are mirrored in Australia. Whilst some universities are developing policy and action to respond to student mental health, there is an absence of a cohesive mental health policy that provides leadership and support in the higher education sector (Orygen, 2017). A paradigm shift focusing on promoting prevention programs and interventions across universities in Australia is warranted (Veness, 2017). As meaningful outcomes for students with disabilities are not currently being met within the Australian context (Dryer, Henning, Tyson, & Shaw, 2016), Australian universities need to be more informed and consistent with legislation and have policies that outline their institutional responsibilities (in alignment with the Disability Discrimination Act DDA). Campus communities are positioned to reach over half the young people in this age group and to provide pathways to primary care and early intervention for students with an emerging or diagnosed mental health difficulty, assisting them manage the 'normal' psychological demands associated with successful transition into higher education (Wynaden, Wichmann, & Murray, 2013).

Universities are well placed for early intervention and prevention with multifaceted strategies presented in the literature. Reavley and colleagues present strategies for mental health support in tertiary institutions in: *Development of guidelines for tertiary education institutions to assist them in supporting students with a mental illness: a Delphi consensus study with Australian professionals and consumers* (2013). They outline the need for policy, support services, staff awareness, mental illness training, fulfilling student rights and responsibilities, and dealing with mental health crises, funding, research and evaluation. Veness (2017), in his IAMHHEC keynote address *The Wicked Problem of University Student Mental Health*, advocates universities have an obligation in committing to and promoting every student's success from the day of enrolment through to graduation (p. 13). Institutional enablers in supporting student mental health and wellbeing cross-institutionally at the systems, course, subject and program level, are essential. Audas (2017) emphasises the role of community links and transitions (e.g., school to work or future study; higher education to



employment; career transitions) in this process, questioning what community structures or opportunities exist to support students navigate transitions (often without secondary school supports), promoting the involvement of persons with lived experiences, intervention and peer support training and the concept of recovery. Audas explains in his keynote address, *Mental health and Wellbeing: How are we doing and what's your role?* that recovery involves community connection as a protective factor for mental wellness: “Finding hope, and developing your self-esteem and resilience; having a sense of purpose and meaning in your life; building healthy relationships with people in your community; gaining independence in your life” (p. 12). It is important to understand that students with high levels of emotional resilience have lower psychological distress and higher wellbeing (Bore et al., 2016): they adapt better when making the transition from high school to university; and experience less life stress in their commencement year of university (Morton, Mergler, & Boman, 2014). Baik et al. (2017) feature the role of resilience and persistence in enabling university students to “engage effectively in complex learning tasks ... respond positively to challenges and make the most of the opportunities available” (p. 1).

Orygen, the national centre of excellence in youth mental health, outlines key institutional processes including: formulate a mental health policy, measure it so it counts, provide leadership and coordination, tap into technology, utilise existing capital, respond to heightened risk, work toward developing sustainable partnerships nationally and regionally (2017). Improved mental health literacy is identified as a critical first step for successful promotion, prevention and early intervention (Australian Government, 2016a; Perre et al., 2016). Bore and colleagues suggest university introductory courses with information about mental health, counselling and resilience building skills such as mindfulness (2016) are possible directions forward in building this literacy. These courses could examine the range of factors that influence students – social interactions, cultural values, community norms, public and institutional policies and procedures (Kirsh et al., 2016) and personal care strategies to monitor nutrition intake, exercise levels, sleep patterns and strategies for positive mental health. More expansive is the *Enhancing Student Mental Wellbeing project* (Baik et al., 2017) inclusive of professional development modules for educators; an institution wide sustainable student wellbeing framework; handbook for academic educators showcasing mental health literacy through best practice conducive to mental wellness; and interactive links to mental health resources.



Mental health in Australia and government policy

Statistics for mental health in Australia reflect global trends and are a growing concern for government policy makers and Australians generally. Half of all mental ill health commence before 14 years of age, and 75% is present by mid-twenties (WHO, 2017). Acknowledging the high prevalence of anxiety, depression, stress and drug and alcohol related problems in the general population with a high concentration between the 16-24 years of age, Orman (2017) in her IAMHHEC keynote address, *Mental Health on Campus – Practical Ways to Help*, isolated eating disorders and Post Traumatic Stress Disorder (child abuse and neglect) as common mental health problems found in higher education (p. 14). Acknowledging that 52.8% of Queenslanders who died by suicide had no diagnosed mental health condition (2011-2013 AISRAP, Brisbane, 2016), Orman states that suicidality can transpire in these mental health difficulties such as stress, depression, anxiety, eating disorders, bipolar disorder and psychotic illnesses (p. 14).

With 20% of the population anticipated to experience mental ill health in any one year, Killackey (2017) describes “mental illness is the illness of young people” (p. 2). Mental health is a priority of the Australian Government in Australia, mental and substance use disorders are estimated to be responsible for 12% of the total burden of disease in 2011, placing it third as a broad disease group after cancer (19%) and cardiovascular diseases (15%) (Australian Institute of Health and Welfare (AIHW), 2016). Audas (2017) discussed the world class policies driving Australian mental health reforms over the past thirty years, claiming that reform has been stifled by “inadequate planning, poor implementation and our complex system of government” (p.19). Referencing John Mendoza, Audas asserts “the results have been disappointing, wasteful of scarce resources and all too often, devastating for the millions of Australians affected by mental illness” (p. 19).

The *Fifth National Mental Health Plan* (Fifth Plan) seeks to establish a national approach for integrated mental health services with the states and territories between 2017 and 2022 (Australian Government, 2016a). The Plan maintains focus on the following: regional service delivery for mental illness, support for people with severe and complex mental illness, suicide prevention, Aboriginal and Torres Strait Islander mental health, stigma, safety, reform and working collaboratively with particular groups within the wider community including ‘schools, universities and other education institutions’. The Plan describes a role for governments, organisations, professional bodies, workplaces, people living with mental illness, their carers and



individuals in the community, yet refrains from suggesting a role for schools, universities and other education institutions.

While commonwealth expenditure on mental health 2012-2013 was \$9.6 billion, contention exists about the level of funding for mental health over the last decade and the lack of a coherent Australia wide strategy (Rosenberg, 2017). When mental health was estimated to be 12% of the total disease burden (Australian Institute of Health and Welfare (AIHW), 2016), the Australian Government Institute of Health and Welfare reported that estimated expenditure on mental health-related services in 2014–15 was around 7.8% of total health expenditure comparative to 7.7% in 2010 (Australian Institute of Health and Welfare, 2016a). Further exacerbating the issue is the prevalence of physical disorders in those experiencing a mental health illness, referred to as ‘comorbid’ disorders. The *National Survey of People Living with a Psychotic Illness* (2011) reports a greater incidence of circulatory problems, diabetes, epilepsy and severe migraines in persons experiencing mental ill health compared with the general population (Australian Institute of Health and Welfare, 2016b).

Australian university students’ mental health

Australian universities have increased numbers of students, including students with a psychological disability, as a result of neoliberal and social inclusion policies to make university education available to a wider group in society (Ganguly et al., 2015; Hughes, 2015). The Bradley Review outlines a national goal of at least 40% of 25- to 34-year-olds having attained a qualification at bachelor level or above by 2020 (Bradley, 2008, p. xviii). According to Hughes, this has led to national government policies that have driven a ‘massification’ of tertiary education and obscured the socio-cultural dynamics that underpin academic success and failure (2015). Gittins argues that governments have pushed for the privatisation of Australia's universities since the 1990s and are seeking to limit federal funding for universities to create a user pays system (2017). Rapid expansion in student enrolments over the last thirty years has led to higher staff-student ratios and less staff support time for students (Tinklin et al., 2005). To work more towards a user pay system, the Council for International Education, an initiative of the Australian Government Department of Education and Training was convened in 2015 to devise a ten-year plan to make Australia more competitive in the international education economy and produced: the *National Strategy for International Education 2025* (Australian Government, 2016b). International fee-paying students rose by 13% from 2015 to 2016 and they



now account for almost one third of university students attending Australian universities (Ireland, 2017). International students face significant language, psychosocial and cultural transition stressors and studies report concerning levels of mental health issues (Vivekananda, Telley, & Trethowan, 2011; Wynaden et al., 2013).

Australian university students are experiencing higher levels of stress than their peers not attending university (Hussain et al., 2013; Larcombe et al., 2016; Laws & Fiedler, 2013; Orygen, 2017). Transition to university life can be complex (Audas, 2017; Killackey, 2017; O'Hagan, 2017) and problematic as young university students not only undertake tertiary study but assume more responsibility for managing their lives, health and finances (Wrench, Garrett, & King, 2013; Wynaden et al., 2013). Adding to this reality is the increasing levels of mental ill health and social dysfunction associated with isolation and addiction to smartphones (Twenge, 2017). The expanded responsibilities that come with studying at university elevate stress levels and are complicit in clinical depression and anxiety-related conditions (Bore et al., 2016; Perre et al., 2016). Further compounding these issues are performance expectations, dis/relocation, financial stress, poor diet, lack of sleep and drug and alcohol abuse, leading to students exiting study before courses are completed (Orygen, 2017). Other stressors include high levels of competition (Stallman, 2012), financial stress (Halliday-Wynes & Nguyen, 2014; Larcombe et al., 2016), and physical and psychological stressors from long periods of sedentary behaviour sitting at a desk (Graham, Richardson, King, Chiera, & Olds, 2014). Equity group students from disadvantaged backgrounds who identify as Aboriginal or Torres Straits Islander or are from rural or remote locations may have mental health disabilities and experience higher attrition rates than fellow students without disadvantage (Edwards & McMillan, 2015; Li & Carroll, 2017; Meuleman, Garrett, Wrench, & King, 2015; Toombs & Gorman, 2011).

University students have traditionally been considered socially advantaged but the impacts of mental illness create disability and stigma and create disadvantage for young people enrolled in higher education courses (Dryer et al., 2016; Hussain et al., 2013; Perre et al., 2016). Students experience difficulties attending to study (and life) requirements and reduced self-efficacy; and, along with perceived discrimination, this manifests in an increased risk of ending their studies (Dryer et al., 2016). Help seeking behaviours are hindered by the stigma of being labelled mentally inept and feeling embarrassed or fearful which further compounds distress (Ganguly, Brownlow, Du Preez, & Graham, 2015; Perre et al., 2016). Stigma can contribute to fear and



isolation and can be more debilitating than the mental difficulty itself, resulting in more negative impacts on social, cultural, economic and political levels (Edwards & McMillan, 2015; Martin, 2010). Mental health difficulties often follow students into their future and can lead to lifelong negative outcomes impacting career prospects, work performance and social relationships (Ibrahim, Kelly, Adams, & Glazebrook, 2013; Dudgeon, 2017; Killackey, 2017; O'Hagan, 2017; Orman, 2017; Vennes, 2016, 2017).

Australian responses to university student mental health

Australia is signatory to international conventions that recognise mental illness as a disability that creates disadvantage (Martin, 2010). In 2008, Australia ratified the *United Nations Convention on the Rights of Persons with Disability* and this is supported nationally by the *Disability Discrimination Act 1992 (DDA)* and the *Disability Standards for Education 2005* and the *Australian Vice-Chancellor's Committee Guidelines for Students with a Disability 2006* (Martin, 2010). These legislation, standards and policies aim to support students with disabilities participate in education on the same basis as their non-disabled peers, but there are concerns this has not translated into effective outcomes on campus, with one contributor being staff unawareness of their responsibilities under the DDA (Dryer et al., 2016). Other contributors are the lack of policy and action response to student mental ill health (Orygen, 2017).

In a formal context in government reports, mental ill health is not considered a factor when defining student disadvantage. The Australian Government *Review of Australian Higher Education Final Report* (2008), commonly known as the Bradley Review, concludes that Australia is falling behind other countries in performance and investment in higher education. One recommendation is to address this trend is to increase student attendance from disadvantaged groups, identified as Indigenous people, those who have low socio-economic status and those living in regional and remote areas. There was no consideration in the report for disadvantage caused by mental ill health. Significant reforms to assist disadvantaged students attend university have occurred in the decade following the Review and their effectiveness has been questioned (Harvey, 2016). The current *2017 Higher Education Reform Package* focuses on improving the sustainability, transparency and accountability of the sector and to continue funding for disadvantaged students through the Higher Education Participation and Partnerships Program (HEPPP), with disadvantage continuing to refer to Indigenous students and students from a low socio-economic status (Australian Government Department of Education and Training, 2017).



Universities are well placed to respond to mental ill health in the student population and to support students with the added demands of higher education (Wynaden et al., 2013; Audas, 2017 O'Hagan, 2017; Orman, 2017; Veness ,2017; Killackey, 2017). Orman (2017) emphasised the consequences of failing to recognise and respond early and appropriately to mental health difficulties results in: “underperformance or academic failure; interpersonal difficulties; development of secondary problems (e.g., drugs and alcohol) ...; stigma, isolation and discrimination; deterioration in mental health; poor physical health” (p. 15). O'Hagan (2017) provides weight to this argument in her “*Failing through the cracks: A lived experience perspective on mental distress at university*” IAMHHEC keynote address, declaring: “The personal, social and economic costs of no response or a narrow response is huge” (p. 15).

However, institutional support is sporadic across the Australian university sector and compounded by many factors, namely a grey area about what role the university should take, who is responsible (the university and/or the adult learner) and staff willingness and capacity to respond (Laws & Fiedler, 2013). RMIT has issued the declaration that Veness (2017) foreshadowed at the IAMHHEC, making students' mental health and wellbeing a core priority of their university: <https://www.rmit.edu.au/news/all-news/2017/aug/rmit-makes-students-mental-health-and-wellbeing-a-core-priority>. Notably, the statement commits RMIT to a three year whole of institution change project and is co-signed by both the Chancellor and Vice-Chancellor.

Nonetheless a lack of a direct responsibility chain – expressed in policy and action – means students who self-identify as having a mental health disability face additional barriers to learning because of the hidden nature of their disability and they may experience hostile or negative attitudes from staff and students resulting in lowered self-efficacy and completion rates, compared to non-disadvantaged students (Dryer et al., 2016). Students do not have effective help seeking strategies (Laws & Fiedler, 2013) and were more inclined to silence or to approach friends. Australian universities are well placed to establish their duty of care for students, ably supported by the national regulator for the higher education sector the Tertiary Education Quality and Standards Agency (TEQSA). University duty of care is expressed in Clause 2.3 Wellbeing and Safety in the *Higher Education Standards Framework (Threshold Standards) 2015* ratified by TEQSA as effective January 2017 (Australian Government Department of Education and Training, 2015). Universities need to intentionally engage in partnerships with primary health and



community mental health care services, consumers, carers, students, counselling and teaching staff to ensure promotion, intervention and institutional enablers are enacted (Veness, 2016, 2017). Staff require training in mental health literacy and early intervention with programs such as Mental Health First-Aid (MHFA) (Lipson, Speer, Brunwasser, Hahn, & Eisenberg, 2014).

Advocating that education is foundational for career sustainability, Killackey (2017) scrutinised the preliminary outcomes of the early intervention exploratory feasibility study in relation to supporting young people presenting expressing interest in educational support or reengagement in education programs (Killackey, Allott, Woodhead, Connor, Dragon, and Ring (2016). In his IAMHHEC keynote address - *How can we best support young people with mental ill health to take their education as far as they can?* - Killackey highlighted pivotal factors in the success of adapting individual placement and support programs supporting the education of current client (15-19 years of age) of the Orygen Youth Health Clinical Program (OYHCP):

Educational expert (teacher) employed in the mental health service; collaborated with youth to customise educational goals; sourced and connected youth to institutions relevant to their educational goals; worked with them supporting attendance, engagement and performance; networked and connected them with supports in the institution; worked with professional and academic staff in the institutions (p. 32).

Parameters for choosing the literature

This paper has focused on the state of mental health wellbeing in Australian universities across the past five years last five years (2013-2017). The substantive collection of peer reviewed literature, reports, policy directives and the IAMHHEC keynote addresses have encompassed different dimensions of mental health. They represent an overview of the current practices and existing gaps advancing mental health and wellbeing in higher education.

Methodological Organisation

A comprehensive search strategy was conducted with an experienced librarian from the field of Psychology. The search covered 2012 – 2017 and included the terms: university education, university, student, mental health and wellbeing, combined with search terms related to barriers, enablers, facilitators, intervention, and empowerment. Base specific search strings were applied and peer review literature was searched using Informit (Arts and Humanities, Education, Social



Science), and ProQuest (Eric and PsychArticles). Due to the number of articles the literature search was limited to the last 5 years as this was deemed more appropriate. Also reviewed were the overarching Australian government acts and policies that guide mental health programs and the mental health policies of Australian universities providing leadership. Finally, the 6 keynote PowerPoint presentations from the Inaugural Australasian Mental Health and Higher Education Conference (James Cook University, June 30-July 1 2017) were included where relevant.

Trends evident in the literature

Our findings indicate that Australia has a world class higher education sector, but there has been an absence of unified policy across the higher education sector for university student mental health management (Orygen, 2017). Universities are bound by legal and institutional requirements to accommodate all students, including those with a disability (Hughes, Corcoran, & Slee, 2016). How to best support students coping with psychological distress and mental ill health is compounded by a lack of empirical evidence (Walton, 2016). Research that explores the perspectives and experiences of university students with a disability is limited (Hughes et al., 2016). The relationship between student success and support services needs further study despite the millions of dollars that have been spent on intervention and support strategies (Walton, 2016). The mental health profile of university students is quite diverse (Wynaden et al., 2013). Further research is required to understand the mental health issues and barriers affecting rural university students (Hussain et al., 2013). Without established disability frameworks, students are unsure about where to access information, who to disclose to, what happens with that information and who has access to it (McAuliffe, Boddy, McLennan, & Stewart, 2012). Direct relationships between a lack of response to university student mental health and successful completion rates has not been evidenced in the research. However successful completion rates will not be improved by a focus on isolated cases because of the complexity of studying at university in the 21st century (Pitman, 2017). A third of Australian university students fail to complete their course (Martin & Koob, 2017). Attention needs to be directed toward supporting student with mental health difficulties complete their studies.

University support services can benefit students dealing with stress (Jual, 2016) and many strategies to improve student services for mental health and wellbeing have been identified in government reports and peer reviewed journals. These include recommendations for more inclusive management of mental health problems, the development of supportive policies and



improved accessibility (Laws & Fiedler, 2013). Other research identifies the need to build resilience, training and attitude change in university staff and the importance of building peer support networks (Ganguly et al., 2015). Authentic peer support is currently gaining momentum (Seeto, Sharp, Wills, & Styles, 2013). Richardson and colleagues identify close social relationships with peers, the need for time management and organisation skills and effective coping strategies as being necessary for student success (Richardson, King, Garrett, & Wrench, 2012). In a meta-synthesis of findings from 16 studies in 5 countries, three common core processes were identified to assist students with mental health difficulties in the university sector: (1) knowing oneself and managing one's mental illness, (2) negotiating the social space, and (3) doing the academic work required (Ennals, Fossey, & Howie, 2015). In the *Australian University Student Mental Health: A Snapshot Psychological Initiatives for Medical Students: A Grass-Roots Approach*, the Australian Medical Student Association (AMSA) report that 13 out of the 20 medical societies now include a position for a Health and Wellbeing Officer (or equivalent) on their committee (2013). Further actions to support Australian universities support students' mental health and wellbeing are proposed by the six IAMHHEC keynote speakers: Audas (2017), Dudgeon (2017), Killackey (2017), O' Hagan (2017), Orman (2017), Veness (2017) (see, Table 1).



Table1. Ways forward – Responses to mental health and wellbeing in Australian Universities

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| <p>Jeremy Audas General Manager Programs & Partnerships, Selectability <u>Mental Health and Wellbeing — How are we doing and what's your role? (PDF, 5422 KB)</u></p> | | | | | | | |
| Developing and enacting appropriate policies and procedures - promoting mental wellbeing and supporting students experiencing mental health difficulties | Localisation and local delivery of mental health services and supports | Building personal resilience through lived experience – the concept of wellbeing, lived experience and strength based recovery and empowerment | Transition well when the natural course of life changes and identity is reshaped (e.g., school to work or future study; high education to employment; dislocation and relocation; career transitions) | Mental health policies need planning and implementation is a community wide agenda at all levels of government – where are we now? Where do we want to be? | Proactive, strategically aligned system, responding to whole-of-life needs | Whole of society approach, enabling access to and engagement with programs, services and consumers | Outcome focused mental health system – access in the right place at the right time |
| <p>Professor Pat Dudgeon Aboriginal and Torres Strait Islander Mental Health: Implications for Universities <u>School of Indigenous Studies, The University of Western Australia (PDF, 19676 KB)</u></p> | | | | | | | |
| Designing and leading culturally informed policies, plans and procedures - promoting mental wellbeing and supporting students experiencing mental health difficulties | Universities are settings for early intervention and prevention, prioritising working 'with' rather than working 'on' Aboriginal and Torres Strait Islander peoples | Curriculum change is pivotal to improving success and retention. Indigenous ways of knowing and doing are integral to the curriculum | Integrating indigenous pedagogy in mental health promotion. support and intervention across all parts of the Australian mental health system | Social and emotional wellbeing recognises the importance of connection to land, culture, spirituality, ancestry, family and community, and how these effect the individual | Closing the access gap with culturally responsive mental health services | Inclusion of Elders and community leaders as educators to inform and practice culturally informed concepts of mental health leadership | Prioritising of wellness, holistic health, and culturally informed and appropriate approaches for Indigenous people |



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| <p>Professor Eoin Killackey Orygen The National Centre of Excellence in Youth Mental Health How can we best support young people with mental ill health to take their education as far as they can? (PDF, 23030 KB)</p> | | | | | | | |
| Creating and managing appropriate plans and procedures - promoting mental wellbeing and supporting students experiencing mental health difficulties | Universities are settings for early intervention and prevention | Recovery needs to be the point of mental health systems. Assisting people overcome their symptoms without regaining their lives is to do only a fraction of what needs doing | On-campus treatment services should be supplemented by preventative health strategies and supported by active partnership with local government and private health services | Consumers hold the key to recovery | Addressing the educational achievement of people with mental illness is more important now than ever before | Each of us has an opportunity, to influence change, advocating for focused support for people experiencing mental health difficulties | Allocate resources to researching, funding and evaluating services and supports |

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| <p>Mary O'Hagan Director PeerZone (New Zealand) Failing Through the Cracks: A lived experience perspective on mental distress at university (PDF, 12992 KB)</p> | | | | | | | |
| Mental distress is a big problem in students Stronger community awareness and capacity | Providing reasonable adjustment for students with mental ill health | Paradigm change- <i>treatment of people with mental illness</i> (psychiatry) to <i>promotion of wellbeing for all</i> (communities) | Wellbeing focus- Wellbeing literacy for all staff and students; advisory services for staff working with students who are struggling; mental health and wellbeing systems conducive to work-study-life balance; promotion and advocacy of wellbeing services and activities | Promoting resilient: Self-management courses; health promoting assessment; low grades/no show checks; student wellbeing hubs; peer supports; medical treatment; counselling; education supports | Reducing stigma - including people with lived experience in the wider wellbeing agenda | Building personal resilience through lived experience – the concept of strength based recovery | Staff undertake mental health literacy training |



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|---|--|--|--|---|-------------------------------------|---|---|
| Dr Jan Orman GP Services Consultant Black Dog Institute and emHPrac <u>Mental Health on Campus — Practical Ways to Help (PDF, 4238 KB)</u> | | | | | | | |
| Developing and enacting appropriate policies and procedures - mental health promotion, prevention and intervention | Universities are settings for mental health promotion and early intervention | Consequences of failing to recognise and support students with mental health difficulties: underperformance or academic failure; stigma, isolation and discrimination; development of secondary problems; further deterioration in mental health | What can be done to provide authentic mental health support if there are no health services available or people in need of care will not go to see them? | Online supports – prevention and early intervention; introduction to face-to-face care; adjunct to face-to-face care Online resources are not a substitute for face-to-face care | Conversations matter: Are you okay? | Focused online support for vulnerable groups - Online treatment programs and self-help programs | We need to do more to improve mental health. Each of us has an opportunity, an obligation, to effect sustainable change |

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|---|---|---|---|---|---|--|--|
| Dr Ben Veness Churchill Fellow <u>The Wicked Problem of University Student Mental Health (PDF, 5557 KB)</u> | | | | | | | |
| There must be a 'tone at the top' that genuinely commits a university to developing policy, plans and practices, improving responses and processes to students' mental health and wellbeing | Three levels of change are required to make positive differences in people's lives - promotion, early intervention and institutional enablers | On-campus treatment services need to be - supplemented by preventative health strategies and supported by active partnership with local government and private mental health services | Sector leaders like The Jed Foundation, are required. These sector leaders need a strong advocacy reach | Responding to the unique needs of diverse groups (e.g., LGBTI, Aboriginal and Torres Strait Islander peoples, people living in rural and remote locations, and international students) requires specific attention in policy, plans and practices | Each of us has an obligation to effect change – research, policy, practice, and service delivery. Create task forces to develop mental health policies at each university and across the higher education sector | Screening programmes are worthwhile when matched with service, and outreach services should be used to target those students who do not or cannot engage via traditional means | Provide reasonable adjustment for students with mental health difficulties |



Key factors have emerged from this literature review and from the IAMHHEC. Good mental health is essential for students to achieve their potential. Student mental health difficulties are complex and global. Mental health literacy is important. The Australian Government and the higher educator sector recognise the prevalence, concerns and complexities presented by student mental ill health, and acknowledge their duty of care. Universities are positioned with expertise, structural and human assets to reach over half the demographic in this age group. Policies and action demand attention, and a unified strategic approach across the higher education sector is required. Humanitarian reasons to fulfil this duty of care are paramount. It also makes smart economic sense to respond with early intervention and avoid costs ‘downstream’. This is an investment in the wealth and prosperity of the nation and is a call for all to be involved as mental health in higher education is “everyone’s business”.



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