



THE WICKED PROBLEM OF UNIVERSITY STUDENT MENTAL HEALTH

Benjamin G. Veness
Report to the Winston Churchill Memorial Trust
January 2016, Sydney, Australia

DECLARATION

THE WINSTON CHURCHILL MEMORIAL TRUST OF AUSTRALIA

Report by – BENJAMIN G. VENESS – 2013 Churchill Fellow

THE MONASH UNIVERSITY CHURCHILL FELLOWSHIP
to explore innovative prevention and early intervention
strategies to improve the mental health
of university students.

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Benjamin Veness
18 January 2016

FOREWORD

Australia and the rest of the world are finally starting to realise that “mental health means mental wealth”. Seventy-five per cent of mental ill health emerges before the age of 25 and if it doesn't kill, it disables or reduces the human and economic potential of generations of young people. The personal, social and economic costs to human society are enormous – estimated to erode \$16 trillion from the world economy in the next 20 years; double the impact of cancer. Much if not most of this burden of suffering and loss is preventable, avertable or treatable. This argument becomes even more overwhelming when we consider the neglected predicament of tertiary students. Twenty-six per cent of young people in the 18-24 age range experience mental ill health in any single year and 50 per cent will have need for care at some point during the transition from childhood to adulthood. While all young people are of absolutely equal value in a human sense, in economic terms some are more equal than others. The waste of creative, economic and productive potential is most dramatic when we consider the impact of preventable, untreated or poorly treated mental ill health in tertiary students.

Benjamin Veness is one of Australia's emerging leaders in health and public policy. At a still early stage of his career (he is now a junior hospital doctor) he has already made a major contribution to public life at the University of Sydney and beyond. Fortunately for Australia, he has focused his energy, curiosity and talent on the awakening, yet misunderstood and long neglected, giant of mental health. He has galvanized and transformed the Australian Medical Students' Association (AMSA) into taking a consistent national leadership role in mental health, one which has continued well beyond his own tenure as President. He has shone the spotlight on the largely overlooked yet huge issue of the mental health of emerging adults who are tertiary students, and has conducted what to my knowledge is the first “deep dive” into international efforts to understand and respond to the mental health needs of tertiary students.

His report is comprehensive and compelling and contains a superb analysis of the rather limited efforts to tackle this issue around the world, and a starting blueprint for Australia to consider. His recommendations are extremely sound and if progressed would begin to transform the situation. I particularly liked the Cochrane-inspired exhortation, “no survey without service”. A combined top down and bottom up approach is clearly required and this must involve leadership from the next generation of students, just like Ben himself has displayed. Novel service cultures, creating the right “tone” from the top, but also shaking up the complacency of the status quo and its limited scope and dated models are additional ingredients.

I sincerely hope Ben will continue to play a leadership role in this vital domain, which is so essential if the true creativity, innovative capacities and productivity of Australia's emerging generations are to be realised. On a world stage, the same lessons need to be learned and solutions explored and tested. This will be a wonderful challenge and ultimately legacy for the base camp that Ben has established here through his Churchill Fellowship. I have huge admiration for him as a person and a leader and congratulate him very warmly on this and his other achievements to date.

Professor Patrick D. McGorry AO
MD PhD FRCP FRANZCP

Australian of the Year 2010,
Professor of Youth Mental Health at the University
of Melbourne,
Executive Director of Orygen Youth Health
January 2016, Melbourne, Australia

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ACKNOWLEDGEMENTS

I would like to thank in particular my referees for my Churchill Fellowship application, child and adolescent psychiatrists Professor The Honourable Dame Marie Bashir AD CVO and Professor Patrick McGorry AO. Marie was the beloved chancellor of the University of Sydney while I was the undergraduate student member of its governing body, the Senate. Pat was recognised as Australian of the Year in 2010 for his dedication to improving youth mental health, and kindly accepted my invitation to return to St Paul's College to speak at the Medicine Faculty Dinner that year. They have each provided unwavering support over a number of years for which I am most grateful.

I also wish to thank Professor Jill White AM, Professor Bruce Robinson AM, Dr Barry Catchlove, Professor Ian Hickie AM, Professor Michael Kidd AM, Chris Tanti and Dr Elizabeth Wiley, among many others too numerous to list here, for their wise counsel and assistance.

Monash University deserves recognition not only for its funding of this particular Fellowship, but also for its unique and sustained dedication to embedding mindfulness meditation within the University. In particular, I am grateful to Professor David Copolov OAM, both a psychiatrist and the University's Pro Vice-Chancellor (Major Campuses and Student Engagement). David is held in high esteem by Monash students as a great advocate of their welfare, and soon after my return to Australia, he invited me to Monash to discuss the preliminary findings of my research. I look forward to continuing our working relationship as I now turn my focus to broad dissemination of this final report.

This report was made possible due to the generosity of the more than 60 people with whom I met. They contributed with both their insights and by assisting me in forming a rather complicated itinerary. It was a busy period with little down time, and I was very fortunate to have the support of various friends, and friends of friends, along the way.

Thank you to my interviewers and to the other volunteers and staff of the Winston Churchill Memorial Trust who make these fellowships possible.

Thank you also to Dr Richard Arnold for lending just some of his many talents to the type-setting of this document, to Ned Latham for his diligence and assistance in collating the itinerary, to Alistair Kitchen for his keen attention to detail as a proof-reader, and to Tim Dolan, Elly Howse, James Lawler and Dr Steve Hurwitz for their suggestions.

Perhaps most importantly, though, I wish to acknowledge all of the students who shared with me, directly or indirectly, their experience of mental ill-health, spurring my initial interest in this critically-important topic. My fervent hope is that this report serves as a catalyst for action by Australian universities, so that a student tragedy need not do so. It would be to our great shame if we failed to mitigate a known significant risk that spreads right across our country's campuses. With sufficient motivation, I believe Australia could easily become a world-leader in university student mental health best-practices, and hope that this Fellowship helps in at least some small way to lead us there.

ABOUT THE AUTHOR



Benjamin G. Veness is a doctor in Sydney, New South Wales, Australia, who also holds a bachelor's degree in accounting and a master's degree in public health. Prior to studying medicine he worked in finance and corporate strategy roles, mostly in the banking sector.

During medical school, Benjamin was twice elected by the undergraduate students to the Senate of his university, its supreme governing body. His interest in student mental health developed during this time, inspired by the stories of his peers.

Benjamin also has extensive experience representing students at both state and national levels, most significantly in his role as President of the Australian Medical Students' Association (AMSA) in 2013. As president, he gained members' support to make student mental health an advocacy priority of the Association, drafting a policy on the topic and establishing AMSA's ongoing campaign for improved mental health services for all university students.

An avid writer, Benjamin is frequently published in both the medical and mainstream press, and in 2015 was invited to become an Australia Day Ambassador. He is continuing various advocacy activities during his medical training, and welcomes opportunities to disseminate and support the implementation of the recommendations from his Monash University Churchill Fellowship to explore innovative prevention and early intervention strategies to improve the mental health of university students.

EXECUTIVE SUMMARY

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Project: The Monash University Churchill Fellowship to explore innovative prevention and early intervention strategies to improve the mental health of university students.

Mental health, one of Australia's nine National Health Priority Areas, is most particularly a problem afflicting youth aged 16-24 years. This is also the age range by which the majority of mental illnesses have had their onset. While youth under-access mental health services relative to older persons, a growing number are pooled on university campuses for tertiary education, with over one third of young Australians seeking a bachelor's degree or higher. This provides an excellent opportunity to target preventative and interventional mental health strategies toward an at-risk, and underserved, population.

Unfortunately, few Australian universities have made a significant commitment to improving their students' mental health, failing to acknowledge its innate connection with their teaching and research objectives. To an extent, this can be attributed to the relatively small number of Australian students who live on campus, thus reducing universities' direct exposure to the manifestation of mental health problems, especially suicide.

This Fellowship involved travel principally to the United States of America, Canada and the United Kingdom, and yielded seven key findings with 49 attendant recommendations for how Australia can improve the student mental health status quo.

The seven key findings were:

1. There must be a 'tone at the top' that genuinely commits a university to improving its students' mental health and wellbeing;
2. Mental health task forces with student representation should be used to develop mental health policies and strategies relevant to each institution;
3. Australia needs a sectoral leader like The Jed Foundation, in particular one with a strong research capability;
4. On-campus treatment services should be supplemented by preventative health strategies and supported by active partnership with local government and private health services;
5. Screening programmes are worthwhile when matched with service, and outreach services should be used to target those students who do not or cannot engage via traditional means;
6. Regard should be paid to the specific needs of minority groups such as LGBTI and international students; and
7. Universities should offer and evaluate mindfulness meditation, which can be taught in groups and with easily-scalable apps.

Of particular note is the key role that philanthropy has played overseas. It could likewise have a transformational impact in Australia, funding a student mental health research centre modelled after The Jed Foundation and partnered with, or nested within, one of our research universities, with a sorely-needed commitment to longitudinal outcome evaluation. In the meantime, each of Australia's 39 chancellors is called upon to set a tone from the top that makes student mental health a core priority of their university.

THE REPORT

INTRODUCTION

CHURCHILL FELLOWSHIPS

The Winston Churchill Memorial Trust was established in 1965 in honour of the late Sir Winston Churchill. It awards a significant number of 'Churchill Fellowships' each year, which fund necessary overseas travel for selected Australians to conduct further research in their chosen field, the findings of which are expected to have benefit when shared with the Australian community.¹

THIS FELLOWSHIP

This report pertains to the Monash University Churchill Fellowship to explore innovative prevention and early intervention strategies to improve the mental health of university students, made possible by Monash University's generous donation to the Winston Churchill Memorial Trust. The itinerary, detailed at Appendix A, included travel principally to the United States of America, Canada and the United Kingdom, with brief visits also to China and Singapore. Its scope included visiting both universities and external mental health agencies with an interest in, or expertise relevant to, university students' mental health.

UNIVERSITY STUDENT MENTAL HEALTH IN AUSTRALIA

Mental health, one of Australia's nine National Health Priority Areas², is most particularly a problem afflicting youth aged 16-24 years³. This

is also the age range by which the majority of mental illnesses have had their onset⁴. While youth under-access mental health services relative to older persons⁵, a growing number are pooled on university campuses for tertiary education⁶. This provides an excellent opportunity to target preventative and interventional mental health strategies toward an at-risk, and underserved, population.

Data from the Australian Institute of Health and Welfare (AIHW) show more than one quarter (26 per cent) of the 16-24 age group experience a mental health disorder in a 12-month period⁷ – the highest incidence of any age group – and we know that roughly 75 per cent of mental disorders have their onset prior to age 25⁸. Among Australian youth, anxiety disorders are the most common, followed by substance use disorders and then affective disorders⁹. Suicide was the leading cause of death in Australians aged 15-24 in the period 2011-13¹⁰.

The Minister for Education and Training, Senator Simon Birmingham, recently noted the high value Australians place on higher education. More than one third of 25-34 years olds now hold a bachelor's degree (compared to only 12 per cent, 25 years ago) and there has been 25 per cent growth in Commonwealth-supported

1 Winston Churchill Memorial Trust, 2016, 'About the Churchill Trust', <https://www.churchilltrust.com.au/about/the-trust/> [cited 2016 Jan 9]

2 Australian Institute of Health and Welfare, 2013, 'National health priority areas', <http://www.aihw.gov.au/national-health-priority-areas/> [cited 2016 Jan 9]

3 Australian Institute of Health and Welfare, 2010, 'Australia's health 2010', Report No: 12, Cat No: AUS 122, <http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=6442452962>

4 Kessler, RC, Amminger, GP, Aguilar-Gaxiola, S, Alonso, J, Lee, S, Ustün, TB, 2007, 'Age of onset of mental disorders: a review of recent literature', *Current Opinion in Psychiatry*, 20(4):359-64

5 Australian Institute of Health and Welfare, 2011, 'Young Australians: their health and wellbeing 2011', Cat No: PHE 140, <http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=10737419259>

6 Department of Education and Training, 2015, 'Reviews highlight decades of higher education funding challenges', <http://ministers.education.gov.au/birmingham/reviews-highlight-decades-higher-education-funding-challenges>

7 Australian Institute of Health and Welfare, 2010, op cit

8 Kessler et al, 2007, op cit

9 Australian Institute of Health and Welfare, 2010, op cit

10 Australian Institute of Health and Welfare, 2015, 'Leading causes of death', <http://www.aihw.gov.au/deaths/leading-causes-of-death/> [cited 2016 Jan 11]

undergraduate places in just the past six years, 2009 to 2015¹¹.

Industry peak body Universities Australia reports that over 1.3 million students were enrolled at Australia's 39 universities in 2013, and that of this, over 600,000 were domestic students aged below 25 years¹². An increasing number of undergraduate students are Indigenous, from a low socio-economic background or from a regional and remote area¹³, which is notable because persons from these groups tend to have lesser access to mental health services, despite also being at increased risk of developing mental health problems.

The epidemiology of mental health problems among university students is uncertain due to a lack of systematic measurement and reporting, but recent Australian research has shown that prevalence is likely to be at least equivalent to age-matched population levels, if not higher¹⁴. In the United Kingdom, the Royal College of Psychiatrists has called for further research in this area, especially as the demographics of modern universities change¹⁵. (In the United States, the American College Health Association has administered the National College Health Assessment since the year 2000, but unfortunately it does not track the same students over time¹⁶.)

11 Department of Education and Training, 2015, op cit

12 Universities Australia, 2015a, 'Data Snapshot 2015', <https://www.universitiesaustralia.edu.au/ArticleDocuments/169/Datacard%202015.pdf.aspx>

13 Universities Australia, 2015b, 'Higher Education and Research Facts and Figures November 2015', <https://www.universitiesaustralia.edu.au/australias-universities/key-facts-and-data#.VpHGRZN95sM>

14 Stallman, HM, 2010, 'Psychological distress in university students: A comparison with general population data', *Australian Psychologist*, 45(4):249-257

15 Royal College of Psychiatrists, 2011, 'Mental health of students in higher education', Report No: CR166, <http://www.rcpsych.ac.uk/files/pdfversion/CR166.pdf>

16 American College Health Association, 2014, 'About ACHA-NCHA', <http://www.acha-ncha.org/overview.html> [cited 2016 Jan 18]

Students are less likely to perform well at university when suffering from mental ill-health.

Psychiatric illness has been shown to be associated with lower educational achievement, decreased employment, lower incomes and lower standard of living¹⁷. Studies specifically of university students have found a correlation between mental health problems and poorer educational outcomes, as well as increased impairment and more days out of role¹⁸. The World Economic Forum and the Harvard School of Public Health claim that mental health conditions are the greatest threat to global gross domestic product, ahead of any other type of health condition, noting the dramatic impact mental health conditions have on productivity and quality of life¹⁹. This is largely due to the timing of onset of these disorders during the critical period of emerging adulthood.

Despite their high burden of disease, youth are less likely to access services for mental health problems compared to other age groups. The AIHW reports that only 23 per cent of those aged 16-24 years who experienced a mental disorder in the preceding 12 months accessed health services, compared with 38 per cent for those aged 25 years and over²⁰.

The health professionals young people most frequently consulted in the 12 months before the AIHW survey were general practitioners (63 per cent) and psychologists (43 per cent), with far fewer young people consulting psychiatrists (17 per cent)²¹. An inverse correlation between usage and cost of service provider is noted. General

17 Gibb, SJ, Fergusson, DM, Horwood, IJ, 2010, 'Burden of psychiatric disorder in young adulthood and life outcomes at age 30', *British Journal of Psychiatry*, 197:122-127

18 Stallman, 2010, op cit

19 Bloom, DE, Cafiero, ET, Jané-Llopis, E, et al, 2011, 'The Global Economic Burden of Noncommunicable Diseases', World Economic Forum, http://www3.weforum.org/docs/WEF_Harvard_HE_GlobalEconomicBurdenNonCommunicableDiseases_2011.pdf

20 Australian Institute of Health and Welfare, 2011, op cit

21 Ibid

practice encounters, mental health-related or otherwise, are much more common for young women than young men, suggesting that young men are at increased risk of disconnection from care.

The situation could be even worse for international students, who constitute one quarter of our student body²². This area is under-researched, however one paper found an “increasing incidence and severity of mental health problems amongst international students”, with Asian international students reported to under-access services relative to their Australian peers²³.

In 2012, the Federal Parliament commissioned the House Standing Committee on Education and Employment to conduct an inquiry into mental health and workforce participation. With respect to student mental health, they concluded:

The Committee recommends that the Commonwealth Government work with peak bodies such as Universities Australia and TAFE Directors Australia to coordinate a national approach to ensure that teaching and other relevant staff at universities and vocational education institutions be educated about ways to support students with mental ill health, with access to staff professional development on mental health issues. Disability liaison officers and student services staff should be appropriately skilled to assist students with a mental illness and have access to ongoing professional development in this area.²⁴

22 Universities Australia, 2015a, op cit

23 Forbes-Mewett, H, Sawyer, A-M, 2011, ‘Mental Health Issues amongst International Students in Australia: Perspectives from Professionals at the Coal-face’, The Australian Sociological Association Conference Local Lives/ Global Networks, University of Newcastle, <http://www.campusreview.com.au/wp-content/uploads/2011/11/Mental-Health-Issues-among-International-Students-in-Australia.pdf>

24 House of Representatives Standing Committee on Education and Employment, 2012, ‘Work Wanted: Mental health and workforce participation’, http://www.aph.gov.au/Parliamentary_Business/Committees/House_of_Representatives_Committees?url=ee/mentalhealth/report.htm

It is not clear what, if anything, has been done pursuant to this 2012 recommendation.

In Australia, a bachelor’s degree takes a minimum of three years to complete, providing many opportunities to access what is normally a difficult-to-reach demographic. In 2011, a ‘National Summit on the Mental Health of Tertiary Students’ was held at The University of Melbourne from 4-5 August²⁵, but it has not been repeated. The recommendations have not been adopted by Universities Australia, and there has been little other work done at a national level in Australia on this important issue. Given this relative lack of engagement and progress in Australia, it is necessary to look abroad for evidence of effective mental health interventions. This report provides key recommendations accordingly.

METHODOLOGY AND LIMITATIONS

The programme for the Fellowship was developed based on my pre-existing knowledge of university student mental health initiatives abroad, internet and literature searches, and recommendations and introductions from mental health academics and professionals in Australia. Meetings were added ad hoc as opportunities arose during the Fellowship. There were many more people and places I wished to visit, but could not for various logistical reasons – principally time and geographic constraints. The full list of meetings, in chronological order, is included at Appendix A. With the exception of conference sessions attended in San Diego, the research underlying this report was based on unstructured face-to-face interviews, in which contemporaneous handwritten or typed notes were made. The focus was principally on whole-

[aph.gov.au/Parliamentary_Business/Committees/House_of_Representatives_Committees?url=ee/mentalhealth/report.htm](http://www.aph.gov.au/Parliamentary_Business/Committees/House_of_Representatives_Committees?url=ee/mentalhealth/report.htm)

25 The University of Melbourne, 2011, ‘National Summit on the Mental Health of Tertiary Students’, <http://www.cshe.unimelb.edu.au/nationalsummit> [cited 2013 Apr 14]

of-institution services and initiatives, rather than those relevant to specific faculties or cohorts of students.

Limitations of this report include: those limitations pertinent to all qualitative research, particularly the biases and subjectivities of both the researcher and subjects; the difficulty in adapting the experience and lessons from unique institutions and foreign cultures to Australian universities; the diversity within the Australian universities to which these recommendations aim to be applied; and the lack of quantitative evaluation of almost all of the interventions that were discussed. This latter point was particularly disappointing, as almost no institution, no matter its repute or the strength of its epidemiology department, was able to provide evidence demonstrating the effectiveness or otherwise of its interventions. Consequently, a key recommendation to emerge is that all interventions should be developed with a prospective eye to evaluation, ideally longitudinal, despite its many challenges.

One of the most significant contextual differences encountered was that most of the universities discussed in this report provide on-campus accommodation to a large proportion of their students. The Australian model, by contrast, is predominantly of a 'commuter campus' in which students remain living with their parents or rent off-campus, and travel to and from university on the days they have lectures or tutorials. In some courses, a full time load may be only 12 contact hours per week. Relatively fewer hours on campus not only reduces the opportunities for intervention, but may also attenuate the perceived responsibility of the institution for their students' mental health.

FINDING ONE

There must be a 'tone at the top' that genuinely commits a university to improving its students' mental health and wellbeing.

"Mental health on campus is everyone's business."

– Daniel Woolf, Principal and Vice-Chancellor of Queen's University²⁶

The Jack Project (since renamed Jack.org) is based in Toronto, Ontario, Canada. Its founder and executive director is a delightful and enthusiastic man named Eric Windeler, who works out of a very modern office campus called the MaRS Discovery District, abutting the University of Toronto. I met him and his colleague Sydney Cormier (then project lead for The Jack Project and formerly a university exchange student to Australia) in Eric's office on a cold winter's morning in la ville reine.

The Jack Project has a lamentable genesis: it is the legacy of Eric Windeler and Sandra Hanington's son, Jack, who died by suicide in March 2010 while a freshman at Queen's University in Kingston, Ontario. Eric and his wife Sandra acted quickly to establish The Jack Project by May of that year, with Eric since coming to work on it full-time. Their vision is 'No More Silence' on the subject of mental health, aiming for a reduction in youth suicide and the increased wellbeing of Canada's young people. Their particular focus was initially on high school and post-secondary students, however has since widened to encompass 'young people' generally. Their board is impressively well-appointed and, as they have grown, their services have expanded to include an annual student summit, student chapters across Canada, peer-to-peer talks, and a major awareness-raising and fundraising bicycle ride.

²⁶ Wong, J, 2011, 'How academic pressure may have contributed to the spate of suicides at Queen's University', Toronto Life, <http://torontolife.com/city/queens-university-suicides/>

In our conversation, Eric spoke highly of the personal commitment to improving student mental health demonstrated by Daniel Woolf, Principal and Vice-Chancellor of Queen's University. In an alumni magazine article, Professor Woolf discloses that he and his wife Julie, a former mental health administrator, both have relatives who have suffered from depression or schizophrenia²⁷. He explains that he was driven to action by Jack's suicide and the tragic series of other student deaths, on- and off-campus, that followed. Professor Woolf began speaking about the issue at various fora, including a meeting of the Association of Universities and Colleges of Canada, which represents 97 public and private not-for-profit universities and university degree-level colleges across the country. He also established a Principal's Commission on Mental Health, which reported in November 2012²⁸.

The Commission's report acknowledges that mental health is an issue of increasing significance in most post-secondary institutions in Canada, including Queen's. More recently, Professor Woolf has noted that "at least 30 per cent of post-secondary students in Canada report mental health problems."²⁹

The report's very first recommendation is:

The commission recommends that affirmation of the value and goal of a healthy community be expressed at the highest levels, including as part of the vision and mandate of the university and in the policy statements of the Board of Trustees, University Council, Senate, the AMS [student government], the SGPS [graduate student society] and all operational and functional units.

²⁷ Woolf, D, 2011, 'Coming to grips with mental health issues', Queen's Alumni Review, 85:8-9

²⁸ Queen's University, 2012, 'Principal's Commission on Mental Health', <http://www.queensu.ca/principal/planning-initiatives/mentalhealth/commission> [cited 2016 Jan 14]

²⁹ Woolf, D, 2015, 'Let's talk', <http://www.queensu.ca/connect/principal/2015/01/28/lets-talk/> [cited 2016 Jan 15]

A decade prior to the formation of The Jack Project, an unfortunately-similar chain of events occurred in the United States. Jed Satow was a sophomore at the University of Arizona in 1998 when he died by suicide. In response, his parents Donna and Phil Satow established The Jed Foundation in 2000 to address the “urgent and unmet need” of helping colleges prevent suicide³⁰. Since then The Jed Foundation has emerged as a leader in student mental health, developing a suite of resources for campuses, including a ‘College and University Suicide Prevention Accreditation Program’.

In their ‘Guide to Campus Mental Health Action Planning’, under the heading ‘Obtain senior administrator support’, The Jed Foundation recommends: “College presidents and senior administrators must establish suicide prevention and mental health promotion as a priority and allocate funding to develop and sustain these initiatives.”³¹

A similar recommendation arose repeatedly in my investigations. In a collaborative effort between the Canadian Association of College and University Student Services (CACUSS) and the Canadian Mental Health Association (CMHA), a ‘Post-Secondary Student Mental Health: Guide to a Systemic Approach’ has been developed³². The first step in their recommended approach is to consider the impact that the broader organisation context has on the ‘wellness’ of those within it. This section recommends establishing: “Institutional vision, mission and strategic goals that reflect the importance of student mental health as a foundation of learning and optimal performance.”

30 The Jed Foundation, 2016a, ‘About Us: History’, <https://www.jedfoundation.org/about/history> [cited 2016 Jan 15]

31 The Jed Foundation, 2011, ‘A Guide to Campus Mental Health Action Planning’, https://www.jedfoundation.org/CampusMHAP_Web_final.pdf

32 Canadian Association of College & University Student Services and Canadian Mental Health Association, 2013, ‘Post-Secondary Student Mental Health: Guide to a Systemic Approach’, <http://www.cacuss.ca/PSSMH.html>

As background to its own recommendations, the report by the Commission at Queen’s University acknowledged in particular the work that had been done at Cornell University, which had sadly developed a notoriety for student suicides (at Cornell, safety nets – literally – were installed in response to suicide attempts off its gorge bridges). I met with Cornell’s associate director for health promotion and director of mental health initiatives, Dr Tim Marchell, while at the NASPA Student Mental Health Conference in San Diego. Dr Marchell was co-author of a paper that Dr Vic Schwartz, medical director at The Jed Foundation, later brought my attention to, and it mounts a very similar argument: “One of the most important ways to foster a healthier educational environment is to get a commitment from senior leadership at the [university] that mental health promotion and suicide prevention is a priority.”³³

This was again reinforced by Howard Adelman, professor of psychology at the University of California, Los Angeles (UCLA), who has worked since 1986 with his colleague Linda Klein on the development of the National Centre for Mental Health in Schools. When I asked him for his advice on effecting change in the university sector, he noted that the biggest problem with how things had been done to date was the piecemeal approach employed. For example, a shooting on campus leads to a particular response, yet five years later nothing fundamental tends to have changed. Better, he argued, to approach the problem from a policy standpoint: what is needed is a unified focus on enhancing the wellbeing of students, faculty and non-academic staff. If you can change the whole culture of an organisation, then you may have an impact.

In Australia, the core business of any university is usually constrained to teaching and research. In contrast, the Commission established at Queen’s University advocated that student (mental) health also be included in their vision and mandate.

33 Eells, GT, Marchell, TC, Corson-Rikert, J, Dittman, S, 2012, ‘A Public Health Approach to Campus Mental Health Promotion and Suicide Prevention’, *Harvard Health Policy Review*, 13(Spring):3-6

A similar sentiment was consistently expressed throughout my interviews, which has informed my belief that Australian universities would serve their students well by doing the same. Such an act would signify a 'tone from the top' which, expressed in some public form, appears to be a prerequisite for effective mental health strategy development and implementation throughout a university.

Pleasingly, in Australia there are already some strong building blocks for such statements. Monash University has worked for many years to embed mindfulness meditation as part of the 'Monash experience'³⁴, and a recent opinion piece by Professor Wai Fong Chua, Pro-Vice-Chancellor (Students) at the University of New South Wales, cogently concludes that "student wellbeing...should be core business for any educator."³⁵

Professor Chua's sentiment is mirrored in the 2014 report from the USA that concluded a year-long collaboration on student mental health issues between NASPA (Student Affairs Administrators in Higher Education), the American Council on Education, and the American Psychological Association. It recommends: "Given the complex relationships among mental health, problematic health behaviors, learning, campus safety, and the quality of the learning environment, mental and behavioral health should be a strategic priority on every campus."³⁶

Genuine, explicit and consistent support for students' mental health should be a core organisational priority for the chancellors and vice-chancellors leading Australia's 39 universities. My hope is that our institutional

leadership adopts a similar attitude to Professor Woolf's, except without requiring a similar catalyst. Such statements should be coupled with inclusion of student mental health within both the strategic plan of the university, and its risk management plan. The next step, of course, is to operationalise the commitment, which leads neatly into Finding 2.

"Promote the health and well-being of students (undergraduate, graduate, and professional) as a foundation for academic and life success."

– Goal in the Cornell University Strategic Plan (2010-15)³⁷

RECOMMENDATIONS

- 1.1** The chancellor and vice-chancellor should make a public commitment to prioritising their students' mental health, noting that it is a university-wide issue and responsibility.
- 1.2** Student mental health should be included in the university's strategic plan.
- 1.3** Student mental health should be included in the university's risk register.
- 1.4** Mental health and resilience should be considered for inclusion as formal graduate attributes.
- 1.5** A single senior staff member (who either reports directly to the vice-chancellor or else to someone who does) should be appointed as 'Head of Student Health' and given responsibility for all student health matters, so as to minimise service fragmentation. Their responsibility should include both mental and physical health, given the crossover between the two.

34 Monash University, 2015, 'Mindfulness at Monash', <http://monash.edu/counselling/mindfulness.html> [cited 2016 Jan 16]

35 Chua, WF, 2014, 'Opinion: Why student wellbeing really matters', <https://newsroom.unsw.edu.au/news/students/why-student-wellbeing-really-matters> [cited 2016 Jan 16]

36 Douce, LA, Keeling, RP, 2014, 'A Strategic Primer on College Student Mental Health', NASPA, <https://www.naspa.org/rpi/reports/a-strategic-primer-on-college-student-mental-health>

37 Cornell University, 2016, 'Cornell University Mental Health Framework', <http://www.gannett.cornell.edu/campus/wellbeing/framework.cfm> [cited 2016 Jan 16]

1.6 Support for student mental health should also come from both state and federal parliament, given their overlapping responsibility for both education and health. As a starting point, the Parliamentary Friends of Youth Mental Health group should make university students' mental health a topic for regular presentation and discussion, and the establishment of a separate group for tertiary education should be considered, similar to the UK's All Party Parliamentary Group on Students.³⁸

38 All Party Parliamentary Group on Students, undated, <http://appg-students.org.uk/> [cited 2016 Jan 3]

FINDING TWO

Mental health task forces with student representation should be used to develop mental health policies and strategies relevant to each institution.

- Q:** What do MIT, Harvard, Cornell, Princeton, Stanford, Queen’s University, and the University of Pennsylvania have in common?
- A:** They have each had at least one student mental health task force.

The Abbott Government proposed significant reforms to university funding, most notably the deregulation of fees³⁹. While the associated legislation struggled to win the support of either the general public or the Senate, the initial response from the Group of Eight (which represents eight of the major Australian research universities) was positive. In their media release at the time, the Group of Eight welcomed reforms that would provide increased funding sufficient to build a “world class Australian Higher Education system.”⁴⁰

Both the then Minister for Education and Training and the Group of Eight made reference to improving teaching and research, but there are other things that would also be required for Australia’s universities to become truly “world class”. The University of Oxford in the United Kingdom, for example, has a very clear

student mental health policy⁴¹, and mindfulness meditation programmes are offered throughout its colleges. Notably, admissions for self harm to the nearby John Radcliffe Hospital are notified to the student’s college doctor for follow-up. UCLA has a similar notification system in place when a student is hospitalised, and it is a recommendation in the Queen’s University mental health plan. Such integration between the health and education systems would be novel for Australia, but should be considered to ensure students at risk are appropriately supported upon discharge.

The starting point for such tight integration of health and tertiary education services is a serious commitment to students’ mental health and wellbeing, as discussed in Finding 1. In the same article by staff at Cornell University that recommended obtaining a commitment from senior leadership for making mental health a priority, the authors shared their experience at Cornell in turning this commitment into practical action: “One manifestation of this commitment is the development of a campus mental health council charged with the purpose of regularly examining relevant mental health issues on campus. These councils are often composed of faculty members, administrators, and students and their conversations can effectively raise the consciousness of people on the campus and shift the larger culture.” A thorough description of the full suite of mental health initiatives at Cornell, including their various campus-wide committees, can be found on their website⁴².

The approach at Cornell aligns well with The Jed Foundation’s recommendations. Its comprehensiveness would be the envy of any Australian university. (It is also well-staffed; Dr Tim Marchell told me that their health promotion staff and communications specialists numbered approximately 10, whereas most Australian

39 Incidentally, a recent meta-analysis showed concerning correlations between unsecured debt (including student loans) and mental and physical health problems. There were, of course, methodological challenges and causation could not be established given the study types, however it is relevant in the consideration of possible impacts of uncapping student fees. Richardson, T, Elliott, P, Roberts, R, 2013, ‘The relationship between personal unsecured debt and mental and physical health: A systematic review and meta-analysis’, *Clinical Psychology Review*, 33(8):1148-1162

40 Group of Eight Australia, 2014, ‘Building a world-class Australian higher education system’, <https://go8.edu.au/article/building-world-class-australian-higher-education-system>

41 University of Oxford, 2015, ‘Oxford University Student Mental Health Policy’, http://www.ox.ac.uk/sites/files/oxford/field/field_document/Student%20Mental%20Health%20Policy%20December%202015.pdf

42 Cornell University, 2016, op cit

universities have no staff dedicated to health promotion on campus.)

Finding 1 discussed the genesis of Queen's University's Principal's Commission on Mental Health. Similar reports have also been commissioned at universities south of the border, including but not limited to the Massachusetts Institute of Technology⁴³, Harvard University⁴⁴, Princeton University⁴⁵, Stanford University⁴⁶, and the University of Pennsylvania⁴⁷.

Many of these reports were, like Queen's, spurred by multiple students' suicides. The University of Pennsylvania has unfortunately had periods in which a significant number of student suicides have both occurred and become publicly known.

The University of Pennsylvania commissioned a 'Mental Health Outreach Task Force' in 2002, and another in 2014⁴⁸. Unusually, the latter did not include any current students. This was heavily criticised by Alison Malmon, a student member of the 2002 group who went on to found the mental health advocacy group Active Minds in response to her brother's suicide. Ms Malmon expressed her thoughts in a damning open letter to her alma mater. In her words, "Let's make mental health a

campus-wide priority and invite our students to lead the way."⁴⁹

Ms Malmon should know. The organisation she founded in 2001 at the University of Pennsylvania has since expanded across the United States, supporting student-run groups that raise awareness, educate and advocate on mental health. When I met with Sara Adelman from Active Minds at their head office in Washington, D.C., they were nearly up to 450 campuses. (They have previously supported a chapter in Queensland, Australia, and suggested they would be open to doing so again.) In the space of just over a decade, such growth in student-led chapters is testament not only to their staff's determination, but also to the huge interest that university students have in effecting positive change on their campus. Anecdotally, on my university campus in Australia, I found that discussions about mental health resonated with almost every student with whom I raised the topic. Similarly so at meetings of the Australian Medical Students' Association, which draws its representatives from approximately half of Australia's universities.

Residential campuses predominate in North America, which is a major difference to the Australian university experience, where even at the oldest of universities, only a small minority of students live on campus. It is therefore much less likely that if an Australian university student dies by suicide, it will be on campus. Indeed, there are almost no publicly-available reports of suicides on Australian campuses. The same imperative for an Australian institution to form a student mental health task force is therefore not present, however I would argue that a student's suicide in any location should still be of concern to their university, and furthermore that suicide is an extreme manifestation of mental health pathology and should not be a prerequisite for action. Encouragingly, the intent to generate

43 Massachusetts Institute of Technology, 2001, 'MIT Mental Health Task Force Report', <http://web.mit.edu/chancellor/mhbf/> [cited 2016 Jan 16]

44 Potier, B, 2004, 'Recommendations from Student Mental Health Task Force', Harvard University Gazette, <http://news.harvard.edu/gazette/2004/06.17/10-mentalhealth.html>

45 Princeton University, c 2003, 'Task Force on Health & Well-Being', <http://www.princeton.edu/hwbtf/> [cited 2016 Jan 16]

46 Stanford University, 2008, 'Student Mental Health and Well-Being Task Force Report', https://wellness.stanford.edu/sites/default/files/taskforce_report.pdf

47 Freinkel, J, 2015, 'Mental health task force releases final report', The Daily Pennsylvanian, <http://www.thedp.com/article/2015/02/mental-health-task-force-recommendations>

48 University of Pennsylvania, 2015, 'Report of the Task Force on Student Psychological Health and Welfare', Almanac Supplement, February 17, <http://www.upenn.edu/almanac/volumes/v61/n23/pdf/task-force-psychological-health.pdf>

49 Active Minds, 2014, 'Your Voice by Alison Malmon', <http://www.activeminds.org/about/media-center/active-minds-in-the-news/5-archived-press/898-the-daily-pennsylvanian> [cited 2016 Jan 16]

effective student mental health policies and strategies is not entirely foreign to Australia.

In August 2011, the first and only 'National Summit on the Mental Health of Tertiary Students' was held in Melbourne. One of the outcomes of the meeting was a document titled 'Guidelines for Tertiary Education Institutions to facilitate improved educational outcomes for students with a mental illness'⁵⁰. The very first bullet point stipulates that: "The institution should have a mental health policy covering mental health promotion, mental illness prevention and services for students with a mental illness."

There is no good reason why every Australian university should not have a mental health policy and strategy, and yet few do⁵¹. Where documents do exist, they are often outdated, suggesting that they are not considered a high priority. One Australian university has a "Mental Health Strategy Working Group" that includes students, but it appears not to have met since September 2013. When searching for mental health policies at Australian universities, it is more common to find that a university has an academic department or unit of study related to mental health policy than an institutional policy themselves. This does, of course, have a positive side: if universities have academic departments that possess the expertise to teach mental health policy development, they are in an excellent position to apply these skills internally, to the institution they know best.

With or without such internal expertise, universities in Australia can take a lot from their colleagues abroad. On top of the individual task force reports referred to above, The Jed

Foundation has developed a document titled 'CampusMHAP: A Guide to Campus Mental Health Action Planning', which is freely available and designed to help step American universities through the process⁵². Shortly after my return to Australia, The Jed Foundation announced a new partnership with the Clinton Foundation Health Matters Initiative that they have called 'The Campus Program'. Within months it had already attracted 56 college and university members, which involves a four-year commitment to improving mental health, substance abuse and suicide preventing programming on campus⁵³. Even if not able to join the Program, an Australian university could seek to access the self-assessment survey to assist in their own planning⁵⁴. Similarly, the aforementioned Canadian 'Post-Secondary Student Mental Health: Guide to a Systemic Approach' can be leveraged by Australian institutions⁵⁵, and the Suicide Prevention Research Centre website⁵⁶ offers a wealth of information and examples collated from across the United States. In the United Kingdom, Universities UK has recently developed a management guidance document for institutions, titled 'Student mental wellbeing in higher education: Good practice guide'⁵⁷. This follows a report from 2002, 'Reducing the risk of student suicide: issues and responses for higher education institutions'⁵⁸, which came as a

52 The Jed Foundation, 2011, op cit

53 The Jed Foundation, 2014a, '56 Colleges & Universities Join The Jed & Clinton Health Matters Campus Program to Support Student Mental Health', <https://www.jedfoundation.org/press-room/press-releases/Jed-Clinton-Campus-Program-Schools>

54 The Jed Foundation, 2014b, 'The Framework for Success', <http://www.thecampusprogram.org/framework-for-success> [cited 2016 Jan 17]

55 Canadian Association of College & University Student Services and Canadian Mental Health Association, 2013, op cit

56 Suicide Prevention Resource Center, 2015, 'Colleges and Universities', <http://sprc.org/collegesanduniversities> [cited 2016 Jan 17]

57 Universities UK, 2015, 'Student mental wellbeing in higher education: Good practice guide', <http://www.mwbhe.com/inc/files/documents/publications/studentmentalwellbeinginhe.pdf>

58 Universities UK, 2002, 'Reducing the risk of student suicide: issues and responses for higher education

50 University of Melbourne, 2011, 'Guidelines for tertiary education institutions to facilitate improved educational outcomes for students with a mental illness', https://mhfa.com.au/sites/default/files/8601_ter_guidelines.pdf

51 A notable recent exception is the Australian National University, which developed a Mental Health Strategy in July 2015 based on the recommendations of the Canadian Association of College & University Student Services and Canadian Mental Health Association guide <http://www.anu.edu.au/files/resource/DSL15450%20MH%20Strategy%20FA.pdf> [cited 2016 Jan 17]

companion to an earlier document, 'Guidelines on Student Mental Health Policies and Procedures for Higher Education'⁵⁹. It is striking that the UK was publishing such guidelines well over a decade before our university sector had even started to do so.

A recent positive step in Australia has been the refresh in late 2015 of the Threshold Standards developed by the Tertiary Education and Quality Standards Agency (TEQSA)⁶⁰. 'Wellbeing and Safety' has become its own subsection under Section 2 (Learning Environment), and details five base requirements of institutions, including that "The nature and extent of support services that are available for students are informed by the needs of student cohorts, including mental health, disability and wellbeing needs."⁶¹ They are an improvement on the original text, but unfortunately they do not come into force until 1 January 2017, and are quite broadly-worded. They are not enough to improve university student mental health, but they do signal industry regulator support for institutions developing solid mental health strategies, and provide a new pressure point for mental health advocates. By implication, they also require institutions to conduct a needs analysis of their students.

Finally, universities should engage their researchers, especially their epidemiologists, as part of any improvement process. As discussed earlier, it was unfortunate not to find consistent examples of good outcome evaluation during this Fellowship. As Australian universities catch up on student mental health, we have a great opportunity to do so in an evidence-generating way.

institutions', http://www.healthyuniversities.ac.uk/uploads/files/uuk_scop_report_reducing_risk_of_student_suicide.pdf

59 Committee of Vice-Chancellors and Principals, 2000, 'Guidelines on Student Mental Health Policies and Procedures for Higher Education'

60 Tertiary Education Quality and Standards Agency, 2015, 'Updated Higher Education Standards Framework', <http://www.teqsa.gov.au/media-publications/news/updated-higher-education-standards-framework>

61 Australian Government, 2015, 'Higher Education Standards Framework (Threshold Standards) 2015', <https://www.comlaw.gov.au/Details/F2015L01639>

RECOMMENDATIONS

- 2.1 A campus-wide mental health oversight committee should be established, to be chaired by the Head of Student Health (see Recommendation 1.4). The committee must include student members and meet at least twice each semester.
- 2.2 The campus-wide mental health oversight committee should be responsible for overseeing the development, implementation and evaluation of a student mental health policy that incorporates a public health approach.
- 2.3 The campus-wide mental health oversight committee should be responsible for overseeing the development, implementation and evaluation of a student mental health strategy that puts into effect the student mental health policy.
- 2.4 The campus-wide mental health oversight committee should be responsible for systematically reviewing all university policies with regard to their impact on students' mental health, and ways in which they could be altered so as to still achieve the aims of each policy, but with better mental health effects⁶².
- 2.5 Adequate project resources including technical expertise should be provisioned in order for these recommendations to be performed efficiently and to a high standard.

62 Dr Helen Stallman at the University of South Australia has collaborated extensively with Associate Professor Daniel Eisenberg at the University of Michigan, with whom I met to discuss the Healthy Minds Study. Their proposal is that universities review each of their policies through a mental health lens. For example, is having university libraries and study spaces open 24 hours a day, seven days a week (common in the institutions I visited) in students' best interests, especially if it risks sending a message that undermines the importance of good sleep hygiene?

- 2.6** Students must be included in discussions and planning that concerns their mental health and wellbeing. Universities should both proactively include them and support them to assist their peers, for example by encouraging the development of Active Minds chapters (or similar) on campuses. Such student-led projects should be eligible for a share of funding directly from the Student Services and Amenities Fee.
- 2.7** Universities Australia should encourage and support member institutions in these tasks, using the updated TEQSA Threshold Standards' implementation date of 1 January 2017 as a deadline for Recommendation 2.1.
- 2.8** The Australian Universities Quality Agency's 'Good Practice Database' (or an equivalent) should be reintroduced by TEQSA and specifically include student mental health good practices.
- 2.9** In the next iteration of TEQSA's Threshold Standards, the 'Wellbeing and Safety' subsection should be further strengthened so as to require each provider to demonstrate an explicit student mental health policy and, as part of TEQSA's audit process, require demonstration that processes are in place to keep the policy current and relevant to the needs of students.

FINDING THREE

Australia needs a sectoral leader like The Jed Foundation, in particular one with a strong research capability.

In the meantime, we can leverage international experience and guidelines in the development of our mental health policies and strategies.

One of the most impressive features of North America's response to student mental health problems, particularly suicides, has been the establishment of national philanthropic organisations focused on prevention. Driven by both the resources and passion of family members of young victims of suicide, these organisations have grown in both their sophistication and reach to become sectoral leaders. Australia would stand to benefit greatly from, in the first instance, leveraging their hard work, but more ambitiously, building upon it.

Based in Manhattan, New York, USA, The Jed Foundation is the most well-developed organisation in the American student mental health sector, and, most likely, the world. Since its establishment in the year 2000, The Jed Foundation has partnered with a wide range of mental health organisations in both the government and non-government sectors, media organisations such as mtvU, and, most recently, the Bill, Hillary & Chelsea Clinton Foundation. It was mentioned repeatedly and always in positive terms at the NASPA Mental Health Conference I attended in San Diego, California. This was a huge, multi-day conference that attracted staff working in university student mental health facilities from across North America. Unfortunately there did not seem to be any other Australians in attendance, but they would be welcome to attend in future; the event is hosted in a different location each year.

The Jed Foundation works with universities, and also provide online resources for students to access directly. Their collaboration with the Bill, Hillary & Chelsea Clinton Foundation is called 'The Jed & Clinton Health Matters Campus Program', and involves a four-year

commitment between the Program and the participating university to "work together to identify opportunities to enhance mental health and substance abuse prevention programming on campus."⁶³ Participating institutions are required to establish "an interdisciplinary, campus-wide oversight team to assess, support and implement program improvements" (see Recommendation 2.1).

One example of their online programmes is 'Transition Year', a website which aims to help students with the transition from high school to university. Another is 'ULifeline', an anonymous online information centre about mental health, alcohol and other drugs. ULifeline also offers both a text-based and telephone counselling service for those students seeking immediate help.

The concept of text-based counselling also arose when I met with staff at The Trevor Project in Los Angeles, California, USA. The Trevor Project focuses on lesbian, gay, bisexual, transgender and questioning [their definition of LGBTQ] youth. Some of the advantages of text-based counselling include that clients can access help discreetly from wherever they may be (as far as anyone around them knows, they are texting a friend or typing an email), conversation threads can easily be stored for future reference, and counsellors may easily seek assistance from their supervisor when needed (as opposed to muting a call or putting the client on hold).

In Chicago, Illinois, USA, I met with Erika's Lighthouse to hear more about their work with school communities to provide education about teen depression, reduce mental health stigma, and equip teens to manage their own mental health. While not focused on university student mental health, Erika's Lighthouse does present to local university students in fields where they may come into contact with teens, for example education, social work, psychology and psychiatry.

⁶³ The Jed Foundation, 2014c, 'Learn About the Campus Program', <http://www.thecampusprogram.org/learn-about-campusprogram> [cited 2016 Jan 17]

Discussed already in this report were Active Minds in the USA, The Jack Project in Canada, and Canada's impressive collaboration between the Canadian Association of College and University Student Services (CACUSS) and the Canadian Mental Health Association (CMHA), which over three years developed the guide, 'Post-Secondary Student Mental Health: Guide to a Systemic Approach'.

While in Canada, I visited Montréal, Quebec, and met with Tony Boeckh, chair of the Graham Boeckh Foundation, named in honour of Tony's late son, who suffered from schizophrenia and died in his early twenties. The Graham Boeckh Foundation aims to "to be a catalyst in bringing about transformational changes that significantly improve the lives of people with or at risk of mental illness"⁶⁴. They partnered with the Canadian Institute for Health Research to offer a prize of C\$25 million – each contributing half – to help achieve this, with the successful tenderer a team called the ACCESS Open Minds network. The Graham Boeckh Foundation is based in Canada but "open to the world", in their words. They have a large number of international partners including Melbourne's Orygen Youth Health, and have worked with Australia's headspace to develop their own integrated service model for youth from 12-25 years of age (i.e. inclusive of most university-aged undergraduate students). They are politically active, and set a strong example for the role that a similar philanthropic organisation could fill in Australia.

In the United Kingdom, I met with Rosie Tressler of Student Minds UK while visiting Oxford. Like Active Minds in the USA, they are focused on peer interventions. Their vision, closely aligned with Finding 1, "is for all universities and health services to recognise positive mental health as a priority for student success."⁶⁵ They started with support groups for students with eating disorders, added a national conference in 2012, and in

2013 absorbed Mental Wealth, which were student-led campaign groups across the UK. They run awards to celebrate student volunteers' achievements, and have undertaken a number of research projects, including publishing a report on what they perceive as best practice for university student peer support groups.

Also in the UK, two graduate students at Oxford University have collaborated to develop a campaign called 'It Gets Brighter', which aims to open dialogue about mental health via hopeful videos posted on YouTube (similar to how the 'It Gets Better' campaign has sought to help queer and questioning youth). A number of prominent Australians have contributed.

In Australia, we have many impressive mental health charities and research organisations, albeit none specifically focused on university student mental health. Monash University has committed impressively to making mindfulness meditation available to all of its students, and the University of New South Wales (UNSW) has supported the establishment of a peer-based mental health programme called Student Minds. Interestingly, academic transcripts recognise students' commitment to Student Minds, subject to a particular participation hurdle. Under the auspices of Student Minds, UNSW has also run two symposia on student mental health.

Most of the international organisations cited above are similar in having a tragic origin. Australia has the opportunity to develop something as similarly-impressive as The Jed Foundation, but without a student's suicide as the catalyst. Such an organisation would gain a significant head-start by leveraging the work already done overseas, adapting it as necessary to the Australian context. More than simply adapting initiatives from abroad, however, it could partner with, or nest within, a major research university, such as a member of the Group of Eight. A professorial chair could be established with funded PhD and post-doctoral researcher positions to provide strength to the research arm of the organisation. Financed with philanthropic support, a student mental health

64 Graham Boeckh Foundation, 2015, untitled, <http://grahamboeckhfoundation.org> [cited 2016 Jan 17]

65 Student Minds, undated, 'About Us', <http://www.studentminds.org.uk/about.html> [cited 2016 Jan 17]

research centre such as this could be responsible for not just sharing and leading best-practice in Australia, but globally. The key difference to most of the institutions I visited abroad would be its commitment to formal research including longitudinal outcome evaluation. Research outcomes would feed back in to service delivery while promising results assist to attract new funds.

While currently only at a conceptual stage, a university student mental health research centre such as this would be a true game-changer, standing to offer significant benefit to Australian university students and society, especially given the status quo's absence of alternate leadership.

RECOMMENDATIONS

- 3.1** Philanthropic investment should be sought to establish a university student mental health research centre modelled after The Jed Foundation and partnered with, or nested within, one of our research universities, with a commitment to longitudinal outcome evaluation. Development (fundraising) plans, particularly at the Group of Eight institutions, should include seeking opportunities to attract a major, transformational donation of this kind in support of student mental health.
- 3.2** Even in the absence of such an organisation, universities should proceed to develop their own mental health policies and strategies, as recommended in Finding 2, informed by international experience and guidelines. Where a university has a medical faculty and, in particular, a school of public health, local expertise should be enlisted at all project stages, including analysis, design, development, implementation and evaluation.
- 3.3** All student mental health initiatives should be designed with a view to evaluation, with such evaluation shared openly and willingly, ideally by publication in a peer-reviewed journal. While cross-sectional or point-in-time studies are usually easier to conduct and can be very helpful, they should ideally be coupled with longitudinal studies that assess student outcomes over time, potentially even post-graduation.
- 3.4** Australian university mental health professionals should be encouraged and supported to seek inspiration from, and share their experiences with, colleagues overseas, for example by attending and presenting at future NASPA Mental Health conferences.
- 3.5** Universities Australia, the Group of Eight, TEQSA, or a similar body should support an Australia and New Zealand equivalent to the NASPA Mental Health conference, for the purpose of best practice sharing and encouraging research in this area, particularly with respect to longitudinal outcome evaluation. An improvement on the NASPA model would be greater incorporation of students as delegates and presenters, in recognition of the central role they both do and can play in both service development and delivery.

FINDING FOUR

On-campus treatment services should be supplemented by preventative health strategies and supported by active partnership with local government and private health services.

Part of the rationale for calling for a university student mental health research centre (Recommendation 3.1) is that whereas intervention outcome evaluation has rarely been attempted, we have collected sufficient cross-sectional data on the prevalence of student mental health problems to demonstrate a significant unmet need for mental health services. No university that I am aware of either domestically or abroad considers its on-campus services to be entirely sufficient to meet demand, therefore service rationing is implemented, usually by placing a limit on the number of face-to-face counselling sessions offered per student in a given academic year.

It is difficult to compare current service levels between institutions in Australia. If the data does exist, it is not readily available. What became clear during the Fellowship, however, was that many of the major universities I visited offered a far broader range of health services than almost any Australian institution. Health promotion teams, counsellors, psychologists, social workers and psychiatrists were common on residential campuses of various sizes.

Like most of the medicine practised in Australia, the focus of our university health services is usually on treating sickness. This is understandable, as symptomatic illness provides an imperative for treatment. It is, however, therefore an illness-centred model and, given demands on services usually exceed supply, we tend to become somewhat stuck in an impossible game of catch-up. The alternative is to invest more in prevention in the hope of staving off illness and optimising students' health.

In the United States, federal money has been used to directly fund initiatives on university campuses. The Garrett Lee Smith Memorial Act – ratified and signed into law in 2004 and

subsequently re-authorised – funds grantees for three years to “implement best practice suicide prevention programs among youth ages 10-24, and all grantees report into a nationwide cross-site evaluation for the GLS program.”⁶⁶

In comparison, funding of treatment services in the United States tended to fall on institutions and their health plans. In terms of counsellors only, Elizabeth Gong-Guy, director of counseling and psychological services at UCLA quoted the International Association of Counseling Services' recommended staffing ratio of one counsellor per 1,000 to 1,500 students. For a large Australian university with 50,000 students, that translates to 33 to 50 full-time equivalent (FTE) counsellors, which none of them have. UCLA also has 6.5 psychiatrists for its 40,000 students, plus a close working relationship with the university hospital. Dr Ira Friedman, director of Stanford's health centre, reported that they had 5.6 FTE psychiatrists plus two psychiatry residents. Harvard's chief of counseling and mental health services, Dr Kathy Lapierre, noted that they have six psychiatrists, six psychologists, 13 social workers and one nurse. Collectively, they see approximately one in five Harvard students each year, and have a panel of external providers to refer to when faced with a student whose needs will likely exceed the capacity of their service.

In the Australian university funding context, it is difficult to see how local universities might come close to meeting these international benchmarks. Validly, administrators may also argue that Australia has public health services which students may access off-campus (an argument that is less strong for international students who hold some form of health insurance but do not have access to Medicare). A compromise would appear sensible, perhaps with universities taking more responsibility for the funding and implementation of preventative programmes, but at the same time working proactively with off-campus services to ensure students in need of assistance are likely to be identified by university

⁶⁶ Suicide Prevention Resource Center, 2015, 'Who We Serve', <http://www.sprc.org/grantees> [cited 2016 Jan 16]

staff, referred efficiently and appropriately for help, and that temporary absences for treatment are accommodated, with students supported appropriately upon their return to studies.

To do this well will require explicit partnerships with local government and private health services, e.g. general practitioners (GPs), private psychologists, community crisis teams, and public and private hospitals. Universities should assist all students to ensure they have access to a regular and reliable GP, who will be able to assist the student in myriad ways, including navigation of the mental health system if necessary. It is valuable for a student to have access to a known and trusted GP in advance of the times when they get sick. By building active partnerships with GPs in the local area, a university would increase these GPs' knowledge of university-specific policies and requirements, better-equipping the GPs to treat their student patients. Examples of this are already occurring on a small scale, with Monash University entering into a relationship in 2014 with the then Medicare Local for provision of a part-time mental health nurse with linkages into a psychiatrist and other multi-disciplinary supports. This should be widely encouraged, especially as Primary Health Networks have now superseded Medicare Locals and, with their larger catchment areas, are even more likely to encompass the same students both on campus and at their home address (reducing the splits of responsibility that could otherwise be an excuse for buck-passing between one service provider and another).

Formal relationships should similarly be explored between universities and other health service providers, including hospitals. Universities should think broadly about potential partners, and include mental health charities. In Scotland, I met with Judith McKinnon, director of human resources at the Scottish Association for Mental Health (SAMH). They had developed and signed a formal memorandum of understanding with Glasgow Caledonian University (GCU) in which SAMH provided services such as mental health training for GCU, employment support for GCU staff returning to work after a significant period

of absence due to a mental health problem, and internship opportunities for GCU students. Fundraising activities may be mutually-supported and GCU would assist staff and students to access the SAMH website and mental health resources.

The mental health policy at the University of Oxford demonstrates the close relationship between the University and the local hospital, John Radcliffe. Any student admitted to the hospital following self-harm will be notified to the student's college doctor. Furthermore, students referred to Oxford's student counselling service after assessment at the hospital will have the same discharge information sent to the counselling service as to the college doctor⁶⁷. Similarly, students at UCLA who present to the university hospital for a psychiatric reason are notified to the University's counseling service. A recommendation of the Report of the Principal's Commission on Mental Health at Queen's University in Canada is that the University "formalize relationships with local hospitals and community resources to share student information, with consent, carefully and discreetly, to ensure appropriate follow up by key professional staff"⁶⁸. A similarly close and formalised relationship should exist between Australian hospitals and universities; it would not be difficult to identify university students, as this information is routinely recorded as part of the social history in almost all patient consultations.

RECOMMENDATIONS

- 4.1** To ensure students-at-risk are identified and appropriately referred for help, both students and staff require mental health literacy training to recognise relevant signs and symptoms, and to understand what services are available on- and off-campus. The introduction of mandatory online modules, which allow for centralised tracking of completion and

67 University of Oxford, 2015, op cit

68 Queen's University, 2012, op cit

recertification rates, should be considered by all institutions. So-called 'gatekeepers' should be prioritised for more detailed training, e.g. tutors, residential advisors, and other persons who have frequent and consistent contact with the same students throughout a semester.

- 4.2** Universities should explicitly partner with external health service providers, including but not limited to GPs, private psychologists, community crisis teams, and public and private hospitals, to ensure that students in need of assistance are likely to be identified by university staff, referred efficiently and appropriately for help, and that temporary absences for treatment are accommodated, with students appropriately-supported upon their return to studies.
- 4.3** Information sharing policies should be developed between universities and external health service providers, to maximise the possibility of efficient data exchange to minimise gaps in service delivery and care.
- 4.4** Universities should seek to develop health promotion teams and initiatives with the aim of reducing the incidence of mental health problems among their students. While not the only appropriate source of funding, governments should facilitate such initiatives via grants programmes akin to the Garrett Lee Smith Memorial Act in the United States, noting that preventative activities that improve domestic students' health can be expected to benefit the government in the long run through reduced lifetime treatment costs. The Student Services and Amenities Fee is a further potential source of funding, especially in respect of that portion of the Fee that is currently being used to subsidise gyms or sporting clubs that are used by only a small proportion of students.
- 4.5** University campuses should be considered favourably by governments as potential sites for mental health workforce training. The Specialist Training Programme, for example, could be used to support the provision of psychiatry registrars to university health services, assuming appropriate consultant supervision could be provided, potentially from within the university's medical faculty.
- 4.6** Primary Health Networks (primary care) and hospital networks (in New South Wales, so-called Local Health Districts) should explicitly include all university campuses within their catchment area as patient groups whose service utilisation needs they must consider. Formal relationships should be established with the relevant universities to clarify each party's roles and responsibilities, especially with regard to transfer of care of a student in either direction.

FINDING FIVE

Screening programmes are worthwhile when matched with service, and outreach services should be used to target those students who do not or cannot engage via traditional means.

Archie Cochrane, a Scottish doctor, played a key role in the development of evidence-based medicine and the field of epidemiology. Eye surgeon Fred Hollows worked with Professor Cochrane during his training, and learned from him the maxim of 'No survey without service'⁶⁹, which heavily influenced Fred's approach in rural and remote Australia. It was not acceptable to Fred to simply document the terrible state of eye health in indigenous communities, even though this data might be very useful in advocating for improved services. Rather, while collecting data, Fred would also run mobile treatment clinics.

Unfortunately, Professor Cochrane's maxim is not universally applied, and in the field of student mental health there have been multiple studies that demonstrate an alarming prevalence of students in distress, but without an accompanying plan to provide treatment. It was therefore of great interest to learn from Elizabeth Gong-Guy at UCLA of the Interactive Screening Program (ISP) developed by the American Foundation for Suicide Prevention and employed on their campus⁷⁰. The ISP constitutes an anonymous stress and depression questionnaire that includes the PHQ-9 depression screening scale as well as questions about suicidal ideation and suicide attempts, alcohol and other drug use, and eating disorders. Each respondent is provided with individualised feedback with options for follow-up as appropriate. This may be anonymous if the student prefers. Given that opening the survey to all students at once may flood counselling resources, UCLA invites 500 students to participate at a time. In a rolling manner, they

aim to eventually offer the survey to all of their students.

Mental health screening was also commonly performed in the waiting rooms at the university health clinics I observed, while students waited to see a GP. This also adheres to the 'No survey without service' maxim, as results can be shared promptly with the GP and any areas of concern addressed during the consultation.

One of the benefits of screening, especially using surveys that offer preservation of anonymity, is that students who are reluctant to seek help, for whatever reason, can nonetheless increase their personal health knowledge and seek out information and support if and when they so desire. Persistent problems with stigma surrounding mental health diagnoses and personal vulnerability, especially in the eyes of many young men, exacerbate the difficulties that young people already face in accessing help (see the Introduction). For this reason, many of the university campuses that I visited also offered various forms of outreach services to make it easier for students to engage. Outreach was performed in a variety of ways, for example by having walk-up consultations in various campus locations, extending service hours to better match students' schedules, offering telephone or Skype consultations to students not on campus, via gatekeeper and peer training that helped those in contact with students in need to identify signs and symptoms of distress and feel confident in making a referral, following up proactively on reports of students who appeared to be in distress, and establishing student-of-concern and threat assessment teams⁷¹.

RECOMMENDATIONS

- 5.1** Mental health screening should be encouraged to identify students at-risk, however it should be married to appropriate and sufficient services to treat the problems identified ('No

69 Overs, M, 2012, 'In Fred's Footsteps: 20 Years of Restoring Sight', The Fred Hollows Foundation, p 19

70 American Foundation for Suicide Prevention, 2016, 'ISP for Colleges & Universities', <http://www.afsp.org/the-interactive-screening-program/isp-for-colleges-universities> [cited 2016 Jan 17]

71 Eells et al, 2012, op cit

survey without service'). A rolling online survey approach such as the Interactive Screening Program should be implemented by university counselling services, with an attempt made to screen first the students likely to be at highest risk of harm.

- 5.2** Students presenting to the GP clinic or health service on campus should be routinely screened in the waiting room for mental health problems, with the results made available to their doctor at the beginning of the consultation.
- 5.3** Outreach services should be developed by all university counselling services so as to reach those students who are less likely to engage directly through conventional means, i.e. calling or visiting to make an appointment for a self-identified mental health issue, or who cannot do so by virtue of not being on campus.
- 5.4** Service availability at each university should be matched to their students' schedules, rather than conforming only to traditional business hours.

FINDING SIX

Regard should be paid to the specific needs of minority groups such as LGBTI and international students.

Raja Bhattar is the proud director of the UCLA Lesbian Gay Transgender Campus Resource Centre, situated prominently on the ground floor of the Student Activities Centre. The Centre has one entrance open to a busy plaza, a large rainbow flag flapping in the breeze, and also a second, much more discrete, entrance accessible from within the building. This was a deliberate design feature, just like their policy of allowing five pages of free printing or photocopying – to provide an ‘excuse’ for visiting the Centre, should a student feel like they would benefit from one (especially valuable to closeted or questioning students). This was described as “meeting our students where they are”, referring to both their literal, physical presence, and also their state of personal need.

UCLA’s is a particularly well-developed lesbian, gay, bisexual, trans* and intersex (LGBTI) campus resource. In the Campus Pride Index⁷² (which has rated university campuses across the United States on LGBTQ inclusiveness since 2007) at the time I met with Mr Bhattar, it was rated 5-stars, was in the top 25 LGBT services in the country, in the top 10 trans* services, and boasted a staff and faculty network as well as an alumni network. The Centre employed three full-time and one part-time staff member, plus 12 paid student interns (payment ensures that these opportunities are accessible to students who need to work to support themselves, and properly recognises the value of their work). On a regular basis, three counsellors from the (very proximal) UCLA counselling service came to the “queer living room” for drop-in appointments. The Centre led the conversion of 45 gender-inclusive restrooms on campus and was seeking funding to relabel 200 more. They ask staff to add their names to the “allies list” that is published annually in the Bruin Daily (the campus newspaper) during “Out Week”. Relatedly,

72 Campus Pride, 2016, ‘Campus Pride index’, <http://www.campusprideindex.org> [cited 2016 Jan 16]

“BRUIN PRIDE” stickers are available for staff to display in their offices (I later noticed that the head of the counselling service had one) and there is a “UCLA ALLY” program in which staff and students may undergo “ally training”, which covers issues such as how to assist a student in the coming-out process.

The Centre is two-thirds funded from student fees, in what sounded similar to Australia’s Student Services and Amenities Fee. The remaining third comes direct from the University, with top-up funding from a separate foundation until the end of 2015. The Centre is so well-developed that it even facilitates subgroups, e.g. the monthly “Crossroads” programme that looks at the specific issues faced by LGBTI members of particular racial groups. All this for a student population of approximately 40,000 undergraduates and postgraduates (akin to a large Australian university).

Stanford University has a slightly different, but also impressive model based out of a charming building named Fire Truck House, which was once a fire station, right near the main quadrangle. Run by paid co-directors but staffed primarily by paid student interns, the service provides outreach to all of the residential colleges as part of ‘Safe and Open Spaces at Stanford’ (SOSA), in which volunteers tell their stories in a way that is safe for both queer-identifying students and those who may not be comfortable with homosexuality. What struck me about both this and the LGBT Campus Resource Center at UCLA, was the dedication of prime real estate and staffing for these services. They took pride of place in the heart of campus and provided impressive levels of support both to students in need, as well as students who wanted to help solve the problems faced by this particular at-risk minority. Like UCLA, Stanford’s service offered free printing for students, access to computers, and chill-out spaces.

At the NASPA Mental Health Conference I attended in San Diego, California, gender pronoun stickers were offered to all delegates to append to their name badges. In this way,

other conference delegates need neither assume nor ask another delegate for their preferred pronouns. It was an impressively-inclusive consideration by the conference organisers, and not something I had ever seen before. By comparison, many universities in Australia still make it difficult for their students to change their name or identify their preferred gender (e.g. forms that unnecessarily restrict choices to male/female or confuse the terms sex and gender). Note that an Australian LGBTI University Guide was published for the first time in early 2015 by the NSW Gay and Lesbian Rights Lobby in collaboration with Star Observer and several other groups⁷³. The UK also ranks universities against an inclusivity checklist⁷⁴.

My Fellowship concluded with brief visits to Beijing, China, and Singapore. There, I met with service providers and medical practitioners, to explore the different cultural attitudes and expectations toward mental health services among Asian students. This is particularly important for Australia given our reliance upon education as an export, and the high proportion of our international students who come from Southeast Asia. The most significant findings were that Asian international students were not necessarily familiar with Western psychological and psychiatric treatment modalities, and that privacy is often assumed not to be assured. Students may often, for example, believe that information they disclose to a counsellor will be shared with their teachers or parents, either automatically or upon request. This poses significant challenges for engaging these students, who are already at heightened risk given the additional pressures on them, including personal and parental expectations, financial stress exacerbated by the work restrictions of student visas, language difficulties and isolation. It is pleasing to see some universities already making an effort to address some of these issues,

73 Australian LGBTI University Guide, undated, 'Home', <http://lgbtiuniguide.org.au> [cited 2016 Jan 17]

74 Gil, N, 2014, 'Six UK universities get top marks for gay-friendliness', The Guardian, <http://www.theguardian.com/education/2014/sep/17/six-uk-universities-get-top-marks-for-gay-friendliness>

for example the University of Sydney's Welcome to Sydney Alumni Program, in which alumni are invited to host a gathering for a small group of international and/or regional students⁷⁵.

RECOMMENDATIONS

- 6.1 Institutional support should be provided to establish well-resourced LGBTI centres in accessible locations, with paid staff and paid LGBTI student interns as necessary, for as long as LGBTI youth remain at disproportionately-high risk of mental ill-health, especially suicide.
- 6.2 Universities should support the data collection efforts of future editions of the Australian LGBTI University Guide, and work to improve their performance on the measures that are identified by LGBTI students as important to them.
- 6.3 The principles applied to management of the increased risk of LGBTI students should be tested against other minority populations such as international students, who may benefit from similar initiatives such as physical spaces with welcoming and culturally-appropriate staff.
- 6.4 Information about student mental health services, particularly assurances about patient confidentiality, should be made available in all languages spoken by a sizable number of international students. This is not only for the benefit of the international students themselves, but also for their family members to understand what services are available and how privacy principles are applied in Australia.
- 6.5 Multi-lingual counsellors and GPs should be employed by universities as required

75 The University of Sydney, 2015, 'Welcome to Sydney Alumni Program', <http://sydney.edu.au/alumni/programs-benefits/welcome-to-sydney.shtml> [cited 2016 Jan 17]

to meet the needs of their student population. Particularly with regard to expressing emotions and internal conflict, language can be a major barrier to the provision of effective care.

- 6.6** Minority groups such as LGBTI and international students should be prioritised in mental health screening and outreach programmes.
- 6.7** Minority groups at increased risk of mental health problems should be identified by each institution as part of the development of their mental health strategy.

FINDING SEVEN

Universities should offer and evaluate mindfulness meditation, which can be taught in groups and with easily-scalable apps.

At the University of Oxford, I met with Chris Cullen, a co-founder of the Mindfulness in Schools Project and now a teacher and trainer at the Oxford Mindfulness Centre. Mr Cullen has also taught mindfulness courses for Members of Parliament and Peers in the Houses of Parliament. At Oxford, mindfulness is taught in the colleges over eight weeks, following the course laid out in the book, 'Mindfulness – a Practical Guide to Finding Peace in a Frantic World' by Williams and Penman. Each session is 75 minutes long, and students pay £40 for the full course. There is usually a waiting list, as demand currently exceeds teaching capacity. Following the completion of the course, students may either continue their mindfulness practice privately or by attending a student-run session, one of which I attended while there.

In late 2015, a report titled 'Mindful Nation UK' was released by the Mindfulness All-Party Parliamentary Group⁷⁶. Encouraged by the scientific evidence for mindfulness, the Group has recommended that mindfulness be made available, with public funding, in the health system, education sector, workplace and criminal justice system. They have recommended that mindfulness be taught in schools, however similar benefits would be expected from teaching it to university students, and it is highly encouraging that mindfulness is receiving parliamentary attention in this manner. Many, if not all, of the counselling services I visited in North America also offered mindfulness to their students.

Within Australia, Monash University stands out by far as the leading university in terms of making mindfulness meditation available to its students. Given that there is already an evidence base that supports mindfulness as a

mental health intervention (noting that there are several different mindfulness curricula and that application of study outcomes should be done with caution), other universities should be encouraged to follow suit, although as with other mental health interventions, longitudinal outcome evaluation is highly recommended to validate and improve its application in this particular setting.

Aside from the promising evidence base, what is also particularly appealing about mindfulness as an intervention, is that it can be taught in groups or even with the aid of apps. There is a burgeoning industry providing a variety of both free and paid products, e.g. Smiling Mind, which was designed in Australia specifically for use by young people. App-based interventions offer an extremely cost-effective and scalable service to students.

RECOMMENDATIONS

- 7.1** Mindfulness meditation courses should be offered by all universities, ideally through either group-based tuition or apps, depending upon students' preference. Implementation should be coupled with a longitudinal outcomes evaluation to hopefully prove benefit in the particular population and to guide future implementation and research directions. It is reasonable to charge a small fee to help cover the cost of face-to-face mindfulness courses.
- 7.2** Australian parliaments should consider embracing mindfulness meditation in a similar way to the UK. In so doing, parliamentarians would hopefully derive personal benefits from adopting a mindfulness practice, but would also gain personal experience that could potentially inform their support of the teaching of mindfulness in educational settings, including the university.

76 Mindfulness All-Party Parliamentary Group, 2015, 'Mindful Nation UK', http://themindfulnessinitiative.org.uk/images/reports/Mindfulness-APPG-Report_Mindful-Nation-UK_Oct2015.pdf

CONCLUSION

"Only the good die young," sang a lustful twenty-something Billy Joel in 1977.

Sadly, that decade, a lot of the good were dying young on our roads. In 1970, the road toll peaked at 3,798 deaths⁷⁷. For Australians aged 15-24, an early demise was, by far, most likely to come from a motor vehicle accident.

Times were different back then. My father turned seventeen while on holidays in north-west New South Wales in the mid-sixties. He entered Baradine Police Station, and the sergeant asked him a few simple questions about road rules. The boy led the officer to my grandfather's grey, 1949 Humber Snipe. Neither of them wore a seatbelt; cars didn't have them⁷⁸. He turned the key and set off around the block, reversed through a farm gate "about a hundred feet wide", and pulled off a parallel park. He hadn't hit anything and so, back in the station, the sergeant signed a piece of paper and that was it. No log books, no P plates, no passenger restrictions, not even a limit on his blood alcohol content.

Society was rightly concerned by the rising road toll and legislators made a commitment to reduce it. The problem was complex, so a wide range of initiatives were implemented. Modifiable risk factors were addressed by mandating seatbelt use, legislating minimum vehicle safety standards, increasing licencing requirements, teaching drivers about the risks of fatigue, improving roads, and outlawing drink-driving. All stakeholder groups were identified and involved; public attitudes were changed. The effect was enormous. Last year, 1,209 people died on our roads⁷⁹, a 68 per cent reduction

on 1970, despite a near doubling of Australia's population⁸⁰.

Road traffic accidents no longer cause the majority of 15-24-year-olds' deaths. Now, if one of our young dies, the most likely reason is suicide. Unfortunately, the risk is much higher if they are Indigenous, male, gay or trans*, or live somewhere rural like Baradine. In 2012, 2,535 people died by suicide in Australia. Of them, 324 were aged 15-24: almost one young person every day⁸¹.

With more than one third of young Australians seeking a bachelor's degree or higher, our 39 universities are in a perfect position to help make a significant, positive difference to the urgent issue of improving youth mental health. Not only would teaching and research outcomes improve for the universities, but benefits would flow to Australian society both immediately and into the future.

When Queen's University in Canada suffered six student deaths in quick succession, the vice-chancellor made mental health a priority. "Mental health on campus is everyone's business," he said. Like MIT, Harvard, Cornell, Princeton and Stanford, Queen's established a student mental health taskforce to address the problem. When Jed Satow, a sophomore at the University of Arizona, took his own life, his parents established The Jed Foundation to address the "urgent and unmet need" of helping colleges prevent suicide. Since then, The Jed Foundation has emerged as a global leader in student mental health, developing a suite of resources for campuses and, recently, a College and University Suicide Prevention Accreditation Program⁸².

77 Australian Bureau of Statistics, 2010, '1370.0 - Measures of Australia's Progress, 2010', [http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/1370.0~2010~Chapter~Road%20safety%20\(4.9.2\)](http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/1370.0~2010~Chapter~Road%20safety%20(4.9.2))

78 Milne, PW, 1985, 'Fitting and Wearing of Seat Belts in Australia: The history of a successful countermeasure', Department of Transport, http://www.infrastructure.gov.au/roads/safety/publications/1985/pdf/Belt_Analysis_4.pdf

79 Department of Infrastructure and Regional Development, 2016, 'Road Deaths Australia—Monthly Bulletins', https://bitre.gov.au/publications/ongoing/road_

[deaths_australia_monthly_bulletins.aspx](#) [cited 2016 Jan 16]

80 Australian Bureau of Statistics, 2012, '1301.0 - Year Book Australia, 2012', <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/1301.0~2012~Main%20Features~Population%20size%20and%20growth~47>

81 Hunter Institute of Mental Health, 2014, 'Facts and stats about suicide in Australia', <http://www.mindframe-media.info/for-media/reporting-suicide/facts-and-stats> [cited 2016 Jan 17]

82 The Jed Foundation, 2016b, 'College and

This Fellowship provided a rare opportunity to gain insight into these and other initiatives that leading universities in North America and the United Kingdom have employed to help their students. Philanthropy has played a key role in many instances and could likewise have a transformational impact in Australia, by funding a student mental health research centre modelled after The Jed Foundation and partnered with, or nested within, one of our research universities, with a commitment to longitudinal outcome evaluation.

Australian universities are investing billions of dollars in campus improvement programmes⁸³. They can be ambitious when they want to be. It is time to do for student mental health what Australia did for the road toll. Both causes of death are preventable.

Too many of our good continue to die young. The starting point to address this is setting the right tone at the top: making student mental health a core priority of every university.

University Suicide Prevention Accreditation Program', <https://www.jedfoundation.org/professionals/programs-and-research/suicide-prevention-accreditation-program> [cited 2016 Jan 17]

83 Gilmore, H, 2014, 'Universities spend billions in race to be the best', The Sydney Morning Herald, <http://www.smh.com.au/nsw/universities-spend-billions-in-race-to-be-the-best-20140314-34s3c.html>

APPENDICES

APPENDIX A: PROGRAMME

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Arquimides Pacheco

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Elizabeth Ozer

Professor of Pediatrics, School of Medicine, University of California, San Francisco

Rachel Loewy

Associate Professor, Department of Psychiatry, University of California, San Francisco

Yan Leykin

Assistant Adjunct Professor, Department of Psychiatry, University of California, San Francisco

Charlie Irwin

Distinguished Professor of Paediatrics, University of California, San Francisco

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Tim Marchell

Director of Mental Health Initiatives and Associate Director of Health Services for Health Promotion, Cornell University

Ken Hsu

Assistant Vice-Provost of Students and Director, Graduate Life Office, Stanford University

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Kirsten McLean

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Elaine Ballantyne

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Gus Niven

Oor Mad History Project, Queen Margaret
University

Judith McKinnon

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Association for Mental Health

TUNISIA

(at the March Meeting of the International
Federation of Medical Students' Associations)

Yao Xu

Chinese Medical Student

Sharon Yang

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CHINA

Si Wen

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Clinical Epidemiologist, Peking University Third
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Chan Chun Ting Tommy

Associate Consultant, Early Psychosis
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APPENDIX B: SUMMARY OF FINDINGS AND RECOMMENDATIONS

FINDING ONE:

There must be a 'tone at the top' that genuinely commits a university to improving its students' mental health and wellbeing.

Recommendations:

- 1.1 The chancellor and vice-chancellor should make a public commitment to prioritising their students' mental health, noting that it is a university-wide issue and responsibility.
- 1.2 Student mental health should be included in the university's strategic plan.
- 1.3 Student mental health should be included in the university's risk register.
- 1.4 Mental health and resilience should be considered for inclusion as formal graduate attributes.
- 1.5 A single senior staff member (who either reports directly to the vice-chancellor or else to someone who does) should be appointed as 'Head of Student Health' and given responsibility for all student health matters, so as to minimise service fragmentation. Their responsibility should include both mental and physical health, given the crossover between the two.
- 1.6 Support for student mental health should also come from both state and federal parliament, given their overlapping responsibility for both education and health. As a starting point, the Parliamentary Friends of Youth Mental Health group should make university students' mental health a topic for regular presentation and discussion, and the establishment of a separate group for tertiary education should be considered, similar to the UK's All Party Parliamentary Group on Students

FINDING TWO:

Mental health task forces with student representation should be used to develop mental health policies and strategies relevant to each institution.

Recommendations:

- 2.1 A campus-wide mental health oversight committee should be established, to be chaired by the Head of Student Health (see Recommendation 1.4). The committee must include student members and meet at least twice each semester.
- 2.2 The campus-wide mental health oversight committee should be responsible for overseeing the development, implementation and evaluation of a student mental health policy that incorporates a public health approach.
- 2.3 The campus-wide mental health oversight committee should be responsible for overseeing the development, implementation and evaluation of a student mental health strategy that puts into effect the student mental health policy.
- 2.4 The campus-wide mental health oversight committee should be responsible for systematically reviewing all university policies with regard to their impact on students' mental health, and ways in which they could be altered so as to still achieve the aims of each policy, but with better mental health effects.
- 2.5 Adequate project resources including technical expertise should be provisioned in order for these recommendations to be performed efficiently and to a high standard.
- 2.6 Students must be included in discussions and planning that concerns their mental health and wellbeing. Universities should both proactively include them and support

them to assist their peers, for example by encouraging the development of Active Minds chapters (or similar) on campuses. Such student-led projects should be eligible for a share of funding directly from the Student Services and Amenities Fee.

- 2.7** Universities Australia should encourage and support member institutions in these tasks, using the updated TEQSA Threshold Standards' implementation date of 1 January 2017 as a deadline for Recommendation 2.1.
- 2.8** The Australian Universities Quality Agency's 'Good Practice Database' (or an equivalent) should be reintroduced by TEQSA and specifically include student mental health good practices.
- 2.9** In the next iteration of TEQSA's Threshold Standards, the 'Wellbeing and Safety' subsection should be further strengthened so as to require each provider to demonstrate an explicit student mental health policy and, as part of TEQSA's audit process, require demonstration that processes are in place to keep the policy current and relevant to the needs of students.

FINDING THREE:

Australia needs a sectoral leader like The Jed Foundation, in particular one with a strong research capability.

Recommendations:

- 3.1** Philanthropic investment should be sought to establish a university student mental health research centre modelled after The Jed Foundation and partnered with, or nested within, one of our research universities, with a commitment to longitudinal outcome evaluation. Development (fundraising) plans, particularly at the Group of Eight institutions, should include seeking opportunities to attract a major, transformational donation of this kind in support of student mental health.
- 3.2** Even in the absence of such an organisation, universities should proceed to develop their own mental health policies and strategies, as recommended in Finding 2, informed by international experience and guidelines. Where a university has a medical faculty and, in particular, a school of public health, local expertise should be enlisted at all project stages, including analysis, design, development, implementation and evaluation.
- 3.3** All student mental health initiatives should be designed with a view to evaluation, with such evaluation shared openly and willingly, ideally by publication in a peer-reviewed journal. While cross-sectional or point-in-time studies are usually easier to conduct and can be very helpful, they should ideally be coupled with longitudinal studies that assess student outcomes over time, potentially even post-graduation.
- 3.4** Australian university mental health professionals should be encouraged and supported to seek inspiration from, and share their experiences with, colleagues overseas, for example by attending and presenting at future NASPA Mental Health conferences.
- 3.5** Universities Australia, the Group of Eight, TEQSA, or a similar body should support an Australia and New Zealand equivalent to the NASPA Mental Health conference, for the purpose of best practice sharing and encouraging research in this area, particularly with respect to longitudinal outcome evaluation. An improvement on the NASPA model would be greater incorporation of students as delegates and

presenters, in recognition of the central role they both do and can play in both service development and delivery.

FINDING FOUR:

On-campus treatment services should be supplemented by preventative health strategies and supported by active partnership with local government and private health services.

Recommendations:

- 4.1** To ensure students-at-risk are identified and appropriately referred for help, both students and staff require mental health literacy training to recognise relevant signs and symptoms, and to understand what services are available on- and off-campus. The introduction of mandatory online modules, which allow for centralised tracking of completion and recertification rates, should be considered by all institutions. So-called 'gatekeepers' should be prioritised for more detailed training, e.g. tutors, residential advisors, and other persons who have frequent and consistent contact with the same students throughout a semester.
- 4.2** Universities should explicitly partner with external health service providers, including but not limited to GPs, private psychologists, community crisis teams, and public and private hospitals, to ensure that students in need of assistance are likely to be identified by university staff, referred efficiently and appropriately for help, and that temporary absences for treatment are accommodated, with students appropriately-supported upon their return to studies.
- 4.3** Information sharing policies should be developed between universities and external health service providers, to maximise the possibility of efficient data exchange to minimise gaps in service delivery and care.
- 4.4** Universities should seek to develop health promotion teams and initiatives with the aim of reducing the incidence of mental health problems among their students. While not the only appropriate source of funding, governments should facilitate such initiatives via grants programmes akin to the Garrett Lee Smith Memorial Act in the United States, noting that preventative activities that improve domestic students' health can be expected to benefit the government in the long run through reduced lifetime treatment costs. The Student Services and Amenities Fee is a further potential source of funding, especially in respect of that portion of the Fee that is currently being used to subsidise gyms or sporting clubs that are used by only a small proportion of students.
- 4.5** University campuses should be considered favourably by governments as potential sites for mental health workforce training. The Specialist Training Programme, for example, could be used to support the provision of psychiatry registrars to university health services, assuming appropriate consultant supervision could be provided, potentially from within the university's medical faculty.
- 4.6** Primary Health Networks (primary care) and hospital networks (in New South Wales, so-called Local Health Districts) should explicitly include all university campuses within their catchment area as patient groups whose service utilisation needs they must consider. Formal relationships should be established with the relevant universities to clarify each party's roles and responsibilities, especially with regard to transfer of care of a student in either direction.

FINDING FIVE:

Screening programmes are worthwhile when matched with service, and outreach services should be used to target those students who do not or cannot engage via traditional means.

Recommendations:

- 5.1** Mental health screening should be encouraged to identify students at-risk, however it should be married to appropriate and sufficient services to treat the problems identified ('No survey without service'). A rolling online survey approach such as the Interactive Screening Program should be implemented by university counselling services, with an attempt made to screen first the students likely to be at highest risk of harm.
- 5.2** Students presenting to the GP clinic or health service on campus should be routinely screened in the waiting room for mental health problems, with the results made available to their doctor at the beginning of the consultation.
- 5.3** Outreach services should be developed by all university counselling services so as to reach those students who are less likely to engage directly through conventional means, i.e. calling or visiting to make an appointment for a self-identified mental health issue, or who cannot do so by virtue of not being on campus.
- 5.4** Service availability at each university should be matched to their students' schedules, rather than conforming only to traditional business hours.

FINDING SIX:

Regard should be paid to the specific needs of minority groups such as LGBTI and international students.

Recommendations:

- 6.1** Institutional support should be provided to establish well-resourced LGBTI centres in accessible locations, with paid staff and paid LGBTI student interns as necessary, for as long as LGBTI youth remain at disproportionately-high risk of mental ill-health, especially suicide.
- 6.2** Universities should support the data collection efforts of future editions of the Australian LGBTI University Guide, and work to improve their performance on the measures that are identified by LGBTI students as important to them.
- 6.3** The principles applied to management of the increased risk of LGBTI students should be tested against other minority populations such as international students, who may benefit from similar initiatives such as physical spaces with welcoming and culturally-appropriate staff.
- 6.4** Information about student mental health services, particularly assurances about patient confidentiality, should be made available in all languages spoken by a sizable number of international students. This is not only for the benefit of the international students themselves, but also for their family members to understand what services are available and how privacy principles are applied in Australia.
- 6.5** Multi-lingual counsellors and GPs should be employed by universities as required to meet the needs of their student population. Particularly with regard to expressing emotions and internal conflict, language

can be a major barrier to the provision of effective care.

- 6.6** Minority groups such as LGBTI and international students should be prioritised in mental health screening and outreach programmes.
- 6.7** Minority groups at increased risk of mental health problems should be identified by each institution as part of the development of their mental health strategy.

FINDING SEVEN:

Universities should offer and evaluate mindfulness meditation, which can be taught in groups and with easily-scalable apps.

Recommendations:

- 7.1** Mindfulness meditation courses should be offered by all universities, ideally through either group-based tuition or apps, depending upon students' preference. Implementation should be coupled with a longitudinal outcomes evaluation to hopefully prove benefit in the particular population and to guide future implementation and research directions. It is reasonable to charge a small fee to help cover the cost of face-to-face mindfulness courses.
- 7.2** Australian parliaments should consider embracing mindfulness meditation in a similar way to the UK. In so doing, parliamentarians would hopefully derive personal benefits from adopting a mindfulness practice, but would also gain personal experience that could potentially inform their support of the teaching of mindfulness in educational settings, including the university.