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PERSPECTIVE PIECE

Student mental health and well-being: Overview and Future Directions‡

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The mental health of third-level students is of major societal concern with the gap between the demand for services and supports offered at crisis level. In Ireland, similar to elsewhere, colleges have responded to this need in vastly differing ways, with student counselling services available to all institutions, and student health departments and sessional psychiatry in some of the larger institutions, with none operating as a single multidisciplinary service. There is an increasing recognition for a more systematised approach, with the establishment of International Networks, Charters and Frameworks. These advocate for a whole institutional approach to student mental health, in addition to the development of an integrated system of supports with effective pathways to appropriate care. This paper, by members of the Youth and Student Special Interest Group of the College of Psychiatrists of Ireland, contextualises student mental health currently and describes future directions for this emerging field. It is a call to action to develop a structure that supports the needs of students with mental health problems across the full range of the spectrum from mild to severe.

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Introduction

The mental health and well-being of third-level students is a topic of increasing interest worldwide over the past few years. Many reports, surveys and initiatives have emerged from countries such as the UK [(The Insight Network and Dig-in, 2019), the Student Mental Health Research Network (SMarTeN, n.d.) https://www.smarten.org.uk//] and Australia [Under the Radar] (Orygen, 2017). There is a recognition that the differentiation between student well-being and mental ill health is unclear (Barkham *et al*. 2019), that institutions differ vastly in terms of their service models (Royal College of Psychiatrists, 2011) and that coordinated, collaborative data collation on the effectiveness of current care models is essential in informing the future development of services (Duffy *et al*. 2019).

In Ireland, mental health in young people has been addressed to varying degrees with the establishment of Jigsaw (A National Centre for Youth Mental Health) and a Youth Mental Health Taskforce; however, significant gaps remain in the delivery of care to this population. Such organisations have emphasised the importance of student mental health with higher education institutions (HEIs), identifying student mental health and well-being as core institutional objectives. Students themselves are central to this movement. In August 2019, the Union of Students of Ireland launched the results of their national student mental health survey (Union of Students in Ireland, 2019), which demonstrated the presence of a collective will to focus on this issue in the context of growing demand and increased complexity of mental health challenges experienced by students.

This article focusses on the following aspects: (1) Challenges faced by third-level students, (2) Irish context and culture, (3) models of care and the role of the College Psychiatrist, (4) relationships to external agencies and (5) relevant national and international developments and (6) a 'whole institution' approach

Challenges faced by third-level students

Starting third-level education marks a significant milestone in the lives of young people, as they move from their former 'child' (family) life to their new 'adult' (independent) life and transition from a world, that for many, is an organised, structured and supported home and school environment, into an unstructured university environment. This transition offers not only freedom, which can be liberating, but also challenges, which can be overwhelming (McLafferty *et al*. 2017). This period of emerging adulthood is defined by

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increased autonomy from parents and shifts in social and relational stability and requires multiple skillsets in order to establish a healthy routine, a supportive peer network and a habit of self-directed learning (Auerbach *et al*. 2018). A range of new experiences faced by students, including social media; sleep disruption; exposure to recreational drugs and binge drinking and financial stresses and career uncertainty, in the context of an increasingly competitive job market (Bewick *et al*. 2010). It is perhaps for these reasons that students demonstrate a poorer sense of mental well-being than their age-matched peers (Karwig *et al*. 2014). Prompt effective adjustment is required to avoid any negative impact on health and academic well-being.

The age of third-level students (mostly ranging from 18 to 25 years) corresponds with a period of accelerated brain development and the peak age of onset of mental illness (Kessler *et al*. 2007). The pressures identified above can bring heightened stress to a young person with pre-existing psychiatric vulnerabilities or unmask previously unidentified difficulties that were scaffolded by the family, such as autistic spectrum disorder or attention deficit hyperactivity disorder. University campus communities are different from communities in the general population in ways that may be important for mental health service utilisation (Eisenberg *et al*. 2007). There are large numbers of students with gender identity issues (McKinney, 2005), international students, students from deprived socio-economic backgrounds, students with disabilities (AHEAD, 2017): groups who are at higher risk of mental health difficulties.

Mental ill health impacts negatively on academic performance and course completion rates (Orygen, 2017). Mental illness can impede university-to-work transitions, damage early stages of career path formation and the acquisition of work values, work ethics and core work skills (McAuliffe *et al*. 2012). Well-being is an important determinant of successful transition across stages of life and career acquisition and retention (Haase *et al*. 2011).

On a positive note, there are several opportunities at college to pursue recreational, sporting and social interests, as well as to form new friendships. Students are often bright, articulate and likely to be curious about themselves. They are more likely to seek counselling and psychotherapy and to benefit from it. Phases of transition can afford opportunities for growth and maturation. College is a unique environment in ways that are relevant to the emergence, detection and treatment of mental disorders in students as it is perhaps the only time when work, leisure, social life, accommodation, medical care, counselling and social support are provided in one environment.

The college years therefore represent a distinct period whereby it is critical to improve early identification and treatment of debilitating mental health issues.

Irish context and culture

Universities are academic institutions, and their primary remit is educational rather than therapeutic. Investment in professional support services is primarily to support students in reaching their academic potential and, therefore, has changed and evolved hugely over the years with changes in the composition of students. Some staff have always had pastoral responsibilities, e.g., personal tutors or accommodation officers, but counselling and health services were developed to address the aspects of student life that made learning difficult, and as a result of the increased student to staff ratio. It is useful to keep in mind the educational aim of higher institutions when trying to understand the nature of support services offered within this context, compared to what is offered in the general population.

Ireland has one of the highest rates of educated employees internationally, with 41% of the workforce with a higher education qualification, increasing to 53.5% in adults <35 years compared to an EU average of 40% (IDA, 2019). The number of students enrolled in third-level institutions has grown significantly from 10% of the relevant age cohort in the 1960s to 65% in 2010 (Hyland, 2011). The student profile has diversified dramatically in recent years, largely driven by national policy that promotes equity of access to higher education across society and protection against discrimination such as The Free Fees Initiative (1996), the Equal Status Act (2000), the Equality Act (2004) and the Disability Act (2005) (Higher Education Authority, 2019). The State has developed two higher education reduced points admission schemes to facilitate this: Higher Education Access Route: for school-leavers from socio-economically disadvantaged backgrounds and Disability Access Route to Education: for school-leavers, whose disabilities have impacted on their second-level education (Higher Education Authority, 2019), two groups at higher risk of mental health difficulties. There has been a steady rise in demand for support services on campus that exceeds these enrolment increases (Thorley, 2017), without matched resourcing to match these trends (Xiao *et al*. 2017).

There is limited research overall investigating the nature and prevalence of mental health issues among students in Ireland. A study conducted by Reachout and the Irish Association of University and College Counsellors (IAUCC) reported that students had significantly lower mental health status than their aged matched peers (Houghton, 2010), and the My World Survey 2 reported significant increases in anxiety and depression since My World Survey 1, with 38% reporting a history of self-harm (Dooley *et al*. 2019). There is international recognition that the field has been under-researched and lacking in a unifying strategy for data collection and reporting. Instead, there have been a plethora of unrelated survey-based

reports with different measures for well-being and illness (Barkham *et al*. 2019). Nonetheless, the WHO World Mental Health International College Student Initiative reported that 35% of first year students screened positive for at least one common lifetime mental disorder (Auerbach *et al*. 2016). The figures reported across studies highlighted high rates of mental distress and resulted in rapid responses by universities that are not necessarily evidence based (Nunez-Mulder, 2018). There is a need first for accurate data collection and education on the differences between well-being and mental ill-health, and second, a need to address the increased strain on existing resources that successful anti-stigma campaigns can cause (Arie, 2017). In Ireland, The HEA Innovation and Transformation Fund has funded a three-year project across higher education institutions to create a National Research group and standardised dataset across student counselling centres. While this is a hugely welcome development, however, the information collected will be limited to students who present to student counselling centres, and will not include those who present to student health centres, external organisations, or the HSE, with mental health issues.

Models of care and the role of the College Psychiatrist

Services that support student mental health differ in their design, staffing and models of care across institutions and none have been effectively evaluated (Royal College of Psychiatrists, 2011). The range of support services available has arisen in the context of supporting the individual and the institution, in its educational aims, and therefore what was deemed appropriate for one institution may not readily transfer to another. Local factors such as the institution's size, culture, strategic priorities, the students' presenting needs and the internal and external resources available all have a role to play. There is, however, increasing recognition that this level of variability is problematic, with calls for university leaders to adopt a strategic approach to mental health and for the development of government-level initiatives and formalised relationships with local health services (Thorley, 2017).

At present, students in higher education have access to a variety of on-campus services including student counselling services, health centres and disability services (Hunt & Eisenberg, 2010).

The Irish Student Health Association (ISHA, 2019) serves as a forum for healthcare providers of students at third level. Many HEIs provide a Student Health Centre on or near campus, which are nurse or doctor led, and differ in their design, staffing and models of care. They generally aim to complement versus replace regular GP or Health Service Executive (HSE) care but due to the needs of this age group, Mental Health generally accounts for approximately 20–40% of all consultations.

Counselling services are embedded across all third-level institutions and are therefore the figurehead of mental health supports offered to students. In Ireland, they see about 6.4% of the student body, an average of one counsellor per 2446 students, which is far below the recommended ratio of 1:1000 (IACS, 2011), and are the largest provider of psychologically based mental health supports for the age range of 18–25 years in Ireland (PCHEI, 2019).

The role and tasks of the College Psychiatrist have developed to incorporate a range of skills specific to their core population. The College Psychiatrist needs to adopt a multi-faceted approach, which encourages collaboration with medical providers, family members to support patients and university support services. Student psychiatry incorporates a biopsychosocial treatment approach with medication, short-term psychotherapy and work to improve nutrition, exercise, sleep and relationships with other people to help support recovery from mental illness and to assist in long-term maintenance of progress made in treatment. In terms of pharmacotherapy, important variables must be considered during the selection process of medication, including potential side effects such as sedation, cognitive clouding, weight gain and sexual dysfunction.

An additional role of the College Psychiatrist is the provision of care alongside concerns for professional practice standards of a student. Institutional obligations and individual responsibility to students with mental health difficulties can be complicated by programmes of study that contain or lead to professional qualifications (Stanely & Manthorpe, 2002). The College Psychiatrist is therefore at times involved with decisions about the fitness of students to continue to study or fitness to practice statements. The College Psychiatrist's duty to maintain confidentiality regarding the student's mental health illness may come into conflict with duties to third parties, such as patients with whom the student will come into contact. This usually occurs in the case of students who are seriously unwell and clearly not coping with the demands of studying.

The role and tasks of the College Psychiatrist are similar across organisations in terms of the range of clinical skills required and dilemmas faced. Their position within the support services and clinical governance structure differs between institutions, however, with vastly differing models of care from one institution to the next (Royal College of Psychiatrists, 2011). There is no agreed role or definition of the College Psychiatrist and their funding source can influence the referral pathway and reporting structure.

For instance, if solely funded by one service within the student support services, it is likely their time will be spent largely meeting the needs of students and staff within that service. Currently, psychiatrists employed in Irish universities are generally employed from a single fund such as Student Health, and while there is flexibility around their response to other services, they do not have authority over a mental health team such as college counselling psychologists. This in itself is not problematic, as a significant proportion of issues within the student population would ideally be managed exclusively by psychological supports and/or primary care physicians, without referral to the College Psychiatrist. However, when the level of need in the individual is such that it warrants such referral, and the mental health records of students are held in several different systems with an unclear clinical governance structure, care for the student may become disjointed, increasing clinical risk and also potentially duplicating work and wasting resources. Having access to a Psychiatrist, whether on site in larger institutions, or via established pathways to secondary care in smaller settings, is integral to the delivery of a comprehensive mental health service for students, to ensure the full range of mental health needs from mild-severe can be met.

In the past decade in the UK, there has been proliferation of multidisciplinary teams within Colleges, with many introducing a single point of access to a mental health and well-being team (Streatfield & Prance, 2016). In addition to an obvious need for more investment, reorganisation and strengthening existing services such as developing a stepped care model would direct the large number of help-seeking students with transient situational problems and uncomplicated symptoms, to appropriate campus-based resources and reduce delay to specialist care for more complex cases (Duffy *et al*. 2019). However, the effectiveness of this model is dependent on an easily accessed clinical triage framework staffed by experienced mental health clinicians, effective interventions and facilitated smooth transitions across the identified steps (Duffy *et al*. 2019).

Finally, it is also important to remember that the vast majority of students are young people and we cannot afford to treat educational systems as separate from the real world. While there is an international recognition that the healthcare system is weakest where it needs to be strongest (McGorry & Mei, 2018), service models have been developed internationally to meet the mental health needs of young people, for example, Headspace in Australia (Rickwood *et al*. 2019). The university sector would benefit from incorporating the knowledge base from this field and partnering with relevant organisations such as the International Association for Youth Mental Health (IAYMH, 2019).

Relationships to external agencies

Students with emerging mental illnesses, similarly to all young people, typically lack sufficient symptom specificity and severity to meet adult-type diagnostic criteria (McGorry *et al*. 2007). This, together with stigma and reduced mental health literacy, limits their access to Adult Mental Health Services (AMHS) (Rickwood *et al*. 2019). Youth-friendly enhanced primary care settings such as Headspace, and quite possibly University Counselling and Health services with sufficient resourcing and service reconfiguration, could be expected to support the needs of a large proportion of this population. However, there is a recognition that without vertical integration (seamless open referral systems to more specialised care) that there is a significant proportion (up to 30%) whose mental needs will not be met, because they are too great to be effectively treated in primary care, and not severe enough to be accepted into AMHS, the so-called ‘missing middle’, wherein lies a missed opportunity for effective treatment, and an increased likelihood for adverse outcomes and the entrenchment of symptoms (McGorry & Mei, 2018).

Students are often a transient population, who lack awareness of the service implications of changing address across catchment areas boundaries. Community services are not designed to meet the significant needs of this group in respect of responding prior to symptom entrenchment and within term time, and the rigidity of catchment area boundaries can essentially act as a barrier to care (Duffy *et al*. 2019).

Due to the continued under-investment in AMHS, universities are left with little choice but to provide mental health support to their students. The provision of student mental health services could result in state services rescinding their statutory obligation to provide evidence-based treatment, particularly where state services are underfunded and overstretched. An ideological rationalisation may occur that the mental health needs of students are fewer than those of other groups by virtue of the fact they are in third-level education. Universities have a duty to support a student’s mental health and well-being during their academic journey, safely within the resources they have in place to do, without and expectation of reorienting themselves as a stand-alone mental health service to buffer the overburdened HSE.

In Ireland, there is no formal relationship between HEIs and HSE mental health services or clear definition of what presentations are the remit of the university and what is the remit of the HSE. As a result, students can struggle to access the care they require in a timely fashion, and university support services often end up managing complex cases far beyond their skill set or their primary care remit. Defining this remit at a national

and local level would be helpful, but unlikely to protect the needs of the student. The development of close ties and partnerships with local external services is vital in order to have accessible pathways to specialist care when required. There are examples of sector-led partnerships creating innovative co-produced student friendly services that are organised around the structure of the academic year example. The Belfast Trust, Queens and Ulster University partnership and The Greater Manchester NHS partnership with the region's four universities (University of Manchester, 2019). At an individual level, the development of a digital student health passport to ensure their health records travel with them has been proposed (Thorley, 2017)

National and international developments

Education policy in Ireland is increasingly referencing a more holistic definition of student success. A goal of the National Plan for Equity of Access to Higher Education, 2015–2021 includes 'enhanced supports/completion rates for students with mental health issues' (Higher Education Authority, 2019).

Recently, student mental health and well-being are gaining traction at the organisational level. The *Okanagan Charter* is an International Charter for Health Promoting Universities and Colleges, which calls upon post-secondary schools to embed health into all aspects of campus culture, and to lead health promotion and collaboration locally and globally (Okanagan Charter, 2015).

Australia has recently started to tackle this area, with a report from Orygen showing that university leaders, staff and students are attempting to respond to these issues, but are doing so without national leadership, data collection or comprehensive guidance and a National University Framework is now in development (Orygen, 2017).

The UK Institute of Public Policy Research is calling for prioritisation of student mental health via a sector-led approach, accompanied by strengthened health service provision and government-level initiatives (Thorley, 2017). The University Mental Health Charter was launched in December 2019 (Hughes & Spanner, 2019), following an 18-month consultation process, building on the work of Student Minds and the Stepchange Framework (Universities UK, 2017). The Charter has two aims. First, to provide a reference point for HEIs to adopt a whole-system approach to mental health. Second, to launch a Charter Award Scheme, which will assess HEIs against the Charter, providing structure, recognition of good practice and an increasing evidence base.

In Ireland, there are a number of recent national developments of relevance. Healthy Ireland and the HSE Department of Health Promotion have developed a *Healthy Campus Charter and Framework* that will be launched in 2020. This outlines guidelines for institutions to follow in the development of their own whole system approach to ensure that health is infused into all aspects of campus life: operations, business practices and everyday teaching.

Connecting for Life: Ireland's National Strategy to Reduce Suicide 2015–2020 (National Office for Suicide Prevention, 2016) urged the HEA as lead agency and in partnership with the National Office for Suicide Prevention to create '*The National Student Mental Health and Suicide Prevention Framework*' (HEA, 2020) via a collaborative consultative process across several stakeholders. It recommends that student mental health and well-being are prioritised at institutional level and provides guidelines for organisations to develop their own whole university approach.

A 'whole institution' approach

A whole institutional approach recognises that there are multiple causes and consequences of mental health and well-being in higher education requiring a collective, creative response. Most importantly, it aims to transform culture at third level into a health promoting setting that no longer delegates mental health to the support services (Universities UK, 2017). A whole institutional approach is enabled by leadership through sustained strategic prioritisation at every institution, with Institutional Leaders and Academic Heads as champions, full engagement from all members of staff and an identified campus Mental Health Committee/ University Taskforce that guides strategic planning, policy development and allocation of resources based on need, identified gaps in services and future projections. *Universities UK* recommend that strategy development is a consultative activity with strong student representation. This guides the policies and procedures linked to the support of student mental health and well-being, taking into consideration the need to balance the support of students with mental health difficulties against the duty of care to the wider student and staff community. Currently in higher education, there are independently developed policies with marked variability across institutions and lack of clarity around how they are implemented in practice or embedded in campus life.

Enhancing the supports that are in place in campus and referral pathways to adult mental health services have been discussed in Sections 3 and 4. Support services are not limited to clinical services, with several institutions providing a wide array of supports such as peer support workers, identified tutors in specific schools, Disability Support Services that support the

educational needs of registered students, Careers Officers, Budget Advisors, Office of International Students, Chaplaincy, to name a few. Similar to the services that provide clinical care, they can be disjointed and suffer from duplication of effort and closed communication systems. Some universities offer a single access point which helps students to navigate the services that are most relevant to their needs.

A key element of a whole system approach is education and training in mental health literacy and suicide awareness for staff and students, to help identify signs of distress and direct students to appropriate resources. Staff need allocated time to train in these areas and online and live opportunities to do so. Mental health literacy training might also help address the confusion at a societal level on the terminology around mental health and well-being, which can focus attention and channel resources away from people who need them most (Barkham *et al*. 2019).

Within education and training lies the possibility of embedding mental health and well-being in the curriculum. Curriculum infusion originally sought to raise awareness of wellness and mental health in a manner that reinforced the academic contents of the course, e.g., architects designing spaces to minimise stress and historians examining madness as a concept (Olson & Riley, 2009); however, it has evolved in recent years to include mental health awareness, life skills, resilience training and mindfulness, and there are a number of examples of this with an emerging evidence base (Houghton, 2019). Another way to support the mental health need of students in their educational attainment is via a commitment to inclusive curriculum design principles (Higher Education Funding Council for England, 2015), which recognise that a course is likely to be more equitable when learning needs are anticipated and student mental health needs are valued (Morgan & Houghton, 2011). This approach does not require everyone to become experts in different mental health conditions; moreover, it encourages academic and departmental staff to reflect on what they ask of their students and to navigate the tension in providing an experience that is challenging from an educational perspective, but not in itself creating undue stress for students (Houghton, 2019).

The community and environment have a role to play. While often associated with the elderly population, there is increasing awareness that young people in the age range of 16–24 years are also susceptible to loneliness (Dooley, 2019; Victor *et al*. 2019). The cure for loneliness is connection; therefore, fostering community engagement by creating an atmosphere in which social networks flourish is important, as are encouraging cultural diversity and providing extra supports to create social opportunities for those most at risk, e.g., international students and first year students. The ready availability of satisfactory, affordable student accommodation would also have a significant impact on student well-being.

Finally, the universities have a role to play in preparing students adequately for third level and managing expectations of both students and their families. Student-facing literature, open days and international recruitment drives need to make explicit that prospective student are expected to be critical thinkers, self-disciplined and self-reliant. In addition to outlining the support services in place, their limitations also need to be made clear (Jones-Davies, 2019). It is important that gaps between what support the institution have promised and what it actually delivers are addressed, as these can determine an individual's decision to apply and accept a place. There are recruitment targets that institutions need to meet for their sustainability and survival but with inadequate knowledge of the expectations and offerings of their institution of choice, and the student may not realistically be able to manage the demands that face them.

Conclusions

There are growing numbers of students accessing third-level education and from increasingly diverse cultural backgrounds. They are in the age range most likely to develop a mental illness. The mental health needs of students are increasing in volume and complexity, and the gap between demand and current student mental health support has reached a crisis level, with increasing pressure on universities to respond. While individually institutions have responded in ad hoc reactionary ways to these trends, there is, rather encouragingly, an increasing number of international and national networks advocating for leadership, strategic planning and data-driven responses and recommendations. In addition to the obvious need for additional financial investment, support services in most institutions would benefit from reconfiguration to an integrated and coordinated system with effective triage, stepped care, smooth referral pathways and embedded research. In addition to that challenge, there is a recognition that universities need to take the lead role in a whole university approach to student mental health, which encompasses the culture and ethos of the institution, good teaching and learning practices, mental health literacy and adequate, clearly defined support services. We believe it is time to develop an evidence-informed structure around student mental health services within third-level institutions and the Health Service in Ireland to address the full range of mental health problems facing students from mild severe. Student's mental health is everyone's business and

progressive solutions will benefit our young people and, ultimately, society as a whole.

Conflict of interest

Authors have no conflicts of interest to disclose.

Ethical Standards

The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committee on human experimentation with the Helsinki Declaration of 1977, as revised in 2008.

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