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Mental health and higher education: mapping field, consciousness and legitimation

Abstract
Some UK academics have declared that they do not want higher education to become part of the social welfare system. In this article we review aspects of policy and practice that suggest that this has already happened. Explicit encouragement of people with mental health problems to undertake courses has proceeded alongside a number of initiatives to make higher education institutions better able to support students in difficulty, and new responsibilities are being unfolded for the staff. There is growing evidence that students' mental health problems are increasing. To make sense of the transformations in the topography of policy and in the consciousness it encourages, we make use of theoretical frameworks such as Bourdieu's notion of field and the generative work of Foucault and Rose, to examine the implications this has for the conceptualization of politics under New Labour and the implications this has for a newly recapitalized notion of responsible individuals.

Key words: Bourdieu, mental distress, universities

Introduction

In May 2004 the UK press reported a speech by Professor Anthony Smith, President of Magdalen College, Oxford, warning that the UK's higher education (HE) system must not become 'a branch of social

welfare' (Smithers, 2004). This prompts a reflection on the extent to which the events that Smith was concerned about have already happened in the British HE system in the early 21st century and the implications this has for contemporary social policy. The fact that Smith was speaking in the future tense – 'become' – masks the extent to which the HE system has already begun to undertake welfare work.

Smith's comment was made in the context of a growing debate as to whether higher education institutions (HEIs) should take applicants' social backgrounds into consideration when offering places. Yet there has yet to be a similar level of debate about the work that HEIs are increasingly being encouraged to undertake in order to support vulnerable students during their studies; nor has there been very much discussion of the way that this kind of work is increasingly seen by policy makers as a means of addressing the agendas of social inclusion and employability which have pervaded the social policy landscape of the early 21st century.

The recent policy alignment between learning and well-being was most explicitly stated in the Green Paper, *The Learning Age*, a key document in setting out New Labour's ideas for the role it sees education playing in Britain in the 21st century:

> For individuals, learning will help everyone to acquire the new skills and qualifications needed for employment and advancement. Learning will increase our earning power. In addition, it will help older people to stay healthy and active, strengthen families and the wider community, and encourage independence. Opportunities to learn will lead us to greater appreciation of art, music, poetry and literature, and develop our potential as rounded human beings. (DfEE, 1998: 3)

In addition, education was seen as the remedy for a variety of other social and individual ills: 'learning will be the key to a strong economy and an inclusive society. It will offer a way out of dependency and low expectation towards self-reliance and self-confidence' (DfEE, 1998: 3). This signalled new territories that education was charged with colonizing, and new tasks for educators and the institutions within which they work. Policies such as this play an important role in helping to construct the kinds of people who inhabit the landscape of what Rose (1999) has called 'advanced liberalism'. A complex tapestry of forces involving the social sciences, medicine, criminology, educational studies and New Labour policy makers, have

combined to create a situation where new forms of sociality and personhood can emerge.

In line with scholars such as Rose, we suggest that the matrix of policies, initiatives, legal frameworks, research and information calls into being new phenomena that can become socially effective agents in their own right. The changing climate of HE could be argued to have created novel forms of consciousness, obligation and responsibility for HEIs and their staff. The addressing of human failure is shifting from what Foucault (1975) called 'the clinic' into other sites and moral surfaces. These have included prisons (Davies, 2004a) and, most importantly for our present purpose, the education system. These discourses of obligation, dysfunction and inclusion, have played a very significant role in making up our educational world in the 21st century, and the persons, phenomena and entities that inhabit it.

We live in a culture where the private conduct and distress of the individual is a matter for political intervention. Not merely the sicknesses of human beings, but also their personalities, intellectual capacities, passions, 'employability' and the forces that mobilize them – their 'identities' themselves – now appear at least potentially to be explicable in terms germane to the policy maker and educationalist, and increasingly in terms of their potential to benefit from inclusion in the education system. The learning age is relentlessly inclusive.

The process by which education struggles to create a particular mode of formulating and dealing with human problems has a specific genealogy that can be traced through the past 250 years. The present debate is contemporary through and through, yet it alludes to anxieties and hopes surrounding the process of education which have shaped discourse on the subject for many decades.

At the same time there is increasing evidence that the benefits of having a degree are not accruing readily to the individuals involved. Taylor (2005), using statistics from the Higher Education Statistics Agency (HESA) demonstrated that, six months after graduating, only 12 per cent of graduates had gone into 'traditional' graduate occupations, including medicine, higher education and science; 29 per cent had gone into either 'modern' or 'new' graduate jobs such as management, information technology, marketing and sales management; and 38 per cent were working in non-graduate employment.

The level of debt students carry away with them from their studies is reported to be rising. Present average levels are believed to be between £12,000 and £13,000 (Grant, 2004; Halpin, 2004) with

students in London graduating with debts of £20,000; considerably more than the reported average £17,000 annual salary of a UK graduate (Taylor, 2005).

This reveals a curious tension. Education is charged with the role of keeping people healthy and strengthening families, as well as building independence and confidence and combating exclusion. Yet there are a growing number of reports to the contrary. The contemporary university graduate is debt ridden and is often unable to secure employment of a kind that allows any prospect of independence and self-reliance.

Students and their well-being: political *Sturm und Drang*?

There are a number of bodies, reports and articles that are raising concerns about the psychological well-being of students in HE (Andrews and Wilding, 2004; Rana et al., 1999; Roberts et al., 1999; Royal College of Psychiatrists, 2003; Stanley and Manthorpe, 2001; Stewart-Brown et al., 2000). This set of concerns goes back a decade, and can perhaps be dated from warnings initially raised about mental health problems in UK university students by Phippen (1995) who found that 85 (56 per cent) of the 152 counselling services surveyed reported an increase in the proportion of seriously disturbed students seen. This report was instrumental in shifting attention and resources to the needs of this group. At the same time another key element in the picture originated, in the form of the Disability Discrimination Act 1995, which defined disability as a physical or mental impairment and required HEIs to ensure that their admission procedures avoid discrimination, but also to develop reasonable provision for disabled people.

The catalogue of accounts of students' mental heath problems is substantial. The National Union of Students identifies leaving home, debt, new relationships and the stresses of study as leading to psychiatric problems. A relatively small proportion of students develop schizophrenia, whose peak age of onset is between 18 and 30 years, and is purportedly made more likely by stress. More common are anxiety-based problems, affecting 46 per cent of male students and 64 per cent of female students, one in ten of whom are also estimated to be bulimic (Crompton, 2004).

This survey of opinions and evidence is necessarily cursory, but it should suffice to show that by the time Professor Smith had made his comments in May 2004, the UK's HE system had perhaps already become intimately involved in the practice of social welfare, catering to some of the most economically fragile and psychosocially vulnerable citizens in the UK. It has become an under-resourced branch of the social welfare system, expected to cater for some of the most deprived groups in society whose welfare has been systematically neglected for generations.

In addition to the evidence we have mentioned already of relatively high levels of mental health morbidity in the student body, there is a growing raft of evidence that the mental health of young people in the UK as a whole is getting progressively worse. Collishaw et al. (2004) reported the results of an analysis of the data from three major studies, concluding that substantial increases in emotional problems and conduct disorders had occurred in the 25-year study period. These differences could not be accounted for by different methods of detecting and reporting problems, but instead reflect a broad secular trend. Thus, people entering the education system are more volatile and vulnerable.

New Labour policy on HE and social inclusion currently suggests that people with mental health problems may benefit from HE and should be encouraged to participate in this to combat social exclusion, because education can 'build self confidence and social networks' (Social Exclusion Unit, 2004: 28). Yet this contrasts with evidence of exactly the opposite taking place in the HE sector. The substantial and increasing presence of mental health problems in HE has been documented by scholars and professional bodies (Royal College of Psychiatrists, 2003), although whether this is because more students are developing mental health problems during HE, or because more students with pre-existing mental health problems are entering HE, is unclear.

This phenomenon is reflected in many HEIs' policies and services. Whereas HEIs have for some time typically provided counselling services for students, some now employ other mental health professionals and have structures in place to support students with mental health difficulties such as sheltered accommodation. Many have detailed policies relating to students with mental health problems (e.g., De Montfort University, 2004; University of Nottingham,

2004; University of Wales, Bangor, 2004). Some institutions have dedicated mental health support workers as part of the university team, such as Nottingham Trent University. Government policy implies that the socially excluded mentally ill could and should benefit from education. We will look at the reactions to and possible consequences of this later.

Education and well-being: a convoluted history

First, let us turn our attention to the history and genealogy of ideas linking mental health and education, for this can help illuminate 'the conditions under which our current forms of truth have been made possible' (Rose, 1996: 106). Like Foucault, Bourdieu too was convinced that the history of ideas contained the keys to understanding them:

> It is . . . from the social history of educational institutions . . . and from the history of our singular relationship to these institutions that we can expect some real revelations about the objective and subjective structures (classifications, hierarchies, problematics, etc.) that, in spite of ourselves, orient our thought. (Bourdieu, 2000: 9)

The history of links which have been hypothesized between mental health, or as it was usually spoken of, mental illness or madness, and education is a long and convoluted one. George Cheyne (1733) seemed to believe that the alleged prevalence of 'nervous disease' among the English was due to their intellectual and cultural superiority, thus ushering in an era of anxiety about the likely effects of education which persisted through the Enlightenment and into the contemporary era.

The links between mental illness and education are particularly prominent in the discourses pertaining to Victorian ideas concerning psychiatric disorder. Two opposing schools of thought are documented. The dominant one for many years suggested that education was detrimental to mental health and indeed could cause serious mental illness. Hawkes (1857: 509), while talking about the prevalence of insanity around him, noted: 'a higher pressure is engendered on the minds of men and with this, there appears a tendency among

all classes constantly to demand higher standards of intellectual attainment, a faster speed of intellectual travelling . . .'.

The discourse that education was hazardous to health was famously applied to women's mental health problems. Feminist writers working in this area have observed that as middle-class women were beginning to organize and demand access to HE (among other things), during the period 1870 to 1910, there was an epidemic of anorexia nervosa, hysteria and neurasthenia (Bordo, 1993; Showalter, 1987). 'Nerve specialists' were perceived to oppose women's efforts to change the conditions of their lives (Showalter, 1987). However, there was a dissenting view, promoted by some early 'mad doctors' and many (female) patients, that education, or academic or intellectual work, would assist patients in their recovery. As Showalter (1987) reports, at Murray's Royal Asylum in Perth, the 'better-class' patients had access to a series of lectures on 'The Natural History of Zoophytes' and 'The Authenticity of Ossian's Poems'. The less privileged patients lectured each other on galvanism, the blood, time, and economic botany. The reforming doctor John Conolly believed in educating the mentally ill as part of his wider 'moral management' philosophy. At Hanwell Asylum, where Conolly was superintendent, illiterate patients were taught how to read and write, and classes in geography, drawing, singing, natural history and arithmetic were held (Showalter, 1987). Interestingly, some people belonging to the 'moral treatment' school of managing madness did believe that the intellectual limitations of the allotted female role of the time and women's restricted education were causal factors in women's mental illness (Browne, 1837; Conolly, 1847).

This view that women's lack of education was responsible for their difficulties was not a common one among later 'nerve specialists', many of whom believed that women pursuing education and work would suffer from disorders such as anorexia nervosa, hysteria, neurasthenia and sterility. The eminent psychiatrist Henry Maudsley maintained that adolescent girls would suffer permanent damage to their reproductive systems and brains as a result of intellectual training (Maudsley, 1874). At the end of the 19th century Clouston gravely counselled that in women 'all the brain energy would be used up in cramming a knowledge of the sciences and there would be none left at all for . . . reproductive purposes' (Clouston, 1898: 582). However, in the later part of the 19th century, there were a small number of women doctors who had qualified who were defending HE

for women, such as Elizabeth Garrett Anderson, although some women physicians also attributed illnesses such as neurasthenia to intellectual ambition.

One reaction to the notion that intellectual work contributed to mental illness was Silas Weir Mitchell's 'rest cure' for neurasthenia, in which the patient (usually female) was confined to bed and forbidden to do just about anything, certainly reading, writing and studying (Poirer, 1983). These ideas are examined in fictional writing of the time, particularly feminist literature written by women such as Charlotte Perkins Gilman, or a few decades later, Virginia Woolf. Both these women dreaded the 'rest cure' and believed that their recovery would be aided if they partook of academic work.

It was so clear to some that education caused insanity in women that one Dr G. Fielding Blandford simply stated the cause of insanity as being 'over-education' on one 'urgency order' (Showalter, 1987). Interestingly enough, when British doctors were faced with the problem of treating 'shell-shocked' soldiers from the First World War, it was realized that the rest cure was not appropriate for them, activity being more beneficial. Thus Siegfried Sassoon was encouraged to publish his poems whilst in hospital. In the 20th century too, there was a growing sense that women might benefit from educational work or writing as this would inscribe order on their troubled minds. Anne Sexton was encouraged to write poetry by her psychiatrist, for example (Middlebrook, 1991).

There is therefore a long tradition of viewing education as curing, or causing, mental illness. The picture is complicated by other factors, such as the prevailing culture and considerations of appropriate behaviour, but there are clearly links. These links have resurfaced and this historical introduction has sought to demonstrate how the ideas that education is a source of succour and stress, deliverance and damage have been incorporated – almost in a Bourdieuian act of 'inclusion' – into the field of theory and practice today.

It is by assimilating this history that the present field of debate can come to have its commonsensical appearance. It becomes a matter scarcely questionable that education and mental health are allied, and that usually this is a positive relationship. This history inscribes as a matter of common reason that education, progress and enlightenment must function in the same direction, and that to demur from this position is evidence of traditionalism, misogyny and elitism.

Government policy: New Labour, new responsibilities

The inclusion of such a history into the field of policy and practice in mental health care has helped to legitimate some profound changes in government policy in relation to both HE and mental health care since the early 1990s. In a sense then, there have been some important requirements for legitimation. What is thinkable and unthinkable, valuable or worthless, is the product of the field of policy in the Bourdieuian sense. This affects with great rapidity the structures within which ideas and policies arise and the principles of thinking that govern and legitimate their operations. This legitimation establishes an orthodoxy or doxa (Bourdieu, 1977: 164–71) where it is entirely reasonable to suppose that education has benefits for the individual and for the nation, and that education enhances mental health and indeed, that education may circumvent the need for mental health care at all. In this way policy makers have presided over shifts in the topography of the field and 'the determinations they impose upon the occupants, agents or institutions' (Bourdieu and Wacquant, 1992: 72–3).

Many more universities were created post-1992 by the conversion of polytechnics and HE colleges to universities. Many more people have been encouraged by the Blair administration to engage in HE with the government setting a target of 50 per cent of people aged 18–30 to undertake HE by 2010. The policy of widening participation has resulted in diverse social and cultural groups engaging in HE who have not traditionally done so (DfEE, 2000). Although much publicity has been given to the issue of lower socio-economic groups participating in HE, efforts have also been made to include more people with disabilities in HE, including people with mental health problems, a group that were never previously considered to succeed in HE in any great number. Widening participation and the advent of mass HE has had a profound effect on the HE system, changing its ethos, sense of purpose, and the kinds of mindsets demanded of its participants.

The mental health care system has also undergone a revolution over the same relatively short period of time. Although many would argue that the provision of mental health services is far from adequate (CHI, 2003), policy makers now seem to be seeing mental health care very differently. Policies of moving people with mental health problems out of institutions and into 'the community' have existed for

many years, yet even as late as 1991, the Department of Health did not consider that education was an appropriate part of the remit of responsibility in the provision of 'care'. Austin (1999: 255) quotes a communication from the Department of Health:

> Local health and family health service authorities are required from next April to produce community care plans addressing the needs for care services of the local population. These plans will not deal with further and adult education as this is not encompassed in the White Paper, Caring For People . . . While I understand your view that further and adult education colleges could be said to provide some 'day services' in certain instances, the view that the D.E.S. and D.H. takes [is that it is] not appropriate to include them within the community care remit.

By 1997, however, the climate had changed considerably: 'Specialist mental health services . . . need to work closely with the agencies responsible for housing, income support, education, employment, training and leisure . . .' (Department of Health, quoted in Wertheimer, 1997: 151). The field thus underwent a shift, such that a remit that had once been confined to health care providers and had not included educational institutions in 1991, had by 1997 expanded so that education was explicitly made a part of the matrix of care available to people with mental health problems.

More recent New Labour policy documents, relating to both HE and mental health, reflect this change in attitude. The government's White Paper, *The Future of Higher Education* (DfES, 2003), talks of the role universities and colleges have to play in 'expanding opportunity and promoting social justice' (p. 4), creating a 'more enlightened and socially just society' (p. 10), and embracing 'social inclusion' (p. 20). It maintains that education is 'the best and most reliable route out of poverty and disadvantage' (p. 68), and states that education must attract and retain 'vulnerable students' (p. 71).

The Special Educational Needs and Disability Act 2001 also now applies to HEIs, making it unlawful for them to discriminate against disabled students and prospective students, including students with mental health problems. It is clear that the role of HE is no longer confined to educating or even educating and training – it is also a force for social change, and change in the purpose, role and identity of the people who pass through it.

This, like any good Bourdieuian field, is cross-referenced and cross-alluded, so the various components in the matrix sustain one

another. The spirit of the Blair government's education White Paper dovetails neatly with New Labour documents concerning mental health policy. The *National Service Framework for Mental Health* (DoH, 1999) talks of reducing the discrimination and social exclusion that is perceived to be associated with mental health problems. The Department of Health campaign 'Mind Out for Mental Health' ran between 4 January 2002 and 31 July 2003 and was aimed at tackling the stigma and discrimination faced by people suffering from mental health problems and promoting their social inclusion. Campaign material contained a number of references to the necessity of enabling people with mental health problems to access education.

The document *Mental Health and Social Exclusion* (Social Exclusion Unit, 2004), also deals with education for people suffering from mental health problems, in terms of both further education (FE) and HE. It is stated that 'participation in learning can have a positive effect on mental health' (p. 80), detailing 'acquiring new skills, feeling more empowered and having a greater sense of purpose, being viewed more positively by others, establishing new friendships, access to better jobs, better housing and easier access to leisure pursuits' (p. 80). It maintains that 'a lack of qualifications can cause and reinforce social exclusion for people with mental health problems' (p. 80), that we need to 'promote access to adult learning, further and higher education' (p. 105) and that educational institutions need to raise awareness, and to develop good practice and effective support for students. The logic then is irrefutable. To hesitate on this helter-skelter is to mark oneself as a reactionary, an elitist or the harbinger of the very kind of stigma or exclusion these policies seek to obviate.

The Social Exclusion Unit (2004: 106) further counsels that:

> Further and higher education institutions will review and make appropriate adjustments to their systems for raising awareness among all staff about issues for students with mental health problems, to ensure that no student is disadvantaged in their access to learning and services.

The Universities UK (2000) guidelines on student mental health make recommendations on developing policies and procedures across individual institutions and recommend raising awareness of relevant legal and 'duty of care' issues, as well as facilitating access to support and guidance services, the provision of training and development opportunities and the greater use of liaison between internal and

external agencies. Staff in HEIs are increasingly being made responsible for ensuring that the changes are implemented, not only in terms of institutional frameworks, but also on themselves, as they are reconfigured into hyper-aware inter- and intra-institutional communicators, securing the safety and well-being of students.

The follow-up document about suicide prevention (Universities UK, 2002) is even more explicit about the duty of care to universities, and their responsibility to ensure that they are health promoting institutions rather than ones that erode the coping resources of students, and the desirability of welfare and counselling services working with statutory mental health services is promoted (p. 18). Tutors and academic staff monitoring student attendance and studying the appearance and demeanour of students to detect any changes are recommended as good practice (p. 17).

Thus, HEIs and their staff are seen as key players in fighting the social exclusion that people with mental health problems face, in keeping them on their courses and indeed in keeping them alive. New forms of scrutiny are unfolded, where universities are checked against their statutory and moral responsibilities and staff encouraged towards a role that involves scrutiny of not only students' academic capabilities, but also what they say, do and look like.

HE staff are thus called upon to monitor and transform the personal and subjective capacities of the students. They are, in the tradition of New Labour political discourse identified by Fairclough (2000), individualized and made responsible. Virtually absent is any consideration of structural, economic or political forces that might conspire to make people vulnerable or distressed, or reduce their material powers. These are reduced to the binary of social inclusion versus exclusion, and oppression is reduced to its anodyne counterpart, 'stigma'. To anyone accustomed to looking at societies as if they were structured in terms of economics, politics, power and social stratification, this might appear to be an extraordinary transformation.

To such a critic it might appear that HEIs and their staff will have an uphill struggle – not necessarily because of any assumed intractability of 'mental illness' itself, but because of the sheer weight of forces ranged against those unfortunate enough to have acquired such a label. The point of mentioning this is not to suggest any simple superiority of one view over another, but to highlight how the picture of policy is artfully constructed to align itself 'naturally' with what we

had always hoped to believe about 'human nature'. In a Bourdieuian sense, it has been legitimated (Bourdieu, 1977).

Higher education today and students with mental health problems

The Royal College of Psychiatrists (2003) noted that 'students with pre-existing mental health problems are entering universities in greater numbers' (p. 24), that the 'number of HE students presenting with symptoms of mental ill health has increased in recent years' (p. 6) and that 'student counselling services in the UK report that increasing numbers of students are presenting with mental health problems of increasing severity' (p. 20). Although they found that 'major' psychiatric disorders are under-represented in the student population, students were found to have increased symptoms of mental ill health compared with age-matched controls.

The report maintained that a number of factors combine creating an environment in which students with pre-existing mental health problems may be at greater risk of illness, and even those who do not have psychiatric problems on entry to HE may become more vulnerable to them. Implications for the government's widening participation policy are also present in the findings of the report. It is noted that 'Students from less privileged backgrounds are more likely to suffer mental ill health' (p. 24) and that it is 'likely that the increased intake of students from less privileged and more disrupted families and communities . . . will be associated with an increase in the prevalence of mental disorder' (p. 25).

Again, there is inconsistency as to whether HE helps or hinders people with mental health problems. The report states that 'in certain cases, entry to higher education is an important part of a patient's recovery from psychiatric illness' (p. 11) and that 'positive aspects of student experience are powerful factors in promoting the self-esteem, resilience and sound mental health that protects against psychiatric disorder' (p. 12). Yet the report also talks of the 'well-known stresses of university life' (p. 24) (e.g. pressure for academic achievement, time management, financial constraints, social relationships, loneliness and homesickness), and notes that these increase the likelihood of breakdown in students with pre-existing mental health problems.

Mounting evidence is beginning to suggest a far greater degree of hardship and personal distress amongst students than was previously suspected. It is difficult to reconcile this with the picture of personal advancement, enhanced 'self-esteem' and social inclusion accomplished through education painted in *The Learning Age* (DfEE, 1998). There is evidence that the stress of university life is increasing. Garner (2004) reported in the *Independent* research carried out at the University of London, which found high levels of stress among students, leading to anxiety and depression, attributed substantially to students' financial difficulties.

As the difficulties of student life increase, the legislative framework supporting the access of students with pre-existing mental health problems to post-compulsory education has been interpreted and implemented with growing zeal. In the late 1990s then, the full implications of disability discrimination were increasingly appreciated. Wright (1998: 5) referred to 'the changes in the legal, funding and educational frameworks [which] create a new agenda for institutions of changed responsibilities and expectations' in the context of the 1995 Disability Discrimination Act. Rana et al. (1999) note that the Disability Discrimination Act 'is already perceived as increasing the numbers of disabled students entering higher education, including students with mental health problems, and this augers major changes for many universities' (p. 4).

Neville Harris (2004a), Professor of Law at Manchester University, argued in *The Times* that universities owe students with mental health problems a legal duty of care in terms of pastoral care and welfare, claiming that underperformance of pastoral duties by a university could give rise to contractual liability and that students threatened with exclusion from their course when their needs prove too difficult for the university to manage, may have an enforceable right. This is believed by Harris (2004b) to be part of broader concerns of citizenship and inclusion. Despite the possibly substantial ramifications of the use of litigation by students, the full implications of the Disability Discrimination Act and European Human Rights legislation have yet to be completely brought to bear on the universities.

The trend then is for existing legislation to be interpreted in a way that is increasingly supportive of students with difficulties and their carers in accessing post-compulsory education. This contrasts with hospitals, general practitioners (GPs) and psychiatrists who are

increasingly exercising their options to refuse to treat patients who are perceived to be too difficult or costly or who would put the institution at odds with the 'challenging new targets' which are being imposed (Carr-Brown, 2003; Carvel, 2002; Davies, 2004b).

Higher education as part of the welfare system?

There are signs that HEIs are not simply admitting increasing numbers of students with mental health problems, but are responding to their needs in quite major ways. HEIs have for many years provided health care facilities for their students and in recent years many have expanded such facilities to include counselling services. However, now a number of HEIs have extended their provision to cater specifically for students with mental health problems. Nottingham Trent University, Loughborough University, South Nottingham College and Loughborough College have joined together to create a particularly well-developed system of support for such students, concerned with the development of transition initiatives. Workers at Nottingham Trent University support students with mental health difficulties through their studies. Other institutions also provide support in conjunction with the statutory services. Some HEIs are now employing professionals such as community mental health nurses. Similar trends can be seen in FE colleges, where students supported in this way can move on to HE.

In the late 1990s and early 21st century the UK's higher education funding agency, HEFCE, funded a number of projects at different institutions to develop and promote what was seen to be good practice in dealing with mental health problems. This included initiatives at Nottingham Trent, Leicester, Lancaster, Teeside and Hull. The initiatives involved a number of activities including surveys and focus group exercises to determine the principal threats to well-being, the development and provision of information in leaflet, booklet and/or electronic form, as well as training programmes. A great many schemes sought to 'raise awareness', either in terms of the identification of problems on the part of students, or of HEIs' legal obligations.

However, although many HEIs are making valiant efforts to respond to the needs of students with mental health problems and there are some examples of meticulous and dedicated practice, an

increasingly austere resource base is blighting the potential rehabilitative and therapeutic effects. Although individual institutions may want to support students with mental health problems, finances are now very strained indeed and academic staff, who often bear the brunt of supporting mentally ill students, are now faced with a vastly increased workload (Stanley and Manthorpe, 2001). If an institution has the resources to run training sessions for staff in working with students experiencing mental health difficulties, many staff will find that the time available has been eclipsed by teaching duties, meetings to improve 'quality' or answering the stream of queries from distressed students themselves. Furthermore, models of training used to educate mental health professionals are not commonly used to educate HE staff on such courses and the awareness raising often employed is not adequate to create an environment for experiential learning. The reality is often a mental health booklet/policy provided on the HEI's intranet for any member of staff motivated to read it.

HEIs are under-prepared and under-resourced for the task of dealing with increasing numbers of students with mental health problems. The whole drift of the advice makes a number of assumptions about the enigma of distress and phenomenologically diverse experience, and presupposes that they can be addressed through an awareness-raised, leaflet-rich, protocol-driven, good practice-enhanced regime. This much is often taken to be commonsensical, but, like generic models of good practice in teaching itself, a moment's reflection suggests that these are merely assumptions which might well prove to be rather fragile in the face of critical scrutiny (Grenfell and James, 2004).

The extent of the HE sector's preparedness in the early years of the 21st century has been documented by Stanley and Manthorpe (2001, 2002). The impression is that of educational establishments struggling to accommodate the needs of vulnerable students. The ethos of self-reliance and independence on which institutions have hitherto relied is counterproductive when students in difficulty are reluctant to seek help or the help that might be available is inaccessible. Indeed, in some cases, for example where courses lead to qualifications in the health care professions, students may be highly motivated to evade 'help' entirely, lest it affect their career prospects (Chew-Graham et al., 2003).

HE staff have themselves felt ill-equipped and under-prepared for the caring role in which the presence of distressed and vulnerable

students places them. There was also concern that HEIs and society as a whole were avoiding the issue of providing appropriate care for students by means of an expansion in the pastoral role of staff, over and above the traditional role of academic guidance. As one of Stanley and Manthorpe's respondents put it: 'I find I have to do considerable "counselling" myself and I think that the university should not put so much pastoral care onto academic staff on the cheap' (Stanley and Manthorpe, 2001: 47).

Academic staff also highlighted a lack of time to deal with students' distress adequately, a finding which echoes that of other surveys (Wassall, 1999). A crucial difficulty is that there is little effective liaison between HE academic staff and other health care agencies such as GPs, community mental health teams and staff in hospitals, who, even if they could be located, were often not forthcoming, perhaps due to the pressures within their own organizations or concerns over confidentiality. Stanley and Manthorpe (2001) report that contact with university counselling services was often easier to initiate, yet there were nevertheless concerns about the difficulty in ascertaining the progress a student might be making, as a result of the need to maintain confidentiality.

Hence, the picture painted in these investigations of the preparedness of HEIs to accommodate students with mental health difficulties is that there is some considerable way to go before the services are established to an appropriate level. In many institutions the pathways to a 'joined up' service such that academic and mental health care services can operate seamlessly and provide care for vulnerable people are fragmented.

Given the difficulties we have identified, it might be wondered whether there is a financial or political incentive behind the growing trend towards the containment of distress, psychosocial difficulties and 'mental health problems' in educational institutions. Perhaps one part of the answer can be found when we scrutinize funding arrangements for students. Education looks cheap yet functional, especially as funding arrangements have increasingly been reconfigured so they do not appear to burden the public purse. Successive governments, including New Labour, have been successful in substantially reducing financial support for students. Full-time students in HE now have to contribute varying amounts to their tuition fees, which already may exceed £1,000 per year, and are very soon set to rise considerably.

In an effort to combat hardship in a small number of cases, in September 2004 the government introduced the Higher Education Grant, a non-repayable means-tested grant of up to £1,000. To be eligible for the full amount, the household income of the student needs to be less than £15,200. Students with a household income above £21,185 are not eligible to receive the Higher Education Grant. The only other means of support available to most students, at the time of writing, no matter how impoverished, is the repayable student loan.

In the light of this, many HEIs themselves are in the process of developing scholarships for some disadvantaged students. To be eligible for other state support, students have to demonstrate special circumstances, for example by having dependants, or disabilities. Some students with mental health problems are technically eligible for Income Support, Incapacity Benefit and Disability Living Allowance. Anecdotal evidence from disability advisors suggests such claims from students are rarely successful, because regulations state that claimants must be 'incapable of work' or 'substantially incapacitated'. Students who are able to demonstrate that they have a disability may be eligible for the Disabled Students' Allowance from their Local Education Authority. However, anecdotal evidence from some university disability advisors suggests that their experience with people seeking to obtain the Disabled Students' Allowance for mental health problems is that this is often very difficult. Thus, in the case of students with mental heath problems, the financial situation is more austere than if they were unemployed or supported through incapacity or sickness benefit.

This intersects in complex ways with other recent popular and political anxieties about the 'cost' of sickness and disability themselves. The growing numbers of people claiming long-term incapacity benefit in the UK have yielded increasing concern in popular and political circles, and after announcing a 'war on welfare' in late 2004, at the time of writing (February 2005), Tony Blair is beginning moves to cut the bill for incapacity benefits, estimated to exceed £7 billion a year (Wintour, 2005). It has been suggested in a number of spirited features in the *Daily Mail* that 'bogus' claimants have been tempted to give up work because of 'generous' sickness benefits, and journalists charged that many of these people are feigning illness (Reid, 2004; Wilson, 2005).

To a government faced with the need to address this self-defined political problem, education – with its much vaunted power to increase people's employability and decrease social exclusion – might be especially attractive. Whilst the process of persuading people with mental health problems on to courses in educational establishments is largely done through low-level individualized intervention by their key workers, the overall outcome of such a policy is to lessen the number of potential claimants of sickness and disability benefits per se and transfer them into another segment of the economy where they are as yet invisible to journalists and place a less obvious burden on the public purse.

Although some 'flagship' schemes that have been set up with extra funding in some HEIs are supplying some students with assistance such as support workers, most institutions are not able to provide such help. Neither is there any indication that the funding that is currently being employed to sustain people on incapacity and sickness benefits will be redeployed to support initiatives within the education system.

There is also little to assess the 'success' of students experiencing mental health problems who enter HE. In many cases there is no follow-up to assess the student's outcome and in other areas follow-up is widely believed to be inadequate. However, some statutory services perceive a mental health worker as having been 'successful' if one of the clients they have worked with enters HE, and at a local level this is believed to be driving the migration of existing clients into the education system. Despite a widespread belief that this is beneficial, there is instead, as we have seen, growing evidence of the fragility of student mental health.

Thus New Labour's policy of encouraging people with mental health problems to enter HE is encouraging them into a situation that is demonstrably likely to yield deterioration in a person's mental health rather than improvement. Despite a policy advocating the inclusion of service users' voices in the formulation of strategy and service planning, as in the *National Service Framework* (DoH, 1999), there has been no discussion in public fora about the desirability of this policy. Hence, parties such as the HEIs, the statutory services and most importantly, people experiencing mental health problems themselves, have not had an opportunity to comment on the problems or success ahead. It is as though this policy has been smuggled in by the government with no open debate and very little media coverage.

However, there is another feature of the debate in the popular media and in political fora where education is at issue, and that is the concern about the possibility of dilution of quality in the light of widened participation in the sector. The presumed lowering of standards or 'dumbing down', combined with the allegedly widespread existence of 'Mickey Mouse' degrees, became especially intense following remarks by minister Margaret Hodge and historian David Starkey, and charges of undesirable 'social engineering' have been made as some in the HE sector express reservations about the New Labour government's attempts to widen participation in HE (Brockes, 2003).

This places an additional constraint on the manoeuvres that can be undertaken by HEIs and staff in them. The pressure to demonstrate the integrity of one's educational provision co-exists with a pressure to widen access and improve progression and completion rates. The HEIs then are left to struggle between the Scylla of accusations of elitism and failure to expand access or make provision for students in difficulty, and the Charybdis of concerns that they are inattentive to academic standards. Of course, there is no inevitable connection between wider access to HE or a kinder environment for those in distress and lower standards. However, sustaining the complex balancing act of getting the best from an increasingly vulnerable and distressed student body is one which universities will surely not be able to pull off indefinitely.

Conclusion: policies, consciousness, legitimation

However the policies are deployed, whether through widespread reform or individual action, a number of theoretically significant features should be noted. This is a policy which is of relatively recent origin but one which appears to have a long and commonsensical pedigree which offers it a degree of legitimation. It is thus unapologetically identified with progress, reform, equality, modernity and with the abolition of stigma and with the gain of apparently desirable personal qualities. It fits neatly with currently modish political discourse to the effect that individuals themselves can be recapitalized – made more employable, have their self-esteem raised, their networks strengthened and their employability enhanced.

This phenomenon also demonstrates how the field in which the various actors play out the drama of mental health and illness in relation to HE has made new things visible and what was once private distress and personal conduct is now a matter of policy, legislation, socially, morally and legally mandated obligation, and changes in the mindset and inferential framework of HE staff are encouraged. This again is done in such a way as to appear commonsensical. After all, who could possibly disagree with helping to prevent suicide, or facilitating people with disabilities to access HE? Yet these changes have populated the educational landscape with new phenomena:

> What was fundamentally invisible is suddenly offered to the brightness of the gaze, in a movement of appearance so simple, so immediate that it seems to be the natural consequence of a more highly developed experience. (Foucault, 1975: 195)

This process of legitimation is concerned with making it look as if we have just learned to see things clearly after years of being bound by prejudices: 'free at last of theories and chimeras, the newly enlightened professional can approach the object of . . . experience with the purity of an unprejudiced gaze' (Foucault, 1975: 195). As Rose puts it: 'the personal and subjective capacities of citizens have become incorporated into the scope and aspirations of public powers' (Rose, 1989: 1).

This new policy landscape, this psychologization and individualization of the ways in which professionals, policy makers, service users and students themselves are encouraged to think about the situation, means that Rose's words – originally written to describe the role of psychology in helping to create the forms of modern life – are equally applicable now to the HE system. As Rose says:

> we need to trace out the ways in which psychological modes of explanation, claims to truth, and systems of authority have participated in the elaboration of moral codes that stress an ideal of responsible autonomy, in shaping these codes in a certain 'therapeutic' direction, and in allaying them with programs for regulating individuals consonant with the political rationalities of advanced liberal democracies. (Rose, 1996: 119)

In terms of practical policy recommendations we have deliberately remained agnostic. It is clear that education and social welfare have been intertwined for many years and that separation of the two

functions may be neither desirable nor possible. Equally, there are examples of successful inclusion and good practice, but little impression of a sustained and fully debated growth in knowledge.

Our major recommendation, then, is that if the social welfare role of education is being expanded, we should at least do this through a fully informed debate involving all stakeholders, within which the best available knowledge of successful practice should be disseminated. If it is decided that this is a desirable policy, then it is clear that staff in universities will require resources and protected time in the academic calendar in which to undertake this effectively. To such a body of people, the provision of 'training' may well appear patronizing and divisive, so perhaps more could be achieved by piquing their curiosity about how best to improve the experience of students and affording them the opportunity to inform themselves.

In this way, perhaps we could move in a more fully informed way towards a model of HE where staff were able to be supportive towards students in distress and we were able to grasp more fully the implications of undertaking a greater proportion of welfare work in educational institutions.

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