

Mental Health, Access, and Equity in Higher Education

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Abstract: *This paper tackles the difficult and often not openly discussed topic of access and equity in higher education for people with mental health difficulties. Recent legislative and policy developments in mental health, disability, anti-discrimination and education mean that all students who disclose a mental health condition can expect fair and equitable treatment. However the findings of an exploratory study at an Australian university reveal that just under two thirds of the 54 students who reported mental health difficulties did not disclose this to staff due to fears of discrimination at university and in future employment. Students who did disclose felt supported when staff displayed a respectful attitude and provided appropriate advice and useful strategies for them to remain engaged in university studies when experiencing mental health difficulties.*

Key Words: *Access and equity, stigma, mental health and wellbeing, education*

INTRODUCTION

Access and equity are at the forefront of legislation, policy and practice in mental health, disability and education in Australia and New Zealand, the United Kingdom, the United States and Canada (Knapp, McDaid, Mossialos, & Thornicroft, 2007). In accordance with these legislative and policy frameworks, government funded universities have clearly articulated access and equity policies and programs. However a dilemma presents itself when students with mental health problems do not disclose the difficulties they are experiencing, or seek assistance, due to fear of possible discrimination (McLean & Andrews, 1999). This paper considers policies and practices in teaching and learning in higher education focusing on issues of access and equity for students experiencing mental health problems within the dominant paradigm of population health wellbeing programs. This is followed by a case study and discussion of the experiences of students with mental health problems enrolled at an Australian university. The main mental health conditions experienced by students are identified and ways in which these have impacted upon their studies. Issues concerning disclosure are considered followed by the identification of the types and sources of assistance that students found most helpful. The paper concludes with a discussion of the key findings of the case study and a conclusion and recommendations for practice and further research.

Policy Context

Worldwide increased efforts are targeted at programs for the prevention of mental illness by Government, the World Health Organization and the World Bank. This is in

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response to predictions that within the next two decades mental health problems will be the largest single burden of illness globally (Mathers & Loncar, 2006). A main focus is on centralization of governance and stronger accountability measures, with population health and wellbeing programs considered to be the most economically viable and equitable solution (World Health Organization [WHO], 2009). Equity of access to mental health care is a central objective of mental health systems in Canada, Australia and New Zealand and has underpinned the National Health Service of the United Kingdom since its inception in 1948. Contrary to popular belief, high levels of government funding and the privatization of healthcare systems does not ensure equity as witnessed in India, the United States, Australia and New Zealand (Leeder, 2003). Equity is an ethical issue with mental health care primarily concerned with access to hope by 'eliminating disparities that are associated with underlying disadvantage or marginalization' (Braverman & Gruskin, 2003, p. 539).

Mental health services today are provided within the dominant paradigm of wellbeing that has seen a shift from a disease to a wellness model. The WHO (2009, p.1) defines 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." The focus of wellness models is on general population health promotion and prevention activities such as nutrition, exercise, stress reduction and developing strategies to deal with barriers to wellbeing. The integration of student wellbeing programs in high stress academic vocational programs has resulted in reports of marked improvements in overall student mental health (Hassed, Sierpina, & Kreitzer, 2008). Wellbeing programs are increasingly preferred by policy makers due to current health care costs under existing primary care models and projected increases considered unsustainable in the long term (WHO, 2009). However such reforms will only succeed if the needs of those with chronic conditions are also met. This shift in funding and emphasis, from primary care to general population wellness models, has been criticized as a further means of stigmatization of those diagnosed with severe mental illnesses with them deemed 'unworthy of social investment' (Reidpath, Chan, Gifford, & Allotey, 2005, p.1). Richardson (2005) argues that the current focus on population health and wellbeing programs fails to address major inequities and system deficiencies in Australia's healthcare system. These policy changes have been influenced by dominant paradigms in community mental health such as deinstitutionalization, normalization and, in more recent years, recovery.

The recovery movement, led by consumers of mental health services, originated in the United States in the 1980s. Central to recovery is hope and the active role taken by the individual to live well in the presence or absence of mental health problems. All of the rhetoric associated with the dominant paradigms in community mental health supports access and equity in higher education.

Higher Education

The World Bank's World Development Report 2000/2001, *Attacking Poverty*, highlights the importance of access to education in dealing with poverty. The Organization for Economic Co-operation and Development (OECD) (2009) highlights

both the individual and national benefits that result from educational equity including social inclusion, improved quality of life and satisfying employment. First onset of mental illness can occur at any age, although it is most prevalent amongst young people with three quarters of first diagnoses occurring between the ages of 16 and 25 (Megivern, Pellerito, & Mowbray, 2003). This is the time when young people are likely to be considering, or embarking upon, post secondary education programs. They may have a pre-existing mental health condition or experience stress that can trigger a first episode of mental illness. The nature of the studies may generate stress that can lead to mental health difficulties.

The incidence of mental health problems amongst university students is steadily increasing with estimates of between 10 to 20 per cent (Collins & Mowbray, 2005). Of particular concern are reports that these students have lower completion rates than all other disability groups (Cavallaro, Foley, Saunders, & Bowman, 2005; Moisey, 2004). It is likely that students with mental health problems experience other forms of disadvantage. Students can experience a cumulative impact due to membership in more than one equity group such as: low socio-economic status, Indigenous or non-english speaking background, rural and remote or other disability. They may also have more than one mental health difficulty. Membership in more than one equity group has been found to reduce the likelihood of success in post secondary education and increase the possibility of withdrawal from studies (John, 2004). However the main disadvantage is the stigma arising from discriminatory attitudes and behaviors that deny students opportunities and the support they require to successfully complete their studies.

Stigma insinuates itself into policy decisions resulting in institutional discrimination with the stigma associated with mental illness, and the hidden nature of the disability, constituting powerful barriers to students seeking and receiving assistance (Martin, 2006). For some people the stigma of mental illness can cause even more negative impacts than the mental illness itself (Link & Phelan, 2006). Nonetheless there is increased evidence that students with mental health problems who receive appropriate support to remain engaged with their studies are successful in postsecondary education (Megivern et al., 2003), experience decreased hospitalization rates (Isenwater, Lanham, & Thornhill, 2002), and increased levels of self confidence, self efficiency and empowerment (Collins & Mowbray, 2005). Those who are able to successfully develop strategies to resist and challenge discrimination experience improved mental health and educational outcomes. They are able to do so by externalizing the stigma and viewing it as a means of oppression. In doing so they are able to study in their chosen area and access opportunities for professional identity and social mobility afforded by educational qualifications (Elstad, 2004).

A barrier to university education is the view that people with mental illness are not suitable candidates for vocational courses such as social work and welfare education (Martin, 2006). However, this view is generally not openly expressed particularly because it contravenes disability discrimination conventions, legislation and university policy and procedures. According to this view it is perfectly acceptable to work with people with mental health problems as clients, but not as colleagues. This creates a dilemma for students as they are informed of university policies and procedures for

access and equity yet are not confident that they will receive the assistance required and may experience discrimination (McLean & Andrews, 1999). This leads some students to hide their mental illness in the fear that it may jeopardize their position at university and future career opportunities.

A further problem arises when assistance is sought, and the staff response is that if a student is mentally unwell they should not be attending classes (Martin, 2006). This reflects the dominant view that people must be symptom-free before they can participate or be let in (Davidson et al., 2004). Students receive a double message as they are advised to take time off to recover, yet if they do so they can be penalized for not attending or participating in class activities, and be put at risk of failure or exclusion. The result is active social exclusion particularly for those students with persistent and ongoing symptoms of mental illness (Reidpath et al., 2005). Those who do not support students with mental illness entering the human service professions may use this as an opportunity to exclude a student under the guise of care and concern or the upholding of educational standards.

Teaching and Learning

Approaches to teaching and learning have changed considerably in recent years providing increased flexibility and opportunities for students experiencing mental health difficulties to remain engaged in their university studies during periods of mental illness. Flexible delivery and different approaches to teaching and learning provide scope for increased responsiveness to individual student needs. The three main approaches used in higher education over the past century are absorption, behavioral, and cognitive, with different instructional architectures used to support each approach (Clark, 2003). Increasingly there has been an emphasis on the more active approaches to teaching and learning both in the classroom and online. The suitability of each approach will vary according to a student's mental health status (Martin & McKay, 2009).

Absorption views of education focus on the transmission of information to students, with learning occurring through the assimilation of this content. Receptive architecture is used with an emphasis on the provision of information (Mayer, 2001). In some forms of receptive instruction students have minimal control over the pacing or sequencing of the information provided. Examples of this architecture include didactic methods such as (non-interactive) lectures and instructional videos. Flexibility is provided to students through the use of information communication technology, such as lectopia, that provide an audio recording of the lecture and visual slides for students to access and download online. This is particularly useful for students who want to keep up with course materials and information but are experiencing mental health difficulties that prevent them from attending university and participating in class discussions.

The behavioral approach was promoted in the first part of the 20th Century by behavioral psychologists, with learning based on mental associations. Educators use directive architecture by providing small amounts of information, followed by questions and frequent reinforcement through immediate corrective feedback to ensure that accurate associations are made. Programmed instruction in short lessons, popular in the

1950s and 1960s, is a prime example of directive architecture. This approach is particularly useful for students with mental health problems that affect concentration.

The cognitive approach to education was developed in the latter half of the 20th Century with an emphasis on the active processes learners use to construct new knowledge. The two main architectures used with the cognitive approach are guided discovery and exploratory (McKay, 2008). Guided discovery architecture uses real world problems or scenarios to drive the learning process. Students typically access various sources of data to resolve problems with instructional support available to help them. Guided discovery provides students with opportunities to try alternatives, make mistakes, experience the consequences of those mistakes, reflect on their results, and revise their approach. Exploratory architecture offers high levels of learner control. Instruction is designed to provide a rich set of learning resources that include: learning content, examples, demonstrations, and knowledge/skills building exercises, complete with the means to navigate these materials. Architectures of this type are frequently used for online courseware. High levels of learner control can be useful for students experiencing mental health difficulties that affect class attendance. However clarity is required on the learning tasks required with regular opportunities for communication and feedback from staff to ensure the required learning outcomes are being met. Open-ended tasks and activities can generate considerable stress and anxiety that can exacerbate a pre-existing mental health condition, due to a lack of structure and clarity and even more so if this is reliant upon group work assessment.

Equitable assessment requires consideration of varied approaches to assess the same learning outcomes. It is the responsibility of the educator to assess a student's performance in a manner that allows them to best demonstrate the learning they have achieved according to the required course outcomes. Students experiencing mental health difficulties during their studies are discriminated against if they are not treated as favorably as other students. Discrimination can also occur if students are required to comply with conditions that are unreasonable and that they do not, or are not able to comply with (Martin & McKay, 2009).

The following discussion of the findings of an exploratory study highlight how the approach to teaching and learning, institutional policies and practices, staff and student attitudes, and support services available, influence access and equity in higher education for student's experiencing mental health difficulties.

CASE STUDY: MENTAL HEALTH EXPERIENCES IN HIGHER EDUCATION

An exploratory research project was conducted in an Australian university in an endeavor to gain an understanding of the experiences of students with mental health difficulties during their studies. A main aim was to identify factors that students identified as affecting their performance and ways that staff might respond to support them to achieve their educational goals.

METHODS

An anonymous online survey was sent to all students enrolled in a School, within an Australian university, identified by the university's Disability Liaison Unit as having the highest number of students with mental health difficulties using their services. This included students enrolled primarily in human services courses in social work, social science, psychology, youth work, planning, environment, international and legal dispute studies. Students were asked to disclose whether or not they had experienced any mental health difficulties during their studies. Those who had experienced mental health difficulties, that had affected their studies, were then invited to complete the online survey. Open and closed questions were asked focusing on three areas: disclosure, impact on studies, and support.

The self-selection process was a significant aspect of the research as it allowed for participation of students who may not have a formal psychiatric diagnosis. It meant that students defined their mental health condition rather than selecting from pre-determined categories of "mental illness." The categories identified by the students were then compared with those used by mental health services during the data analysis. Previous studies of this nature have surveyed students who have declared a mental illness, and registered for Disability Liaison Unit services.

The survey was posted online for a six-week period with a request to participate sent to 1,517 students in the School. This method proved effective as students were able to anonymously share their experiences in their own time. A total of 54 students responded – 3.6 percent of the student body. It is not possible to accurately gauge the proportion of students with mental health difficulties given it is likely that not all students experiencing mental health difficulties would have elected to participate in the research.

The survey included ten open questions to be answered only by those students who self-identified as having experienced mental health difficulties during their studies. Students were asked what their mental health condition was, whether or not it had affected their studies, and if they had disclosed this to university staff. Students who had not disclosed were asked for reasons why they had not done so. Those who had disclosed were asked to provide details of how staff had responded and what they found most helpful, and most problematic. Students were asked to provide details of services used when they experienced mental health difficulties and, finally, general comments and/or advice to staff and/or students. Frequencies were recorded for the responses to each question with thematic analysis also used to collate and present the study findings. Students were not limited in their responses to each question. This meant that if a student recorded more than one category in response to a particular question, each response would be reflected in the data. For instance, Figure 1 presents each diagnosis mentioned with some students having more than one diagnosis, with Figure 2 on area of study affected, showing 85 responses from the 54 students surveyed. Other questions recorded the actual number of students who gave a particular response, as in the reported number of students who had disclosed their mental health difficulties to staff.

LIMITATIONS

As a small exploratory study of students in one university the study findings are not generalizable. Given the anonymous survey and the self reporting of students of their mental health status, it was not possible to verify that students really had the mental health conditions they reported. The sample size is small and self selecting and as such it is potentially biased as the larger population of all students experiencing mental health difficulties is not included in the study. The length of the survey was limited to 10 questions that did not include demographic data on age, gender or cultural background. A longer survey that collects detailed demographic information would be useful for further research. The collection of detailed demographic data would enable analysis according to gender, age, cultural background and socio-economic status.

In addition, further broad scale research that provides a brief mental health screening tool to select survey participants would be useful to identify the impacts of different types of mental illness, particularly schizophrenia and personality disorder, on students' education experience and performance. A comparative case study approach comparing metropolitan, regional, rural, remote and international experiences would provide further insights.

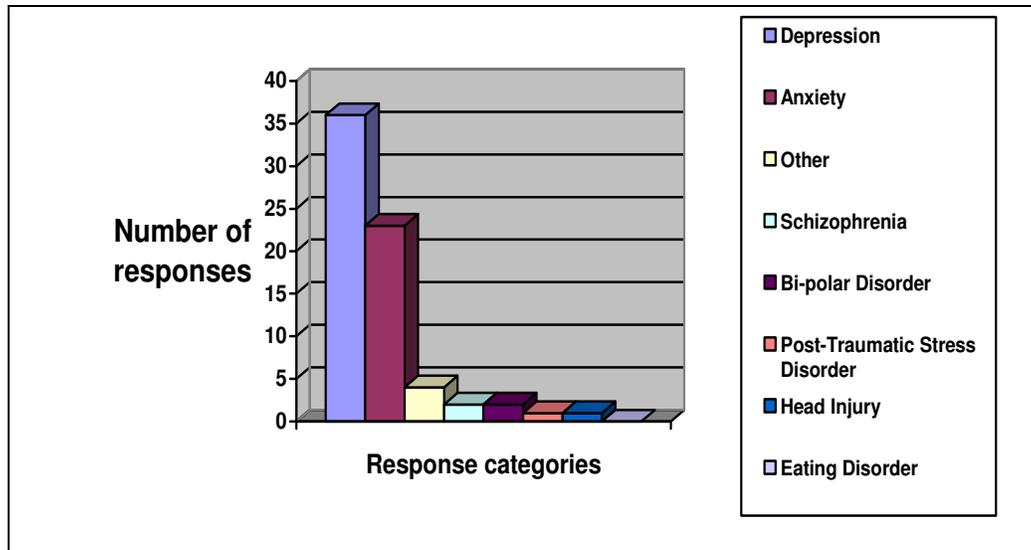
FINDINGS

The mental health conditions identified by students are presented, followed by consideration of those who had, or had not, disclosed and reasons for this. The impact of disclosure on study performance is presented, alongside strategies students found most helpful during periods of mental illness.

Mental Health Condition

The main mental health conditions identified by students were depression (n= 35) and anxiety (n=23), with anxiety including students with eating disorders (See Figure 1). Two students were recorded for both schizophrenia and bi-polar affective disorder. Individual students reported post traumatic stress disorder, obsessive compulsive disorder, dissociative identity disorder, Asperger's syndrome, head injury, autism and epilepsy. These latter responses would not normally be classified as mental health conditions by today's standards; however, this was not the case in the not too distant past.

Just over half of the students (n=28) reported multiple conditions with just under half recording a dual diagnosis of depression and anxiety (n=25). Three students reported dual, triple and quad diagnoses. The dual diagnosis was dissociative identity disorder and anxiety. The triple diagnosis was post-traumatic stress disorder, anxiety and depression. The quad diagnosis was Asperger's syndrome, autism, anxiety and obsessive compulsive disorder.

Figure 1: Mental Health Condition

A couple of students reported physical problems triggered by their mental health condition. One experienced anxiety that resulted in physical problems that caused further, and more serious mental health problems with depression. The other student's physical condition led to mental health difficulties with anxiety. The complex interplay of mental and physical health conditions is illustrated in the following student comment:

My mental health condition under extreme forms of stress can activate an underlying physical condition. High stress and ongoing fatigue directly impact on this physical condition which ultimately is life-threatening if not managed.

Disclosure of Mental Health Condition

The majority of students, slightly under two thirds (n=34) had not disclosed to university staff about their mental health condition or the problems they were experiencing with their studies, even though many were experiencing considerable difficulties.

Reasons for not disclosing varied. Some students did not disclose because there was no need to, even though for all but one student, their mental health condition had impacted negatively on their studies. Some students did not disclose for reasons of privacy and confidentiality. Others were embarrassed or had past bad experiences disclosing to staff. One student was concerned that staff might not understand and ask difficult and personal questions, with another student noting that communicating with anyone was difficult when unwell. A further student had only recently been diagnosed.

Concerns were expressed that students would be seen by staff as telling lies and/or wanting privileges (n=12). A further concern was a fear of being found out, judged, stigmatized and discriminated against by being treated differently from other students;

possibly losing their place at university and being discriminated against in the workplace (n=9).

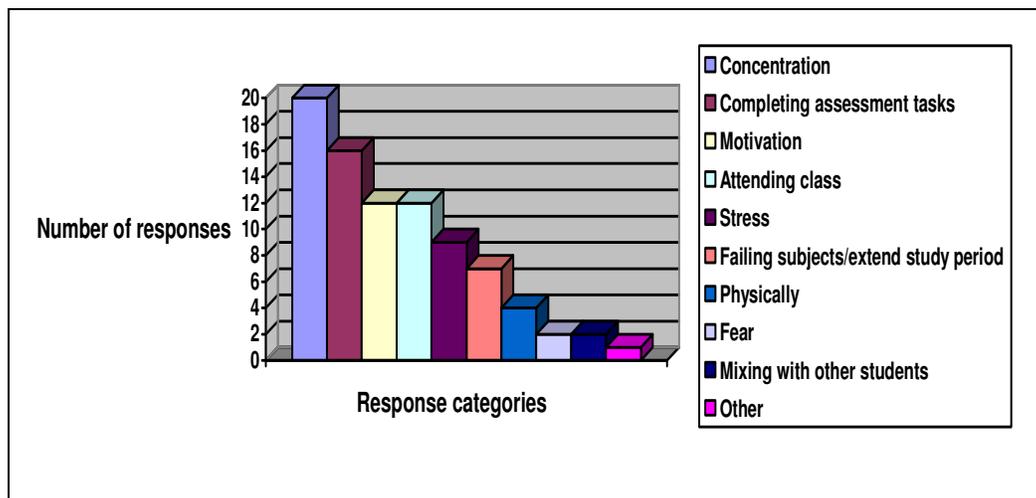
Of those who did disclose their mental health condition to staff (n=20), the responses were mostly positive (n=18), with only two students reporting a negative experience. The main assistance provided was for gaining extensions and Special Consideration. In some instances where extensions were granted, additional support was needed. Students wanted staff to understand the reasons why they were not finishing their work on time. While support was provided, students found it difficult to ask for help. Some staff members tried to be helpful but their efforts were misguided, resulting in embarrassment for the student, particularly when they were singled out for special treatment in front of the student group:

I'm worried I'll be treated differently or given unwanted attention. However, in the past I have used the Disability Liaison Service to make contact for me. One staff member contacted by the DLS on my behalf then addressed me about my "special needs" in front of the whole class, with everyone's attention, when we had a test saying 'If you don't feel well at any time, you can just leave if you need to.' I never attended that class again, failing it, and have never disclosed to any staff since.

Impact of Mental Health Condition on Studies

All but one student reported that their mental health condition had impacted negatively on their studies as illustrated in Figure 2.

Figure 2: Areas of Study Affected by Mental Health Condition



Physical, psychological and social difficulties were experienced in the areas of; concentration (n=20), completing work on time (n=16), motivation (n=12) and attending

classes (n=12). Other areas affected included increased levels of stress (n=8), failing courses (n=6), poor physical health (n=4), fearfulness (n=2) and problems mixing with other students (n=2).

Physical problems included tiredness and exhaustion from not sleeping well, extra time required to complete study requirements as well as overall poor physical health. Inadequate sleep affected mood and coping skills as well as energy levels and academic performance. Students who had a first episode of mental illness, or who went undiagnosed, experienced considerable difficulties with their studies, often over extended periods.

Main psychological difficulties were in relation to concentration and maintaining motivation and focus, as well as managing the disturbing signs and symptoms of the particular mental health condition. For many students this was lowered mood and feelings of overwhelming sadness. Poor concentration impacted negatively on most areas of study including attendance, participation, and assessment, with students losing confidence in themselves and their abilities. It was particularly difficult for students to maintain the focus required if they could not see the relevance of their studies for the future. Feelings of guilt and failure were experienced in relation to studies, for not submitting work on time and having to apply for Special Consideration, and life in general.

Socially students experienced main difficulties in coping with everyday life as well as their studies. Attending and participating in class was problematic for many students who feared an exacerbation of their condition and that others might find out and not understand:

The main difficulty for me is the fear being found out and considered somehow less than acceptable. This means I don't and won't ask for an extension on the grounds of what is going on in my life at the time, and avoid at just about all cost ever asking for an extension or some kind of support, in case it makes me more open to being found out. I don't want people starting to interact with me on the basis of their interpretation of what such a diagnosis means, rather than taking me for who I am in the present moment. I'm fearful that I won't have the resilience to pull through an episode and get stuff in on time, that I will burn myself out keeping up a façade.

The university where this study took place did not have an attendance policy. However it was apparent that it was generally difficult to meet the course requirements for those who did not attend classes. Motivation, attendance, and the submission of assignments were affected during periods of mental illness and hospitalization. Often there were major difficulties in managing to complete assessment activities in the set timeframe, with the work submitted not of a standard that students believed reflected their true abilities.

The failure to attend class was connected with low levels of motivation, difficulties with concentration, and high stress levels. Students feared that they might not have the resilience required to pull through and worried about lost time when unwell. The

following comment highlights the added problem of first onset of mental illness and not being diagnosed:

The hardest thing was trying to keep up with the work and not fall too far behind. I was lucky it happened towards the end of semester so although I had a lot of essays to do I had a six week break to recover. Once medicated it only took me a month or so to get back on my feet, however there were three months when I went undiagnosed where my studies really suffered.

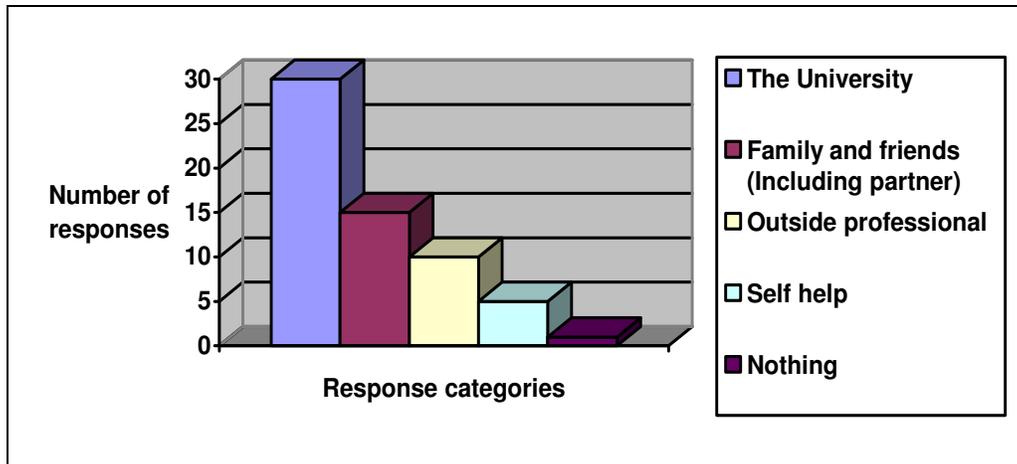
Raising the issue and asking staff for help was a main difficulty for students. They were particularly concerned that a lack of understanding from staff and students would result in stigma and negative discrimination leading to restricted opportunities at university and in future employment. Negative experiences with faculty, administrators and staff from counseling and disability services left students feeling disempowered, particularly when deemed ineligible for services, with one student describing feelings related to being ‘shut out’:

My main problem was being shut out. Like when I became so depressed and anxious and withdrawn, absolutely no-one made an effort to contact me, to give me the opportunity to explain my circumstances. I know they expect us to be responsible adults but adults are not immune from illness. You do need to look after your students. Staff need training in mental health and how it can affect your studies. I nearly cried when a staff member demanded to know how depression could impact on my studies, the experience was really undermining.

Additional time was needed during the recovery period to attend regular treatment. A cumulative impact was experienced by students who were members of more than one equity group. Further difficulties were experienced when English was a second language and when alcohol and other drugs were used in excess. The cost of treatment caused financial hardship for some students with this particularly an issue for students with a longstanding mental health condition.

Most Helpful Assistance

Half of the students surveyed sought assistance from services within the university (n=27) and just under half from outside services (n=26), with some of these students using a combination of services within and outside of the university. A smaller number of students (n=8) did not use any services. As illustrated in Figure 3, of those who sought assistance just under two thirds of students (n=30) found the university to be most helpful even though many of these students had not disclosed their mental health condition. The next main source of support was family and friends (n=15) followed by professionals outside of the university (n=10). A small number of students who were using services felt that the best support came from themselves and not service providers (n=5) with one student gaining most support from a pet. All, with the exception of one student, who found that ‘nothing was helpful’, were able to access some kind of positive assistance.

Figure 3: Source of Most Helpful Assistance

Sources of assistance within the university were of both a practical and supportive nature and were provided by academic, administrative, counseling, disability, student union and housing services staff. Students valued online access to staff, course information, support services, and information about their rights and responsibilities, so that they could continue with their studies when it was difficult to attend the university. Special Consideration with extensions of time for assignments, altered assessments, and changed exam venues was helpful. The attitude and approach by staff was critical as this impacted on a student's ability to disclose about a mental health condition and seek the support required as reflected in the following student comment:

Tutors need to not just see their role as 'teaching and marking assignments.' They should take a personal interest in the students as they are after all our role models whilst at university. It sometimes feels like lecturers and tutors are 'untouchable' thereby being difficult to approach. Teachers who understand and are open for discussion are more approachable.

Students appreciated staff who treated them with respect and dignity; were understanding, supportive, and trustworthy; and provided reassurance, information and advice without being too intrusive. Some students wanted time off to recover while others did not want to do so. These students appreciated staff who reassured them and supported them while they continued with their studies when unwell. Remaining connected to the university was important with one main point of contact preferred. Given the effort required at times to attend class, when unwell it was appreciated when this time was well spent. Structured lectures were preferred by those who found it difficult to interact with others.

Family and friends were main sources of support and encouragement as they listened and provided emotional and practical assistance with organization and time management. Students appreciated a non-judgmental attitude, understanding, kindness, and loyalty – in

spite of the mental health condition. However, students were mindful of not being a burden and straining these relationships.

Services from outside the university were provided by general medical practitioners, specialist mental health youth services, mental health crisis services, psychiatrists, psychologists, social workers, nurses, counselors and therapists. Some students required regular medication with this increasing when the symptoms of their condition were exacerbated. Other interventions included counseling and assistance with coping skills and problem solving. Counseling approaches that addressed issues of stigma and mental illness and used an empowerment approach, combined with practical assistance, were particularly helpful. Wellbeing approaches for stress management and relaxation were also used, including massage.

Students found access to a regular worker important for accessing reports for applications for Special Consideration. Having to explain the situation to a stranger was difficult, even more challenging when unwell, and in some cases not possible due to the mental health condition at the time. The financial costs incurred for some of these services was also an issue.

A range of self help strategies were used by students. Maintaining a positive outlook and remaining connected with university, family, and friends were generally considered important. Approaching staff required considerable motivation and communication skills, particularly at times when these were impaired. Early intervention from academic staff and counseling services was preferred, with concerns that services could only be accessed if problems were acute. Students found it important to acknowledge their reduced level of capacity at different times and to make allowances for this.

A holistic approach to general health and wellbeing was noted with students finding physical exercise, eating well, and regular sleep vital. Relaxing in a quiet area and meditation assisted with stress reduction and remaining calm and positive. One student found playing computer games relaxing. However not all of the 'most helpful' coping strategies reported by students were positive including illicit drug use, social isolation, and self harm.

Students made a number of recommendations for improvements, including respectful relationship building with staff, generic distribution of information on access and equity services through varied face to face and online media that are easily accessed by all students. Students wanted understanding from staff and flexible and responsive arrangements to suit their particular and changing needs. What they did not want was pity or special favors. Nor did they want a lowering of academic standards. If students did attend classes when unwell, they wanted the time to be well spent – given the effort involved in getting there. The following student quote directed at both staff and students highlights the individual response needed:

If you want to help us then ask us what we think would help - every student with a mental illness will have special/different needs. Your School is like your family for as long as you're there. Treat it as such and expect to be treated as though you belong and have a place, even if you make a few mistakes.

This sense of belonging extended beyond respectful and responsive relationships with staff to developing friendships with other students, with staff expected to take an active role in facilitating this:

Encourage friendships during first year. I don't know how you'd do that, but during my first year course they heavily encouraged friendships and having somebody in class, and who you can talk to about class, has helped me cope with the stress immensely.

Students commented on the University procedures for Academic Progress – similar to most universities – that involve sending an “at risk” letter to students whose results are in the bottom quartile, and inviting them to attend a student progress interview:

You cannot possibly extract this information from them when they feel they are under attack from their School. Call each student before sending out the letter, arrange to meet them informally, discuss the letter with them, come up with a way to address the problem THEN mail them a letter explaining the outcomes of that meeting. It might also be nice to inform students on their rights etc. special consideration, equitable assessment, remission of fees etc. It's all too easy to feel like you're stuck when you have a problem at university.

Students noted the importance of addressing possible mental health difficulties early in the semester in a general manner with *all* students and making information accessible through multiple face-to-face and online sources:

I think it would be extremely helpful if tutors were to speak broadly to their tutorial groups about this very issue at the start of semester and the possible need for non-disclosure, directing any student to the Disability Liaison Unit-without any assumptions of mental health status of the persons in the tutorial group. Obviously this would be a general directive, as it cannot be guaranteed that a student will speak up in class, nor approach the tutors afterwards.

DISCUSSION

The study findings illustrate the important and central role the university plays in the development of policy and provision of both academic and support services, to increase the likelihood of successful educational outcomes for students experiencing mental health difficulties during their studies. However as mentioned earlier, it is important to note that these study findings are limited, due to the small sample size and number of survey questions, and are therefore not generalizable to other settings.

Key study findings include the importance of respectful communication and relationship building; between staff and students, and students with each other. Individual responses that allow for flexible and active learning approaches, with appropriate levels of structure, facilitate a learning environment that allows students to remain engaged with the university. The early provision of information on student rights and equitable assessment to all students, with multiple access points, reduces the likelihood of discrimination arising from the stigma of mental illness.

The majority of students in the study experienced multiple levels of disadvantage, due to the presence of more than one mental health condition, thereby increasing vulnerability. The complex interplay between physical and mental health was also evident amongst the study participants.

While the study design allowed students to identify their own mental health conditions, these were consistent with the diagnostic categories in the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association. Thus students defined their mental health conditions according to the dominant medical paradigm used for eligibility for mental health services in Australia today. As in previous studies of student mental health, the main disadvantage was stigma arising from fear of discriminatory attitudes and behaviors.

Stigma prevented the majority of students from disclosing their mental health condition. Students were fearful of discrimination in their studies and in future employment, worried that they may be considered undesirable or unsuited to their chosen profession. Interestingly however, almost half of the students were able to gain assistance without disclosing their mental health condition. However, this type of assistance is potentially limited as disclosure is needed for eligibility for Disability Support Services and Special Consideration. It raises the issue of limits to disclosure applied by the students themselves as well as confidentiality of service providers within and outside the university. A key consideration is whether or not staff actually need to know details of a student's mental health condition to best assist them. Further research on disclosure would be useful focusing on issues concerning process, content, response and outcome.

A comparison of students who disclosed and those who did not reveals that those who did not disclose experienced a range of mental health conditions and difficulties that were no less significant than those experienced by students who did disclose. The majority of those who did disclose received helpful assistance. This suggests staff are able to provide appropriate support, and implement more appropriate teaching and learning strategies, when they are aware of the particular difficulties a student faces. This is another area for further substantive research.

Staff development and training in mental health, access and equity in education can provide staff with the knowledge, attitudes, and skills required to intervene effectively in accordance with university policy and legislative requirements. The study findings are consistent with those of Pilgrim (2005, p. 99), with helpful conversations by supportive and empathic staff, without specialized knowledge in mental health, appreciated by students and leading to positive outcomes. Useful conversations with academic and administrative staff facilitate an understanding of how a student's mental health impacts upon their studies, what their rights are, available assistance and how to best access this. Counseling, disability support and student right's services are particularly important in instances where academic and administrative staff responses are either not forthcoming or inappropriate.

The study findings highlight the dilemma that arises when students are not diagnosed, or are unable to communicate effectively due to their mental health condition at the time,

thereby preventing them from being able to seek assistance in an appropriate and timely manner.

The students in the study experienced a range of psychological, social and physical difficulties that impacted negatively upon their studies. The tendency to not disclose mental health difficulties created further problems, with students not attending class in fear of being found out and discriminated against.

Consideration is required of the most appropriate teaching style that best suits the changing and often complex needs of students experiencing mental health difficulties, with suitable architecture to support this. Increasingly students are able to access course materials and other relevant information for their studies online. The cognitive approach to teaching and learning using guided discovery and exploratory architecture, for online course materials means students can continue their studies during periods of mental illness. However the open-ended nature of much of this learning can be problematic with appropriate teacher guided structure and guidance required, particularly if a student is experiencing cognitive difficulties. The availability of lectures online also provides students with greater flexibility. Given the availability of quality online course materials, particularly in more recent years, a main challenge is how much classroom activity is required to meet both university and professional standards and requirements to prepare students for the human services workforce.

Early intervention is crucial for preventing mental health problems by averting fears and anxieties and assisting with the necessary adjustments and changes required to engage in university studies. Many newly enrolled students do not know where and how to get assistance when they experience mental health difficulties. Commencement of studies at university generates considerable stress, and it is therefore important that academic and counseling support and services are offered to prevent first onset or relapse of mental illness. Clear explanations of student rights, staff responsibilities, course expectations, study workload, and assessment requirements provide students with the necessary information required to adequately plan for their studies. The ongoing provision of information on support services available throughout their studies is beneficial, particularly prior to and during peak assessment periods. This includes information on university policies and procedures for extensions, special consideration, equitable assessment, remission of fees, and university academic progress procedures.

A wellbeing preventative approach, targeted at all new students can alleviate stress thereby reducing vulnerability to mental illness. For students who have disclosed a mental illness, particularly those who have applied through university access and equity programs, targeted support can be provided at the outset if required. This study has shown that disclosure is more likely to lead to positive outcomes when university staff have a respectful attitude and provide appropriate assistance and advice, supported by university policies and services.

CONCLUSION

Legislation and policy in mental health, disability, anti-discrimination and education espouses principles of fair and equitable treatment for students experiencing mental health difficulties. In practice however, a major barrier to the enactment of these principles is non-disclosure of mental health difficulties by students due to fears of discrimination. The exploratory study findings presented in this paper support the findings of previous studies that consider stigma to be a major obstacle preventing students from disclosing mental health difficulties and receiving appropriate assistance. Student mental health and educational outcomes can be improved by universal wellbeing programs and targeted interventions for those students experiencing mental health difficulties. Targeted interventions are required that address the stigma of mental health so that students can confide their difficulties to staff in the confidence that they will be treated fairly and with dignity and respect. At the same time students require assurance that measures will be put in place to assist them to do their best work and remain engaged with their studies during periods of mental ill health. The dominant paradigm of recovery in mental health and access and equity in higher education, alongside increased flexibility in the design and delivery of higher education programs, means that the future for students, experiencing mental health difficulties in social work and welfare studies is more hopeful than ever before. Further research, in particular, substantial comparative case studies, that include a brief mental health screening tool and demographic data, will result in transferable knowledge generation.

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