

# Students & Mental Health Resource Pack

Produced by - [www.rethink.org/at-ease/](http://www.rethink.org/at-ease/)



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**rethink**  
severe mental illness

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## Students and Mental Health Resource

### Introduction

The IRISS project was set up in October 1993 as a joint venture between the **National Union of Students (NUS)** and the **National Schizophrenia Fellowship (NSF) (now Rethink)**. The project was a response to the perception of both organisations - from their different perspectives - that mental illness was a considerable, but largely hidden problem amongst students, and likely to increase given the increased pressures placed upon students and the developments that have taken place in higher education recently. There was also concern that mental illness was contributing to the worrying levels of students' dropping-out of their studies and the rise in suicide and attempted suicide amongst that population.

IRISS broadly aimed to achieve two things:

- To increase mental health awareness and dispel the stigma commonly attached to mental illness.
- To further develop the support available to students with experience of mental health problems and those who became ill for the first time at college.

The resource pack centres around six chapters which cover the most frequently requested topics and offers a basic introduction to the issues concerning mental health in education. These chapters are also intended to encourage discussion and should be used in conjunction with recommended reading and videos.

We hope that people with a diversity of roles within a variety of educational environments will find the contents relevant and thought provoking, and an effective basis for their own training. IRISS is no longer running but Rethink is still active in the student community. The @ease website <http://www.rethink.org/at-ease> is our latest resource.

Suggestions as to the usefulness of the resource will be appreciated by email at: [at-ease@rethink.org](mailto:at-ease@rethink.org) Alternatively, you can write to us at:

Rethink,  
@ease,  
4 - 14 Low Street  
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Your local Rethink group or project will also respond to your enquiries. To find out more about Rethink surf <http://www.rethink.org>

If you have a question or need advice, the National Advice Service is staffed by experienced advisors with in depth knowledge about all areas to do with mental illness. The service is open 10 am and 3 pm Monday to Friday and can be reached on 020 8974 6814. Alternatively, you can email them at [advice@rethink.org](mailto:advice@rethink.org)

NB This version of the resource has been adapted from the original.



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# Students and Mental Health Resource

## What is mental illness?

### 1.1 Introduction

In this resource we use "mental illness" as an umbrella term to cover a wide range of problems that are as varied in nature and severity as "physical illness". Mental health problems are, however, harder to detect and understand because, unlike most physical illnesses, the symptoms cannot be readily perceived and tested.

Mental illness affects one in four of the population at some stage of their lives. The range of problems include "severe mental illnesses" such as schizophrenia and manic depression, eating disorders such as anorexia and bulimia nervosa, depression, anxiety, obsessions and phobias.

More information about different mental health problems can be found in the Health of the Nation booklet, "Mental illness - what does it mean?"

### 1.2 Why are students vulnerable?

The figures for the population in general mean that 1 in 100 people will develop schizophrenia, the most common severe mental illness, before the age of 45.

It appears to be a characteristic of severe mental illness that it usually strikes during late teens and early twenties which means many members of the current student population could be affected.

So what makes students susceptible to severe mental illnesses such as schizophrenia?

#### Genetic influences

It is possible to predict to some extent whether an individual may be at risk by looking for diagnosed mental illness in members of their family. But hereditary influences are only one contributory factor - people with no family history of severe mental illness do become ill and the majority of people with a mentally ill relative do not fall ill.

To give some idea of the increased risk due to an inherited tendency, here are some generally accepted probabilities relating to schizophrenia:

- 1 in 100 of the general population will develop schizophrenia by

the age of 45, i.e. all of us have a 1% chance.

- If an individual has one parent with the illness, the probability of developing it increases to 1 in 10 (10%).
- If both parents have the illness, the probability of becoming ill increases to around 4 in 10 (40%).

These figures refer to a higher risk of developing the illness - not a certainty! Moreover, a child with an aunt or grandparent with schizophrenia is only slightly more at risk than someone without a relative who has schizophrenia.

### **Environmental factors**

To a large extent it is impossible to generalise about what may happen in a person's life which increases their vulnerability to mental illness. All of us experience times where life seems largely a succession of problems and we are familiar with feeling stressed and under pressure. Mental health problems usually arise in response to stress and there are several elements in student life which may act as this kind of trigger for someone who is susceptible to developing mental illness.

- **Living away from familiar emotional and practical support:** for most students going to college is their first experience of living away from the family home. Some people find it difficult to adjust and the pressure to make new friends, succeed in new studies and manage their own financial and practical affairs can be a great source of stress.
- **Financial problems:** many students now expect to finish their studies in debt - to the bank, to the student loans company and possibly to a credit card company as well. Student incomes are low, even when supplemented by part time work, and the pressures of combining studying with work can be considerable.
- **A poor standard of living:** the ability of colleges to offer their students decent and reasonably priced accommodation, food and leisure facilities varies enormously and many students may feel that they are left ill-prepared to manage on their own. Many students live in low or low standard accommodation in areas that are socially and economically run down. Many more will eat food that is cheap and convenient rather than nutritionally balanced and find meeting the costs of essentials such as fuel and clothing difficult.
- **Diminished graduate job prospects:** There is no doubt many students worry about a "job at the end of it all".
- **Academic / exam pressures:** succeeding academically has always been a concern, particularly at the start when many new students wonder if they can cope with the demands of a course. Exams are a traditional source of stress, particularly if the difference between a (2:2) and a (2:1) means the difference between a chosen career or postgraduate studies and having to rethink your future. In recent years when the competition for

many post graduate courses and graduate jobs has been so fierce, this is the situation facing many as they sit their final exams.

- **Friends / relationship worries:** finding a peer group is possibly one of the most important ways of establishing daily support whilst settling into a new life at college. Homesickness and problems adjusting to a new environment can be made worse by feelings of social isolation. Relationship problems can also be a source of stress, and whilst this is so in any context, these problems can be made worse by the "close knit" atmosphere of many student communities where people frequently live and work in close proximity.
- **Lifestyle, alcohol / drug abuse:** often student life provides the first opportunity to live independently away from the family and to "experiment" outside of a conventional "nine to five" lifestyle. Students frequently have irregular eating and sleeping patterns and combining these with a hectic social life and the demands of studying can be both physically and mentally detrimental. In addition, the use and abuse of alcohol and other drugs, can affect the mind as adversely as the body. This is not restricted to people with a "crack", "smack" or "coke" problem.

Frequent use of party drugs such as ecstasy, LSD, amphetamines and even cannabis have all been associated with Toxic Psychosis. This is similar to the psychosis found in severe mental illness, but which should respond to medication within weeks and not return as long as the person involved does not re-use the offending substance. It has, however, been suggested that a toxic psychosis can actually be the start of a long term mental illness in those who are genetically vulnerable, acting as an environmental trigger for a problem which might not otherwise have arisen for years - if at all.

It is also important to remember that mental effects of consistent and heavy alcohol abuse can be as difficult to cope with as the physical effects, and that drugs such as "coke" and ecstasy have their own problems relating to the anxiety and depression of coming back down to everyday life.

To find out more about NSF's public policy on schizophrenia associated with the use of street drugs or abuse of alcohol click here, [http://www.nsf.org.uk/who\\_is/public\\_policy.html](http://www.nsf.org.uk/who_is/public_policy.html).

### **The risk of suicide**

There has been growing concern about the number of student suicides although due to the subject's sensitivity and the risk of copycat attempts, there has been little publicity until recently.

In 1993 a report by a consultant psychiatrist into student suicides at Oxford University brought the subject to light. Between 1976 and 1990, 21 students had committed suicide and 254 had attempted suicide. Despite Oxford's prestigious reputation the report suggested that academic pressures alone were not a key factor, and generally

recommended that the educational and social pressures on students should be reduced. Around 1993 this led to the university increasing its counselling service, providing extra support and advice on study skills and introducing a more structured introduction to university life for freshers.

It was suggested that half of those Oxford students who committed suicide and a third of those who attempted suicide were suffering from psychiatric disorders or problems with personal or family relationships. It is difficult to know how much of a "special case" Oxford is in this respect as there is little data about student suicide outside of individual universities and colleges.

### **1.3 What is severe mental illness?**

This term usually refers to mental health problems which seriously disrupt a person's capacity to function in their everyday life and may endanger their own safety and those of others. Perhaps it is useful to think of mental health as a continuum ranging from the relatively mild anxieties, disappointments and frustrations of everyday life to severe problems affecting mood, the ability to think and communicate rationally, and even sensory perception. In an extreme case of mental disorder an individual may be psychotic and lose touch with reality to the extent of hearing and seeing things which are not there, and holding delusional beliefs. An individual can experience a psychosis due to a number of reasons but for most it will be part of a severe mental illness such as schizophrenia or manic depression.

The following are common symptoms of schizophrenia:

- **Thinking:** often people develop false beliefs which are usually without a rational basis, for example, becoming paranoid and thinking that people are conspiring against them; or that they are a famous person; or someone else can hear or control their thoughts. Thinking may also be generally confused and speech muddled.
- **Moods and feelings:** people may have moods and feelings which seem unrelated or are inappropriate, for example, they may state that they have lost their feelings or emotions, lose interest in family, friends and pastimes which they used to enjoy, or respond to sad news inappropriately.
- **Hallucinations:** most commonly people hear voices but they may also see, taste, smell or feel things which are not there.
- **Behaviour:** with the above possibly occurring it is not surprising that people experiencing severe mental illness often behave oddly, possibly becoming very withdrawn socially; apparently sleeping by day and wandering around at night; disappearing for days on end; or reacting and behaving in ways which are out of character.

## 1.4 Treatment and prognosis

Current medical thinking about the nature of severe mental illness concentrates on the chemical imbalances which occur in the brain when a person becomes ill. These imbalances can be corrected chemically by medication and the most severe symptoms alleviated. While there is no "cure" for illnesses such as schizophrenia, it seems likely that increasingly a number of people diagnosed as suffering from a severe mental illness will be able to lead more stable lives as more effective forms of medication are developed and advancements are made in the use of psychological therapies.

Although the majority of those diagnosed as having a severe mental illness will need to take some form of long-term medication, it is misleading to generalise about either the severity or the longevity of the illness. To take schizophrenia as an example: after a single episode accompanied by a diagnosis of the illness 25% of people will recover completely within 5 years; 50% will continue to display symptoms which fluctuate, often disappearing completely and then reoccurring over time; 15% will have severe, persistent problems and 10% will suffer a lifelong incapacity.

The capability for returning to a "normal" life involving employment, education, family and social life etc. varies enormously and it would be misleading to make assumptions about a person's capacity in any of these areas based upon a psychiatric diagnosis.



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# Students and Mental Health Resource

## What is mental health awareness?

### 2.1 Introduction

There has been great progress in terms of psychiatry's understanding and treatment of mental health problems. Popular knowledge has, however, generally not kept pace. Few people really understand in practical terms what schizophrenia, psychosis, psychopath or neurotic mean or what causes these illnesses. When mental illness does affect a person's life, either directly or via a friend or relative who becomes ill, they are thrown into a confusing new world of mental health services that can be very distressing.

At present there is much discussion between professionals, users of mental health services and their carers about the need to increase mental health awareness amongst the general population and to promote the recognition that mental health is an issue as relevant to every one of us as our own physical health.

Until mental illness affects our own lives, either directly or indirectly, most peoples understanding of it is based upon images portrayed in the media and the entertainment industries. In recent years many people will have heard the term "community care", read about Christopher Clunis stabbing Jonathan Zito, seen pictures of Ben Silcock climbing into the lions den at London Zoo, seen "Silence of the Lambs" and know that Van Gogh cut off his ear. But how much do any of these sources really tell us about the causes, nature and extent of mental illness?

### 2.2 Some facts about mental illness

#### Who are the mentally ill?

We know that approximately a quarter of the UK's population suffer from mental illness at any one time, but who are they? Research indicates that while mental illness can and does happen to anyone, it is more likely to be diagnosed in certain subgroups of the population.

#### Women

55% of those diagnosed as having a mental illness are female, although men are more likely to be referred for specialist psychiatric help. Once a psychiatric diagnosis has been made, however, women are twice as likely as men to be admitted to a psychiatric hospital and receive two thirds of all prescriptions for psychiatric drugs. (source: Journal of

Mental Health).

### **Ethnic Minorities**

There is controversy about the over-representation of people from ethnic minorities diagnosed as mentally ill. Generally levels of diagnosis seem disproportionate to the figures for the population as a whole. For example, rates per 100,000 for psychiatric hospital admissions in England and Wales in 1971 and 1981 showed that Irish people continued to have the highest rates of admission for all diagnoses.

For severe mental illness, however, the Afro-Caribbean population has the highest incidence. It has been estimated that they are between 3 and 12 times more likely to receive a diagnosis of schizophrenia. Afro-Caribbean's are also more likely to be compulsorily detained in hospital under a section of the 1983 Mental Health Act; more likely to be held on a secure ward or in a special hospital; and more likely to receive higher doses of medication.

### **The homeless**

It is estimated that around one third of those living on the streets are suffering from some form of mental illness.

## **2.3 Equal Opportunities - meaning and implication for those with mental health difficulties**

### **Discrimination**

Even today mental illness remains a taboo subject for many people. The subject is often considered not only embarrassing, but also shameful, and in the past many people with mental health problems were shut away from "normal" society.

Even with the developments that took place in psychiatric medicine in the 1950s, the stigma attached to mental health problems has remained. Lack of general understanding or awareness has meant that stereotypes of "nutters", "loonies" and "maniacs" have persisted in popular imagination and still pervade and shape the responses of people and organisations to those with a psychiatric history.

Unfortunately, this lack of understanding usually deters people from disclosing their psychiatric history as they feel that the response will not be sympathetic. In turn, their silence helps to perpetuate the "vicious cycle" of discrimination as their continuing stability is never seen to contradict the assumptions which necessitated silence in the first place.

People's reluctance to be honest about their psychiatric history can affect all areas of their life and can be extremely detrimental to their rehabilitation. Sadly this caution is often justified. The following are some of the areas where discrimination against people with experience of mental health problems commonly takes place:

## **Employment**

Application forms sometimes indicate that failure to disclose details of previous mental illness can lead to dismissal if later found out. Someone who has experience of a mental health difficulty may not want to identify difficulties on a form for fear of not being invited to interview. Once employed, this person may worry that they may be "found out".

## **Education**

Much of this resource discusses the need to encourage students and potential students to disclose their experience of mental health problems and for educational organisations to develop means of supporting both them and those students who become ill for the first time at college. There is no doubt that in recent years professionals in many further and higher education establishments have begun to initiate this process and implement real equal opportunities at a grass roots level.

## **Accommodation**

With the implementation of community care the majority of people with a psychiatric history are expected to live independently in the community. For those who have been living in institutions this will mean living at least for part of the time in group houses or hostels. Plans for such houses are often met with fear and hostility by local residents.

## **Insurance**

Although people with diagnoses such as schizophrenia can, for example, legitimately obtain a driving licence or go on holiday it is harder for them to obtain the relevant insurance as a psychiatric diagnosis is viewed, often incorrectly, as an increased insurance risk.

## **Social acceptance**

When members of their own family may be reluctant or find it difficult to talk openly about mental health problems, it is not surprising that people are reluctant to talk about their psychiatric history with others they do not know very well, and only disclose certain details at well chosen moments, if at all. The fear of social rejection can be overwhelming and for people whose confidence is already fragile the possibility of being rejected or treated differently if they disclose their psychiatric history, only increases their distress and potential paranoia.

## **Mental illness as a special needs category - appropriate responses**

Much of the fear surrounding mental illness stems from the extremely negative associations attached to labels such as manic depression, phobia, and obsessive behaviour etc. It is necessary to remember that mental illness affects ordinary people and it is impossible to generalise about actual causes or patterns of the illness. Behind the label is a person like everyone else, unique but ordinary. Although a student with mental health problems may need extra support and help, it is

important to remember that they are a person first and foremost.

However, for organisational reasons it is easier to deliver support as part of an organised system. That does not mean however, that support cannot be tailored to individual needs. The possible details of such a support system are explored fully in chapter 5, and the aim is to ensure that as far as possible a person's potential for educational achievement is not compromised by recurring mental health or related problems. In this sense, this group of students can be viewed like other minorities for example, overseas students, students who are single parents or have physical disabilities, who, due to special circumstances, may need extra support.

Some organisations may subsequently find it easier to view students with experience of mental health problems as a "special needs" category and implement provision in this context, others may find this too formal or inappropriate. It is something which is hopefully being discussed amongst staff and students of each organisation.

## **2.4 Mental health awareness in the educational environment**

So far we have discussed the need for mental health awareness both in society generally and at a very practical level in educational organisations. Outlined below are some suggestions of ways to increase mental health awareness, firstly in a day to day practice for students with experience of mental health problems, and secondly in terms of promoting awareness amongst students and staff.

Checklist for mental health awareness in day to day practice in your educational organisation:

- Is there an equal opportunities policy?
- Is there accessible information about mental health issues in conjunction with a source of support and advice?
- Is there a recognised and accessible support structure for students who have had or who develop mental health problems?
- Are there links with local mental health services/organisations, like Rethink?
- Is there a counselling service?

### **Ideas for mental health awareness promotion**

- Liaise with local mental health groups, most will happily give you the benefit of their knowledge and experience. To contact Rethink surf <http://www.rethink.org>
- Organise mental health awareness events/ days/weeks
- Fundraise for mental health charities

- Cover events/issues in the student media
- Encourage student volunteers to work in local mental health projects
- Incorporate mental health issues as part of general health and welfare awareness events, for example, freshers' fairs stalls, students' union staff training



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# Students and Mental Health Resource

## What if a student becomes ill?

### 3.1 Introduction

Mental health problems can be difficult to recognise if you have no previous experience of them. A person who is becoming increasingly mentally ill may not realise or accept that there is anything wrong. This often bewilders and frustrates those around them who are concerned and wish to help but do not understand what is happening.

In student communities where there is often a strong emphasis on respecting one another's independence and to "live and let live" it is even more difficult to know how to help a person if it means acting against their will. It is probably also harder than in the rest of conventional "9 to 5" society to assess when a person's behaviour might be indicative of a mental health problem. For example, if routines are flexible when is skipping lectures and staying in bed all day no longer "normal" student behaviour?

This chapter is intended to explain how a student who seems to be experiencing mental health problems can access the mental health services and receive help, or how those concerned and acting on their behalf can do so. We also hope to encourage discussion about the difficult issues which may arise in the process concerning a person's free will, right to confidentiality, even civil liberties. While it is important for this chapter to raise such questions there is no way of providing easy answers. Organisations will need to reach policy decisions based on their own circumstances.

### 3.2 Who to approach initially

If possible the person should be persuaded to go, of his / her own accord, to at least seek some advice or specialised knowledge, although this may not necessarily be professional psychiatric help. If this is not possible the following agencies should be available to advise in most colleges:

- Student union welfare officers
- University/college counselling service
- University/college health team or GP. Some colleges have a GP or a nurse or even a small team or health professionals on campus who can always be approached for guidance.

What if the person refuses to go of their own accord? Like most specialised medical services the usual route to treatment under the mental health services is via a GP. It is preferable if a person goes of his/her own free will, but it is quite possible that they will see little point in doing so and become increasingly resentful of the repeated suggestion. It is possible to make a referral on an individual's behalf, although this will probably require a breach of confidentiality.

### **Confidentiality**

In these situations, particularly if students' union and organisational staff have been approached by a "worried friend", it is important that they have a defined statement of policy to refer to for guidance. This would contain the principle that it may be necessary to act without a student's permission if their mental health has seemingly deteriorated to the extent of threatening their personal safety or that of others. It is worth discussing in what circumstances confidentiality can, if ever, be justifiably breached and the best way of expressing this in a policy.

Perhaps the problem is even greater for concerned peers who are not formally bound by statements of institutional policy and who may worry about the long and short term consequences of their actions. However, if it has been decided that it is necessary to act without the person's consent it should be possible to contact their GP, i.e. make a referral on their behalf, who will make a visit.

If it is not possible to contact the person's GP the local Community Mental Health Team (CMHT) or psychiatric hospital should be able to offer advice.

### **3.3 What if there is an emergency?**

For someone who has little experience of severe mental illness, approaching and helping someone who is psychotic can be frightening and distressing. This section aims to outline the ways in which help can be sought for a person whose mental health has deteriorated to the extent of requiring urgent treatment - usually when their speech or behaviour leaves little doubt that they could harm themselves or others.

#### **How to approach a person who is psychotic**

- Approach them from the front, never without warning from behind
- Give the person room to breathe and do not touch them unless you are sure they do not feel threatened by you
- Do not rush into sudden actions
- Do not stare
- Never leave the person to guess your intentions - their imagination may run riot; tell them what you are about to do before you do it
- Continue to reassure the person about what is happening but at

the same time try not to be patronising

- Do not try to contradict or reason logically against a delusion, but do try to protect the person from its consequences
- Do not humour the person by pretending to agree with their delusions - it may well rebound on you later. If necessary make it clear that you do not share their belief, but you accept that they feel that way
- To help assess the situation, test whether the person knows what is going on around them, i.e. where they are, who you are, what day it is, any potential dangers of their situation, but try not to obviously interrogate them.

### **How to access help**

- Contact the person's GP. The GP should visit the person urgently and may implement the procedure for compulsory admission to hospital (see below)
- Contact hospital accident and emergency (A&E) departments. A duty psychiatrist can examine the person. They may also prescribe short term medication if necessary and refer to a more appropriate psychiatric service. But only take someone to A&E if you feel that it is safe to do so.
- Contact your local Social Services department. They can send along an approved social worker, (ASW), i.e. someone with specialist mental health training
- Contact the police. As a last resort the police can escort a person to hospital or implement compulsory admission. If someone is posing an immediate danger to themselves or others, call the police at once.

### **Voluntary and compulsory hospital admission/detention**

It is possible that if a person's mental health has deteriorated so visibly as to necessitate others to contact help on their behalf, he / she will need to be seen by a psychiatrist. This may either be as an informal patient who attends hospital and accepts inpatient or outpatient treatment or their own free will; or as a formal patient who is admitted or detained in hospital against their wishes according to one of several sections of the 1983 Mental Health Act.

The first is free to leave hospital and refuse treatment, the second is not. If it seems that compulsory admission to hospital maybe necessary, a mental health assessment will be executed by 3 professionals:

- A doctor, normally the GP of the person being assessed
- An approved doctor, i.e. someone with specialised mental health experience, normally a psychiatrist.
- An approved social worker (ASW), i.e. someone with specialised

mental health assessment training and experience

The aim of the assessment is to decide whether the person's mental health problem is of a nature and a degree which necessitates hospital admission. These professionals have the legal authority to sign a form and admit the person to hospital although they are obliged to explain clearly what they are doing. The ASW will arrange for the person to be taken to the hospital where on arrival they should be given a leaflet explaining their right to appeal against detention. The ASW should also explain this to the nearest relative. If a person wishes to appeal against their detention, contact the local mental health or citizen's advocacy group who will be able to provide advice and guidance as to how to do this effectively.

### **3.1 What will happen in hospital?**

Usually people will be treated as outpatients or receive treatment mainly from their GP for their mental health problems. But if a person's ability to function in everyday life is seriously impaired a course of hospital treatment as an inpatient maybe necessary. Most patients stay in hospital for a number of weeks on acute/admission wards.

#### **Who gives the treatment?**

- **Psychiatrist:** a consultant based at the hospital will have responsibility for diagnosing and prescribing medication and other forms of treatment. Their role is usually supervisory and patients will have more day to day contact with registrars (junior psychiatrist) who assist the consultant.
- **Psychiatric Nurse:** patients will have most contact with the nurses who have specialised psychiatric training. On the wards they manage the daily care of patients and can also provide companionship, entertainment and support.
- **Clinical Psychologists:** who have specialised training in psychology - the study of the human mind and human behaviour - and mental health issues, but unlike psychiatrists they are not necessarily doctors. Their skills are used mainly in the assessment of mental health problems and the provision of "talking treatments" such as psychotherapy and counselling.
- **Occupational Therapist:** Occupational therapy will often play a major part in treatment, aiming at helping patients to live as independently as possible after hospital. Occupational Therapists (OT's) can help people to identify areas in which they lack confidence or which cause them anxiety. They are then encouraged to work on these areas which can range from cooking to relaxation skills to information technology.

#### **What kind of treatment can be expected?**

The most common form of treatment offered in hospital is drug therapy. The aim is to find the minimum dose necessary for the drug to remain effective.

- **Anti-psychotic drugs (neuroleptics):** these principally act to reduce psychotic symptoms, i.e. hallucinations, delusions etc. and can have a tranquillising effect. Neuroleptics are not addictive. They are effective in treating acute psychosis but may also be used for long-term treatment. They can produce a variety of side effects which can be very disturbing including restlessness (or drowsiness in some cases), skin sensitivity, impotence, involuntary twitches and tremors. Side effects should be monitored very closely and additional medication to counterbalance them can be prescribed. These drugs are usually taken orally as pills or syrups although some patients have them administered as depot injections on a weekly, fortnightly, three weekly or monthly basis.
- **Anti-depressant drugs:** these usually take 2 - 3 weeks to take effect and relieve the symptoms of depression. They are not addictive but can cause side effects such as drowsiness and some can react extremely badly with alcohol and certain foods.
- **Anti-anxiety drugs:** these are prescribed to reduce anxiety and agitation and can help with sleeping problems. They are effective as a short term means of relieving symptoms but tend to be less effective over long-term use and can be addictive.

#### **Non-drug treatments include:**

- **ECT:** electroconvulsive therapy is used mainly when other forms of treatment have failed. It is normally used in the treatment of severe depression. Under anaesthetic and muscle relaxants, electric currents are passed through the brain for about half a second. It is accepted that confusion for about half an hour after treatment is common. However, the treatment is controversial with some patients complaining of long-term memory loss and other damaging effects.
- **Psychotherapy:** in this talking treatment the therapist explores with the patient what could be behind their problems. This can be very valuable although it is argued that it should be used cautiously with patients who are psychotic, as they may actually deteriorate if their symptoms are delved into too deeply.
- **Cognitive therapy:** this is a talking therapy based on the premise that unwanted or unpleasant emotions are linked to a person's negative beliefs. These beliefs are gently explored and challenged. Some types of cognitive therapy are used to treat conditions such as schizophrenia.

#### **What support can be provided by the college?**

Admission to a psychiatric hospital can be a frightening, isolating experience and many students will probably appreciate visits from their friends and members of staff with whom they have good working relationships. Patients should however be asked about whom they want to see and warned before a visitor appears.



## Students and Mental Health Resource

### After hospital - care in the community

#### 4.1 Introduction

The NHS and Community Care Act 1990 implemented the principle that those with special needs who had been traditionally cared for in institutions should instead live as independently as possible in the community. The term "special needs" generally refers to the physically disabled, the elderly, people with learning disabilities and those with mental health problems. Theoretically these individuals should be able to obtain services which:

- Enable them to live in their own home
- Enable them to be independent
- Are tailored to their individual needs

Local authority social services departments now have a legal duty to assess a person's needs for community care; ensure that the appropriate services are provided; and to publish an annual community care plan for the area.

Services are provided by social services, by local health authorities and by voluntary or private organisations and should be tailored to meet the different needs of each individual. This requires a diversity of services in each locality and effective co-operation between the range of agencies and professionals who may be involved in delivering a person's care. The highly publicised cases whereby people with mental health problems have committed homicides in the community, have led to reports which question the quality and efficiency of care delivered not only to those particular individuals but to all of those assessed as being in need.

## 4.2 What is "aftercare"?

This term describes the care a person with mental health problems should receive after they have left hospital. It should be discussed before the patient is discharged with their "key-worker" - usually a social worker who will be responsible for co-ordinating that person's aftercare and liaising with the various agencies involved.

**Care management:** this term refers to the care delivered to all those assessed by social services as being in need according to section 47 of the NHS and Community Care Act 1990. Forms of support include housing, home help, information and advocacy, training, day care etc. Assessment can be limited or comprehensive as can the resulting care plan. Everyone will have a key-worker and those with many needs will be assigned a Care Manager.

**The Care Programme Approach (CPA):** this is a more specialised system of delivering care and aftercare to those in touch with psychiatric services.

It is intended to ensure that everyone leaving psychiatric hospital has a formal discharge plan and people being treated in the community have a care plan.

The assessment is carried out by a multi-disciplinary CMHT including psychiatrists, nurses, GP, psychologist and social workers and should involve the patient and their family, with the patient's consent.

**Requirements under section 117 of the 1983 Mental Health Act:** this stipulates that those sectioned under treatment order (3) or a hospital order made by the courts (sections 37/41 and 47/49) have a legal right to aftercare.

## 4.3 Who provides this care?

A range of professionals are involved as can be seen by the breakdown of a CMHT above, but the following are most likely to be in regular contact with the person receiving care.

**Community psychiatric nurses (CPN's):** CPN's will call at people's homes to provide support and advice and may also administer medication. They work closely with GP's and may be based at local surgeries.

**Social Workers:** these will work closely with users of the mental health services, their carers and with other professionals to assess a person's needs, plan appropriate care and give guidance on how to work with other agencies.

**Residential and day care workers:** the staff of hostels and day services may range from trained and specialised professionals, i.e. nurses, OT's, counsellors and care assistants to volunteer befrienders and those who provide the food and do the cleaning. All offer support to service users either individually or in groups.

#### **4.4 What services should be available?**

These services form part of many care plans and should be available in most areas.

**Counselling:** a talking treatment which is less formal than psychotherapy, and tries to help the client focus on particular difficulties at an immediate and practical level.

**Day care:** this may be at a day hospital or at a specialised unit. This can provide a range of activities aimed at building confidence and independence ranging from social activities to occupational therapy, training and education.

**Befriending:** volunteers offer support and friendship on a one to one basis by visiting people in their own homes.

**Advice and advocacy:** national and local voluntary organisations often provide specialised advice and information centres which are frequently linked to local advocates if there is not a specialised advocacy agency in the area. If a person is not confident or finds it difficult to express their views they can have an advocate who will speak on their behalf.

**Crisis facilities:** some areas will have crisis beds where people with mental health problems can go at short notice. There may also be some form of 24 hour help line or an out of hours service which can be accessed when other facilities are closed.

**Education & training:** opportunities for vocational training or further academic studies can form an important part of a person's care plan. Studying can promote a sense of

personal achievement or progress and open doors to further opportunities.

#### **4.5 What support can be provided by the college?**

Students with experience of mental health problems tend to either be returning to interrupted studies or beginning a course having recovered. Both are potentially capable of successfully completing the course although in order to do so they may need additional support from the college. This is discussed more fully in the next chapter.



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# Students and Mental Health Resource

## Support for students with experience of mental health problems

### 5.1 Introduction

Students who arrive at college with a psychiatric history are often tempted not to disclose their experience, usually because they are anxious about how staff and fellow students will react, and because they are worried that they will jeopardise their future academic and employment success. In doing so they effectively cut themselves off from support which may be readily available if they need it.

To enable such students to reach their full educational potential and feel confident that any difficulties will be met with understanding, educational institutions need to publicise and execute a commitment to providing appropriate support when necessary. Some possible ways of doing so are explored below, as is the need to offer such support at each stage of a student's career - from pre-admission to final assessment.

How educational institutions provide this support will depend on individual circumstances including current procedures and resources. It is hoped that this chapter will be useful as a basis for discussion amongst staff and students as to how such support may be successfully developed in their own organisation.

### 5.2 Pre-entrance guidance for students

#### Positive publicity

It is worth investing time and resources in encouraging potential students to declare previous mental health problems, as it will be easier to provide the appropriate support if later difficulties do arise.

Organisations can encourage openness by declaring their intention to provide support in pre-admission material i.e. college prospectuses and course information. The following are suggestions for positive publicity which will encourage candidates to overcome the fear of "labelling" and to be open about previous mental health difficulties and possible future needs.

#### Equal opportunities policy/statement

It would be useful for an organisation's statement of Equal Opportunities to specify that "mental health problems" or "previous psychiatric history" will not lead to discrimination even if this is already implied.

Many organisations also put mental health under the umbrella term of "disability" and yet it is worth clarifying that this term does include mental health difficulties as candidates with this experience may not feel themselves to be permanently disabled or maybe unsure whether this term applies to them.

### **Statement of confidentiality**

If candidates are to divulge details of their psychiatric past they will need reassurance that their right to keep such sensitive information largely confidential will be respected. Each organisation could produce a statement of confidentiality specifically tailored for this group of students which would guarantee that any information will be shared only with specified individuals with the student's permission.

It is worth considering how much information about a candidate's history the organisation, and specifically who in the organisation, needs to know. If too many staff have access to unnecessary details this can hinder the student's sense of independence and progress.

A student should know exactly what information the college has about them and from what source. They should also know who within the organisation has access to this information and which individuals from outside agencies may be contacted and in what circumstances. This is more easily achieved if each student participates in preparing their own support plan which could outline problems which may arise and the most appropriate support which could then be offered. Students should feel they understand why certain people, i.e. tutors or lecturers should have access to information and why in certain circumstances it may be necessary to break the pre-agreed boundaries of confidentiality.

### **Encouraging pre-entry contact to discuss possible support needs**

For most students the admissions interview may be their first and last contact with the university / college and increasingly places are allocated without a formal interview taking place. However, candidates with mental health problems may appreciate a more detailed introduction to the organisation and staff, and it could also be useful for them to discuss the various ways they could access additional support if needed. Publicity material should therefore encourage candidates to arrange a visit before application.

Most candidates will not want to be treated as "special cases" to the extent that their admissions interview is dominated by discussion of their psychiatric history rather than assessment of their overall suitability for a place. Previous mental health problems should not be ignored, but the interviewer should, as with other candidates, show interest in the "whole person".

### **5.3 Ongoing support**

Ongoing support for students with mental health difficulties may range from small adjustments to daily teaching practices to specific problem solving by specialist support professionals. The providers of this support can range from subject lecturers / tutors, pastoral tutors, union welfare facilities, and student run provision from college help lines to "in house"

and external counselling facilities.

The main responsibility of an educational organisation to any student is educational. Both staff and students can feel confused if they are uncertain of the appropriate level of support that should be provided. For example, subject teachers may be happy to provide extra support concerning a study topic but feel out of their depth if the problem extends beyond the academic. The appropriate boundaries between different kinds of support could be defined and included in a written statement to be discussed with each student as to what this may mean in practice.

The support available and the procedures for provision and access should be made as clear to students as possible. It would be helpful to have statements of general procedure that are discussed with students at the start of their studies along with their personal support plans. Although all plans are by nature provisional, it should make implementation of support simpler if a student has previously indicated how they feel possible problems are best dealt with and who, at what stage, should be involved.

### **In the classroom**

Support can be provided at the simplest level by teaching staff understanding that some students may still experience mental health difficulties or related problems that interfere with their ability to study effectively.

These could include problems with:

- **Concentration:** a student may find it difficult to concentrate in lectures, workshops, while reading, etc.
- **Memory:** students may have difficulty absorbing information and need greater repetition.
- **Lethargy:** this may easily be a side-effect of medication rather than disinterest or apathy.
- **Poor timekeeping / attendance:** could be the sign of a poorly motivated student, the side-effects of medication or possibly the symptoms of a recurring mental health problem!

Sympathetic staff who are willing to listen without being judgmental provide a valuable form of support. The source of a student's problem may not be academic, but lecturers and tutors should not need to acquire professional counselling skills or in-depth knowledge of mental illness. It is appropriate to respond with sensitivity as to any student's needs, to show interest and then to refer the student on as outlined in institutional and individual support plans, if the problem does seem to require more specialised help.

Work on improving study skills / methods can be a valuable form of support for students in these circumstances. For example, looking at whether a student has particular difficulties with specific topics, assessing generally how study methods could be improved including

ways of improving concentration and memory, how reading and note-taking could be made more effective, how to answer questions, etc. Students could participate in drawing up their own study plan from home in case later problems necessitate a break from attending classes.

### **Outside the classroom**

In research studies students with mental health problems stress the value of having "one named person" whom they can talk to about any difficulties. This may be someone other than the subject tutors and lecturers who they see every day and there is no doubt that support may be required beyond that which can be reasonably expected from teaching staff.

- **Student union welfare staff:** welfare officers receive training on how to provide advice and information on many areas of student life including mental health awareness. They act as points of reference, outlining the options open to a student with a particular problem and referring people to the appropriate outside agencies who offer more specialised assistance.
- **University/College counselling services:** these exist in most further and higher education organisations and are staffed by professional counsellors. Counsellors should be aware of local mental health resources and their referral procedures.
- **Local mental health services/groups:** the extent to which individual students are in regular contact with the local mental health services will vary considerably. Some may have a Care Plan (see Care Programme Approach CPA in chapter 4), others may see a psychiatrist a couple of times a year or others may never see a mental health professional, relying solely on their GP. It may be useful to establish contact with the local Community Mental Health Team(s) (CMHT) who should be able to offer general advice and information and specific help in a crisis.

Local mental health support groups would probably welcome being consulted and will often provide speakers for mental health awareness training. Rethink can pass on information about local contacts. Phone 020 7330 9100 for information.

- **Crisis lines (local and national):** many universities run their own crisis lines which can provide a similar sort of support to their national counterparts, The Samaritans, for example. These listening services can provide on the spot support and then refer on to other agencies for more practical forms of assistance. Some towns and cities may also run their own help line and all these services should be advertised to students.

### **Support for staff**

Educational staff, like most people, often know very little about mental illness until it somehow affects their lives. If an educational organisation is to make a commitment to implementing real equal opportunities for people with experience of mental health problems, it becomes even

more important that staff have access to the facts as opposed to the common misconceptions about mental illness. This will be reassuring and will provide a far more accurate picture of what to expect. This can be achieved through workshops with input from mental health professionals, service users and their carers.

"Sounding board" facilities may also be useful for staff to access their own responses to students whose mental health problems require some extra support. These may be provided by regular ongoing contact with the Community Mental Health Team and local mental health groups, possibly in the context of an in-house listening / counselling support network with the organisations own counsellors. Staff may welcome the opportunity to compare collectively their experiences and "let off steam" on a regular basis.

#### **5.4 Flexible teaching and assessment**

Ideally teaching and assessment systems would be flexible enough to accommodate day to day and longer term disruptions due to mental health difficulties so that the student's potential for progress and achievement is affected as little as possible. In practice this will not be possible for the majority of courses taught in most organisations but there are still ways of gradually introducing provision for these "special needs". However these options for making life easier will suit some students better than others, and much progress will still depend on individual capabilities and preferences.

#### **Teaching**

- **Open Learning:** this is only possible with certain subjects at certain levels which require the minimum of supervision. Implementing Open Learning, where practical, will present opportunities for those who would like to study but whose experience of mental health problems undermined their confidence or have made them unsure of their ability to take on a traditionally taught course. Open Learning enables people to work at their own pace, as and when they feel ready. There may, however, be problems concerning the additional motivation that may be required in order to work with little social contact.
- **Modules:** increasing numbers of degree courses now have a modular structure, i.e. broken down into individual modules which are taught and assessed independently of the others. Therefore, if a student's studies are disrupted they will not lose as much ground as in a traditionally structured course which, for example, may require repetition of the entire academic year. Successfully completed modules will still count towards a degree, only those disrupted will have to be repeated and it should be easier to resume studying at a later date.
- **Return to study packages:** these can act as useful introductions to full-time study that enable the student to regain confidence and explore skills and interests before undertaking a full time course.

## Assessment

- **Exams:** the pressure of exams is anticipated and accepted as a necessary evil by all who sit them. There is no doubt that resulting stress levels can be extremely high for students with no experience of mental health problems and in many cases can be strongly implicated in causing them. The majority of degree courses no longer rest solely on performance in final examinations and many are based on mixed assessment.
- **Continuous assessment:** assessment can be continuous, i.e. based on the student's work throughout the course. Few courses would include all work set, but many will base assessment largely on certain pieces throughout the year. This is generally less stressful than the preparation for and experience of exams and students with experience of mental health problems may feel more comfortable with it. However, it is possible to argue that with this type of assessment there is pressure with each piece of relevant work which can add up to continuous stress throughout the duration of the course.

## How organisations can help ease the pressure

There are ways in which organisations can and do make special arrangements for students who are unable to cope with the stresses involved in the usual means of assessment. Students who are unable to cope should feel able, without stigma, to turn to the support of their tutors, student union welfare facilities, college counselling services and other support systems available. Ultimately individual cases will be treated with discretion but below are some ways organisations can help:

- **Aegrotat degree:** if, for example, a student is assessed as being medically unfit to take a crucial set of exams, the college may award an aegrotat degree which is like a normal honours degree but without a classification.
- **Postponement:** under certain circumstances it is possible to postpone taking a set of exams if a candidate is unlikely, for a very good reason, to do themselves justice. It is also sometimes possible for deadlines on dissertations etc. to be postponed, although again there must be good reason.
- **Informal vivas:** some organisations consider these as an alternative to written exams for candidates who feel they can perform better when discussing a subject face to face.

The above are just some examples of how educational establishments can and do provide alternative means of assessment.

For students with mental health problems it is essential that they are aware of all these forms of support.



- 1 Everyone has mental health
- 2 What life throws at us
- 3 Having a problem
- 4 Asking for advice
- 5 Most people sort it out



## List of organisations

### Mental health

#### **Rethink**

Rethink exists to improve the lives of everyone affected by severe mental illnesses by providing quality support, services and information and by influencing local, regional and national policies.

[www.rethink.org](http://www.rethink.org)

email: [info@rethink.org](mailto:info@rethink.org)

#### **Rethink Advice Service**

Providing support to people with a severe mental illness, their families and carers.

Tel: 020 8974 6814 (10am-3pm weekdays)

#### **Depression Alliance**

Provides information, support and understanding to people who are depressed and their carers.

Tel: 020 7633 9929

[www.depressionalliance.org](http://www.depressionalliance.org)

#### **Depressives Anonymous**

Self-help organisation offering support, organising group meetings and producing a bi-monthly newsletter.

Tel: 01702 433838

#### **Fellowship of Depressives Anonymous**

Self-help organisation offering support, organising group meetings and producing a bi-monthly newsletter.

Tel: 01702 433838

#### **Stand - Stress, Anxiety and Depression**

Through STAND's website, publications, conferences and the development of support groups, it provides accessible information, education, support and better understanding of the most common, yet serious, mental health problems

[www.depression.org.uk](http://www.depression.org.uk)

#### **Jewish Association for the Mentally Ill (JAMI)**

Offers guidance, counselling and support to sufferers and their carers. Runs social clubs, produces a voluntary newsletter and runs a help and referral line.

Tel: 020 8343 1111.

**Manic Depression Fellowship**

Provides support, advice and information for people with manic depression, their families and carers.

Tel: 020 8974 6550 (9am-5pm, Mon -Thurs, 9am-4pm Fri)

**Mental Health Foundation**

Provides information and research on mental health issues

Tel: 020 7535 7400 (switchboard)

[www.mentalhealth.org.uk](http://www.mentalhealth.org.uk)

email: [mhf@mentalhealth.org.uk](mailto:mhf@mentalhealth.org.uk)

**MIND**

Support for anyone worried about their own or others' mental health problems.

Tel: 0345 660 163 outside London

Tel: 020 8522 1728 in Greater London (local call rates) — weekdays 9.15am to 4.45pm.

[www.mind.org.uk](http://www.mind.org.uk)

**Threshold Women's Mental Health Initiative**

National information line run by women for women.

Tel: 0845 300 0911 (all calls charged at local rate, open 2pm-5pm, Mon-Thu)

24-hour ansaphone outside office hours

**Channel4 Health house - mind site**

This site looks at a range of emotional and psychological problems and gives information on their possible causes, what can be done to treat them and how people who are experiencing difficulties and their families and friends can cope and help.

[www.channel4.com/health/mind](http://www.channel4.com/health/mind)

**Mindout campaign - Read the Signs**

Read the Signs is a mental health website for young people. It has information on the signs of mental health problems, information on various issues and real life stories, also has information on where to get help.

[www.readthesigns.org/](http://www.readthesigns.org/)

**Saneline**

A national, out-of-hours telephone helpline which provides support and information to anyone coping with mental illness. It is open everyday from midday until 2am on the lo-call number: 0845 767 8000

[www.sane.org.uk](http://www.sane.org.uk)

**Alcohol/drug problems****ADFAM National**

Adfam is a national charity working with families affected by drugs and alcohol and is a leading agency in substance related family work. It provides a range of publications and resources for families about substances and criminal justice and operates an online message board and searchable database of local support groups that helps families hear about and talk to people who understand their situation.

Adfam runs a range of training programmes on substances and family

support. It also operates direct support services at London prisons for families of prisoners with drug problems. A list of resources is available online at: [www.adfam.org.uk](http://www.adfam.org.uk)  
Tel: 020 7928 8898 (office hours)

**Alcoholics Anonymous (AA)**

Encourages people to share their experiences, provides mutual support and information on local helplines.  
Tel: 01904 644 026 (Mon-Thurs, 9am-5pm, Fri 9am-4.30pm)

**Al-Non Family Groups UK and Eire**

Offers understanding, support and information on local groups to families and friends of people with alcohol problems.  
Tel: 020 7403 0888 (24-hour confidential helpline)  
[www.hexnet.co.uk/alanon/](http://www.hexnet.co.uk/alanon/)  
email: [alanonuk@aol.com](mailto:alanonuk@aol.com)

**National Drugs Helpline**

A confidential service providing free information and advice to anyone with questions or concerns about drugs. Also makes referrals to other appropriate agencies. Information is available in a variety of languages.  
Tel: 0800 77 66 00 (24-hour helpline)

**Narcotics Anonymous**

Runs a network of self-help groups for drug users, based on the AA model.  
Tel: 020 7498 9005

**Release**

A national 24-hour helpline for advice and information on drug-related problems. Also offer a range of publications.  
Tel: 020 7729 9904, 24-hour service on 0171 603 8654

**Turning Point**

Offers rehabilitation, counselling and information for people with drug, alcohol and mental health problems.  
Tel: 020 7702 2300  
[www.turning-point.co.uk](http://www.turning-point.co.uk)

**Channel4 Health house - drugs site**

If you're looking for straightforward, non-judgemental information about drugs, including alcohol, Or if you're worried about your drug use, or about someone else's, If you want advice or help, Or are you just interested in the implications of the widespread use of drugs and the diverse forms it takes, Then this site is for you.  
[www.channel4.com/health/drugs](http://www.channel4.com/health/drugs)

**Bereavement**

**Cruse Bereavement Care**

Provides counselling, advice and information for bereaved people.  
Tel: 020 8940 4818 (Head office) 0181 332 7227 (Helpline)

**London Bereavement Network**

A referral agency for bereavement services

Tel: 020 7700 8134 for information on services in your area

[www.bereavement.demon.co.uk](http://www.bereavement.demon.co.uk)

**National Association of Bereavement Services**

Tel: 020 7247 0617

**Benefits/money****Department of Social Security**

For information on benefits

[www.dss.gov.uk](http://www.dss.gov.uk)

**National Union of Students**

[www.nus.org.uk](http://www.nus.org.uk)

**Bullying****Anti-Bullying Campaign**

Provides advice, information, understanding and support to parents of bullied children and to children themselves. It also trains teaching and non-teaching staff to deal with bullying.

Tel: 020 7378 1446 (weekdays 9.30am to 5pm).

**Carers****Rethink Advice Service**

Providing support to people with a severe mental illness, their families and carers.

Tel: 020 8974 6814 (10am-3pm weekdays)

[www.rethink.org](http://www.rethink.org)

email: [info@rethink.org](mailto:info@rethink.org)

**Carers National Association**

Provides information about benefits, services and other kinds of help for carers.

Tel: 0808 808 7777 (weekdays 10am to 12pm, and 2pm to 4pm)

freephone

**Complementary therapies****British Acupuncture Council**

For training information please send a SAE.

Tel: 020 8735 0400 for a list of local practitioners

[www.acupuncture.org.uk](http://www.acupuncture.org.uk)

email: [info@acupuncture.org.uk](mailto:info@acupuncture.org.uk)

**British Medical Acupuncture Society**

Society of medical doctors who practice acupuncture.

Tel: 01925 730727

[www.medical-acupuncture.co.uk](http://www.medical-acupuncture.co.uk)

**British Wheel of Yoga**

Tel: 01529 306851 for information on local contacts

[members.aol.com/wheelyoga](http://members.aol.com/wheelyoga)

**Institute of Complementary Medicines**

A charity which maintains the British Register of Complementary Practitioners.

[www.icmedicine.co.uk](http://www.icmedicine.co.uk)

**Society of Homeopaths**

Publishes and maintains a register of professionally qualified homeopaths.

Tel: 01604 621400

[www.homeopathy.org.uk](http://www.homeopathy.org.uk)

## Counselling/psychotherapy

**British Association for Counselling and Psychotherapy**

Information on counselling and registered counsellors.

Tel: 01788 550899

[www.bacp.co.uk](http://www.bacp.co.uk)

email: [bacp@bacp.co.uk](mailto:bacp@bacp.co.uk)

**Samaritans**

Offer confidential emotional support to anyone in crisis — open 24 hours a day, 365 days a year.

Tel: 0345 90 90 90 (in the UK) local call rate

Tel: 1850 60 90 90 (in the Republic of Ireland) local call rate

[www.samaritans.org.uk](http://www.samaritans.org.uk)

**Relate**

Offers marital and couple counselling and psychosexual therapy at 130 centres in England and Wales.

Tel: 01788 573 241

[www.relate.org.uk](http://www.relate.org.uk)

**United Kingdom Council for Psychotherapy**

Provides information on registered psychotherapists and services in your area.

Tel: 020 7436 3002

**Westminster Pastoral Foundation**

General counselling service with specific service for young people. Charges are made on a sliding scale according to how much you can afford.

Tel: 020 7937 6956

[www.wpf.org.uk](http://www.wpf.org.uk)

## Eating/weight problems

### **The Eating Disorder Association**

Information and help on all aspects of eating disorders including Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorder and related eating disorders.

Tel:

**Adult helpline** (for over 18's): 0845 634 1414 (8.30am to 8.30pm Mon to Fri)

**Youthline** (for under 18's): 0845 634 7650 (4.00pm to 6.30pm Mon to Fri)

**Recorded Information Service:** 0906 302 0012 (calls cost 50p per minute and the message lasts approximately 8 minutes)

[www.edauk.com](http://www.edauk.com)

### **Eating Disorder Recovery Online**

[www.edrecovery.com](http://www.edrecovery.com)

### **Weight Watchers**

Provides help lose weight in a healthy way

Tel: 0345 123000 to locate your nearest Weight Watchers meeting

[uk.weightwatchers.com](http://uk.weightwatchers.com)

## Homelessness/Accommodation

### **Centrepoint**

Registered charity and housing association aiming to ensure that young people are not at risk because they do not have a safe place to stay.

Tel: 020 7629 2229.

[www.centrepoint.org.uk](http://www.centrepoint.org.uk)

### **Rethink**

Offers a number of important services, eg housing projects, drop-in centres, employment projects and carer and user groups around England, Northern Ireland and Wales.

Tel: 0845 456 0455 — for further information

[www.rethink.org](http://www.rethink.org)

email: [info@rethink.org](mailto:info@rethink.org)

### **Shelter**

Dedicated to preventing homelessness, by providing practical advice and information.

Tel: 0808 800 4444 (24-hour helpline).

Your local Shelter Housing Advice line will be listed in the Yellow Pages under 'I' for Information Services.

[www.shelter.org.uk](http://www.shelter.org.uk)

Email: [info@shelter.org.uk](mailto:info@shelter.org.uk)

## Self Harm

### **National Self-Harm Network**

Campaigning for rights and understanding of self-harm.

Write to: PO Box 16190, London NW1 3WW **LifeSIGNS**

Aim to support all people who are affected in anyway by self injury within the United Kingdom and beyond. They support people using self injury, and support people who know self injurers and people (including Health Care Workers) who are interested in self injury

They offer a packed website, with a moderated Message Board, a free monthly Newsletter, and real-life training to other organisations.

Email Support: [info@lifesigns.org.uk](mailto:info@lifesigns.org.uk)

Website: <http://www.lifesigns.org.uk/>

## Sexuality/sexual health

### **Brandon Centre**

Provides information and counselling for young people, aged 12-25.

Specialises in contraception, pregnancy and psychosexual problems.

Tel: 020 7267 4792/3

### **Impotence Association**

For information and support

Tel: 020 8767 7791 or information and support

### **Lesbian Youth Support Information Service (LYSIS)**

Offers support service, helpline, pen-pal scheme, research, telephone and correspondence counselling.

Tel: 01706 817235 (helpline Wed 7-9pm)

### **London Bisexual Group**

Offers telephone and correspondence counselling and support.

Tel: 020 8569 7500 (helpline Tues-Wed 7.30-9.30pm)

### **London Gay and Lesbian Switchboard**

Provides telephone counselling and referral service for lesbians and gay men, plus information, advice and support.

Tel: 020 7837 7324 (24-hour helpline)

### **Marie Stopes International**

Reproductive health care organisation providing contraception advice, help with unplanned pregnancy, abortion and emergency contraception services. Branches around the UK.

Tel: 0845 300 8090 for information on your nearest branch.

[www.mariestopes.org.uk](http://www.mariestopes.org.uk)

### **National Aids Helpline**

Provides information and advice on HIV and Aids

Tel: 0800 567123, 24 hours

**Relate**

Offers marital and couple counselling at 130 centres in England and Wales.  
Tel: 01788 573241  
[www.relate.org.uk](http://www.relate.org.uk)

**Terrence Higgins Trust**

Provides advice, information and counselling for people affected by HIV.  
Tel: 020 7242 1010, 12 noon -10pm daily  
[www.tht.org.uk](http://www.tht.org.uk)

## Stress

**BBC Radio 1 Life Essentials site**

Information on stress, relationships, drugs & alcohol, families and a range of other issues from the BBC's Radio 1 Essentials website  
[www.bbc.co.uk/radio1/onelife/health](http://www.bbc.co.uk/radio1/onelife/health)

**Channel4 Health house - stress site**

Feeling stressed? Are life's demands getting on top of you? Do you think you can't cope? This site can help answer all your questions about stress. You can find out how to recognise whether you are suffering from stress, how stress can harm your health and lots of tips and suggestions for beating stress - from medication to mirth.  
[www.channel4.com/health/stress](http://www.channel4.com/health/stress)

## Volunteer work

**The National Centre for Volunteering**

Has a database of organisations in your area looking for volunteers and can provide lists on request.  
Tel: 020 7520 8900 (Mon-Fri, 9am-5pm)  
[www.volunteering.org.uk/](http://www.volunteering.org.uk/)  
Email: [centrevol@aol.com](mailto:centrevol@aol.com)

## Young people

**Alateen**

Part to Al-Anon for young people aged 12-20 who have been affected by someone else's drinking (usually a parent).  
Tel: 020 7403 0888 — for information

**Childline**

The UK's only free national helpline for children and young people in trouble or danger. Provides a confidential counselling service.  
Tel: 0800 1111 (24-hour helpline)  
[www.childline.org.uk](http://www.childline.org.uk)

**Young Minds**

Aims to increase public awareness of the mental health needs of children, young people and their families.

Tel: 020 7336 84445

[www.youngminds.org.uk](http://www.youngminds.org.uk)



a Rethink production  
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When your car  
breaks down  
you can get help  
within  
**60 minutes.**

When your mind  
breaks down  
it can take  
**18 months.**

**Together we can  
cure  
the 3 biggest  
mental  
health problems.**

**Prejudice.  
Ignorance.  
Fear.**