University Students and Mental Health
An Assessment of On-Campus Services and the Increasing Pressures Faced by Universities

Abstract

Mental health is increasingly becoming a challenging issue on university campuses. At many levels of administration and student services, concern has been expressed over the increase in the number of students with mental illness as well as the increase in the severity and complexity of the cases being presented. This paper will evaluate the services that are currently being provided on campuses for students with mental illness and the gaps where other services and interventions may be required for student success.

I. Introduction

Mental health is increasingly becoming a challenging issue on university campuses. At many levels of administration and student services, concern has been expressed over the increase in the number of students with mental illness as well as the increase in the severity and complexity of the cases being presented. It is not fully understood why there is an increase in the number of students presenting with mental illness on university campuses. There is speculation as to the effectiveness of medication, the power of early diagnosis and intervention, and the increase of mental illness in society as a whole. This paper will evaluate the services that are currently being provided on campuses for students with mental illness and the gaps where other services and interventions may be required for student success. Twenty-six interviews were conducted with mental health service providers (counselling services, and accessibility services) at 17 universities in Ontario. The vast majority of the information collected was qualitative. Presently, there is an inconsistent approach to data collection on mental health issues across the university sector. This makes cross-sector comparisons difficult.

1 A list of the questions asked of key informants can be found in Annex A.
Medical staff at student health services were not included in the original survey, but their input has been included in the sections on Health Services. Mental health professionals at the Centre for Addiction and Mental Health (CAMH) were also consulted to better understand the challenges surrounding serving students with mental illness.

II. What is Mental Health and What is Mental Illness?

Mental illness is commonly feared and often misunderstood. The World Health Organization characterizes mental health as “a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community” (World Health Organization 2008). Mental illness on the other hand, is not merely a disturbance in mental health, but according to Julio Arboleda-Florez, who writes on mental health reform for the School of Policy Studies and Centre for Health Services and Policy Research at Queen’s University it is “an insidious, incapacitating, and devastating psychological development that seriously affects intellectual functioning, mood states and behaviour to the point of seriously affecting an individual’s professional and social standing” (Arboleda-Florez 2008, S14).

From these two almost polar definitions it is clear that mental illness can be best understood as a spectrum of conditions that can affect normal cognitive, emotional, or behavioral functioning and may be caused by social, psychological, biochemical, genetic, or other factors, such as infection or head trauma. Mental illness can disrupt thinking, feeling, mood, and the ability to relate to others and to work (Health Canada 2002, 7). Multiple mental disorders are also common and may also be combined with substance abuse disorders.

Serious mental illness is often episodic in nature. Treatment and recovery may take place over a long period of time or a lifetime of struggle, and patients may experience periods of high function and almost no symptoms, as well as periods of acute symptoms and hospitalization. The nature of mental illness is critical to consider in the development of policy. Acute mental illness and periods of intense symptoms cannot be considered in isolation from periods of stability and social integration. Mental health professionals widely agree that appropriate supports can reduce the severity and length of mental health episodes and reduce the potential for risky behaviour.
III. Mental Illness in Canada

According to Health Canada, 20 percent of Canadians will personally experience mental illness during their lifetime (Health Canada 2002, 3). Mental illness affects people from all different backgrounds, regardless of age, culture, education or income levels (Health Canada 2002, 15). It can be triggered by a number of factors and may be caused by a "complex interplay of genetic, biological, personality and environmental factors" (Health Canada 2002, 15). Crucial to understanding the importance of developing comprehensive university policy on addressing the challenges and concerns surrounding universities and mental illness is an overview of the common demographics that suffer from mental illness. Health Canada’s A Report on Mental Illness in Canada reports that youth aged 15-24 are the most likely demographic to suffer from certain mental disorders or substance dependency problems with the onset of most mental illnesses and psychological disorders occurring during adolescence and early adulthood (2002, 7). This demographic coincides with the age at which the majority of students attend university. Youth aged 15-24 are most likely to suffer from selected mental disorders such as mood disorders, schizophrenia, anxiety disorders, personality disorders (including eating disorders), first onset psychosis, suicidal behaviors, or substance dependence problems (Statistics Canada 2003).

Of youth aged 15-24, 18 percent reported having feelings and symptoms consistent with one of the following mental disorders: mood disorders, anxiety disorders, personality disorders, schizophrenia and suicidal behavior (Statistics Canada 2003). Only 12 percent of those between 25-44, and eight percent 45-64, and less than three percent of those 65 and older reported having similar feelings (Statistics Canada 2003). To further compound the issue, it is reported that youth are less likely to use resources for problems concerning their mental health or use of illicit drugs. In the same survey, Statistic Canada reports that only 25 percent of youth reported accessing a resource for help (Statistics Canada 2003).

IV. Students and Mental Illness

Statistics provided by the Ministry of Training, Colleges and Universities (MTCU), report an overall increase of 32 percent in the university population since 1991-1992 (MTCU, 2008, 4). Over this same period of time, there has been a 320 percent increase in the number of students with disabilities using the services of the access offices (MTCU 2008, Table 1). The percentage of university students with disabilities using the services of the access offices has grown from 1.12 percent to 3.8 percent (MTCU 2008, Table 1). The most recent data shows the majority of this population required accommodation services
for a primary disability that was non-visible (including learning disabilities and mental illness) rather than visible (MTCU 2008, 8). Although there may be overlap between visible and non-visible disabilities, the data point towards a shift taking place in the population.

The Canada Campus Survey conducted by the University of Montreal and CAMH reports that students are more likely to suffer from psychological distress than the general population, or the general youth demographic, which is reported by Statistics Canada to be at 18 percent of youth aged 15-24 (non-students and students) (Statistics Canada 2003). According to the Canada Campus Survey, 29 percent of students report elevated levels of psychological distress, 47 percent report stress, 32 percent report worry/sleep loss, 31 percent report being unhappy or depressed and 32 percent report hazardous drinking (Adlaf et al. 2004, 61).

Directors of university counselling services are acutely aware of the challenges that this presents. According to the Canadian Counselling Centre Survey, 2004/2005, 92 percent of counselling centre directors reported “believing that the number of students presenting severe psychological issues has increased in the last five years” (Crozier and Willihnganz 2006, 75); 89 percent reported “believing that the severity of issues that students are presenting has increased in the last five years” (Crozier and Willihnganz 2006, 75); and 97 percent reported “an increase in the number of counselling centre clients taking psychiatric medication” (Crozier and Willihnganz 2006, 82). Counsellors expressed general concern for the increase in students with severe psychological problems and the growing demand for services without the appropriate growth in resources (Crozier and Willihnganz 2006, 88). Increasingly, students are arriving on campuses across the country with pre-diagnosed mental illness or with their first episode occurring on campus. This impression is consistent with the views expressed in interviews conducted with representatives from counselling services and accessibility services at seventeen publicly-funded universities in Ontario.

V. Problem Definition and Agenda Setting

John Kingdon discusses how ideas are put on “the agenda” in his book Agendas, Alternatives, and Public Policies. In the opening chapter he presents three processes – problem recognition, policy proposals and political events - as serving as either impetus or constraint to moving policy items forward (1995, 18). Leslie Pal, in Beyond Policy Analysis, also considers the importance of problem definition as essential in moving specific policies forward and creating awareness around certain problems. Both authors discuss the significance of “focusing events” in capturing public and government attention
and stimulating debate and discussion around specific policy areas (2006, 103). Although these events may be indicative that there are underlying problems, they do not define the issues by themselves. Pal stresses that they need to be reflected upon and interpreted in order for coherent policy to be made.

The mood among mental health professionals and interviewees in student services suggests that the majority of media attention focused on mental health and mental illness is negative. This might negatively perpetuate the stigma associated with mental illness and could result in fewer people seeking the supports they require to overcome an episode of illness. On campuses, this has been no exception: students’ mental health has enjoyed almost exclusively negative media attention. Most notably, the Virginia Tech shooting on April 16, 2007, dominated the airways on this issue, and more locally in Ontario, the suicide of a Carleton University student brought negative attention to how universities are handling mental health problems.

In the wake of these events, many universities are considering, or are in the process of, developing policies related to at-risk students and crisis intervention. This is an incredibly important step in ensuring safety on campus for students, staff and faculty. As discussed in Supporting Students: A Model Policy for Colleges and Universities, published by the Bazelon Centre for Mental Health Law, there is currently broad consensus on encouraging students to seek out mental health support when they are feeling depressed, overwhelmed or anxious. Conversely, there is no agreement on how schools should respond to a crisis (Bazelon 2007, 1). While it is critical that universities have policies in place for the safety and protection of community members in the event of a behavioural crisis, it is equally critical that they have appropriate supports in place. All too often institutions respond to students with mental illness punitively, rather than supportively. Not only can this further isolate the student from professional supports and knowledgeable personnel, it may also discourage other students to come forward and seek assistance for a mental health problem (Bazelon 2007, 2).

The challenges that students face on campus are reflective of the neglect of the mental health sector and the “non-system” of Canadian mental health services. Currently, Canada and Ontario lack a comprehensive national health plan or comprehensive mental health strategy. In his final report on the future of Canada’s public health care system, Building on Values: The Future of Health Care in Canada, Roy Romanow describes mental health as the “orphan child” of Canadian health care (2002). Along with a variety of other comprehensive health reforms, the report advocates for the expansion of Medicare coverage for the inclusion of mental health care services “as medically necessary services under the Canada Health Act, and available across the country”
This report goes on to support a case management approach to treating mental illness, explaining that "recurrent institutionalization can be prevented or minimized, and very large savings to the system can be realized when appropriate homecare is in place in the community" (Romanow 2002, 179).

Unfortunately, the inclusion of these services is not yet a reality across the country. At the provincial and national level, capacity needs to be increased in the mental health care system as a whole. All regions need the ability to offer comprehensive care; this includes treatment, rehabilitation and support services that focus on promoting mental health and preventing mental illness. The Ministry of Health and Long Term Care website states:

The Ontario government is committed to ensuring that people with serious mental illness can get help when and where they need it. To support its commitment, the government is creating a coordinated and integrated system of mental health services so that people with serious mental illness can easily access a range of consumer-centered services and support as close to home as possible (MOHLTC 2008).

Despite this goal, mental health services across the province are “diverse and fragmented with many services and supports operating independently of each other” which allows for gaps in the continuum of service provision and difficulties in system navigation (Final Report 2002, 10-11). Further, “the needs of people living with mental illness are not being met equitably across Ontario” (Final Report 2002, 11). It is obvious that mental health is a complex policy issue that will require multiple integrated interventions. In the following sections I will evaluate the services that are currently being provided on campuses for students with mental illness in Ontario and the gaps where other services and interventions may be required. This analysis, for the most part, is drawn from the results of the 26 interviews with mental health services providers reported earlier in the paper.

**VI. Services Available on Campus**

**Access Offices/ Centres for Students with Disabilities**

The duty to accommodate students with disabilities comes from the *Ontario Human Rights Code*. Students with disabilities are accommodated on campus through Disability Services, or Accessibility Offices (henceforth “access offices”). Access offices have the primary goal of assisting students in achieving academic success though providing innovative services and accommodations for students with disabilities. Accommodations may include making class materials available in alternate formats, note taking, sign language interpreters, computers with adaptive software, reduced course loads, more
time on exams, extensions and other measures (OSAP website 2009). Accommodations remove barriers for students with disabilities and allow them to gainfully participate; they do not alter the requirements of specific programs or give students an advantage over those without disabilities.

All access offices require students requesting accommodation for a disability to provide medical documentation as to the nature of their disability or disabilities and the limitations or restrictions that arise from the disability. The access office is then responsible for putting these accommodations in place through communications with faculty members and departmental staff. It should be noted that due to privacy legislation, the nature of the disability remains confidential and cannot be disclosed without the student’s consent. Only the type of accommodation required is communicated to faculty members.

Counselling Services

All Ontario university campuses offer counseling services to their students free of charge. These services were originally set up to deal with a high volume of students for short-term situational issues. Personal counselling, career counselling, academic counselling, consultations as well as emergency response are the primary responsibilities of counselling services. Key informant interviews with representatives from the university community, as well as the Canadian Counselling Directors Survey suggest that there is growing concern about the increasing number of students with mental illness and the increase in severity and complexity of the issues being presented at counselling services (Crozier and Willihnganz 2006, 75). Interviews with key informants revealed that counselling services do not have the appropriate staff or expertise to serve mentally ill students on a long-term basis or to serve students with severe mental illness.

Some counselling centres have access to a psychiatrist through health services or as a part-time consultant. If available, psychiatrists are often part-time and do not provide psychotherapy or any long-term treatment. As the demand for their services is extremely high and increasing on campuses, they generally are only available for consults, prescribing medications, and diagnoses.

Health Services

University health services provide medical care for students who are living away from home and not able to access their family doctor or students who do not have family doctors. It is often the first point of contact for students suffering from mental illness. As more students are presenting with severe mental illness, the demands on the physicians in health services increase. Physicians have a critical role to play in the lives of students
with mental illness. They are able to rule out physical causes of mental health symptoms and treat concurrent disorders. Mental health medical visits typically take longer than other appointments.

VII. Funding

Access Offices

Access offices are primarily funded by the Access Fund for Students with Disabilities (ASFD), and administered through MTCU, which provides approximately $9 million for colleges and universities. This funding is allocated to every publicly-funded institution in Ontario based on full-time student enrollment. Additionally, there is Access to Opportunities funding that is allotted based on the number of students using access services (approximately $4 million for colleges and universities in 2006-2007 and $4.4 million in 2007-2008), the Interpreters Fund for students who are deaf, deafened and hard of hearing, and the Transition from School to Postsecondary Education funding that is used to provide an online resource for students and parents of students transitioning to universities (MTCU 2008, 9). Total funding for college and university students with disabilities in Ontario has increased by 245 percent, from $12 million in 1991-1992 to $41.4 million in 2007-2008 (MTCU 2008, 9).

Students may also be eligible for the Ontario’s Bursary for Students with Disabilities (BSWD) and the Canada Study Grant for the Accommodation of Students with Permanent Disabilities (OSAP 2009). These grants provide non-repayable financial assistance to full- and part-time students for disability-related services, supports and equipment that they may need to participate in postsecondary education (OSAP 2009). Eligible students receive up to $2,000 from the BSWD and up to $8,000 from the Canada Study Grant (OSAP 2009). The grants may be used towards: tutoring, readers note takers, interpreters (oral and sign), attendant care for studies, talking calculators, tape recorder, vision/learning aids, hearing amplifiers, learning disability assessments, computers and software, special needs accessories for computers, counselling, specialized chairs and other supports (OSAP 2009). The BSWD is a component of OSAP.

Counselling Services

Counselling Centres are most often funded centrally through the institutional budget with top-ups through student ancillary fees (key interviews; Crozier and Willihnganz 2006, 34). Universities have chosen a variety of methods in their service set-up. Some universities have a central office for counselling services; others have a central office as well as
counsellors that are integrated into programs and faculties or residences. In some instances, the faculties/programs may be partially responsible for covering the costs of a counsellor. Other universities integrated counselling services with health services.

Health Services

Campus health facilities are dependent on the OHIP billing of each physician and not funded through central university budgets. A percentage is generally retained to assist with overhead costs and support staff. On-campus health services are doctor-centered medical services. Medical referrals are necessary in order to access psychiatric services. Some health services offices have a psychiatrist available to them on a full- or part-time basis. Some universities receive a small top-up from student ancillary fees. This is generally targeted towards health promotion programs and services that are not covered by OHIP, such as medical notes.

VIII. Key Issues Surrounding Accommodating and Supporting Students with Mental Illness

The services that are available on campuses indicate that universities are committed to the success of their students and students with disabilities. There should be no exception for students with mental illness. University access offices have the primary goal of assisting students who have been diagnosed with disabilities to achieve academic success. As the number of students with mental illnesses increases, there are a number of difficulties that arise in accommodating these students as well as issues surrounding undetected students and potential safety and behavioural problems. The following are brief descriptions of some of the key issues surrounding accommodating and supporting students with mental illness.

Documentation

While documentation is often very clear for physical disabilities and learning disabilities in terms of specifying the type of accommodation that is required, this is not always the case for mental illness. Access offices often receive proof of diagnoses with no indication of how to best accommodate students academically.

Assessments and Determining Accommodation

Whereas accommodations for students with physical disabilities or learning disabilities may be evident and are well established and understood, establishing appropriate accommodations may be a trial and error process for students with mental illness. To
further complicate matters, if the student does not have a contingency plan in place in the event of a crisis, accommodations may need to take place retroactively after an episode of acute illness.

There are no universal guidelines that indicate what academic accommodations are best suited to assist students with mental illness. Further, there is an individual element as to the effectiveness of the accommodation - accommodations that work for one student are not guaranteed to work for another. If students have been recently diagnosed with mental illness, or have not received accommodations in the past, they may not be able to self-advocate for an appropriate accommodation, as they are unaware of what strategies would best assist them in reaching their academic goals. One key informant noted that while there has been sufficient research on successful learning strategies for students with learning disabilities, there is little knowledge or understanding as to the most successful way to accommodate students with mental illness.

Resources

Key informant interviews revealed that employees in access offices might manage upwards of 150 students. While accommodating students with visible disabilities or with learning disabilities may require only one or two visits per semester, accommodating students with mental illness often requires more intensive resource allocation. Establishing effective accommodations for students with mental illness may take multiple visits to the access centre and may require a substantial amount of communication and advocacy with faculty and administration for retroactive accommodation due to absence or illness. Time-intensive activities for common difficulties include dropping classes past the add/drop date, granting extensions after due dates, resolving financial difficulties, granting deferred standing, and writing letters of support. This can be a substantial resource burden on access offices. As the number of students with mental illness increases, it becomes more difficult to be proactive in establishing accommodations for students.

Physicians in health services are also seeing students with mental illness in growing numbers. The time required for a mental health medical visit is longer than the time required for an ordinary medical visit. Managing students with mental illness creates increasing demands on their time.

Stigma, awareness and creating cultures of acceptance, acknowledgement and trust

Stigma was consistently identified as one of the most common barriers for people seeking treatment and in disclosing their mental illness to friends, family and colleagues,
or in the classroom. Although there are more students with mental illness seeking assistance now than ever, it is suspected that there are many more students who are undetected and do not seek treatment. Without proper diagnosis, treatments and supports, students with mental illness are at a higher risk for episodes of acute illness or behavioural problems than those receiving supports. A few key informants noted that students with mental illness often do not identify with the services provided at the access office. They may not be aware that they are eligible for academic accommodations due to their illness or that accommodation could be a critical component of their academic success as well as beneficial in supporting their mental health.

Key informants observed that students with mental illness often seek assistance from the access office late in the semester after a period of feeling overwhelmed or after a crisis. If students can be successfully encouraged to seek accommodations sooner, they could benefit from simple accommodations such as being advised to take a reduced course load. Accommodations such as this could be integral in maintaining periods of mental health and stability. Awareness materials and campaigns for faculty, staff and students are an integral part of informing the university community about mental illness, the services available on campus and in the community, and how they can be used most effectively. Awareness campaigns can assist in promoting a culture of acknowledgement and trust on campus, and encourage more students, faculty and staff to seek treatment if they are experiencing symptoms of mental illness.

Key informants indicated that the episodic nature of some mental illnesses needs to be more properly understood by faculty, staff and students on campus. While students with mental illness may go through periods of withdrawal, hospitalization, mania or psychosis, they will also go through periods of stability and success. Even if symptoms have not been directly present in the classroom, students with mental illness should be encouraged to seek accommodations and appropriate services. Achieving a better understanding of the nature of mental illness on campus could assist students with mental illness succeed academically and receive the accommodations they deserve.

Identifying Supports for Faculty and Staff

Faculty and staff may feel under-equipped in handling difficulties or behavioural problems that can arise regarding students with mental illness. This may be particularly relevant with regards to part-time staff, instructors, or visiting faculty. It is critical that faculty and staff are aware of on-campus and community resources, how to act, react or assess threats and at-risk students. Appropriate response in emergency situations is critical, as well as awareness of strategies that may prevent situations from elevating to crisis level.
Informants and mental health professionals agree that in order to prevent mental health emergencies, faculty and staff need to be well aware of the services available on campus and how to utilize these resources.

Students seeking assistance in managing their illnesses are less likely to experience an acute mental health episode and are more likely to seek assistance in the event that they begin experiencing acute symptoms. For this reason, health services are often the first point of contact. Many access offices and counselling centres provide print and web-based resources for faculty and staff that can be accessed on a voluntary basis. Other mechanisms of resource delivery include: information and training provided during new faculty orientation, counsellors provided within faculties, presentations on request at faculty meetings or at deans’ meetings, and optional training and seminars on accessibility and disability issues. Training in identifying at-risk students and how to refer students with mental illness is not mandatory. Key informants indicated there are many faculty and staff who are not familiar with how to assess and respond to at-risk students or assist them in seeking help.

Service Set-up

University counselling centres were originally set up to deal with a high volume of students for short-term situational issues. Many centres have established strict session limits or guidelines that restrict the number of visits in order to handle the volume of requests. Personal counselling, career counselling, academic counselling, consultations, and emergency response have historically been the primary role of counselling centres. They are not designed to serve students with severe mental illness, or those requiring long-term care. This design of service delivery poses a problem as the number of students with more severe and complex mental illness increases on campus. As previously noted, some universities have a psychiatrist available to them on campus through health services, or in consultation with counselling services, while others have to rely on the services available in the community. On-campus psychiatrists are often part-time and do not provide psychotherapy or any long-term treatment. As the demand for their services is extremely high, they generally are only available for consults, prescribing medications and diagnoses. One key informant noted that her university’s ability to refer students to a psychiatrist was based on her previous work experience in a psychiatrist’s office and her continued positive relationship with her previous employer. She mentioned her desire to formalize this arrangement and to create other mechanisms for referral into community mental health services.
There are a variety of service delivery models that have been chosen at different universities. Some universities have integrated counselling services into health services, into faculties, or into residences. Those who had chosen these models felt they were effective in meeting the needs of their students. Key informants indicated that it might be useful to identify best practices in service delivery models in order to improve the services available on campus.

**Inaccessibility of Treatment/Lack of Regional Services**

Students in need of long-term mental health care encounter the same difficulties as the rest of the community: long wait lists for access to external psychiatric services and unreliable availability. Although psychologists or psychotherapy may offer a viable alternative and helpful treatment to long term-psychiatric care, their services are not covered by OHIP and are often out of reach for most students and most sufferers. University counselling services, although not properly equipped to handle severe cases of mental illness or long-term care, are often a student’s only option for support. These shortages may be further exacerbated by regional capacity and individual/institutional relationships to mental health service providers. Universities located in larger city centres (such as Toronto, Hamilton, Ottawa) are able to access services more readily than those located in regional centres Thunder Bay, North Bay, or Peterborough. However, even institutions in large cities report long wait times and difficulties when referring students for long-term mental health care. More mental health professionals and services are required to properly meet the needs of those with mental illness, including meeting the needs of students.

In the National Physicians Survey, 71 percent of physicians indicated that patient access to psychiatrists in Ontario is fair to poor (National Physicians Survey 2007, Q25a). This is indicative of a general shortage of psychiatrists and services for those suffering from mental illness. These shortages are exacerbated by regional differences. Key informants indicated that some universities have strong connections to community mental health care providers and others do not. One key informant indicated that students are able to access initial mental health services more readily than community members, due to the services available on campus. The informant believed that on occasion they have had students with mental illness enroll at the university in order to access a psychiatrist and that those students had left school after accessing the required treatment.
Culturally Appropriate Services and Counselling for International Students, First and Second Generation Canadians

One of the key things about mental illness is that it affects the way that you think about yourself - your spiritual and cultural beliefs. People relate much better to people of their own culture. If you are the person with the illness, the relationship you have with your care provider – your doctor or nurse – is probably the most crucial thing to getting well and gaining recovery. If that person is able to understand your cultural belief system, then the chances of a successful outcome is better (Dr. Janice Wilson, New Zealand Deputy Director General of the Mental Health Directorate, quoted in Kirby 2005, S9).

Offering culturally relevant mental health and counselling services for foreign students or students from a variety of cultural communities is a complex task. As universities strive to attract more foreign graduate students and are becoming increasingly diverse, there are a number of concerns that need to be addressed with regards to providing culturally relevant and appropriate services to address diverse mental health needs.

1) Assessment tools

Assessment tools and treatment mechanisms for mental illness may not be culturally appropriate in all instances. It is crucial for counsellors and accessibility staff to be trained in cultural sensitivity and aware of where culturally appropriate services can be sought out. This will help prevent negative impacts resulting from barriers to access (Kirby 2004, 7).

2) Complexity of mental illness

International students or students from different cultural communities may present to counselling staff or access offices with complex mental health issues. Key informants noted that students may present with issues such as post traumatic stress from fleeing countries stricken by war or unrest, living in refugee camps, or being separated from their families. Further, students who have not been in Canada for long, or who have been raised in non-western households may have cultural ideals that conflict with western counselling methods. Counselling staff is not always equipped to offer relevant cross-cultural counselling.

3) Medical Coverage

International students may not have the same medical coverage as domestic students and it may be more difficult for them to access external services if necessary.
IX. Interventions and Solutions

1) Identifying Students and Helping Them Access Services

Because of the stigma associated with mental illness, many students who need assistance managing their illnesses do not seek the appropriate help. These students may behave erratically, or exhibit signs of distress in different areas of campus. Because university campuses are so large it is often difficult for one department or person to identify or flag a student as being “at-risk” without cross-campus communications between various participants. Access centres, counselling centres, residence, health services, security and the university equity office should coordinate in order to stage “early interventions” with at-risk students.

Recommendation: Establishing At-risk Student Committees

In light of some recent events on university campuses involving students with mental illness, some universities have formally set up, or are in the process of setting up “crisis teams” or “at-risk student committees” to respond to students in crisis or to identify students who may be in crisis. McMaster, Brock, Ryerson and other institutions have been successful in setting up these early intervention initiatives that aim to balance students’ need to access services, with safety and behavioural difficulties.

Key informants were positive about the creation of these committees and were supportive of the role they will play on campus in identifying and assisting at-risk students. Access centres, counselling centres, residence, health services, security and the university equity office were often mentioned as participants on these teams. These teams will provide a mechanism for flagging undetected students that may be acting out or behaving erratically in different areas of campus. Students exhibiting signs of distress can be identified to the committee, by staff, faculty or other students where their behaviour can be evaluated and an intervention staged if necessary. Key informants believed that these committees would assist in crisis prevention on campus. Universities who have not yet done so should set up an “at-risk students” committee in order to identify undetected students with mental illness on campus that may be in need of assistance. Those universities who have already established these committees may serve as a resource to universities who are in the planning stages, or who have not yet set up “at-risk student” committees.
2) Providing Adequate Services for Students with Severe Mental Illness

Students with mental illness may not be adequately supported by the services available on campus. They may need to transition into community services if they require long-term care or hospitalization. If this is the case, university students are subject to the same shortages in health and mental health professionals as the rest of the province and encounter the same difficulties as the rest of the community: long wait lists for access to external psychiatric services and unreliable availability. Further, key informants noted that there is often a poor understanding in community mental health services of what services are available on campus and what services are not. This can create confusion and slow down the referral process. What is needed are better transitions between community mental health services and campus services, so that treatment can be seamless. Further, students across the province should receive the same quality of care, regardless of where they choose to pursue their studies.

**Recommendation: Open Dialogue and Formal Partnerships with Regional Mental Health Services**

Formal partnerships with community mental health providers can assist in facilitating referrals for long-term care and services that are not available through the university. A dialogue needs to be established with community mental health service providers in order to better understand the boundaries and limitations of the services available on campus, and how smooth transitions can be facilitated between university services and community services.

Universities and regional mental health services could develop tool kits to better inform students of the mental health services available both on and off campus. Regional services may also be able to assist universities in developing guidelines for accommodations, provide insight into the nature of mental illness, and assist with training faculty and staff on crisis intervention or threat assessment.

3) Building Client Centered Services

Informally and formally there is a great deal of communication that takes place between counselling services, health services, and access services. Communication between these services can be effective, as it allows for the most appropriate individualized supports to be put in place for each student with mental illness. Moving to a more formal case management model would ensure that the services available on campus, and off campus where necessary, are working to complement each other (Intensive Case Management Service Standards for Mental Health 2005, 2).
**Recommendation: Taking a Case Management Approach**

Key informants indicated that taking a case management approach to students with mental illness might be the most effective means to success on campus. Case management is an “operational framework for the delivery of mental health services and supports” (*Intensive Case Management Service Standards for Mental Health* 2005, 17). Under this framework a case manager and the mental health services consumer are directly involved in managing the consumer’s needs (*Intensive Case Management Service Standards for Mental Health* 2005, 2). Although this approach is widely anticipated to be the most effective in working with students with mental illness there are a number of difficulties associated with it.

**Time- and Labour-Intensive**

Taking a case management approach would be time- and labour-intensive. It would require a case manager to be assigned to students with mental illness in order to facilitate communication across different services both on and off campus. The manager would be responsible for advocating on behalf of the student, putting accommodations in place and developing a contingency plan with the student in the event of an acute episode of illness. As noted earlier, key informants indicated that caseloads may be upwards of 150 students at some institutions and they do not currently have the resources to provide this level of service.

**Privacy and Confidentiality**

Counselling and health services are confidential services and information about a student cannot be shared with staff, faculty or others unless the student consents or there is a threat to safety. Privacy is often critical for individuals seeking mental health care. Taking a case management approach would require the consent of the student accessing the service, as it would allow information to be shared across different university services more readily beyond the traditional “circle of care” of health information custodians.

Whether the case management approach is adopted or not, key informants indicated that they are not always clear on the interpretations of privacy legislation and how to best serve students under those conditions. Counselling centres are able to disclose information for the purpose of crisis intervention or to protect a student from an imminent threat to his or her safety in order to mitigate risk, however the interpretation of what constitutes an imminent threat is often unclear.
4) **Maintaining Consistent Protocols**

The ability to respond quickly and effectively to a mental health emergency (such as an episode of psychosis, mania, or depression) and to identify at-risk students is critical in a university setting in order to reduce the potential of threatening behaviour. At the same time, it is also essential to have the services and supports in place in order to prevent a mental health emergency.

**Recommendation: Adopting Explicit Policies**

The Bazelon Centre for Mental Health Law suggests that universities adopt explicit policies that outline their dedication to the success of students with mental health problems, the accommodations that students are entitled to, confidentiality and conditions surrounding leaves of absence (both voluntary and involuntary) and returning from leave (Bazelon 2007, 2). Such a policy would place “particular emphasis on how to deal fairly and non-punitively with students in crisis, and how to support those whose mental health problems may be interfering with their academic, extracurricular or social lives” (Bazelon 2007, 2), and move towards creating a culture of acceptance and openness towards mental illness.

**X. Conclusion**

The challenges surrounding accommodating and supporting students with mental illness are complex. As the number of students with mental health problems continues to rise on campuses, universities will feel increased pressure to support these students. This will require additional resources dedicated to providing these services, and seeking out community partnerships where on-campus supports are not possible. Clear guidelines for crisis intervention and to protect faculty, staff and students in the event of a behavioural emergency are required in addition to an assessment of current university policies and procedures. Where policies and procedures interfere punitively with students with mental illness, they should be reconsidered in favour of mental health support and promotion. Policies must be established that balance the need for safety with the need to provide supportive services.
XI. Annex A

Questionnaire for key informants in access offices, counselling centres and health services at Ontario universities

1. What are the challenges related to serving mentally ill students?
   (get specifics: detection, non-detection, stigma, resources, other?)

2. Are the numbers of mentally ill students going up?

3. What types of mental illness are most common in students?

4. Are there specific problems related to serving international students?

5. What are the services provided on campus? Are full services available? Is a psychiatrist available on campus? Is this adequate?

6. What else would be helpful/reasonable?

7. What kinds of outreach resources are provided for students, faculty and staff? At what points (entry? registration? etc)

8. What happens with undetected students? How are students flagged? Is there a clear crisis intervention policy?

9. When are most students diagnosed? Before entry to university or during?

10. Could anything be done centrally that would assist in serving these students?

11. How are the parameters of accommodation established? Does this ever pose a problem in negotiating with faculties?

12. What are the other areas of concern surrounding these students?

References


Crozier, Sharon and Nancy Willihnganz. 2006. Canadian Counselling Directors Survey.


Interviews with representatives from access services, counselling services and health services at 17 publicly funded universities in Ontario.


