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"Not Always Smooth Sailing": Mental Health Issues Associated with the Transition from High School to College

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Students who transition from high school to college are often excited by the new phase of their lives. However, they are exposed to circumstances and expectations which place them at risk for psychiatric disorders or that may exacerbate pre-existing problems. In this paper, we discuss risk factors and other issues associated with students transitioning to college or university life, identify challenges for health professionals, and suggest possible strategies to improve the mental health of young adults on college campuses. Academic staff and health care providers need to be aware of how best to engage and assist students during an important phase of their life. Processes and care pathways also need to be easily understood, user friendly, and appropriately resourced. It is anticipated that staff, students, and industry health care providers will benefit from a greater awareness of some of the mental health issues that may occur in higher education.

In this paper, we discuss risk factors associated with students transitioning to college and university, set out some of the challenges for health professionals on college campuses, and then suggest possible strategies to improve the mental health of young adults on those campuses. It is anticipated that staff, students, and industry health care providers will benefit from a greater awareness of student issues in higher education. In this paper, we use the terms "college" and "university" interchangeably to denote the more advanced stage of education.

TRANSITION TO COLLEGE AND IMPLICATIONS FOR MENTAL HEALTH

Students commencing college or university studies are often young and, having worked hard to attain entry into college are excited by this new phase of their lives. However, they will need to cope with the academic and social demands of university (Bayram & Bilgel, 2008). Among the many practical issues, and potential stressors, are the loss of one's school friends, the need to form fresh relationships and groups, potentially moving away from home and becoming acquainted with new college roommates, dealing with different methods of learning, and the expectation of increased autonomy in life and studies. Further, older adolescents during college, especially those living away from home, have lessened parental oversight, generally have complete responsibility for self-management of their own mental and physical health (which includes seeking care, taking medications, keeping medical appointments, etc.), and are often away from the support network of their family. Thus, the transition to young adulthood presents educational opportunities, career prospects, and the chance to develop personal relationships. However, while these are all conducive to growth, stress associated with adolescence places young people at risk of mental ill-health (Usher, Jackson, & O'Brien, 2005), and may precipitate the onset or reoccurrence of a psychiatric disorder (Blanco et al., 2008).

Differentiating normal and early adult behaviours can be challenging. So-called "young healthy adults" may lack motivation, energy or interest, appear disorganised, restless, irritable, moody, distracted or tired, and experience changes in sleep or appetite. All of these features can also be associated with psychiatric disorders. However, critically, to qualify for a psychiatric diagnosis, the symptom(s) need to be severe and protracted, rather than mild and fleeting, and lead to disruption in functioning (social, school, or work).

Today, many students transitioning to college or university are ill-prepared for the adjustments required, including the academic requirements, and cannot effectively manage study, work,

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and the various extracurricular demands (Cook, 2007). Although college students may be perceived as privileged, mental disorders are as prevalent among them as same-aged non-college students, and these disorders seem to be growing in number and severity (Hunt & Eisenberg, 2010). The number of students with serious mental illness has grown significantly in recent years and epidemiological research shows that the past-year prevalence rate of mental illness is highest (39%) for those who are 15–21 years of age, which corresponds to traditional college years (Mowbray et al., 2006). Averaging across several research studies, about 12–18% of students on campuses have a diagnosable mental illness (Mowbray et al., 2006). Furthermore, the rate of suicide in this population has outpaced that of young adults who are not pursuing postsecondary education (Mowbray et al., 2006). The way that students cope with stress and difficulties can impact on their adjustment to university life (Dyrbye, Thomas, & Shanafelt, 2006).

College and university-age students are exposed to circumstances that place them at risk for psychiatric disorders or that may exacerbate pre-existing problems (Ahern, 2009; Bayram & Bilgel, 2008; Blanco et al., 2008; Cook, 2007; Eisenberg, Gollust, Golberstein, & Hefner, 2007; Hicks & Heastie, 2008; Zivin, Eisenberg, Gollust, & Golberstein, 2009). In a national US study on the mental health of college students and their non-college-attending peers, Blanco and colleagues (2008) found psychiatric disorders, in particular alcohol use disorders, to be common in the college population. In the literature, there are consistent reports of an increased number of students presenting with serious psychological problems, such as anxiety, depression, stress, suicidality, and substance abuse (Bayram & Bilgel, 2008; Kitzrow, 2003). For example, a systematic review (Dyrbye et al., 2006) of depression, anxiety, and indicators of psychological distress among US and Canadian medical students, reported higher rates of depression and anxiety than in the general population and age-matched peers. Potential factors that may be contributing to high rates of psychiatric problems among college students include the increased recognition and more effective treatment of childhood and adolescent psychiatric disorders (e.g., through early intervention and improved psychotropic medication), which may help young people finish school and be eligible for further education (Kitzrow, 2003).

Risky behaviours make students vulnerable in relation to their emotional and physical health, with further implications for their academic program of study. Common risky behaviours include substance use or misuse (e.g., alcohol and prescription and street drugs) (Baldwin et al., 2009; Slutske, 2005; Usher et al., 2005), abnormal eating patterns, and sexual activity, which may lead to anxiety, stress, depression, and threats to self-esteem (Ahern, 2009; East, Peters, O'Brien, & Jackson; 2010).

Other types of at-risk student behaviours include excessive absenteeism, non-attendance without notice, tardiness, late submission of assignments, decreased productivity, and an inability to make decisions (Clark, Farnsworth, & Springer, 2008). In addition, various life adversity issues, such as paternal absence, are associated with adolescent mental health and well-being (East, Jackson, & O'Brien, 2006, 2007). It is also not uncommon for college students to spend excessively or experience poor sleep patterns (Vallido et al., 2009), both of which compound low self-esteem, negative self-image, and feelings of loss of control, and have the potential to negatively affect academic performance (Cook, 2007; Vallido et al., 2009) and lead to failure with an academic program.

There is compelling evidence that older adolescents in college are at risk of mental health difficulties. A recent US survey has found that at least 34.1 of students experience stress, 26.1% of students report sleep difficulties, and 24.7% report working in paid employment 20 hours or more a week (The American College Health Association, 2008, cited in Ahern, 2008). In a web-based survey of university students, 2% of students reported suicidal ideation in the past four weeks, and those with financial struggles were found to be at higher risk for mental health problems (Eisenberg et al., 2007). Furthermore, a nationwide survey of college counseling services representing 302 institutions and more than 2.6 million students, revealed that 89.4% of respondents believed there had been an increase in students with severe psychological problems over the past five years; 55.7% reported an increase in self-injury such as cutting, and 70.6% reported an increase in crisis situations requiring an immediate response (Gallagher, 2009). The survey also revealed that of 103 student suicides in the preceding year, 80% were of students who were known to be depressed and 27% were medicated at the time of death (Gallagher, 2009).

CHALLENGES FOR HEALTH PROFESSIONALS ON COLLEGE CAMPUSES

Since the inception of campus-based counseling services in the 1940s, there has been an increasing awareness of mental health issues in students (Locke, 2009). Despite this awareness, and the many strategies that have been developed to support students, student mental health continues to cause concern, with compelling evidence to suggest that both severity and prevalence of mental health problems are increasing (Gallagher, 2009). Higher education institutions expend considerable resources on counseling and other student health services.

However, though many institutions do work hard to provide programs and services to reduce mental health problems in students, others still have not responded adequately. Lawsuits have been brought against large institutions, alleging "inadequate or negligent treatment of mental health problems," raising the issue of an institution's responsibility when dealing with unwell students, including those at risk of suicide (Kitzrow, 2003, p. 171). Incredibly, out of fear of legal liability if the student dies by suicide, some colleges and universities have banned students who have suicidal ideation or demonstrated suicidal acts or behaviours from campus, either by immediate suspension or mandatory withdrawal (Appelbaum, 2006).

Among college students in the US, suicide is the second leading cause of death; approximately 1,100 students die annually by suicide (Wilcox et al., 2010). Policies that make suicidality an infringement of a school's disciplinary code are disconcerting, given that suicidal ideation and attempts are common among students (Appelbaum, 2006). Best (2005) identifies deliberate self-harm by young people as a growing concern and, although those working in mental health may be unsurprised, others in mainstream institutions are increasingly confronted by this problem and are not necessarily sure how to respond. Being placed on mandatory leave is not the best option for students who may end up disconnected from their support networks; in fact, home may be the source of conflict (Appelbaum, 2006).

THE CHALLENGE FOR ACADEMIC STAFF

Academic staff often feel ill-equipped to deal and manage disruptive and problematic student behaviours, such as disrespect, sarcastic remarks, rudeness, abuse, arriving late, cell phone usage during class, and unpreparedness (Clark, 2008a, 2008b). These behaviours may, however, be indicative of poor coping and mental health problems on the part of the student.

Early detection and treatment may reduce the persistence of psychiatric disorders, associated functional impairment, and loss of productivity (Blanco et al., 2008). However, unlike the situation at middle or high schools, where parents can alert teachers to psychological problems faced by their children and school counsellors can triage or help to rectify problems, colleges often have fewer processes and systems to help impaired students. Class sizes are often large and vulnerable students can fall through the cracks. Indeed, in Blanco and colleagues' (2008) national US study on the mental health of college students and their non-college-attending peers, almost half of college-age individuals had a psychiatric disorder in the previous year, and college students were less likely to have received treatment in the previous year for their drug/alcohol use disorders in contrast to their non-college-attending peers.

While academic staff are not a substitute for a student counselling service, the principle in loco parentis applies to academics in that they have a professional and legal duty to respond to the student—that is, to act in the student's best interests. Kitzrow (2003, p.173) states: "Philosophically, institutions need to adopt the attitude that student mental health is an important and legitimate concern and responsibility of everyone in higher education" instead of being the sole responsibility of counselling services. For example, if a student health professional is under the influence of, or abusing, substances in either the academic or clinical setting, then staff have a responsibility to protect the student and client from the potential for harm, as the student's ability to provide safe, supportive, and effective health care is impeded (Asteriadis, Davis, Masoodi, & Miller, 1995; Clark & Farnsworth, 2006). One can start simply by discussing concerns with the student in a private area, including the sign(s) and behaviour(s) observed and bearing in mind that similar observations may also be made in students who might not be chemically impaired, but may in fact have a mental health problem (or, perhaps, who have coexisting drug/mental health problems) (Asteriadis et al., 1995) [see Asteriadis et al. (1995) for an example of a comprehensive policy and procedure for chemical impairment and Clark & Farnsworth (2006) for a recovery program].

Students and staff need to be aware of common mental health difficulties and corresponding signs and symptoms so that they are well informed about intervening and can facilitate appropriate referral, thereby helping students overcome the negative effects of seeking help (Cook, 2007). Thus, coordinated education and awareness-raising programs are needed so that persistent behaviours that indicate that there is something amiss for the student are not ignored, minimised, or rationalised (O'Quinn-Larson & Pickard, 1989). Diverse student needs may raise challenges in relation to staff expertise, with some staff not feeling knowledgeable or confident enough to identify and address the mental health issue. Hesitancy in tackling student behaviours may relate to staff finding it difficult to distinguish between behaviours related to impairments versus aptitude or temperament (Clark et al., 2008). Mental health problems can impact on all aspects and levels—individual, interpersonal and institutional—of campus life (Kitzrow, 2003).

For many students, having a mental health concern and accessing mental health services may result in feelings of fear and shame. Staff attitudes themselves are important and, given the perceived stigma that may be associated with mental illness, education programs need to systematically address the education needs of the community about the range of problems and resources and services that are available (Becker et al., 2002). Staff working in higher education are dealing with diverse student populations, decreasing resources, and the erosion of public trust (Clark, 2009). It is also important that factual information is contextualized, such as in the case of those who self-harm, to promote a non-judgemental approach (Best, 2005). University settings should strive to provide a culture in which all members feel they can express themselves safely without discrimination, threats, intimidation, or harassment (Clark, 2008b). Staff also need education to identify disruptive and at-risk behaviours (Clark et al., 2008). It is no longer appropriate to maintain a code of silence around this issue and staff have a crucial role to play in the promotion and prevention of mental health difficulties.

STRATEGIES TO IMPROVE THE MENTAL HEALTH OF YOUNG ADULTS ON COLLEGE CAMPUSES

There is clear evidence that "college student mental health is a serious and growing concern in higher education" (Locke, 2009, p. 21). Indeed, discussion concerning the adequacy of mental health services to meet the needs of students has emerged in part as a result of several high profile suicides and the fragmented campus mental health service provided (Mowbray et al., 2006), as well as concerns about growing demand for

mental health services on campus (Gallagher, 2009; Locke, 2009). While it is acknowledged that the way forward is not completely clear (Locke, 2009), it is clear that processes and care pathways need to be easily understood, user friendly, and appropriately resourced and provide a range of services—brief therapy, individual or group counselling, or referral to off-campus resources. University counselling centres have experienced a sharp increase in demand (Gallagher, 2009; Kitzrow, 2003), and many counselling centres are more clinical and crisis-oriented. This provides challenges for services, which need to be responsive, available, and effective in order to best meet the needs of the entire student population, not only those students experiencing a psychological emergency, such as threatened suicide (Mowbray et al., 2006). Gallagher's (2009) findings highlight challenges to meeting goals of improving student mental health; these include meeting the increased demand, managing growing waiting lists of students seeking support, ensuring adequate psychiatric input, and managing the tensions between student confidentiality and appropriate disclosure where necessary.

The American College Health Association (2010) considers it important to take a more integrated approach between counselling and health services on college and university campuses so that support services and systems are better aligned. This, however, requires administrative coordination, the merging of diverse systems, philosophical consensus among staff, allocating resources, and ensuring that there is clear communication within the university about services. In turn, this integrated approach may enhance staff morale and satisfaction and improve communication, staff relationships, education, and training across disciplines (The American College Health Association, 2010).

Furthermore, clear policies that are understandable and comprehensive are required to ensure that staff can identify behaviours along an at-risk continuum from subtle signs associated with mental illness or substance abuse problems to more established and clearcut features. These policies will need to include unequivocal examples of behaviours and the procedures attached to them. These must, however, ensure due process for students experiencing difficulties in addition to structured support for staff. Clark and colleagues (2008) outline the development of a comprehensive policy initially targeted at chemical impairment, which then proceeded to include mental illness, as well as disruptive and at-risk behaviours. For college or university settings, tackling this spectrum of problems, and addressing all three domains in one inclusive policy, is likely to be more efficient. Such policies and procedures can impact significantly on designated professional responsibilities, and on students whose quality of life is restricted by at-risk behaviours. Further work is also needed to ascertain how academic programs can structure curricula and support to decrease student distress and assist those who are struggling (Dyrbye et al., 2006).

Academic staff need to view the increasing rates of mental disorders as an opportunity to engage large numbers of students who can be accessed during a critical phase of their life, and thereby address a significant public health problem among late adolescents and young adults (Hunt & Eisenberg, 2010). For this to happen, the research base needs to be broadened and agreement made about an agenda that promotes and recognises "that mental health is a foundation for the well-being and academic success of students, all colleges and universities, regardless of their interest in mental health per se" (Hunt & Eisenberg, 2010, p. 8). Mowbray and colleagues (2006) recommend that staff, students, and their families be educated during orientation about early warning signs and symptoms of mental illness as well as campus mental health services. The provision of good mental health care may assist to prevent tragedies, and may also help to retain students (Kitzrow, 2003).

It is reassuring to note that the sharp peak in mental health service use on campuses may be a result of a more positive attitude toward mental illness (Kitzrow, 2003). Mental health services should link with, where appropriate, first-episode psychosis services. Typically, these services have sustained contact with people experiencing their first psychotic episode, are community-focused, integrated with other health care, and provide a seamless interface with all involved agencies (England, Lester, & Birchwood, 2009). Without early intervention services, young at-risk students may experience a long prodromal phase, leading to chronic mental illness (Mowbray et al., 2006). It needs to be emphasised that many students will experience their first episode of psychiatric illness in their late teens or early twenties—75% of mental disorders begin before age 25 (McGorry, 2005)—and that early intervention can assist many individuals to pursue adult goals without interruption (Mowbray et al., 2006).

The literature recommends that treatment provided by large university counselling services should be separate from administrative processes, and that the treatment should be confidential (Appelbaum, 2006), although Gallagher (2009) highlights tensions that can exist between competing demands to maintain confidentiality and also meet organizational requirements for information. Faculty members need to be careful not to delve too deeply into students' individual issues but rather identify concerns, provide referrals, and support the student's academic progress. Further, communication about a student's mental health issues becomes complex when considering regulatory requirements (i.e., how much can/should faculty know about the mental health treatment a student is receiving?).

CONCLUSION

It is not uncommon for college students to demonstrate at-risk behaviours and experience mental health problems that impair their emotional and physical health and have implications for their academic program of study. Differentiating between so-called "normal" early adult behaviours and mental illness can be challenging. With increasing rates of mental disorders among older adolescents and young adults, academic staff need to be aware of how best to engage students whose transition to

university life places them at risk for psychiatric disorders or exacerbates pre-existing problems. Appropriate help for psychological problems can positively impact on students' well-being, academic success, and retention. Processes and care pathways need to be easily understood, user friendly, and appropriately resourced to ensure a range of services. Staff also have a responsibility to intervene with students who may be displaying psychiatric symptoms. With increasing rates of mental health problems, staff need to view this as an opportunity to engage students and assist them during an important phase of their life.

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