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"Just coming in the door was hard": supporting students with mental health difficulties

Sue Jackson and Margo Blythman

1 . Introduction

A student in your writing center displays such high level of anxiety that it also begins to impact on those working in the writing center. The student's behavior might tip over into the unacceptably aggressive and thus provoke a sharp response from the writing center director. Is this just everyone having a bad day or could it indicate a much deeper problem?. Students with mental health difficulties have been a growing concern for us in recent years in our study support team in a UK university. The UK Higher Education Statistics Agency indicates that, in 2003-4, 12.03% of the total numbers of students declaring a disability disclosed a mental health problem. In our college, LCC (London College of Communication, University of the Arts London), our statistics showed that 29.5% of our students, declaring a disability, had disclosed a mental health issue by the end of the same academic year. We are at present half way through our 2005-6 academic year and that number has increased to 37.14% of our students with disabilities. Students will frequently not disclose their disability before they apply because they are worried that they may not be accepted onto the program or even because the initial onset of a mental health breakdown may happen during their time at university.

In this chapter we examine the implications, through our particular perspective, of this situation for those of us working in study support/writing centers. We explain how study support works in our university and indicate in what ways it is similar and in what ways it differs from many US models of writing centers. We locate developments we have initiated within current UK government policy pressures and opportunities and then outline our approach to issues of disability. We then explain what this means in human terms by outlining a small number of examples one of us has developed through direct work with students. We use these examples to identify key issues in supporting students with mental health difficulties, how to read the warning signs and suggest some strategies from our own experience that writing centers could consider to assist the students. Finally we offer insights from this experience to institutional barriers and identify ways forward to make institutions more disability friendly. Our overarching aim is to ensure the right of students with mental health difficulties to a university education, where they are not disadvantaged by their disability.

2 . Adjusting the university, not just the student

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We approach the topic from a perspective of changing the university as well as the student. Tinklin and Hall (1999) point out that universities provide a lot of assistance to individual students to get round barriers that ideally should be removed.

The American literature on writing centers often explores the relationship between the writing center and the demands of the university and argues that the writing center is in an excellent position to encourage change (Grimm 1996; Nelson and Evertz 2001; Trimbur 1987; Wallace and Simpson 1991). Cooper (1995) argues for:

> writing centers as having the essential function of critiquing institutions (p.136)

Writing centers have considerable experience of one on one sessions with students and so are in an ideal position to identify institutional structural and cultural barriers that students face. Grimm (1999) argues:

> Writing centers are uniquely situated to begin offering more complicated representations of students; representations that change the way we talk about students- not as incomplete and undeveloped individuals "who need our help", but as complicated people with history, class and culture……. Rather than helping the Other become more like us, the work of the writing center might instead include developing the ability to see ourselves as the Other, to recognise the limits of our world views and cultural assumptions. (p.13-14)

We argue, therefore, that universities and colleges need to change both structurally and culturally if they wish to be inclusive institutions.
We approach the topic from a perspective of changing the university as well as the student and return later to strategies that build on this perspective.

3. Study support in the UK

In the UK the equivalent to a writing center is usually study support, also sometimes called "learning development". We are part of the study support team in the London College of Communication, which is one of five colleges comprising University of the Arts London, the biggest specialist Art and Design educational institution in Europe and possibly the world. For us, study support is a service accessed by students where the main focus is on helping students develop their academic writing. We interpret this quite widely and would include help with research skills, overall structuring and planning and time management as well as grammar and expression. We also support students working on oral presentations. Additionally, at University of the Arts London, support for students with English as a second language, students with learning disabilities (dyslexia is the UK term) and students with any other kind of permanent or temporary disability, including mental health difficulties, are all supported within study support, with most study support tutors having an expertise in one of these areas. Students can self refer, be referred by faculty or student services counsellors, or be brought by their friends. In our university there is not one sole location for this work and sometimes we work in-class with students. In the UK, study support tutors tend to be either

tenured or part time faculty rather than students and, as a result, we often have a more "teacherly" approach (Devet et al 2006).

In University of the Arts London this means that academic support for students with mental health difficulties is located within an academic unit rather than within a student services unit. This has a number of advantages. It means that we are recognised and respected (mainly!) by other faculty as fellow teachers. We often have more teaching experience and pedagogic knowledge than many of our colleagues elsewhere in the university who have been appointed for their disciplinary expertise rather than their knowledge of teaching and learning. These factors mainly make much easier any negotiations around changes in the way a course is delivered although there can occasionally be difficulties with faculty whose approach to teaching is radically different from ours.

4 . Why are we interested in mental health issues?

Declared mental health difficulties are on the rise in the UK. There are various possible explanations for this. It might simply be that there is less stigma attached and more government legislative and funding support so people are more willing to declare. Or facets of modern life, such as increased drug use, might indicate an actual increase. We also are in an era when there is more encouragement to support students for whom being successful at university is really problematic. There have been recent legislative changes affecting the rights of students with disabilities in higher education (Open University 2006). There is also a strong government policy imperative to “widen participation” i.e. open up universities to groups who have been traditionally excluded. This makes it a key time to effect improvements both in provision and in institutional culture for students with disabilities. Widening Participation is a key tenet of UK Labour government policy. It is part of a government agenda of social inclusion and this has been of benefit to students with disabilities. Widening participation is not just about increasing numbers of students. It is also about reaching disadvantaged groups. In the UK this is mainly a social class issue but it also opens the door for more progress on disability.

But this is combined with government policy of keeping down public expenditure. This means that there are rapidly rising staff-student ratios and more students who have had less social and educational preparation for university education.

Traditionally, higher education in the UK was elitist and for very small numbers. The massive expansion in the last twenty years now means that teaching groups are very large. (Trowler 1998) This puts students in general under more pressure (Yorke and Longden 2004) since there is less help available from faculty and this can be particularly difficult for students with mental health difficulties. However it has also led to a general re-thinking of university teaching and learning methods and the realisation that good practice for one group of students is often best practice for all. There is now

more willingness to adapt the curriculum, offer a variety of forms of evaluation/assessment, modify the delivery of teaching, put lecture notes on the university intranet, give clear handouts, allow students to tape record lectures, offer extra time for assignments and make special arrangements for exams. All this has helped to improve the situation for students with disabilities (Riddell et al 2005).

5 . Social models of disability

The authors operate within a social model of disability. Social models focus on the need for society to remove the barriers that prevent disabled people from participating, whether these are environmental or social factors. We do not see disability as a fixed category (Riddell et al 2005) but rather as a relationship between the individual student and the contemporary requirements of society in general and the university in particular. Thus we see disability as socially constructed. We contrast this with a medical model which sees disability as requiring "fixing" the student. A social model means that the university needs to adapt to suit a more diverse student population. Academic staff, course designers and curriculum development teams are responsible for creating access to the curriculum. The arrangements for the assessment/evaluation of students are dealt with by the university at strategic levels as well as at the level of the individual student and so examination of structural factors also gives us insight into the nature of barriers that students face. According to this model, disability is a social state rather than a medical condition that can be cured.

Thus part of our focus is on trying to achieve structural and cultural change within the university, such as changes in methods of teaching, rather than a sole focus on helping students cope with existing practices. This social model puts pressure on the institution and presents challenges. Within this context mental health difficulties create even more of a challenge. Student behavior can be difficult to understand; this behavior may raise the anxiety levels of faculty and non-teaching staff. At LCC, we are attempting to make a difference to the learning experience not only of students with mental health difficulties but to all students. Of course, students with mental health difficulties generally need to receive extra support to help them to cope with the environments that they find themselves in. However, to achieve the right balance, both the students and the institution need to be helped to change and adjust. Higher education institutions need to look more carefully at the flaws in the learning environment as well as the support of individual students.

6 . Legislation on the rights of students with disabilities

Support for students with disabilities is at a key development point in the UK because there has been considerable legislation and policy developments in the last few years. The key policy driver is the Disability Discrimination Act (DDA) which came into force in 2002. This is our equivalent of Section 504 of the Rehabilitation Act of 1973 and Title II of the ADA (1990).

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In Britain the DDA part 1 section 1 defines a disabled person as someone who has a "physical or mental impairment which has a substantial and long term adverse effect upon his ability to carry out normal day-to day activities" (Open University 2006). This includes students with mental health difficulties. It has to be a form of mental distress which is "clinically well - recognised". It includes the following, even if controlled by medication: depression, bipolar disorder, schizophrenia, phobias and eating disorders. Such a student cannot be treated less favourably for a reason relating to their disability. The university has to make "reasonable adjustments". Reasonable adjustments can be either "an individual adjustment' for a particular student such as the right to present an assignment in an alternative format, often called 'accommodated assessment", or it can be "an anticipatory adjustment" where, for example, the university offers a variety of assignment formats to all students. Reasonable adjustments could include changing standard procedures, adapting the curriculum, adapting teaching delivery or providing alternative forms of assessment/evaluation. It can also involve adapting facilities, including those such as writing centers, and providing additional services like materials in alternative formats. It also involves training staff to understand their responsibilities.

For students with mental health difficulties this could be interpreted as recognising that some situations put such students under intolerable pressure. These might include being with large groups of people, group work, presentations, having to absorb information under pressure and having rigid deadlines. Universities are required to be proactive in identifying barriers and work to remove them. In a writing center this might translate into entitlement to additional appointments or the right to work with the tutor in a private space.

From 2006 the legislation in the UK has been strengthened by a new statutory responsibility to promote disability equality. This requires institutions of higher education to move beyond minimum compliance and to mainstream disability equality in everything they do (Equality Challenge Unit 2006). It is a requirement that disabled people are actively involved in developing the action plan. Universities will have to report on, not only educational opportunities available to students with disabilities, but also on how well they achieve. The action plan must include the implementation of measurable improvements.

7. Some examples

We now turn to some examples of students one of the authors has worked with recently in order to illustrate the way issues might present themselves, give insights into the student's perception of the pressures of being a student and indicate the action taken to support the student. All names have been changed to protect confidentiality.

Example 1

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Geraldine disclosed her mental health difficulties before she enrolled on her degree course. She presented with depression and a number of years battling with eating disorders: bulimia and anorexia. She asked for a meeting prior to applying for a course and disclosed that she was still undergoing weekly therapy with a therapist with whom she had made great progress. She was anxious that her studies should not interfere with this progress but was very nervous about starting university. With the tutor's intervention, including two access visits to familiarize her with the site, the student felt at ease, gained confidence, had a successful enrolment and a successful start to her course. She was able to get used to the look and atmosphere of the college and had got to know her study support tutor.

With her writing, she often feels overloaded and does not know where to begin, in which order to plan her work or how to structure her assignments. She had a particularly difficult school experience while she was battling with her eating disorder and finds people in authority difficult to manage. She will do anything she can to avoid getting started on her work and often the stress will make things much worse. She will feel so bad that she is unable to attend class. She concentrates on minutiae, like clothes, to distract herself from bigger problems but the minutiae then also become stressful and important.

Our strategy was to offer Geraldine 1:1 weekly tutorials to help structure and plan assignments, to ensure all deadlines are met and procedures correctly followed, and to give emotional support. Contact is maintained as often as required to try and contain the anxieties and create boundaries. Contact is also made with other staff who teach Geraldine. She is extremely anxious about forthcoming exams and arrangements have been made for her to take her exams in a separate room so that she can monitor her own anxiety without worrying about everyone else in the room.

This support is very important to Geraldine. It helps her deal with the tension between desperately wanting to achieve but also being afraid of achievement.

Example 2

Josef, who is 20, sought help for his studies, but environmental factors were interfering in his life. He had little money, as he found it hard to hold down a part time job. He also had an abusive girlfriend, was self harming, had suicidal thoughts, was depressed and not able to complete any work. He had already been given a second chance by his programme director, but did not complete the year. It had taken a year before he was able to trust us enough to disclose that he had depression. With our encouragement he has now finally got a referral to a psychiatrist. He was given weekly study support, in which his work was carefully monitored and checked. This helped him complete the work for the year, giving him the possibility of entering his senior year.

Josef needed constant encouragement. He often phoned to cancel his appointments, giving various excuses including lack of money for the fare to college. When he did come, he was often close to despair and cried and talked about the difficulties of his relationship and his self-harming. In this situation, it was often helpful to focus on the studies, rather than the environmental situation. It normalised the circumstances and helped him to forget the difficulties for a short time and to achieve something. It was really important to ensure that he achieved something during each tutorial. His life seemed full of failure and to achieve a small amount of work, raised his self esteem, which helped his overall confidence to make changes in his life.

Example 3

Dan, a mature student of 28, was quick to fly into an aggressive temper whenever he was unable to comprehend what was required or when he did not get the expected response from a tutor. He disclosed that he had suffered with depression following a motor bike accident some years earlier and recently had been diagnosed with dyslexia and dyspraxia (a learning difficulty causing motor co-ordination difficulties due to lack of integration of timing, force and spatial awareness), neither condition which he fully understood. The educational psychologist said he had one of the worst cases of dyslexia she had ever seen.

Reading and writing were particularly difficult for Dan and his organisational skills were almost non-existent. Part of our strategy with Dan was to ensure that faculty had the study support tutor on their email list so that she was copied in to any communications between them and the student. This has helped him to make a good start to his dissertation and major practical project. The study support tutor is not an expert in his field but having the tutors' notes enabled her to help him to remain focused on his subject. He was given weekly tutorials to help him make progress in bite sized chunks. The study support tutor tried not to overload him so that he found each task manageable and always left the tutorials with a plan for the week. He also emailed her his work to look at in advance of their meetings.

This student often complained of being "stuck in molasses" in his head when he is writing. When this happened, the study support tutor normalised the situation so that he accepted that everyone is able to work sometimes and not at other times. When he peaked he found he could work at double the speed, to make up for any lost time.

Example 4

Gilly, however, was not one of our success stories. She had two previous attempts at higher education before coming to our university, the first she stopped after expressing dissatisfaction with the course, the second for medical reasons. She presented with a chronic back condition and suffered

from Obsessive Compulsive Disorder. She was not on medication, preferring to use natural alternatives, having found that conventional medication like Ritalin caused her concentration difficulties.

It soon became apparent that Gilly was unable to cope, often late for lectures as a result of her OCD. Gilly's teachers started to have concerns about the number of times she would ask the same question even after writing down the answers and taping the conversations. She was also often agitated and thinking about giving up the course, overwhelmed by the number of forms she had to complete. As the weeks progressed, Gilly's anxieties increased. She managed her first essay well with support, although she wrote much more than required and did double the amount of research necessary. Gilly found group work particularly difficult as she was constantly checking and rechecking all the arrangements with the rest of the group. She felt she was unable to manage the editing as she was too slow, although the group had been happy to accept her ideas for the content of the video. She became convinced that she was lazy and included this in her self -assessment form. As her anxieties increased so did the number of phone calls to study support, even when she knew no one would be there. This increased the level of anxiety in the study support department. The course faculty decided that Gilly was unable to manage without in-class support as she was taking up too much faculty time. Other students complained that her behaviour was too upsetting. The agreed solution was that Gilly would receive individual support from a specific faculty member for three hours a week, enabling her to opt out of some classes. She would also change groups so that her group tutor would be a full time faculty member. She also agreed to seek more help for her OCD.

However, before this could be put in place, Gilly made the decision to leave the college and defer her place for a further year. Gilly did not return. We learned from that experience that form-filling is very difficult for people with OCD as the amount of checking and re-checking needed increases anxieties. We now feel that, for some students, in-class support is vital if students are to achieve their potential and faculty are to be supported.

8. Staff response

Faculty and other staff working with students continue to be concerned about how to respond to students with mental health difficulties who express such high levels of anxiety in a variety of explosive ways, given the extra time and work needed to assist these students. Providing suitable boundaries for the student with mental health difficulties is also important. Very often their life is in chaos and ensuring that they are contained, knowing where to come to if they have a problem, ensures that fewer staff are involved and levels of anxiety are lowered. In this section we identify some indicators that students might have mental health difficulties and suggest what can be done to help and dangers to avoid. But first it is worthwhile indicating some general principles.

First, for tutors working in a writing center it is vital to be aware of all other relevant support services in the university and to use them, not only as a referral point for students but also as a source of advice and support for tutors themselves. These services are likely to include those responsible for implementation of Americans with Disabilities legislation and also other parts of student services of various kinds. It is important to get to know these people, understand their role and how it interconnects with yours and always be willing to seek advice both in general and about a specific student. Of course much of their work will be confidential and they will not necessarily enter into a full discussion with you about all aspects of the student's life but they will be willing to offer help and support in your role. Writing Center tutors pride themselves in being 'people oriented' (Harris 1990) but this has boundaries. Do not attempt to counsel students yourself. One student told us:

> Some people in my past…have thought it appropriate to make curing me their business so I approach telling people with caution…

Second, it is important to realise how vital confidentiality is in this area. Students with mental health difficulties have "hidden" disabilities; they are not visible like a mobility impairment. Additionally there is often still a stigma attached to mental health difficulties. This means that such students should never have their problems discussed or indicated in any public way. All discussion should be limited to appropriate professional conversations and, for a more general discussion, the student should be anonymised as we have done with the case studies in this chapter.

There is, however, another side to confidentiality. Boquet (2002) points out that "the principle we claim to hold nearest and dearest to our writing center hearts (is) that the benefit of the writing center is the personalized attention" (p.80). However, this has its dangers. It is important not to let students tell you very serious things, such as suicidal tendencies, and then swear you to secrecy. In these circumstances the best thing to do is say to the student that you can't agree to keep such information secret but you will pass it on with care to people who can help. It is important then immediately to tell your line manager and whoever you have identified with this responsibility within the wider university.

Third, it is important to remember that some of the indicators of behavior we are about to describe can also be found in students who do not necessarily have a mental health problem. Some of the issues discussed are part of what Gillespie and Lerner (2000) call "trouble-shooting" and they offer general good advice on a number of these matters. Young and Fritzsche (2002) explore the nature of procrastination in student writers. It is always a matter of judgement to decide whether or not a particular form of behavior is a matter of concern in any individual student.

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The following are some key warning signs in student behavior and suggested strategies:

- Student is late for almost every appointment. In these circumstances it is worthwhile taking a little time to try to find out from the student why they are always late. Writing center literature emphasizes the importance of tutor listening skills (Bokser 2005; Harris 1986) and this is a key aspect of supporting students with mental health difficulties. Their lateness might indicate a deeper problem. Some students may be on medication which can interfere with sleep patterns.
- Student shows a very high level of anxiety or agitation; this means that you feel anxious too. In these circumstances it is helpful to refer the student immediately to some of the more expert help we suggested above. It is important to document this referral and tell your line manager.
- Student discloses that s/he is feeling suicidal. In these circumstances you should ask the student if they are intending to kill themselves now. If so, you should immediately contact the university emergency services in the same way as you would if a student had a medical emergency. If not immediate, then refer the student to the appropriate counselor, contact or inform the advisor directly yourself and make sure you tell your manager and document what happened.
- Student fails to get started on an assignment or is unable to structure their work. It is important never to embarrass the student in front of others. Give the student a framework to work from and suggest a starting phrase or sentence.
- Student appears to be “lazy”, or showing lack of commitment. Be sympathetic and try and find a step-by-step approach – the student may be on strong medication for depression or painkillers, which can cause them to “slow down”. Never tell them that they are not welcome in the writing center because of their apparent lack of commitment.
- Student can't sit still and concentrate. Try and find out if the student is on any medication, or is having sleeping difficulties or is having an anxiety attack. Plan to complete a very small section of work, so that something is achieved before they leave you. Make another appointment as soon as possible. It may be that they will need to be referred to a medical doctor or for some counselling as well.
- Student shows distress and leaves the room. Always follow up this situation within an hour or two, to ensure that the student is not in distress due to a breakdown or mental health crisis. Make another appointment to continue working with them and maybe refer to a medical doctor or for counselling. It is important for a student to understand that you are prepared to focus on their studies, not on their mental health.
- Student will not want to finish all his/her work. This may be due to the fact that they have not planned for the future. If they are depressed they may not see a future. In a tutorial discuss the possibilities for “the next step” in their career.
- Student complains of being “stuck” with their writing. Normalise the situation. Tell them this happens to everyone and that when they are

unstuck they will be able to work twice as quickly. Get them started by asking them to tell you what they want to write and write the first couple of sentences for them. Help them to plan the next two paragraphs within the framework.

- Student does not hand in work by the deadline, although you know they have done something. If they give you work to read, always keep a copy before handing it back. Some students are perfectionists and will never be satisfied. You can be the judge of what is “good enough”.
- Be aware of sensitivity of topic. One anorexic student told us:

One day anorexia was brought up in class and sparked a debate. My super-sensitive reaction surprised even me.

Be aware when you are discussing these issues with one student that other students who are present in the room may be listening and feeling uncomfortable. You must be aware of the inappropriate use of colloquial language such as saying someone is "nuts".

- If a student is anxious about their ability to cope, suggest the student records lectures, so they do not have to become anxious trying to make notes
- Many students suffer from anxiety and depression. It is important to remember that praise is essential. Be positive
- If a student indicates that he/she is getting help from another part of the university, e.g. a specialist within student services or whoever has responsibility under the ADA, make contact with that person and ask for advice on how to work with the student in the Writing Center

9. Strategies to adjust the university, not just the student

We argued earlier for the necessity of changing the university, not just the student, a position that follows on from a social model of disability. In this section we identify issues that universities need to address and suggest some strategies.

First, universities need to become more flexible around opportunities for students to take time out and return later to the same program. Recent research, in the area of social class participation but equally applicable to students with mental health difficulties, suggests that the UK is not good at this (Quinn et al 2005). Currently, universities and colleges in the UK are rewarded financially and in terms of reputation for getting students through in the minimum period, which is three years for a Batchelor's degree in England. The United States, with a different history of participation in higher education, offers us some lessons in a more flexible approach.

Second, culturally universities need to do considerable work with all employees, both faculty and support staff, to give them a greater understanding of mental illness and how to cope with students with mental health difficulties. Those working in universities, at all levels, at times

misinterpret behavior and are also made personally uneasy, leading to fear. Tinklin and Hall (1999) point out:

> Sometimes staff were apparently well-meaning but ill-informed, or were operating on assumptions about a student's needs without checking with the student concerned…….many staff had a positive attitude but insufficient experience or knowledge. (p.191)

This comment applies to faculty as well as other staff since, in the UK, the term "staff" includes faculty.

Third, an issue requiring both structural and cultural change is the need to make both teaching and learning methods and modes of assessment/evaluation more inclusive. Tinklin et al (2004) point out that this requires challenging fundamental, conventional notions of what counts as effective teaching and learning. This makes changing assessment/evaluation one of the hardest aspects to achieve. Structural changes might include less dependence on attendance at large formal classes, a wider variety of possible ways of learning and the use of varied assessment/evaluation methods. If these are open to all students then this normalises a number of things that are really helpful to students with mental health difficulties. Assumptions of normality are central to an inclusive approach (Shevlin et al. 2004; Tinklin and Hall 1999). Some current research, taking place at Plymouth University in the UK (SWANDS 2002), has shown that by offering all students a choice of type of assessment that has been agreed before the start of the course, then fewer adjustments, if any, need to be made for disabled students. These types of changes require cultural change as well as structural since such changes in teaching and learning can only work with the co-operation of faculty and administrators. Shevlin et al. (2004) point out that there are issues of both attitude and awareness.

Fourth, there needs to be recognition by administrators and funders that some students cost more to educate than others because of additional support needs. It is not possible to work on a model of "the universal student". There needs to be part of the university which identifies all available external funding to support this work but it is important not to be entirely reliant on "special" money. Rather the needs of some students should be seen as a question of social justice. However, there is also a danger in large amounts of additional support of failing to develop students' independent learning. Hampton and Gosden (2004) argue that students who do receive additional support in various ways should still be encouraged to "minimise their reliance" on assistance for this reason.

Finally structural location of support for disabled students can reinforce particular messages. Location within student services can reinforce a medical model of students who need to be "fixed" (Borland and James 1999) whereas location within the part of the university responsible for equal opportunities and civil rights indicates a political recognition of the nature of disability as

socially constructed. Even here we need a note of caution. Shevlin et al (2004) point out that often:

> Official institutional policy appears to support the social model, but in everyday practice the medical model is deeply ingrained and dominant. (p.27)

Conclusion

The UK National Disability Team concluded in 2004 that:

> There is a deal of debate around a definition of mental illness since the concept depends upon interpretation of what constitutes “normal” behavior. What might be defined as acceptable thoughts, feelings and behavior in one setting would be considered totally unacceptable in another. The acceptance depends upon the social, historical and cultural context in which we live. (National Disability team 2004)

In this chapter we have suggested that better support for students with mental health difficulties, including writing center support, requires an investment in changing structures and cultures within the university as well as helping the individual student. We would not want to suggest that this is easy. We see ourselves at the beginning of this journey, at a point where these changes are matters of debate and discussion rather than safely embedded. This journey is, however, one that those of us committed to social justice in relation to educational opportunity need to travel.

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