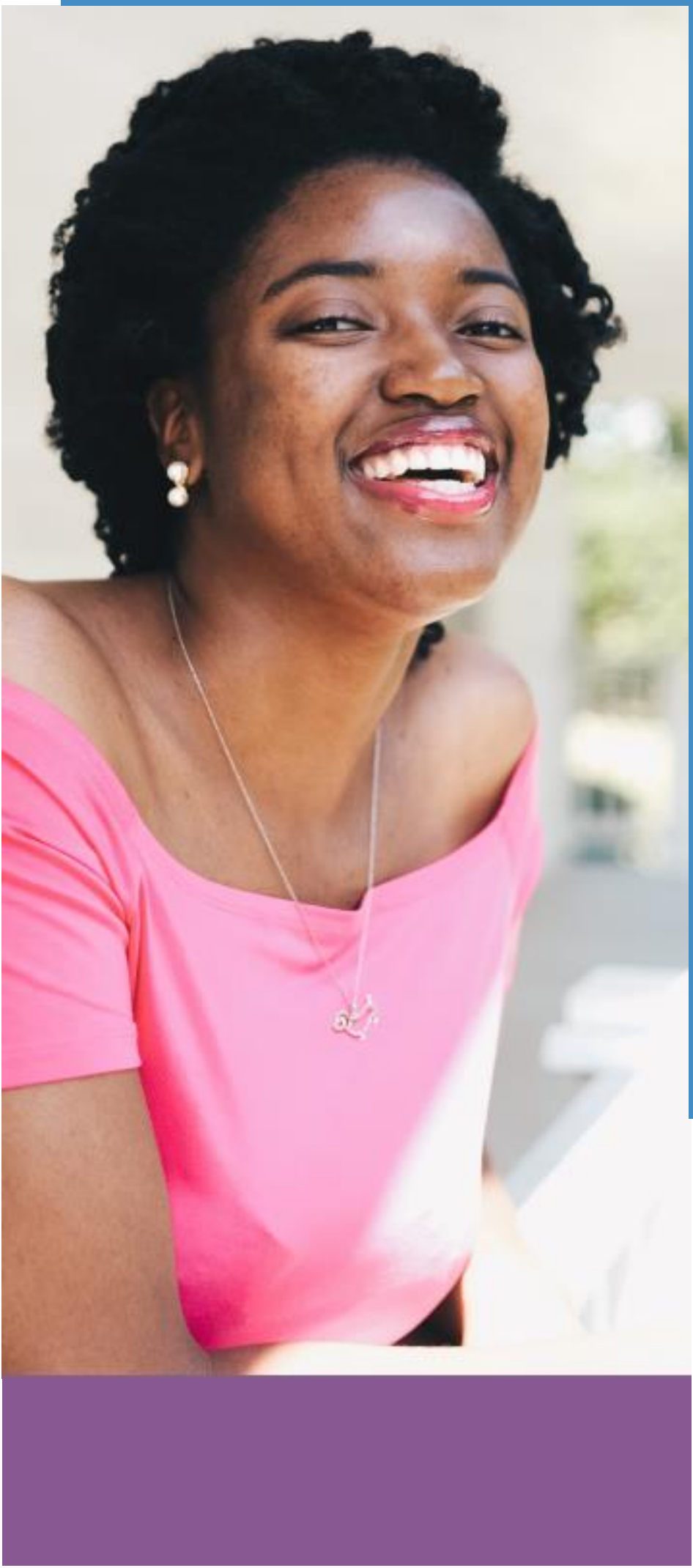

Student Mental Health Scoping Highlights Report

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April 2022

Oxford Academic Health Science Network
Mental Health

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Glossary

- A&E – **A**ccident and **E**mergency department
- ADHD – **A**ttention **D**eficit **H**yperactivity **D**isorder
- AMHT/CMHT– **A**dult **M**ental **H**ealth **T**eam/**C**ommunity **M**ental **H**ealth **T**eam
- ASD – **A**utistic **S**pectrum **D**isorder
- BMI – **B**ody **M**ass **I**ndex
- CAMHS – **C**hild and **A**dolescent **M**ental **H**ealth **S**ervices
- DSM – **D**iagnostic and **S**tatistical **M**anual of Mental Disorders
- ED – **E**ating **D**isorder
- EDPS – **E**mergency **D**epartment **P**sychiatric **S**ervice
- EIP – **E**arly **I**ntervention in **P**sychosis
- GP – **G**eneral **P**ractitioner
- IAPT – **I**mproving **A**ccess to **P**sychological **T**herapies
- ICD – **I**nternational **C**lassification of **D**iseases
- NHS – **N**ational **H**ealth **S**ervice
- OCD – **O**bsessive **C**ompulsive **D**isorder
- PD – **P**ersonality **D**isorder
- SMI – **S**evere **M**ental **I**llness

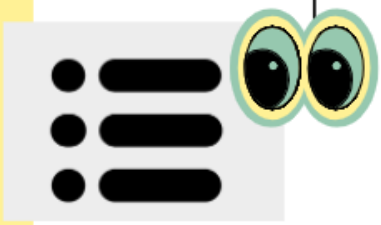
Executive Summary

There are growing concerns about the mental health and wellbeing of students in the UK. Work has been undertaken as part of a collaborative approach across the South East of England together with NHS England. The Oxford Academic Health Science Network sought to scope the challenges and good practice within the context of the local area to inform key stakeholders and explore if there is a role supporting the improvement of the mental health offer to students within Berkshire, Oxfordshire and Buckinghamshire.

What We Did

Between October and December 2021, we undertook a series of semi-structured interviews with individuals from primary and secondary care, third sector organisations, university counselling and welfare teams, and students.

Themes from the interviews centred around three topic areas **being human, recently emerging themes, and organisational challenges.**



Being Human

- Acknowledging the human experience and the ups and downs of life for students
- Support can be given by anyone through taking a human approach
- Validating how students are feeling and acknowledging their feelings and experiences as difficult
- Viewing distress and confusion as a normal part of maturation
- Avoiding over medicalising emotional distress and encouraging the use of internal resources rather than a need to be 'fixed' by external agencies

Recently Emerging Themes

- Reduced opportunities to socialise impacting on young people's development in terms of life experience and traditional adolescent risk taking and preparation for university
- Increases in complex student mental health presentations and social anxiety
- Digital approaches are useful for less severe mental health problems
- The use of digital approaches risks digital exclusion and could potentially contradict digital health promotion
- Students will use online platforms but when reaching out for help to services they want to see someone face to face

Organisational Challenges

- Challenges that are present for everyone trying to access mental health services not only students
- Difficulty accessing secondary care, particularly for eating disorders, ADHD, autism and complex needs
- A need for better communication and information sharing between organisations and improved transitions of care
- Greater understanding between universities, primary care and secondary care about the services available and the remit and role of each part of the sector

Conclusion

There is a wealth of good work going on within organisations to support student mental health. Changes to improve the offer to support the mental health of students will require input from all partners and a collaborative approach, whether that be addressing systemic issues causing organisational challenges or wider utilisation of a human approach.

The purpose of this report is to reflect the thoughts, feelings, challenges, and opportunities as described by those participating in our interviews, and to gather these in one place for further consideration. We hope that this will help to inform future initiatives in the field of student mental health, taking the current experiences and situations within the sector as a starting point and avoiding making assumptions about what the system or students need.

Introduction

NHS England has identified student mental health and wellbeing as an area of concern. Across the South East work is being undertaken as part of a collaborative approach to support organisations to address the needs of students. The Oxford Academic Health Science Network (Oxford AHSN) sought to scope the challenges and good practice within the context of the local area, to inform key stakeholders and explore if there is a role supporting the improvement of the mental health offer to students within Berkshire, Oxfordshire, and Buckinghamshire.

The interviews yielded rich information and therefore the results of this scoping work have been condensed into this highlights report and will be provided in detail in a further full report. It is hoped that these reports will provide intelligence to key stakeholders that may not otherwise be available by providing equal opportunity for all sectors to contribute, including those who may be seldom heard from the ground level.

In addition to providing intelligence around students who make up a large population in our local areas, several of the themes arising also apply to anyone attempting to access mental health care. Therefore, this information can be used to inform the ongoing community mental health transformation work currently taking place.

Background

There are currently about 2.5 million students at UK universities, and approximately one in three of these will experience clinical levels of psychological distress during their time at university (Bewick BM, 2008). Anxiety and depression are the most commonly experienced mental illnesses in the student population, but students also experience eating disorders, self-harm, OCD, bipolar disorder, psychosis and personality disorders (Student Minds , no date). The median age of Higher Education students overlaps the peak age of onset of mental health illness, with 75% of all mental health difficulties developing by mid-20s (Royal College of Psychiatrists, 2011), though of course not all students are young, and many mature students face the triple pressure of student life, working, and supporting a family (Student Minds , no date). All of this can contribute to decreased performance and interpersonal problems (ACHA, 2007) leading to academic failure and dropout, job difficulties and negative social outcomes (Patel V, 2007). Tragically, in recent years there has been an increase in the number of student deaths by suicide nationally (IPPR, Institute for Public Policy Research, 2017).

Recent studies have highlighted the impact of COVID-19 on exacerbating the mental health issues of young people and students, such as financial pressures, uncertainty about life after university, inequalities and access to effective treatment (Student Minds, 2021). There has been a particular increase in eating disorder referrals for children and young people. Students also reported lower life satisfaction (Blackbullion, 2021) and whilst the Prince's Trust found 52% of children and young people believe COVID will make their generation more resilient, over 40% feel their lives are on hold, they are not in control of their lives, have increased anxiety, and feel it will be harder than ever to get a job (Prince's Trust, 2020).

Universities within the Thames Valley – the local picture

The following universities are situated within the Thames Valley.

Location	University	Number of students (approx.)
Berkshire West	University of Reading (incl. Henley Business School)	23,000
	University of West London – Berkshire Institute for Health in Reading	Not known
Buckinghamshire	Buckinghamshire New University – Wycombe and Aylesbury	14,000
	University of Buckingham - Buckingham	2,700
Oxfordshire	Brookes University - Oxford	17,000
	University of Oxford	25,800
Total		**82,500**

Aim and method

The purpose of conducting scoping work within the Oxford AHSN geographical area (Berkshire, Buckinghamshire, and Oxfordshire) was to identify what is working well and where good practice can be shared, to discover what the challenges and concerns within the system are, and what recommendations can be made to improve the mental health offer to students. The scoping work also examined the use and role of digital health support in student mental health as a particular interest area of the AHSN and the recent changes to the use of more online teaching and support in response to the recent pandemic.

The scoping work consisted of a total of 24 semi-structured interviews of approximately one hour in length. Participants were contacted via email, identified either through existing contacts from staff within the Oxford AHSN, knowledge of key roles and teams in the NHS and third sector systems, university websites, and suggested contacts from other participants.

A total of 32 individuals participated across the 24 interviews: including individuals from primary and secondary care, third sector organisations, university counselling and welfare teams, and students.

The interviews were conducted online via Microsoft Teams and always involved two interviewers from Oxford AHSN (one male and one female). This allowed for contemporaneous notes to be taken more easily and for the interviewers to compare their understanding and interpretation of the information offered.

It was agreed that the interviews would not be recorded to allow the interviewees greater license to speak freely. Any comments and direct quotations that appear within the following report are not ascribed to those who made them. This was also another condition of the interview process designed to encourage openness and honesty.

Once the interviews had been completed, themes from the conversations were identified and reviewed.

Limitations

The main limitation from this scoping work is the limited number of students interviewed. Therefore, the reported themes are mainly representative of the professionals who work with students and who have reported student views second hand.

As the initial engagement with participants was via direct emails and the interviews conducted via Microsoft Teams there were challenges to identifying individual students to take part. Time was also limited and resources to proactively seek the engagement of students about their mental health in an appropriate and safe way proved challenging. However, additional focussed work could be undertaken in the future if there is an appetite to take this work forward. Indeed, engagement with student groups to contribute to the development of any aspects of this work will be essential.

Additionally, while every effort was made to reach out to individuals from across the three counties and the healthcare system to ensure equal representation, the pressures and needs on the frontline due to acuity and the continuing pandemic meant that some individuals were unable to be reached or to participate. In the future, if further work were to go ahead, engaging individuals from community mental health teams and eating disorder services would be considered alongside more student participation.

Available support

All universities reported having a wide range of support in place that students can access around mental health and wellbeing, including:

- Counselling services - staffing of these services varied across universities from psychotherapy trained staff to mental health nurses and mental health advisers
- Disability advice services
- Welfare teams
- Wardens within student accommodations
- Pastoral support
- Drug and alcohol support
- Peer support programmes
- Mentoring
- Student Unions
- Oxford University has individual college welfare support staff
- Campus Recovery College
- Online resources - podcasts, videos mindfulness courses and online workshops

Initiatives such as Wellness Wednesdays (½ day low touch support for all students to come together informally) were considered to be particularly helpful as well as self-help resources such as a healthy student checklist, a self-completed tool with basic questions about healthy living.

Several universities have or are planning to roll out a mental health programme or mental health first aid to all staff to support responding to students in distress and identifying where things are more serious.

One university reported that they have had widespread success with an online programme, consisting of 23 topics including perseverance, tolerating uncertainty, and promoting being able to be self-reliant. The programme follows the student journey through the academic year. To acknowledge their commitment students' can receive a certificate when they attend a set number of webinars, complete worksheets, and a reflective piece. Student feedback has been positive, particularly during Covid-19, where they felt it allowed them to feel connected to the university and provided strategies to adjust to the new situation.

Some universities reported GP and IAPT (Improving Access to Psychological Therapies) services attending Freshers' Fairs and Welcome days to support registration to local surgeries and promote awareness. Attending these events was thought to be helpful in working together to engage and support students, as well as universities holding complex case panels or weekly meetings to go through high-risk cases and where GPs can raise students for welfare checks.

IAPT services reported that whilst they do not have student specific treatment options, they do try to engage students and support universities through bespoke work such as live events on various topics, and the use of wellbeing champions, podcasts and videos.

Secondary care mental health services reported that they do not have specific services for students, but that students do have access to services through adult care pathways. EIP (Early Intervention in Psychosis) teams reported they support students in two ways, those that are with the service and subsequently move away to university, and those that are at a local university.

Private psychiatry is available to students, either with private insurance or using their own finances. It was reported that students are increasingly accessing private healthcare.

The human approach: validating how students are feeling The idea of a human approach resonated across all sectors as being a positive and helpful way to support students with less severe mental health problems;

**"I'm a big believer in validation…
it is difficult/hard and you are doing well,
this will pass and if it doesn't try this."**

Welfare teams were reported as doing this well for students and this could be the approach that academics take to support students who are distressed. A widespread concern was the increased instance – perceived or otherwise – of academic staff encountering an upset student and, through concern, engaging welfare staff; rather than kindly offering support, one human to another, and allowing the student to express their distress. GPs reported that students valued coming in to talk to someone impartial and non-judgemental, who they don't know, to "get things off their chest" and be listened to. This was particularly pronounced after COVID, where lots of students reported being nervous about mixing with other people again.

Students supporting each other All sectors reported that students go a long way to support each other and viewed this positively alongside wellness ambassadors and peer support.

"Often it is the people around students who pick up when they are mentally unwell, particularly with psychosis, and people are more informed and aware of mental health."

However, some concern was shared about instances where very unwell students are being supported by a few close friends in halls of residence. The student's erratic behaviour and attempts to take their own life could, understandably, be draining on those students impacted as well as university staff.

Resilience was a point of discussion for many participants. It was commonly noted that students feel persecuted by the word 'resilience' and experience it as blaming. Terms such as emotional empowerment or internal resource or internal skills were thought to be more acceptable and engaging.

Many participants observed that parenting has changed over the years. In general, parents are more involved in the lives of their student children when they enter university life.

There was some discussion over the need for separation for young people from their parents to enable problem solving and management of their own distress, to avoid the development of pseudo-maturity in students, where they are highly intelligent but still hold the idea that a parental figure will step-in to problem solve. The term 'snowploughing' (where parents force obstacles out of their children's paths) was referred to and raised as not helpful to build resilience or the ability to cope with adversity.

However, participants and students also raised that the focus of resilience has been on individuals, where there is a need to consider what it is that the system does around mental health. If this were pursued, then resilience takes on more helpful models for both the system and the individual, but this requires humility in the system.

Distress and confusion as a normal part of maturation Several participants from across the sector raised concerns around those students with mental distress, rather than mental illness, and the risk of the over medicalisation of emotional distress. This feeds into an idea that students need to be 'fixed' by external agencies (or medication).

Too often "mental health" has become a generic term which, when used loosely, unhelpfully encompasses a range of thoughts and feelings which may – or may not – require intervention from clinicians or counsellors. Some words, such as depression, have lost their (clinical) meaning; particularly when used to describe common emotions such as feeling sad or disappointed.

Secondary care participants reported that it is sometimes difficult to sift through who really needs a secondary service and who needs help managing distress and that there needs to be closer working relationships as local systems based on the populations are unable to flex as the population changes.

Transition into university was identified as, by its nature, difficult and fraught with uncertainty and new challenges. It is common for students to arrive at university not being able to contain their emotions. The risk of pathologising feeling sad/distressed/overwhelmed as self-identified/diagnosed mental health conditions are becoming increasingly common.

It was also noted that such (self-imposed or clinically identified) labels can become how students see a part of their character or, indeed, 'who' they are: "I am a bit OCD" or "I am like this because I have ADHD."

Fixed attitudes, both negative and positive, about students and student life A perception that was raised when discussing how secondary care clinicians engage with students was the sense that clinicians, often in mid-life, were influenced by their own memories or recollections of being a student when engaging with students expressing problems. This could lead to an inaccurate sense of understanding of what it is like to be a student in the 2020s, as the clinician's recollections of their own student days may well be idealised or romanticised, and not analogous with the realities of modern student life.

Alternatively, it was noted that some clinicians might express a low opinion of students (through terms such as "snowflakes"), viewing students as having an 'easy ride' and that this might also be unhelpful when a student was seeking help or understanding.

Recently Emerging Themes

Reduced opportunities to socialise Two years of the pandemic and lockdown has deprived young people of the opportunity to socialise and develop in terms of life experience and traditional adolescent risk taking. There is a widespread observation that some students are more emotionally immature among the most recent intake and encountering a culture of excess without previous exposure which might prepare them for this. Concerns centred around younger students (18-year-olds) who have had 2 years with limited contact with others, impacting on their development around social skills, practical skills, organisation, and preparation for university life (social, relationships, and alcohol etc.)

Reduced access to face-to-face support The change to remote teaching was highlighted as impacting on tutors' ability to spot and manage distress with 'after class or tutorial' conversations no longer taking place that could resolve or manage distress. Online lessons and support were identified as being at the expense of building relationships and social connections with students and allowing the student to feel part of university life; particularly when tutorials and lectures can be accessed remotely from a student's room.

Increase in student mental health presentations All universities reported that the mental health of students has got worse; feeling frustrated for students who genuinely need secondary care but having nowhere to send them. Counselling services reported that there are a lot more students arriving who had previously been supported by CAMHS, having intensive support that cannot be offered or replicated by university teams. Anxiety in students was reported as increasing over the last 5 years but that particularly social anxiety has risen after the pandemic. It was felt that COVID-19 has exacerbated mental health problems for students and added a new dimension, particularly for students who need to isolate after a positive PCR (Polymerase Chain Reaction) or lateral flow test.

Changes in demography within student body It is acknowledged that an increasingly diverse group of students are attending university. However, the assumption remains that those attending university are the privileged and affluent. This is not always the case and there is a perception that social pressures for those at university have increased due to the wide range of financial positions within the student body and many more students are now working while studying. Students from middle income families were thought to experience the most difficulty regarding finances as they are not poor enough to qualify for lots of help and not wealthy enough to cover all their expenses. Paying for education was thought to have had an impact on the expectations students have from universities, which in some instances altered the traditional relationship between academics and students.

Furthermore, the 'traditional' or expected culture at university (heavy drinking, experimenting with drugs, identity, and sexuality) remains stubbornly intact and those joining from diverse backgrounds, where such traditions are either prohibited for religious reasons or simply not part of their social experience, can feel alienated or pressurised into fitting in. This can be experienced negatively or cause (or exacerbate) a sense of cultural conflict which can be challenging and potentially lead to a withdrawal from "university life".

Recently Emerging Themes

Digital as both a blessing and a curse All participants felt that digital platforms (apps and websites) have a place to support student mental health. Digital solutions were viewed as being most useful for less severe mental health problems, psychoeducation and prevention, and some participants reported that apps were not viewed as serious ways to help mental health by students. The most frequently mentioned digital platforms were SilverCloud, Calm Harm, Sleepio, Mindfulness apps (such as Calm and Headspace), Papyrus (support line), Young Minds and Togetherall (formerly known as Big White Wall). All sectors referred to their own websites, the use of emails, telephone, and video calls as part of digital approaches, reporting a hybrid of these and face to face for teaching or delivering care/therapy in response to the pandemic.

The use of digital technology such as video calling was highlighted as an easier way for students to access clinical services, reducing stigma and bypassing sitting in mental health waiting rooms or counselling rooms and therefore could be harnessed for engagement. However, primary and secondary care representatives reported concerns over digital exclusion, highlighting large disparities in the socioeconomic status of students. In relation to teaching/university life it was raised that the use of technology poses the risk of meta conversations and echo chambers going on outside the classroom and that this can reinforce cliques and make others feel isolated.

Additionally, it was thought that giving students apps to use was at odds with digital health promotion considering the negative associations with excessive smart phone use and social media etc.

International students' expectations Those arriving from the USA, Canada, Israel, and Singapore to study, in particular, were reported as at times having unrealistic expectations of what an NHS health service can provide for mental health support. Being able to see a psychiatrist the next day, or replication of intensive psychotherapy and requesting private resources and/or referrals from universities being among such examples. Preparing international students for coming into an NHS health care system was suggested and for services to have more cultural awareness, ensuring that expectations are realistic in both directions.

Prescribing Managing expectations of international students included the difference in prescribing with students from the USA and Canada reportedly arriving with prescriptions for high levels of stimulants for ADHD that are either not prescribed in the UK or not prescribed in the same way. Additionally, students from Eastern Europe and Russia were described as sometimes arriving with high levels of medications including multiple antipsychotics, antidepressants, and benzodiazepines.

Reluctance to seek help There was wide agreement among participants that some international students (particularly from Asia) only access help at the point of crisis or in extremis. Reasons for this reluctance to seek help centred around feeling ashamed, perceptions that it is weak to ask for help at the early stages and mental health being a 'taboo' topic and not often spoken about in their home countries. One participant spoke of their experience of international students feeling under enormous pressure to achieve at university and feeling that suicide is a better outcome than failing.

Organisational Challenges

All participants recognised that there is a lack of capacity in the health system for those seeking help for mental health conditions, particularly existing secondary care mental health services. Staffing was thought to be the main reason for demand exceeding capacity, both recruitment and retention of staff. Concerns were also raised about the impact on existing staff working as hard as they can and still being unable to meet the demand. Oxfordshire based teams were identified several times as being particularly difficult to recruit staff due to the cost of living. However, despite these challenges positive and effective relationships were reported between universities and early intervention in psychosis (EIP) teams, the emergency department psychiatric liaison services (EDPS) and the department of psychiatry (associated with Oxford University). Effective communication, sharing of information, engaged leads and open mindedness were highlighted as reasons for these positive relationships.

Access to AMHTs/CMHTs was raised due to too long waiting times and experience of students unable to access help then becoming so unwell that they need to be sectioned under the mental health act or drop out of university despite a real determination to study. Shorter university terms could result in students accessing care and beginning to engage with treatment, only to return home to potentially unsafe or unsupportive places, undoing or undermining the positive clinical work that has started. It was suggested that student mental health is not necessarily viewed as adult mental health and possibly not always taken seriously by secondary care services.

For some students A and E was thought to have become a way to access instant face to face support 24/7. Seeking private mental health care was described as an option that some students choose as a "workaround" to the system and the waiting times. It was acknowledged that this is costly and not universally affordable.

It was acknowledged by secondary care participants that AMHTs are not set up to support students when they return home, but that services could work beyond their boundaries with the right information sharing protocols, practice, and structure. Secondary care providers felt that they were quite responsive in assessing very ill patients but then there can be a big gap/wait/delay before starting treatment. However, when considering access to AMHTs/CMHTs it was suggested that, when under pressure, services,

"put their heads down' to cope with demand and 'gate keep' rather than working together."

This, in turn, can lead to services being reluctant, or refusing to accept new referrals, thus making the service harder to access.

Organisational Challenges

There were specific mental health conditions that were spoken about by participants as being particularly concerning:

ADHD and Autism

Participants reported increased interactions with students requesting ADHD or autism assessments. Students were reported as more literate on neurodiversity and clearer on what might be wrong and what they want. Students might not have been diagnosed before starting university but then find they are not able to adapt like their contemporaries to their new environments - both academic and social - and seek to explain this sense of not fitting in (or finding study difficult) through a diagnosis.

Extremely long waiting lists for assessments (12 months to 3 years depending on locality) have resulted in more students paying for private ADHD assessments, despite already having been pre-screened by GPs and practice nurses in primary care. This is because current guidelines state that individuals are unable to start treatment without first seeing a psychiatrist for confirmation of diagnosis and initial treatment such as prescribing medication. Without medical evidence universities reported that they are unable to access resources to put support in place for students with ADHD or autism to support them with their studies.

Eating Disorders

Participants reported higher numbers of students with eating disorders and concern around the potential for high mortality associated with this condition. A lack of funding and resourcing were highlighted as leading to excessively long waiting lists, inability to hand over care for students with eating disorders from other parts of the country, and only students who are in extremis, or inpatients, being able to access eating disorder services.

Participants also expressed concern about GPs, practice nurses and university counsellors 'holding' very unwell students with eating disorders and some students feel they needed to stop eating, or exacerbate symptoms, to be "ill enough" to access help. Access to services based on rigid Body Mass Index (BMI) criteria (<16) was thought to be sending the wrong message of needing to lose more weight to get help and students working around the NHS system and accessing private healthcare.

Furthermore, some students with a possible eating disorder maintain an unhealthily low BMI at around this threshold to avoid being 'sent home' or admitted for treatment.

Complex needs

Increasing numbers of students with complex needs were reported from 2 or 3 a year to 2 or 3 a term. These students were typically described as those with personality disorder or extreme emotional distress and the risk of self-harm or suicidality. Primary care and university participants typically considered these students as high-risk individuals and reported anxiety around supporting them. The Complex Needs Service was identified as being the most appropriate service for students with complex needs, but extremely long waiting lists were raised as a concern that potentially a student could wait most of their university time (up to 3 years) to be accepted and potentially then move away and need to join another waiting list.

Organisational Challenges

Crisis support There was agreement that a significant proportion of students (particularly some international students) did not seek help until they were in crisis. Location of crisis services (particularly for a campus within a rural geography) was raised as an issue, if students were very unwell or in crisis [suicidal], the expectation to travel by public transport to a mental health hospital/base for assessment was viewed as unsafe and a significant barrier. Crisis services were reported to at times come to campus if asked, but attending campus was not always offered.

Appreciated support from across the sectors Universities felt that the offer they have for students is of good quality and all other sectors viewed university wellbeing and counselling services as a great resource for students and felt that staff would go a long way to support students;

> **"wellbeing teams are a really great thing to be available to students."**

GPs and IAPT services being willing to see students, even if they are not registered with the university surgery, was seen as a significant removal of a large barrier to accessing care. Good relationships with primary care were seen as important and valued by all organisations. GPs felt they identified eating disorder (ED) and severe mental illness (SMI) well, and when students joined the surgery and declared ED or SMI they would follow up with the student within a few days.

Dual registration of students within their hometown and university was raised by participants as challenging for efficient information sharing between agencies. Additionally, the reliance on students to be 'registered' with 2 GPs can present an issue to access primary care. Additionally, students not registered with a local GP has the potential to make information sharing, for higher risk students, difficult and was a point raised by the IAPT services interviewed.

Admission to mental health inpatient wards also posed a challenge, as individuals are admitted where they are registered with a GP which can mean they are admitted away from their established support network. It was suggested that students should have a choice as to where they can be in hospital; at home or where their university is.

Communication between the university and the health system (all parts of the system and in all directions) was consistently raised as a challenge. Specific incidents included between GPs and AMHT and crisis services around establishing who is prescribing for the student and students who had taken overdoses and then seen by crisis teams but with no information being fed back to GPs. As well as incidents of GPs seeking advice from secondary care for students they are concerned about, but either not receiving a response or experiencing long waits for responses. It was reported that communication and information sharing can be quite complicated if a student is also receiving care from the private sector.

Communication between IAPT staff and wellbeing staff was highlighted as important to avoid duplicating work for the students. One service described how before COVID there had been talks about students having a mental health passport to help quicker access to services by containing information from home services to new GPs and local services. Student participants felt there was poor communication between the different parts of the hierarchy in the university and between universities.

Organisational Challenges

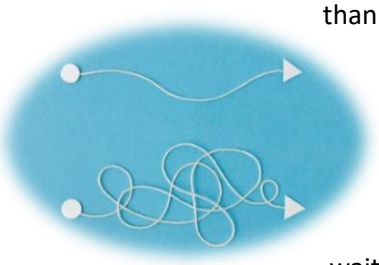
Consent was raised as a thorny issue for universities to share information with families and other professionals when they are concerned about students' mental health and vice versa. University participants commented;

"parents ring clearly concerned, and we can't tell them anything."

Consent to information sharing between universities and health and social care teams supporting students, was highlighted in order to make reasonable adjustments on arrival to universities and then bring in others to help offer support when worried about a students' safety. University participants highlighted a lack of clear identification or intervention on arrival to university in relation to care leavers;

"we don't have any information from CAMHS or social care re: care leavers to then put things in place on arrival and need to know who the professional lead for the student is and who is holding them."

Transitions of care for students with existing mental health conditions from hometown AMHTs/CMHTs to university town services was raised as challenging. The transition to university was seen by participants as a big life change and a time where students with pre-existing mental health conditions need "need wrap around support", especially in the first 6 months to get settled in, rather than being discharged from health services.



This transition of care was reported as being particularly problematic in Oxford due to a higher threshold. Additionally, the need to be referred to a local AMHT and start again on a waiting list means that students may go from receiving a lot of support to none. Poor transitions of care were raised as risky where students could be left waiting and being held by the GP despite needing secondary care support.

Participants reported that there was usually 5 months to 1 year's notice that an individual will be going to university and therefore a 'big push' should be made after confirmation from UCAS to organise transition and to meet the new team or agree virtual continuation of support in the first few months during handover.

Holding risk Despite feeling that their offers of support to students were good, university and GP participants raised concerns over holding the risk for students who are mentally unwell. Reporting that they feel they are left to hold and contain students at elevated risk of harm, who need support from NHS services, and are left managing students until when, or if, they take time out from university. Student mental health was described as a difficult and risky area that requires a lot of time and energy. The notion of who holds the responsibility for students was present in all third sector interviews and the need for flexibility when working with students highlighted, as some students will want to keep seeing their hometown team, potentially virtually, and others may want a new team and be seen face to face.

Organisational Challenges

Differing expectations of services were raised between organisations. Specifically, around the referring of students to secondary mental health teams. Although all sector participants agreed that there was a gap in services to support students, particularly those with complex needs, a mismatch between the expectation around the support available for these students was noted between universities and colleagues in primary care and, particularly, secondary care.

GPs reported referring students to AMHTs/CMHTs where they are seen once before being returned to the GP, when the expectation was for the referral to lead to some further support after exhausting primary care options. Secondary care participants recognised that there is a disconnect between university welfare/wellbeing services having students who are too unwell and referring to the AMHT and then the AMHT not taking on the student as not appropriate/not unwell enough.

University participants felt that secondary care providers and some students appear to labour under the misconception that their university provides "wrap around care". Representatives from several universities were keen to remind us that their primary (if not their sole) purpose is to support students to engage with their studies and stay at university.

Secondary care participants acknowledged that risky behaviours of students cause a lot of anxiety for all those supporting them, but that this can result in a clash of approaches; where the university wants to rush in and "save" the student and the mental health team see the best way to support these students as less is more. Furthermore, identifying the potential harm to some students from the involvement of lots of different professionals and the purposeful waiting time for some services to allow for periods of reflection, on the part of the student/patient, and to prepare for what the service provides. This delay – for clinical rather than practical reasons – is possibly not understood by (or sufficiently well communicated to) university staff and can, in some instances, lead to the perception of a "lack of urgency" on the part of the AMHT.

All participants felt that there could be better understanding between universities, primary care and secondary care about the services available, the communication between them and the remit of each part of the sector.

Recommendations for further actions

Magic wand solutions Participants were asked if they had a 'magic wand' what would be the one thing would they change. When reflecting and writing up their responses, it became apparent that these fell into two of the three overarching themes of the paper.

Changes around being human

- Support university staff to use a human approach, so they can be a calm, confident and containing person when faced with a distressed student and not jump to needing to get a 'qualified person'
- Staff to feel confident to ask questions around suicide/suicidality and then signpost if the answer is yes
- Support parents and families to prepare students for universities e.g., allowed to say no and for students to have responsibilities and freedoms
- A weekly safe space to offer students a place to come and focus on wellbeing and reflection
- Students to know exactly who their support from the university is e.g., personal tutor and when they can access them for support.
- A buddy system, with low level training for identifying students who are struggling if not in place already
- Stop assuming and stating that students have poor mental health
- More non medicalised options to be available

Changes around organisational challenges

- In reach and drop-in sessions with appropriate professionals from external services rather than students having to go to multiple different persons or services
- Robust support for those with existing mental health illness around transition into university
- Improved access to secondary care services; particularly eating disorder, ADHD and autism services
- Mandating universities to link with secondary care and mental health services so that the system is more "joined up" with shared goals and not left to chance (or whether a student is registered with a local practice)
- Moving from a place of managing enormous pressure, resulting in being overly restrictive about who is accepted and what we do, to a way where we work together as a system to meet the need of each person
- Improved communication and liaison between agencies to help create the supportive scaffold for students to engage and ensure knowledge sharing, managing expectations and smooth ongoing work for all who are involved
- Students informing wellbeing teams at universities who their care co-ordinator is and if they can contact them
- Improve AMHT support offer to GPs, so there is someone to go to and get help/advice when needed
- A university out of hours service
- Better screening and suitability consideration for students with pre-existing mental health conditions and planning of support needed before they arrive at university

- Investment for enhanced services for students who don't meet AMHT criteria but too unwell/risky for counselling services at universities, this could be provided by the university with qualified staff BUT mindful and considerate that for some of the risky students lots of involvement can be harmful in the long term
- At Oxford University each college to employ a full-time counsellor during term time, it would fill up quickly but would ease the stress on other services and students would feel supported rather than feeling that they are being pushed from pillar to post

'Cluster 3.5 service'

An idea suggested by one of the participants captured the thoughts and reflections of many others, this was informally referred to as a 'Cluster 3.5' service. This is so named to represent mental illness that is between cluster 3 Non-Psychotic Moderate Severity and cluster 4 Non-Psychotic Severe (i.e., 3.5). A mental health cluster is a global description of a group of people with similar characteristics that categorise into different mental health descriptions based on severity, duration and combination of symptoms. The description of this service would be to:

- Support individuals who may have early signs and symptoms of mental illness or have a crisis but not yet be unwell enough to access secondary care
- Work with individuals with pre-diagnostic broad prodromes
- Be a preventative service that has experienced clinicians at the front line, who understand the context in which students are working and recognise the developmental stage that each student is at and that they are all different (i.e., 17 years and 365 days doesn't = adult)
- Ensure easy to access, quick response, be responsive, flexible in modality and able to respond to a range of needs from acute psychosis to relationship breakdown distress
- Provide out of hours service provision
- Accept referrals from any secondary care service across the country for students coming into the area
- Investigate interesting research questions such as, those who don't fit a label, what interventions work for them? How do you define a troubled mental state that doesn't fit in DSM/ICD10 diagnosis?

Potential solutions Throughout the interview process several potential solutions, or hopes for the future, were articulated by those being interviewed. Although the following list is not exhaustive, some of the potential areas for further exploration or work to take forward include:

- The creation and circulation of a directory of potentially "verified/safe" digital interventions for universities to use (which would require continuous updating)

- The potential for preparation of young people (and their parents) to manage the transition into university and develop self-management skills and increase potential to do well academically. Providing resources that are accessible, such as the Reading University's Life Tools programme offering webinars/talks and online resources addressing various aspects of student life and prepare for life beyond university.

Recommendations for further actions

- Utilising the window of notice from UCAS notification to university commencement to engage young people (and their carers) as soon as a place is accepted at a university, rather than in the immediate weeks before their attendance.

- Clarity around what universities can - and cannot - offer their students in terms of support (it is not "wraparound care") and this includes with university academic staff who are, in some instances, conflating unhappiness or an emotional crisis with "mental health". There is a wider point about the ubiquity with which mental health language is used; frequently imprecisely. E.g. "I am depressed" rather than “I am feeling sad and lonely”.

- The location of mental health and wellbeing services. Interviews suggest that where an offer is promoted proactively, or a service is well-signposted and hosted on-campus, uptake and engagement is far greater. Indeed, "out of sight is out of mind" applies to services (such as GP surgeries) which are situated away from university campuses.

- Delivering a proactive and preventative approach, positioned in positive psychology such as The Life Tools programme which aims to develop emotional intelligence focused on personal, academic, and professional development. The Life Tools certificate is recorded on students’ transcripts, and psychology students include it as part of their continuing professional development (CPD) logs.

Conclusion

We recognise the good work that is going on within local organisations to support student mental health and it was clear through the interviews that people are taking student mental health seriously. It is evident that there are two distinct groups that most students in need of support will fall into. Both will require different solutions and approaches to resolve.

Those with serious mental illness requiring secondary care intervention are currently faced with organisational challenges and the impact of lengthy waits for access to specialist services. These challenges are mostly long standing and intractable and will require systemic changes, involving the support of senior managers across the system to effect change, almost certainly at a national level.

Those experiencing less severe mental health issues and mental distress could benefit from wider utilisation of a human approach, kindness and time. However, with resources already stretched how this is achieved will need further consideration and exploration.

What is certain is that any change within the system will require input from all partners and a collaborative approach, including the involvement of the student voice. Out hope is that this work will help to inform new and ongoing changes to the provision of care, particularly within the community mental health transformation work ad for students to be considered within the population of people accessing services.

The appetite for change and engagement in this agenda amply demonstrated in participants’ willingness to share their thoughts, experiences, knowledge and passion for student mental health bodes well for the development of local innovations and the potential for the sharing of good practice at a local, regional, and potentially national level.

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