

Institute for Public Policy Research



NOT BY DEGREES

IMPROVING STUDENT MENTAL
HEALTH IN THE UK'S UNIVERSITIES

Craig Thorley

September 2017

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SUMMARY

60-SECOND SUMMARY

Levels of mental illness, mental distress and low wellbeing among students in higher education in the UK are increasing, and are high relative to other sections of the population.

Around three-quarters of adults with a mental illness first experience symptoms before the age of 25. With widening access to higher education the student population is more closely reflecting the UK's wider socioeconomic and demographic make-up, and a growing proportion of students would appear to be affected by mental illness. Over the past 10 years there has been a fivefold increase in the proportion of students who disclose a mental health condition to their institution.

Students can be at added risk of experiencing poorer mental health and wellbeing relative to other young people, due to a combination of factors relating to academic, financial and social pressures. This is evident in the high levels of mental distress reported by students, and the extent to which universities report experiencing dramatic increases in the number of students seeking support, predominantly through access to university counselling services.

Poor mental health and wellbeing can affect students' academic performance and desire to remain in higher education. In the most severe and tragic circumstances, it can contribute to death by suicide – levels of which have also increased among students in recent years.

The higher education sector and government both have an interest in helping to improve the mental health and wellbeing of students. Universities should make the issue a strategic priority and adopt a 'whole-university' approach based on prevention and promotion, early intervention and low-level support, responding to risk and crisis management, and referral into care and treatment. There is currently too much variation in the extent to which universities are equipped to meet this challenge. This sector-led approach should be complemented by strengthened NHS provision and new government initiatives to ensure that no student is held back by their mental health.

KEY FINDINGS

Today's generation of young adults (aged 16–24) are more likely to experience mental illness than previous generations of young adults. This is driven primarily by significant growth in the proportion of young women who experience a mental health condition.

- In England, 19 per cent of 16–24-year-olds experience a mental health condition, up from 15 per cent in 2003. Among this age group, 28 per cent of women experience mental health problems, compared to 10 per cent of men. This difference between the sexes is also evident in Scotland, Wales and Northern Ireland.
- 62 per cent of students to enrol in higher education in the UK in 2015/16 were aged under 25 (rising to 89 per cent of undergraduate enrolments).

The number of students to disclose a mental health condition to their institution has increased dramatically over the past 10 years, with variation in rates of disclosure between different groups of students.

- In 2015/16, 15,395 UK-domiciled first-year students at HEIs in the UK disclosed a mental health condition – almost five times the number in 2006/07. This equates to 2 per cent of first-year students in 2015/16, up from 0.4 per cent in 2006/07.
- Mental health conditions account for an increasing proportion of all disability disclosed by first-year students (17 per cent in 2015/16, compared to 5 per cent in 2006/07).
- Female first-year students are more likely than male first-year students to disclose a mental health condition (2.5 per cent compared to 1.4 per cent) (2015/16). In 2009/10, male and female students were equally likely to disclose a mental health condition (both 0.5 per cent).
- Undergraduates are more likely than postgraduates to disclose a mental health condition (2.2 per cent compared to 1.4 per cent) (2015/16).
- Just under half of students who report experiencing a mental health condition choose not to disclose it to their HEI.

Students experience lower wellbeing than young adults as a whole, and experience lower wellbeing than was the case in previous years.

- Young adults aged 20–24 are less likely than any other age group to record high levels of wellbeing (life satisfaction, feeling that things done in life are worthwhile, happiness and low anxiety). In 2017, less than 1 in 5 students reported high levels of each of these four key wellbeing indicators.

Where support and treatment is lacking, poor mental health can lead to increased risk of students dropping out of university, or in the most severe and tragic cases, death by suicide.

- A record number of students died by suicide in 2015. Between 2007 and 2015, the number of student suicides increased by 79 per cent (from 75 to 134).
- Suicide is, in general, often linked to the presence of mental health conditions, although just 25 per cent of people who die by suicide in the UK were in contact with mental health services during the year prior to their death.
- In 2014/15, a record number of students (1,180) who experienced mental health problems dropped-out of university, an increase of 210 per cent compared to 2009/10.

Higher education providers have – over the past five years – experienced significant increases in demand for counselling and disability services.

- 94 per cent report an increase in demand for counselling services, while 61 per cent report an increase of over 25 per cent. In some HEIs, up to 1 in 4 students are using, or waiting to use, counselling services.
- 86 per cent report an increase in demand for disability services, while 31 per cent report an increase of over 25 per cent. In some HEIs, up to 1 in 4 students are using, or waiting to use, disability services.

There is variation in the ways in which higher education providers design their strategic response to student mental health and wellbeing.

- A range of prevention and promotion activities are widespread across the HE sector. ‘Buy-in and direction from senior leadership’ is considered by universities to be the most important factor in helping to improve student mental health and wellbeing. However:
 - 29 per cent have designed an explicit mental health and wellbeing strategy

- 43 per cent design course content and delivery so as to help improve student mental health and wellbeing, despite the vast majority indicating that this is important
- 29 per cent do not monitor the attendance of all students; 45 per cent have a student medical practice (GP) based onsite; 67 per cent do not provide students access to NHS mental health specialists who can deliver interventions onsite; and 23 per cent do not work closely with NHS secondary mental health services.

RECOMMENDATIONS

1. **The HE sector should collectively adopt student mental health and wellbeing as a priority issue**, with individual institutions developing their own ‘whole-university’ approaches, which are subject to quality assurance and continuous improvement, and underpinned by common principles which draw on best practice.
2. **HEIs should commit to increase the amount of funding dedicated to services which promote and support the mental health and wellbeing of students.** Individual HEIs should commit to provide additional investment in line with an honest and accurate analysis of current student need and reasonable future projections.
3. **Government should facilitate a more systematic national strategy to improve the quality of data on the mental health and wellbeing of students, and the effectiveness of interventions within a university context.** This should involve amending the Adult Psychiatric Morbidity Survey to include data collection on mental illness among students, and commissioning research into the effectiveness of mental health and wellbeing interventions within a university context.
4. **Government should facilitate the introduction of place-based coalitions which aim to improve the health of local student populations through greater integration across services.** This should include the introduction of a new Student Health Fund into which local health and education partnerships can bid, and new pilots of 0–25 mental health services in places with high student populations.
5. **Government should introduce a new Student Premium to top-up the funding of GP practices with high proportions of student-patients**, given the NHS has recognised students as an ‘atypical’ population likely to lose out from current funding arrangements.
6. **Government should pilot a new digital NHS Student Health Passport**, to improve the continuity of healthcare and treatment among students who move between home and university, and ensure that they have control over their own health data.

1. INTRODUCTION

Across the UK, there is a growing appreciation that mental health matters. For individuals, it can affect their ability to learn, earn, form strong and meaningful relationships, and live long and healthy lives. For government, it can affect productivity, demand for public services and levels of expenditure on out-of-work benefits.

But as awareness of the importance of maintaining positive mental health continues to grow, and stigma relating to mental illness is slowly chipped away, other parts of society are also required to consider their own role in relation to public mental health and wellbeing.

In any given year, one in four adults experiences at least one diagnosable mental health problem, such as depression, anxiety or a more severe and enduring illness. As such, any public institution which comes into contact with large numbers of people will encounter mental illness, and has an interest in maximising positive mental health and wellbeing. To this end, government is due to publish a green paper on children and young people's mental health and the role of schools, while the independent Stevenson-Farmer review will explore ways to improve mental health at work.

There is, however, a need also to consider the extent to which the UK's universities are equipped to meet the challenge posed by students' mental health and wellbeing needs.

On the one hand, there is a growing public narrative suggesting a 'crisis' in students' mental health, with frequent stories of long delays in accessing counselling, and tragic reports of student suicides. On the other, young people today are often accused of being 'snowflakes' unable to cope with ordinary life events.

What these narratives are likely to conceal, though, is the real extent of poor mental health and wellbeing within the student population; the extent to which this has changed over time; the reasons why this may have changed over time; the extent to which universities are currently meeting the challenge; and what more can be done (including by government and other actors such as the NHS). This report looks to provide answers to these questions.

First, by seeking to clarify terminology, arguing in favour of universities understanding mental health and wellbeing as existing along a continuum on which all people, at all times, are located somewhere (chapter 2).

Second, the report explores levels of mental illness, mental distress and low wellbeing among the wider population of young adults in the UK – who make up the majority of the student population – and how they have changed over time (chapter 3), before turning to consider the same questions in respect of students, in particular (chapter 4). It then sets out the factors which are likely to have driven changes to prevalence rates and demand for mental health services among students and the extent to which these are associated with the student experience (chapter 5).

Third, having established the extent and trajectory of mental health and wellbeing need among students in the UK, the report then turns to consider the strategies that universities are implementing in order to meet the challenge. It explores how services are configured across the sector and changes in the level of demand as reported by universities (chapter 6), before focusing on the two key elements of a 'whole-university approach' to mental health and wellbeing – prevention and promotion (chapter 7) and access to support, care and treatment (chapter 8).

The final chapter of the report sets out a number of recommendations – targeted at universities, government and the NHS – for improving the mental health and wellbeing of students, and ensuring that all those who require support, care or treatment are able to access it (chapter 9).

1.1 ABOUT THIS REPORT

The evidence described in this report was collected in the following ways.

Extensive review of existing literature and new analysis of secondary datasets

An in-depth literature review was conducted to draw out the most reliable data on student mental health and wellbeing within the UK. This incorporated academic publications, government reports, thinktank and other research studies, and media reports. This was accompanied by new IPPR analysis of data from the Higher Education Statistics Agency (HESA), the Higher Education Funding Council for England (HEFCE), and data released to us in advance by Unite Students and Student Minds.

New survey analysis

This report also presents the findings of a survey of 58 higher education providers from England, Scotland and Wales (including both universities and further education colleges that deliver HE courses). The survey was open to all higher education providers within the UK who were members of Universities UK, GuildHE and the Mixed Economy Group. (Institutions from Northern Ireland were invited to participate, but no responses were received).

Qualitative, stakeholder analysis

Between February and March 2017 IPPR researchers collected primary data from six UK universities invited to participate as case studies: Brunel University London; De Montfort University; the University of Birmingham; the University of Dundee; the University of Leeds; and the University of Wolverhampton. For each university which participated, face-to-face and telephone interviews were conducted with senior management (including vice-chancellors); leaders of student services, counselling and disability services; local NHS primary care leaders; and local NHS mental health secondary care staff. At each university, a focus group was also held, involving 8–10 students with some experience of accessing the institution's mental health and wellbeing services.

The findings from these six case studies were then supplemented by those from a further eight institutions, each of which participated in a telephone interview with IPPR researchers.

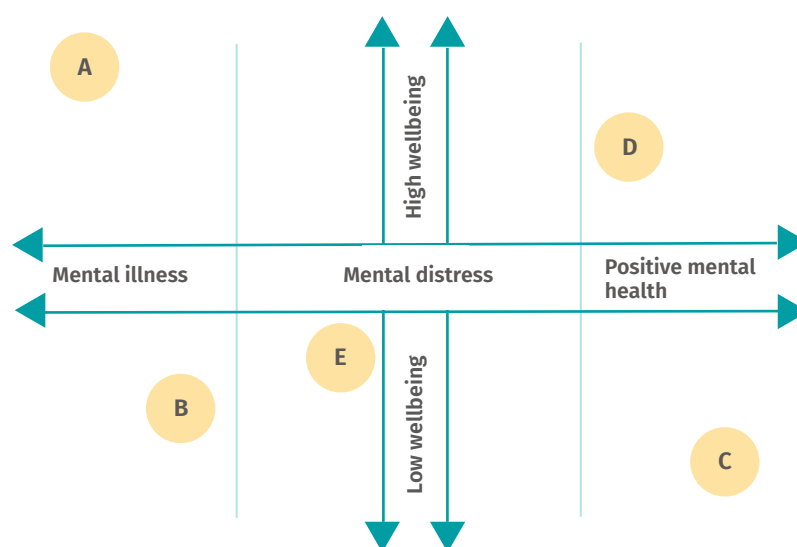
Key themes were drawn out from this data using a framework analysis approach.

2. MENTAL HEALTH AND WELLBEING ALONG A CONTINUUM

Like physical health, mental health is something that is experienced by everyone, all of the time. It exists along a continuum and can, therefore, be positive or negative to different degrees. Understanding mental health in this way helps us to appreciate its fluidity and the possibility for it to change over time. We are all somewhere on this continuum at any particular time in our lives; where exactly we fall helps us to understand the level of support and treatment that we might require.

Similarly, wellbeing exists along a continuum, and can be positive or negative to different degrees. While mental health and wellbeing will inevitably affect one another to some extent, they are best understood as being distinct. Figure 2.1 sets out how mental health and wellbeing could interrelate, as experienced by individuals.

FIGURE 2.1
Mental health and wellbeing along a continuum



Source: IPPR model, adapted from Student Minds¹

Note: For example, Person A experiences a severe and enduring mental illness, but also experiences high levels of wellbeing.

¹ <http://www.studentminds.org.uk/for-everyone.html>

In the following chapters, we assess levels of mental health and wellbeing according to three categories.

- **Mental illness** relates to where an individual experiences the symptoms of one or more clinically diagnosable mental health condition. These conditions can range from the severe and enduring – such as bipolar disorder and psychosis – to more common conditions such as depression and anxiety. An individual with a mental illness may or may not have received a diagnosis, and may or may not be seeking or receiving treatment. They do, however, experience symptoms which meet the threshold for a diagnosis.
- **Mental distress** relates to where an individual reports negative mental health, but where it is not clear that this meets the threshold for a clinical diagnosis. In this report, mental distress is understood as where individuals self-report mental health problems, which have not been subjected to clinical screening measures.
- **Wellbeing** relates to the extent to which an individual is feeling good and functioning positively. In this report, it is generally taken to be measured across four key indicators – happiness, life satisfaction, feeling things done in life are worthwhile, and low anxiety.

Figure 2.1 locates five different points along the mental health and wellbeing continuum.

- Person A experiences a severe and enduring mental illness, but also experiences high levels of wellbeing. This person may, therefore, be managing their mental health condition effectively and receiving the appropriate treatment, and otherwise leading a happy and fulfilling life.
- Person B experiences a common mental health condition, but is also experiencing low wellbeing. This person may be failing to receive effective treatment, affecting their happiness and causing them added stress. Similarly, they could be receiving effective treatment, but other factors in their life might be causing them to experience low wellbeing.
- Person C experiences positive mental health, but low wellbeing. They are mentally healthy – in the sense that they do not have a diagnosable mental health condition or exhibit symptoms of mental distress – but may also experience low levels of happiness or satisfaction with their life.
- Person D experiences positive mental health and high levels of wellbeing. They do not have a mental health condition, are not exhibiting symptoms of mental distress, and are generally happy and satisfied with their life.
- Person E is exhibiting some symptoms of mental distress. It is not clear that this meets the threshold for a clinical diagnosis of a mental health condition, but they are none the less reporting that they do not consider their mental health to be positive. This is coinciding with low wellbeing, indicating they are also experiencing low levels of happiness and satisfaction.

3.

MENTAL HEALTH AND WELLBEING AMONG YOUNG ADULTS

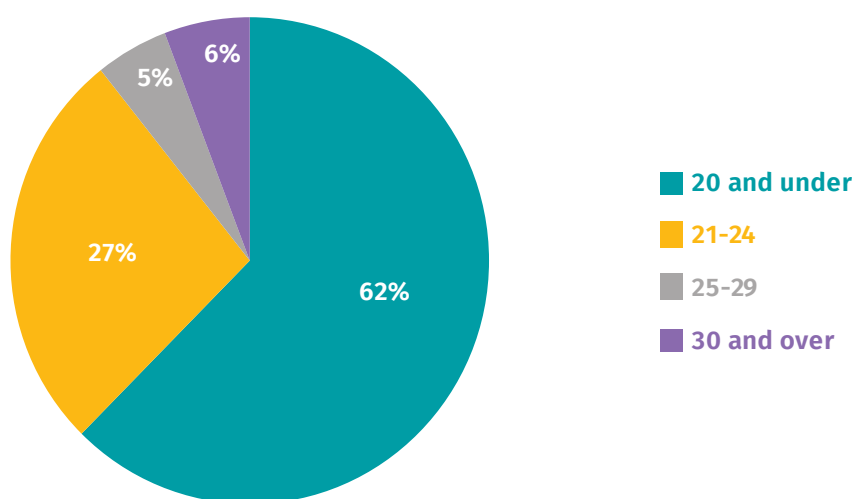
Positive mental health and wellbeing are important means for people of all ages to be able to lead happy, healthy and productive lives. Mental distress and mental illness can, on the other hand, lead to a number of adverse life outcomes for individuals, as well as contribute added costs to the economy and wider society.

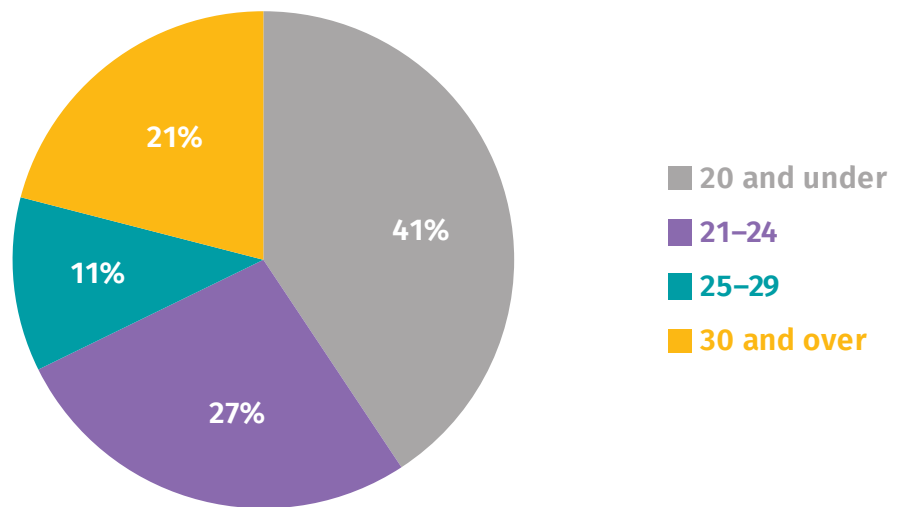
This report focuses on the mental health and wellbeing of the student population in the UK. However, it is important to first set this within its wider context. This chapter, therefore, explores levels of mental illness, mental distress and wellbeing among young adults – who make up the majority of the student population in the UK – and how these have changed over time.

FIGURE 3.1

Two thirds of students to enrol in higher education in the UK are aged under 25 (rising to 89 per cent of undergraduate enrolments)

UK student population, split by age (enrolments in all course types and levels) (2015/16); UK student population, split by age (full-time undergraduate students only) (2015/16)





Source: IPPR analysis of Higher Education Statistics Agency data (HESA 2017a)

How old are students in the UK?

Young adults make up the majority of the student population. In 2015/16, more than two-thirds (68 per cent) of all students who enrolled on a course in a higher education institution (HEI) in the UK were aged 24 or below (including both postgraduate and undergraduate courses, as well as both full-time and part-time courses).

For full-time undergraduates, which accounted for 63 per cent of all enrolments in 2015/16, 89 per cent were aged 24 or below.

3.1 MENTAL ILLNESS

Mental illness is a broad term which covers a wide range of conditions of differing severity.

Those conditions that are more severe and enduring are less common. For example, around 1 in 100 adults in England experience psychotic disorder, while around 1 in 50 exhibit traits of bipolar disorder (McManus et al 2016). Young adults (aged 18 to 25) are at higher risk of developing severe and enduring mental illnesses such as schizophrenia and bipolar disorder (RCPsych 2011). There is, however, a long-term trend of broad stability in the prevalence rates of many such conditions, including psychotic disorder (McManus et al 2016). This compares to a number of more common mental health conditions that affect a larger and increasing section of the population. It is these conditions, therefore, which we examine in more detail below.

These findings are taken from the Adult Psychiatric Morbidity Survey (APMS) – which provides the most detailed insight into levels of mental illness within the English population – as well as the Scottish, Welsh and Northern Irish health surveys respectively (McManus et al 2016).

Young adults aged 16–24 today are more likely than previous generations of young adults to experience common mental health conditions

Approximately one in six people experience a common mental health condition, such as depression or anxiety, in any given week (McManus et al 2016). Between 1993 and 2014, there was a gradual increase in the proportion of working-age adults in England who experience symptoms of common mental health conditions (from 14 per cent to 18 per cent) (Stansfeld et al 2016).

Around three-quarters of adults with a mental illness first experience symptoms before the age of 25, with the peak age of onset for most conditions falling between the age of 18 and 25 (Kessler and Wang 2008). However, there is mixed evidence from the UK as to the extent to which young adults are more likely than older adults to experience mental illness.

- In England, unlike for most other long-term health conditions, the likelihood of experiencing a common mental health condition does not increase with age. Instead, prevalence rates are spread relatively evenly between younger and older working-age adults (McManus et al 2016).
- In Scotland, young adults score more highly than older age groups across a number of indicators of mental illness. Compared to all older age groups, adults aged 16–24 are more likely to experience at least one symptom of depression (22 per cent) or anxiety (28 per cent), as well as to report ever having deliberately self-harmed (18 per cent) (Scottish Government 2015).
- In Wales, young adults are the least likely to report being treated for both depression (8 per cent) and anxiety (6 per cent) (although this could reflect a higher proportion of young adults experiencing mental illness without accessing treatment) (Welsh Government 2015).
- In Northern Ireland, young adults are not – overall – more likely to experience mental illness than older age groups (Northern Ireland Government 2016).

Young people today are, however, marginally more likely than previous generations of young people to experience mental health conditions. In 1993, 15 per cent of people aged 16–24 experienced a common mental health condition, whereas in 2014 this had grown to 19 per cent.

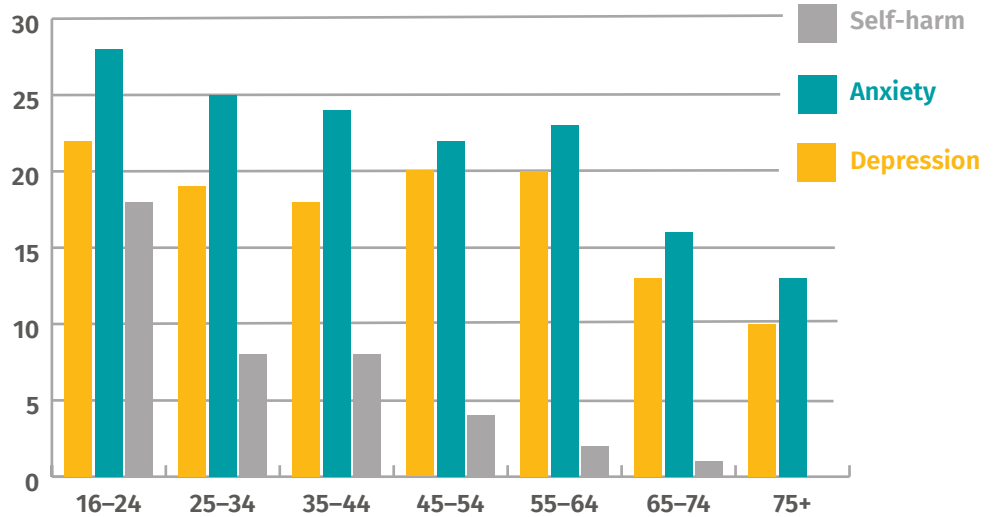
Increased prevalence of common mental health conditions among young adults has been driven primarily by increased rates among young women

There is a significant, and widening, gap between prevalence levels among men and women. In England, among all age groups, women are more likely than men to experience common mental health conditions. However, for people aged 16–24, there is the widest difference between the sexes, with women almost three times more likely to experience a mental health condition than men (28 per cent compared to 10 per cent).

Figure 3.4 shows how increased prevalence of common mental health conditions among young adults over recent years has, therefore, been driven largely by growth among women, with no overall growth among men between 1993 and 2014.

FIGURE 3.2

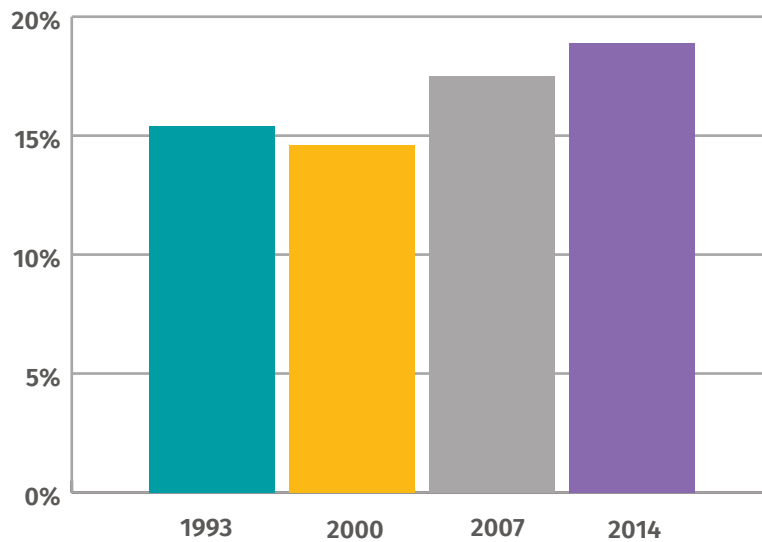
In Scotland young adults are most likely to experience mental illness
Proportion of adult population in Scotland who experience at least one symptom of depression or anxiety (CIS-R)², or who report ever having deliberately self-harmed (split by age) (2012–15) (%)



Source: Scottish Health Survey (Scottish Government 2015)

FIGURE 3.3

Young people today are marginally more likely than previous generations of young people to experience mental health conditions
Proportion of people aged 16–24 in England who experienced a common mental health disorder in the past week (1993–2014) (%)



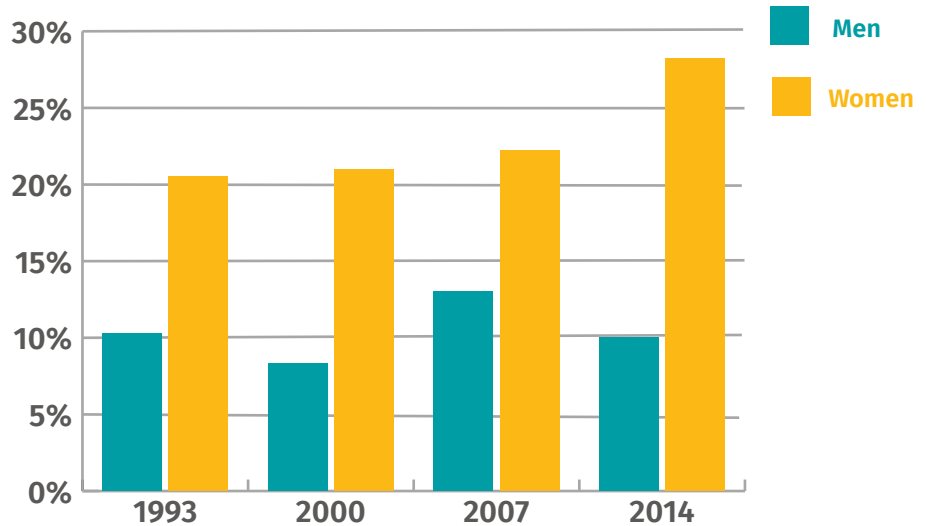
Source: Mental Health and Wellbeing in England: Adult Psychiatric Morbidity Survey 2014 (McManus et al 2016)

² The Revised Clinical Interview Schedule (CIS-R) is a well-established tool for measuring the prevalence of mental disorders.

FIGURE 3.4

In England young women are now almost three times more likely than young men to experience a common mental health condition

Proportion of people aged 16–24 in England who experienced a common mental health disorder in the past week (split by sex) (1993–2014) (%)

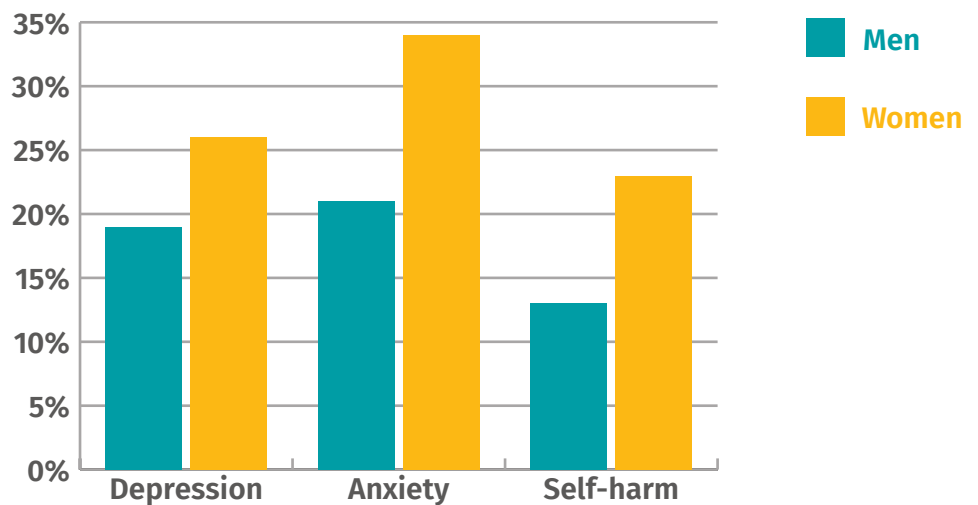


Source: Mental Health and Wellbeing in England: Adult Psychiatric Morbidity Survey 2014 (McManus et al 2016)

FIGURE 3.5

In Scotland, young women are also more likely than young men to experience mental illness

Proportion of adults aged 16–24 in Scotland who experience at least one symptom of depression or anxiety (CIS-R), or who report ever having deliberately self-harmed (2012–2015) (%)



Source: Scottish Health Survey (Scottish Government 2015)

In Scotland, women aged 16–24 are also significantly more likely than men to have experienced mental illness (see figure 3.5). This is also true in Northern Ireland, where women in the same age group experience significantly higher rates of mental illness (29 per cent) compared to women in all older age groups. Among men, the rate was 13 per cent among those aged 16–24, lower than the rate among men aged 25–64 (Northern Ireland Government 2016).³

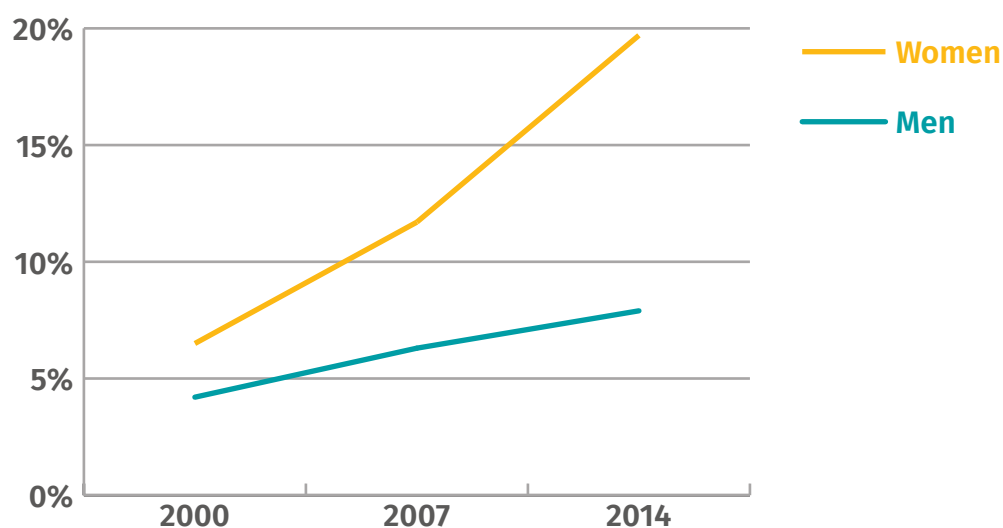
Other proxies also suggest rates of mental ill-health among young adults, and particularly young women, are increasing. In 2014, 1 in 5 women aged 16–24 in England reported having ever self-harmed (20 per cent), compared to 1 in 13 men in the same age group (8 per cent). Women aged 16–24 were three times more likely to report ever having self-harmed in 2014 compared to 2000 (7 per cent), while men in this age group were twice as likely (4 per cent).

This trend, is however, reversed when looking at deaths by suicide. Across all age groups, men are three times more likely to die by suicide than women. Both men and women aged under 30 are the least likely to die by suicide, compared to older males and females (ONS 2016a).

FIGURE 3.6

Since 2000, the number of young men and women reporting self-harm has doubled and trebled respectively

Self-harm ever (reported face-to-face) in 16–24 year olds (split by sex) (2000; 2007; 2014) (England) (%)



Source: Mental Health and Wellbeing in England: Adult Psychiatric Morbidity Survey 2014 (McManus et al 2016)

3.2 MENTAL DISTRESS

The surveys referenced above provide the best insight into levels of diagnosable mental illness in the UK. However, surveys which collect data on self-reported mental health problems are also of value. While not all of these self-reported

³ The Health Survey Northern Ireland uses the general health questionnaire (GHQ) to test for the prevalence of mental illness among the population, with a high score indicating the likely prevalence of mental illness for an individual.

problems will meet the threshold required for a clinical diagnosis, they do point to the level of mental distress – within the population.

For example, 2017 survey data found just 13 per cent of adults in the UK report that they live with high levels of positive mental health. There is, however, significant variation according to age, with 7 per cent of young adults (aged 16–34) reporting positive mental health, compared to 10 per cent of people aged 35–54 and 19 per cent of people aged 55 and over (MHF 2017).

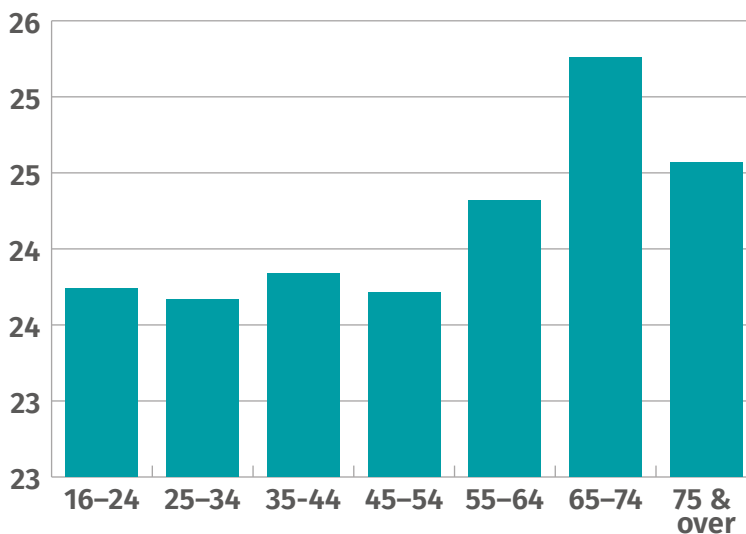
The same survey found nearly two-thirds of adults report having experienced a mental health problem. Again, young adults were the most likely (70 per cent), compared to those aged 35–54 (68 per cent) and 55 and over (58 per cent) (ibid).

3.3 WELLBEING

As well as mental illness and distress, it is also important to understand levels of wellbeing within the adult population.

FIGURE 3.7

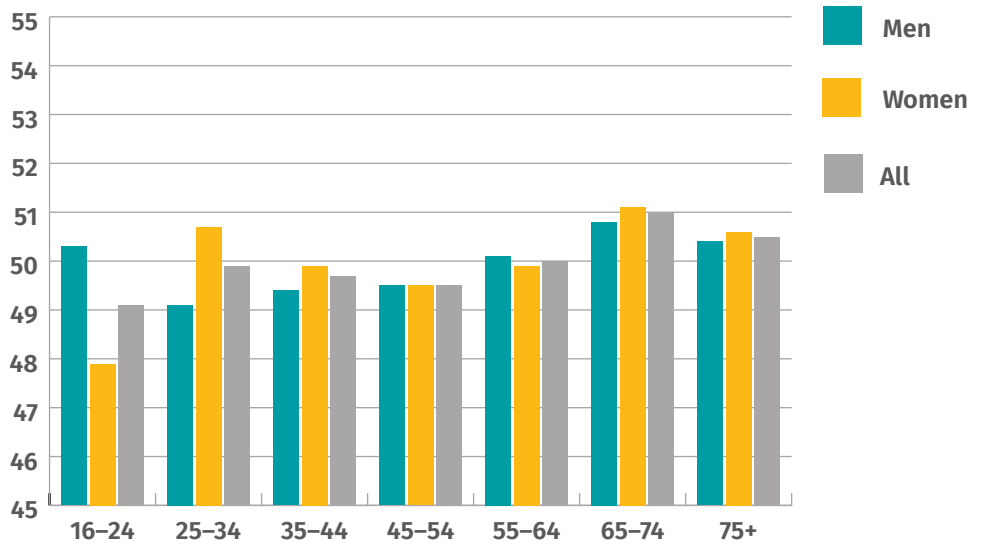
Overall, young people report levels of wellbeing similar to those in middle age
Adult population mental wellbeing (split by age) (2012–13) (rating of 7–35) (UK)



Source: Office for National Statistics (ONS 2017a)

FIGURE 3.8

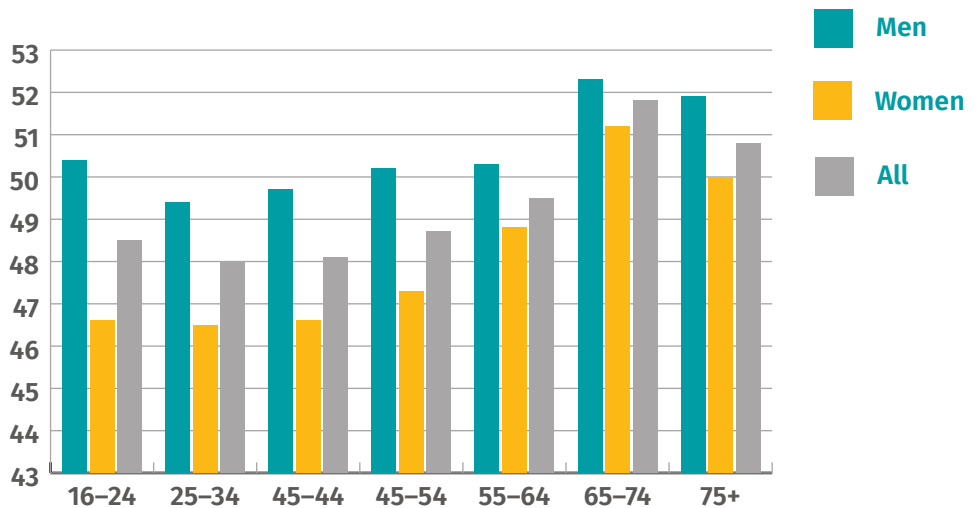
In Scotland, young women experience lower wellbeing than all other groups
Mean wellbeing score (split by age and sex) (2015) (rating 14–70) (Scotland)



Source: Scottish Health Survey (Scottish Government 2015)

FIGURE 3.9

In Wales, young women are also more likely to experience lower wellbeing
Mean SF-36 mental component summary score (MCS) score, (split by age and sex) (2015) (Wales)



Source: Welsh Health Survey (Welsh Government 2015)

Overall, mental wellbeing is estimated to have remained relatively stable over recent years, with little variation across the nations and regions of the UK (ONS 2017a, Scottish Government 2015). Figure 3.7 shows how in the UK overall, young

adults (aged 16–24) experience levels of wellbeing which are roughly equal to older age groups (with the exception of those aged 55 and above, who experience higher wellbeing). However, in both Scotland and Wales, young women (aged 16–24) are found to experience significantly lower wellbeing than all other groups (Scottish Government 2015, Welsh Government 2015) (see figures 3.8 and 3.9).

This data may, however, conceal some variation within the 16–24 age group. When broken down into two parts (16–19 and 20–24), the former scores more highly across a number of individual wellbeing indicators, while the latter scores below the average across all adults (see table 3.1) (ONS 2017b).

TABLE 3.1

Proportion of adults who report very high levels of four key indicators of mental wellbeing (split by age group) (October 2015 to September 2016) (UK) (%)

Year	Life satisfaction	Life worthwhile	Happiness	Low anxiety
16–19	35	34	38	41
20–24	27	31	32	39
All adults	29	35	34	40

Source: Office for National Statistics (ONS 2017b)

3.4 SUMMARY

The majority of students in higher education within the UK fall within the age range at which people are most likely to develop the first symptoms of mental illness. What is more, today’s generation of young adults (aged 16–24) are more likely to experience mental illness than previous generations of young adults. This trend is, however, driven primarily by significant growth in the proportion of young women who experience mental health conditions, for example in England, 28 per cent of women aged 16–24 experience mental health problems, compared to 10 per cent of men in the same age group.

There would also appear to be growing levels of mental distress in the UK, where adults report experiencing mental health problems, even where these have not been subjected to clinical screening measures and so may fall short of the threshold for diagnosis.

Finally, wellbeing also appears to vary according to age. Women aged 16–24 are most likely to experience low wellbeing, and adults aged 20–24 are least likely to record high levels of four key wellbeing indicators (life satisfaction, feeling that things done in life are worthwhile, happiness and low anxiety).

The majority of students in the UK are aged 16–24. In the next chapter we consider these three domains – mental illness, mental distress and wellbeing – within the context of the student population, specifically.

4.

MENTAL HEALTH AND WELLBEING AMONG STUDENTS

Young adults are at heightened risk of developing the first symptoms of mental illness, and are also more likely than previous generations of young adults to experience mental health conditions. There is also some evidence to suggest that they experience heightened levels of mental distress and lower wellbeing. The majority of students in higher education in the UK fall within this age range.

In this chapter we explore levels of mental illness, distress and wellbeing among the student population specifically, how these have changed over time, and how they differ from prevalence levels within the wider age cohort.

Student numbers in the UK

While there has been a significant expansion in the total number of people who choose to enrol in higher education over the past 25 years, there has been a slight reduction since student numbers peaked in 2009/10. Since then, the number of enrolments has fallen by 16 per cent (from 1.19 million to 0.99 million) (HESA 2017a). This fall is due predominantly to a reduction in the number of people studying postgraduate courses and undergraduate courses which are not their first degree.

As detailed in chapter 3, enrolments in full-time undergraduate courses are made up largely of people aged 24 or below. And for this group, there has been continued growth in enrolments. In 2015/16, the number of enrolments in first-degree undergraduate courses was 10 per cent higher than in 2008/09 (542,575 compared to 494,055) (HESA 2017a).

There are a number of factors which are likely to have contributed to this sustained growth in the number of young people choosing to attend university to study as undergraduates. These include:

- a continued wage premium for graduates relative to non-graduates: the median wage differential between graduates and school-leavers has remained flat at around 35 per cent over the past two decades for people aged 25–29 in the UK (IFS 2016)
- changes to the structure of the labour market to accommodate a greater proportion of graduates (ibid)
- removal of the government's cap on student numbers from 2015/16, incentivising HEIs to increase their intake
- a 'widening participation' agenda which has seen modest relative increases in the number of young people from more deprived socioeconomic backgrounds attending university (DfE 2016)
- despite tuition fees increasing significantly in 2012, simultaneous reforms – such as more generous maintenance grants and loans –

increased the amount of up-front funding available to poorer students entering higher education (IFS 2017)

- the UK is now the second most popular destination, after the United States, for international students, who generated over £25 billion for the UK economy in 2014/15 (UUK 2017).

The effect is that a large and growing proportion of people are choosing to enrol in undergraduate courses in the UK, with a majority falling within the age range in which there is an added risk of experiencing mental health problems.

4.1 MENTAL ILLNESS

There is a widespread lack of robust data on the prevalence of mental health conditions among students in the UK. Statistics on the number of students who disclose a mental health condition to their HEI do, however, provide a proxy for rates of mental illness among the student population.⁴

Disclosing a mental health condition to a higher education institution

The primary purpose of encouraging disclosure of mental health conditions and other disabilities is to ensure that students are able to access additional support to which they may be entitled while studying. For students with a disability which meets a certain threshold of severity, HEIs may be entitled to receive Disabled Students' Allowance (DSA) funding to be spent on additional support. While not all students who disclose a mental health condition will be entitled to receive DSA support, generally those with conditions deemed to be substantial, long-term and re-occurring will be. And for those students unsure as to whether their condition meets these criteria, disclosure can be a way of finding out (UCAS 2016).

The predominant way for university applicants to formally disclose a mental health condition is via their UCAS form during the application process. Disclosure at this initial stage will mean the HEI is aware of the student's condition(s) from the outset, and can help to determine their eligibility for receiving different kinds of support. However, students can also choose to disclose a mental health condition at any point thereafter for the duration of their time at university. For postgraduate students, however, it is not possible to disclose a mental health condition via UCAS, and instead opportunities to disclose are largely limited to the reporting arrangements made available by individual HEIs.

More students than ever are declaring a mental health condition

Over the past 10 years, there has been a significant increase in the number of first-year students who disclose a mental health condition to their HEI (see figure 4.1). In 2015/16, there were 15,395 UK-domiciled first-year students at HEIs in the UK who disclosed a mental health condition – almost five times the number in 2006/07 (3,145).⁵

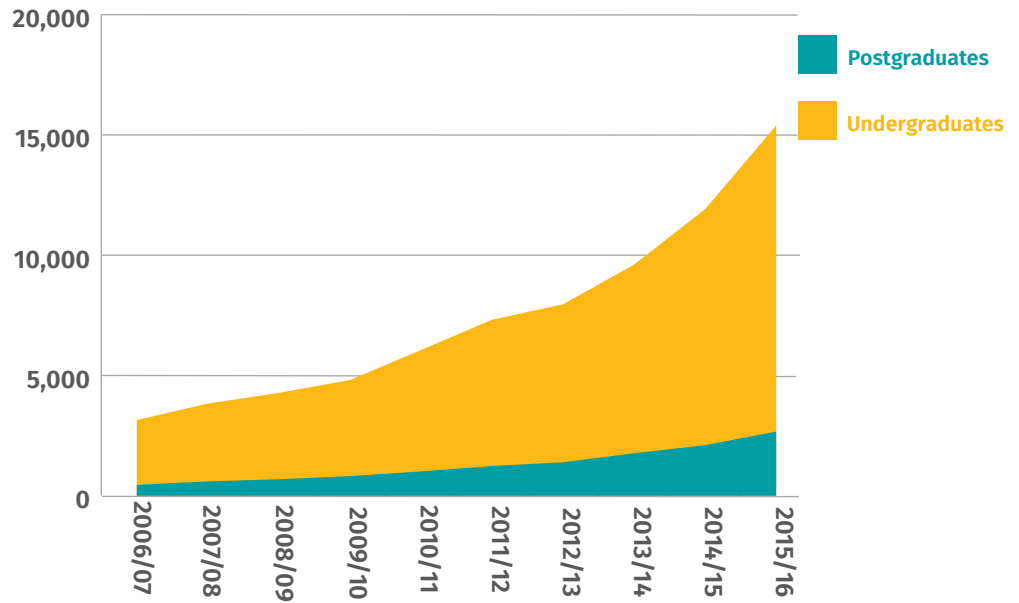
⁴ Disclosure' should, here, be interpreted as where a student formally communicates to their HEI that they experience an enduring or disabling mental health condition (as opposed to approaching a member of university staff about their mental health in a less formal way).

⁵ In 2015/16, UK-domiciled students accounted for 81 per cent of all enrolments at HEIs in the UK (6 per cent were other EU-domiciled and 14 per cent came from countries outside the EU) (HESA 2017a).

FIGURE 4.1

Five times as many HE students in the UK to disclose a mental health condition than was the case ten years ago

All UK-domiciled students with a disclosed mental health condition (such as depression, schizophrenia or anxiety) at higher education institutions (split by full-time/part-time; undergraduate/postgraduate) (UK) (2006/07–2015/16)

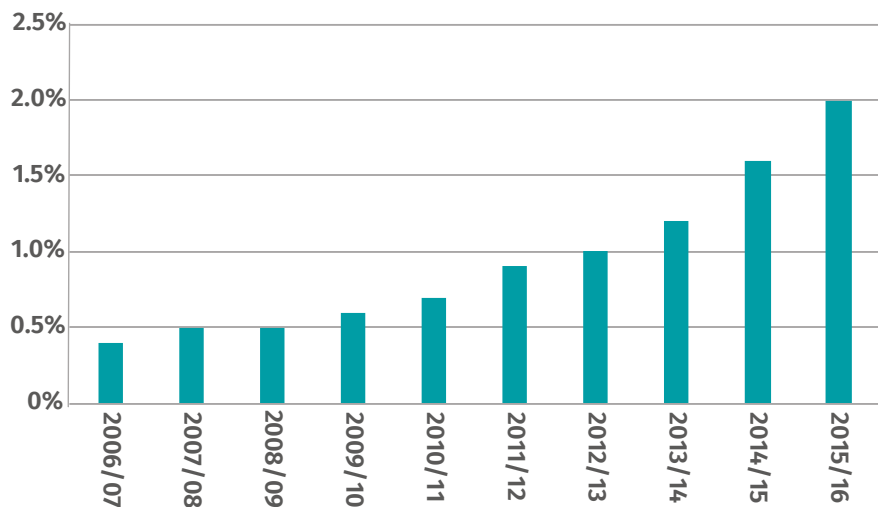


Source: IPPR analysis of Higher Education Statistics Agency data (2017b)

FIGURE 4.2

HE students are five times more likely to disclose a mental health condition compared to ten years ago

The proportion of all UK-domiciled first-year students who have disclosed a mental health condition (such as depression, schizophrenia or anxiety) at higher education institutions (UK) (2006/07–2015/16) (%)



Source: IPPR analysis of Higher Education Statistics Agency data (2017b)

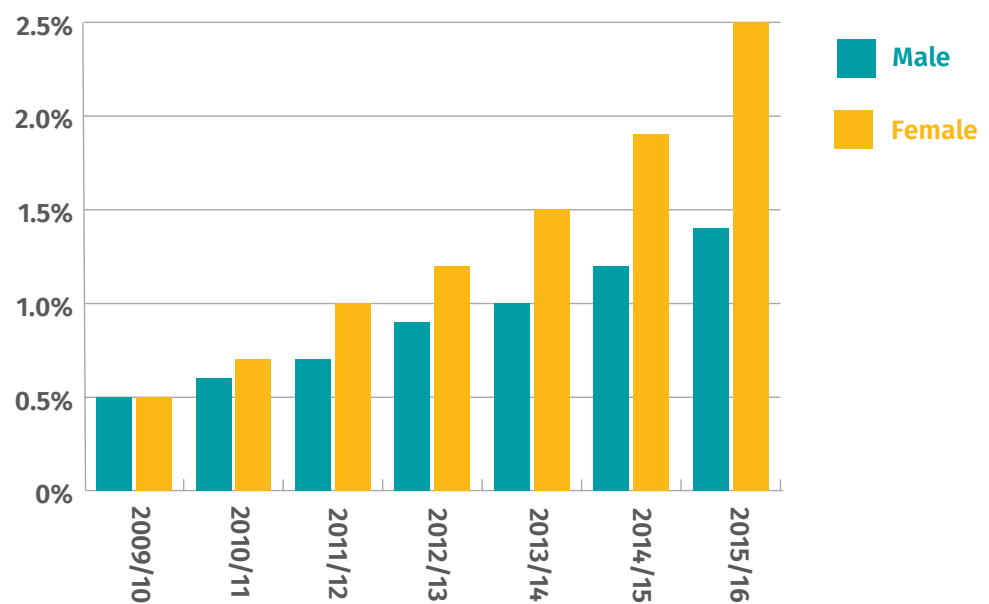
A growing proportion of students are disclosing a mental health condition

A student is five times more likely to disclose a mental health condition to their HEI than was the case 10 years ago. Two per cent of UK-domiciled first-year students disclosed a mental health condition in 2015/16, up from 0.4 per cent in 2006/07 (see figure 4.2). The rate of growth has accelerated since 2011/12.

FIGURE 4.3

Female students are now significantly more likely than male students to disclose a mental health condition to their HEI

The proportion of all UK-domiciled first-year students who have disclosed a mental health condition (such as depression, schizophrenia or anxiety) at higher education institutions (split by sex) (UK) (2006/07–2015/16) (%)



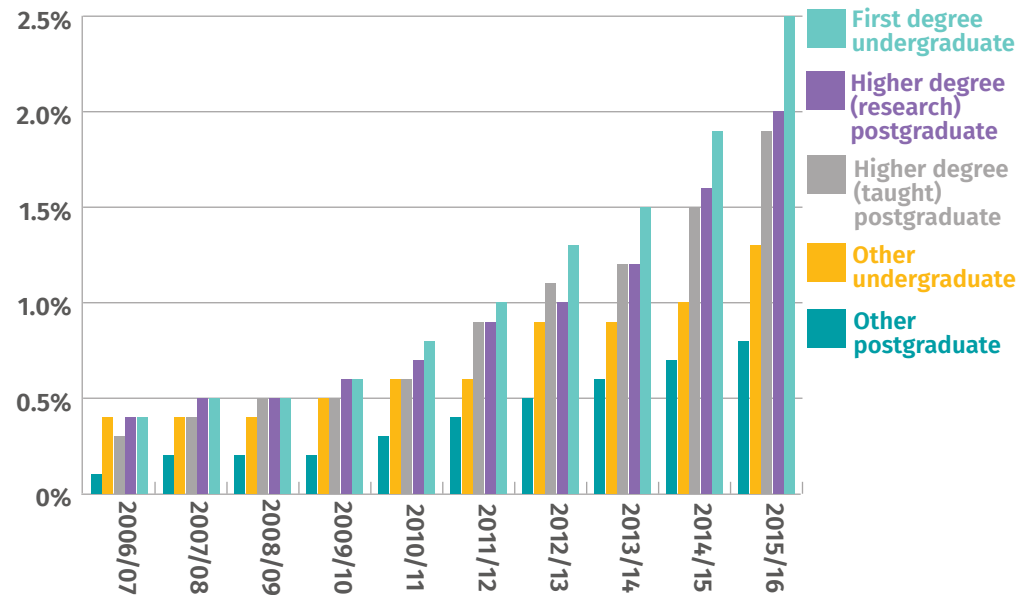
Source: IPPR analysis of Higher Education Statistics Agency data (2017b)

This, does, however, mask variation across and within different groups of students.

First, **female students are significantly more likely to disclose a mental health condition than male students.** In 2006/07, first-year male and female students were equally likely to disclose a mental health condition (0.5 per cent). Over the next 10 years, both male and female students became more likely to disclose. However, by 2015/16, 2.5 per cent of female students disclosed a mental health condition, compared to 1.4 per cent of male students (see figure 4.4). So while male students are three times more likely to disclose a mental health condition than they were 10 years ago, female students are five times more likely.

FIGURE 4.4

The likelihood of disclosing a mental health condition varies according to degree type
The proportion of all UK-domiciled first-year students who have disclosed a mental health condition (such as depression, schizophrenia or anxiety) at higher education institutions (split by level of study) (UK) (2006/07–2015/16) (%)



Source: IPPR analysis of Higher Education Statistics Agency data (2017b)

Second, **undergraduates are more likely than postgraduates to disclose a mental health condition** (2.2 per cent compared to 1.4 per cent). However, this too conceals variation between types of study. Figure 4.4 shows how, in 2006/07, there was little variation between and among first-year postgraduate and undergraduate students. But by 2015/16:

- first-degree undergraduates were the most likely to disclose a mental health condition (2.5 per cent), and were twice as likely compared to ‘other undergraduates’⁶
- postgraduate students studying research-based higher degrees were marginally more likely to disclose a mental health condition than those studying taught higher degrees (2.0 per cent compared to 1.9 per cent).

Third, **full-time students are more likely than part-time students to disclose a mental health condition**. Despite being equally likely to declare a mental health condition in 2009/10 (0.5 per cent), by 2015/16 2.3 per cent of first-year full-time students declared a mental health condition, compared to 1.4 per cent of first-year part-time students.

Mental health conditions account for an increasing proportion of all disability disclosed by students

Among those who disclose a disability, students are more than three times more likely to disclose a mental health condition than was the case 10 years ago. In 2015/16, mental health conditions accounted for 17 per cent of all disclosed

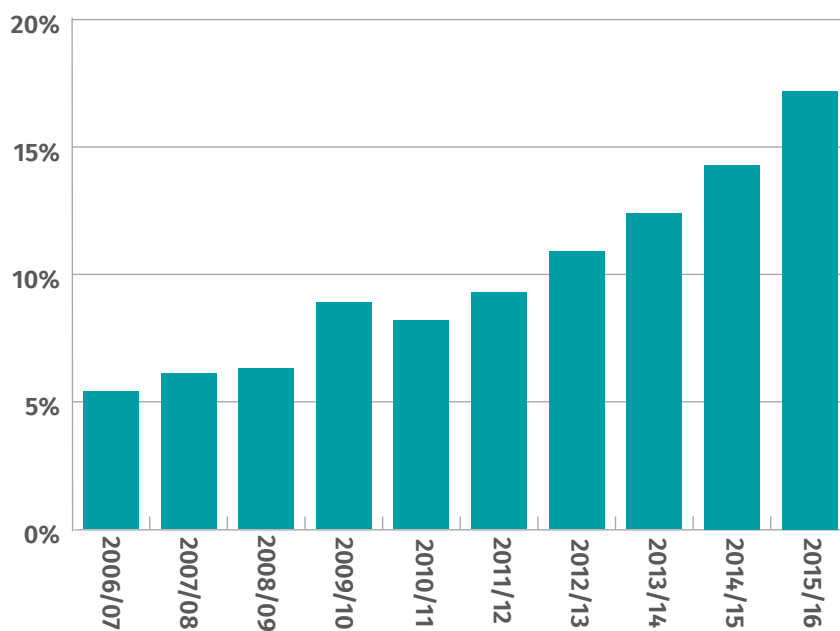
⁶ ‘Other undergraduates’ includes qualification aims equivalent to and below first-degree level, including, but not limited to: Professional Graduate Certificate in Education (PGCE) at level H; foundation degrees; diplomas in higher education, Higher National Diploma (HND); Higher National Certificate (HNC); Diploma of Higher Education (DipHE); and Certificate of Higher Education (CertHE).

disability among first-year UK-domiciled students, compared to 5 per cent in 2006/07 (see figure 4.5).

FIGURE 4.5

Mental health conditions account for an increasing proportion of all disability disclosed by HE students in the UK

The number of all UK-domiciled first-year students who have disclosed a mental health condition (such as depression, schizophrenia or anxiety) to their higher education institution, as a proportion of the total number of students who have disclosed a disability (UK) (2006/07–2015/16) (%)



Source: IPPR analysis of Higher Education Statistics Agency data (2017b)

Why are disclosure statistics likely to underrepresent the actual level of mental illness among the student population?

Methodology of data collection

Due to an imperfection in the way data is collected, the actual number of mental health disclosures is likely to be higher than described in this report. When disclosing a disability, applicants and students are able to select a category of condition from a shortlist, which includes both ‘a mental health condition, such as depression, schizophrenia or anxiety’ and ‘two or more impairments and/or disabling conditions’. However, they are only able to select one of these options, meaning among those who have two or more disabilities, it is not known how many experience a mental health condition. In the most extreme case, were all first-year students who disclosed two or more disabilities to their HEI in 2015/16 to experience a mental health condition, the figure for mental health disclosures would rise from 15,395 to 23,670 (or 3.1 per cent of all first-year students).

Significant numbers of students who experience a mental health condition do not disclose it to their HEI

According to survey data, less than half (48 per cent) of students who report experiencing a mental health condition have disclosed it to their

HEI (42 per cent of first-year students, rising to 50 per cent of students in year 2 and 53 per cent of students in year 3+).⁷

Similarly, just over one-third (37 per cent) of university applicants who report experiencing a mental health condition have declared, or intend to declare, it to the HEIs to which they have applied (HEPI 2017).

There are two main sets of factors which can help to explain low rates of disclosure among students who experience a mental health condition.

Stigma

Students may choose not to disclose a mental health condition if they feel that their relationships with peers or university staff, as well as other opportunities to succeed while at university or after graduating, might be adversely affected as a result.

Among students with experience of mental distress, the main reason given for not talking to other students about their mental health was ‘not wanting students to think less of them’ (ECU 2014). There is, however, some evidence that the majority of students are aware of issues surrounding mental health and are sympathetic to those who experience mental illness. For example, just 8 per cent of students report not knowing anyone who experiences mental health problems; an overwhelming majority (84 per cent) accept that mental illness is as serious as physical illness; and just 3 per cent say they would be more cautious around a person experiencing mental health problems (YouGov 2016).

Students may also opt not to disclose their condition if they believe they are likely to be subjected to institutional stigma or prejudice from staff. Students who do not disclose report doing so through fear that they will receive ‘unfair treatment’ as a result (ECU 2014). Relatedly, disclosure could be perceived as limiting future opportunities. For example, among university applicants with a mental health condition, 47 per cent who have no career in mind anticipate disclosing their condition, falling to 34 per cent among those with a particular career in mind (HEPI 2017).⁸ This suggests that, for some students, disclosing a mental health condition is viewed as having the potential to jeopardise their route into a future career or profession.

Stigma can also vary according to culture, and so be more commonly associated with particular demographic or socioeconomic groups. For example, non-UK and EU applicants are less than half as likely to declare, or intend to declare, their condition (19 per cent compared to 40 per cent of UK applicants). This could be caused, in part, by some students travelling to study in the UK from countries where mental illness is more heavily stigmatised. Similarly, applicants from the least deprived socioeconomic backgrounds (AB) are the least likely to declare, or intend to declare, their condition (29 per cent), as are applicants from fee-paying schools (27 per cent compared to 39 per cent of applicants from non-fee paying schools). Again, this could be caused, in part, by less deprived socioeconomic groups retaining higher levels of stigma on issues surrounding mental health.

Conversely, some groups report a higher propensity to disclose a mental health condition. For example, applicants who are gay or lesbian are more likely to declare their condition (49 per cent, compared to an average of 37 per cent). Applicants intending to study the arts are more likely to declare

⁷ Data is drawn, with permission, from the *Unite Students Insight Survey 2017*, which will be published on 16 October 2017.

⁸ Underlying data provided by Unite Students.

their condition (45 per cent), while both humanities/social studies and STEM applicants are less likely (33 per cent).

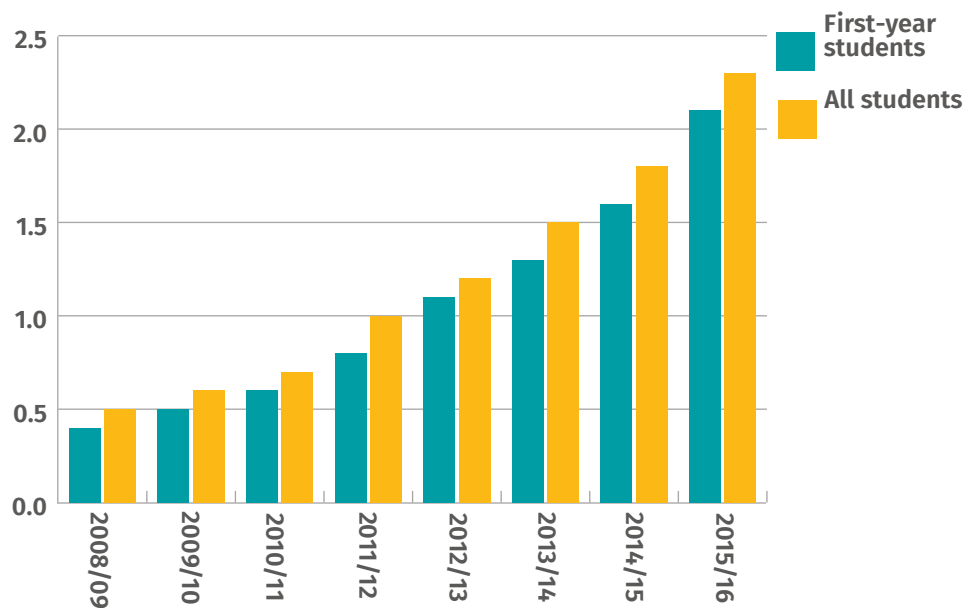
Lack of awareness of importance or availability of receiving support

According to Student Minds, ‘students do not feel that their institutions actively encourage [them] to disclose mental health difficulties’. Among students with experience of mental health problems, just 28 per cent report having been aware – when applying – of the support and adjustments that were available to them (ECU 2017). Another reason cited by students who do not disclose is that they did not think they will receive support or adjustments as a result (ibid). That some students are aware of support, but do not think it applies to them, suggests that the information which does reach students is not always clear. It is, therefore, important that universities encourage disclosure among eligible students, and provide clear information on the benefits of disclosure, including how sensitive data will be stored and managed (Student Minds 2017).

FIGURE 4.6

The vast majority of students who disclose a mental health condition to their HEI do so in their first year

The proportion of UK-domiciled students with a disclosed mental health condition (such as depression, schizophrenia or anxiety) at HEFCE-funded higher education institutions (split by first-year/all students) (England) (2008/09-2015/16) (%)



Source: IPPR analysis of data provided by the Higher Education Funding Council for England (HEFCE)

The vast majority of students who disclose a mental health condition do so during their first year

In 2015/16, 2.1 per cent of UK-domiciled first-year students studying in HEIs in England disclosed a mental health condition. That this figure rises only very slightly (to 2.3 per cent) when *all* students are considered demonstrates how the vast majority of students who disclose a mental health condition to their HEI do so in their first year. But, even so, a significant number of students go on to disclose

a mental health condition during their second or third years. This group is likely to be made up of some who did not disclose their condition in their first year for the reasons discussed in the box above, and some who did not first experience symptoms until after their first year.

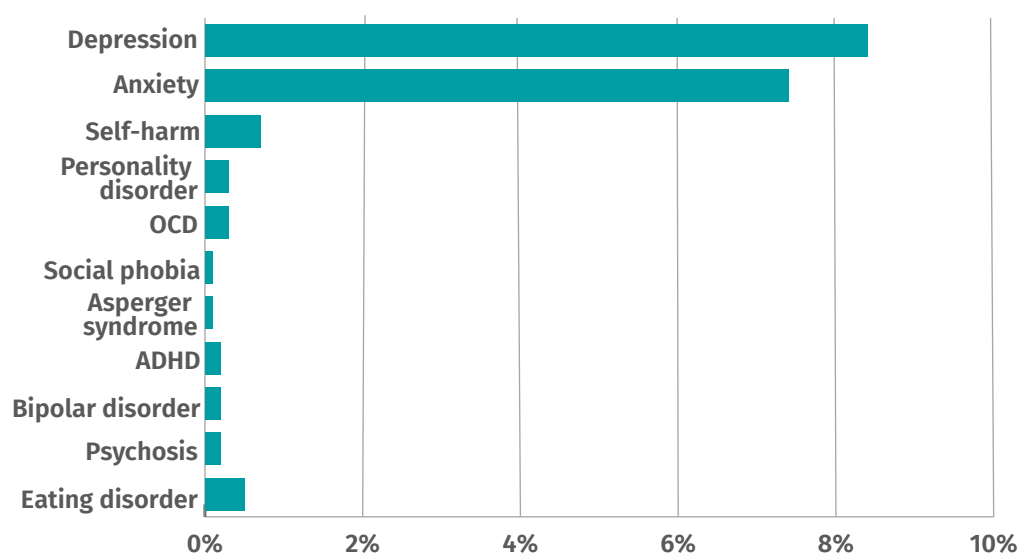
There has, then, been a steady increase in the proportion of first-year students who disclose a mental health condition to their HEI. While this is not a reliable indicator of actual levels of mental illness within the student population, it does point to growing levels of demand for mental health support among students.

Due to the wide variation in definitions and methods of measurement, it is difficult to draw direct comparison between levels of mental illness and distress in the student population as opposed to among 16–24-year-olds as a whole.

FIGURE 4.7

Among students who access primary care in England, 7–8 per cent experience depression and anxiety

The proportion of student-patients across 12 student medical practices in England recorded as experiencing mental health conditions (split by mental health condition) (Jan–Dec 2016) (%)



Source: IPPR analysis with the Student Health Association

Some studies have estimated that levels of mental illness are similar among the student population to that within the total population of young adults. For example, using the general health questionnaire (GHQ) measure, Macaskill found 17.3 per cent of students to exhibit symptoms of mental illness, which is broadly similar to the levels among young adults reported in the APMS in 2007 and 2014 (Macaskill 2012).

Others, meanwhile, have estimated that students are more likely to experience symptoms of mental illness. For example, an internet-based survey conducted across four UK HEIs by Bewick et al (2008), and which used the CORE-10 measure, found 29 per cent of students recording levels of psychological distress which fell within the clinical range (with 8 per cent recording levels which were moderate-to-severe or severe).

Within the context of studies such as these, the proportion of students who disclose a condition would appear to fall significantly below the overall prevalence of mental health conditions within the student population (even when also taking into account levels of disclosures of ‘two or more disabling conditions’ and survey data on the proportion of mental health conditions which are not disclosed).

Which mental health conditions are most prevalent among the student population?

With the assistance of the Student Health Association (SHA), we conducted a very small survey of student medical practices in England to determine what proportion of patients who access primary care (and are students) are recorded as experiencing different mental health conditions.

Among the 12 practices to take part in the survey, between 64 and 100 per cent of the patients seen were students (during January to December 2016).

Drawing on anonymised data from practices’ electronic patient (EMIS) records, we tested for the number of student-patients who were recorded by practitioners as experiencing different mental health conditions.

Among these conditions, the most prevalent was depression, present among 8.4 per cent of student-patients, followed by anxiety (7.4 per cent). All other conditions were significantly less prevalent, and were recorded as being present for between 0.1 and 0.7 per cent of student-patients (see figure 4.7).

Although drawing on a very small sample – meaning caution should be taken in drawing firm conclusions – this data demonstrates the relative prevalence of different mental health conditions among students who access primary care.

4.2 MENTAL DISTRESS

As well as a significant increase in the number of students who formally declare a mental health condition to their HEI, there is also a high level of self-reported mental distress among the student population. While not always meeting the threshold for a clinical diagnosis, this is likely to have a significant effect on individual students’ ability to thrive both academically and personally, as well impacting on demand for a range of student services.

Table 4.1 summarises the findings from a number of student surveys to have been conducted over the past five years. While there is variation in the methodologies used, meaning the results are not directly comparable to one another, these surveys generally find high levels of mental distress among the student population. In particular, there would appear to be high levels of stress and anxiety, and a significant proportion of students also report having experienced suicidal thoughts.

These surveys suggest that levels of mental distress range from affecting 12 per cent to 78 per cent of the student population, making it difficult to determine the extent of mental distress in students relative to the total population of young adults.

TABLE 4.1**Levels of self-reported mental distress reported by students in the UK vary dramatically between surveys**

Summary of key findings from surveys exploring levels of mental distress among UK student population (2013–16)

Year	Organisation	Methodology	Key findings
2013	YouthSight	Representative sample of 1,000 full-time undergraduate students from a range of institution-types	<p>75 per cent of students reported having experienced psychological distress while at university</p> <p>65 per cent reported having experienced stress; 43 per cent reported having experienced anxiety, loneliness or feeling unable to cope; 33 per cent reported having experienced depression or homesickness; and 8 per cent reported having experienced suicidal thoughts</p> <p>female students were significantly more likely than male students to experience stress, anxiety, homesickness and feeling unable to cope (YouthSight 2013)</p>
2013	National Union of Students (NUS)	Online questionnaire Sample of 1,285 students	<p>26 per cent of students reported having experienced mental health problems (16 per cent reported having a current diagnosis)</p> <p>80 per cent reported having experienced stress while at their current place of study; 55 per cent reported having experienced anxiety; and 49 per cent reported having felt depressed</p> <p>14 per cent reported having thought about self-harm; 13 per cent reported having experienced suicidal thoughts (NUS 2013)</p>
2015	National Union of Students (NUS)	A self-selecting sample of 1,093 students studying both further and higher education courses	<p>78 per cent of students reported having experienced a mental health problem in the past year (with or without a diagnosis)</p> <p>87 per cent reported having experienced stress in the past year; 77 per cent reported having experienced anxiety; and 69 per cent reported having felt depressed</p> <p>36 per cent reported having experienced thoughts of self-harm in the past year (NUS 2015)</p>
2016	Unite Students	Sample of 6,504 students and 2,169 applicants	<p>12 per cent of students and 12 per cent of applicants reported experiencing mental health problems</p> <p>anxiety and depression were higher among students with self-reported mental health conditions (82 per cent and 79 per cent respectively) than applicants with self-reported conditions (77 per cent and 70 per cent respectively)</p> <p>32 per cent of students reported always or often feeling down or depressed over the previous four weeks; and 62 per cent reported feeling stressed or worried (Unite Students 2016)</p>

Year	Organisation	Methodology	Key findings
2016	YouGov	Sample of 1,061 students	<p>27 per cent of students reported suffering from a mental health problem</p> <p>of those who reported experiencing a mental health problem, 77 per cent reported experiencing depression, 74 per cent reported experiencing anxiety, and 14 per cent reported experiencing an eating disorder</p> <p>63 per cent of students reported experiencing levels of stress which affect their day-to-day lives (YouGov 2016)</p>

4.3 MENTAL WELLBEING

There is some evidence that levels of wellbeing are declining among students. Comparing between its surveys in 2016 and 2017, Neves and Hillman (2017) find reductions in the proportion of students who score highly across four key wellbeing indicators (see table 4.2). What is more, a smaller proportion score highly across all four of these indicators than is the case among the wider population of young people aged 20–24.

TABLE 4.2

Proportion of students who report very high levels of four key indicators of mental wellbeing (2016–17) (UK) (%)

Year	Life satisfaction	Life worthwhile	Happiness	Low anxiety
2016	16	22	21	21
2017	14	19	19	19

Source: Student Academic Experience Survey 2017 (Neves and Hillman 2017)

The Unite Students (2016) survey also gives an insight into levels of wellbeing among students, with the following key findings.

- 73 per cent of students report being satisfied with their life, while 13 per cent report not being satisfied.
- The average mental wellbeing score for students is 65. As is the case among the wider population, women and those from more disadvantaged socioeconomic groups (DE) report lower wellbeing (64 and 63 per cent, respectively).
- Roughly two-thirds of students report feelings which could be linked to lower wellbeing, including being 'tired or lacking in energy' (63 per cent) and being 'stressed or worried' (62 per cent). Around one-third report feeling down or depressed (32 per cent) or 'isolated or lonely' (30 per cent).
- Compared to the average among all students, students with a mental health condition are significantly less likely to report experiencing positive feelings, such as being confident, optimistic or relaxed. They are also significantly more likely to report experiencing negative feelings, such as being stressed, lonely, depressed or rejected.

4.5 SUMMARY

There is a lack of robust data on levels of mental illness within the student population. The best available proxy is data showing the number of students who

disclose a mental health condition to their HEI. While this cannot be equated to the overall prevalence of mental health conditions, statistics on disclosures do point to a number of important trends.

- More students than ever are declaring a mental health condition. In 2015/16, 15,395 UK-domiciled first-year students at HEIs in the UK disclosed a mental health condition – almost five times the number in 2006/07.
- A growing proportion of students are declaring a mental health condition – 2 per cent of first-year students disclosed a mental health condition in 2015/16, up from 0.4 per cent in 2006/07.
- Mental health conditions account for an increasing proportion of all disability disclosed by students – in 2015/16, mental health conditions accounted for 17 per cent of all disclosed disability among the student population, compared to 5 per cent in 2006/07.

There is also variation in rates of disclosure between different groups of students.

- Female students are more likely than male students to disclose a mental health condition – in 2015/16, 2.5 per cent of female first-year students disclosed a mental health condition, compared to 1.4 per cent of male first-year students.
- Undergraduates are more likely than postgraduates to disclose a mental health condition – in 2015/16, 2.2 per cent of first-year undergraduates disclosed a mental health condition, compared to 1.4 per cent of first-year postgraduates.
- Full-time students are more likely than part-time students to disclose a mental health condition - in 2015/16 2.3 per cent of full-time first-year students declared a mental health condition, compared to 1.4 per cent of part-time first-year students.

While it is not possible to conclude from this data that overall prevalence of mental illness is increasing, it is evidence that a growing number and proportion of students are seeking support and adjustments from their HEI in relation to a mental health condition. However, survey data also shows that just under half of students who report experiencing a mental health condition choose not to disclose it to their HEI. This shows that HEIs still have more to do to ensure that all of those who require support are able to access it.

There is a significant level of mental distress among the student population, as demonstrated by surveys of self-reported mental health problems. This despite wide variation in the results of these surveys – likely resulting from differences in methodology and terminology.

Students experience lower wellbeing than is the case among young adults as a whole, and would appear to experience lower wellbeing than was the case in previous years.

5.

RISK AND REWARD: STUDENT LIFE, MENTAL HEALTH AND WELLBEING

There has been steady growth in prevalence rates of mental illness among young adults over the past 25 years, and over the past 10 years there has been growth in the proportion of students who disclose a mental health condition to their HEI. There are also a growing number of students who experience some form of mental distress or low wellbeing, for which they are likely to benefit from support and treatment.

This chapter considers the two preconditions of HEIs being able to respond effectively in order to support students with mental health and wellbeing needs. First, they should consider the factors which are likely to be driving mental illness, mental distress and low wellbeing, and the extent to which these are associated with the student experience. Second, they should consider the benefits of maintaining a mentally healthy student body, and conversely, the implications – both to students and HEIs – of failing to respond to this challenge.

5.1 RISK AND CAUSAL FACTORS

The steady growth in prevalence rates of mental illness among young adults over the past 25 years should also have led to increased prevalence rates among students. This is particularly true within the context of efforts to ‘widen participation’ in higher education, which has led to modest growth in the proportion of students who are from more deprived socioeconomic backgrounds (DfE 2016). While mental illness, mental distress and low wellbeing can affect all kinds of people, they are more common among those from more deprived socioeconomic backgrounds (Stansfeld et al 2016). An expected result of widening participation should, therefore, be that levels of mental illness come to more closely resemble rates within the overall population (RCPsych 2011). This – along with gradual erosion in stigma and greater visibility of support – is likely to have contributed to more students disclosing a mental health condition.

But what causal factors are driving mental illness, mental distress and low wellbeing among students? And relatedly, what factors are affecting demand for care, treatment and support? These factors are multiple and complex, but can be divided into two sets - the first relating to young adults in general, and the second to students in particular.

Factors affecting prevalence rates and demand for services among young adults

First, there has been a **growth in the number of people who experience mental illness and distress during childhood and adolescence**. On average, three children in every classroom have a diagnosable mental health condition, which is estimated to be twice as many as in the 1970s (Layard 2011). There appears also to have been a particular acceleration in the last few years – between 2009/10 and 2014/15 the number of under-18s admitted to hospital due to self-harm increased by more than 50 per cent (Burt 2016). Today’s generation of young adults are therefore more likely to have experienced mental health problems – and received some

kind of support – before reaching adulthood. Among students with experience of mental health problems surveyed by Student Minds (forthcoming (a)),⁹ 79 per cent reported first developing symptoms when at school.

Second, **the current availability of services for people with mental health needs is insufficient**. Relative to physical health services, there has been chronic, long-term underinvestment in mental health services. Mental ill-health accounts for 23 per cent of NHS activity, but spending on secondary mental health services is equivalent to just half that proportion (NHS England 2016a). One effect of this underinvestment is that a low proportion of those who require support and treatment are able to access it. The government has committed to invest an additional £1 billion in mental health services up to 2020/21. While welcome, this investment will result only in modest increases in the availability of care and treatment. For example, it is projected to increase the proportion of adults with common mental health conditions who are able to access treatment from 28 per cent to 35 per cent over five years (NHS England 2016b). The majority who remain unable to access care and treatment through the NHS risk their conditions worsening as a result.

On top of this, significant **cuts to community-based services over recent years have reduced opportunities for early intervention**, which could have resulted in more young adults' experiencing deteriorating mental health. For example, the value of the early intervention allocation to local authorities fell by 55 per cent between 2010/11 and 2015/16, from around £3.2 billion to £1.4 billion per year (NCB and TCS 2015). In addition, local authorities face annual real-terms reductions of 3.9 per cent to their public health budgets each year up to 2020/21 (Nuffield Trust et al 2015). These services are an important means of prevention and early intervention, which have the potential to reduce demand further downstream.

Third, changes to the nature of society and transition to adulthood – largely driven by the effects of **new digital technologies** – are likely to be affecting levels of mental illness and distress experienced by young people. For school-aged children, cyber-bullying, sexting, excessive screen-time and access to websites that reinforce harmful behaviours are all thought to have a negative impact on mental health and wellbeing (Thorley 2016). Variations on these challenges also exist for young adults. For example, excessive use of social media risks young people entering into constant comparison with the lives of others, which could impact self-esteem and life satisfaction (Brown 2016). Increased use of Facebook has, for example, been found to be associated with reduced wellbeing among young adults (Kross et al 2013).

Fourth, there has been a gradual **erosion in stigma and improvement in public attitudes relating to mental health** in recent years, linked to the success of anti-stigma campaigns such as Time to Change.¹⁰ The National Attitudes to Mental Illness study has found improvements in public attitudes to mental health, with 11 per cent more people reporting that they were willing to live, work and have a relationship with someone with a mental health problem in 2016 than was the case in 2009.¹¹ The stigma associated with mental illness has been shown to be a factor in preventing people from accessing services (Mojtabai 2009). The erosion of stigma and improvements in positive public attitudes in recent years could, therefore, reasonably be expected to have contributed to an increased willingness among young adults to seek support and treatment.

9 Data is drawn, with permission, from Student Minds survey of 134 students in 2017, the full results of which are due to be published later this year.

10 <http://www.time-to-change.org.uk/>

11 <https://www.time-to-change.org.uk/news/significant-improvement-public-attitudes-and-behaviours-%E2%80%93-latest-research-shows>

Factors affecting prevalence rates and demand for services among students

In addition to the factors which have driven up the prevalence and visibility of mental illness and distress among young adults, there are a number of university-related factors which are also likely to be significant. According to the Royal College of Psychiatrists, 'the student population is in some ways more vulnerable than other young people' (RCPsych 2011). What, then, are the specific university-related factors which may affect students' mental health and wellbeing, and increase demand for support?

Studying at university places **academic demands** on students which are likely to be different from those they have experienced previously. Study has been found to be the primary cause of stress among students (reported by 71 per cent of students) (YouGov 2016). Similarly, an NUS (2013) survey found the top four 'triggers' of mental distress all to be related to study. In general, higher education courses will require a greater degree of self-directed learning, with students taking on more responsibility to manage their own workload (RCPsych 2011). This has the potential to affect students' ability to cope, even where courses are structured in different ways. For example, a humanities student with a small number of contact hours per week may struggle to organise their time effectively with limited direction, while a medical student whose course more closely resembles a regular working day may struggle to cope with having insufficient 'downtime'. In both cases, students are required to adapt to new environments and ways of learning (ibid). An inability to make this transition effectively has the potential to affect mental health and wellbeing.

It has been argued that students today risk stress from increased **pressure to gain a high-class degree**. There is a wide discrepancy in the proportion of students who achieve a First, compared to the proportion who expect to achieve one when beginning their course (Brown 2016). This is particularly significant within the context of today's competitive graduate jobs market. 'Finding a job after university' is the second highest cause of stress reported by students (YouGov 2016). And these concerns are not unjustified – between 2004 and 2014, the proportion of younger workers who were graduates working in non-professional/managerial jobs doubled from 7 to 13 per cent, as the graduate jobs market has failed to keep up with the supply of new graduates (Thorley and Cook 2017). Young graduates in jobs for which they're overqualified are more likely to experience mental health problems (ibid), but it is also true that the anticipation of entering a competitive jobs market could have an adverse effect on students' mental health and wellbeing.

University life can also mean that some students struggle to cope with **social pressures**. These can be linked to the pressure to establish and fit in with an entirely new group of friends; the pressures associated with living in close proximity to others in halls or shared flats; the ability to cope while outside of traditional support structures (friends and family); and increased levels of exposure to, or peer pressure associated with, drugs and alcohol (NUS 2013). Students who struggle to cope with these pressures risk becoming socially isolated and lonely, with loneliness identified by students as a significant challenge relating to their mental health (Student Minds 2014). Struggling to cope with social pressures can mean the university experience fails to live up to the expectation that it will be 'the best time of your life', with further potential to impact on mental health and wellbeing (Student Minds forthcoming (b)).¹²

Students can also face considerable **financial pressures**. When entering higher education, many young people will, for the first time, take on responsibility for

¹² Taken, with permission, from Student Minds' forthcoming report *Building Better Student Mental Health*.

budgeting and managing their own income and expenditure. Many choose to work part-time in order to support themselves, which can also bring additional pressures. One in four students identified their job as a main cause of stress (YouGov 2016). Increased tuition fees and the prospect of graduating with considerable levels of debt has also been found to cause stress among students (Student Minds 2014).

These pressures can often culminate around specific points during students' journey through higher education, when their mental health and wellbeing are therefore at particular risk. Studies suggest that, among undergraduates, prevalence rates of mental illness are highest during the second and third years, and are considerably lower at admission and during first year (Macaskill 2012, Andrews and Wilding 2004). These fluctuations could be driven by different stages of an undergraduate degree being associated with different groups of pressures. For example, in the second year, increased academic pressure could coincide with moving out of university-provided accommodation and the splintering of friendship groups which had been based around living together in halls.

5.2 THE EFFECTS OF POOR MENTAL HEALTH AND WELLBEING AMONG STUDENTS

Experiencing mental illness or distress, or sustained low wellbeing, while at university can have a number of adverse effects on students' lives. According to the Royal College of Psychiatrists, 'early adult life is a crucial stage in the transition from adolescence to independence as an adult. Underachievement or failure at this stage can have long-term effects on self-esteem and the progress of someone's life' (RCPsych 2011).

One risk associated with poor mental health and wellbeing is the effect on students' grades, leading to the potential for **academic failure**. This may result in students receiving lower grades than they would otherwise, or being required to repeat an academic year. In either case, where mental illness or distress affects academic performance, it means students may be failing to reach their potential (ibid). Formal support for disabled students – through Disabled Students' Allowance (DSA) and reasonable adjustments – are intended to correct the potential for mental illness to affect academic performance. However, for the significant proportion of students who choose not to disclose a condition, or who experience mental distress without a diagnosis, formal support of this kind is not available.

Poor mental health and wellbeing is also associated with an added risk of **dropping out of university**, particularly where support is unavailable or not sought. On average, 6.3 per cent of undergraduates studying their first degree drop out of university before the beginning of their second year of study (HESA 2017c). Consideration of dropping out from university is stronger among those with poor mental health, with 4 in 10 having considered or strongly considered dropping out (Unite 2016). A record number of students with mental health problems are dropping out of university, which is perhaps unsurprising given the increase in disclosures observed in chapter three. In 2014/15 – the most recent year for which data is available – 1,180 students who experienced mental health problems dropped-out, an increase of 210 per cent compared to 2009/10 (Marsh 2017). A desire to leave university is correlated with social isolation, stress and financial pressures, while students with high levels of wellbeing and life satisfaction are less likely to want to drop out (ibid). Students who drop out of university will incur tuition fee costs despite being unable to yield a 'graduate wage premium', and there will also be a loss of return on the public investment made.

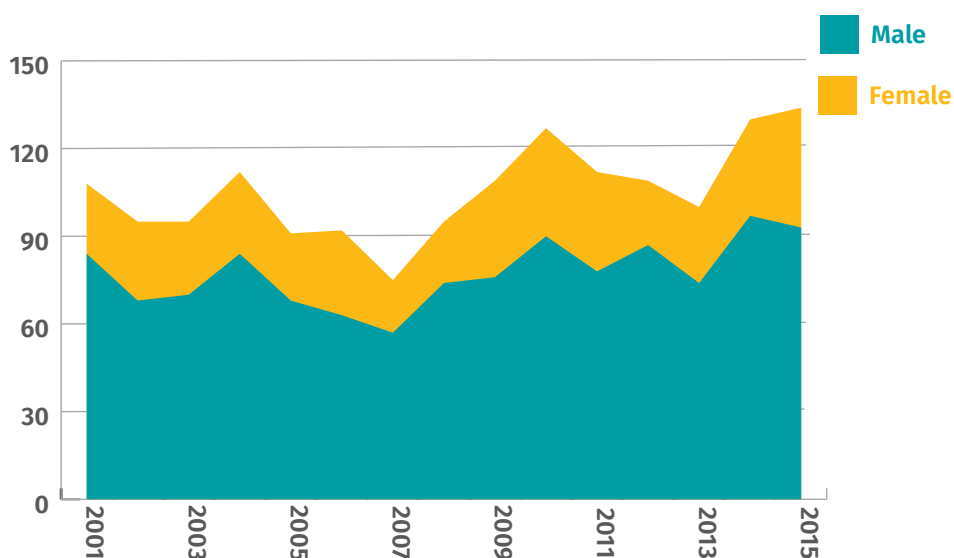
Relatedly, poor mental health and wellbeing while at university could have a negative impact on students' **future career prospects**, particularly where this has led to lower grades, repetition of years, or dropping out altogether (RCPsych 2011). Students who drop out of university experience worse labour market outcomes, and are more likely to be unemployed or in low-skilled jobs (Davies and Elias 2003).

In the most tragic instances, mental illness and distress while at university can be associated with **student suicide**. In 2015, there were 134 deaths by suicide among students in England and Wales, the highest level since 2007. Between 2007 and 2015, the number of student suicides increased by 79 per cent (from 75 to 134) (ONS 2016b).

FIGURE 5.1

The number of student suicides has increased since 2007

The number of deaths by suicide among students (split by sex) (2001–2015) (England and Wales)



Source: Office for National Statistics (ONS 2016b)

A growing number of universities in the UK have, therefore, been affected by at least one student suicide, with a small number – such as the University of Bristol in 2016–17 and the University of York in 2015–16 – having experienced multiple suicides within a short period of time.

Suicide is often linked to the presence of mental health conditions such as depression or personality disorder, and alcohol or drug misuse (Windfuhr and Kapur 2011). Despite this, just 25 per cent of people who die by suicide in the UK were in contact with mental health services during the year prior to their death (NCISH 2015). Official suicide statistics also conceal the number of suicide attempts, and the extent to which suicidal thoughts are prevalent among students. As we saw in chapter 4, surveys of students suggest a significant proportion have experienced suicidal thoughts, and would therefore benefit from timely support and preventative interventions to reduce the potential risk of suicide.

The death by suicide of a student while at university has a devastating effect not only on the student's family, but on the entire university community. For

university staff, it means informing a student's family that they have passed away. For the student's friends, classmates and housemates, it means struggling to come to terms with a tragic loss. This often requires that they are able to access counselling and support themselves, which constitutes additional expenditure and resource for the university.

Finally, where individual HEIs do not respond to the challenge of student mental health effectively, they risk incurring **reputational damage** which could threaten their future viability. As the HE sector comes to publish more data relating to drop-out rates, student satisfaction, alumni destinations and outcomes, this information is likely to affect applicants' decisions about where to study.

5.3 SUMMARY

Widening participation in higher education means we should expect to have seen prevalence rates of mental illness and distress among the student population increase, and move closer to those among young adults in general (which have also increased).

Prevalence rates and increased demand for services among young adults are likely to have increased due to a number of factors associated with modern society, including the effects of digital technologies and reduced capacity for early intervention in the community due to austerity cuts. In addition, students face a number of specific risk factors which could lead to them experiencing poorer mental health and wellbeing, such as academic demands, the pressure to gain a high-class degree, social pressures and financial worries.

The effects of experiencing poor mental health or wellbeing while at university can be significant. For students, it can mean added risk of academic failure and dropping out of university, which in turn have the potential to harm future career prospects. In the most tragic circumstances, it can also lead to added risk of student suicides, which are currently at their highest level since records began 15 years ago. For HEIs, failing to support students' mental health and wellbeing can have a significant impact on their reputation and finances.

6.

THE CHALLENGE: RISING DEMAND FOR STUDENT SERVICES

It is clear that the HE sector faces a considerable challenge in responding effectively to students' mental health and wellbeing needs, and that the stakes are high for both students and HEIs.

In this chapter, we begin to unpick the results of our survey of HEIs and case study visits from across the UK to explore: how student services are configured across the sector, and the extent to which mental health and wellbeing services play a role; the extent to which demand for student services – including mental health and wellbeing services – have increased over the past five years; and the extent to which HEIs consider mental health and wellbeing to be a strategic priority.

6.1 THE SHAPE OF STUDENT SERVICES

In most cases, Student Services is the department through which HEIs deliver support relating to students' mental health and wellbeing. Responses to our survey indicate that overall responsibility tends to fall with a departmental lead (such as a director of student services, or equivalent), and that this is often overseen by a member of the senior leadership team (such as an assistant principal or deputy vice-chancellor), or even the vice-chancellor.

Our survey asked HEIs to describe the configuration of their internal mental health and wellbeing services. The results suggest some degree of consistency in the way services are designed, with the most common model where services are split into three separate teams or services.

1. **Wellbeing services** – This part of Student Services is staffed by health and wellbeing advisors, or equivalent.¹³ This service is primarily intended to deliver low-intensity guidance and support, to assist in the development of coping strategies, and to signpost onto non-medical services from which students might benefit (such as financial support). This service is often targeted at students who demonstrate low levels of mental distress, such as stress and anxiety, but who lack a clinical diagnosis. Interventions delivered by this service are typically brief, and consist of a small number of individual sessions or group workshops.
2. **Counselling services** – This part of Student Services is staffed by counsellors, and sometimes also includes (non-staff) associate/volunteer/placement counsellors.¹⁴ This service is usually targeted at students who demonstrate

¹³ Survey responses suggested alternatives within this role-category, including: life and wellbeing advisors; mental wellbeing advisors; health promotion and wellbeing advisors; wellbeing practitioners; health and welfare advisors; wellbeing assistants; welfare advisors; wellbeing coaches.

¹⁴ In order to receive accreditation by the British Association of Counsellors and Psychotherapists (BACP), counsellors must demonstrate that they have conducted 450 hours of practice, with at least 1.5 hours of clinical supervision per month. Universities often therefore use a small number of non-accredited (trainee) counsellors to deliver interventions to students as a means of working towards accreditation. In all cases, trainee counsellors should be subject to effective day-to-day line management and clinical supervision by senior counsellors.

moderate levels of mental distress. Interventions are typically limited to a maximum number of one-to-one sessions (often six), although the service often also plays a role in the delivery of group workshops.

3. **Disability services** – This part of Student Services is staffed by mental health coordinators, or equivalent.¹⁵ This service is usually targeted at students who are in receipt of disabled students' allowance (DSA) or who experience mental illness which meets a clinical threshold for diagnosis. Interventions typically consist of one-to-one specialist mentoring, support in accessing DSA where it is not accessed currently, liaison on reasonable adjustments, and – in the most severe cases – working with clinical professionals to determine a student's 'fitness to study' (RCPsych 2011).¹⁶

FIGURE 6.1

The Director of Student Services (or equivalent) is most commonly responsible for student mental health and wellbeing within HEIs

Who holds overall responsibility for the health and wellbeing of student at your institution? (UK) (n=50)



Source: IPPR

Alongside these teams – and within a wider Student Services directorate – are a range of other support services which are not directly linked to student mental health and wellbeing. According to the results of our survey, these can include (but are not limited to): international student support; careers and employability; financial advice and assistance; academic affairs, timetabling and exams; campus, residential and accommodation support; admissions, induction, transition and retention support.

15 Survey responses suggested alternatives within this role-category, including: disability advisors; mental health support workers; mental health inclusion officers; mental health advisors; mental health mentors.

16 This usually occurs in the case of students who are seriously unwell and clearly not coping with the demands of studying, and who are unlikely to complete their course. Clinicians need to be aware of disability legislation when offering advice on fitness to study or fitness to practise.

There is, though, also variation between institutions. For example, smaller HEIs may group wellbeing, counselling and disability services together, with roles spanning accordingly, while college-based HEIs may have a reduced central function alongside a large number of small student support services catering for individual colleges.

Two-thirds (65 per cent) of respondents to our survey indicated that they do not outsource any mental health or wellbeing services to external providers. Some HEIs did, however, report outsourcing services, or otherwise subscribing to some form of external provision. These included the following:

- 24/7 counselling or support service (e.g. Nightline)
- online self-help services (e.g. Silvercloud)
- psychiatry support to assist with ad hoc fitness to practice assessments
- crisis line for signposting to out-of-hours support
- use of freelance counsellors and/or mental health advisors to support internal capacity during periods of high demand
- occupational health service (sometimes including a remote counselling service)
- NHS provision (such as counselling, cognitive behavioural therapy [CBT], psychodynamic therapy and access to a 'life coach')
- specialist counselling services (such as Rape Crisis services).

Case study: Student Services configuration

The University of Wolverhampton employs 10 mental health tutors within its disability service, each of whom have background in counselling and community support. Having previously been employed as freelancers, they have since been brought onto the university staff. The disability service targets support at students who are entitled to disabled students' allowance (DSA). Those requiring low-level support work with tutors for 30 hours per academic year, while those with more severe and enduring conditions work with them for 60 hours per year. Through mental health tutors, the service aims to deliver an 'enabling' model of support.

Alongside the disability service is the university's counselling service, which aims to 'provide the counselling that allows education to happen'. Counselling is not available simultaneously to secondary mental health care, and so is targeted primarily at students without a diagnosis. The service continues to run out of term time, but has a significantly reduced capacity. The service considers an important part of its role to be keeping track of where referrals are coming from (for example from accommodation services), and then working with those services to find ways to support students more effectively and thereby reduce the number of referrals.

Student Services at the university has framed suicide and self-harm as safeguarding issues, meaning each has a strategic lead who is responsible for implementing effective interventions, and who reports directly into senior leadership.

Ulster University has a Student Health and Wellbeing Service, which includes an initial triage function, as well as both health and wellbeing and money advice services. All staff within the service have a certificate in counselling as a minimum, while health and wellbeing advisors – who provide one-to-one support for students' pre-therapeutic (academic/self-esteem) needs – have professional qualifications in nursing, social work or similar.

Since 2014, the university's counselling service has been outsourced to a private provider, which is reported to have improved value for money and eased pressure on waiting lists. Referrals can come into the provider through the Health and Wellbeing Service, academic staff or self-referral, with a 24/7 telephone service also available to students.

The counselling provider sends a monthly report to the university detailing the number of students who have been seen, the number of sessions to have been delivered, the number of students who did not attend (DNA), and the number of students who are 'at risk' (with, where appropriate, detail on whether they are set to return to their studies).

As a collegiate university, the University of Oxford divides responsibility for student mental health and wellbeing between individual colleges and the central university function. Each of the 38 independent halls and colleges has their own specific wellbeing teams, which includes chaplains, part-time nurses and postgraduate hall wardens. Funding for student welfare and wellbeing is divided 50/50 between colleges and the central function.

It is also vital that Student Services (and its component parts) is not the only department which is concerned with students' mental health and wellbeing. Our survey asked HEIs to rate the importance of collaboration between their own mental health and wellbeing services and other parts of the institution (see figure 6.2). The responses show that this kind of internal collaboration is considered by HEIs to be important. They rated collaboration with the students' union as being the most important (4.63), followed closely by collaboration with non-academic departments (4.56), academic departments (4.50) and the student body (4.33).¹⁷

Student Services comprises a network of general welfare and pastoral support provided through academic teams, and dedicated peer-mentoring available to all new students. There are also three tiers of specialist support provided centrally. The first tier is a highly visible student information desk available at both campuses, and mirrored online, for initial and transactional queries and signposting. The second tier provides more intensive, but still generalist support for welfare and behaviour concerns, and is a point of referral for [students identified as] 'cause for concern' [from] across the institution. The third tier provides specialist, expert advisory and support services in the areas of: disability; specific learning difference (dyslexia, dyspraxia, dyscalculia, etc.); wellbeing and mental health; chaplaincy; and finance (which is also partly provided by the Students' Union).

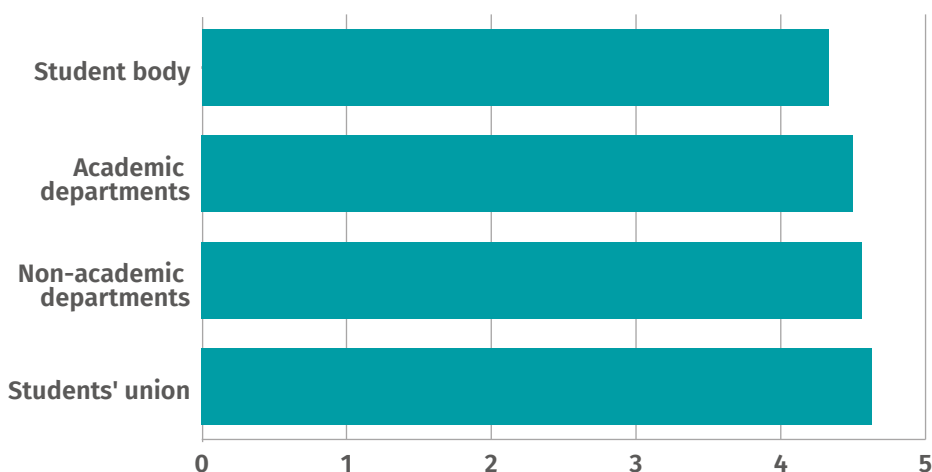
HEI survey response (Q: Please describe the way student services are configured at your institution)

¹⁷ The Students' Union is distinguished here from the wider student body. The former is understood to be a formal organisation with its own structures and representatives, with whom HEIs' mental health services are able to interact. The latter relates to less formal interaction with groups of students or individuals.

FIGURE 6.2

HEIs consider different kinds of internal collaboration to be important to help improve student mental health and wellbeing

In your view, to improve student mental health and wellbeing, how important is collaboration between an HEIs' own mental health services and each of the following? (mean score) (rating 1–5 [where 5 is extremely important]) (UK) (n=48)

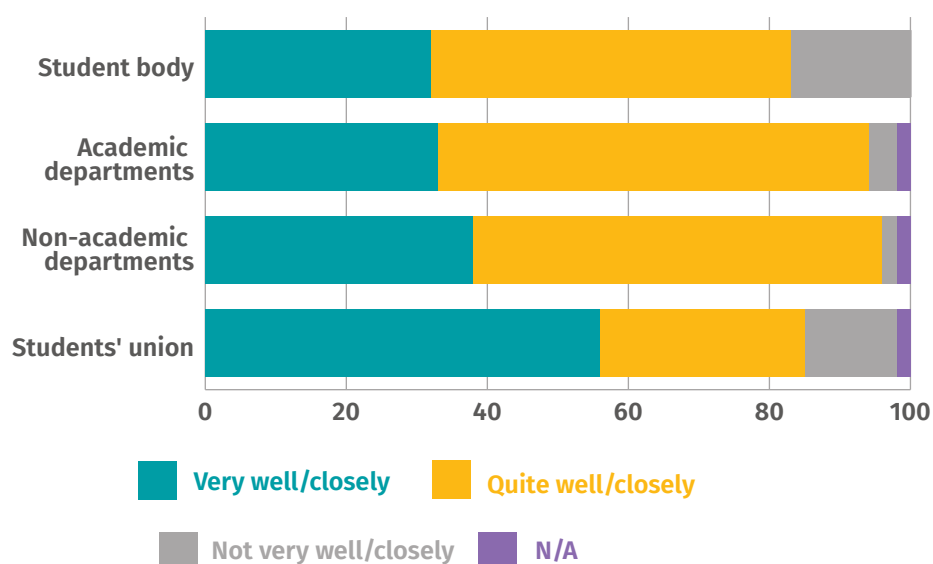


Source: IPPR

FIGURE 6.3

The vast majority of HEIs report strong internal collaboration with a view to improving student mental health and wellbeing

In practice, how well/closely does your HEIs' mental health services work with each of the following? (UK) (%) (n=48)



Source: IPPR

We then asked respondents to indicate how well/closely, in practice, their institution's own mental health and wellbeing services work with other parts of the institution. For all four, a majority of HEIs reported a good level of

collaboration see figure 6.3). However, the results also demonstrate that there is room for improvement within the sector. Seventeen per cent of HEIs reported that their mental health and wellbeing services do not work well/closely with the students' union, while 13 per cent reported that they do not work well/closely with the wider student body. There were very few HEIs who reported that their mental health and wellbeing services do not work well/closely with either non-academic or academic departments. However, in both cases a majority report 'quite close' collaboration, with around a third reporting 'very close' collaboration – again, suggesting there is room for improvement in strengthening the extent of internal collaboration within HEIs.

Case study: Collaboration between student services and other departments

De Montfort University has introduced a Students at Risk (SAR) group, which brings together staff from both inside and outside of Student Services, and acts as an important information-pooling and risk-management tool.

The SAR group consists of a committee which meets weekly to discuss students who are a particular cause for concern, including in relation to their mental health and wellbeing.

Referrals come into the group from academics, security staff and others, and so the group provides a referral route for staff who might feel they lack expertise to address concerns about students.

The group aims to provide a forum to examine students' mental health and wellbeing within its wider context, and also pick up associated behavioural issues. Discussion within the group helps in determining an appropriate response for individual students, and helps to maintain a consistent approach if there are multiple referrals on the same student from different sources. It therefore allows a basic assessment of risk before referring on to the appropriate service (either internal or external), and also helps build institutional memory (which spans departments) on what has worked well in the past.

Leeds University Union (LUU) runs a Student Advice Centre which sits outside the structures of the university, but which was identified by the vice-chancellor as being an integral part of the university's capacity to support students' mental health and wellbeing. LUU plays an important preventative role, raising awareness through campaigns and providing support to students at particularly stressful times during the academic year. It can also be an important referral route into student services, and help to ensure that student voice is represented when strategic decisions on mental health and wellbeing are taken by senior management.

6.2 RISING DEMAND

Our survey reveals that HEIs have – over the past five years – experienced significant increases in demand for (overall) student services, counselling services and disability services:

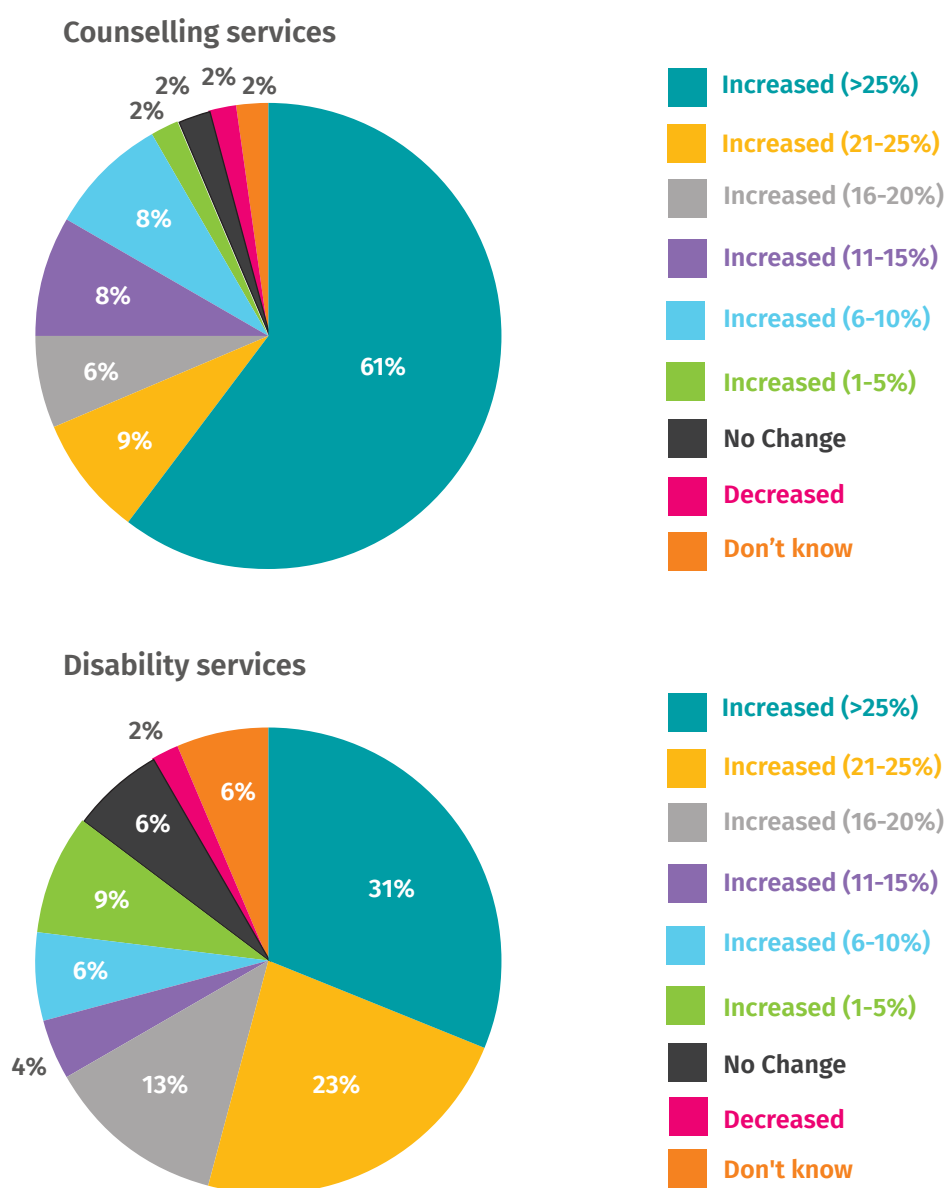
- 81 per cent report an increase in overall demand for student support services, while 41 per cent report an increase of over 25 per cent
- 94 per cent report an increase in demand for counselling services, while 61 per cent report an increase of over 25 per cent
- 86 per cent report an increase in demand for disability services, while 31 per cent report an increase of over 25 per cent.

These findings reflect data collected elsewhere, which also points to considerable increases in demand. For example, freedom of information (FOI) data show the number of requests for counselling provision increased by 28 per cent across 90 HEIs between 2013/14 and 2015/16 (Marsh 2017), while the number of requests among Russell Group universities increased by 68 per cent between 2011/12 and 2015/16 (Sandeman 2016).

FIGURE 6.4

Demand for counselling services and disability services within HE are increasing. Almost two-thirds (61 per cent) of HEIs report that demand for counselling services has increased by more than 25 per cent over the past five years.

How has demand for the following services changed at your institution over the last five years? (split by service type) (UK) (n=48)



Source: IPPR

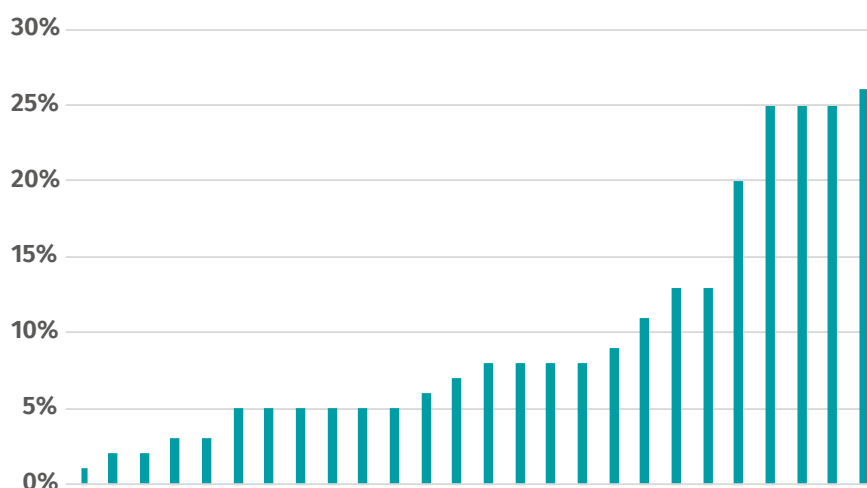
We also asked HEIs to report on whether, and the extent to which, demand for online/digital support (for example self-management apps); peer-support; and out-of-hours support for mental health and wellbeing has increased over the past five years. However, in each case, between 32 and 45 per cent of respondents indicated that they did not know the extent to which demand has changed. This suggests that a significant proportion of HEIs are failing to keep accurate and up-to-date records of the extent to which non-traditional forms of mental health and wellbeing support are being used by students. This, in turn, could suggest an overreliance by institutions on traditional forms of support (such as counselling) at the expense of ensuring students are able to access a broad suite of mental health and wellbeing services.

Case study: Demand for counselling services in higher education

In keeping with our survey findings, our case study visits suggest that HE counselling services have been particularly affected by a growth in demand for student support. For example, the University of Leeds has experienced a 50 per cent increase in demand for counselling over the last five years, and an 18 per cent increase in demand over the last twelve months. Similarly, the University of Birmingham estimated a 5–6 per cent annual increase in demand over the past 10 years. And the University of Dundee reported an increase in demand of around 70 per cent over the past eight years. Among all HEIs which took part in this research as case studies, the only variation relates to the extent to which demand for counselling has increased.

FIGURE 6.5

In some HEIs, up to 1 in every 4 students is using, or waiting to use, counselling services
What is the proportion of the student population using, or waiting to use, counselling services at your institution? (UK) (%) (n=26)



Source: IPPR

As a result of this increased demand, a significant number of students are using, or waiting to use, counselling or disability services. However – despite a relatively

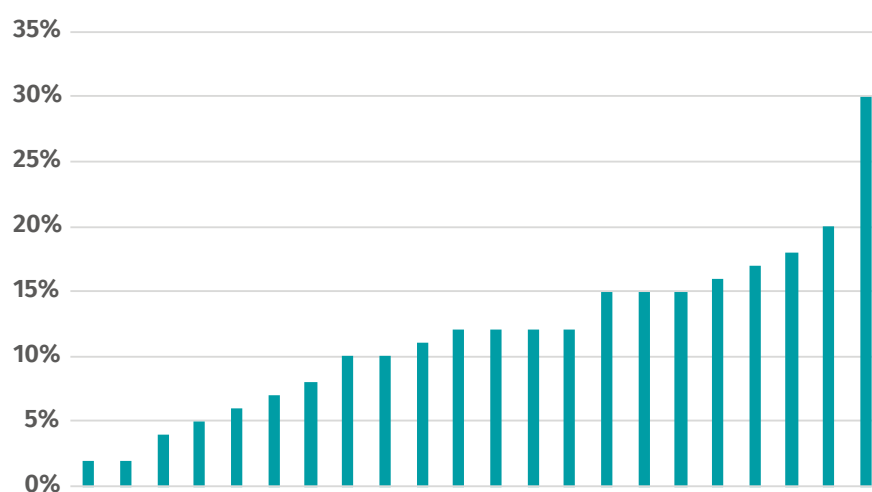
small sample size – our survey shows significant variation across the sector (see figures 6.5 and 6.6).

- In some HEIs, the proportion of students using, or waiting to use, counselling services can be as high as 1 in 4, while in others it is less than 1 in 20.
- The majority of HEIs report that between 10–20 per cent of students use, or are waiting to use, disability services.

FIGURE 6.6

There is variation between HEIs in the proportion of students using, or waiting to use, disability services – the mean across our sample was 13 per cent of students

What is the proportion of the student population using, or waiting to use, disability services at your institution? (UK) (%) (n=22)



Source: IPPR

However, around half of HEIs were not able to provide us with accurate statistics. Similarly, very few institutions were able to provide us with information on the proportion of students accessing alternative means of mental health and wellbeing support (such as online/digital support, peer support or out-of-hours support). Together, this suggests there are serious deficiencies in many HEIs’ ability to collect reliable and up-to-date data on the extent of use of both traditional and non-traditional means of mental health and wellbeing support among students.

6.3 STRATEGIC APPROACHES TO STUDENT MENTAL HEALTH AND WELLBEING

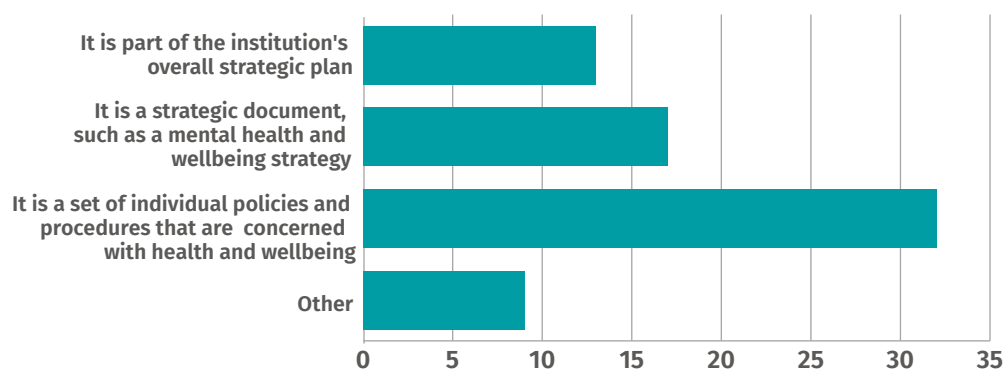
Partly as a result of this increased demand, HEIs are increasingly coming to view student mental health and wellbeing as a strategic priority. There is, however, variation in the form HEIs’ mental health and wellbeing strategies take (see figure 6.7). A majority (54 per cent) of HEIs to respond to our survey reported that their strategy is in the form of a set of individual policies and procedures which span the institution. A smaller proportion reported that it takes the form of an explicit strategy document (29 per cent), or forms part of the institution’s overall strategic plan (22 per cent).¹⁸

¹⁸ HEIs were able to select more than one answer to this question. Among those who selected ‘other’, four respondents indicated that a ‘mental health and wellbeing strategy’ is being constructed and is due to publish in 2017–18.

FIGURE 6.7

The majority of HEIs do not have an explicit strategy on student mental health and wellbeing

What form does your institution's strategy to improve students' mental health and wellbeing take? (UK) (n=51)



Source: IPPR

The ways in which HEIs' strategic responses to mental health and wellbeing are conceived and delivered are likely to be based, in large part, on how leaders in the HE sector understand the extent of their responsibilities in this space. There are different understandings within the sector about what a 'whole-university approach' to mental health and wellbeing means in practice, and what the best way is to achieve it. Figure 6.8 shows the most common themes to emerge when our survey asked HEIs to describe their understanding of a 'whole-university approach'. These themes suggest that such an approach should:

- consider the mental health and wellbeing of both staff and students (n=15)
- prioritise staff awareness and training (11)
- emphasise prevention and promotion (11)
- be embedded into all parts of university life (10)
- be underpinned by policies and procedures (9)
- incorporate the provision of specialist support (9)
- recognise that mental health and wellbeing is everyone's responsibility (8)
- incorporate buy-in and leadership from senior management (8).

FIGURE 6.8

'A whole-university approach' means different things to different HEIs
What do you understand by a 'whole-institution' approach to mental health? (n=50)



Source: IPPR

6.4 SUMMARY

The predominant model of delivering mental health and wellbeing services through student support within the HE sector in the UK is to deliver separate wellbeing, counselling and disability services. Wellbeing and counselling services aim to deliver short interventions to students demonstrating different levels of mental distress, while disability services are targeted at those students in receipt of – or likely to be eligible for – disabled students' allowance (DSA).

HEIs report that it is important for Student Services – and its component parts – to work closely with other parts of the institution. A majority of HEIs report a good level of collaboration between their internal mental health and wellbeing services and academic departments, non-academic departments, the students' union, and the wider student body – although there is clear room for improvement in all four cases.

HEIs have – over the past five years – experienced significant increases in demand for (overall) student services, counselling services and disability services:

- 81 per cent report an increase in overall demand for student support services, while 41 per cent report an increase of over 25 per cent
- 94 per cent report an increase in demand for counselling services, while 61 per cent report an increase of over 25 per cent
- 86 per cent report an increase in demand for disability services, while 31 per cent report an increase of over 25 per cent.

As a result, a significant number of students are using, or waiting to use, these services, although there would appear to be significant variation between institutions:

- the proportion of students using, or waiting to use, counselling services can vary from 1 to 26 per cent

- the proportion of students using, or waiting to use, disability services can vary from 2 to 30 per cent.

HEIs are increasingly coming to view student mental health and wellbeing as a strategic priority, although there is variation in the extent to which HEIs' strategies are explicit. Less than one in three (29 per cent) HEIs report having designed an explicit mental health and wellbeing strategy. HEIs also have different understandings of what should constitute a 'whole-university approach' to student mental health and wellbeing, although a significant number emphasise the importance of prevention and promotion and the provision of specialist support.

In the following two chapters, we consider these two key components of a 'whole-university approach' to mental health and wellbeing in more detail.

7.

PREVENTION AND PROMOTION

The first central function of a ‘whole-university approach’ must be to promote positive mental health and wellbeing among students and – wherever possible – prevent the emergence of mental illness, mental distress or low wellbeing. Chapter 5 described how students are likely to experience a number of risk factors as a result of being young adults in a university setting, and how poor mental health and wellbeing can lead to a number of adverse effects, including on academic performance and students’ wider ability to thrive and achieve their potential.

In this chapter – drawing on the results of our survey of HEIs and case studies – we explore the extent to which HEIs value prevention and promotion, and which particular initiatives are commonly available to students.

7.1 PREVENTION AND PROMOTION ACTIVITIES

Our survey asked HEIs to rate the importance of different initiatives and activities in helping to improve student mental health and wellbeing. Respondents were able to give each initiative and activity a score of 1 to 5 (where 1 is not important at all and 5 is extremely important). The average score across all responses shows that all 12 initiatives and activities are considered by HEIs to be important (see figure 7.1).

Case study: Teaching and learning models – course content and delivery

De Montfort University has introduced Universal Design for Learning (UDL) – which it describes as normalising a system of anticipatory reasonable adjustments to learning. This initiative began life as a means to improve the teaching and learning experience of students entitled to DSA, and to promote a ‘social model’ of disability by moving further away from a ‘deficit model’. An initial audit identified hotspots where improvements could be made. This led, for example, to the introduction of a system of ‘lecture capture’ rather than assigning individual note-takers to DSA-entitled students who struggled with keeping notes.

Since its introduction, UDL has expanded into all programmes across all levels of the university, and so is targeted at the entire student population (with ‘UDL champions’ based in each academic faculty). For example, from September 2017, all students will have access to the ‘DMU Replay’ service, which captures all lectures and aims to ensure that students too anxious to actively participate in lectures and tutorials do not miss out on learning as a result.

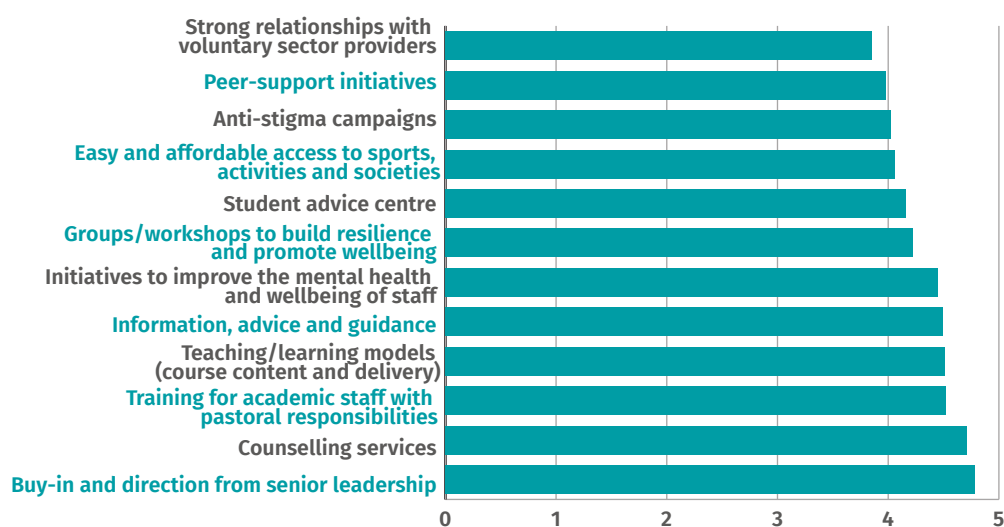
UDL is based on an understanding that ‘the biggest part of student experience is teaching practice’, and aims to take as many special requirements into account as possible in order to break down barriers in student culture.

'Buy-in and direction from senior leadership' scored most highly as a means of improving student mental health and wellbeing (4.78), followed by 'counselling services' (4.71). The initiatives/activities to score least highly – although still considered important – were 'strong relationships with voluntary sector providers' (3.85) and peer-support initiatives (3.98).

FIGURE 7.1

'Buy-in and direction' from senior leadership is considered by HEIs to be the most important factor in helping to improve student mental health and wellbeing

How important are each of the following initiatives and activities, which aim to improve student mental health and wellbeing? (mean score) (rating 1–5 where 5 is extremely important)] (UK) (n=49)



Source: IPPR

Case study: Training for academic staff with pastoral responsibilities

The University of Cumbria has made training available for all staff on suicide prevention and awareness as part of a wider drive to create 'compassionate campuses'. It has proved to be extremely popular – 12 per cent of all staff have been trained, with extra sessions provided to accommodate demand, despite participation being voluntary. The course's popularity is thought to be due, in part, to its condensed length – it is delivered via one half day session, and is based on the Columbia Suicide Severity Rating Scale (CSSRS) screening tool.

The University of Worcester looks to ensure that all academic staff who work with undergraduates have completed additional training modules on mental health. Half of the university's six institutes also have a 'mental health lead' – a member of academic staff responsible for identifying training and practice opportunities to enable colleagues to support student mental health and wellbeing.

Arts University Bournemouth is a comparatively small HEI, with approximately 3,500 students in total. As such, it reports benefiting from close cooperation between student services (including counselling services) and academic staff. The HEI's size means there are relatively well-

established routes of referral from academic departments into student services, and that academic staff who are concerned about a student can easily access informal support and guidance (while working within the confines of student confidentiality).

Case study: Buy-in and direction from senior leadership

The University of Birmingham's vice-chancellor told us that his institution considers student mental health and wellbeing to be a strategic priority for two reasons. First, it is necessary to help students to thrive and realise their potential (both academically and personally) – and so relates to educational opportunity and achievement. Second, it is one of the central responsibilities of the 'university community' (hence why the university also seeks to support staff experiencing mental health problems).

The University of Worcester also reports that buy-in from senior leadership has been integral in the development of their 'Suicide Safer' project, which was launched in 2014. The university's vice-chancellor initiated the multi-agency project, bringing together representatives from local government, public health, the NHS and the voluntary sector to develop a new model of suicide prevention targeted at the university's students, with the potential to be applied to the wider community also. The strategy itself is built on three pillars – education, support and research – and includes specific initiatives including staff training, awareness-raising activities and the establishment of a countywide Suicide Audit Group to learn from completed suicides and identify trends. As one of a small number of HEIs in the UK with an explicit suicide prevention strategy, the University of Worcester's senior leadership have also been involved in sharing learning from their project with the wider sector, delivering public lectures and participating in policy roundtables.

We then asked respondents to indicate which of the same set of initiatives and activities are in place at their institution (see figure 7.2). 'Counselling services' and 'information, advice and guidance' were the only ones present among all HEIs. All others were present in at least 73 per cent of HEIs. Those initiatives and activities which were least widespread tended to be those which respondents also rated as the least important (such as 'strong relationships with voluntary sector providers' and 'peer-support initiatives'). The exception was 'teaching and learning models which promote positive mental health and wellbeing (course content and delivery)', which, despite being rated as the fourth most important factor in improving student mental health and wellbeing, was present in less than half (43 per cent) of HEIs. This suggests that a majority of HEIs should take measures to ensure that the nature of course content and delivery does not result in academic rigour being sought at the expense of students' mental health and wellbeing. As we saw in chapter 5, the two are not mutually exclusive, but are instead likely to be mutually beneficial.

FIGURE 7.2

Less than half of HEIs design teaching and learning models with a view to improve student mental health and wellbeing, while a range of other initiatives are more common

Which of the following initiatives and activities, which aim to improve student mental health and wellbeing, are in place at your institution? (UK) (%) (n=49)



Source: IPPR

Case study: Peer-support initiatives

The University of Oxford has an established peer-support system, which is led by the counselling service. A member of the counselling team acts as the ‘peer-support trainer’, training peer-support groups in each of the university’s 38 independent halls and colleges, as well as in each academic department. The university aims to ensure that there are trained peer-supporters among students of different ages and with different characteristics (for example, Rainbow Peers for LGBTQ+ students, and Peers of Colour for BME students), as well as within a range of sports and clubs.

There is high demand from within the student body to be involved with the initiative – between 350 and 400 students are trained each academic year, and those who make it on to the training must first go through a competitive selection procedure.

Training consists of 10 three-hour sessions, and takes an academic term to complete. Students receive training on healthy relationships, how to manage people in distress, how to make appropriate referrals, the importance and limits of consent, and elements of mental health first aid.

Once trained, peer-supporters can advertise themselves as such on campus, and arrange to hold surgery-like sessions with other students. Their presence is also intended to spread support within the student community in an organic and informal way. Where there is cause for concern, peer-supporters are able to refer students into the university’s counselling service (5–8 per cent of referrals come via this route), or contact the peer-support trainer.

Case study: Groups/workshops to build resilience and promote wellbeing

The University of Dundee has introduced a number of initiatives which aim to help build resilience and improve wellbeing within the wider student body. For example, Student Services produces introductory materials for transition into university; ‘live smart’ and ‘learn smart’ toolkits have been developed to help enhance students’ life and academic skills, respectively; ‘stress-busting’ and ‘life skills’ workshops aim to help students understand when a stressful experience is an ordinary part of student life, and when it is something more serious; a ‘res-life’ toolkit aims to build resilience, tackle homesickness, boost life skills, and lay on activities to help students in residence get to know one another; and a ‘stay on course’ initiative looks to involve friends, tutors and parents in supporting students who are struggling academically.

Our survey also asked HEIs to report whether they deliver initiatives to support the mental health and wellbeing of groups of students with particular characteristics. A significant number reported that they do not offer this kind of targeted provision, suggesting that targeted mental health and wellbeing initiatives are not widespread. Among those HEIs which did report targeted provision, it was tailored to some combination of the following groups of students:

- international students
- students on courses identified as containing above-average levels of mental health risk
- postgraduate students
- BME students
- mature students
- LGBT students
- young carers
- care leavers
- victims of childhood sexual abuse.¹⁹

Case study: Targeted prevention and promotion initiatives

The London School of Hygiene and Tropical Medicine (LSHTM) has a student cohort which consists entirely of postgraduates, a significant proportion of whom are international students. This kind of intake means students are likely to present with different mental health and wellbeing issues – for example, LSHTM reports one of the major challenges it faces is helping students to adapt to student life after many have spent long periods in work as adult professionals. The large proportion of international students at LSHTM also presents issues with ensuring students feel able to access support for their mental health and wellbeing, and that they are not prevented from doing so by cultural stigma. To help overcome this barrier and ensure stigma is tackled on campus for international students, LSHTM holds a non-compulsory welcome event for international students, which is run by the student advice and counselling service.

De Montfort University has introduced a Course-Specific Interventions (CSI) system, which works accredited wellbeing activities into a small number of courses identified as posing above average levels of mental health or

¹⁹ A number of other responses indicated that targeted services are available to these groups, but that these services do not have an explicit mental health or wellbeing focus or rationale.

disability risk. The system looks to develop emotional resilience within the context of specific course content, and forms part of the university's corporate retention (and attainment) strategy. It involves partnership working between academic staff and staff in mental health and disability services, and arose partly due to concerns that students were failing courses as a result of anxiety problems. CSI aims to help students understand that they are not experiencing issues such as anxiety in isolation, and so creates opportunity for peer-support.

7.2 SUMMARY

The promotion of positive mental health and wellbeing, and the prevention – wherever possible – of the emergence of mental distress and low wellbeing are crucial parts of a 'whole-university approach' to mental health and wellbeing. HEIs consider a range of prevention and promotion initiatives to be important, particularly buy-in and direction from senior leadership and the provision of counselling services.

The majority of prevention and promotion initiatives would appear to be widespread across the HE sector, particularly those – such as counselling provision – which are considered to be the most important. However, less than half (43 per cent) of HEIs report delivering teaching and learning models which promote positive mental health and wellbeing. This suggests that, for most HEIs, strategies to promote mental health and wellbeing do not yet include making changes to the ways in which their core business – course content and delivery – is designed. HEIs consider this to be an important means of building resilience within the student community, despite it being a relatively untapped resource.

8. **ACCESSING SUPPORT, CARE AND TREATMENT**

The second central function of a ‘whole-university approach’ must be to ensure that those students experiencing mental illness, mental distress and low wellbeing are able to access support, care and treatment. This is particularly important for students experiencing mental illness. For these students, HEIs must be equipped to manage risk, respond to crises, and refer students into appropriate external services. For the significant proportion of students who experience mental distress which is unlikely to meet the threshold for treatment through the NHS, HEIs must be able to provide the support necessary to ensure they are able to thrive and meet their potential.

In this chapter – drawing on the results of our survey of HEIs and case studies – we explore the extent to which HEIs value support, care and treatment for students experiencing mental illness, mental distress or low-wellbeing, and which particular initiatives are most common within the sector.

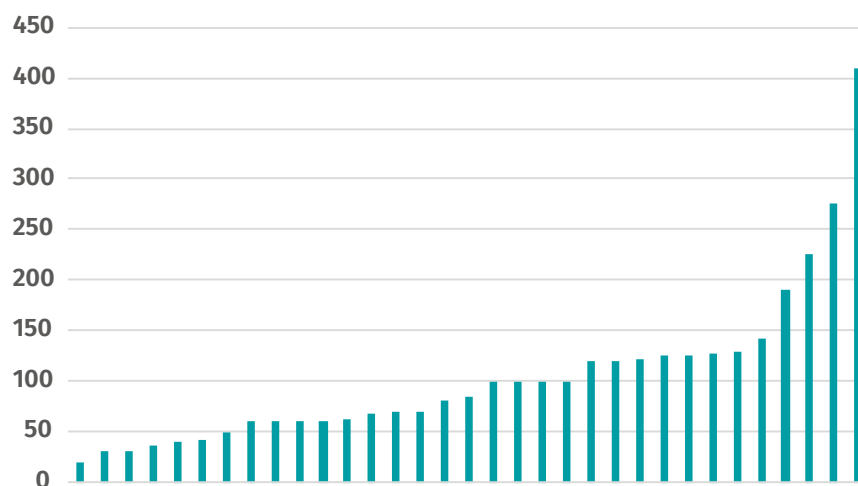
8.1 SUPPORT FOR MENTAL DISTRESS – UNIVERSITY COUNSELLING SERVICES

Within a university setting, the predominant means of support for students experiencing low-levels of mental distress is counselling. Chapters four and five showed how counselling provision is delivered by most, if not all, HEIs in the UK, and how a majority of HEIs report a significant increase in demand for counselling provision over the past five years. However, the total number of hours of counselling made available to students can vary dramatically between individual institutions. Among those to respond to our survey, this varied from 19 hours to 410 hours available per week (with an average of 104 hours) (see figure 8.1).

FIGURE 8.1

There is a high level of variation between HEIs in the total number of hours of counselling provision available to students – the mean across our sample was 104 hours per week

What is the total number of hours of counselling available to the student body each week at your institution? (UK) (n=33)



Source: IPPR

Our case studies suggest that some HEIs have adapted the design of their counselling provision in order to manage increased demand. The following themes emerged from case studies.

- There is variation in *how* students are able to access counselling. However, the most common routes are through drop-in, completing an online form, telephone booking, or being referred by a member of university staff.
- It is common for the number of individual counselling sessions students can access to be capped at six, other than in exceptional circumstances. However, many HEIs also told us that – in reality – the majority of students who access the service do not need or want their full quota. For example, students at the University of Dundee are entitled to up to 6 sessions, although the average number undertaken in practice is 3.8. However, HEIs also reported a need for some degree of flexibility. For example, Arts University Bournemouth is trialling a partnership with the local counselling college as a means of providing counselling support over and above the six-session limit for the small number of students who require it.
- An increasing number of HEIs are moving towards the ‘Cardiff model’ of counselling provision (Cowley 2007). For example, at the University of Birmingham, within four weeks of submitting an online form, students will undertake a 90-minute, solutions-focused ‘therapeutic consultation’, followed by a further appointment a number of weeks later to discuss progress. The consultation will also determine which students are offered up to six counselling sessions. The University of Leeds uses a similar model, and reports that online forms can be completed by as many as 40–50 students each day, demonstrating the extent of demand.
- Other HEIs, meanwhile, have introduced an enhanced ‘triage’ function to determine eligibility for counselling services. De Montfort University has introduced a Single Point of Access (SPA) function which acts as a triage point prior to students accessing counselling, mental health or disability services. The SPA is staffed by members of all three teams and aims, in part,

to reduce waiting times for university counselling services. Students can book a 30-minute ‘triage’ appointment online, following which they can be referred into the university’s counselling, mental health or disability services where appropriate (as well as other student services such as Money Advice).

- Some HEIs are looking to find innovative ways to increase the capacity of their counselling provision. For example, Brunel University London has increased the number of trainee counsellors within the service, and a new Student Support and Welfare Team has been created in order to help manage demand while ensuring students remain able to access appropriate support.
- We also heard a number of reports of counselling services increasingly performing a ‘holding’ function for students who require access to more specialist services, but who face lengthy waiting times into NHS care. For example, the University of Leeds reported that one-third of the counselling service’s caseload is made up of students who are identified as requiring some degree of ‘risk management’ – implying an increased level of severity.

Despite the variation in how counselling services are delivered, and which students are able to receive support, a strong counselling function is likely to form a central part of an HEI’s approach to improving student mental health and wellbeing. According to the Royal College of Psychiatrists (2011), ‘the student group is one whose education and experience have often fostered capacities for reflection and introspection. They are more likely to seek some form of counselling or psychotherapy and have a greater chance of benefiting from it.’

Counselling has a long history of delivery within HE in the UK, meaning the provision is established within individual HEIs, and that there are high levels of collaboration and knowledge-sharing across the sector as a whole. Counselling interventions also benefit from the potential to be subjected to established outcome monitoring, primarily through the Clinical Outcomes in Routine Evaluation (CORE-OM) tool. This is important as it allows staff within student services to determine the extent to which counselling has had a positive impact, and whether follow-on interventions are necessary. For example, academic studies have suggested that two-thirds (63 per cent) of students who undertake counselling at university experienced an improved CORE-OM score (49 per cent among those who began with a score within the clinical range) (McKenzie et al 2015).

8.2 MANAGING RISK AND RESPONDING TO CRISIS

Our survey asked HEIs to rate the importance of different initiatives in helping to manage risk and respond to crisis in relation to student mental health, by assigning each a score of 1 to 5 (where 1 is not important at all and 5 is extremely important). The average score across all responses shows that all six initiatives are considered by HEIs to be important (see figure 8.2).

Case study: Training on responding to mental health crises for security/accommodation staff

At Brunel University London, security officers have been trained by the disability and counselling services in responding to mental health crises among students. This forms one part of the security service’s wider remit to ensure ‘safer campus communities’.

Their training enables security staff to provide an effective means of ‘first response’ where crises occur on campus out of hours. Where security staff are called to an incident, they attend in pairs and provide a ‘dynamic assessment’ on the scene, while also maintaining contact with supervisors

located at an on-campus assessment centre. Based on the information provided by security staff on-scene at the incident, supervisors can then make a call on the best way to proceed, including the possibility that security staff will take the student to A&E and sit with them while they wait to be seen.

Similarly, the University of Worcester has built into the job descriptions of security staff a requirement to be alert to signs of mental distress among students. Security staff also receive Mental Health First Aid (MHFA) training, and a number have received Applied Suicide Intervention Skills Training (ASIST). In addition, the security service operates a system whereby a daily report is sent to the university's counselling service to highlight cases of concern.

'Training on responding to mental health crises for security/accommodation staff' and 'strong relationships with local NHS mental health services' were rated as the most important (4.43), followed by 'specific training on mental health for academic staff' (4.35). The initiatives to score least highly – although still considered important – were having a 'student medical practice (GP) based on site' (3.55), 'attendance monitoring (for all students)' (3.69), and having 'NHS mental health specialists able to deliver interventions on site' (3.82).

Case study: Attendance monitoring

The University of Chester has adopted a university-wide approach to student retention, which includes intelligent use of data and analytics, and a system of monitoring students' attendance as a means of enabling early intervention.

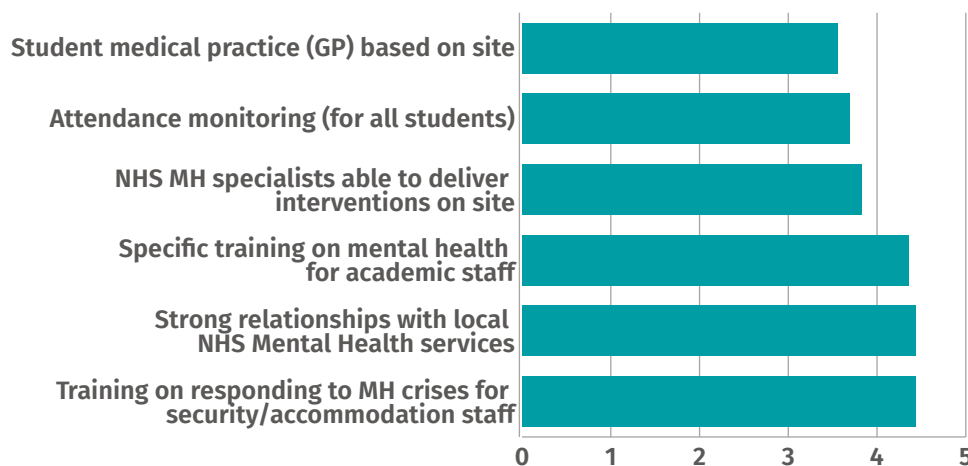
All undergraduate students have access to a digital app which enables them to log their attendance, by 'checking-in' at classes. The software then generates real-time reports on students' attendance patterns, which students can view using the app. Students are assigned a personal academic tutor who is also able to view their attendance reports, with certain attendance patterns triggering an enquiry (described as being 'supportive' rather than 'disciplinary').

Personal tutors can thereby act as a 'gateway' into different early-intervention approaches where appropriate, to support students who might be struggling and who are at risk of dropping out. Tutors can, for example, refer students into the 'Student Futures' service, into which a number of mental health and wellbeing initiatives are integrated alongside other areas of student services.

Although there is no assumption that there is a mental health or wellbeing problem underlying every case of low attainment, overlap in some instances has been observed. Tutors therefore receive training on how to differentiate between levels of severity, and what is likely to be an appropriate response. The process aims to help develop a culture of resilience rather than one where every problem leads to a student being referred on to specialist support. It was stressed to us by staff at the university that 'it is not the monitoring which makes the difference, it is the contact'.

FIGURE 8.2

'Providing training for security staff' and 'developing strong relationships with local NHS mental health services' are considered by HEIs to be the most important factors in helping them to manage risk and respond to crises in relation to student mental health
How important are each of the following initiatives in helping HEIs to manage risk and respond to crisis in relation to student mental health? (mean score) (rating 1–5 where 5 is extremely important)] (UK) (n=49)



Source: IPPR

We then asked respondents to indicate which of the same set of initiatives are in place at their institution (see figure 8.3). None were found to be present among all HEIs to take part. The three rated as the most important were also those which were in place in the majority of institutions – 83 per cent reported providing training on responding to crises for security/accommodation staff; 82 per cent reported having strong relationships with local NHS mental health services; and 84 per cent reported providing specific training on mental health for academic staff.

Case study: Student Medical Practice (GP) based on the university site

At Brunel University London, there is a GP practice located on the main university campus, which offers a full GP service with bookable appointments and also emergency appointments available on the day. Between 80 to 85 per cent of the practice's patients are students. The practice is located a few yards away from the building in which counselling services are based. This level of geographical proximity has the potential to help create strong relationships between university and NHS staff, and therefore ensure that students experiencing a health problem or disability can access appropriate support.

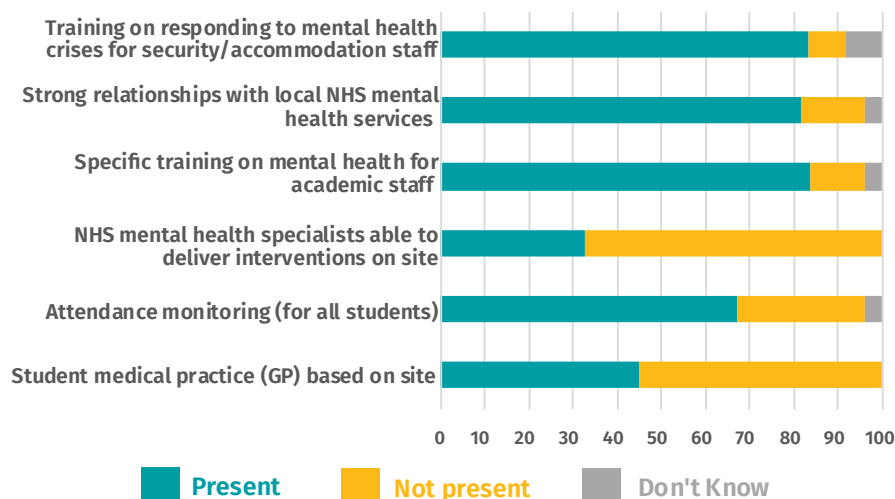
For example, the practice reported a close working relationship with the university's disability services, which enables them to provide recommendations on adaptations and reasonable adjustments, as well as advise on 'fitness to study' where appropriate. And while the practice does not refer students directly into the university's counselling or disability services, it does encourage them to 'walk-in' where appropriate.

A mental health nurse is also based at the practice, effectively providing an intermediary level of care between primary and secondary. The location of the practice means that – despite the nurse being NHS-funded – they are available to students on campus (providing they have been referred through the GP).

FIGURE 8.3

A majority of HEIs train security and academic staff to respond to mental health crises and manage risk, while less than half host a student medical site or NHS mental health specialists who are able to deliver interventions onsite.

Which of the following initiatives – which aim to help HEIs manage risk and respond to crisis in relation to student mental health – are present at our institution? (UK) (%) (n=49)



Source: IPPR

However, despite the other three initiatives also being considered important by HEIs, far fewer reported them being present at their own institution. Almost one in three (29 per cent) reported that they do not monitor the attendance of all students, while less than half (45 per cent) reported that there is a student medical practice (GP) on site. Most worryingly, just one-third (33 per cent) reported that students are able to access NHS mental health specialists who can deliver interventions on site, despite this being rated by the same set of HEIs as an important means of managing risk and responding to crises in students' mental health.

Case study: NHS mental health specialists able to deliver interventions onsite

The University of Dundee has a very small university health service located onsite, which consists only of a mental health nurse and an office manager. Unlike alternative models, where NHS-trained staff are employed in generic mental health or disability roles within universities, the mental health nurse at the University of Dundee is employed as a nurse, and is an honorary NHS employee with access to central NHS systems.

The mental health nurse has a caseload of around 20 students, with a waiting list of 14 weeks (which is reported to be increasing each academic year).

The service aims to fill the gap between student services and NHS provision, with the majority of referrals coming from GPs, where students with mental health needs do not meet the threshold for accessing statutory services. Students typically receive between 6 and 16 sessions, which begin as weekly and then become more spread out over time.

The nurse is able to deliver different interventions to students, and can also provide a joined-up care plan or mental state assessment. Early sessions are used to conduct an initial (biopsychosocial) assessment, which then enables the nurse and student to opt for a specific therapy (such as CBT or solutions-focused therapy) to be taken forward. For each student on the caseload, the mental health nurse liaises with the GP or (where appropriate) secondary services.

For some small or specialist HEIs – such as St George’s, University of London – there is additional scope for students to benefit from access to support, care and treatment. At St George’s, all courses are healthcare-related, largely with vocational components. This means the university has a strong relationship with the adjoining acute NHS mental health trust. As a result, occupational health (OH) provision is available to students to self-refer into, and a consultant psychiatrist is available to deliver one session per week to some students who are in contact with the counselling service. Given the relationship between the university and the trust – and the presence of the psychiatrist onsite – referring students into secondary mental health services is less problematic than is the case elsewhere in the HE sector.

In some HEIs, mental health specialists from outside the NHS are available to students. The London School of Hygiene and Tropical Medicine (LSHTM) works with a consultant psychiatrist from the private sector, who is consulted on an ad hoc basis as determined by the university’s counselling service. The psychiatrist provides a one-off therapeutic assessment, enabling the student to be provided with a diagnosis where appropriate, and with details passed onto the GP (perhaps in order to provide evidence necessary for a DSA application). The counselling service acts as an intermediary between student and psychiatrist throughout the referral process. This provision was described as being necessary within a small specialist institution such as LSHTM, particularly within the context of the difficulty in getting timely referrals into the NHS.

However, in some other HEIs, there has been a deliberate attempt to avoid bringing clinical mental health specialists onto the university site, in order to draw a clear line between what it is and is not within the power of a university – as an education provider – to deliver. For example, the University of Wolverhampton has concentrated its efforts on improving staff awareness on responding to crises and referring into statutory provision, rather than expanding the internal capacity for delivering care and treatment.

8.3 CARE AND TREATMENT: EXTERNAL PARTNERSHIPS AND COLLABORATION

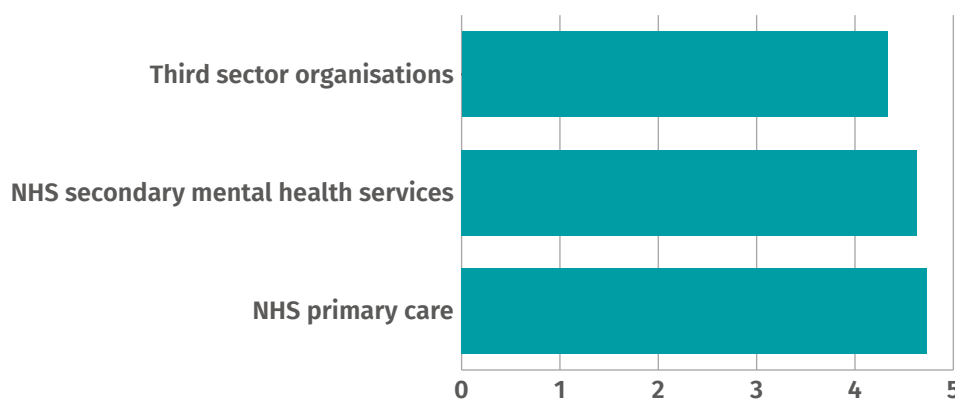
Our survey asked HEIs to rate the importance of collaboration between their institution and three different potential external partners in relation to student mental health and wellbeing. Respondents scored the importance of each potential partnership from 1 to 5 (where 1 is not important at all and 5 is extremely important). The average score across all responses shows that all three are considered by HEIs to be important (see figure 8.4).

Collaboration with NHS primary care services was reported as being the most important (4.73), followed closely by collaboration with NHS secondary mental health services (4.63), and third sector organisations (4.33).

FIGURE 8.4

HEIs consider strong relationships with NHS and voluntary services to be important in relation to student mental health and wellbeing

In your view, how important is collaboration between an institution's mental health services and each of the following external services/organisations? (mean score) (rating 1–5 [where 5 is extremely important]) (UK) (%) (n=48)



Source: IPPR

We then asked respondents to indicate how well/closely, in practice, their institution works with the same set of potential external partners (see figure 8.5). A majority of HEIs reported a good level of partnership and collaboration with all three external partners: 86 per cent reported working well/closely with NHS primary care services, 75 per cent reported working well/closely with NHS secondary mental health services, and 67 per cent reported working well/closely with third sector organisations. However, the results again demonstrate there is considerable room for improvement within the sector.

Case study: Strong relationships between student services and NHS provision

The University of Leeds is a member of the Leeds Student Health and Wellbeing Partnership, which aims to share best practice through collaboration between the city's universities, NHS providers and clinical commissioning groups (CCGs).

The university's Student Services have developed a model whereby they work in partnership with the Leeds Student Medical Practice, with this partnership underwritten by the university's Student Support Strategy. The practice sees 300 patients each day, one-third of whom present with mental health-related complaints.

As part of this collaboration, students benefit from a 'mental health worker project' initiated by the practice and the university, after successfully bidding together into the NHS Better Care Fund.

Three mental health workers have been employed in order to help students experiencing mild to moderate anxiety or depression; isolated sleep disorders; or eating disorders (the service originally covered a wider range of mental health diagnoses, but this had to be slimmed down following high levels of demand). The aim of this provision is to ensure timely access into support, care and treatment for students, and so prevent long waiting times that exist elsewhere in the NHS.

Eligibility is determined according to the GADS7 and PHQ9 measures, with the service intended for students who do not meet the eligibility threshold for more intensive NHS care and treatment. A student who receives a low score is referred into alternative services (such as the university's counselling services), a high score results in referral into IAPT or NHS secondary mental health services, and an intermediate score means a student is eligible for the 'mental health worker' project.

Eligible students then receive a 45-minute appointment, in which they can receive CBT interventions, with an upper limit on sessions as determined by NICE guidelines.

The university covers 25 per cent of the cost, which means that the mental health workers spend a quarter of their time based on university premises.

As well as long waiting lists, there are also longstanding problems in the NHS with a 'cliff edge' existing between child and adolescent mental health services (CAMHS) and adult mental health services. This is largely due to differences in the eligibility threshold between the two, with many young people who access CAMHS up to the age of 17 or 18 being unable to access adult services.

As a means of correcting this problem, there is growing momentum behind the establishment of 0–25 mental health services. Forward Thinking Birmingham (FTB) is one such service, and has been in operation since April 2016. The service effectively replaced CAMHS in Birmingham, and includes treatment teams, crisis teams, talking-therapy provision, eating disorders, early intervention in psychosis, and a number of community 'hubs'.

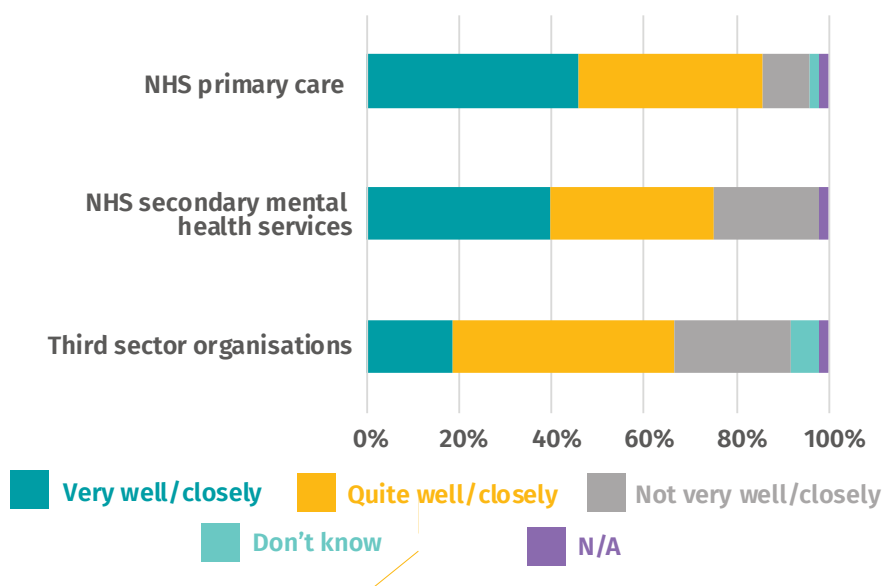
The University of Birmingham has established a working relationship with FTB, in order to jointly support those students who require access to secondary mental health services. While liaison between the university's student services and FTB was reported as not yet being seamless, it was recognised by both sides as being an important means of ensuring continuity of care for students with mental health needs (for example, by having the potential to improve the quality of referrals and reducing the risk of a 'clash of expectations' between services).

Around one quarter of HEIs report that they do not work well with either NHS secondary mental health services (23 per cent) or third sector organisations (25 per cent). This is a worrying finding given that both were rated as being very or extremely important by respondents. Although a smaller proportion (10 per cent) indicated that they do not work well with NHS primary care, this does suggest that a significant proportion of students across the UK are likely to be missing out on the benefits of close partnerships between HEIs and GPs.

FIGURE 8.5

HEIs report high levels of collaboration with external partners in relation to student mental health and wellbeing, although 1 in 4 report that they do not have strong relationships with NHS secondary mental health services.

In practice, how well/closely does your institution work with each of the following external services/organisations to improve student mental health and ensure students can access support? (UK) (%) (n=48)



Source: IPPR

Funding allocations for NHS primary care – do students lose out?

In England, funding is allocated to GP practices according to the General Medical Services funding formula (the Carr-Hill formula). A significant proportion (at least half) of per-patient funding is allocated in the form of a 'global sum', calculated according to the likely workload generated by individual patients. This is, in turn, weighted on the basis of the characteristics of the patient cohort (for example, their age and gender), levels of morbidity and mortality in the local area, patient-list turnover (as newer patients tend to engender higher workload), and local staffing costs. The 'global sum' is then topped-up by other funding pots, most notably from the Quality and Outcomes Framework (QOF), which allocates funding according to high-quality provision for patients with prominent long-term conditions.²⁰

This method of allocating funding does, however, fail to account for 'atypical' populations of patients. According to NHS England (2016c) 'there are some practice populations that are so significantly atypical that using the GMS funding formula would not ensure the delivery of an adequate general practice service'. University populations are identified as one of three atypical populations, along with 'unavoidably small and isolated' sets of patients and practices with 'high numbers of patients who do not speak English'.

The evidence in this report supports the argument that students (particularly those aged under-25) constitute a patient cohort with atypical health needs and, therefore, funding requirements. The prevalence rates

²⁰ <http://www.nhshistory.net/gppay.pdf>

of mental health conditions among young adults are high relative to older age groups, and have increased over time. What is more – due to a combination of factors related to academic, financial and social pressures – students within this age cohort are at added risk of experiencing mental illness or distress. Our sample of student medical practices suggests as many as 7–8 per cent of students who access primary care experience depression and anxiety.

NHS England (2016c) has produced new guidance to encourage local commissioners to identify and support practices which serve ‘atypical’ populations, in order to ensure that patients are able to receive effective care. It is not yet clear, however, how far this guidance has translated into the reallocation of funding locally.

In 2015/16, the average NHS per-patient payment to GP practices in England was £142.62, up slightly from £141.09 in the previous year (ibid). However, this can be significantly lower in student medical practices for the reasons outlined above. Dr Dominique Thompson – Director of Student Health Services at the University of Bristol – has argued that her GP practice, at which almost all patients are students, receives just two-thirds of the average funding allocation as a result (Thompson 2017).

8.4 SUMMARY

Enabling students with mental health needs to access support, care or treatment is the second crucial part of a ‘whole-university approach’ to mental health and wellbeing.

For students experiencing mental distress, the HE sector has a long history of providing counselling provision which can help students develop strategies to thrive academically, personally and socially, and help them to overcome traumatic or difficult periods. However, as a result of a huge growth in demand, many HEIs are redesigning elements of their counselling provision. Some HEIs are increasingly playing a ‘holding’ function, as students with clinical levels of need struggle to gain effective and timely referral into the NHS.

HEIs also play an important role in managing risk and responding to crisis. HEIs consider a range of initiatives in this space to be important, particularly providing training on how to respond to mental health crises for security and academic staff, and forging strong relationships with local NHS mental health services.

In a significant proportion of HEIs, there are initiatives which are considered to be important but are not in place:

- almost one in three (29 per cent) do not monitor the attendance of all students
- less than half (45 per cent) have a student medical practice (GP) based onsite
- just one-third (33 per cent) enable students to access NHS mental health specialists onsite.

It is also important for HEIs to collaborate with different external partners to ensure students can be referred into treatment where necessary. HEIs consider collaboration with NHS primary care services, NHS secondary mental health services and third sector organisations all to be important. However, around a quarter (23 per cent) do not work well with NHS secondary mental health services, meaning a significant number of students may have added difficulty receiving treatment, which in turn enhances the risk of mental health crises occurring.

9.

CONCLUSIONS AND RECOMMENDATIONS

Prevalence of mental illness, distress and low wellbeing is rising among young adults in the UK, and this is also true among students. Across the entire UK population, insufficient numbers of people with mental health needs are able to access support, care and treatment, and this is reflected among students also. As a result of a complex array of societal and economic factors – as well as a gradual erosion in stigma – demand for mental health support among students is increasing at a rapid rate.

In order to be able to respond to this demand effectively via appropriate, evidence-based interventions, HEIs must first ensure they have a clear understanding of mental health and wellbeing among their students, and that they can differentiate between different types and severity of need. In order to help them achieve this, HE leaders should understand mental health and wellbeing as existing along a continuum.

There is, however, significant variation in the extent to which HEIs are currently equipped to meet this challenge. Depending on the institution at which they study, students are likely to receive different levels of access to support.

There is also a set of underlying ‘structural’ problems – such as absence of robust national data and imperfections in NHS funding mechanisms – which make it more difficult for HEIs to respond effectively, and therefore for all students to progress through higher education in a way that supports their mental health and wellbeing.

While HEIs are primarily education providers, they also have a responsibility to, and interest in, protecting and promoting students’ mental health and wellbeing. It is important that the HE sector works together with the NHS – and that both are supported by government – to take on this challenge.

With this in mind, and drawing on the findings from this research, we set out a number of recommendations for reform, targeted at the HE sector, the NHS and government.

RECOMMENDATIONS FOR UNIVERSITIES AND THE HE SECTOR

Recommendation 1: The HE sector should collectively adopt student mental health and wellbeing as a priority issue.

IPPR supports the initiative – led by Universities UK – to create a strategic framework through which individual providers can develop a ‘whole-university approach’ to mental health and wellbeing.²¹ This initiative should, however, possess a number of key features.

- **Provider-led:** the HE sector in the UK is wide and varied. Too much prescription on what the components of a ‘whole-university approach’ should be is therefore likely to result in services which do not fit the needs

21 <http://www.universitiesuk.ac.uk/policy-and-analysis/stepchange/Pages/about-our-work.aspx>

of particular student populations. HEIs should be responsible for developing their own approach, rooted in an understanding of their students' particular needs and characteristics.

- **Audit and quality assurance:** some variation in the shape of individual institution's mental health and wellbeing services is inevitable within the context of the UK's HE sector. However, it is also important that individual approaches are measured and that they meet a minimum level of quality and effectiveness. As such, the sector should develop a validated mental health and wellbeing audit as a means to assess the appropriateness and effectiveness of individual institutions' approaches to student mental health and wellbeing.
- **Continuous improvement:** Given the high variation in the quality and availability of services, the HE sector should adopt a commitment to continuous improvement in relation to student mental health and wellbeing. This will enable good practice to become more widespread, and bad practice to be eroded. This will require a commitment by the sector to transparency, via the online publication of strategies, as well as the publication of data on service use and effectiveness.

Recommendation 2: 'Whole-university approaches' to student mental health and wellbeing should be underpinned by common principles

Despite a commitment to the development of provider-led strategies, there are common principles which should underpin them. In keeping with the findings of this research, institutions' 'whole-university approaches' to student mental health and wellbeing' should be based on:

- strong leadership from senior management
- robust data and evidence
- engagement with staff and students
- prevention and promotion
- early intervention and low-level support
- responding to risk, and crisis management
- appropriate access into care and treatment
- strong relationships with external providers.

Recommendation 3: 'Whole-university approaches' should draw on examples of best practice

Drawing on these common principles, this research has identified a number of examples of best practice which are likely to be applicable across the sector, and which HEIs should therefore look to incorporate in their own 'whole-university approaches' where appropriate.

- Designing course content and delivery in a way which promotes positive mental health and wellbeing, while maintaining an emphasis on academic rigour. This could, for example, involve embedding accredited wellbeing modules into first-year undergraduate courses, in order to build students' resilience ahead of their transition into second and third years, where the prevalence of mental health problems is known to increase significantly.
- Training for academic and pastoral staff on the institution's processes for internal referral and responding to crises.
- Close collaboration between student services and security and accommodation services, including training for security and accommodation staff on responding to crises and suicide prevention.
- Using digital software to monitor the attendance of undergraduate students, in order to induce a culture whereby students take responsibility for their own

learning, and to more easily identify those who have become disengaged and may require additional support.

- Securing a permanent seat on local CCG mental health steering groups, in order to influence funding decisions and form effective partnerships with local providers.

Recommendation 4: HEIs should commit to increase the amount of funding dedicated to services which promote and support the mental health and wellbeing of students

This research presents extensive evidence of the level of mental health need among the UK's student population, and the gap that exists in the sector's current capacity to meet this effectively.

Particularly within the context of increased tuition fees, it is reasonable that students expect a higher level of service, with easier access and shorter waiting times, than is currently available at many institutions.

Alongside innovative service design, more resources will give institutions the best chance to improve the quality and availability of services to support students' mental health.

Individual HEIs should commit to provide additional investment in line with an open and robust evaluation of current student need and reasonable future projections.

RECOMMENDATIONS FOR GOVERNMENT AND THE NHS

Recommendation 5: Government should facilitate a more systematic national strategy to improve the quality of data on the mental health and wellbeing of students, and the effectiveness of interventions within a university context

- The Adult Psychiatric Morbidity Survey (APMS) should be updated so as – from 2021 – to collect data on the prevalence of mental illness among students. The current availability of data on levels of mental illness and distress among students in the UK is insufficient, and relies too heavily on sporadic academic studies or the use of proxies. A robust national survey – which uses clinical screening measures to determine prevalence rates – would be a vital tool in helping to understand levels of mental illness and changes over time.
- The National Institute for Health Research (NIHR) and Department for Education should jointly commission research into what works in enabling positive mental health and wellbeing and delivering support for mental distress among student populations – including through effective prevention and early intervention. This is an important part of building the evidence base on which whole-university approaches are refined over time.

Recommendation 6: Government should facilitate the introduction of place-based coalitions which aim to improve the health of local student populations through greater integration across services

These coalitions should consist of education providers, NHS services, local authorities and clinical commissioning groups. The Department of Health should look to drive local integration by the following means.

- Introducing a new Student Health Fund into which partnerships of HEIs, primary care providers, NHS secondary care services, and voluntary sector providers are able to bid. The existence of this fund would recognise the particular health needs of students, encourage NHS commissioners to

- prioritise student mental health when taking funding decisions, and encourage integrated working across the HE sector, the NHS and the voluntary sector.
- Piloting five new 0–25 mental health services into which local coalitions of health providers are able to bid to host. This model has the potential to improve the quality and consistency of care and treatment for students, particularly those who are drawn from the local area. Criteria for selecting successful bids should include the extent to which local HEIs are involved, the extent to which student populations would benefit, and the extent to which bids demonstrate learning from existing examples of 0–25 provision, such as Forward Thinking Birmingham.

Recommendation 7: Government should introduce a new Student Premium to top-up the funding of GP practices with high proportions of student-patients

It is vital that GP practices receive sufficient NHS funding to meet the needs of students who require access to primary care. NHS England has identified students as a patient cohort with atypical health needs who risk losing out from effective primary care due to the current method of allocating funds to GP practices. In some cases, student medical (GP) practices with high proportions of student-patients receive per-patient funding equal to two-thirds of the national average. As such, government should introduce a new Student Premium to reduce this shortfall, and so recognise the added risk of mental illness and distress among students. For each student aged under-25 registered as a patient, a GP practice should receive an additional £23 by way of Student Premium.²²

Recommendation 8: Government should create and develop a digital NHS Student Health Passport to improve the continuity of healthcare and treatment among students

Students are unique patients in that they are likely to be based in different areas of the country at different points in the year, and therefore can encounter a wide range of clinicians (including in multiple GP practices and secondary care providers, as well as clinicians based in university settings). For students with mental health needs, effective treatment and continuity of care across providers can, however, be made more difficult by the often-antiquated systems of technology and data sharing within the NHS.

As such, the Department of Health should provide new funding to create, develop and pilot a new digital Student Health Passport. This would provide a patient-held record of the range of primary and secondary healthcare services used by students, which in turn would be used to update the central GP record.

Students pose unique challenges in relation to sharing health data and records across geographies. They also pose opportunities due to, for example, their advanced levels of digital literacy relative to other groups. Students are therefore an important population in which to pilot innovative approaches to health data, which have the potential to spread more widely across different patient groups in the NHS.

²² In 2015/16, there were 1 million students to enrol in HE courses in the UK, 68 per cent of whom were aged under 25. Assuming similar levels of enrolments in future years, the maximum total cost to government of a £23 Student Premium would be £15.5m per year. In reality, it would be far lower than this, given that not all students choose to register with a GP.

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