GUIDE TO BEST PRACTICE IN

IN INTERNATIONAL STUDENT MENTAL HEALTH 2018

ENGLISH AUSTRALIA

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FOREWORD

When we surveyed ELT colleges in 2017 on mental health issues, nearly 40 per cent of them reported speaking with students who had had suicidal thoughts. That's almost half the English language schools around Australia having to talk to a student who is thinking of killing them self. How do you even begin to address this?

Trying to address this is what prompted us to write this guide. Too often, colleges have few specific resources that can help guide them when thinking about student mental health. We wanted to put something out that is practical, easy-to-use and specific to the unique situation of international students and colleges.

Because it is a unique situation that these students and colleges are in. Students, who are far from home and with few support options, and colleges, who see the language barriers that these students face, are all in a unique situation. Colleges need a specific guide so that they can support their students.

This Guide is packed full of case studies and best practice examples from colleges who have had to support international students experiencing mental health issues. From working with students who are under 18 to questions on confidentiality, you will find tools and information that will help you create an environment where students feel supported should they ever have any mental health concerns.

Now, more than ever, we need to create these environments. In our 2017 survey, over 50 per cent of colleges believed that mental health issues had increased in the last two years.

Come 2018 and the issue has gained a lot of media attention, particularly the social isolation that many international students feel. If this guide helps you create a college where your students know they can get help and turn to you for that help, then the guide has succeeded.

Let's help make our international students look back on their stay in Australia with fondness. Their stay poured $28 billion into the economy in 2017. We want them to talk to us when they are struggling and if we've created the right environment then they will talk to us. I hope that this guide makes that possible. I hope that our international students don't feel like Daniel Kang, a Singaporean student who said, 'I sometimes find that I just resort to speaking as little as possible to save myself any shame.'

CEO English Australia

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EXECUTIVE SUMMARY

1.1 Why are International students vulnerable?

Australian ELICOS providers are aware that mental health issues can seriously impact on student course progress. Students may arrive with a pre-existing mental health disorder or experience mental health difficulties while in Australia. Situational factors such as grief, relationship break-up, assault, financial stress – among many others – may significantly affect individuals.

International students face challenges beyond the norm

Most obviously, these students are away from home and their usual support networks. Whether or not they are ready to do so, they will have to cope with some degree of independent living. They are far from their home culture and faced with a range of differences in culture, food, language and so forth.

International study costs add significant pressure to the student

Whatever their course of study, there will be significant financial costs that are often being borne by someone other than the student, be it family or some other source of funding. This can create added pressure to succeed.

Students can rarely adjust their study demands and comply with their visa requirements

A reduced study load is often a flexibility that is available to a local student, but it is not a simple matter to provide this to an International student.

Limited english can restrict communicating the complexities of mental health issues

The language associated with mental health is complex, and it may be hard for ELICOS students to articulate exactly what is going on for them.

Under 18 students add complexity

The 2017 English Australia Market Report showed that 13 per cent of ELICOS students were under 18 years of age. This adds another layer of complexity to questions of disclosure and confidentiality.

1.2 Colleges themselves face their own unique challenges

The cost of mental health support services limits the support elicos providers can give

It is commonly observed that effective professional mental health support can be expensive. That is, employing fully qualified staff such as clinical psychologists can be beyond the means of many institutions – and the cost of referring students to specialist external services can also be substantial.

Staff may have limited experience in dealing with mental health issues

While many colleges have engaged in Mental Health First Aid training and Applied Suicide Intervention Skills Training (ASIST), some staff may still have had little exposure to or experience with mental health issues. Further, staff may not clearly understand who exactly is responsible for mental health issues within their institution.

Students may believe disclosing mental health issues will adversely affect them

Stigma associated with mental health means that students may be unwilling to disclose difficulties they are experiencing and access help. Some fear that disclosure may adversely affect their course progress or that their issues will be relayed to people in their home countries.

Students may not be aware they have a mental health issue

There are many students with undiagnosed issues – especially those

arriving with pre-existing and undisclosed conditions. Few disclose a mental health condition before arrival even though they have the opportunity to do this in enrolment documents.

Students may not continue their medication in australia because it is costly

Many of those with an existing condition or diagnosis do not bring their medication to Australia and others discontinue their medication in Australia after it runs out for the first time, especially if they do not know how to access their medication in Australia.

Staff may not understand how confidentiality works with mental health

There is concern about understanding and clarifying the limits of confidentiality, especially with students under 18 years of age.

The effects of 'culture shock' compared with mental illness may be hard to distinguish

Feelings of helplessness, a sense of not being fully in control – leading to symptoms such as feeling vulnerable, fearful, anxious, confused, crying or sleeplessness can all reflect 'culture shock' and mental illness. This further compounds managing ELICOS students' mental health.

Students may not have experienced the Western mental health model of care

There may be significant differences between the Western mental health model of care and other models used in students' home countries. Different understandings of mental health can mean that students have different expectations of what a mental health issues is, how it can be treated and what 'confidentiality' is.

2. What mental health issues do ELICOS students experience?

The most common conditions that affect international students are:

- anxiety
- depression
- extreme worry
- grief related stress.

Forums helped us understand the mental health challenges elicos providers face

These forums, in late 2017 and early 2018, allowed us to collect qualitative data on these challenges. We also surveyed ELICOS providers to understand the mental health landscape that they face.

ELICOS providers are increasingly dealing with mental health issues

Over 50 per cent of ELICOS colleges surveyed believe the number of students with mental health issues has increased in the past two years. This is placing an increased strain on the quite limited resources of many ELICOS providers.

The feedback in our member survey is reasonably consistent with wider statistics

Our survey statistics parallel the ABS' but these figures do only show the reported instances of mental health issues. Many mental health issues are often cloaked in a sense of shame or secrecy, for example eating disorders or addictions, so the instances of these issues may be higher.

All conditions are serious regardless of their frequency

Some conditions that occur less frequently include suicide and self-harm, perhaps two of the most serious conditions.

'Suicidal thoughts' and 'self-harm' are critical and you must take them seriously

Suicidal thoughts are one of the risk indicators for attempted or completed suicide and a student who expresses some sort of suicidal ideation cannot be ignored. Self-harm behaviours are not necessarily associated with suicide but are serious and require swift intervention.

Extrapolating ABS figures to International students may imply suicide does occur

While the probability of such critical events occurring in any particular institution is low, it is very clearly a possibility that must be considered.

3. What are the key features of best practice in mental health?

This list has been derived from Reavley et al. (2011) *Guidelines for tertiary education institutions to assist them in supporting students with a mental illness*, with some modification to be more relevant to the international student context in general and ELICOS context in particular.

Written policy
Institutions should have clearly articulated written policy for staff and for students outlining how the college manages mental health issues.

Promotion
Institutions should clearly promote the mental health services available to students via a range of channels and media.

Staff training and awareness
Institutions should have clear processes and training for staff members who are required to respond to students experiencing mental health difficulties.

Healthy lifestyle Promotion
Institutions should offer activities which are proactive preventative measures that encourage social engagement, physical activity and other healthy lifestyle activities to create an environment where mental health issues are less likely to occur.

Early identification
Institutions should have procedures in place to identify students with mental health issues as early as possible, in the knowledge that this leads to more effective intervention.

Availability and provision
Institutions should be able to directly provide short-term mental health services to students or be able to quickly refer students to external service providers.

Reasonable adjustments
Students experiencing mental health issues should be able to access reasonable adjustments to matters affecting their academic progress such as assessment deadlines and attendance requirements.

Communication and record keeping processes
Institutions should have clear processes for communicating with students regarding mental health issues.

4. What extra resources are available to colleges?

This guide provides extra resources such as contact information for general and specific service providers that deal with mental health. However, it is difficult to be highly specific about local resources available to any particular college. Local services can vary quickly with funding arrangements. Colleges should seek to update contact information about resources at least annually.

Provide staff with a small number of resources rather than an extensive list

Providing staff with a large data base of all the mental health resources that are available in an immediate geographical area can result in confusion and miscommunication. This is because there are a substantial number of services such as those dealing with sexual assault, gambling, substance abuse and multiple private practitioners. It can be almost too easy to develop an unwieldy resource package that is difficult to use. It is better practice to advise staff of a small number of resources, such as:

- Who to call in an emergency or obvious crisis (such as security or police)
- 24/7 crisis numbers
- An operational area/person within the college such as counselling, student advisory services or the principal that has responsibility for further management of the presenting issue.

That area or person should maintain a more comprehensive working resource list.

5. Where can a college find further information?

The Guide concludes with an annotated set of further reading suggestions, which can help those who wish to pursue information in more depth.

CHAPTER 1:

WHAT CHALLENGES EXIST FOR INTERNATIONAL STUDENTS AND ELICOS COLLEGES?

1.1 Why are international students vulnerable?

Mental health issues are a significant challenge in the international student environment in Australia in many ways. Most importantly, a serious mental health problem is distressing to the student involved. Moreover, the the student's capacity to meet study demands in a timely and effective way may be compromised, which can affect their ability to succeed in their chosen course.

Recent media focus on student mental health has raised its profile

The mental health of students has been an area of media attention in recent years. In particular, the media has often focused on students in higher education, who are a vulnerable group for several reasons:

- The majority of students are within the age range 18-24, which is typically when a number of mental health issues first become apparent.
- Few higher education students have the financial resources to access mental health services at full market price. In addition, some overseas student health cover may have a qualifying period or other potential barriers to access services.
- The academic demands, expectations and deadlines that higher education students are expected to meet can compound mental health problems.

International students are away from home and their usual support networks

For International students, there are additional aggravating factors. In particular, these students are away from home and their usual support networks. Whether or not they are ready to do so, they will have to cope with some degree of independent living. They are far from their familiar culture and faced with a range of differences in their education, food, language, accommodation and so on.

International study costs add significant pressure to the student

Whatever their course of study, there will be significant financial costs that are often being borne by someone else other than the student, be it family or some other source of funding. This can create added pressure to succeed. Students may not necessarily be studying a course they would have chosen as a personal preference – but instead may be enrolled in something that is expected to "pay off" in some way.

In many cases, families in a student's country of origin are direct stakeholders in the student's education in Australia. If they are aware of mental health problems being experienced by the student in Australia, parents and other family members may become very concerned. However, often the family remains uninformed of mental health issues unless they reach a critical point.

Students can rarely adjust their study demands and comply with their visa requirements

Visa compliance demands for International students also add to their levels of stress. Most notably, International students are expected to maintain a full-time study load and satisfactory progress. ELICOS students are required to study a minimum of 20 hours per week face-to-face and maintain a minimum of 80 per cent attendance. These expectations add a layer of difficulty if mental health issues are experienced by the student. A reduced study load is often a flexibility that is available to a local student, but it is not a simple matter to provide this to an International student.

Limited English can restrict communicating the complexities of mental health issues

For ELICOS students there are two other factors. They are enrolled in ELICOS courses precisely because their English language ability is limited. The language associated with mental health is complex, and it may be hard for ELICOS students to articulate exactly what is going on for them. Most psychotherapeutic interventions are heavily dependent on language, and most providers of such services in Australia will be speakers only of English. There are major challenges for mental health professionals in Australia in providing assistance to clients with limited English language.

Under 18 students add complexity

The second factor for ELICOS students is that there is a proportion of them who are under 18 years of age (in 2017, the English Australia Market Report showed that 13 per cent of ELICOS students were under 18). This adds another layer of complexity to questions of disclosure and confidentiality.

1.2 Colleges themselves face their own challenges

Forums helped us to understand the mental health challenges ELICOS providers face

In late 2017 and early 2018, a series of discussion forums with key staff from English Australia member institutions in different Australian states took place to collect qualitative data for this Best Practice Guide. At the same time, an online survey of ELICOS colleges was undertaken with 94 institutions responding. The comprehensive survey data alongside the qualitative data from the forums give a snapshot of the current mental health landscape in the ELICOS sector.

The cost of mental health support services limits the support ELICOS providers can give

In this context, survey respondents noted some issues in how they are able to deliver support. Firstly, it is commonly observed that effective professional mental health support can be expensive. That is, employing fully qualified staff such as clinical psychologists can be beyond the means of many institutions – and the cost of referring students to specialist external services can also be substantial. For some smaller institutions, there can be resourcing issues in accessing appropriate external professional mental health services in a timely way.
Many ELICOS students are not fluent in English and find it hard to articulate mental health issues. It can be difficult to find affordable counsellors in the community who speak the students' home country language.

Staff may have limited experience in dealing with mental health issues

Many smaller colleges do not employ a professional counsellor who has no other duties. At the same time, many colleges indicate a challenge for them is a shortfall in staff expertise and/or exposure to mental health issues. The person who was described as having responsibility for mental health issues was sometimes variously described as the principal, director, senior teachers, or student services staff – that is, staff who may not have specific professionally registered qualifications in these issues. In very many cases, colleges have sought to equip these key staff by engaging in Mental Health First Aid training, Accidental Counsellor training and Applied Suicide Intervention Skills Training (ASIST).

Good practice examples

College A does not have a dedicated student counsellor. Instead, they have identified staff members who are usually the first respondents to students experiencing mental health difficulties, or who are responsible for having issues escalated to them. These include student services staff, accommodation officers, the Director of Studies and the Principal. The college engaged an external provider to deliver the Mental Health First Aid course to these staff. Staff found the course useful for being better equipping them to recognise when issues need to be outsourced to a professional, such as a psychologist or doctor, and for raising their confidence levels in assisting students. This approach has also freed up the time of senior management as fewer cases have been escalated to them.

College B notes they do have specialist staff, but that it is also useful to have a wider safety net: "We have a dedicated student counsellor and customer service manager who are responsible to ensure contact with the student is made and additional support hours are available. With ELICOS students, they are also approaching the senior teacher when they feel they would like to have someone to speak with who is closer to them. Forms of communication will include phone, email, Facebook, agent, family member, emergency contact etc."

College C provides a dedicated student counsellor. "That staff member works with the customer service manager to ensure contact is made with students who have shown some behavioural signs that they may be dealing with a mental health issue. That is, we don't wait until the student makes an appointment to see someone; we reach out to students who we see as being at-risk."

Students believe disclosing mental health issues will adversely affect them

There is stigma associated with mental health and students may be unwilling, for whatever reason, to disclose and then access help. Some are fearful that disclosure will mean they are sent home or that it will affect their grades.

Students may not be aware they have a mental health issue

There are many students with undiagnosed issues – especially those arriving with pre-existing and undisclosed conditions. Few disclose a mental health condition before arrival even though they have the opportunity to do this in enrolment documents.

Students may discontinue their medication in Australia

Many of those with an existing condition or diagnosis do not bring their medication to Australia and others discontinue their medication in Australia after it runs out for the first time. This can be due to the cost of medications in Australia or because students do not know how to access their medications and prescriptions here.

Staff may not understand how confidentiality works with mental health issues

There is concern among some ELICOS colleges about understanding and clarifying the limits of confidentiality, especially with students under 18 years of age.

The effects of 'culture shock' compared with mental illness may be hard to distinguish

It can sometimes be difficult for college counselling staff to distinguish between mental health and the relatively common stress associated with Acculturative Stress (sometimes referred to as "culture shock"). Many students will find the transition to study in Australia to be psychologically demanding. There may be feelings of helplessness, a sense of not being fully in control – leading to symptoms such as feeling vulnerable, fearful, anxious, confused, crying or sleeplessness. These mimic some more severe psychological problems but are a normal part of adjustment and are usually time limited to a few weeks or up to a month or two. Effective orientation programs will go a long way to helping students with this kind of transition.

Another significant challenge for education providers is the difference between the Western model of mental health used in Australia and other models used in International students' home countries, where there may be a significantly different understanding of mental health. For example, the systems of Chinese medicine or Indian Ayurvedic medicine are very different from the Western model. Some students may also come from regions where there is an animist view of mental health or from traditions where religious views cross over into views on mental health.

International students may perceive mental health issues and treatment differently

International students therefore often have different expectations of what a mental health issue is, how it is diagnosed and what treatment options are available, which can create potential barriers to help seeking among students. Students may also come from a background where confidentiality and disclosure issues do not have the same meaning. Education providers should ensure they provide explanation of the Western model of mental health to students to demystify not only some of the terminology used but also how the system works, who they key people are and what students can expect if they attend counselling or mental health services.

Insurance providers use the Western mental health model to frame benefits payable

It is also important to educate International students around access and benefits available to support treatment for mental health illness. The Western mental health model uses Mental Health Care Plans that follow the Medicare framework and provide benefits as listed in the Medicare Benefits Schedule (MBS). This model allows for benefits to be paid with those counselling type services not deemed as psychiatric, which is consistent with the Western psychiatric model.

Some insurance providers cover psychiatric sessions but check your student's policy

Note: the benefits of Overseas Student Health Cover (OSHC) for mental health support are based on the OSHC Deed requirements and framed in the following way at the time of publication of this Guide – "After having completed a 2-month waiting period for pre-existing psychiatric illness with valid Student visa and valid policy, overseas students access a benefit per the MBS fees with the maximum of 10 sessions per calendar year." Precise terms of coverage can change from time to time, and ELICOS providers may find it useful to check the policy product disclosure statement for specific information.

Appendix A explains in more detail the Western mental health model process for diagnosing mental health issues and treatment options.

Good practice example
ELICOS students may be reluctant to connect with professional help. **College D** has taken this approach: "Attendance is often our way of getting reluctant students to seek help for mental health difficulties. If mental health issues are given/suspected as the reason for absences, we help the student make an appointment with a trained counsellor and ask them to discuss the absences with the counsellor and to find out whether the counsellor would support a break from study. If there is a formal deferral, we stay in touch with the student to make sure they are making positive steps to improve the mental health issue. In some cases, we ask that the student have an ongoing plan for treating their mental health problems. In the case of anxiety, we can arrange an intervention plan which reduces the number of class hours and stress from study, in return for attending the remaining classes. In serious cases, we have a daily check-in and the student is contacted every day that they miss class to make sure they are OK."

Appendix B shows a poster from one ELICOS college which explains the different services available in Australia that can assist people with mental health difficulties. The poster uses simple language that International students can understand and it aims to demystify the Western mental health model for students.

Case Study: DUELI, Deakin International, Deakin University – Breaking down barriers

DUELI is an English Language Centre based in Deakin University in Melbourne and has an enrolment of 600-1000 ELICOS students.

Our first contact with students is at orientation. Our DUELI Leadership and Internship Program Leaders (Leaders), students who have completed their English language studies and are now enrolled in an award course at Deakin, provide the welcome speech and flag available support services.

After the welcome, students are taken on a campus tour led by a teacher and accompanied by a (student) Leader and sometimes also by a DUELI Volunteer (current DUELI students). The Leaders assist with answering questions students are too scared to ask the teacher and they provide advice and tips from their own experience.

On the tour, the campus medical centre is introduced and the services discussed. We link feelings/ problems with the service so that students have a better grasp of the different services, particularly with counselling, which is not common in many overseas countries. We explain that if you feel sad and lonely or are not sleeping well or feel very homesick you can speak to a counsellor. We compare it to being sick (e.g. having the flu) and seeing a doctor and explain that in Australia seeing someone for mental health difficulties is normal and very common - and importantly - completely confidential.

We emphasise that student's parents, schools, husbands or wives cannot be given any information about the appointment as this is often a concern. Recently, we had a student that was hesitant to meet a psychologist because he didn't want his university in his home country to get the information as it would impact on his ability to find employment later on.

The Leaders are visible through the Intake as they provide weekly social activities for the students focussed on wellbeing (cooking classes, resume writing, sports games etc.). Students often ask questions of the Leaders because they can relate to them. Leaders and Volunteers refer students to student advisors either because the student has asked for help or because the Leader or Volunteer is concerned about the student.

The Leaders and Volunteers are provided with information during their training about support services and different behaviours and feelings which students may not realise warrant attention.

They are taught that in Australia help-seeking behaviour is encouraged and that confidentiality is of the utmost importance. In my experience students are often as likely to trust a fellow student (Leader or Volunteer) as a staff member they are not familiar with.

Case study by Krystal Agourram, DUELI Student Experience and Engagement Coordinator

CHAPTER 2:

WHAT MENTAL HEALTH ISSUES DO ELICOS STUDENTS EXPERIENCE?

Our mental health survey helped identify issues that students face

One of the aims of the mental health survey undertaken by English Australia was to collate data on the mental health landscape in the ELICOS sector. A key question asked was: "In the past 2 years, which mental health issues have students at your institution experienced?" Table 1 shows the the broad range of issues that students face.

Four key conditions are prevalent in ELICOS students

It is highly likely that staff in ELICOS colleges will be faced with the four most frequently reported issues in any cohort of students:

- anxiety
- depression
- extreme worry
- grief related stress.

This information can help guide ELICOS colleges?

The issues in Table 1 can act as a guide for ELICOS colleges in a number of ways including:

- Ensuring support services are available to their students in these areas;
- Planning staff training areas;
- Creating awareness campaigns and activities for students;
- Creating prevention campaigns and activities for students.

Table 1: "In the past 2 years, which mental health issues have students at your institution experienced?"	Percentage Reported
Anxiety	89.29
Depression	80.95
Extreme worry (e.g. due to financial concerns, study)	72.62
Grief related stress*	67.86
Social withdrawal	52.38
Panic attacks	52.38
Suicidal thoughts	39.29
Domestic violence	38.10
Internet and/or gaming addiction	38.10
Feelings of extreme highs and lows	36.90
Substance abuse	29.76
Self-harm (e.g. cutting) or risk of self-harm	28.57
Debilitating acculturative stress	25.00
Eating disorders	25.00
Drastic change in behaviour/demeanour	21.43
Psychosis	17.86
Post-traumatic stress (PTS)	15.48
Paranoia	13.10

*Grief related stress can be related to a number of different causes such as a death of a family member or a relationship break-up.

Note: In addition to these difficulties, many ELICOS colleges have also reported that insomnia and sleeping difficulties are very common among their students.

ELICOS providers are increasingly dealing with mental health issues

Over 50 per cent of ELICOS institutions surveyed note an increase in how often they are dealing with mental health issues over the past 2 years.

A little over one third report that such issues arise at least weekly. Unsurprisingly, smaller institutions have to address mental health difficulties less often. There are implications for service delivery in this.

A larger enrolment means it is more likely that the institution will have in-house mental health services and that staff will have some regular exposure to and practice in responding to mental health issues. For smaller colleges, a major mental health crisis may be very infrequent. Such institutions probably will not have specialist staff and may be challenged each time a major event occurs.

The feedback in our member survey is reasonably consistent with wider statistics

There are no comprehensive national figures for International students at a whole population level, and we must therefore rely on extrapolating from data for the more general population. In this way, using the most recent data available from the Australian Bureau of Statistics on the 'Mental Health of Young People,' (2007), it is evident that our survey data reported in Table 1 is quite consistent with statistics from the wider community.

Appendix C shows the most recent data available from the Australian Bureau of Statistics on 'Mental Health of Young People' and an extrapolation of this data to the International student population in Australia.

Students may hide some of the other reported conditions

For example, "Social Withdrawal", "Internet/Gaming Addiction", "Domestic Violence", "Substance Abuse", and "Eating Disorders" are issues that are often cloaked in a sense of shame and secrecy; and they are also likely to recur or relapse over extended periods of time. This means that they may be occurring more than is represented in this data.

All conditions are serious regardless of their frequency

We must also remember that low frequency of occurrence is not an indicator of seriousness. For example, ELICOS institutions do not report highly frequent instances of "Psychosis," "Post-Traumatic Stress Disorder" or "Paranoia." Nonetheless, these are debilitating and distressing issues for the student involved and may have significant ripple effects on staff and other students.

'Suicidal thoughts' and 'self-harm' are critical and you must take them seriously

Finally, we should note the categories of "Suicidal Thoughts" and "Self-harm (e.g. cutting) or risk of self-harm" must be taken very seriously. Suicidal thoughts are one of the risk indicators for attempted or completed suicide and a student who expresses some sort of suicidal ideation cannot be ignored. Self-harm behaviours are not necessarily associated with suicide but are serious and require swift intervention.

Extrapolating ABS figures to international students implies suicide does occur

There appear to be no statistics specifically pertaining to International student suicide in Australia. However, if we extrapolate from Australian Bureau of Statistics figures for Australians (which may or not be valid for International

students), we could anticipate several dozen completed suicides per year across the nation. We should also be aware that for every completed suicide, there are many more attempted suicides. So while the probability of such critical events occurring in any particular institution is low, it is very clearly a possibility that must be considered.

Suicide risk indicators

Research suggests that people do not attempt suicide "out of the blue." Some risk indicators include:

- An expressed sense of hopelessness – e.g. in conversation, emails or on social media.
- Easy access to lethal means – although in many respects we all have access to lethal means, easy access to ropes, firearms, drugs and the like increase the risk level.
- History (previous attempts, past trauma or abuse, family suicide).
- Recent major loss – such as poor academic results, relationship break-up, death in family, social conflict.
- Impulsive or aggressive tendencies.
- Alcohol and other substance abuse – a person whose thought processes are affected by a psychoactive substance may act out whilst under the influence.
- Untreated mental illness, especially depression.
- Lack of social support - international students are often at higher risk.
- Resistance to seeking help.

Students showing such indicators should be connected to professional help as soon as possible.

Suicide safety plan

Appendix D contains a sample Suicide Safety Plan. If you are satisfied that a student does not have any immediate intent to act on suicidal thoughts, but you are nonetheless concerned for their wellbeing, it is useful to agree on a Safety Plan. This is intended only to help manage a situation in the short term until the student can be linked to professional help.

Good practice examples

College E ensures that any expressed threat of self-harm or suicide is taken seriously. For example, if a student says in an email something like: "If I fail this assignment, I'll jump in front of a train", it should not be dismissed as a threat. Staff members are asked to follow up by asking directly if if the student has been thinking about suicide, and if so, to explore details to get a picture of whether there is any clear plan or intention. Staff will show interest and will have clear information about services immediately available to the student. If the student is able to reassure the staff member that they are not suicidal, they are still provided with support information and 24-hour crisis information. Staff are very specifically directed to avoid being sworn to secrecy by the student, and will seek support and consultation for what has occurred with another staff member – preferably the counsellor or "direct-report" mental health staff member– as soon as possible.

College F has an easy-to-use "check-in" system where students at-risk of self-harm can send an "I'm OK" message on a daily basis.

College G ensures that a critical number of staff members, including those responsible for student counselling, some student services staff and some key teaching staff, have undertaken the 2 day Applied Suicide Intervention Training (ASIST) course.

CHAPTER 3:

WHAT ARE THE KEY FEATURES OF BEST PRACTICE IN MENTAL HEALTH?

ELICOS colleges are conducive to identifying student mental health difficulties

Difficulties with mental health are generally first manifested in places other than treatment centres. Problems will show first in the home, the classroom, the workplace, or amongst friends and colleagues. The relatively intimate environment of an ELICOS centre, where students meet with the same teacher and classmates for the duration of a course which is usually at least five weeks long, makes it an important place where students can be supported through mental health difficulties. Given that up to 70 per cent of ELICOS students are on pathways to higher education, the ELICOS centre can be seen as a critical opportunity for early intervention into mental health issues.

Essential elements derived from Reavley et al. (2011) and our research

It is therefore crucial to consider how we respond. Section Three of this Guide explores in detail the essential elements of effective practice in managing International student mental health. This list has been derived from Reavley et al. (2011) ***Guidelines for tertiary education institutions to assist them in supporting students with a mental illness***, with some modification to be more relevant to the International student context in general and ELICOS context in particular. These modifications are based on data from our mental health survey and discussions from our mental health forums.

Best practice in mental health issues should focus on two goals

When considering these essential elements, it is important to remember the two key goals of effective practice in addressing mental health issues with International students:

Goal One: To connect the student to the most appropriate source of professional help in the most timely way.

Goal Two: To enable the student to succeed with their program or enable the student to return home with as much dignity as possible.

3.1 There are ten essential elements of best practice

1. Written policy

Institutions should have a clearly articulated written policy for staff and for students outlining how the college manages mental health issues.

This should include step-by-step procedures which address the key issues listed below:

- mental health promotion and mental illness prevention
- services for students with mental health issues
- the place of mental illness within disability policy
- the provision of services for students with mental health issues
- crisis and critical incident processes
- staff training and awareness.

Mental health professionals should be consulted in forming these policies. It is essential to review policy from time to time to ensure that is compliant with legislation and meets the needs of stakeholders.

Samples of written policies

- University of Western Australia: www.hr.uwa.edu.au/policies/policies/equity/mental-health
- Sydney University: www.sydney.edu.au/dam/corporate/documents/about-us/values-and-visions/healthy-sydney-university-mental-wellbeing-policy-brief.pdf

2. Promotion

Institutions should clearly promote the mental health services available to students via a range of channels and media. This should not be limited to orientation periods but should be re-delivered in different ways throughout different study periods. At least some of the material should be available in languages other than English, if possible.

Channels for promotion include:

- printed information on posters, pamphlets/brochures
- college websites
- electronic channels that students access such as the Learning Management System (LMS) or social media platforms
- screens in classrooms, libraries and administration areas
- global and targeted emails – particularly during high stress periods (for instance assessment deadlines or examinations)
- student mentors or student leaders
- communication channels within student residences
- special events such as establishing a Mental Health Week, an RU OK? campaign or mental health workshops
- class curricula (some institutions have embedded welfare and mental health awareness units in curricula).

Good practice examples

College H notes: "We have posters in the centre, information in student handbooks of how to access help and a flowchart for teachers to follow to assist them when students have presented with issues. The wider University has developed modules for all students (including ELICOS) to access from the Learning Management System and it runs mental health campaigns such as RUOK? Day."

College I offers mental health seminars and workshops around exam time. Workshops include interactive activities such as role plays where students can practice asking each other if they are OK and encouraging their peers to seek help from the school counsellor.

College J asks their student ambassadors (current higher level students who have been at the school for longer) to check in with their peers. "They have helped us to identify a few minor issues with some students struggling to cope or adjust beyond the expected initial 'culture shock' period. They generally defuse a lot of new student anxiety as students know they can speak with someone from the same culture in their language."

Case Study: Curtin English – Embedding mental health information in the curriculum

Curtin English operates as part of Curtin University, Perth. It enrols approximately 300 ELICOS students.

To help destigmatise mental health and make it easier for students to seek help, Curtin English has included mental health topics in the classroom curriculum and social program it offers. All new students to Curtin English are required to take "Curtin Life." Approximately five hours of class time is spent on mental health issues within Curtin Life largely focusing on mental health awareness raising and recognition of warning signs and symptoms as well as strategies to overcome these.

Curtin Life also places emphasis on physical and social activities that help prevent mental health issues and a concerted effort is made to help students become involved. Student leaders are invited to organise class groups to attend exercise classes such as Spin, Zumba and yoga along with staff from Curtin English and to participate in fitness events held in Perth such as the "HBF Run for a Reason." Physical activities are offered every one to two weeks and are emphasised during busy periods and Curtin English assessment weeks.

Some of the outcomes of Curtin Life include:

- Students can identify the different services available at Curtin University and can prioritise those of most benefit to them.
- Students can identify and discuss the differences and similarities in cultural awareness between their home country and Australia.
- Students can identify and suggest ways of overcoming culture shock in different scenarios.
- Students can understand the importance of healthy living to support their studies by creating a list of activities.
- Students can discuss ways of creating a study and life balance based on different scenarios.
- Students can understand the terms stress and depression and can identify signs of these in themselves and their peers.

Appendix E contains sample lesson content from Curtin Life.

Case study information provided Leanne Howarth, Manager Teaching Programs, Curtin English

3. Staff training and awareness

Institutions should have clear processes and training for staff members who are required to respond to students experiencing mental health difficulties. There should also be clear procedures for making all staff aware of the institution's mental illness policies and procedures.

Best practice in staff training includes the following practices:

- Giving staff who are not professionally qualified in mental health access to information that gives them a sound awareness of the range and nature of mental illness, how common it is, warning signs and indicators, likely effects on study, information to help

dispel myths and to reduce stigma associated with mental illness and ways to support students with mental illness.
- Providing the opportunity for a critical proportion of staff to complete the more intensive training provided by Mental Health First Aid.
- Developing clear protocols for staff to follow if they suspect a student is having difficulties with mental illness and providing training in these protocols. The general principle of the "Two Stop Shop" is recommended – that is, if the first person that a student approaches is not able to help, then the second person that the student sees should be in a position to provide help or advice. This model is workable when all staff have a sound awareness of the range of services and support available to students.
- Providing training to all staff about how to proceed in the case of a critical incident or mental health crisis.
- Providing the opportunity for support service teams to meet regularly to share information (within the limits of confidentiality) regarding students of concern.
- Providing staff who are professionally qualified in mental health with appropriate professional development support to maintain their expertise and registration.

Good practice examples

One institution uses a 'Students in Distress Flowchart' with its teaching staff to assist them in determining levels of student distress and respond appropriately. Teachers are trained in the use of this Flowchart by counsellors from the Student Counselling Service.

Appendix F shows this Flowchart.

College K says: "The college ensured the Manager of Teaching Programs and Coordinators did the Mental Health First Aid course and some of our teachers have also completed the two-day course. We aim to ensure all teaching staff do it. The course helped raise awareness of mental health within the centre as opposed to it being a 'taboo' subject. It enabled staff to identify issues and deal with them appropriately before referring students to the experts."

At one college counselling staff conduct professional development sessions with class teachers where they focus on a particular mental health issue that the teachers' students may experience, such as anxiety and/or panic attacks. Teachers are presented with situations that might occur with their students and role-play how they would respond to these. Counselling staff offer their support and expertise during these workshop sessions.

Some colleges have collated materials and useful websites about mental health on their teacher Learning Management System for staff to refer to when necessary.

How to suggest counselling

- Set a time to talk privately.
- Communicate your concern.
- Ask and listen.
- Bring up idea of counselling as resource.
- Avoid a power struggle.
- Don't diagnose or be judgmental.
- Remain calm.
- Normalize counselling.
- Stress confidentiality.
- Describe the counselling service or nominated student counsellor at the institution and how to access, in detail.
- Recommend a specific counsellor.
- Look for leverage: e.g. career or health focus.
- Check back with student; allow some time.

A POOR PRACTICE EXAMPLE: WHAT STAFF SHOULD AVOID

The behaviours below are not only unhelpful but can potentially make things worse:

- Over-reacting – magnification of issues and involving too many people.
- Under-reacting – missing the seriousness of the issue.
- Downplaying – "pull your socks up; you'll get over it".
- Fearful responses – reacting to unusual or eccentric behaviour by amplifying your own anxiety.
- Super Rescuer – believing it is your role to "fix the issue".
- Personalising – "this is what worked for me, so it will work for you".

4. Healthy lifestyle promotion

Institutions should offer activities which are proactive preventative measures that encourage social engagement, physical activity and other healthy lifestyle activities to create an environment where mental issues are less likely to occur. The easiest mental health problem to address is the one that does not take place.

Examples of preventative activities include:

- Social engagement activities – especially those involving face-to-face contact. Examples include student excursions, volunteer groups, special events (such as fundraisers) and cultural events.
- Physical activities – mental health experts are aware that exercise is possibly the single most important behaviour that makes an early difference to many mental health problems. Examples include discounts on gym membership, ad hoc social sports such as Frisbee (space permitting), or organised team sports, which have additional social benefits.
- Relaxation/meditation/mindfulness – these activities are especially useful for students susceptible to anxiety. Many institutions have established relaxation, meditation or mindfulness groups and/or classes.
- Independent living skills programs– students can struggle with budgeting, shopping and basic cooking. Poor diet and financial worry can raise stress levels.
- Programs/workshops/campaigns aimed at targeting unhelpful behaviours such as smoking, alcohol and other drugs, gambling and excessive internet usage.

Good practice examples

College L has negotiated an agreement with a local gym whereby their students receive discounted memberships.

College M makes treadmills available to students. They place them at the end of empty corridors and in otherwise unused spaces.

College N has a gardening club where students plant and grow vegetables and then take them home. Students report benefitting physically, mentally and financially from this. The initiative also encourages belonging and promotes mindfulness.

College O offers art therapy classes to its students. They also have days when friendly dogs are brought into the campus, as pets are proven to decrease stress and increase positivity and can make students feel less homesick.

5. Early identification

Institutions should have procedures in place to identify students with mental health issues as early as possible, in the knowledge that this leads to more effective intervention. If there is a pre-existing mental health condition, it is useful to know about it as soon as possible.

Approaches that can assist in early identification and intervention include:

- Promoting information that "de-stigmatises" mental health as much as possible so that students feel it is OK to disclose a mental health condition. Effective promotion often gives the message that a mental health issue is just like any other health issue. The principle should be "you wouldn't tolerate a major toothache for very long without seeing a dentist....so why tolerate something that messes with your head before seeing a counsellor?"
- Ensuring there is a clearly-identified person or service that students can approach with mental health issues and making sure students are aware that their confidentiality will be respected.
- Training all staff to be aware of the signs of disengagement that may indicate a mental health problem. Non-attendance, reduced participation, failing to submit work, not logging into student portals and poor grades all show that a student is struggling in some way.
- Developing systems to identify disengaged students and those who are struggling and to check-in with them and/or ensure that contact is made with them.
- Action taken on visible signs of a distressed student – such as a student in tears, highly stressed, inappropriately angry, signs of poor self-care, visibly affected by drugs/alcohol or any other behaviour that appears inappropriate or extreme in the circumstances. Such students should be connected to support services as soon as possible.
- Simple reporting processes for staff and students. The most likely people to observe that a student is experiencing mental health issues will be housemates, friends, class teachers or student services staff. There should be clear and simple ways for these people to advise responsible staff of their concerns so that appropriate action may be taken.

Pre-disclosure of existing mental health illnesses

Colleges should encourage students and agents to disclose their mental health conditions or learning difficulties at the earliest possible stage. Most ELICOS

colleges give students the opportunity to disclose pre-existing mental health issues on their enrolment forms. However, colleges reported in our survey that students rarely do pre-disclose this information.

Enrolment forms should clarify reason for pre-disclosure question

One way to increase the rate of disclosure is to make it clear on enrolment forms that pre-disclosure will not adversely affect the student and that, on the contrary, the information will be used to assist them and make any necessary provisions for them to be able to succeed in their course(s). It must also be noted that some enrolment forms frame the disclosure question in terms of disclosing a "disability." This may partly explain the low rate of disclosure as incoming students may not necessarily see a mental health issue as a disability.

Good practice examples

College P has a policy whereby non-attendance for two days will trigger the following procedure: 1) A staff member will try to call the student to check that they are OK. 2) If they cannot reach the student by phone, an email and text message will be sent to the student expressing the college's concern about their well-being and asking the student to contact them to confirm they are OK. They also let the student know that if they do not hear back from them by the next day, and cannot get in contact with their nominated emergency contact person, the college will need to contact the police to report them as a missing person.

One college notes that administration staff play an important role in early intervention to mental illness. Staff report any concerning behaviour they observe to the Student Advisor, who follows up with the student. One time, a reception staff member observed that a student regularly sat at the couch near Reception and spoke aloud to himself and would approach the desk and ask illogical questions. This student was later diagnosed as experiencing a psychotic episode.

College Q says: Any student with a current attendance under eighty percent receives a warning letter in class and is required to attend an appointment with the Student Advisor. In this appointment (scheduled during class time to maximise the student being available to attend) the Advisor ascertains if the student needs any extra support. Students who miss their scheduled appointment are followed up with by email and text message. In one case a Student Advisor contacted a student by text message to notify her she had missed her attendance appointment. She had been absent for two days and promised to come in the next day to explain. The following day she disclosed that on the previous weekend she had been raped.

Signs of distress that may indicate a mental health issue:

- Student feeling overwhelmed
- Crying excessively
- Feeling hopeless and/or worthless
- Looking dirty and disheveled
- Hearing voices/ paranoia
- Intoxicated/high at college
- Excessive response to small incidents - "the last straw" behaviour
- Lack of response to empathic contact – the individual who just doesn't seem reachable
- Poor academic performance
- Not attending class
- Odd or unusual thought processes in written or oral classwork
- Interpersonal withdrawal/isolation.

Case Study: Greenwich College Sydney – Being proactive
Greenwich College Sydney has approximately 2000 students (900 ELICOS and 1,100 VET students).

At Greenwich, a staff member designated as a counsellor is employed to coordinate mental health issues. Whilst the staff member is a psychologist, she also has other responsibilities within student services and does not directly provide psychotherapy herself.

The college maintains close relationships with students' agents in order to be informed of any pre-existing mental health conditions. Teaching staff are also encouraged to be alert for behavioural signs that a student is struggling including poor attendance, excessive tiredness, unusual behaviour and poor academic results.
Because the college is not able to directly deliver mental health services, the counsellor maintains a comprehensive resource list of services within the community that may be of help to the student. This includes government agencies, community organisations, religious groups, private medical and psychological services.
If a student is identified as potentially having a mental health issue (but not in a crisis situation), a three-meeting process is implemented:

Meeting One: The counsellor speaks with the student and directs them to one or more appropriate sources of help. A clear goal is to empower the student to make the connection with the service by themself.

Meeting Two: Occurring two weeks later, this is a follow up to ensure the student has acted on the advice. If the student has not contacted the help provider, there will be further intervention to help the student do so. For those students who have sought help, this meeting is an opportunity to monitor progress in addressing the issue affecting them.

Meeting Three: The final meeting is scheduled two weeks later to again monitor progress and check in with the student about the external service they are accessing. During this meeting, the college can also address whether the college needs to consider any study adjustments, such as deferred assessment deadlines.

This case study was provided by Chaido Kiourkou, Operations and Admissions Manager Greenwich College Sydney

6. Availability and provision

Institutions should be able to directly provide short-term mental health services to students or be able to quickly refer students to external service providers.

The National Code of Practice for Providers of Education and Training to Overseas Students 2018 (the National Code) sets down standards with respect to support services that are of relevance to mental health issues. Whilst mental health is not specifically mentioned by name in Standard 6, applicability can be inferred in this Standard.

Some mental health problems require long term and specialist help. For example, a student with a diagnosis of schizophrenia will have needs that a college will probably be unable to meet independently. Some mental health problems are also subject to chronic relapse – such as substance abuse, gambling, and eating disorders. There is no expectation that colleges will be able to provide long-term mental health services although, where a student is accessing external services, institutions should play a part in the management of longer term mental health issues.

Within that understanding, good practice will include:

- For institutions with enrolments over 3,000 students, there should be a professional qualified service as described within the Best Practice Guidelines for the Provision of Counselling Services in the Post-Secondary Education Sectors of Australia and New Zealand. For example, employing a registered Psychologist, Social Worker, Clinical Psychologist, Counselling Psychologist or Psychiatrist.
- For smaller institutions, it is essential to have a working relationship with at least one professionally qualified mental health service provider such as a registered Psychologist.
- It is also essential to have a working relationship with General Practitioners in the vicinity of the college. GPs are able to make referrals to psychiatrists and psychologists and students will normally be able to access health insurance funding for that purpose after any waiting period limits have been met.
- Where it is not possible to employ a specialist, colleges should ensure that a critical mass of their staff have undertaken Mental Health First Aid training or something of an equivalent standard.

Case study – Sam, an ELICOS student

A teacher flagged Sam* to the Student Advisor (SA) at one college because he had missed classes, was not focussed in class and had not submitted work. The SA attempted to contact him but the phone number provided was incorrect. The SA then left an appointment slip for Sam in the class role and the teacher ensured that he received it and, with Sam's consent, walked him to the SA's office to ensure he attended the appointment.

In the appointment, the SA discussed why she and his class teacher were concerned. Sam disclosed that he had suicidal thoughts and that he didn't know what to do. The SA connected Sam to the counselling service the college had access to. Unfortunately, no appointments were available so Sam met with a doctor.

The SA established a good relationship with Sam and instructed him to check in at the office each day so that the SA knew he was at school. The next day he checked in but disclosed that he had missed the counselling appointment the doctor had made for him. The SA scheduled a new appointment and flagged it with the medical centre as urgent. Sam also disclosed that he was very hungover because he had been drinking all night. He said that he was drinking to numb himself because he was struggling and he needed to be mentally absent, but was trying to stay away from drugs because he was a former drug addict. His father sent him to Australia to study because he had been a regular drug user in his home country and he wanted him to have a fresh start.

In addition to experiencing withdrawal from drugs he was suffering from depression, was sexually promiscuous which caused him anxiety the next day, was socially isolated because he was gay but had not come out to his family and friends, who he thought would not be supportive, and was falling behind in school. Although he kept missing some of his medical appointments, he checked in each day with the SA who would encourage him to attend the appointments. The SA also provided information on Queer Support groups and AA groups in the area. The SA was able to liaise with Sam's teacher explaining that his absences were known and necessary and that the teacher should not query them with him. Sam was then diagnosed with a non-life threatening disease which further impacted on his concentration and motivation. Although he did not submit assessment tasks knowing he would fail, he continued to go to school to check in with the SA.

Although he failed the ELICOS unit on his first attempt he re-enrolled and continued attending his appointments (most of them). With encouragement he became more active in seeking academic help and subsequently passed the unit. He is now studying at university and continues to come and visit the SA to let her know how he is going. He is still in regular contact with the support services that the SA initially connected him with.

Had the SA not been involved, Sam disclosed that he would have stopped attending class because of not wanting to explain the sensitive natures of his problems to his teacher. Having one central point of support not only ensured a trusted confidant with an understanding of all the issues impacting on Sam, but also meant he did not have to continue disclosing quite sensitive information and that he could receive support and understanding from his teacher without having to disclose the details (the teacher understood that he was experiencing difficulties because of communication from the SA, but did not know the details). Additionally this protected his teacher from having potentially traumatising information disclosed to him. Having the SA as the liaison between teacher, student and support services meant that the student had a single point of contact to ensure a streamlined system of support.

*Not real name

7. Accessibility of service

Institutions must have the capacity to respond to urgent mental health needs and connect students with appropriate services in a timely manner, including students studying off campus and students who experience mental health crises outside of standard office hours.

Institutions which have effective practices in maximising the accessibility of mental health services do the following:

- Make information about how to access mental health services highly visible at many contact points – especially at "first contact" points such as front offices and main websites.
- Give students the opportunity to disclose any existing mental health issue(s) on Enrolment Forms. Forms should carry the clear proviso that the information will only be used to connect students with appropriate support services and will not affect their academic progress.
- Clearly sign-post the location of on-campus counselling services or the office of the person responsible for handling mental health issues in the first instance. Such locations must be physically accessible to all students.
- Have clear processes which identify whether students have urgent mental health needs and ensure they have the capacity to address those needs quickly.
- Provide students with clear options about who to contact if crises arise outside of institutional office hours.
- Have relationships with professionals and organisations that can assist with complexities that arising because of the diversity of linguistic, cultural or ethnic background of International students. For example, many colleges maintain a working list of interpreters; ethnic community organisations and religious organisations/services.

8. Reasonable adjustments

Students experiencing mental health issues should be able to access reasonable adjustments to matters affecting their academic progress such as assessment deadlines and attendance requirements.

No-one argues that it is inappropriate to provide some flexibility and support for a student with a physical disability such as visual impairment or a temporary illness or injury. However, there can sometimes be more debate when it comes to mental health problems. It is important to remember that mental health issues are specifically covered under the Disability Discrimination Act 1992 - "a disorder, illness or disease that affects a person's thought processes, perception of reality, emotions or judgment or that results in

disturbed behaviour" - and that a failure to make reasonable adjustments is potentially in breach of that law.

Providers must be able to affirm that students have met the study outcomes of their course. Therefore, any reasonable accommodation must not jeopardize educational outcomes. Depending on the situation, it may be appropriate to consider delayed submission of assignments, substitute forms of assessment and modified exam conditions. For International students, it is difficult to offer a reduced workload, although this is not totally impossible under exceptional circumstances.

In order to negotiate reasonable adjustments institutions should:

- Have a clearly defined and documented process for a student to apply for reasonable adjustment(s) on the grounds of mental health issues.
- Normally require written support from a doctor or mental health professional who has assessed the student's mental health. Documentation should include commentary on the impact of the problem on the student's capacity to meet study demands, and if possible some estimate of the time the problem began and how long it may last. It may also contain a recommendation of what is considered a "reasonable adjustment" but the college itself must have the final decision on what consideration is applied.
- Allow students to present alternative documentation/evidence in the case of situational events that affect their mental health. For example, the recent death of a family member may affect a student's ability to attend to study.

Note: Staff who are not qualified in mental health should not be placed in a position to make a judgment about whether the student's mental health issue is genuine.

The Australian Disability Clearing House on Education and Training website has some useful examples of reasonable study adjustments for mental health issues.

www.adcet.edu.au/disability-practitioner/reasonable-adjustments/study-learning-adjustments/

Good practice examples

College R uses a generic form for any student seeking consideration of their circumstances, whether that is illness, injury, bereavement or mental illness. Students may use this form to apply for extensions to a submission date, deferral of exams, adjustment of missed attendance and late withdrawal from enrolment.
On the form there is a section for a medical practitioner or other appropriately qualified person to complete. The practitioner should indicate whether the student is affected by a temporary or chronic condition, or temporary exacerbation of a chronic condition. However, the student's privacy is respected in that there is no requirement to name the condition. The practitioner is also asked to give an indication of the period during which the student has been affected.

They will indicate the effect on study by stating whether the student was unfit to attend to, or had reduced capacity to attend to study. If the student wishes, they may add their own written submission, but students are normally encouraged to rely on the professional opinion of the practitioner. Staff receiving the application may therefore have confidence that the presenting issue has been appropriately assessed. One staff member observed – "this means I do not have to make an uninformed judgment. The only grounds I would have to refuse such an application would be if I thought the doctor had colluded with the student or had been negligent in some way; and I am not prepared to take that sort of position.

But sometimes I feel OK in refusing or negotiating a bit on such an application if our faculty has some additional information that wasn't available to the doctor. For example, if it is clear that the student seems to apply for deferred assessment every semester, we may be aware that there is an ongoing problem, whereas the doctor may have only seen a single episode".

College S comments: "We had a student who had a significant mental health incident where he was hospitalised in a Mental Health ward. We kept in regular contact with the hospital and his family and when he was given permission to return to class, we developed a 'return to study plan' to ease him back into study and an 'action plan' that had clear steps about what to do if he needed assistance or had a relapse."

Case study –Reasonable adjustments for Obsessive Compulsive Disorder (OCD)
Hannah *, an ELICOS student, struggled to meet deadlines for essays and assignments. When under pressure or in situations when she was unsure whether she could come up with a perfect answer, she would choose not to attempt a task at all. In exams, she would read the questions repeatedly, and if unable to give a perfect answer to one of them, she would not attempt answering any of the exam questions. As a result, the student was in constant agony, suffering depression and anxiety attacks.

Actions taken by the college:

- Hannah was counselled by Student Services and referred to a GP, and subsequently to a psychologist.
- She was offered to re-start her pathway program after being unsuccessful in the first semester.
- The College implemented a Modified Learning and Assessment Plan, which included assignment and test deadline extensions, alternative assessments (e.g. replacement of some assignments with a questionnaire answered orally, creative assignments where the student was able to demonstrate knowledge in an alternative way - pictures, diagrams, videos) and mid-year exams in a separate room with the invigilator handing out questions to the student one by one, which eliminated the student's pre-emptive reading and subsequent anxiety.

Hannah's results improved dramatically with these interventions. The psychologist kept working with her and initiated two useful meetings with Student Services at the college. She progressed and acquired invaluable skills to manage the condition. Eventually, she no longer required modification of every test/assignment and sat her final exams with other students.

Hannah completed her pathway course and progressed to her next course at university. She is still getting limited assistance from Disability Services there.

*Not real name

9. Communication and record keeping processes

Institutions should have clear processes for communicating with students regarding mental health issues. There should be sound record keeping of any contact between the college, student and any other stakeholders.

To ensure best practice in communication and record keeping, institutions should:

- Clearly designate which staff members are responsible for initiating contact with a student about a mental health issue. This is typically someone from the counselling service (or other mental health professional on staff) or a person in a senior position such as a Director of Studies, Faculty Dean, or Manager of Student Services.
- Maintain formal records kept on individual cases in a confidential file. Consideration must be given as to how and where confidential information will be stored and which staff will have access to it. Best practice in file confidentiality includes storing information in: 1) a section of the Student Management System (SMS) firewalled off so that only authorised staff can access that information, 2) an entirely separate database from the SMS and 3) a paper-based records system stored under lock and key.
- Be persistent when trying to contact students experiencing mental health issues. Some students may not check formal institutional communication channels during difficult times. If no response is given from a student of concern via official channels, institutions should use alternative means of communication to establish contact such as private email addresses, phone numbers or social media platforms. Once contact has been made, communication should revert to formal channels as soon as possible.
- Collect student feedback about the mental health services available to them in the form of satisfaction surveys or similar.
- Maintain anonymous data about mental health issues across the institution and student feedback about mental health services in order to evaluate and develop services for the future.

Good practice example

College T has a shared drive which is divided into a number of shared folders with different staff access. Access to the folders is via each staff member's individual log in. The college Director manages who can access each folder by liaising with the IT team and giving them a list of log in IDs that should have access. When a staff member leaves, their access is removed. In this way, they are able to maintain a high level of file confidentiality regarding student mental health issues.

10. Support for staff and other students

The behaviour of some students with mental health issues may impact on others, depending on the nature of the issue. For example, some critical incidents or the occasionally confronting behaviour associated with psychotic episodes have the potential for ripple effects on others. Institutions should consider how support can be provided to staff and to other students who may have been affected by mental health incidents.

Good practice will include the following:

- Staff should have access to someone with a higher level of expertise in mental health for advice in dealing with any student mental health illness.
- Opportunities to "de-brief" must be provided for staff and/or students who have been affected by a critical incident. This may include direct observers of the event, colleagues and friends of the student. Individuals should be identified and offered support.
- In some circumstances colleges may need to follow up after a few months with key people/victims to check that they are not vulnerable to PTSD.
- Some incidents may require a formal process to provide closure, for example a memorial service.

Good practice examples

College U notes: "Our Staff are encouraged to de-brief after an event/crisis and they have access to an Employees Assistance Program (EAP) - up to 3 visits paid for by our employer with an external provider if we need to further de-brief outside the workplace."

College V observes: "We found it particularly helpful to debrief after dealing with students in crisis and use the situations as case scenarios. It is important for us as a team to know we are supported while offering support and to share experiences and solutions."

3.2 Crisis intervention

Colleges need clear protocols to follow in a mental health crisis situation

In addition to the ten elements of effective practice listed above, colleges should have very clear protocols to follow in the event of needing to address a student mental health crisis. Any critical incident plan will have four broad phases. These are:

Phase 1
The immediate response to a critical incident
Phase 2
Crisis management during a critical incident
Phase 3
Recovery from a critical incident
Phase 4
Evaluation and critical incident review.

Crises may include incidents such as threat of harm to self or others, actual harm to self or others, specific statements expressing suicidal intent, suicide attempt, suicide completion, psychotic episodes, panic attacks or other severe emotional distress, particularly in public places. We may also regard any sudden death, serious accidents and assaults as critical

incidents that require an immediate response. Any crisis intervention plan must anticipate what the college's response will be if one of these events takes place.

Colleges must identify who is responsible for responding to a mental health incident

Colleges should have a clearly identified person or office with responsibility to coordinate a response to a mental health crisis incident. Where the college has a counselling service or mental health specialist on staff, responsibility should lie with them. If not, responsibility should lie with a senior staff member. The responsible office or officer should consult widely within the college to develop an agreed critical incident plan.

The highest priority is to address safety

In cases where there is risk of harm or severe psychotic/delusional behaviour, there should be procedures in place to contact police and ambulance services and means to safely transport an at-risk student to hospital as soon as possible.

Dealing with suicide risk

In cases where there is an apparent suicide risk:

- Staff members should never deal with a potentially suicidal student alone without consultation with other staff as soon as is practicable.
- A suicide risk assessment should be carried out by a doctor or qualified mental health professional. Assessment may indicate that a student needs hospitalisation, or it may be feasible to put in place some lower level safety plan.

Dealing with distressed or distressing behaviour

In circumstances where students are acting in a distressed and/or distressing manner:

- The college should provide a quiet private space as soon as possible to assist the student to regain some emotional equilibrium.
- Once a student has calmed sufficiently to talk, seek to explore the situation.

What to do after a mental health crisis incident

Specific steps should also be followed after a critical incident. Effective practice should consider the following points:

- Other people who may have been affected by a crisis incident should be identified and an appropriate outreach process carried out.
- After any immediate emergency has passed, it is important for the college to get back to normal functioning as soon as possible.
- There needs to be an authorised channel of providing clear information about what has been happening. Rumours and lack of clarity have the potential to make things worse, whereas accurate knowledge provides the opportunity to properly process what has occurred.
- Depending on the nature of the critical incident, it may be important to follow up with key participants/victims some months later to ensure that the individuals are not vulnerable to PTSD.
- The aftermath of some incidents may require some sort of formal process to provide closure – a memorial service, or a public Question-and-Answer Forum or similar.
- Evaluation and review will address whether the college needs to consider any preventative measures to guard against a repeat of such an incident, as well as assessing the quality of the

response to the incident. There should be a written report that summarises the incident.

Appendix G details an example of a Critical Incident Response Plan from Curtin University's Counselling and Disability Service. (Note: The plan has been modified to be more appropriate to an ELICOS context).

3.3 Student rights and responsibilities

Confidentiality

The most significant student right is to confidentiality within the normal safety and legal limits that apply to this concept. The meaning of confidentiality should be clearly articulated and explained in any information given to students about mental health support.

Students over 18 years of age should be informed that:

- Any information disclosed about their mental health issue will not be disclosed to any other agency or authority without their written consent.
- Any records will be maintained securely, and that no unauthorised person will have access.
- Depending on the nature of the service, students may need to be told that their information is confidential to the service rather than just to the person they have spoken to. For example, if a student sees a different doctor or counsellor on different occasions, that different practitioner will normally have access to any client record.
- There may be cases where the college needs to share information with particular staff in order to assist the student to manage a mental health issue. This should always be done with the informed consent of the student.
- Confidentiality will be suspended if there is any threat of harm – either to the student or to others. Normally an effort is made to limit the spread of information to what is required to ensure immediate safety.
- Confidentiality may be compromised if a legal order is made by a court for the college to provide student records.

There is no situation in an ELICOS college where a student can be guaranteed of total confidentiality of all information that he or she may disclose.

The broad defining principles of confidentiality are that:

- Information should remain confidential unless there is a clear duty to act in the interests of safety. If any individual is in danger of harm, then confidentiality may be breached without necessarily informing the student.
- In cases where there is no actual danger to any person, but the college has a legal obligation to disclose information, the student must be informed that this is the case.
- In all other cases, information may only be disclosed with the informed consent of the student.

Students who are under 18 years old also have a right to confidentiality which includes all the points listed above. However, the National Code of Practice for Providers of Education and Training to Overseas Students (2018) Standard 5 states: "Good practice is for providers which deliver courses as a part of a package of courses to communicate with each other about sharing responsibility for approving accommodation, support and general welfare arrangements for under-18-year-old overseas students." That is, it useful to establish under what circumstances the college would seek to communicate with a parent or nominated other person on mental health issues.

Good practice should acknowledge:

- It would be appropriate to make contact with parents or nominated others in the event of serious suicidal behaviour or other threats of major harm, serious injury or arrest.
- It is mandatory to report suspected abuse and/or neglect of minors – this will need to be explained to minors who report such behaviour taking place where they are living in Australia. If they report abuse or neglect that had taken place in their home country, there is no obligation to report that.

Good practice examples

College W provides all students with a written Statement of Rights and Responsibilities on their first contact with the counselling service. Whilst confidentiality is clearly assured on the service's website, they explicitly relay the rights and responsibilities to students. Students sign the Rights and Responsibilities Statement acknowledging they have read it. One copy is given to the student and another is retained by the service.

College X notes: "1. Students above 18: Information is kept confidential unless the student has given consent to release information to their teacher or agent, for example. 2. If there is a critical incident then this is managed under the [institution's] critical incident procedure. I.e. appropriate staff, agents and/or parents are informed. 3. Students under 18: Guardian or carer is informed as soon as possible. Note, a psychologist will not typically inform guardians or carers of any mental health concerns that are not serious in order to maintain confidentiality. However, Education Managers are able to inform carers and guardians."

The counselling unit at one college which is based in a university follows the confidentiality guidelines related to the legal and organisational requirements of the university as well as the Psychology Board of Australia. This is because the unit counsellors include one registered clinical psychologist.The Psychology Board of Australia has adopted the Australian Psychological Society Code of Ethics for the profession. This outlines confidentiality for psychologists in further detail than the university's requirements.

In summary, this is the confidentiality policy the college adheres to :

1. All personal information from students accessing counselling and wellbeing support is treated confidentially and will not be discussed with anyone unless the student's permission is obtained.
2. Confidential personal information may be disclosed under some circumstances as follows: if information is subpoenaed by a court of law or reporting of information is required by the law, or if failure to disclose the information would place the student or another person at serious and imminent risk, harm or danger, or the student has provided prior approval to a) provide a written report to another professional or agency, e.g. a GP or a lawyer, or b) discuss the material with another person, e.g. a GP, teacher or family member.
3. Under the Health Records and Information Privacy Act 2002 (HRIPA) we are also required to keep student files for seven years after the last date of contact, or if the student was under 18 at the last date of contact, the file must be kept until the student is 25 years of age.

Other student rights

- Students with mental health issues should be treated with respect and dignity.
- Students have a right to be consulted and to give or refuse consent to any proposed treatment plan. However, they should be made aware that the consequences of refusing treatment may affect their ability to complete their course of study.
- Students should have access to an appropriate process for complaint if they are dissatisfied with the service provided to them.

Student responsibilities

- Students have a responsibility to disclose a mental health issue that is affecting their capacity to meet the demands of their course and to provide appropriate supporting documentation.
- If students have consented to a treatment plan to address their mental health issue, they have a responsibility to actively engage in that plan.

CHAPTER 4:

WHAT EXTRA RESOURCES ARE AVAILABLE TO COLLEGES?

This Guide provides extra resources such as contact information for general and specific service providers that deal with mental health. However, it is difficult to be highly specific about local resources available to any particular college. Local services can vary quickly with funding arrangements. Colleges should seek to update contact information about resources at least annually.

Provide staff with a small number of resources rather than an extensive list

It can be tempting to develop a comprehensive data base of all the mental health resources that are available in the immediate geographical area, and to distribute this to all staff. But this can result in confusion and miscommunication as there are a substantial number of different types of services such as those dealing with sexual assault, gambling, substance abuse and multiple private practitioners. It can be almost too easy to develop an unwieldy resource package that is difficult to use. It is better practice to advise general staff of a small number of resources, such as:

- who to call in an emergency or crisis (e.g. security or police)
- 24/7 crisis numbers
- counselling or student advisory services or details of the person who has responsibility for managing a presenting mental health issue.

College counselling services or the responsible person/people for mental health issues should maintain a more comprehensive resource list. That localised resource list should include as many of the resources below that are applicable.

Internal sources of help

- Course co-ordinators, supervisors, tutors
- Accommodation managers
- Student Services
- Counselling Services
- Occupational Health and Safety
- Health Services
- Disability Services
- Multi-Faith Services/chaplaincy
- Student Union

External sources of help

- General Practitioners
- National Community Mental Health Care Database (NCMHCD)
- Police contacts other than 000 emergency calls
- Mental Health Response Line
- Health Direct
- Crisis Care
- Primary care and secondary psychological and specialist services (e.g. eating disorders, alcohol)
- Voluntary organizations (help lines, support groups, advocacy, counselling and specialist services)
- Web resources

Crisis contacts

- In an emergency – i.e. if any person is physically at risk - call 000
- Lifeline: Phone 13 11 14, available 24/7 www.lifeline.org.au/

More general resources

At the time of writing, all the services listed in this Guide indicated that they were available to International students. Nonetheless, it is important to be aware that many services have limited resources and there may therefore be potential delays in accessing services.

- Headspace: www.headspace.org.au/
- Beyondblue: www.beyondblue.org.au/
- Mental Health First Aid: www.mhfa.com.au/

Pointers to further resources

The sites below provide search options to locate local services, programs, resources and research on a broad range of health issues:

- MentalHealth.gov: www.mentalhealth.gov/get-help/immediate-help

- Mental Health Online: www.mentalhealthonline.org.au/pages/useful-resources/crisis-services

- Healthdirect: www.healthdirect.gov.au/

- University Health and Wellbeing: www.healthyuniversities.org/: Unites researchers, lecturers, students, health professionals and other support staff (domestic & international) with a goal of promoting healthy universities.

- JED Foundation: www.jedfoundation.org/mental-health-resource-center/: An American source with a large number of useful information-style resources.

Online self-help resources

There are a growing number of online resources for mental health issues. Some are self-help resources, while others are aimed at being used with guidance from a mental health professional. A summary and brief review of many of these is available at Beacon 2.0: www.beacon.anu.edu.au/

The list below offers a broad range of other options.

- Black Dog Institute: www.blackdoginstitute.org.au/: Provides information, videos and online self-help tools and apps.

- Butterfly Foundation: www.thebutterflyfoundation.org.au/: Offers a range of services from information to treatment programs for eating disorders and body image issues.

- Head to Health: www.headtohealth.gov.au/: A government website that assists people to find the most appropriate mental health resources.

- Mental Health Online: www.mentalhealthonline.org.au/: An online treatment clinic for people with mental health problems and an initiative of the National eTherapy Centre (NeTC) at Swinburne University of Technology.

- QLife: www.qlife.org.au/ or phone 1800 184 527: Australia's first national counselling and referral service for people who are LGBTQIA+. It provides peer supported telephone and web-based services and is available to anyone currently based in Australia (operates 3pm - midnight daily). QLife also has a search resource linking to state-based services.

- SANE Australia: www.sane.org/: Offers mental health awareness, online peer support and information, stigma reduction, specialist helpline support, research and advocacy. The SANE Help Centre provides referrals to any person living in Australia who needs to manage mental health concerns.

- thedesk: www.thedesk.org.au/about: A comprehensive set of resources to support tertiary students to achieve mental and physical health and wellbeing.

- Moodgym: www.moodgym.com.au/: A series of interactive resources particularly aimed at addressing depression and/or anxiety.

- Smiling Mind: www.smilingmind.com.au/: A free app that assists with mindfulness meditation.

- My Wellbeing Mate App: www.holyoake.org.au/wellbeing-mate-app/: A free app providing free access to helplines, websites, guides, videos, inspiring talks, apps and more.

- Family Planning Alliance Australia: www.familyplanningallianceaustralia.org.au/services/: Provides links to services in each state related to reproductive and sexual health.

NOTE: There are a number of other resources identifiable by an Internet search, but at the time of publication many indicated that they were not available to International students.

State resources

Victoria
Mental Health Advice Line:
Ph. 1300 60 60 24 for immediate health advice from a nurse.

New South Wales
Mental Health Line:
Ph: 1800 011 511 for a 24-hour/ 7 days a week telephone service.

Australian Capital Territory
Mental Health Crisis Team:
Ph. 1800 629 354 or
(02) 6205 1065 for a 24-hour/7 days a week service for assessment and treatment of mentally ill people in crisis situations.

Queensland
Queensland Government:
Ph. 13 HEALTH (13 43 25 84) for a 24-hour/7 days a week service for health information, advice or referral.

Northern Territory
Mental Health Support:
Ph. 1800 NT CATT (1800 682 288) for a free and confidential 24-hour hotline for mental health inquiries.

Western Australia
Mental Health Emergency Response Line:
Ph. (08) 9224 888,
1300 555 788 (Metro),
1800 676 822 (Peel) for emergency psychiatric assessment and advice for mental health clients and their carers.

Rural Link
Ph. 1800 552 022 for a specialist after-hours mental health telephone service for rural communities.
Mon-Fri: 4.30pm-8.30am
Saturday, Sunday, Public holidays:
24-hours

South Australia
Mental Health Services:
Ph. 13 14 65 for 24-hours/7 days a week advice and information in a mental health emergency.

Tasmania
Mental Health Helpline:
Ph. 1800 332 388 for a free state-wide 24-hour/7 days a week service for mental health crisis reaching all regions.

CHAPTER 5:

WHERE CAN A COLLEGE FIND FURTHER INFORMATION?

The Guide concludes with a small set of further reading suggestions, which can help guide those who wish to pursue information in more depth.

Australian and New Zealand readings on mental health among students

Note:The Journal of the Australia and New Zealand Student Services Association (JANZSSA) is the most used publication by student service practitioners for articles related to domestic and International student mental health issues. JANZSSA archives can be accessed from the ANZSSA website at https://anzssa.com/.

- Ang, P.L.D. and Liamputtong, P. (2007). "Out of the Circle": Reflection on Conducting Research into the Views of International Students from Mainland China Towards the Use of University Counselling Services, JANZSSA, 30, October 2007, 6-26.

- Atherton, K. and Tennant, J. (2012). Mental Health Coordination: From Calm to Crisis in 0.3 Second, JANZSSA, 40, October 2012, 23-25.

- Booker, C. (2011). International students in the dark about mental health services, Meld Magazine, December 16, 2011. Retrieved from: https://www.meldmagazine.com.au/2011/12/international-students-mental-health-services/

(NOTE: This article is aimed at students.)

- Elliott, J.S. and Murray, S.M. (2011). Responding to Mental Health Issues for International Students. Workshop presented at the Australian International Education Conference, Adelaide, October 2011, the ANZSSA Biennial Conference, Sydney, December 2011 and the ANZSSA/ISANA Joint Conference, Adelaide, December 2014.

- Forbes-Mewett, H. and Sawyer, A.M. (2011). Mental Health Issues amongst International Students in Australia: Perspectives from Professionals at the Coal-face. The Australian Sociological Association Conference Local Lives/ Global Networks, University of Newcastle New South Wales. November 29–December 2.

- Khawaja, N. and Dempsey, J. (2008). A Comparison of International and Domestic Tertiary Students in Australia. Australian Journal of Guidance and Counselling, 18 (1), 31-46.

- McNaught, K. (2014). Why Every University Needs an Effective 'Mental Health Plan', JANZSSA, 44, October 2014, 1-8.

- O'Keeffe, P. (2013). Mental Illness within Higher Education: Risk Factors, Barriers to Help Seeking and Pressures on Counselling Centres, JANZSSA, 41, April 2013, 12-20.

- Reavley, N. J., Ross, A., Jorm, A.F. and Killacke, E. (2011). Introduction to Guidelines for Tertiary Education Institutions to assist them in Supporting Students with Mental Health Problems, JANZSSA, 38, October 2011, 23-33.

(NOTE: Reavley et al. is possibly the most comprehensive publication in this list and it provides an excellent outline on mental health issues. It also contains a useful reference list.)

- Rosenthal, D.A., Russell, J. and Thomson, G. (2008). The health and wellbeing of international students at an Australian university, Higher Education (2008) 55: 51. Retrieved from https://doi.org/10.1007/s10734-006-9037-1

- Simpson, A. and Ferguson, K. (2012). Mental Health and Higher Education Counselling Services - Responding to Shifting Student Needs, JANZSSA, 39, April 2012, 1-8.

- Turudia, K. and Tomyn, A. (2017). The Student Health Review: Supporting the health and wellbeing of international students. Paper presented at the ANZSSA/ISANA Joint Conference, Gold Coast, December 2017.

- Verness, B. (2016). The wicked problem of university student mental health, Sydney: The Winston Churchill Memorial Trust of Australia (2016). Retrieved from https://www.churchilltrust.com.au/media/fellows/Veness_B_2013_The_wicked_problem_of_university_student_mental_health.pdf

- Vivekananda, K., Telley, A. and Trethowan, S. (2011). A Five Year Study on Psychological Distress within a University Counselling Population , JANZSSA, 37, April 2011, 39-57.

- Wang, S., Lee, S. and Wahid, Z.T. (2013). University Student Mental Health: The Australian Context, Report of Australian Medical Students' Association Student Mental Health and Wellbeing Committee. Retrieved from http://www.amsa.org.au/wp-content/uploads/2013/09/AMSA-SMHW-The-Australian-Context-of-Student-Mental-Health-Report.pdf

Selected international publications on mental health among students

NOTE: Readers should be aware that the demographic attributes of International students in other nations may be markedly different from those in Australia.

- Bauer, S. (2018). Stress-busting strategies for international students, The PIE Review 17, 22-27.

- Bradley, G. (2009). Responding effectively to the mental health needs of international students, Higher Education (2000) 39: 417. Retrieved from https://doi.org/10.1023/A:1003938714191

- Eisenberg, D., Downs, M.F., Golberstein, E. and Zivin, K. (2009). Stigma and Help Seeking for Mental Health among College Students, Medical Care Research and Review, 66, 5, 522-54. Retrieved from http://journals.sagepub.com/doi/abs/10.1177/1077558709335173

- Furnham, A. and Trezise, L. (1983). The mental health of foreign students, Social Science and Medicine, 17, 6, 365-37.

(NOTE: This older article demonstrates that many of the same issues were being observed in 1983 as are discussed today.)

- Storrie, K., Ahern, K., and Tuckett, A. (2010). A systematic review: Students with mental health problems - A growing problem, International Journal of Nursing Practice 16: 1–6. Retrieved from http://onlinelibrary.wiley.com/doi/10.1111/j.1440-172X.2009.01813.x/full

(NOTE: This article contains a very comprehensive reference list for further reading).

- Yorgason, J.B., Linville, D. and Zitzman, B. (2010). Mental Health Among College Students: Do Those Who Need Services Know About and Use Them?, Journal of American College Health, 57:2, 173-182. Retrieved from https://www.tandfonline.com/doi/abs/10.3200/JACH.57.2.173-182

Statistical data, the DSM-5 and ICD-10

- Beyond Blue (undated). Stats and facts. Retrieved from https://www.youthbeyondblue.com/footer/stats-and-facts

(NOTE: This provides data on incident rates of mental illness in a very reader friendly style.)

- Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (2013), American Psychiatric Association.

- Headspace (2010). Mental Health Statistics and Reports. Retrieved from https://headspace.org.au/health-professionals/mental-health-statistics-and-reports/

(NOTE: These incident rate data are from the Australian Bureau of Statistics.)

- International Statistical Classification of Diseases and Related Health Problems 10th Revision (2010) (ICD-10), World Health Organisation. Retrieved from http://apps.who.int/classifications/icd10/browse/2010/en#!

- Lifeline (undated). Statistics on Suicide in Australia. Retrieved from https://www.lifeline.org.au/about-lifeline/lifeline-information/statistics-on-suicide-in-australia

- Mindframe (2017). Facts and stats about suicide in Australia. Retrieved from http://www.mindframe-media.info/for-media/reporting-suicide/facts-and-stats

- Sadock, B.J., Sadock, V.A. and Ruiz, P. (2014). Kaplan and Sadock's Synopsis of Psychiatry: Behavioral Sciences/Clinical Psychiatry, 11th Edition, Lippincott and Wilkins, Baltimore.

(NOTE: Kaplan and Sadock's Synopsis of Psychiatry is a useful reference book on mental illness. It features a section on the commonly used medications in mental illness, which can be useful when a student is not quite sure exactly what medication they have been using.)

Further reading on traditional medicine and mental health

- Fernando, S. (2010). Mental Health, Race and Culture, Palgrave MacMillan, 3rd Edition.

(NOTE: Chapter two provides an overview of Western psychology compared to other traditions.)

- Shore, J.H., Richardson, W.J., Bair, B. and Manson, S. (2015). Traditional Healing Concepts and Psychiatry: Collaboration and Integration in Psychiatric Practice, Psychiatric Times, Jun 30, 2015, Volume 32. Retrieved from http://www.psychiatrictimes.com/special-reports/traditional-healing-concepts-and-psychiatry-collaboration-and-integration-psychiatric-practice

- Soh, N.L. and Walter, G. (2017). Traditional and Alternative Medicine Treatments in Child and Adolescent Mental Health, Chapter Two, Traditional and alternative medicine, IACAPAP Textbook of Child and Adolescent Mental Health. Retrieved from http://www.iacapap.org/wp-content/uploads/J.2-ALTERNATIVE-072012.pdf

Guidelines for resourcing- ANZSSA and Orygen provide comprehensive suggestions

- Best Practice Guidelines for the Provision of Counselling Services in the Post-Secondary Education Sectors of Australia and New Zealand (updated September 2010). Retrieved from https://anzssa.com/Public/Guidelines.aspx

- Orygen, (2017). Under the radar. The mental health of Australian university students, Melbourne: Orygen, The National Centre of Excellence in Youth Mental Health, 2017. Retrieved from www.orygen.org.au/Policy-Advocacy/Policy-Reports/Under-the-radar/Orygen-Under_the_radar_report.aspx

APPENDIX A:

THE PROCESS FOR DIAGNOSING MENTAL HEALTH ISSUES AND TREATMENT OPTIONS

Most mental health professionals in Australia are trained according to DSM-5

If students see a psychologist or psychiatrist, they will encounter the Western model of mental health. Most mental health professionals in Australia have been trained to classify mental health issues according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). To a lesser extent, some are trained to use the system of the International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10). Both classify mental health in a similar but not identical way.

Mental health diagnoses fall into categories that differ in treatment options

In essence, if a client meets certain diagnostic criteria, then they will receive a particular diagnosis. There are a substantial number of these listed within a series of categories such as Depressive Disorders, Anxiety Disorders, Obsessive-Compulsive and Related Disorders, Schizophrenic Spectrum and Other Psychotic Disorders, Bipolar and Related Disorder, Trauma and Stressor-Related Disorders, Feeding and Eating Disorders and Substance-Related and Addictive Disorders. Each category provides information about cause/origin, onset, progression, incident rates and treatment options.

The complexity of mental health issues can lead to different diagnoses

Both the DSM-5 and ICD-10 acknowledge that mental health issues are highly complex and that diagnostic criteria for different issues can overlap a great deal. It can be confusing to clients of mental health systems if they receive different diagnoses from different mental health professionals, however, this occasionally does happen.

Treatment Options

The two main treatment options in the Western model of mental health issues are medication and/or some form of the many "talk therapies" practiced in psychology.

Medication

Psychotherapeutic medications can only be prescribed by a doctor or a psychiatrist. There are some mental health issues that are extremely difficult to manage without medication. For example, psychosis. Other mental health issues may not necessarily require medication, but medication may help stabilise an individual and create a platform for further therapy. This is especially so for serious depression and recurrent anxiety. Management of medication should always be in consultation with a doctor or psychiatrist. If students seek advice about their medication from anyone else, it is important to refer them back to their doctor.

Psychotherapy

Virtually no counselling service in any post-secondary institution in Australia is staffed at a level that allows for long term psychotherapy. Most services therefore operate on some form of brief intervention model, often with some limit to the number of sessions available to clients in a calendar year or teaching period. Most in-house counselling services are obliged to connect students to external services for issues that require longer term specialist help.

It is important to remember that colleges retain some level of responsibility for case management when a student is referred to external professional help and systems should be in place to check-in with these students on a regular basis.

APPENDIX B:

RMIT TRAINING MENTAL HEALTH AWARENESS POSTER

Seeking help

Everybody experiences difficult situations. Sometimes, we can't solve our problems alone and we need to get help or advice from others. You can ask for help from family, friends, teachers, classmates or professionals.

General Practitioner (GP)

A General Practitioner (or GP) is a doctor who is trained to help you with any kind of physical or mental health issues. A GP is the first person you should talk to about any medical issues. Visit the Level 3 Information desk to find a GP nearby.

Psychologists

Psychologists are health professionals who are specifically trained to assist people with mental health issues or conditions. This can range from study stress and homesickness to depression and anxiety.

RMIT offers a free counselling service to all students. Visit the Level 3 Information desk to make an appointment.

Other options

If you would rather talk to someone in person there are some helplines you can call 7 days a week, 24 hours a day.

Lifeline	ph: 13 11 14 (if you are feeling sad and distressed)
Beyond Blue	ph: 1300 224 636 (if you are feeling anxious or depressed)

We're here to help

Talk to us

wellbeing@rmit.edu.au | Level 3 Information desk

RMIT TRAINING

APPENDIX C:

AUSTRALIA BUREAU OF STATISTICS DATA EXTRAPOLATION

Appendix C shows the most recent data available from the Australian Bureau of Statistics on 'Mental Health of Young People' (2007) and an extrapolation of this data to the International student population in Australia.

Mental Health of Young People, 2007
Released at 11.30am
(Canberra time) 19 July 2010

YOUNG PEOPLE 16-24 YEARS WITH A MENTAL DISORDER (a) (b), by Disorder class, Persons	%
Any 12-month mental disorder(a)(b)	
Anxiety disorders	
Panic Disorder	2.2
Agoraphobia	2.8
Social Phobia	5.4
Generalised Anxiety Disorder	1.3
Obsessive-Compulsive Disorder	2.2
Post-Traumatic Stress Disorder	7.7
Any Anxiety disorder(b)	15.4
Affective disorders	
Depressive Episode(c)	2.8
Dysthymia	**0.3
Bipolar Affective Disorder	3.4
Any Affective disorder(b)	6.3
Substance Use disorders	
Alcohol Harmful Use	8.6
Alcohol Dependence	2.9
Drug Use disorders(d)	3.4
Any Substance Use disorder(b)	12.7
Any 12-month mental disorder(a)(b)	26.4
No 12-month mental disorder(e)	73.6
Total persons aged 16–24 years	100.0

** estimate has a relative standard error greater than 50% and is considered too unreliable for general use

(a) Persons who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview.

(b) A person may have had more than one mental disorder. The components when added may therefore not add to the total shown.

(c) Includes Severe Depressive Episode, Moderate Depressive Episode, and Mild Depressive Episode.

(d) Include Harmful Use and Dependence.

(e) Persons who did not meet criteria for diagnosis of a lifetime mental disorder and those who met criteria for diagnosis of a lifetime disorder (with hierarchy) but did not have symptoms in the12 months prior to interview.

It should be noted that these figures speak only of some diagnosable mental health disorders – they do not address situational variables that may also affect a student's mental wellness such as grief, relationship break-up, assaults or addictive behaviours such as harmful use of the internet. Neither do these data include psychosis. For the moment though, we will consider only the implications of these figures on the assumption that we can reasonably extrapolate them to the International student population.

Australian government figures from the Department of Education and Training indicate that in 2017 there were close to 800,000 International students enrolled in Australia, and that of these approximately 155,000 were ELICOS students.

(Sources: https://internationaleducation.gov.au/research/International-Student-Data/Pages/InternationalStudentData2017.aspx and https://internationaleducation.gov.au/research/International-Student-Data/PublishingImages/IST_2017/2017Graph_Table2.png)

In any calendar year, this would mean that we could anticipate:

- over 100,000 experiencing a Substance Use disorder
- around 120,000 International experiencing one of the Anxiety disorders
- 48,000 experiencing an Affective disorder
- Around 200,000 students would experience one (or more) of these mental health disorders.

To extrapolate to ELICOS students, around 30,000 students could have experienced a mental health disorder in 2017. Given this high number, we must consider the potential impact of these on a student's capacity to meet study demands.

APPENDIX D:

SAMPLE SUICIDE SAFETY PLAN TEMPLATE

If you are satisfied that a student does not have any immediate intent to act on suicidal thoughts, but you are nonetheless concerned for their wellbeing, it is useful to agree on a Safety Plan. This is intended only to help manage a situation in the short term until they can be linked to professional help. A template model can follow the headings shown below. The student should participate in developing responses to each section.

Safety plan

List any signs that will help you recognise that things may be getting worse (e.g. thoughts, images, mood, situation, behaviour).

What can I do myself? What will help me take my mind off my worries? (E.g. relaxation, take a walk or other physical activity, read, listen to music, watch TV, write, colour in, engage in some process llike doing a jigsaw puzzle).

What can help make my environment safe? (E.g. avoid alcohol, other drugs, gambling, store any medications safely, anything else?)

What people and places can provide distraction?

Name	Name
Phone	Phone
Place #1	Place #2
Emergency contacts (relatives, close friends):	
Name	Phone
Relationship	
Name	Phone
Relationship	
My doctor and/or my counsellor	
Doctor's Name	Phone
Counsellor's Name	Phone

If I need urgent help:
Phone Lifeline any time on 13 11 14

I agree to contact (college name) by _____ [date & time]. I give permission for the college to contact my emergency contacts listed above if I do not make contact by this time.
Name:
Signature:
Date:
Witness Signature:

APPENDIX E:

"CURTIN LIFE" SAMPLE LESSON CONTENT

Since 2017, all new students to Curtin English in Perth have been required to take "Curtin Life". Approximately five hours of class time is spent on mental health issues within that component and there is also emphasis on the kinds of physical and social activities that help prevent mental health issues.

SAMPLE lesson content – Curtin Life

A quiz on cultural awareness. Making a list of 'forces that shape individual cultures'. Collaborative question and answer tasks to understand different cultures and how this can impact students on arrival in another country.
Identifying the stages of culture shock and where each student fits into this. Produce a leaflet or video for international students on how to overcome culture shock. Extension task: Write an article for the student newsletter about a situation when you experienced culture shock. Tell the readers how you were affected by this.
The benefits of different physical activities on your mental health. Read (skim and scan) the Curtin Stadium timetable to answer questions about the different classes. In groups, students make a list of the activities they will participate in and why. Students are invited to go to Curtin Stadium for a 10 day free trial pass and are reminded to sign up to the social events that week at Curtin English. **Extension task:** Make a video across your study period of the Curtin English fitness events you attend ready to post on Facebook.
Understanding of the term study – life balance. Students complete a flow chart in different stages recognising the reality of being an international student and the stresses and strains this can cause, comparison of their life in their home country with their life in Australia and then discuss the 'ideals' and how to achieve these in the new environment. Students produce a list of suggestions to hand out at the Curtin English orientation for new students.
Use of a Dictogloss to introduce the background of stress and depression. Students discuss a time when they might have felt stressed and share why they may have been stressed.
Raising awareness of stress and depression in the western world and why people may not want to talk about it. **Extension task:** Students are given different mental health organisations to re-search ready to feedback in the following lesson.
Students are given the symptoms of stress and depression and are asked to put them under the correct category. Students can discuss if they have ever experienced any of the symptoms or if they know of anyone who has. Students are given role-play cards and / or come up with a list of situations whereby they have witnessed the symptoms and write a dialogue and present this to the class offering advice and suggestions.

APPENDIX F:

STUDENTS IN DISTRESS FLOWCHART

This adapted Flowchart has been provided by Adelaide University Counselling Service as an example of how The English Language Centre at the University of Adelaide trains teachers to respond to students in distress.

Assisting Students in Distress

High Level Distress

At Risk
A student threatens to harm themselves or others.

At Risk to Self
Let the student know: you are concerned about them; their safety is your priority; as part of your responsibility you will need to contact professionals who can assist them.
Within Business Hours:
Counselling Support 8313 5663
Outside of Business Hours:
Mental Health Telephone Triage Service 13 14 65
At Risk to Others
Calm the situation eg. use non-threatening body language, listen to their concerns, let them know you want to help. Advise others to leave the area. Contact the Police **000**
Then Security Services 8313 5444

After the Event
Keep a record. Notify your manager (who may need to notify Legal & Risk).Notify Manager of Counselling Support 8313 5663 If injury occurred, notify OHS Officer. Debrief with supervisor or Employee Assistance Program: 8352 9898 AH 0418 883 855

Not at Risk
A high level of distress, but not at risk of causing harm.

You May
Let them know you are concerned.
Refer them to the CounsellingService. Involve others e.g. ask student 'Is there someone we can contact?'

Early Intervention Group
Inappropriate, concerning or intimidating behaviour can be referred to this group
8313 3191 eig@adelaide.edu.au

Assisting Students in Distress

Low Level Distress

Emotional Issues
(low level)

You may
Refer them to the counselling service

Counselling Support
8313 5663
Student can make an appointment by walking in, phoning the service direct or filling in the online self-referral form on counselling support website.
Staff can phone & accompany a student to counselling if they are distressed.
Staff can request a duty counsellor to see the student immediately or attend the situation

How to Talk to an Upset Person
1. Stop
2. Listen
3. Summarise emotion: "I can see you are really upset"
4. Summarise practical concern
5. Action

Practical Issues

Aboriginal & Torres Strait Islander Education & Support
8313 3623

Accommodation Service
8313 5220

Advocacy, Appeals, Financial
EWO 8313 5430

Disability Support
8313 5962

International Student issues
8313 4828

Medical
University Health 8313 5050

Writing Centre 8313 0280
Maths Learning Centre 8313 5862

APPENDIX G:

MODIFIED CRITICAL INCIDENT RESPONSE PLAN FROM CURTIN UNIVERSITY'S COUNSELLING AND DISABILITY SERVICE

This example Critical Incident Response Plan has been provided by Curtin University's Counselling and Disability Service. The the plan has been modified to be more appropriate to an ELICOS context.

CRITICAL INCIDENT POLICY & PROCEDURES

INTRODUCTION

This is the (edited) critical incident policy for the Counselling & Disability Services, Curtin University of Technology. The policy is a guideline for the counsellors who may encounter a critical incident and who need to determine an appropriate intervention and response. It will also assist counsellors who are exposed to critical incidents to deal with the after effects that may emerge. It is not the policy for Curtin University as an institution.

DEFINITION

A critical incident is an event or situation that presents the potential to cause cognitive, emotional, physical and behavioural distress for University staff or students and interferes with the individuals' ability to perform their responsibilities.

Potential critical incidents include:

1) Death of staff &/ student (on or off the campus)
2) Life threatening injury
3) Natural or public disaster
4) Drug/Alcohol overdose
5) Community Health Issues (such as, infectious diseases, exposure to toxic substances)
6) Attempted Suicide
7) Sexual Assault
8) Mental Health Crisis
9) Client/ hostility/aggression

CRITICAL INCIDENT POLICY & PROCEDURES

CRITICAL INCIDENT RESPONSE PROCEDURES

When critical Incidents and crises occur, they can have a significant impact on the individual and/or the university community. Such critical incidents will require an immediate response. When a critical incident is reported, the staff member designated as the Critical Incident Manager should be informed of the situation.

The Critical Incident Response Procedures are designed to maximize human safety and security, protection of property, limit risk and danger, restore normal functioning of the University and assure responsive communications with the University.

These procedures are mobilised whenever a critical incident or crisis affecting the University reaches proportions that cannot be handled by established measures.

The procedures are intended to be sufficiently flexible to accommodate contingencies of all types, magnitudes, and duration. When a critical incident occurs or is reported:

- The Critical Incident Manager will do an initial assessment to determine the Level of Critical Incident.
- The Critical Incident Manager will contact the staff/students involved to determine a need for support.
- If support is required, the Critical Incident Manager will mobilize the Critical Incident Response Team.

  (Editor's note: The Critical Incident Response Team is a previously established small group of stakeholders who have expertise and interest in the management of a Critical Incident.
- It may include staff as from such areas as security, public relations, senior executive, medical centre, as well as staff members of the Counselling Service).
- The Critical Incident Response Team will provide for the safety and security needs of the staff and/or students of the university and their next of kin o Counselling, guidance and support for all university staff and/or students exposed to the critical incident will be provided.

CRITICAL INCIDENT POLICY & PROCEDURES

When there is a direct request for support following a critical incident to the service, reception staff shall inform the Critical Incident Manager or the duty counsellor who will mobilize the Critical Incident Response Team:

- The Critical Incident Response Team will provide for the safety and security needs of the staff and/or students of the university and their next of kin.
- The Critical Incident Response Team will assess the need for support, or a defusing or information/support session with the individuals affected by the critical incident.
- Counselling, guidance and support for all university staff and/or students exposed to the critical incident will be provided.

SUPPORT & DEFUSING

The university has a commitment to providing appropriate supports to staff and students during and after every critical incident. These supports include defusing and/or information/support sessions. The Critical Incident Response Team will ensure that defusing is offered to all persons involved in a critical incident who request it. Such defusing should be offered as soon as possible, usually within 12 hours of the incident.The Critical Incident Response Team will also ensure that intensive support is offered to all persons involved in a critical incident if deemed necessary or requested. Such support should occur within three to seven days of the incident. Support and defusing may be offered on an individual or group basis.

LEVELS OF EXPOSURE

There are six possible levels of exposure. Each level has its own level of intervention. It is useful to determine the exposure level when responding to the critical incident. Those who are on the higher levels will normally have a higher priority to be followed-up than those on lower levels.

- Primary level: These are the people who have experienced the maximum exposure to the critical incident. They were personally involved or the critical incident or witnessed the event.
- Secondary level: The relatives and close friends of those who are affected by the critical incident.
- Third level: The rescue, recovery, investigating officer or person discovering the critical incident. This is any person who may have arrived at the scene/ accidentally discovered the incident. Examples include security officers, medical officers or paramedics who assist with the victims of the incident.
- Fourth level: The immediate community involved. This may be the colleagues of the deceased, lecturers/students who knew the person, etc.
- Fifth level: Persons not directly involved by the incident yet induced into stress. Colleagues who work in the same division but not same environment. Students who may be doing the same course of the deceased, but who were not friends.
- Sixth level: People who are indirectly involved. For example - the barman who noticed the driver was drunk, but continued to serve him alcohol.

APPENDIX H:

EXAMPLE PRIVACY CONFIDENTIALITY STATEMENT NOTICE AND RELEASE OF PERSONAL INFORMATION CONSENT FORM

Collection and use

The personal information you provide to the (college name) Counselling staff will be used in the provision of appropriate counselling and support to you. Use of the service is voluntary, however if you do not provide all the personal information requested by a counsellor we may not be able to provide the support you may need. We are required to keep records of each counselling session you attend for the purposes of monitoring progress and statistical analysis of our service's efficacy (e.g., attendance numbers and common presentation issues). We will not use your name, contact details or other identifiable data in these statistics.

Disclosure

We will not disclose your personal information or attendance details with anyone outside of the (college name) Counselling service except if:

- you have given us your written consent to do so, which may be by your prior approval (see below).
- it is required or authorised by law.
- we have reasonable ground to believe that the disclosure is necessary to lessen or prevent a serious and imminent threat to the life or health of you or any other person.

Security and retention

Your counselling file is electronically stored securely and safely at (college name). It is not connected to your student file and only the (college name) Counselling staff whose duties require it can access your counselling file.

Please note that under the NSW State Records Act 1998 we are required to keep your file for seven years after the last date of contact, or if you were under 18 at the last date of contact, the file must be kept until you are 25 years of age.

Access and correction

You have the right to access and correct personal information about you held by (college name). Please speak to <appropriate (college name) officer> in the first instance.

Consent

I _____(full name) give permission for the (college name) Counselling and Wellbeing Support service to disclose my personal information to assist in my care and treatment during the period __/__/____ to __/__/____ as listed below:

- teachers/academics/relevant (college name) staff (details if required)
  _____
- relevant government and community-based agencies (details if required)
  _____
- my medical practitioners and other allied health professionals (details if required)
  _____
- family member/friend/carer (details if required)
  _____
- Other (please specify)_____

I understand that I can withdraw or change my consent at any time; however, I am also aware of the limits to confidentiality as outlined above.

_____ Signature __/__/____ (date)

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