Mental Health Foundation Scotland

Thriving Learners

Realising student potential and wellbeing in Scotland

Thriving Learners: Initial Findings from Scottish HEIs (2021)

Chris Maguire

Julie Cameron

The ROBERTSON Trust 60 YEARS 1961-2021

Universities Scotland

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Research Advisory Group

Professor Pamela Gilles (Chair), Glasgow Caledonian University

Annette Davidson, Robert Gordon University

Alaa Elaydi, formerly of Universities Scotland

Katie Gilbert, NUS, Think Positive

Molly Greasley, formerly of NUS, Think Positive

Luke Humberstone, (Chair of LAG) UWS Union

Professor Simon Hunter, Glasgow Caledonian University

Lauren Knight, Universities Scotland

Susannah Lane, Universities Scotland

Shona Littlejohn, Open University in Scotland

David Lott, Universities Scotland

Dr. Mark McCann, University of Glasgow

Heather Sloan, Universities Scotland

DonnaMarie Steel, The Robertson Trust

Ruth Unsworth, University of St. Andrews

Learner Advisory Group

Luke Humberstone (Chair), University of the West of Scotland

John Fleming, University of Dundee

Olivia Ford, University of Strathclyde

Niamh McCrossan, University of Edinburgh

Jordan Sleeman, University of Strathclyde

Emma Walsh, University of St. Andrews

Vincent Waters, Glasgow Caledonian University

Mental Health Foundation

Vlad Cherman

Claire Fleming

Amy Tucker

Naomi Wilson

Designer

David Peasland

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Contents

Forewords

This is one of the largest and most significant studies of university student mental health that has ever taken place in the UK.

Students have shared their experiences of mental health and wellbeing - good and bad - at a time when they have also had to deal with the stresses of COVID-19. Despite the unprecedented circumstances students engaged with us and we have a great response rate which gives us real confidence in the findings. We can clearly see that there are profound challenges across all of our universities for student mental health. Equally, the study also highlights inequalities in mental health and wellbeing within our student populations.

We believe that Universities are pivotal to people's life chances and to helping create a fairer society. So, it is imperative that we now respond to the findings to enable each student to flourish through their university experience. The commitment from Universities Scotland and University Principals to respond to the findings in a meaningful and substantial way, is

Lee Knifton
Director for Scotland & Northern Ireland,
Mental Health Foundation

extremely encouraging. As the UK's leading charity for public mental health, The Mental Health Foundation is committed to working in partnership with Universities Scotland and HEI stakeholders to enhance provision to enable each student to thrive. We now have a clear evidence base to draw upon to inform this journey. We aim to repeat this research in coming years in order to understand changes and to help inform and review progress.

I want to thank every student who took the time to participate in this survey for their openness and candour in sharing their lived experience. It is hugely valuable that so many did so. Their contribution makes this the largest ever survey of student mental health, certainly in Scotland if not the UK.

We'd committed to run this survey before the COVID-19 pandemic. As it turned out, students took part in this survey during Scotland's second lockdown, after months of disruption to their education and the heightened health and financial concerns that the pandemic caused for many. The data are a cause for concern. I think it is very important that we captured this insight when we did. That's not to say that all findings can be attributed to the effects of the pandemic. However, it is important that we have real insight into the student experience from that time so that we can continue to plan and manage our holistic support for students in the best way possible in each of our institutions. The data also allows us to have the necessary conversations with our partners in Government and in the NHS, about how we manage the challenges together and what more we can do.

The data achieves most where it catalyses action. As universities, we are determined that it will. Mental health is a strategic commitment of every institution in Scotland and a personal priority of every Principal. We have robust frameworks to track and measure progress and I am proud

Professor Pamela Gillies
Principal and Vice-Chancellor,
Glasgow Caledonian University

that, in Scotland, we already have a well-established partnership model, working with students and others, to support student mental health and wellbeing across our institutions. There is more that can and will be done. We will act, individually and collectively, on the findings and recommendations in this important report. Having had the benefit of being close to the research throughout, I can say that we've wasted no time and we are already acting on the findings. We owe that to every student in our institutions.

Context

The age at which most young people attend university is known to be the highest risk life stage for the development of mental health problems[1].

Almost 75% of severe mental health problems emerge before the age of 24[2] and in Scotland they affect 1 in 4 of those aged 16 to 24[3]. For many students, the exciting new experiences university offers, also brings new challenges for them to navigate, in many cases without their immediate support network. This is often further compounded by increased academic pressures, and for some, the considerable stress associated with financing their studies. As a result, it is estimated that 40% of higher education students experience a mental health problem during their first year of study[4] and in a recent survey over 70% reported 'concerns' about their mental wellbeing[5].

Unfortunately, in recent years these numbers have steadily risen. According to a 2019 government report, the number of students in higher education experiencing mental health problems has doubled since 2014/2015[6]. The past decade has also seen a fivefold increase in the number of students who have disclosed a mental health condition to their Higher Education Institution and over 90% of Higher Education counselling services have reported an increase in demand for their services[7]. Sadly, between 2007 and 2015, the number of student suicides also increased by 79 per cent (from 75 to 134)[8].

It is important to note that mental health problems are not evenly distributed across the student population. Our mental health is influenced by a variety of factors, including our social, economic and physical environment. Age, gender, race, socioeconomic status and sexuality therefore place some student groups at higher risk[9,10,11,12]. As Higher Education institutions have become increasingly diverse in recent years, rising social inequalities across the UK, have been reflected in growing mental health inequalities amongst the student population[13]. The wider, societal costs of this should also not be underestimated.

In most developed countries, over 50% of young people are in higher education[14]. Good mental health and wellbeing contributes to students' ability to effectively engage in and succeed on their programme of study. Conversely, it is known that in Scotland, poor mental health impacts on students' ability to continue with their studies more than any other type of disability[15]. This, in turn, has potential consequences on their future income, employment and other life opportunities[16].

Since 2019, the COVID-19 pandemic has further exacerbated this situation. In addition to the widespread anxiety and stress experienced due to the pandemic itself; nationwide lockdown measures created significant uncertainty surrounding the continuation of courses[17]; and resulted in thousands of students isolated or in small 'bubbles' in university accommodation[18]. Higher education students have also had to contend with a drastically altered learning landscape, which has had a monumental effect on the delivery of teaching, relationships and, importantly, the provision of student services[19]. Some surveys have since estimated that higher education students have been particularly vulnerable to the mental health effects of the pandemic[20,21]. However, to date, few nationally representative studies have provided a robust indication of the extent to which student mental health has been impacted.

It is known that strategies to prevent young people from developing mental health problems, by addressing some of their societal and structural root causes, lead to significantly improved long-term educational, physical health and mental health outcomes[22]. Similarly, early intervention to prevent difficulties from becoming long-standing, stops young people from reaching crisis, and avoids more long-term suffering, poor health and complex intervention[23,24]. Despite this, accessing mental health support can be confusing, disjointed, and difficult for students to navigate. Specifically, at the time help is most needed, young people with complex problems often fall into the gap between child and adult mental health teams, or between service boundaries due to moving for university, leaving many unsupported and vulnerable[13]. Others are left on ever expanding waiting lists for university counselling services, which are struggling to keep up with demand. Meanwhile their mental health often continues to deteriorate and access to alternative forms of support is limited[13].

In recognition of these difficulties, in recent years the Scottish Government has increased funding for community based mental health services for children and young people. They also continue to recognise the important role of the university and further education sector in supporting the mental health and wellbeing of the student body. This is reflected in the 2021/22 Programme for Government which has committed to prioritizing student mental health; guarantees the provision of an additional 80 student counsellors within the sector and outlines plans to develop a Student Mental Health Action Plan. In addition, their national COVID-19 recovery plan states that their "commitment to national wellbeing will shape our recovery and help to create a greener, fairer and more resilient Scotland".

Our Thriving Learners survey therefore aims to provide a snapshot of the mental health experiences and challenges faced by students from across our universities and colleges. The largest ever of its kind, it is our hope that the findings of this survey will be used to inform policymakers and higher education institutions on the current state of student mental health and that the knowledge and insights gathered will help shape future best practice responses for supporting student's emotional well-being across Scotland.

The structure of the report will be as follows: first a methodological overview and then the demographics of the sample; following that will be descriptive statistics of the survey questions with sub-analyses across both age and gender; an overview of protective and risk factors; and finally, an overview of the qualitative findings and the discussion and recommendations.

Methodology

Methodology

Study Aim

The main aim of the Thriving Learners study is to improve understanding of the mental health and wellbeing of Scottish students that will lead to recommendations on prevention, early intervention and support of student's mental health and wellbeing within higher and further education institutions. This is the first time an in-depth and wide-reaching study has been undertaken within the Scottish context.

The specific objectives of the study are to:

1. **Investigate the current state of student mental health and wellbeing in Scotland.**
2. **Explore the landscape of provision within each institution including networks, collaborations and gaps between institution supports, local NHS services and community services and networks.**
3. **Explore the relationship between a range of risk and protective factors on learners' mental health and wellbeing and experiences of support. These will include adverse childhood experiences and other life experiences, quality of relationships and social connections, and individual health behaviours.**
4. **Understand what supports and protects the mental health and wellbeing of learners in relation to personal networks, membership of groups and societies and availability/access to specific mental health services.**
5. **Identify evidence of what works/ emerging positive practice to prevent mental health problems and promote wellbeing among learners.**

This large-scale study is being conducted in two phases. Phase 1 explores student mental health and wellbeing within Higher Education Institutes (HEI) in Scotland in the academic year 2020/2021 and phase 2 Further Education Institutes in the academic year 2021/2022. This report is focused solely on the findings from HEI in Scotland.

This work has been funded by The Robertson Trust and conducted in partnership with Universities Scotland, and with support from the Universities Scotland Student Mental Health & Wellbeing Working Group which is chaired by Professor Pamela Gillies.

Governance

Research Advisory Group

A Research Advisory Group (RAG) was established to provide oversight to the running of this project. The RAG comprises of academics and staff working within student mental health and wellbeing in HEIs. There are 12 members representing the following institutions:

- Universities Scotland
- The Robertson Trust
- National Union of Students Scotland
- Glasgow Caledonian University
- Open University in Scotland
- Robert Gordon University
- University of Glasgow
- University of St. Andrews

The group is chaired by Professor Pamela Gillies, Principal and Vice-Chancellor of Glasgow Caledonian University.

The RAG provided input, both practical and methodological, throughout the life of the project. This has ranged from helping to draft the survey, helping with promotion of the survey, guidance with the analysis, helping shape the interviews and identifying interviewees and providing insight for the final recommendations. The RAG will continue to be involved in future analyses and dissemination of findings.

Learner Advisory Group

A Learner Advisory Group (LAG) was also established. This group was recruited through the Universities Scotland Student Mental Health & Wellbeing Working Group which was asked to approach students who were engaged with student mental health. This group comprised of 10 members from the following institutions:

- Abertay University
- University of Dundee
- University of Edinburgh
- Glasgow Caledonian University
- Robert Gordon University
- University of St. Andrews
- University of Strathclyde

- University of the West of Scotland

The group is chaired by Luke Humberstone, Vice President of Welfare & Wellbeing at the University of the West of Scotland.

The LAG has provided input and guidance to ensure that the survey was relevant for students, testing the survey for content and length and helping with promotion.

LAG members were renumerated with a £50 voucher per half day for their time.

Ethical Considerations and Approval

A favourable ethical opinion was granted for this work in November 2020 by the Ethics Committee at the University of Strathclyde. An amendment in December 2020 was accepted for the qualitative component of this work.

Careful consideration was taken in the design of this survey to ensure that participants were not unduly upset by participating and to allow us to collect valuable data on sensitive topics. The survey contained questions concerning adverse childhood experiences (ACEs) and suicidal ideation. It was highlighted in our consent form that questions on these topics were asked and appropriate helplines were signposted at this point. Prior to these questions in the survey itself there was another content warning which, again, had appropriate signposting. Upon completion of the survey there was additional signposting and direct links to the support provided by their individual institution

Consent

Survey

Prior to beginning the survey, participants were presented with a participant information page. This included: information on the purpose of the survey, the survey sponsor, the information being collected within the survey, and how the data will be analysed, used, stored, and destroyed. This page also detailed that participants involvement was voluntary, that they could withdraw from the survey at any point during completion and that they had the option to skip some questions. Also included on this page, were the e-mail contact details of the researchers to allow participants to ask any further questions should they wish to do so.

After presenting the participant with the preceding information, they could then proceed to give their consent to participate in the survey. This page summarised the preceding information to ensure that the participant was clear about what they were agreeing to. Giving their consent then allowed the participant to proceed to the survey questions.

Interviews

Interviews were undertaken with those working in student mental health and

wellbeing services within HEIs. A selection of stakeholders took part and explored the provision of mental health and wellbeing services, both formal and informal, offered within the university as well as barriers, facilitators and gaps around provision of support within their own institution and across the sector.

Participants were provided with information on the purpose of the study, what their involvement would entail, and how the information they provided will be used, stored, and analysed in the form of a participant information sheet. This was made available prior to the scheduled interview. Contact details of the researcher were also included so that participants could ask further questions about the study. To ensure this was understood, we asked participants for written consent (either in-person, via a scanned signature, or typed signature). Where consent was given via a typed signature, we also asked participants to provide their consent via e-mail. Oral consent was also sought before the interview began.

Data Collection

Survey

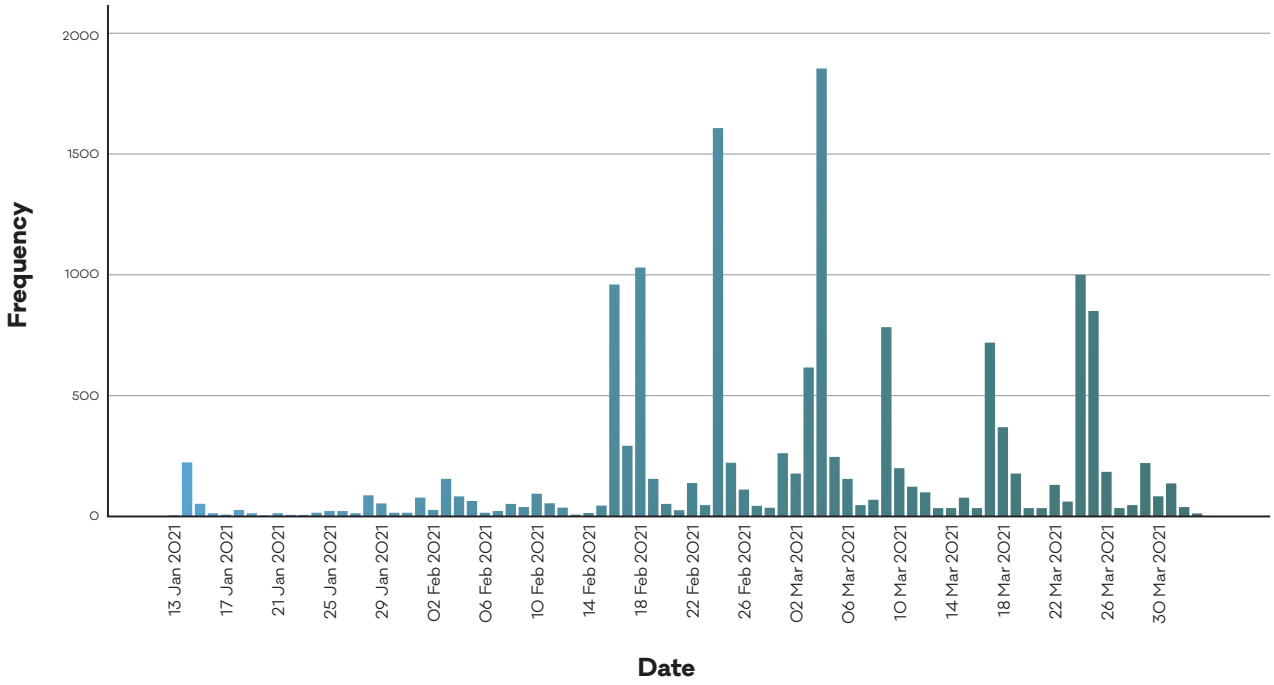
For time and reach purposes we elected to implement self-selecting sampling. This ensured that we could reach the highest number of students in the time available. Communication plans were created in conjunction with individual HEIs to reach as many students as possible within the institutions. These plans included targeting student facing communications such as social media accounts (primarily Twitter but Facebook, LinkedIn and Instagram were also used), student intranets and student newsletters. These approaches had limited success in the early stages of data collection. It was established that the most effective method of generating responses was an all-student e-mail from a central communications team; 15 of the 19 HEIs sent an all-student e-mail.

The survey was live from 13 January 2021 to 2 April 2021. After consultation with the communications teams from the HEIs we elected to have the data collection period open for longer and to target promotion within HEIs individually, rather than launching to the sector as a whole. This was due to other commitments that the HEIs had, most notably the National Student Survey which is live from January to March each year. This approach allowed us to work with each HEI to find time that worked for them to promote the survey to their students. However, all students were responding to the same survey link meaning that any student from any institution could answer at any point during the data collection period.

There was an incentive of £200 of voucher prizes available per institution; two £75 vouchers and one £50 voucher.

The survey was distributed via SmartSurvey. Please see the table below for a breakdown on when responses were submitted.

Table 1. Response dates



Interviews

The interview data collection period was April 2021 to June 2021. Participants were recruited using snowball sampling. The members of the Universities Scotland Mental Health & Wellbeing Working Group were our access point to staff members within their HEIs. In some instances, the members of that group were participants, depending on their position within their HEI. Participants were not remunerated for their participation.

Design

Survey

Our primary aim of this survey, as outlined by Outcome 1, was to investigate the current state of student mental health and wellbeing. We used validated measures where possible. Our other aims were to examine a range of protective and risk factors that may play a role in student mental health and wellbeing. To this end a number of questions about friendships, relationships, general health, exercise, membership of student societies, coping mechanism (both positive and negative) and adverse life experiences were asked.

The survey was designed to take no longer than 15 minutes and consists of mostly closed questions. These decisions were taken to increase the chances of initial, and sustained, engagement from participants. This is not, and was not designed to be, an exhaustive study on all factors that can impact student mental health and wellbeing and will not be presented as such. Which questions were included in the final survey was informed by our RAG and LAG groups.

Three validated scales were utilised in the survey:

- The 10-point ACEs scale – The CDC-Kaiser Permanente Adverse Childhood Experiences (ACE) Study is one of the largest investigations of childhood abuse and neglect and household challenges and later-life health and wellbeing.
- The Patient Health Questionnaire-9 [PHQ-9] – The PHQ 9 is the depression self-administered module from the PRIME - MD diagnostic instrument for common mental disorders. It is an open access screening instrument for depression regularly used within health and social care settings and general population surveys.
- The 7-point SWEMWBS scale - The Warwick-Edinburgh Mental Wellbeing Scales[25] were developed to enable the measuring of mental wellbeing in the general population and the evaluation of projects, programmes and policies which aim to improve mental wellbeing. The items are all worded positively and cover both feeling and functioning aspects of mental wellbeing, thereby making the concept more accessible. The scale has been widely used nationally and internationally for monitoring, evaluating projects and programmes and investigating the determinants of mental wellbeing. In this survey, the Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS) was used, this is scored from 7-35, as opposed to the full WEMWBS, scored out of 70. Below the mean is presented across the overall sample, age and gender as well the level of 'Low', 'Moderate' and 'High' wellbeing, using the cut-off points from the University of Warwick scoring template, across the overall sample, age and gender. The cut-off points are: a score of less than 20, 'Low', a score of 20-27, 'Moderate' and a score of more than 27, 'High'.

Other questions in the survey mirror questions within other large data collections in both Scotland and the UK. This will allow for general population comparisons and comparisons with similar studies conducted with students elsewhere. The surveys used for this have predominately been the Scottish Health Survey, the NUS Think Positive survey and the Northern Ireland Mental Health Youth Prevalence study.

The survey was tested for both content and length by our LAG and two separate Pilot Groups. The Pilot Group participants were renumerated with a £15 voucher for an outlet of their choice.

The survey was anonymous, insofar as no personal identifiers such as name or e-mail address were asked in the survey. Students domiciled in Scotland were asked to provide a postcode to allow for Scottish Index of Multiple Deprivation (SIMD)

analysis; these postcodes were stripped from the data set after being converted by the SIMD toolkit. The prize draw was made available at the end of the survey in the form of a link to another survey so that survey responses were not linked to an e-mail address in the prize draw.

Interviews

The primary aim of the interviews was to gain insight into current provision within HEIs to support student mental health and wellbeing as well as views into barriers and facilitators to accessing support, the relationship between HEIs and broader mental health supports (including third sector and NHS) and gaps in provision. The discussion guide was informed by the RAG and the LAG and provided opportunities for open discussion and reflection by the interviewee.

Response Rates

Survey

Overall, there were 15,128 respondents to the survey. This figure equates to a 6% sample of the Scottish HEI student population[26]. There were responses from every HEI in Scotland and the breakdown per institution is detailed in the Demographic section of this report.

This number has been defined by the number of respondents who consented to take part in the survey and told us which HEI they attended; both questions were mandatory at the start of the survey. If a respondent did not consent and did not select an HEI then they were routed to the end of the survey. The figure of 15,128 has been used as the base to calculate response rates to the other questions. Tables outlining the response rate for each section of the survey are provided in Appendix 1.

Interviews

The interviews were conducted on a mixture of Microsoft Teams and Zoom. In total, fifteen interviews and seven focus groups were conducted in the data collection period, coming to a total of thirty-five participants. Please see the table below for this breakdown.

The interviews and focus groups came from the following institutions and organisations:

- University of Aberdeen
- Abertay University
- University of Dundee
- University of Edinburgh
- University of Glasgow
- Glasgow Caledonian University
- University of the Highlands and Islands

- Open University in Scotland
- Robert Gordon University
- University of St. Andrews
- University of Stirling
- University of Strathclyde
- University of the West of Scotland
- Scottish Funding Council
- COSLA
- The Robertson Trust

Analysis

Survey

The survey data were collected on a secure SmartSurvey account. Once the data collection period had closed the data were downloaded from SmartSurvey and cleaned on a combination of Excel and SPSS. As part of the cleaning process any identifiable information such as IP address was stripped from the data set. After postcodes had been converted into the relevant SIMD data they were also stripped from the data set. Once the data were cleaned, they were then deleted from SmartSurvey as per our ethical guidance.

Analyses were run on both SPSS and R by different members of the research team. The descriptive statistics have been fully validated on both platforms to ensure robustness. All questions were analysed by age and gender. To test for association either a chi-square test or a Kruskal-Wallis test was conducted, followed by post-hoc Mann-Whitney U tests to investigate specific group differences. It is detailed in the body of the report which test has been utilised for which data. Effect sizes were also calculated for analyses conducted – these will either be referred to within the text or be available in Appendix 4.

For the analysis throughout the report the data set has been treated as a whole with no data at individual HEI level presented. Furthermore, this report contains only the first wave of unadjusted analysis and reporting. This covers the descriptive statistics, displayed by both age and gender and a deeper look at the validated measures against certain protective and risk factors. Future analyses will take place on this data and will inform a series of briefing papers and journal articles on specific topics from the data. This will ensure that more in-depth analyses can be peer reviewed.

Interviews

Once the interviews were conducted, interviewee details were anonymised. Code names were allocated upon completion of the interview. Therefore, audio recordings and subsequent transcriptions were labelled with a generic code, for example 'Participant1'.

The interview data were analysed thematically via a coding framework by different members of the research team. Similar to the survey data, the interview data will be presented as a whole in this report and individual HEIs will not be identified in the text.

Limitations

Self-selecting sample

For time and reach purposes we elected to implement self-selecting sampling. This ensured that we could reach the highest number of students in the time available. All students were given an equal opportunity to engage with the survey but there was no onus on them to do so. This may have resulted in self-selection bias within the sample, insofar as those who wanted to engage with the survey have done so. Furthermore, this may in some way account for the high levels of question completion rates within the survey.

Cross-sectional data

As a result of our sampling method, it is important to note that the data presented in this report are cross-sectional and thus meaning we cannot establish causality between factors and instead we are highlighting associations between different measures used and looking at whether there are differences on one measure when we look at levels of another measure.

Representation

As a result of the sampling method our sample is not representative of the entire HEI student population in Scotland. The sample is over-represented by females and those identifying as other genders and under-represented by males. There is also an over-representation of EU-domiciled students. For most other demographics the sample is broadly representative, this is discussed in greater length in the Demographics chapter.

Question changes

Two questions were changed at an early point during the data collection period. One question relating to trans identification was deemed to not meet best practice in its original guise therefore after this was highlighted it was reframed. Additionally, when the survey was first published it had the validated measure General Health Questionnaire-12 [GHQ-12] but that was removed for copyright reasons and replaced with the Patient Health Questionnaire-9 [PHQ-9]. There were limited amounts of GHQ-12 data collected but none will be presented within this report. Both question changes were approved by the Ethics Committee at the University of Strathclyde.

Imperfect questions

There are some questions in the survey that are either imperfect, contained an error in the wording or there was an error with the survey software.

Question 7 – pertaining to ethnicity. We sought to align with national data sets in the options for this question and included a text box for categories that were not covered in our options. There was some confusion between ethnicity and nationality both in some of the options provided and also the other options returned by participants. As a result, this data should be treated with a degree of caution.

Questions 8 and 33 – pertaining to disability and service usage and awareness. These questions provided a list of options from which respondents could select from. A quirk in the survey software resulted in anybody who skipped the question being classified as a negative response to the question. This resulted in the questions appearing to have a 100% response rate as the software counted everybody, including those who had stopped responding to the survey at that point. The figures for these questions have been calculated by replacing negative values with missing values for respondents who had not answered three questions either side of the question; these participants were considered to have dropped out of the survey by that point.

Question 19 – pertaining to exercise. This question did not include an option for '0' days of exercising, this has possibly resulted in the figure for 1 day of exercising as being artificially high. These data should be treated with caution.

Question 31 – pertaining suicidal ideation and attempting to kill yourself. These two options were asked in the one question meaning it is impossible to disaggregate these responses from each other. As a result, this data should be treated with caution when being reported on.

Weighting

We elected not to weight the gender data for analysis in this report. Weighting the data may be revisited in future analyses, particularly if the data from Phase 1 and Phase 2 are ever presented together.

Interview range

Interviews across a greater number of HEIs and stakeholders were planned prior to the data collection period. However, due to time constraints on the data collection period the range of interviews conducted is fewer than anticipated.

Student interviews

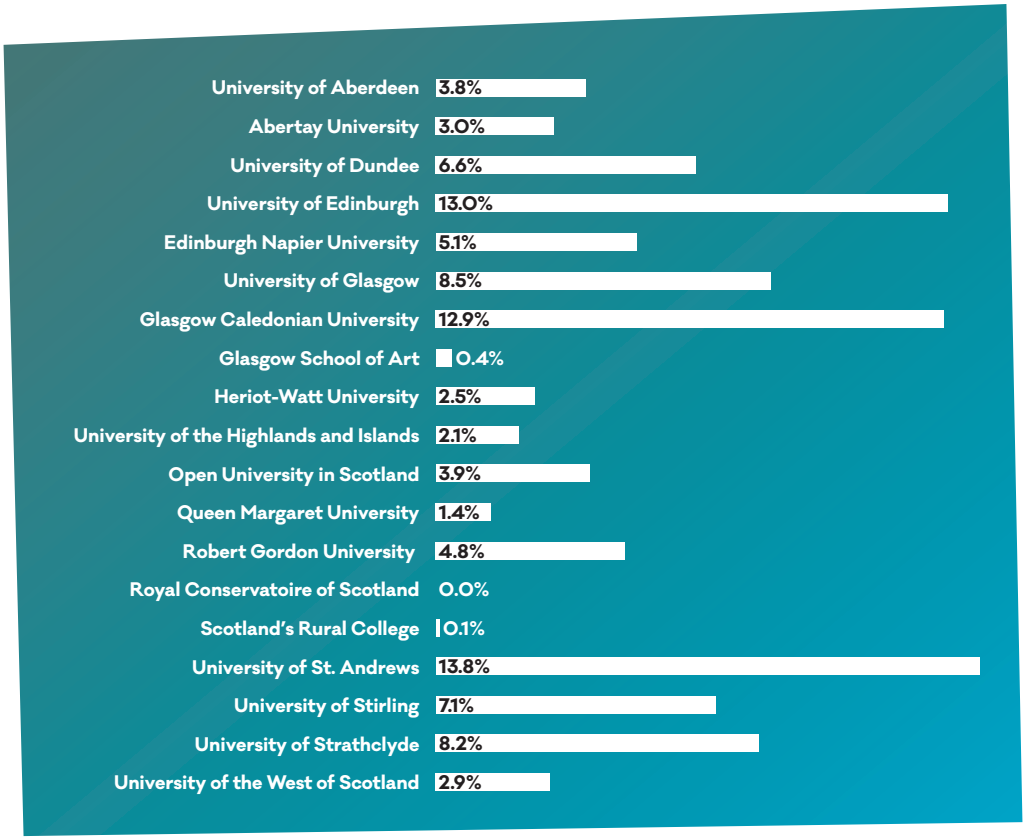
There was no plan to include interviews with students within this study as they were being represented in the survey. In hindsight the qualitative data may have benefitted from a student voice within it. This is something that could be considered for future iterations of this work.

Demographics

Demographics

This section outlines the Scottish HEI sector demographics to serve as a reference point for the survey sample which is detailed below. Unless stated otherwise all figures have been taken from the most recent figures published by Higher Education Statistics Agency[26] (HESA). Graph 1 provides the study completion rates by percentage of students at each institution.

Graph 1. University response.

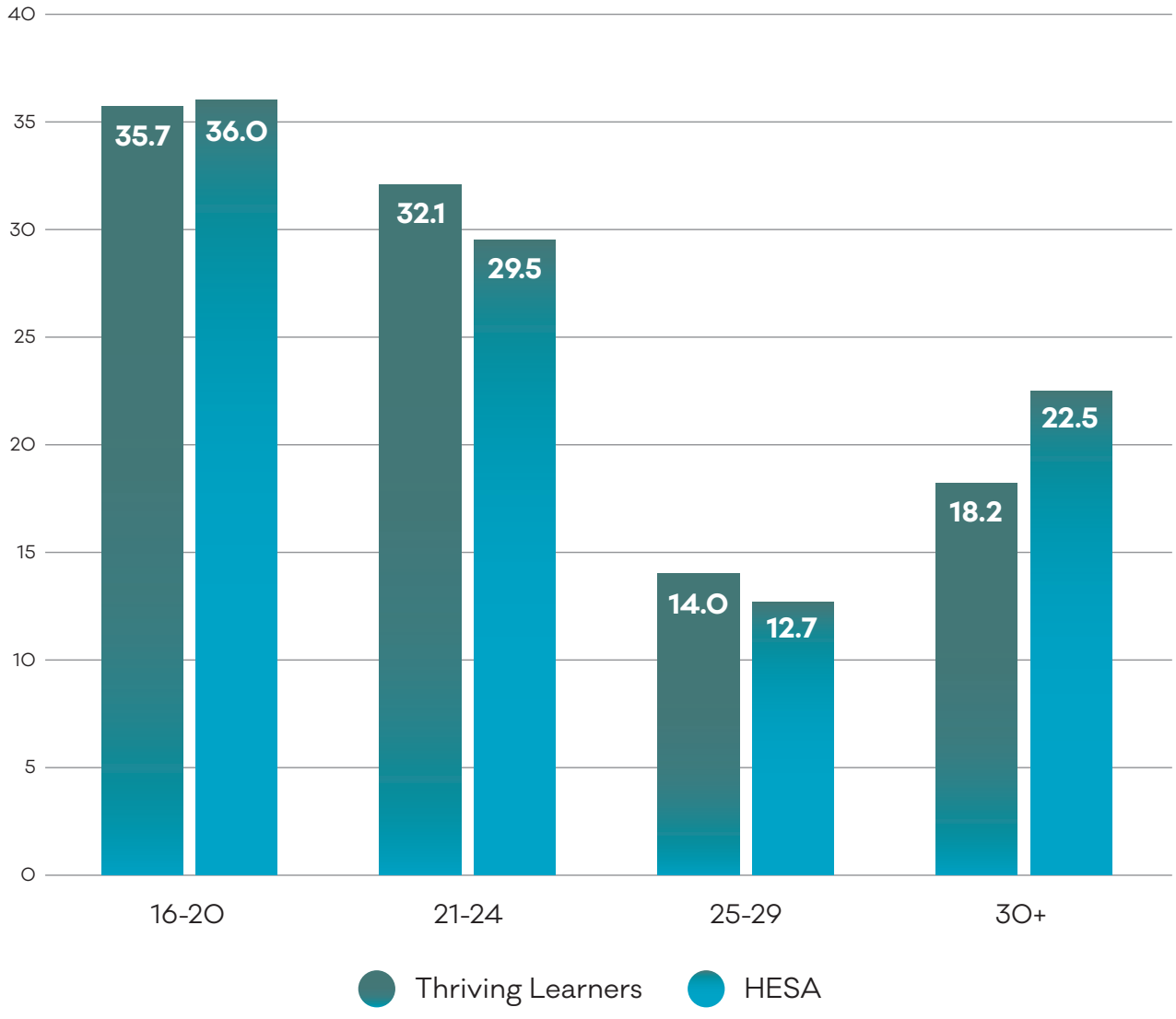


n = 15,128

Age Profile

The sample is slightly underrepresented within the oldest age group (30+) and slightly over-represented across the 21-29 age ranges. However, overall, the sample is robust in terms of age representation.

Graph 2. Age profile v HESA.



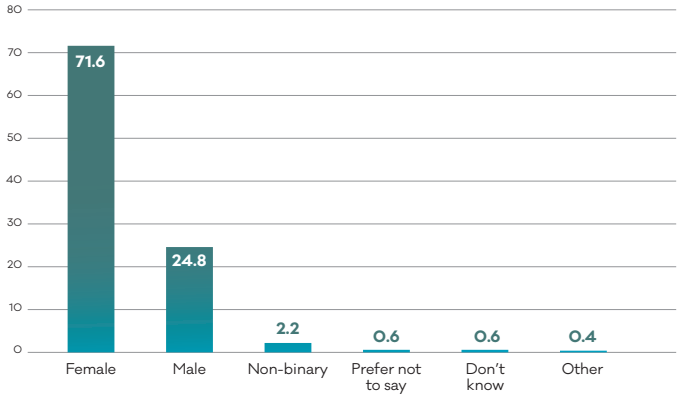
n = 14204

Gender Profile

Nearly three-quarters (71.6%) of respondents were female and just under a quarter (24.6%) were male. A further 2.2% were non-binary, 0.6% preferred not to say, 0.6% didn't know and a final 0.4% identified as another gender not listed here.

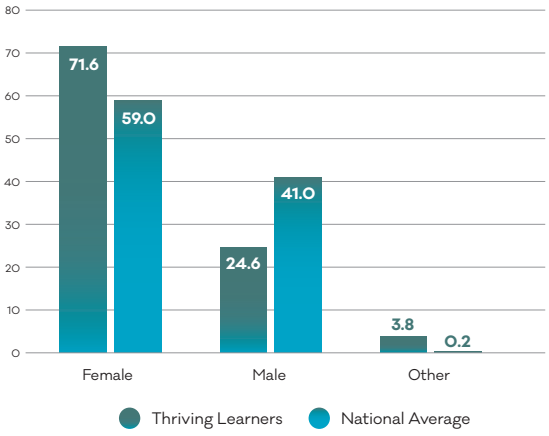
Females are noticeably overrepresented in the sample. The sample is also overrepresented in 'Other' genders – which nationally only account for 0.2% reported 'Other' genders. For the purposes of presenting cross tabulated data later in the report we have combined all non-binary categories of gender as 'Other', to allow it to be reported on. However, some caution should be used in comparing these figures with the national average due to potential differences in how this data is collected.

Graph 3. Gender Profile



n = 14301

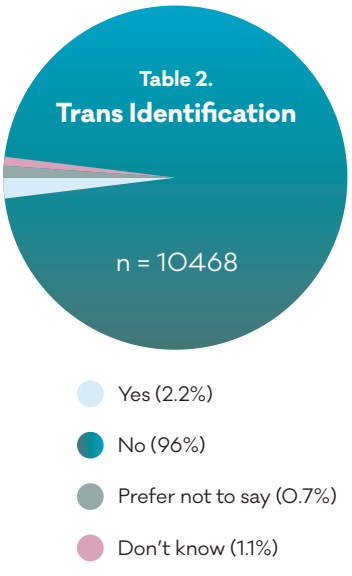
Graph 4. Gender profile v HESA



n = 14301

Trans Identification

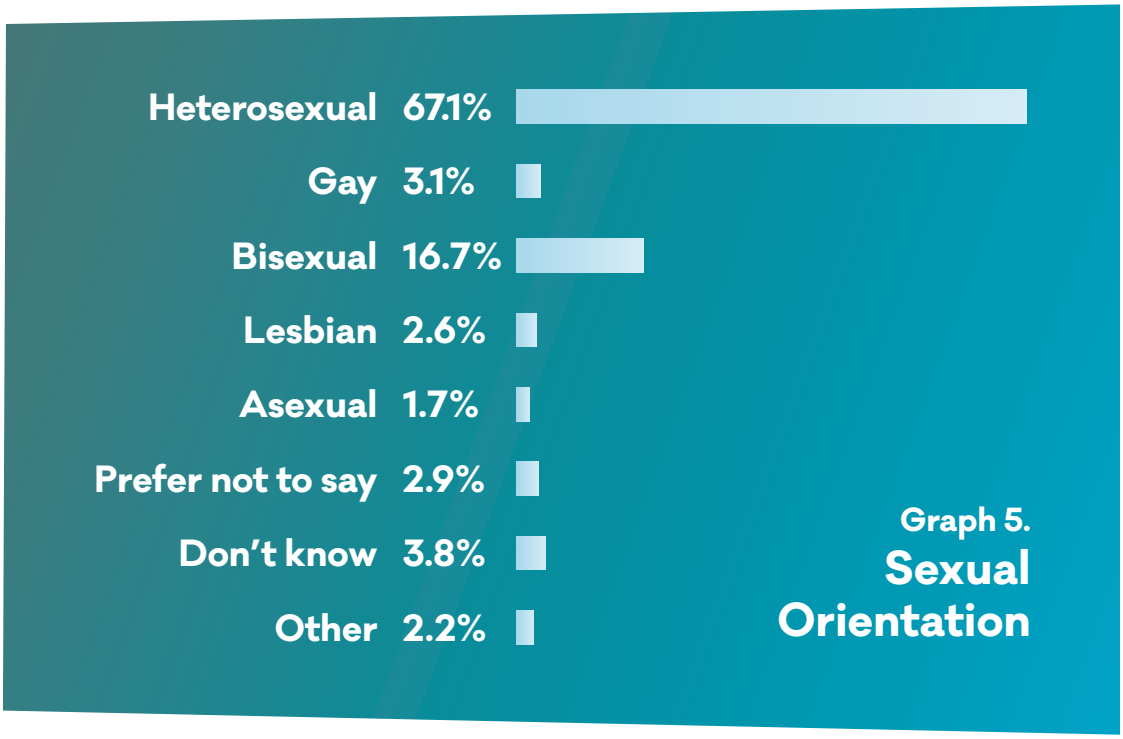
2.2% of 10,468 respondents identified as trans – at time of publication there are no HESA or national data set figures to compare with. This question was changed during the data collection period – see methodology section for further details. Nearly half (48.9%) who considered themselves to have a trans identify identified as non-binary, over a quarter (28.3%) as male and 12.9% as female.



Sexual Orientation

Over two-thirds (67.1%) identified as being heterosexual. 1 in 6 (16.7%) identified as being bisexual and a collective 5.7% identified as gay and lesbian.

The Sexual Orientation in Scotland (2017) release reported that 96% of adults in Scotland were heterosexual and 2% were classed as Lesbian, Gay, Bisexual or Other (LGBO), a further 3% either did not know or chose not to say. However, 29% of all LGBO adults were aged 16-24 and another 20% were 25-34, age categories that broadly cover the sample. Whilst the sample is underrepresented in heterosexual respondents compared to the national Scottish population, we also know that adults who identify as LGBO are likely to be younger, which may account for some of this difference.



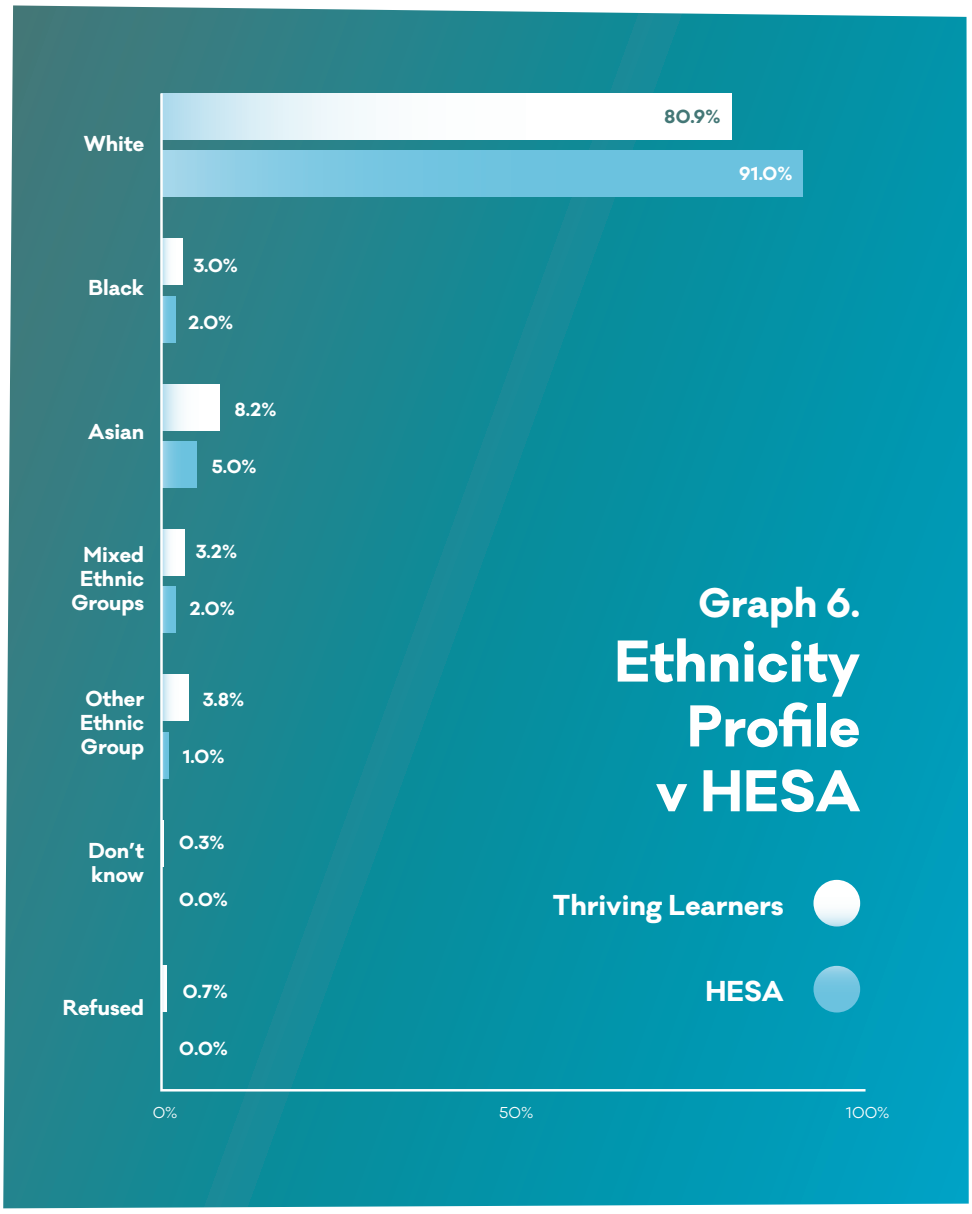
Graph 5. Sexual Orientation

n = 14278

Ethnicity

The sample is underrepresented in White students and overrepresented in Black, Asian, Multiple or Mixed Ethnic Groups and Other Ethnic Groups. Due to a difference in presentation of data there is no comparative figure for Don't Know or Refused in the HESA figures.

Our methodology for collecting this data differed from HESA and the groups listed above are comprised from a broader range of ethnic groups. For further breakdown of ethnicities please see Appendix 1 – Tables 7a and 7b.



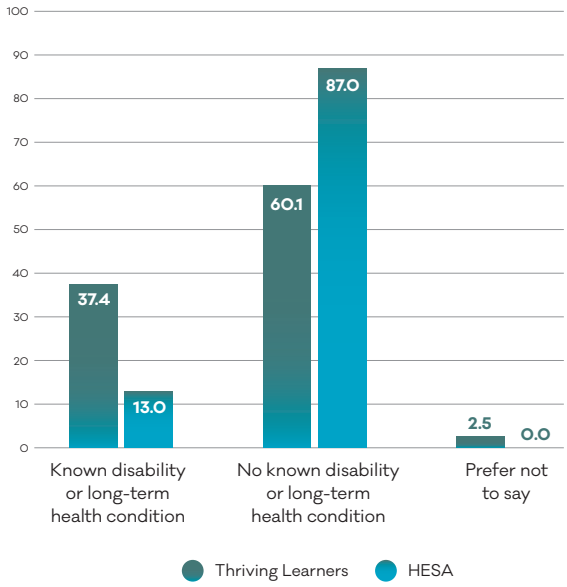
n = 14290

Disability

The sample is overrepresented in terms of students with a known disability or long-term health condition. Again, there may have been a difference in the methodology for these questions, so some caution is warranted when comparing the figures.

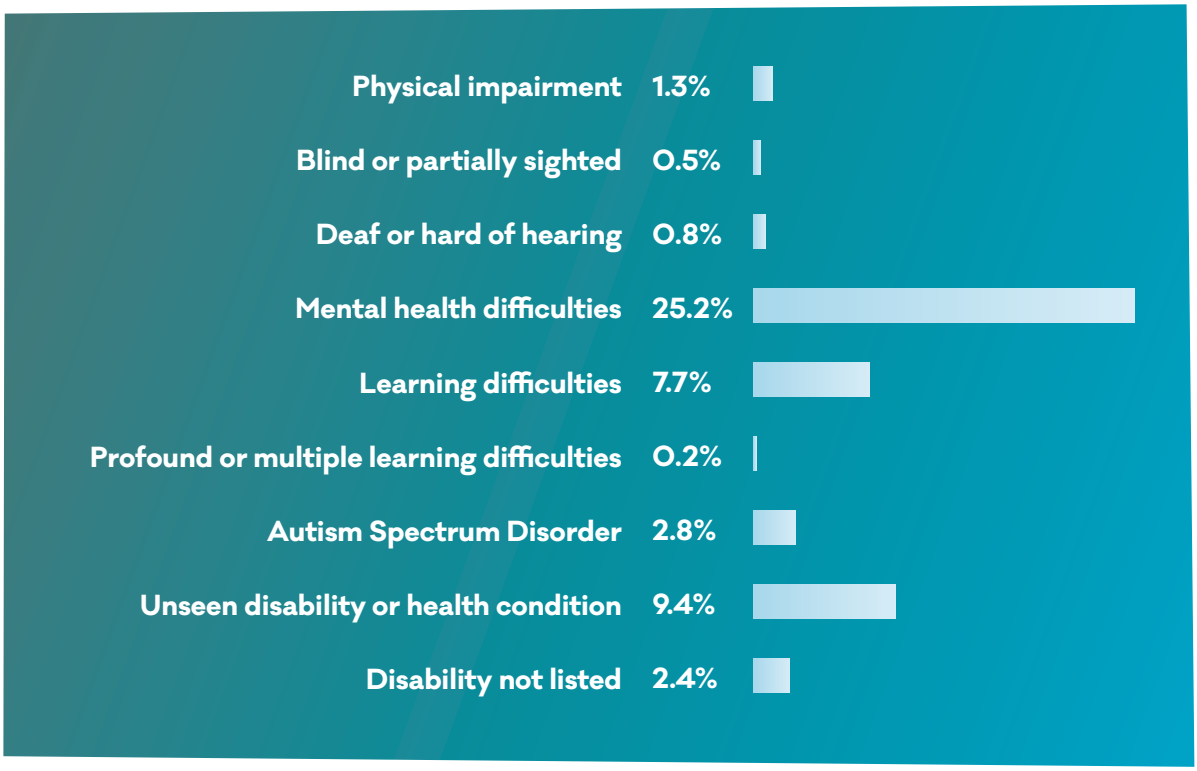
The largest identified disability or long-term health condition was 'Mental health difficulties' with a quarter (25.2%) of respondents identifying with it. The next largest category with just under 1 in 10 (9.4%) was unseen disability or health condition.

Graph 7. Disability or long-term health condition profile v HESA



n = 14308

Graph 8. Type of disability or long-term health condition



n = 14308

Full-time or Part-time Student

The sample has an overrepresentation of full-time students and subsequently an underrepresentation of part-time students.

Undergraduate or Postgraduate

The sample is very close to the HESA figure across the undergraduate and postgraduate split.

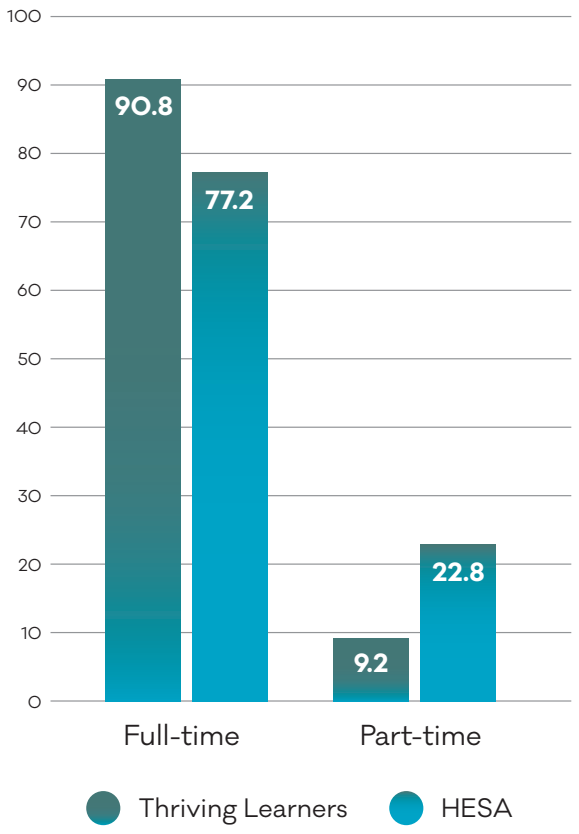
75% undergraduate respondents consisted of:

- 1st Year – 24%
- 2nd Year - 20%
- 3rd Year – 17%
- 4th Year – 13%

25% postgraduate respondents consisted of:

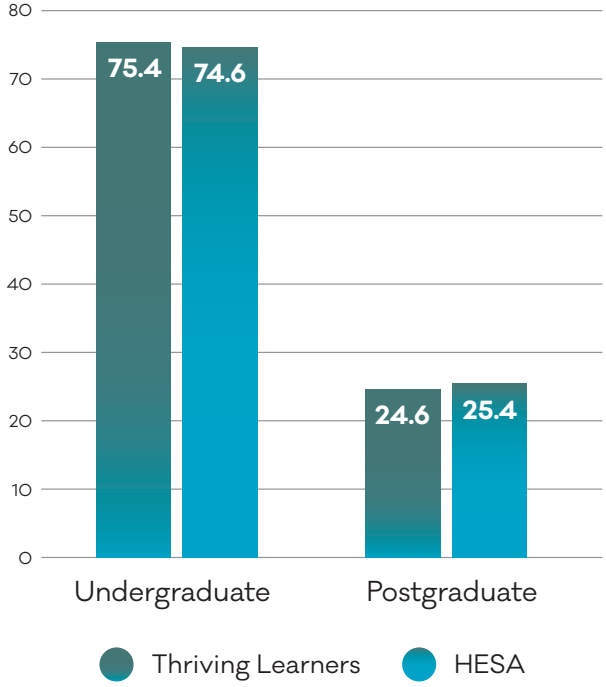
- 2% Diploma
- 16% Masters
- 7% PhDs

Graph 9. Full-time or Part-time profile v HESA



n = 14254

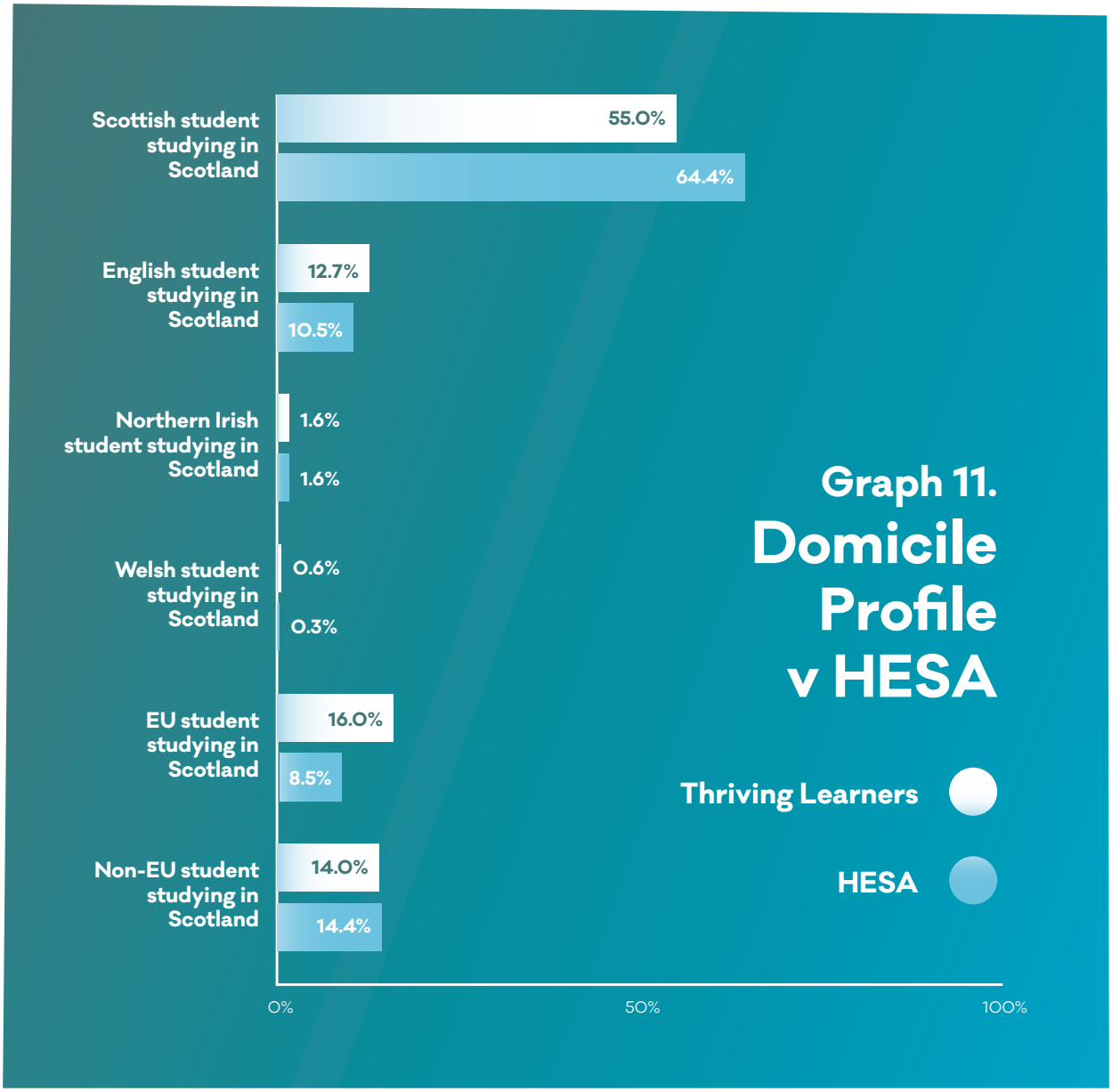
Graph 10. Undergraduate or postgraduate profile v HESA



n = 14268

Domicile

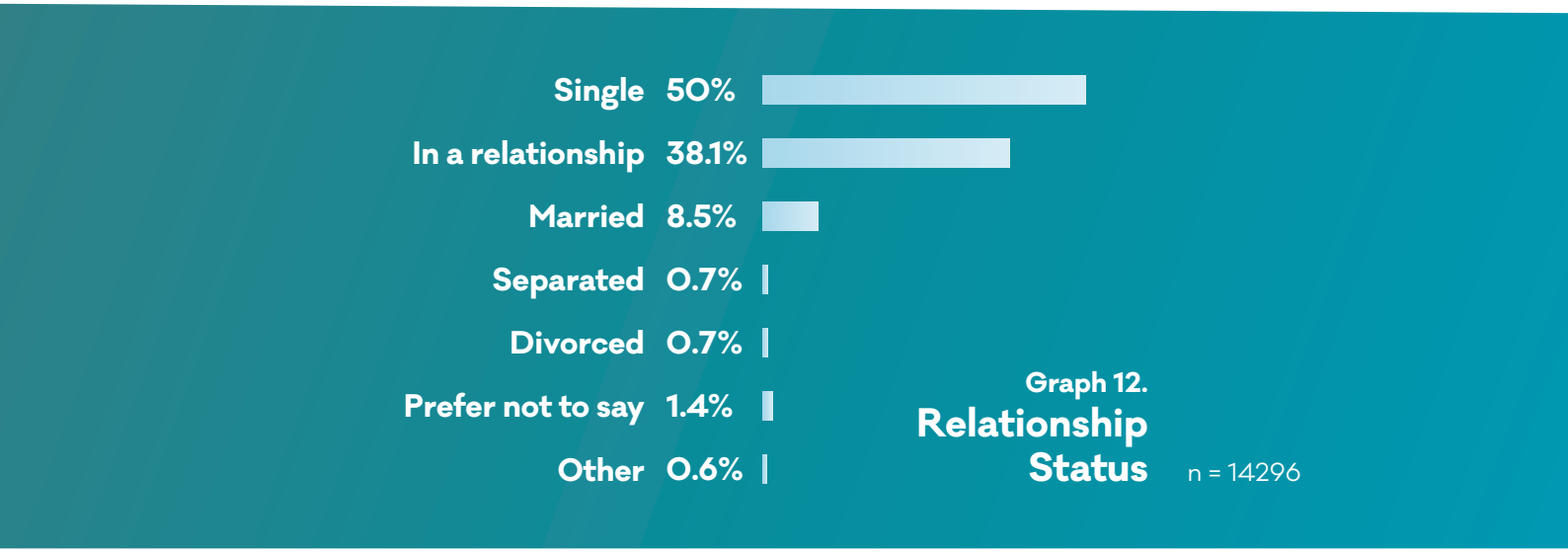
There is an underrepresentation in Scottish domiciled students, a slight overrepresentation in English domiciled students and a noticeable overrepresentation in EU domiciled students. The remaining categories are close to the respective national figures.



n = 14259

Relationship Status

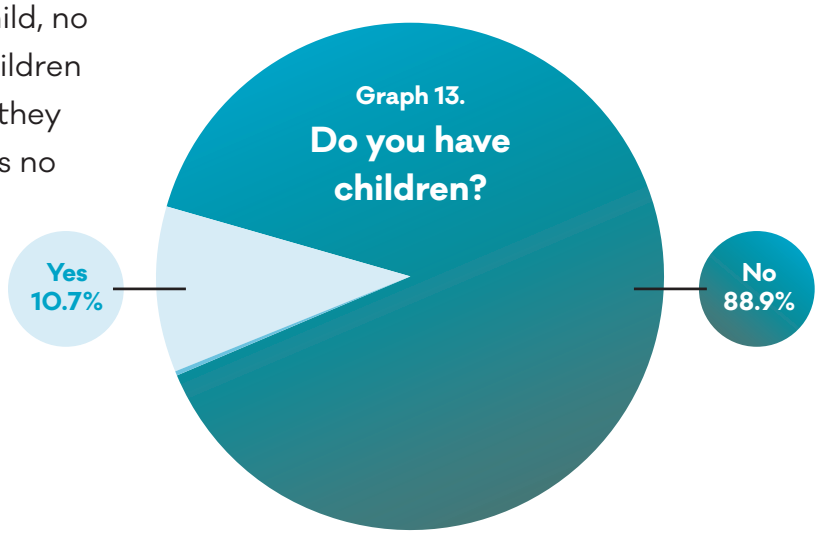
Half (50%) of respondents were in single, a further 46.6% were either in a relationship (38.1%) or married (8.5%). 0.7% were separated and another 0.7% were divorced. 1.4% preferred not to say and 0.6% defined their relationship status in another way. There is no comparable HESA data available.



Graph 12.
Relationship Status
n = 14296

Children

1 in 10 (10.7%) respondents had children. It should be noted that the question simply asked whether they had a child, no data was collected on how many children a respondent may have or whether they were the primary care giver. There is no comparable HESA data available.

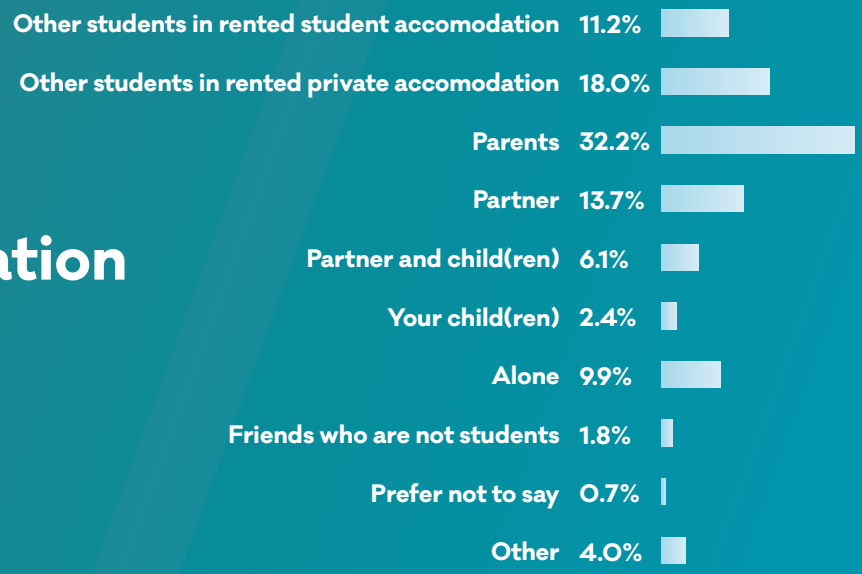


Graph 13.
Do you have children?
n = 14278

Accommodation Status

Nearly a third (32.2%) of respondents lived with their parents, the biggest response in any one type of accommodation. Just under another third (29.2%) lived with other students either in rented student accommodation (11.2%) or rented private accommodation (18.0%).

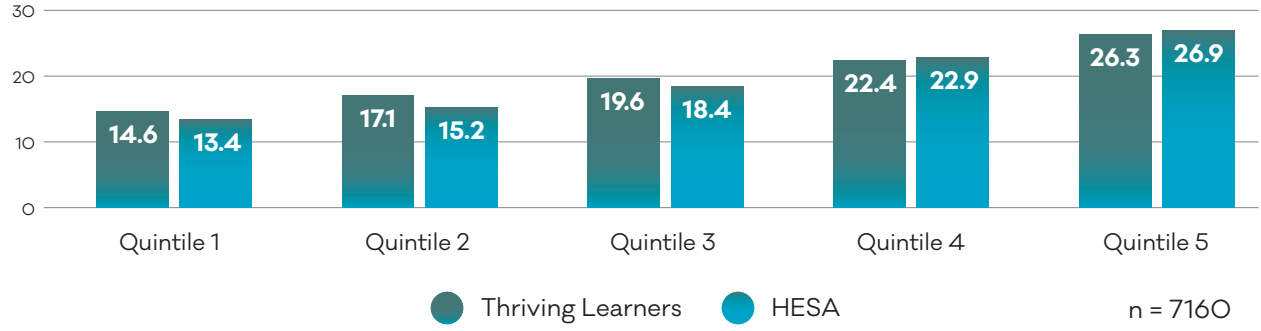
Graph 14.
Accommodation Status
n = 14294



SIMD

The sample largely mirrors the HESA data, although with a slight overrepresentation in students from the lower Quintiles (1-3) and a slight underrepresentation in students in the higher Quintiles (4-5).

Graph 15. SIMD profile v HESA



Employment

The majority (57.4%) of respondents did not have a job. The remaining 42.6% did have a job. Of those who did have a job they worked the following hours:

- 23.3% worked 0-15 hours
- 11.2% worked 16-28 hours
- 2.3% worked 28-35 hours
- 5.8% worked 35+ hours%

Graph 16.
Employment Status

Has a job (42.6%) Does not have a job (57.4%)

n = 14279

Health and Wellbeing

Health and Wellbeing

This section reports on the questions the survey asked concerning respondents health and wellbeing.

Respondents were asked to complete the Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS) as well being asked questions about their general health and exercise levels. The section will provide some context to national data sources, where available and comparable, and then show a summary of the key findings. Following that it will show each response to a question, then a summary of the breakdown by age and then by gender, followed by graphs showing this information. Additional information can be found in the Appendices.

Context

Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS)

The Scottish Health Survey uses the Warwick-Edinburgh Mental Wellbeing Scale[27] (WEMWBS) to measure wellbeing at national level for Scotland. WEMWBS is scored from 14-70 with a higher score generally indicative of better wellbeing.

In the most recent published figures (from 2019 but revised in 2020 the national mean score for wellbeing was 49.8, which sits in the 'Moderate' level. This was slightly lower for men (49.3) than it was for women (49.6). The means for younger age groups, 16-24 (49.5) and 25-34 (49.1), were broadly in line with the national mean.

General Health

The Scottish Health Survey[27] reported that 71% of adults described their health as 'good' or 'very good'. Slightly more men (72%) reported 'good' or 'very good' health than women (71%). Younger age groups were higher than the national average, with 85% of those aged 16-24 and 80% of those aged 25-34, describing their health as 'good' or 'very good'.

Summary

SWEMWBS figures are lower than the Scottish national figures. The mean of respondents sits within the 'Low' wellbeing level compared with national mean sitting within the 'Moderate' wellbeing level:

- 73.5% reported 'Low' wellbeing
- Wellbeing was generally higher for male students and older students but still low overall.
- Low wellbeing decreases through the age groups with nearly four-fifths (78.1%) of those aged 16-20 reporting Low wellbeing compared with 61.9% of those aged 30+
- Other genders have noticeably lower wellbeing than both males and females, having a higher score for Low wellbeing (84.9%) compared to females (74.8%) and males (68.0%)

General health of respondents is noticeably lower than the Scottish national figure (60% 'Good' or 'Very good' v 71% 'Good' or 'Very good'.

- Self-reported general health across the age groups is similar

Exercise levels varied across genders, with other genders reporting lower levels of exercise than females and males, but not age groups.

Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS)

Nearly three-quarters (73.5%) of respondents reported having Low wellbeing. Just under another quarter (24.7%) reported having Moderate wellbeing and 1.7% reported having High wellbeing.

The mean score for respondents was 18.65, which falls into the 'Low' level.

SWEMWBS by Age

Reporting of Low wellbeing decreases through the age groups with nearly four-fifths (78.1%) of those aged 16-20 and over three-quarters of those aged 21-24 (76.3%) reporting Low wellbeing compared with the 71.0% of those aged 25-29 and 61.9% of those aged 30+.

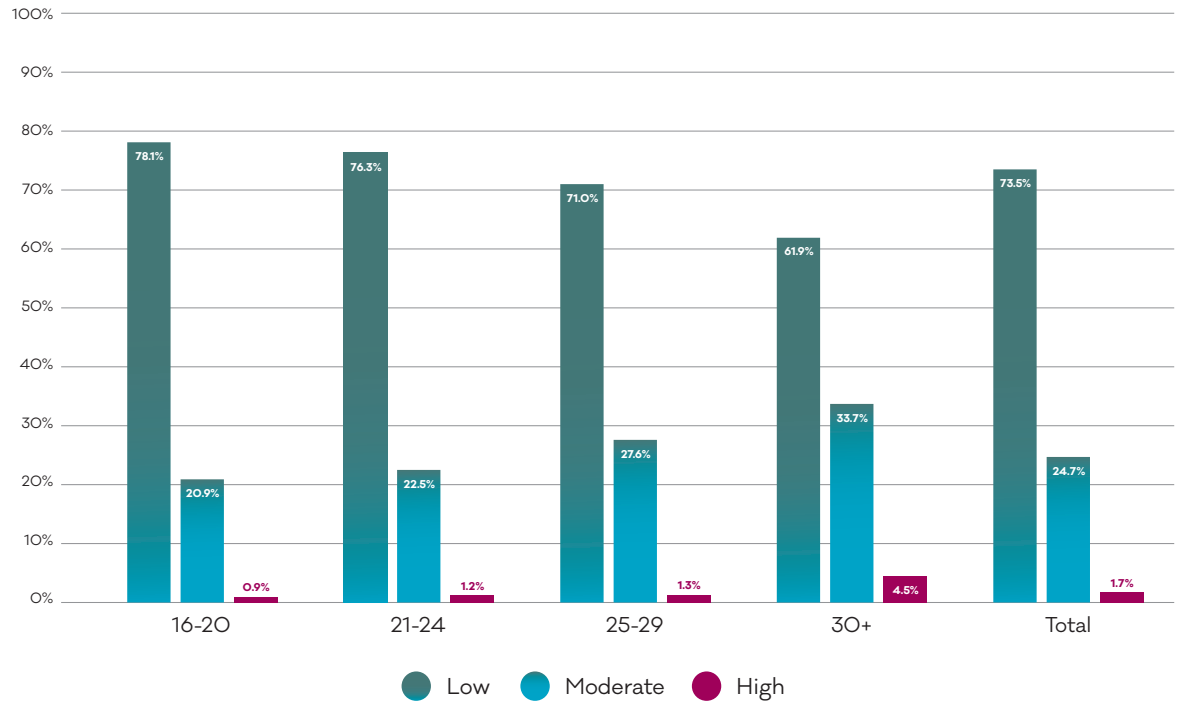
A Kruskal-Wallis test showed there was a significant difference across all groups, H (3) = 271.65, p < .001). Bonferroni corrected post-hoc Mann Whitney U tests explored this effect. All groups were significantly different from all other groups (all p < .001) except for the comparison between the 16-20 and 21-24 age groups (p = .244). This indicated that the younger age groups (16-20 and 21-24) reported lower wellbeing than the older groups.

SWEMWBS by Gender

Other genders have noticeably lower wellbeing than both males and females, having a higher score for Low wellbeing (84.9%) and lower scores for Moderate (14.8%) and High (0.4%) wellbeing compared to males (Low = 68.0%, Moderate = 28.6% and High = 3.4%) and females (Low = 74.8%, Moderate = 23.9% and High = 1.2%). Females also have worse outcomes than males, having a higher score for Low wellbeing and lower scores for Moderate and High wellbeing.

A Kruskal-Wallis test showed that there was a significant difference across groups, H (2) = 106.43, p < .001). Bonferroni corrected post-hoc Mann Whitney U tests explored this effect. All groups were significantly different from all other groups (all p < .001).

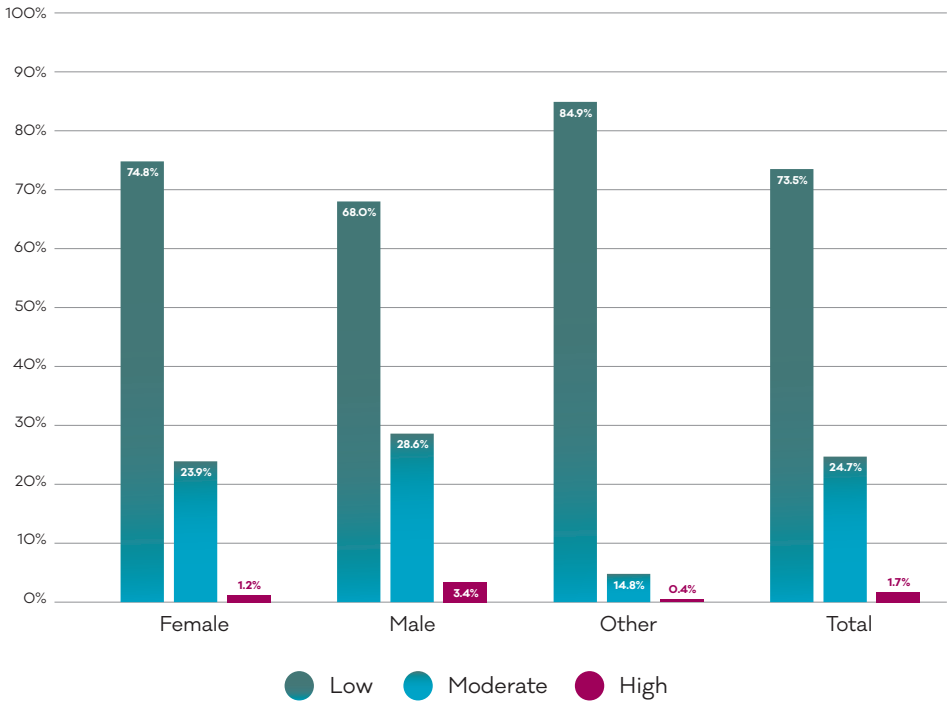
SWEMWBS by Age



Graph 17. SWEMWBS by Age

n (age) = 13832 n (total) = 13941

SWEMWBS by Gender

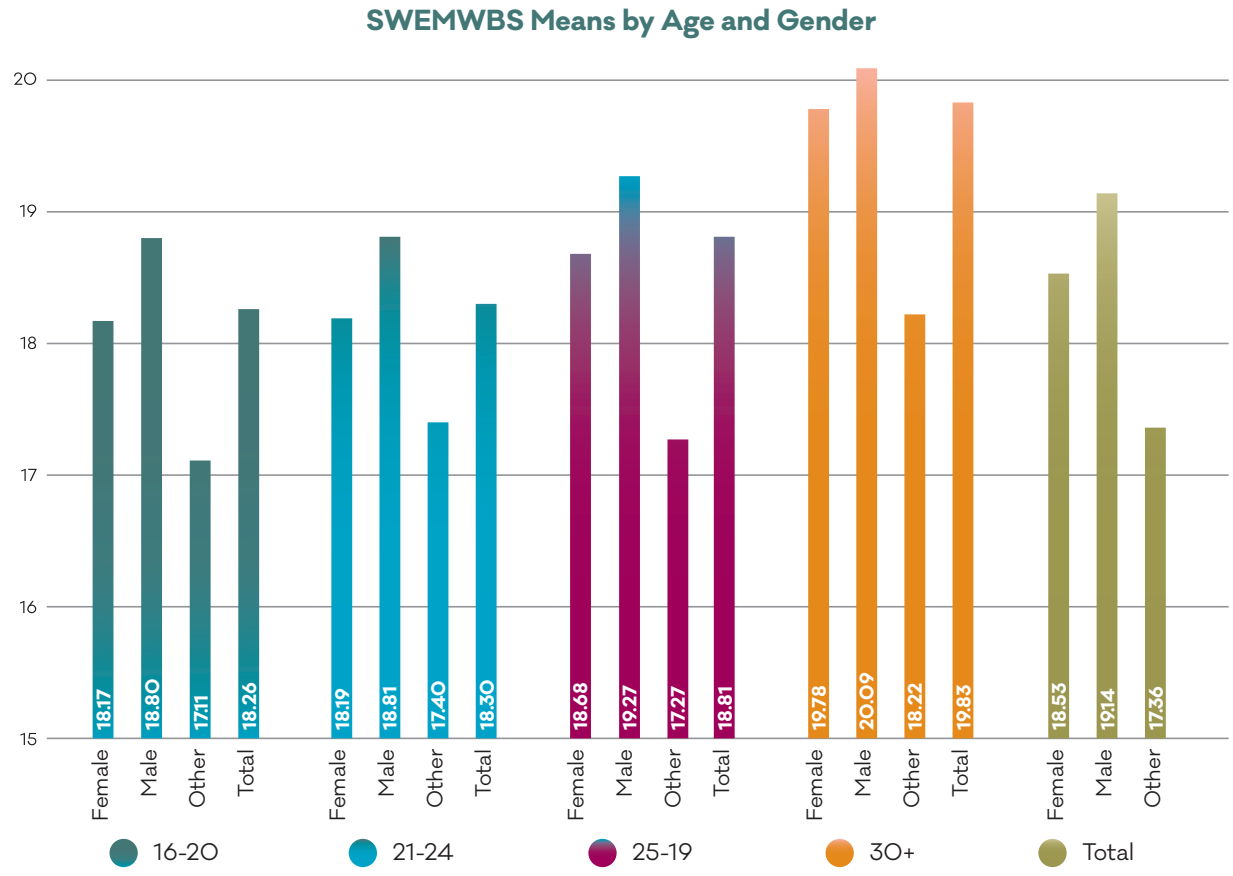


Graph 18. SWEMWBS by Gender

n (gender) = 13927 n (total) = 13941

SWEMWBS by Mean

In general, males had higher SWEMWBS scores than females who in turn had higher scores than other genders and wellbeing increased through the age groups. One group, males aged 30+, had a score of over 20, meaning they were the only group in the 'Moderate' level.



Graph 19. SWEMWBS Means by Age and Gender

n (age/gender) = 13832 n (total) = 13941

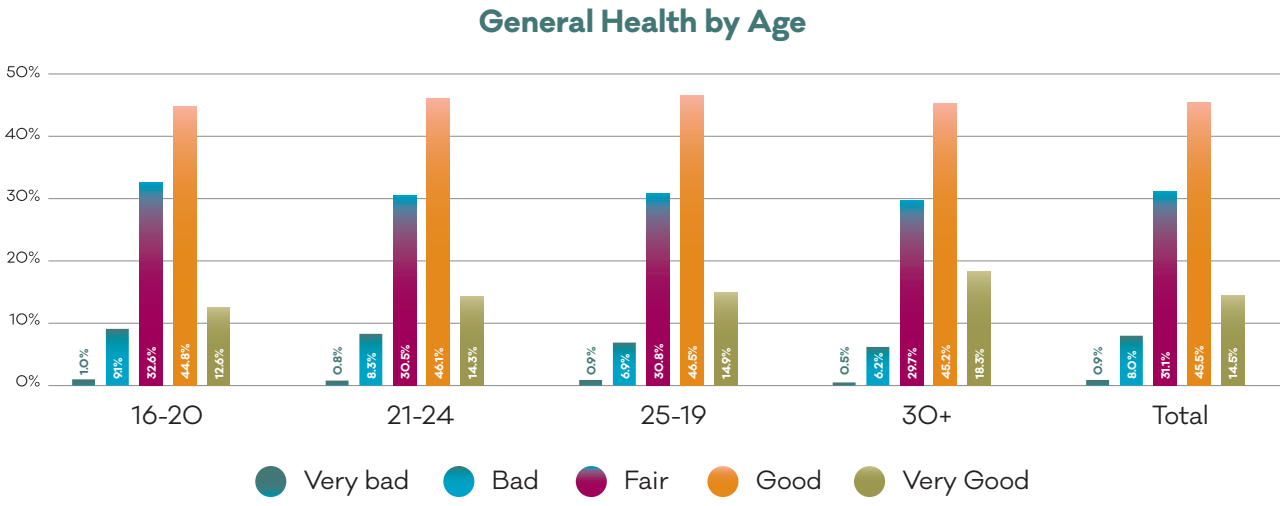
General Health

6 in 10 (60.0%) respondents reported that their health was Good or Very Good. Just under 1 in 10 (8.9%) reported that their health was Bad or Very Bad. Just under a third (31.1%) reported that their health was Fair.

General Health by Age

Self-reported general health across the age groups is similar with those in the oldest age group, 30+, having slightly higher scores for Good and Very Good (63.5%) compared to those in the youngest age group, 16-20 (57.4%).

A Kruskal-Wallis test showed that there was a significant difference across groups, H (3) = 54.367, p < .001). Bonferroni corrected post-hoc Mann Whitney U tests explored this effect. All groups were significantly different from all other groups (all p < .001) except for the comparison between the 21-24 and 25-29 age groups (p >.05) and the 25-29 and 30+ age groups (p=.054). This suggests that the youngest age group (16-20) are more likely to have poorer health than the older groups.



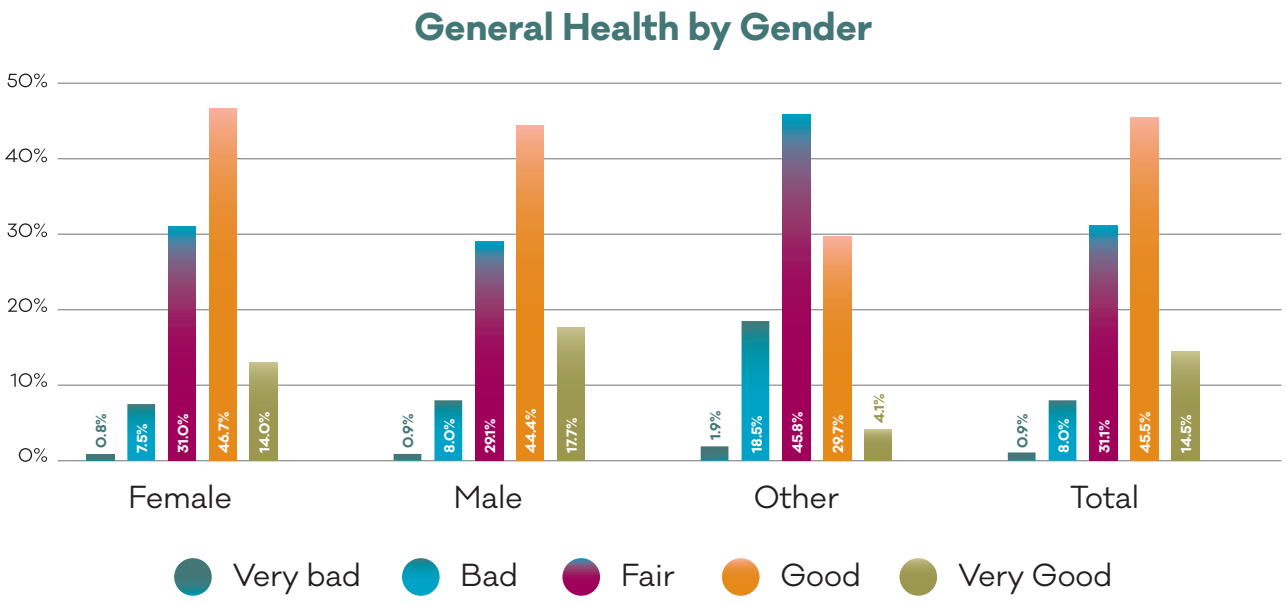
Graph 20. General Health by Age

n (age) = 13699 n (total) = 13807

General Health by Gender

Self-reported health varies noticeably across genders. Female and male have similar profiles with slightly more males reporting Good health overall. Other genders have noticeably worse reporting of health; with just over a third (33.8%) reporting Good or Very Good health compared with 60.7% of females and 62.1% of males.

A Kruskal-Wallis test showed that there was a significant difference across groups, $H(2) = 186.06$, $p < .001$). Bonferroni corrected post-hoc Mann Whitney U tests explored this effect. All groups were significantly different from all other groups (all $p < .001$).



Graph 21. General Health by Gender

n (gender) = 13793 n (total) = 13807

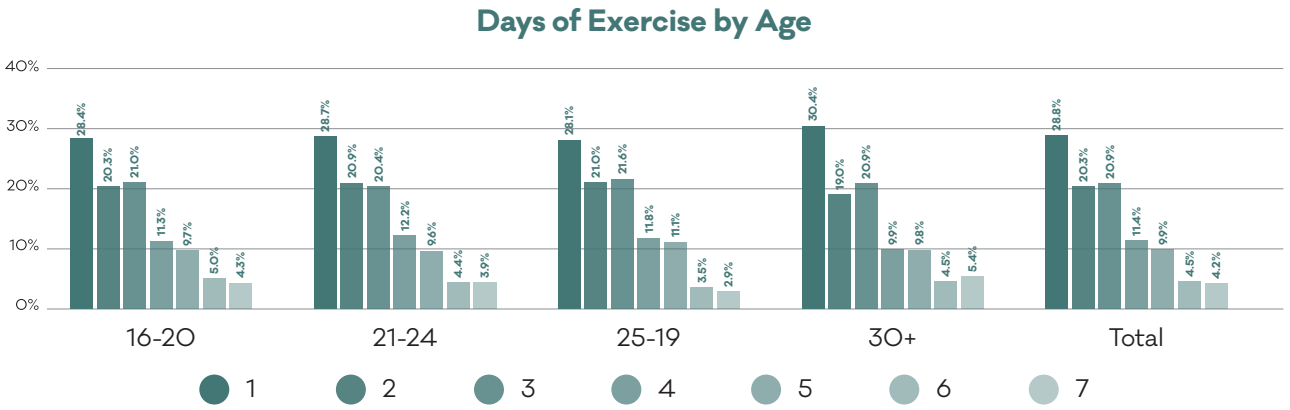
Exercise Levels

Over a quarter of respondents (28.8%) exercised one day a week, a further fifth exercised two days (20.3%) and also three days (20.9%). Around one in 10 exercised four days (11.4%) and five days (9.9%). A further 4.5% exercised six days and 4.2% exercised seven days.

It should be noted that an error in the asking of this question omitted the option of 'Zero' days, therefore these figures should be treated with caution, particularly the figure for 'One' day.

Exercise by Age

A Kruskal-Wallis test showed that there was no significant difference across age groups, H (3) = 1.26, p =.738).



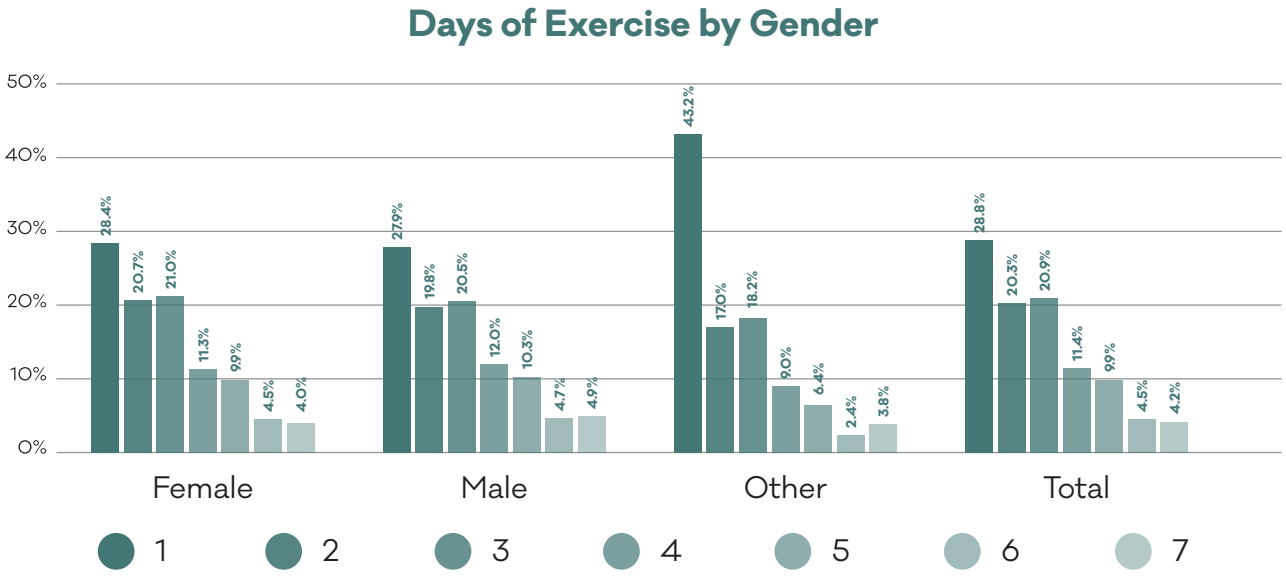
Graph 22. Days of Exercise by Age

n (age) = 13452 n (total) = 13558

Exercise by Gender

Noticeably other genders reported lower levels of exercise with over two-fifths (43.2%) reporting 'one day' of exercise compared with just over one quarter of females (28.4%) and males (27.9%).

A Kruskal-Wallis test showed that there was a significant difference across gender groups, H (2) = 45.03, p < .001). Bonferroni corrected post-hoc Mann Whitney U tests explored this effect. Other genders were significantly different from female and male groups (p < .001) but female and male groups did not differ (p = .170).



Graph 23. Days of Exercise by Gender

n (gender) = 13544 n (total) = 13558

Life Experiences

Life Experiences

This section reports on the questions the survey asked concerning life experiences.

Respondents were asked to complete the Adverse Childhood Experiences (ACEs) questionnaire as well being asked questions about bullying and food insecurity. The section will provide some context to national data sources, where available and comparable, and then show a summary of the key findings. Following that it will show each response to a question, then a summary of the breakdown by age and then by gender, followed by graphs showing this information. Additional information can be found in the Appendices.

Context

Adverse Childhood Experiences (ACEs)

The ACEs questionnaire was included in the Scottish Health Survey[27] for the first time in 2019

- 15% reported having experienced 4 or more ACEs which is the first national figure for Scotland.
- In Wales 12% report experiencing 4 or more ACEs and 9% in England report experiencing 4 or more ACEs.

In Northern Ireland nearly half (47.5%) of 11-19 year olds had experienced at least one ACE and 5.7% had experienced three or more ACEs. Females were

significantly more likely than males to report three or more ACEs (7.0% vs 4.6%).

There is no consistency however in how ACEs data has been collected across the national studies so some caution is required in comparing figures.

Bullying

At present there are no national reported figures for bullying within the HEI sector in Scotland.

The Annual Bullying Survey[28] reported that 25% of 12-18 year olds in the UK had experienced bullying in the previous 12 months. 63% of them said that this had a moderate to extreme impact on their mental health.

In Northern Ireland, 16.8% of 11–19-year-olds had experienced 'traditional' bullying and 14.9% experienced cyberbullying. Rates of 'traditional' bullying were higher for males than females (20.7% vs 13.0%) and rates of cyberbullying were higher for females than males (17.9% vs 11.9%)[29].

Food Poverty

The Scottish Health Survey[27] reported that 9% were worried about running out of food in the previous 12 months.

Summary

Adverse Childhood Experiences (ACEs)

Nearly 1 in 6 (15.8%) students had experienced 4 or more ACEs and nearly two-thirds (62.4%) had experienced at least 1 ACE.

- Older age groups (25.1% of those aged 30+) had experienced 4 or more ACEs more than younger age groups (13.2% of those aged 16-20)
- Other genders (26.6%) had experienced 4 or more ACEs more than females (16.6%) or males (11.7%).

Bullying

Nearly a fifth (19.5%) of students had been emotionally bullied in the previous semester.

Younger age groups (23.9% of those aged 16-20 compared with 14.2% of those aged 30+) and other genders (23.6% compared with 21.5% of males and 18.6% of females) reported higher levels of emotional bullying.

Food Insecurity

In the previous 12 months: over a fifth (21.5%) of students worried about running out of food; nearly a quarter (23.5%) ate less due to a lack of resources or money; and 7.2% resided in households that had ran out of food.

Food insecurity increased through the age groups – worries about running out of food increased from 1 in 6 of those aged 16-20 years to over a quarter (28.4%) of those aged 30+. 1 in 20 households of those aged 16-20 years ran out of food compared to 1 in 10 households of those aged 30+.

Other genders reported more food insecurity than females and males – around a third (31.1% and 33.5% respectively) of other genders worried about running out of food or ate less due to lack of resources or money.

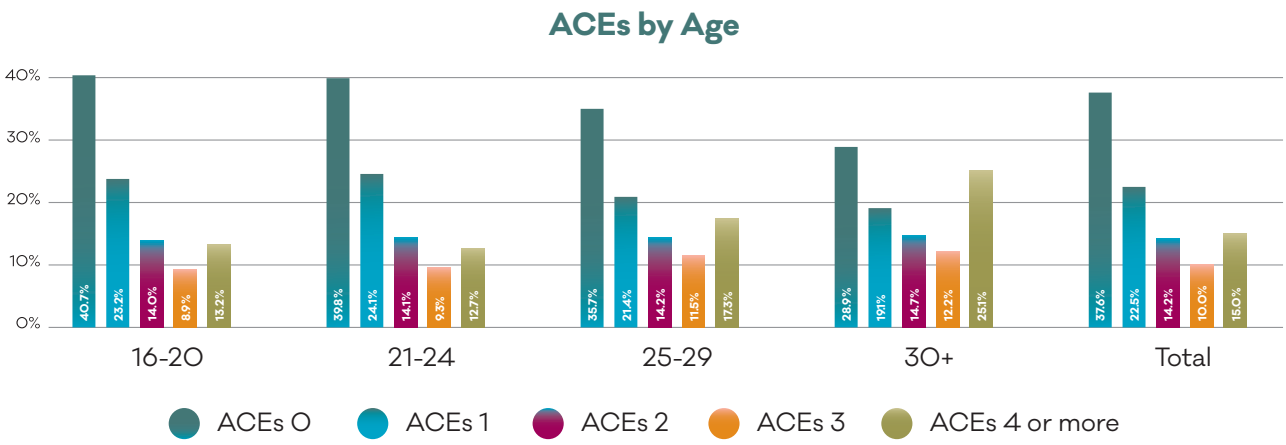
Adverse Childhood Experiences

Nearly two-thirds (62.4%) of respondents had experienced at least 1 adverse childhood experience. 15.8% of students reported having experienced 4 or more ACEs.

ACEs by Age Group

A quarter of respondents aged 30 and over had experienced 4 or more ACEs, compared with 13.2% of those aged 16-20.

A Kruskal-Wallis test showed that there was a significant difference across groups, H (3) = 235.44, p < .001). Bonferroni corrected post-hoc Mann Whitney U tests explored this effect. All groups were significantly different from all other groups (all p < .001) except for the comparison between the 16-20 and 21-24 age groups (p >.05).



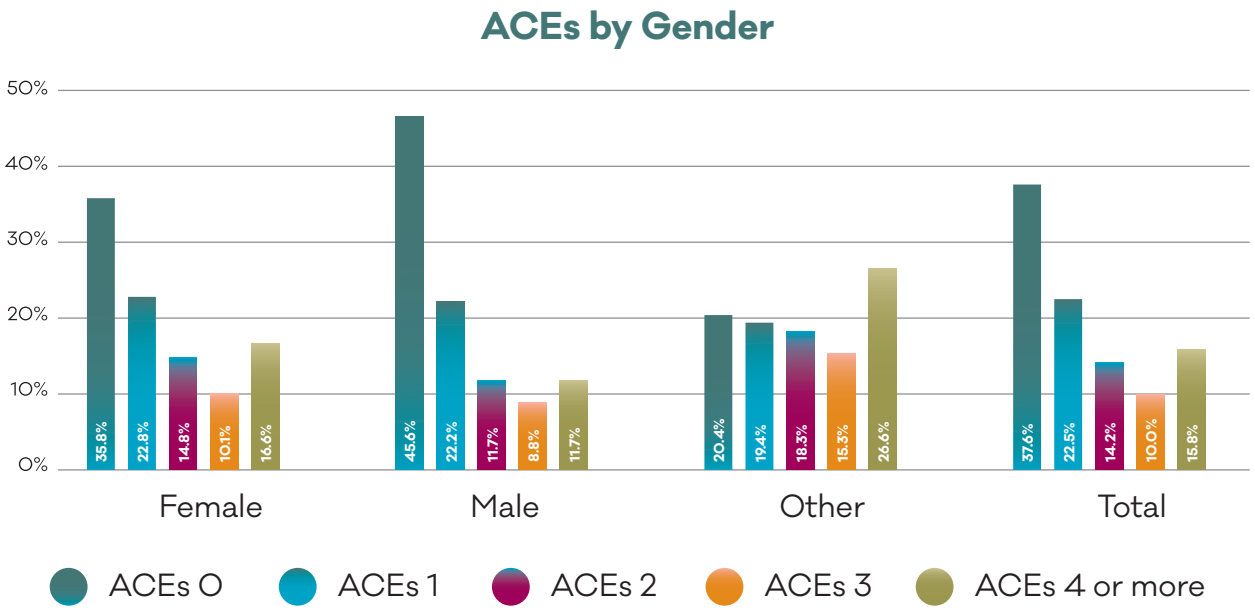
Graph 24. ACEs by Age

n (age) = 13101 n (total) = 13195

ACEs by Gender

Overall, female and other genders had experienced more adverse childhood events than males. Nearly half (45.6%) of all male respondents had experienced O ACEs, compared with a third (35.8%) and a fifth (20.5%) of females and other genders respectively. Females (16.6%) and other genders (26.6%) are both higher than the average ACEs 4 or more score of 15.8%; with other genders being noticeably higher.

"A Kruskal-Wallis test showed that there was a significant difference across gender groups, H (2) = 212.77, p < .001). Bonferroni corrected post-hoc Mann Whitney U tests explored this effect. All groups were significantly different from all other groups (all p < .001), indicating that other genders reported more ACES than females who themselves reported more ACES than males.



Graph 25. Adverse Childhood Experiences by Gender

n (gender) = 13182 n (total) = 13195

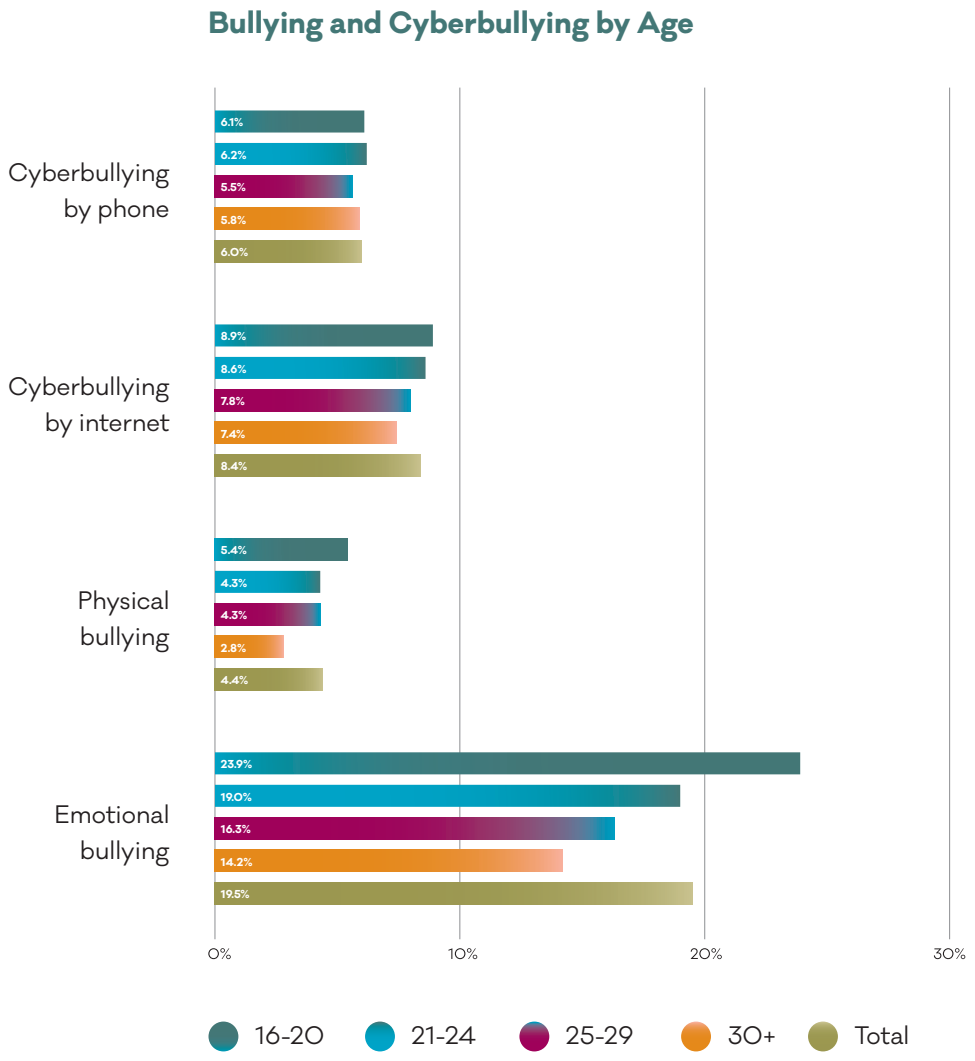
Bullying and Cyberbullying

The most commonly reported form of bullying experienced in the previous semester was emotional bullying (19.5%), followed by cyberbullying by mobile phone (6%). Physical bullying was the least common to be experienced (4.4.%).

Bullying and Cyberbullying by Age

In general, reported bullying decreases as respondents go up in age. The most notable differences are within the emotional bullying category; with nearly a quarter (23.9%) of those aged 16-20 years reporting that they had been emotionally bullied, compared with 14.2% of those aged 30+.

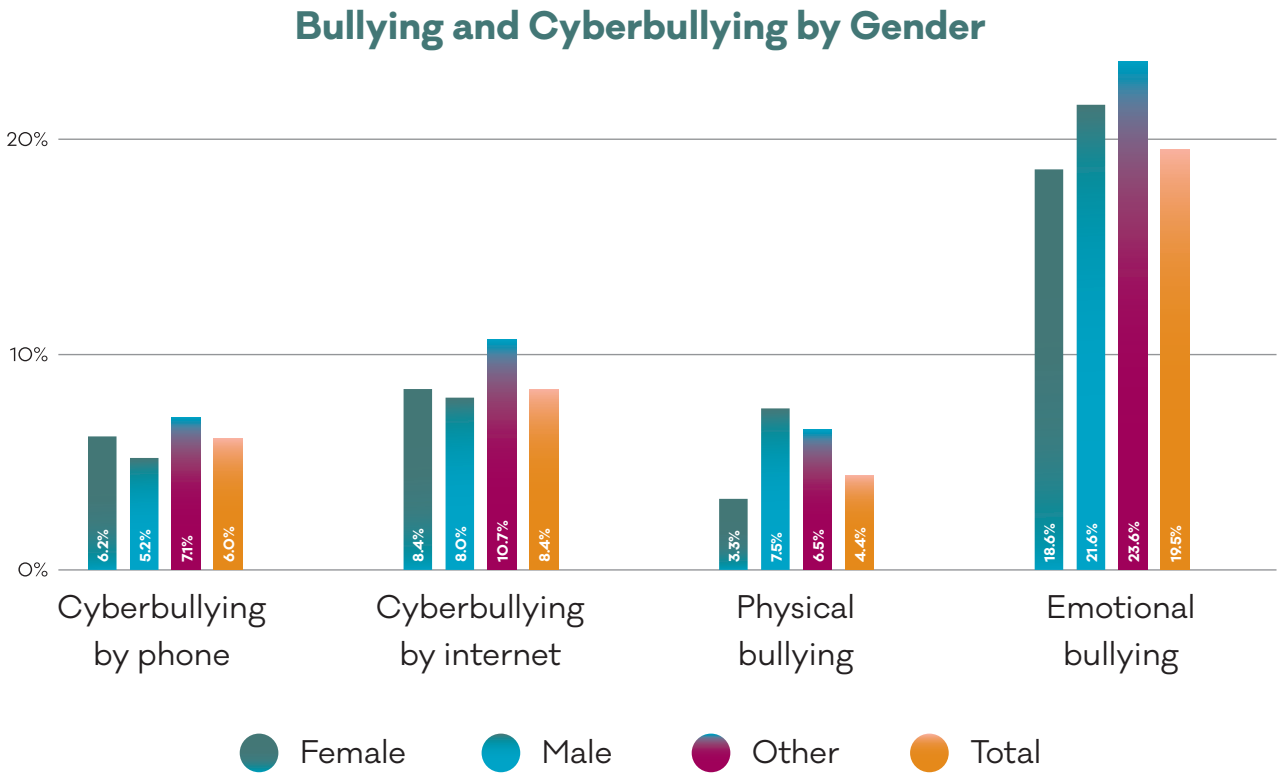
Chi-square tests only revealed a significant association between age and bullying for physical bullying ($\chi 2$ (3) = 26.50, p < .001) and emotional bullying ($\chi 2$ (3) = 111.29, p < .001).



Graph 26. Bullying and Cyberbullying by Age n (age) = 13196 n (total) = 13294

Bullying and Cyberbullying by Gender

Typically, those identifying as other genders reported being bullied more than males and females; except for physical bullying which more males reported. Nearly a quarter (23.6%) of other genders reported being emotionally bullied. Chi-square tests only revealed a significant association between gender and bullying for the physical bullying ($\chi 2$ (2) = 108.67, $p < .001$) and emotional bullying ($\chi 2$ (2) = 18.71, $p < .001$).



Graph 27. Bullying and Cyberbullying by Gender

n (gender) = 13283 n (total) = 13294

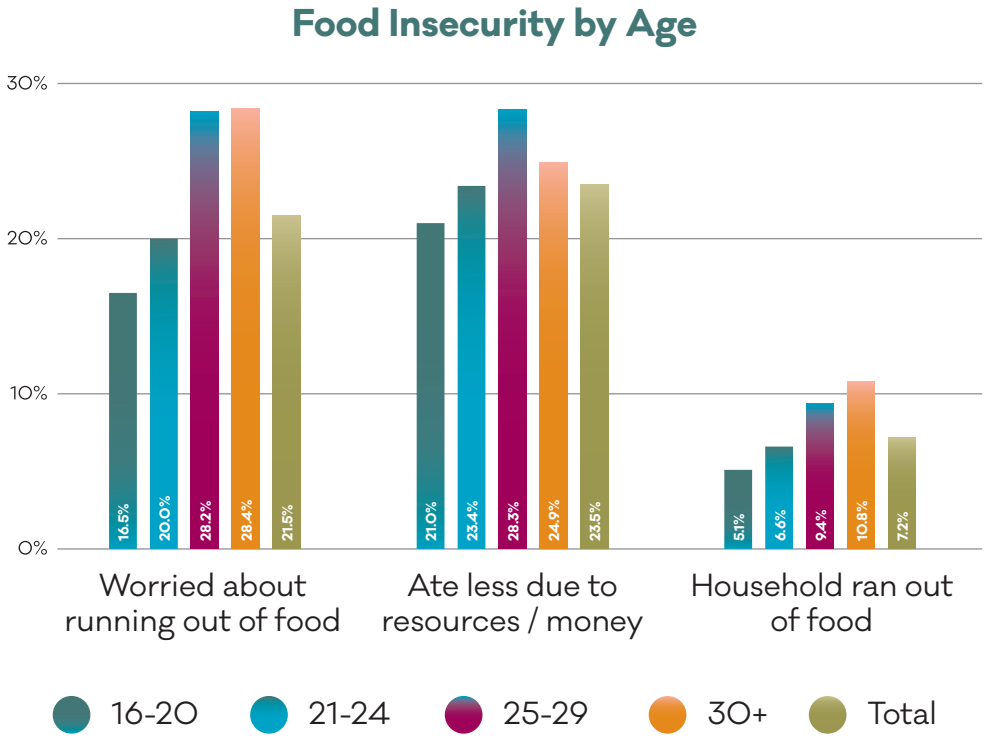
Food Insecurity

Nearly a quarter of all respondents (23.5%) reported haven eaten less due to a lack of resources or money. More than a fifth (21.5%) were worried about running out of food within the previous twelve months. 7.2% of respondents reported that their household ran out of food within the previous twelve months.

Food Insecurity by Age

Overall, it appears food insecurity increases with age with 25-30+ year olds reporting higher levels of insecurity than those aged 16-24 years old. This is particularly noticeable in worrying about running out of food and households who ran out of food – where 1 in 10 (10.8%) respondents aged 30+ reported being in a household that ran out of food compared with 1 in 20 (5.1%) of those aged 16-20.

Chi-square tests revealed a significant association between age and food security across the three questions: worried about running out of food ($\chi 2$ (3) = 190.73, p < .001), eaten less due to money and resources ($\chi 2$ (3) = 41.97, p < .001) and household ran out of food ($\chi 2$ (3) = 94.70, p < .001).



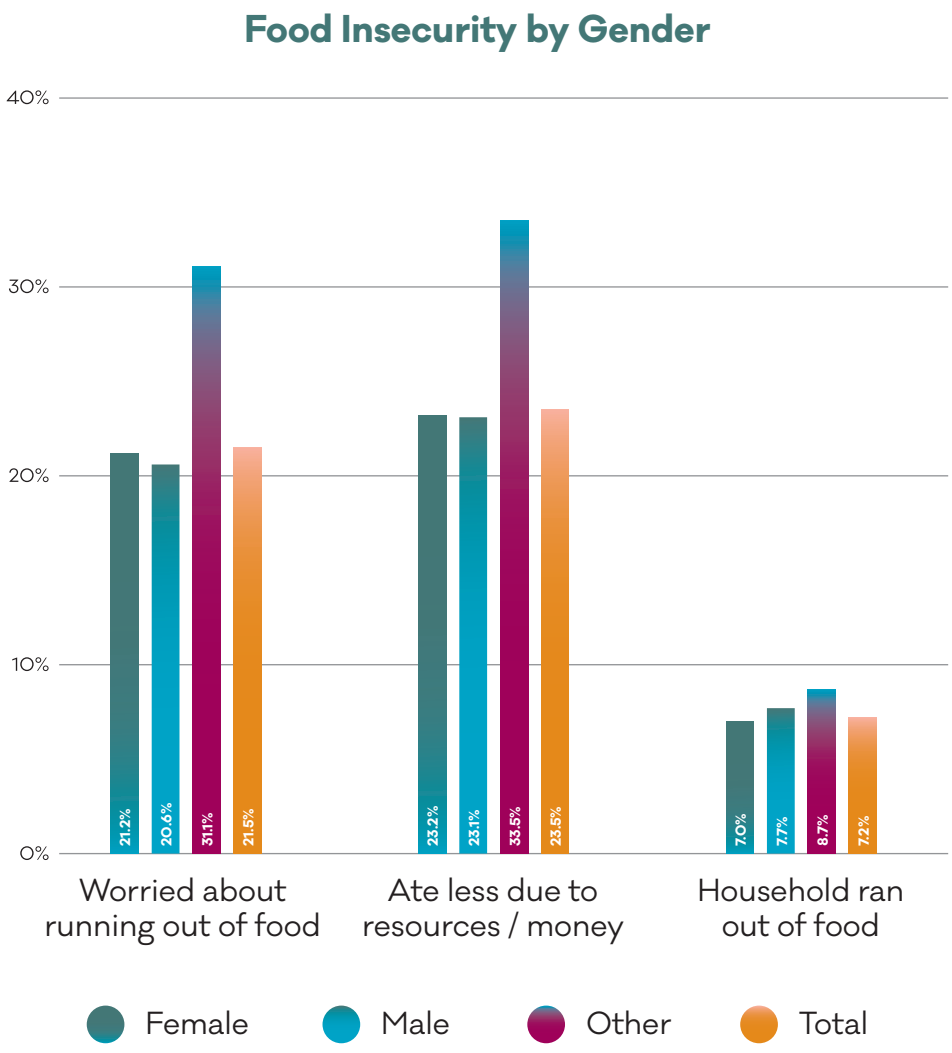
Graph 28. Food Insecurity by Age

n (age) = 13218 n (total) = 13316

Food Insecurity by Gender

In general, other genders were more likely to experience food insecurity. Noticeably so in the worried about running out of food and eating less due to resource/money questions. Male and female responses were broadly similar across all three questions.

Chi-square tests only revealed a significant association between gender and food security across worried about running out of food ($\chi 2$ (2) = 29.56, $p < .001$) and eaten less due to money and resources ($\chi 2$ (2) = 28.78, $p < .001$).



Graph 29. Food Insecurity by Gender

n (gender) = 13304 n (total) = 13316

Mental Health Experiences

Mental Health Experiences

This section reports on the questions the survey asked concerning mental health experiences.

Respondents were asked to complete the Patient Health Questionnaire 9 (PHQ-9) as well being asked questions about mental health diagnosis, serious psychological issues, stigma relating to mental health, self-harm, and suicidal ideation and attempts to kill themselves. The section will provide some context to national data sources, where available and comparable, and then show a summary of the key findings. Following that it will show each response to a question, then a summary of the breakdown by age and then by gender, followed by graphs showing this information. Additional information can be found in the Appendices.

Context

PHQ-9 context

- In Scotland in 2019, 17% of all adults had a GHQ-12 score of four or more, which is indicative of a possible psychiatric disorder[27]. Women (19%) were more likely than men (15%) to record a GHQ-12 score of four or more. A direct comparison cannot be made between the PHQ-9 and the GHQ-12.

Stigma context

- Research from See Me, Scotland's national mental health stigma and discrimination programme, suggests that over half (56%) of people with a mental health condition have experienced stigma and discrimination[30].

Current mental health diagnosis context

- It is estimated that around 1 in 4 people in Scotland are affected by mental health problems in any given year[27].
- In 2015/16, 2% of UK-domiciled first-year students at HEIs in the UK disclosed a mental health condition, five times higher than the figure in 2006/07[31].
- In 2019/20, 19.7% of the adult Scottish population were prescribed drugs for one of, or any combination of, anxiety, depression and psychosis[32].

Self-harm context

- In 2018/19, 7% of the Scottish population had ever self-harmed in their life[27].

Ideation/suicide context

- In 2018/19, 7% of the Scottish population had attempted suicide at some point in their life[27].
- UK student suicide rates increased by 52% between 2000/01 and 2016/17, reaching 4.7 per 100,000 of the population[31].
- Between 2012/13 and 2016/17 male students in the UK were more than twice as likely to die by suicide than female students, despite being more than three times less likely to report a mental health condition[31].

Summary

A collective 35.5% reported either Moderately Severe or Severe symptoms of depression compared with 40.1% reporting None to Mild symptoms.

- Severity of symptoms generally decrease through age groups – nearly a fifth (18.3%) of those aged 16-20 reported Severe symptoms compared with 1 in 10 (11.8%) of those aged 30+.
- Other genders reported higher levels of Severe symptoms (31.9%) than females (16.2%) and males (13.2%).

Over half (56.9%) reported concealing a mental health problem for fear of stigmatisation and a further 1 in 6 (16.5%) were not sure if they had concealed a mental health problem for fear of stigmatisation.

- Younger age groups 16-20 (58.5%) and 21-24 (59.6%), reported higher levels of concealing mental health problems for fear of stigmatisation than older age groups, 25-29 (54.6%) and 30+ (51.3%).
- Other genders (77.6%) reported higher levels of concealing mental health problems for fear of stigmatisation than females (59.2%) and males (44.6%).

Over a quarter (26.6%) reported having a current mental health diagnosis and a further tenth (10.7%) were unsure whether they had a diagnosis.

- The youngest age group, 16-20 (23.5%) had the lowest levels of diagnosis and those aged 25-29 (29.5%) had the highest levels.
- Other genders (46.6%) had higher levels of diagnosis than females (28.6%) and males (17.4%).

Nearly half (44.6%) reported that they had experienced a serious psychological issue that they felt needed professional help.

- This increased through the age groups from 4 in 10 (40.7%) of those aged 16-20 to nearly half (47.8%) of those aged 30+.
- Nearly two-thirds (64.9%) of other genders reported having

experienced a serious psychological issue that required professional help compared with 46.1% of females and 36.9% of males.

More than 1 in 10 (12.0%) reported that they had intentionally self-harmed within the last six months.

- Reports of self-harm decreased through the age groups from 1 in 6 (16.9%) of those aged 16-20 to 1 in 20 (5.1%) of those aged 30+.
- Other genders (29.5%) reported more self-harm than females (13.0%) and males (6.5%).
- Just under a fifth (19.6%) reported that they had either had suicidal ideation or attempted to kill themselves in the last six months.
- Levels were consistent across age groups but dropped for the 30+ group.
- Levels of reported ideation or attempts to kill themselves were higher for other genders (39.7%) than for females (18.9%) or males (18.2%).

PHQ-9

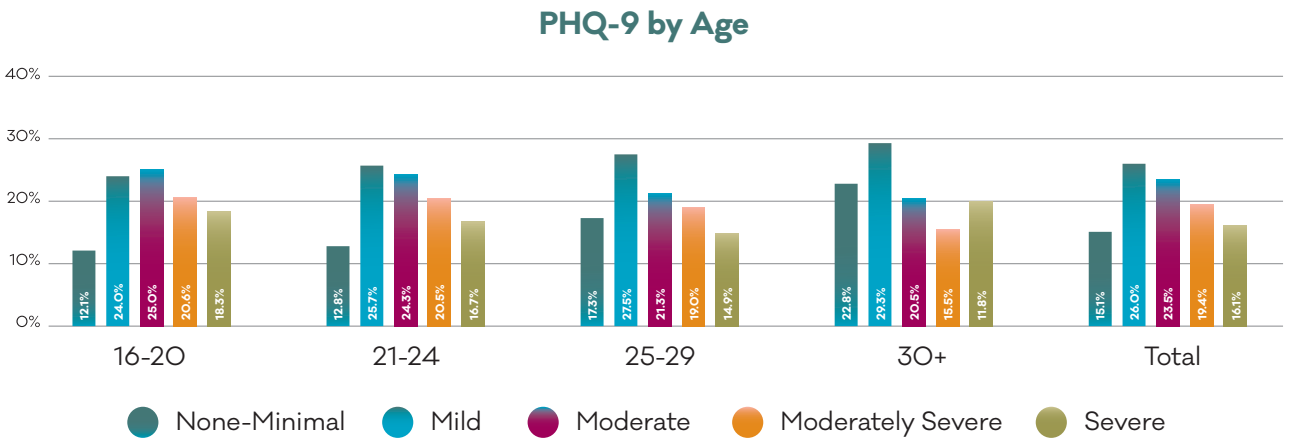
The PHQ-9 asks respondents nine items, each of these are assigned scores of 0, 1, 2, and 3, to the response categories of: 'not at all', 'several days', 'more than half the days' and 'nearly every day' respectively. The total PHQ-9 score for the nine items ranges from 0 to 27. These are then assigned into bands: 0-4 is 'None-Minimal', 5-9 is 'Mild, 10-14 is 'Moderate', 15-19 is 'Moderately Severe' and 20-27 is 'Severe'.

A quarter of respondents (26%) reported Mild symptoms with a further 15% reporting None-Minimal symptoms of depression. Nearly 60% of respondents collectively reported Moderate, Moderately Severe and Severe symptoms. The mean score was 11.9% which falls into the Moderate band.

PHQ-9 by Age

In general, the share of respondents reporting anything above Moderate symptoms decreases as age increases. Nearly a fifth (18.3%) of those aged 16-20 had Severe symptoms compared with just over a tenth (11.8%) of those aged 30+. Respondents aged 30+ had the largest share of those displaying None-Minimal or Mild symptoms with 52.1% compared with 36.1% in 16-20, 38.5% in 21-24 and 44.8% in 25-29 years.

A Kruskal-Wallis test showed there was a significant difference across age groups, $H(3) = 202.25$, $p < .001$). Bonferroni corrected post-hoc Mann Whitney U tests explored this effect. All groups were significantly different from all other groups (all $p < .001$) except for the comparison between the 16-20 and 21-24 age groups ($p = .141$).



Graph 30. PHQ-9 by Age

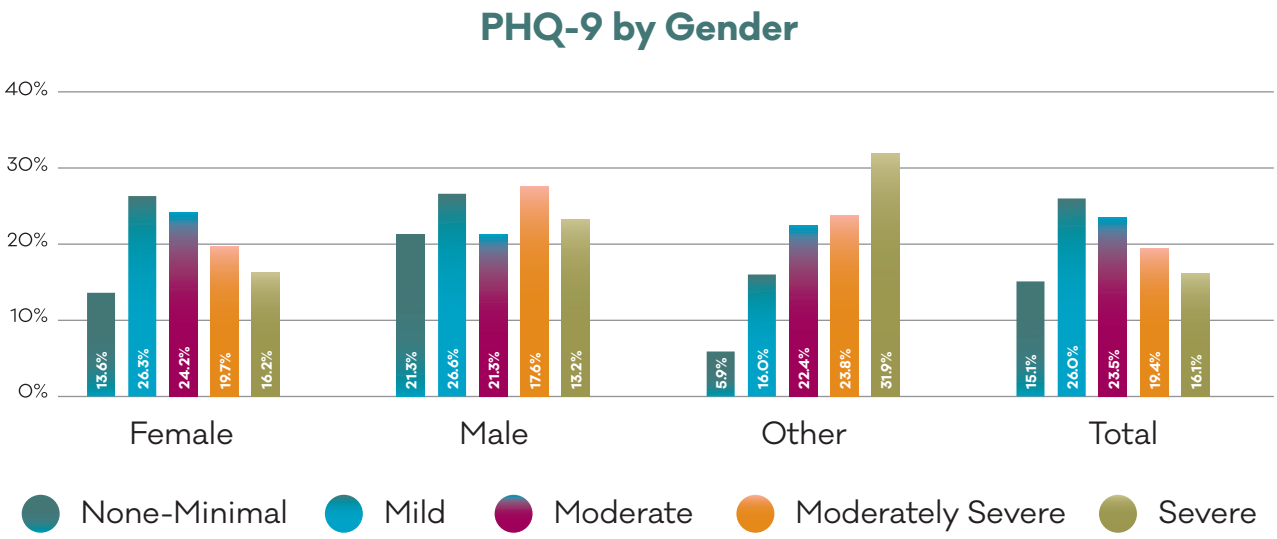
n (age) = 12513 n (total) = 12604

PHQ-9 by Gender

The female and male responses are quite similar in distribution except for the None-Minimal category which is noticeably higher for males. Both female and male have similar responses for Mild and then for the remaining more severe categories females score slightly higher than males.

Other genders have a quite markedly different distribution from those identifying as male or female. Nearly a third of other genders (31.9%) report Severe symptoms. With another near quarter (23.8%) reporting Moderately-Severe. Only 5.9% other genders report None-Minimal symptoms.

A Kruskal-Wallis test showed there was a significant difference across gender groups, H (2) = 194.65, p < .001). Bonferroni corrected post-hoc Mann Whitney U tests explored this effect. All groups were significantly different from all other groups (all p < .001), indicating that other genders reported higher scores than female who in turn reported higher scores than males.

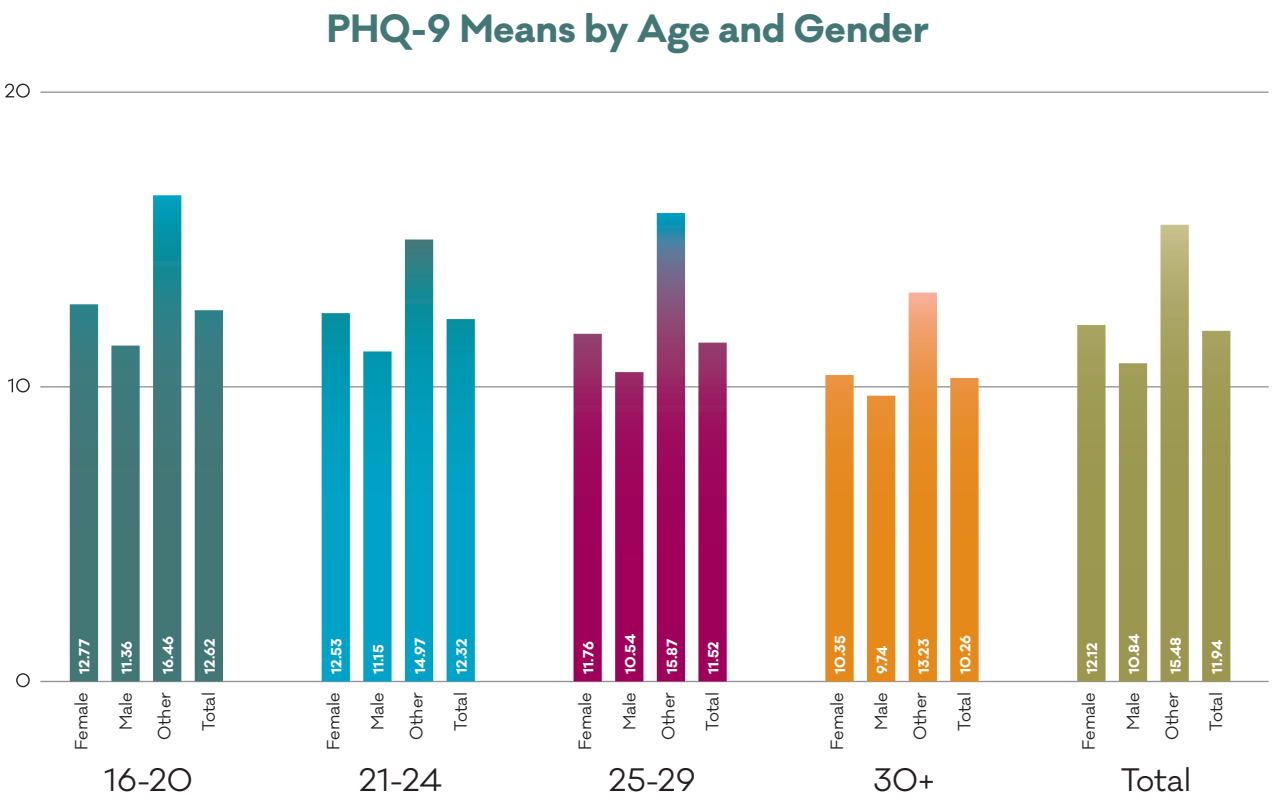


Graph 31. PHQ-9 by Gender

n (gender) = 12592 n (total) = 12604

PHQ-9 Means

The mean score for the PHQ-9 reduces as age increases, from 12.62 for those aged 16-20 years to 10.26 for those aged 30+. The mean across all groups by age and gender continue to fall within the Moderate band with the exception of 30+ males (9.74) which falls within the Mild band. Furthermore, the mean for other genders (15.48) was much higher than females (12.12) and males (10.84) – the other genders mean score is in the Moderately Severe band.



Graph 32. PHQ-9 Means by Age and Gender

n = 12604

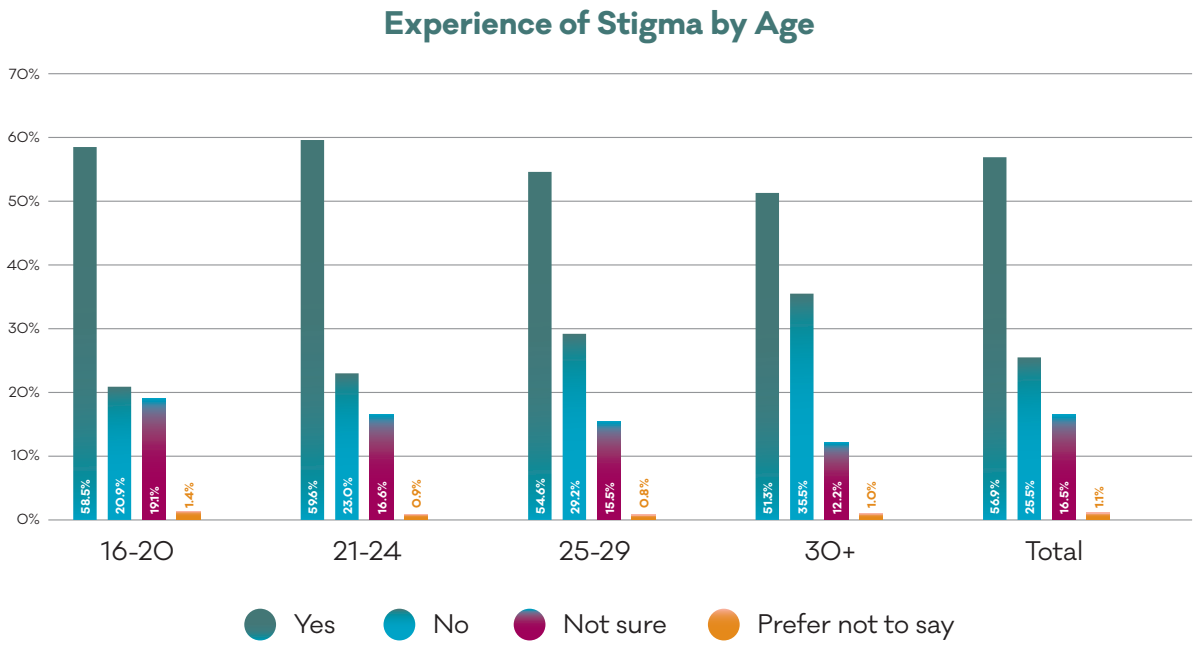
Experience of Stigma

Over half of respondents (56.9%) reported that they had concealed mental health problems for fear of stigmatisation and a further 16.5% reported that they were unsure whether they had concealed mental health problems for fear of stigmatisation. A quarter (25.5%) reported that they had not concealed mental health problems for fear of stigmatisation.

Experience of Stigma by Age

Stigma levels are relatively similar across age groups with over half of all age groups reporting they have concealed mental health problems for fear of stigmatisation. Overall, the younger age groups (16-20 and 21-24 years) have higher levels of experienced stigma than the older age groups (25-29 and 30+). The levels of respondents reporting no stigma increases as you go through the age group with over a third (35.5%) of those aged 30+ reporting no stigma compared with 20.9% of those aged 16-20. Conversely those respondents not sure whether they had concealed a mental health problem due to fear of stigmatisation decreases with age falling from just under a fifth (19.1%) of those aged 16-20 to just over a tenth (12.2%) of those aged 30+.

A Kruskal-Wallis test showed there was a significant difference across age groups, $H(3) = 105.89$, $p < .001$). Bonferroni corrected post-hoc Mann Whitney U tests explored this effect. All groups were significantly different from all other groups (all $p < .01$) except for the comparison between the 16-20 and 21-24 age groups ($p > .05$).

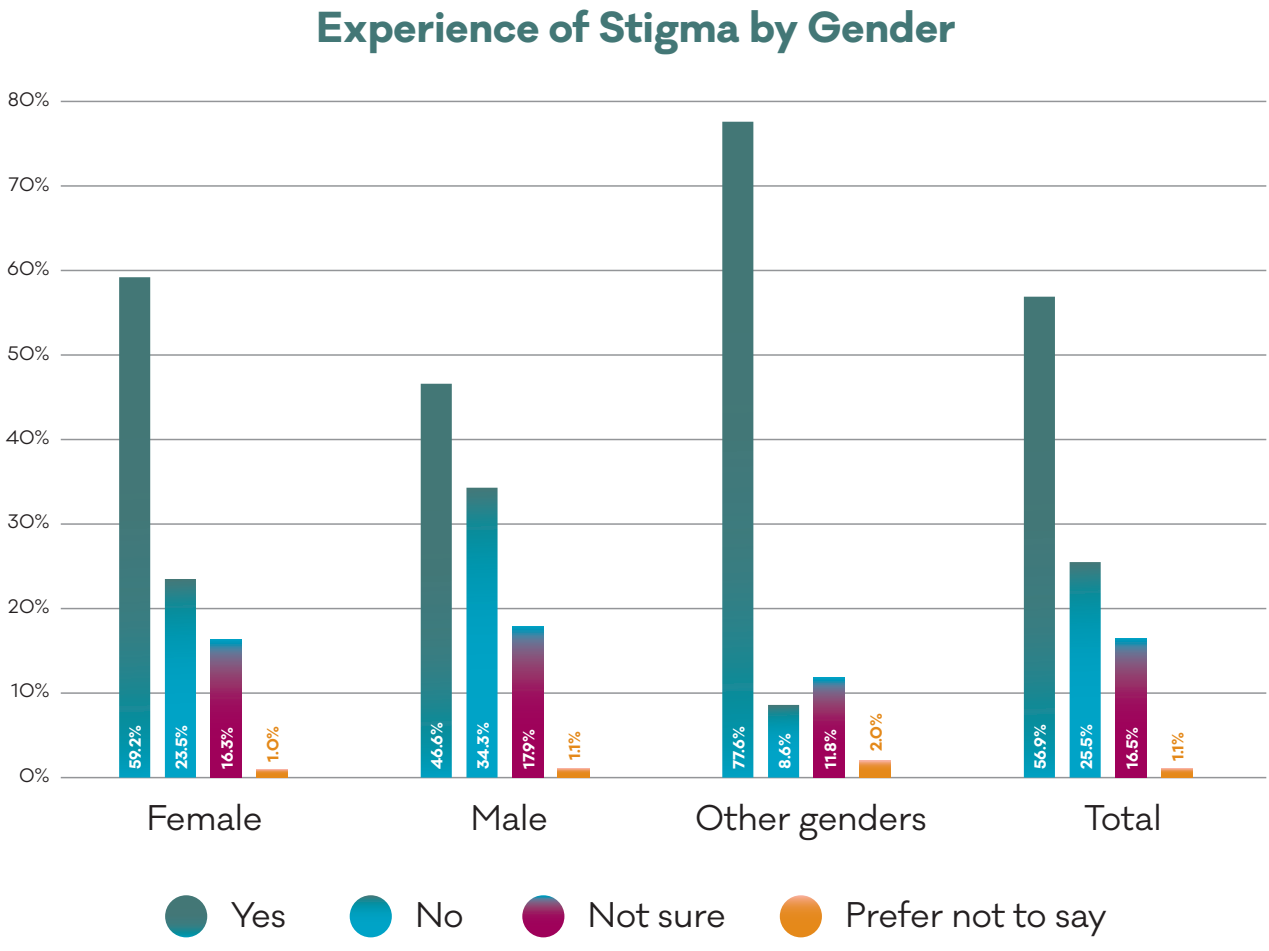


Graph 33- Experience of Stigma by Age n (age) = 13058 n (total) = 13154

Experience of Stigma by Gender

Females (59.2%) and other genders (77.6%) report higher levels of concealing mental health problems for fear of stigmatisation than males (46.6%). A higher proportion of males (17.9%) were not sure whether they had concealed a mental health problem for fear of stigmatisation than females (16.3%) or other genders (11.8%).

A Kruskal-Wallis test showed there was a significant difference across gender groups, H (2) = 283.79, p < .001). Bonferroni corrected post-hoc Mann Whitney U tests explored this effect. All groups were significantly different from all other groups (all p < .001).



Graph 34. Experience of Stigma by Gender

n (gender) = 13142 n (total) = 13154

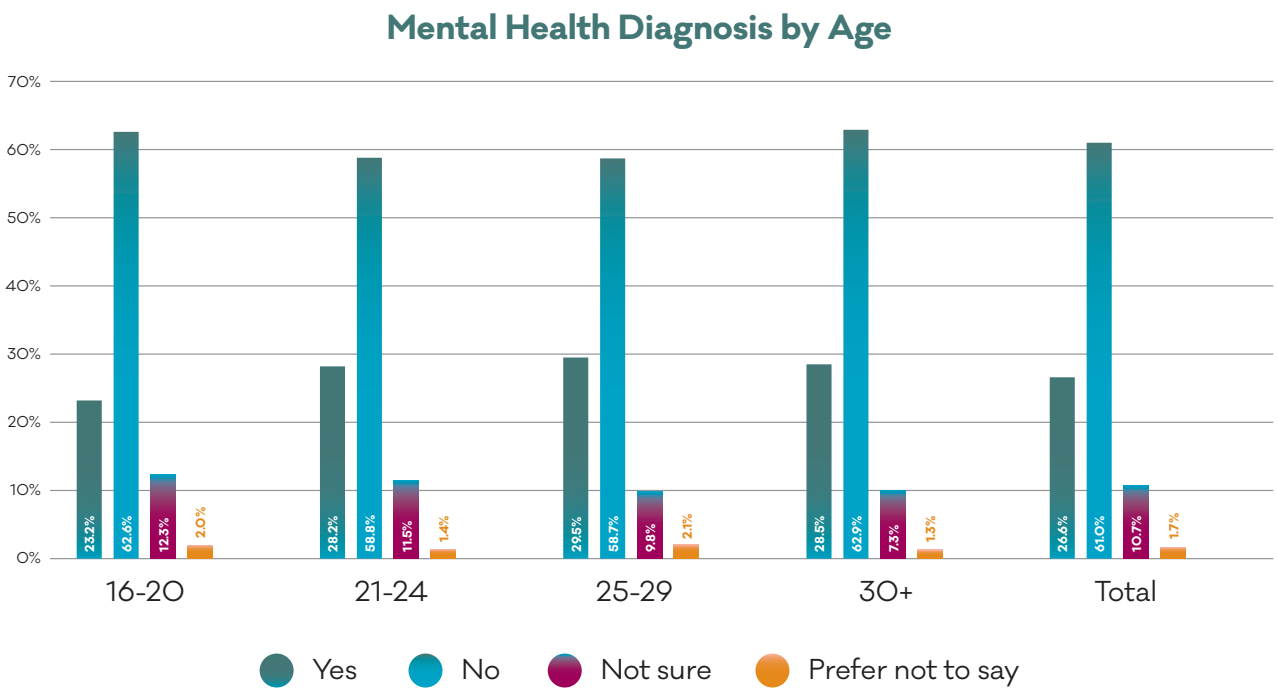
Mental Health Diagnosis

Over a quarter (26.6%) reported having a current mental health diagnosis and a further 10.7% were not sure if they had a current mental health diagnosis. Approaching two-thirds (61.0%) did not have a current mental health diagnosis.

Mental Health Diagnosis by Age

Levels of mental health diagnosis were consistent across the 21-24 (28.2%), 25-29 (29.5%) and 30+ (28.5%) age groups and slightly lower in the 16-20 (23.2%) group.

A Kruskal-Wallis test showed there was a significant difference across groups, H (3) = 26.83, p < .001). Bonferroni corrected post-hoc Mann Whitney U tests explored this effect. Only two age groups (16-20 and 21-24 and 16-20 and 25-29) were significantly different from each other (p<.001).



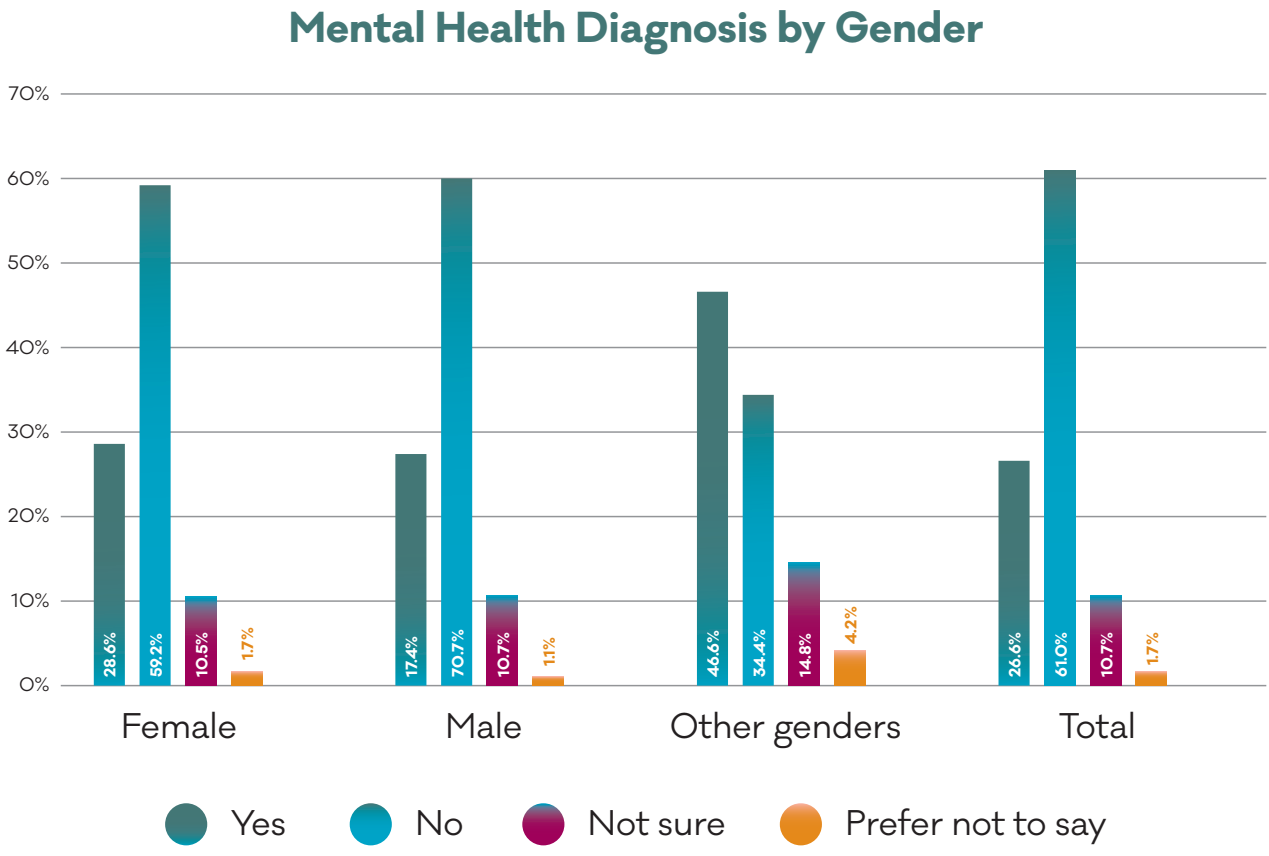
Graph 35. Mental Health Diagnosis by Age

n (age) = 13066 n (total) = 13162

Mental Health Diagnosis by Gender

Females (28.6%) and other genders (46.6%) have significantly higher rates of diagnosis than males (17.4%). Males and females have very similar rates of not being sure whether they have a diagnosis and other genders have slightly higher rates of not being sure of whether they have a diagnosis.

A Kruskal-Wallis test showed that there was a significant difference across gender groups, $H(2) = 301.05$, $p < .001$). Bonferroni corrected post-hoc Mann Whitney U tests explored this effect. All groups were significantly different from all other groups (all $p < .001$), indicating that other genders reported higher levels of diagnosis than females, who in turn reported higher levels of diagnosis than males.



Graph 36. Mental Health Diagnosis by Gender

n (age) = 13150 n (total) = 13162

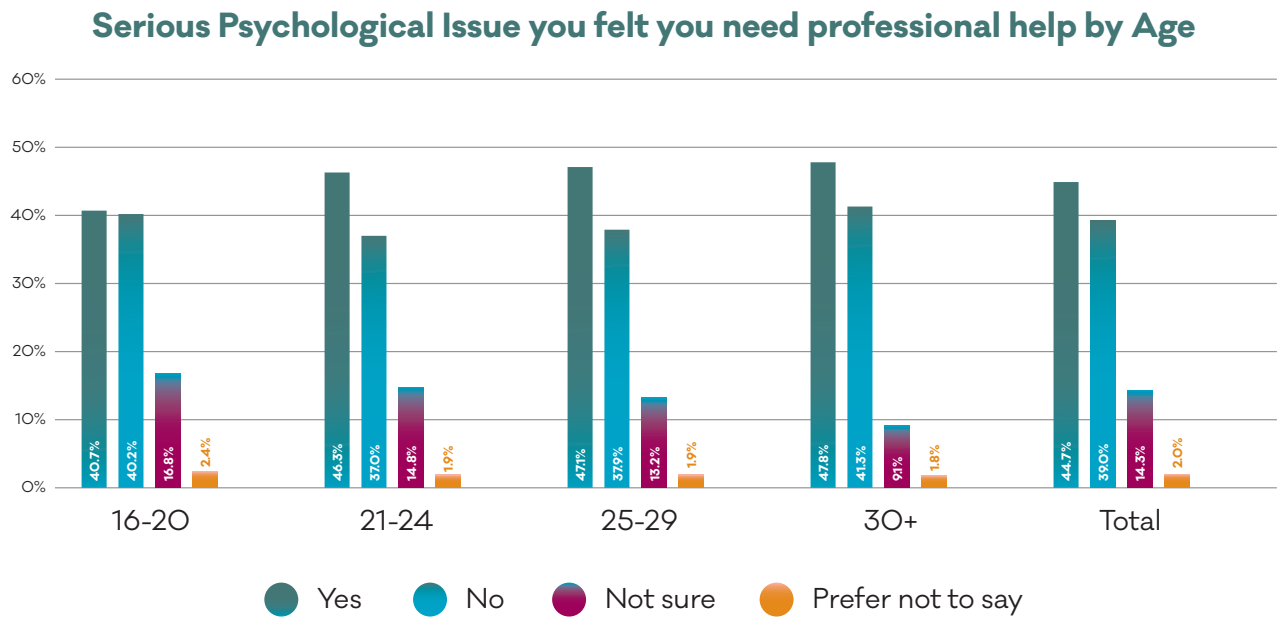
Serious Psychological Issue

Nearly half (44.6%) of students reported that they had experienced a serious psychological issue that they felt that they needed professional help for and a further 14.3% were not sure whether they had experienced a serious psychological issue that they felt that they needed professional help for. 39.1% reported that they had not experienced a serious psychological issue that they felt that they needed professional help for.

Serious Psychological Issue by Age

Levels of having experienced a serious psychological issue that you felt you needed professional help for increased through the age groups from 4 in 10 (40.7%) of those aged 16-20 years to approaching half (47.8%) of those aged 30+. Conversely levels of not being sure if you have experienced a serious psychological issue that you felt needed professional help decrease as you go through the age groups from 16.8% of those aged 16-20 to 9.1% of those aged 30+.

A Kruskal-Wallis test showed that there was a significant difference across age groups, H (3) = 25.81, p < .001). Bonferroni corrected post-hoc Mann Whitney U tests explored this effect. Three ages groups (16-20 and 21-24 (p<.001), 16-20 and 25-29 (p=.002) and 16-20 and 30+ (p=.03) were significantly different from each other. The remaining age groups were not significantly different from each other.



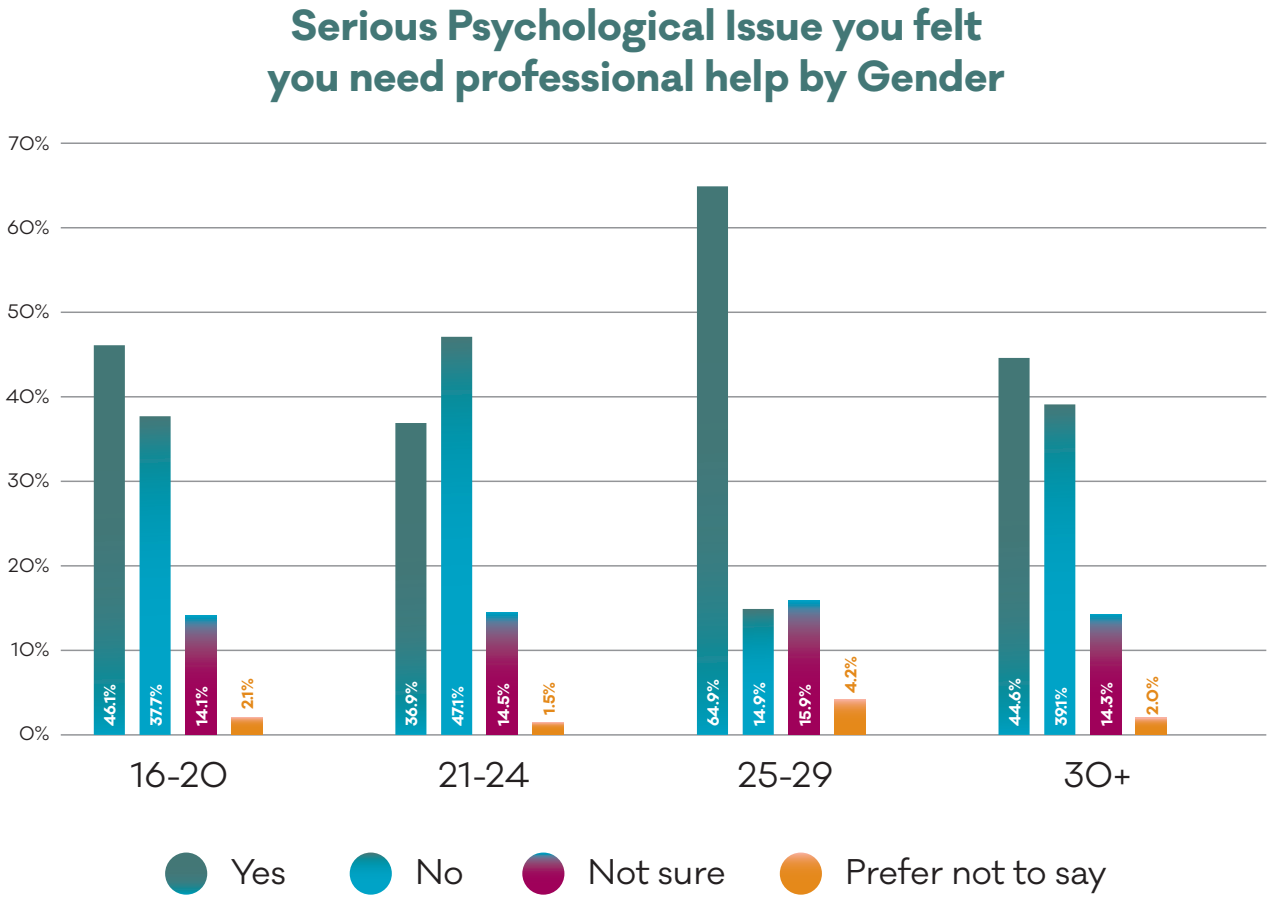
Graph 37. Serious Psychological Issue by Age

n (age) = 13057 n (total) = 13170

Serious Psychological Issue by Gender

Females (46.1%) and other genders (64.9%) had noticeably higher rates of experiencing a serious psychological issue that they felt required professional help than males (36.9%). Males (14.5%), females (14.1%) and other genders (15.9%) have very similar rates of not being sure whether they have experienced a serious psychological issue that they felt required professional help.

A Kruskal-Wallis test showed that there was a significant difference across gender groups, $H(2) = 225.06$, $p < .001$). Bonferroni corrected post-hoc Mann Whitney U tests explored this effect. All groups were significantly different from all other groups (all $p < .001$), indicating that other genders reported experiencing a serious psychological issue more than females, who in turn reported more than males.



Graph 38. Serious Psychological Issue by Gender

n (gender) = 13145 n (total) = 13170

Receiving support for serious Psychological Issue

This question was only asked of those that had responded 'yes' to the previous question as to whether they experienced a serious psychological issue which they felt they needed professional help for. Of those who reported 'yes' over a third (34.9%) reported that they were receiving support for the serious psychological issue they had experienced. Nearly two-thirds (63.1%) were not or had not received support for the serious psychological issue they had experienced. A further 2.0% were not sure if they had received support.

Receiving support for serious Psychological Issue by Age

Levels of receiving support for a serious psychological issue are relatively consistent across the age groups with 16-20 (32.2%) being slightly lower than the others and 25-29 (37.0%) being slightly higher.

Receiving support for serious Psychological Issue by Gender

Females (35.7%) and other genders (40.3%) have slightly higher rates of receiving support for a serious psychological issue than males (30.6%). Males (2.4%), females (1.9%) and other genders (2.1%) have very similar rates of not being sure whether they have experienced a serious psychological issue that they felt required professional help.

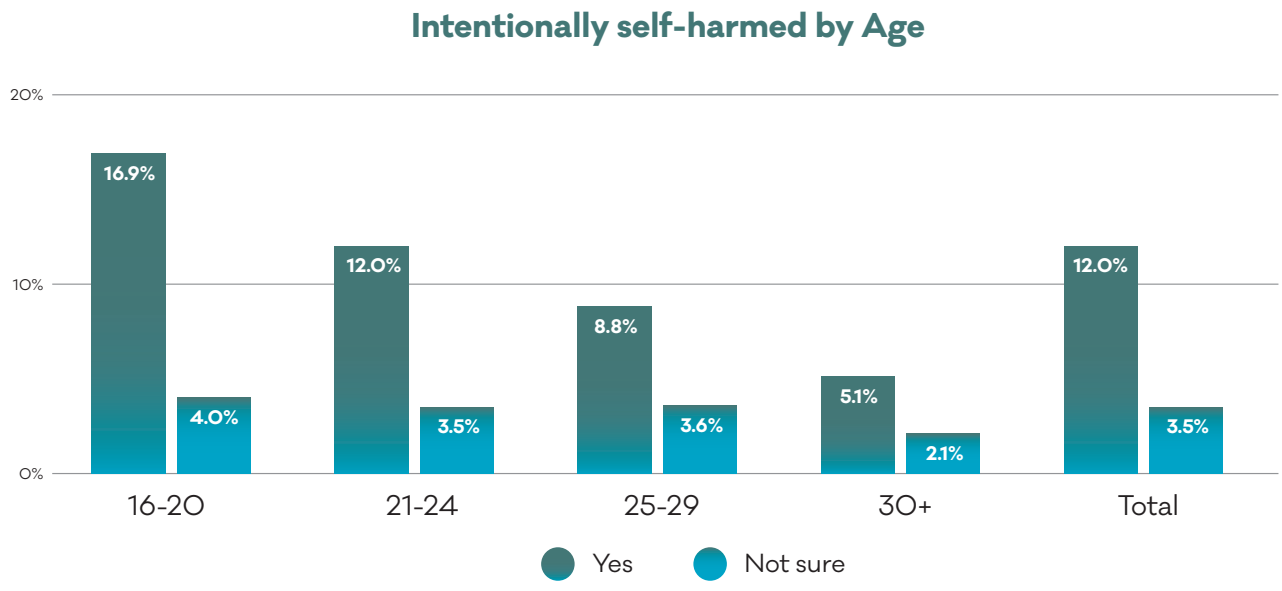
Self-harm

More than 1 in 10 (12.0%) reported that they had intentionally self-harmed within the previous six months and a further 3.5% were not sure if they had intentionally self-harmed within the previous six months. 83.3% had not intentionally self-harmed. Those who reported that they had self-harmed were asked a follow-up question about whether they sought medical assistance due to injuries sustained from self-harming. Less than a tenth (6.6%) of those that had intentionally self-harmed had sought medical assistance due to injuries sustained from self-harm.

Self-harm by Age

Intentional self-harm in the previous six months decreases as age increases with over 1 in 6 (16.9%) of those aged 16-20 years to 5.1% of those aged 30+. Levels of not being sure whether you intentionally self-harm also decrease as age increases from 4.0% of those aged 16-20 to 2.1% of those aged 30+.

A Kruskal-Wallis test showed there was a significant difference across age groups, $H(3) = 253.79$, $p < .001$). Bonferroni corrected post-hoc Mann Whitney U tests explored this effect. All groups were significantly different from all other groups (all $p < .001$ except for 21-24 and 25-29 ($p=.013$)).



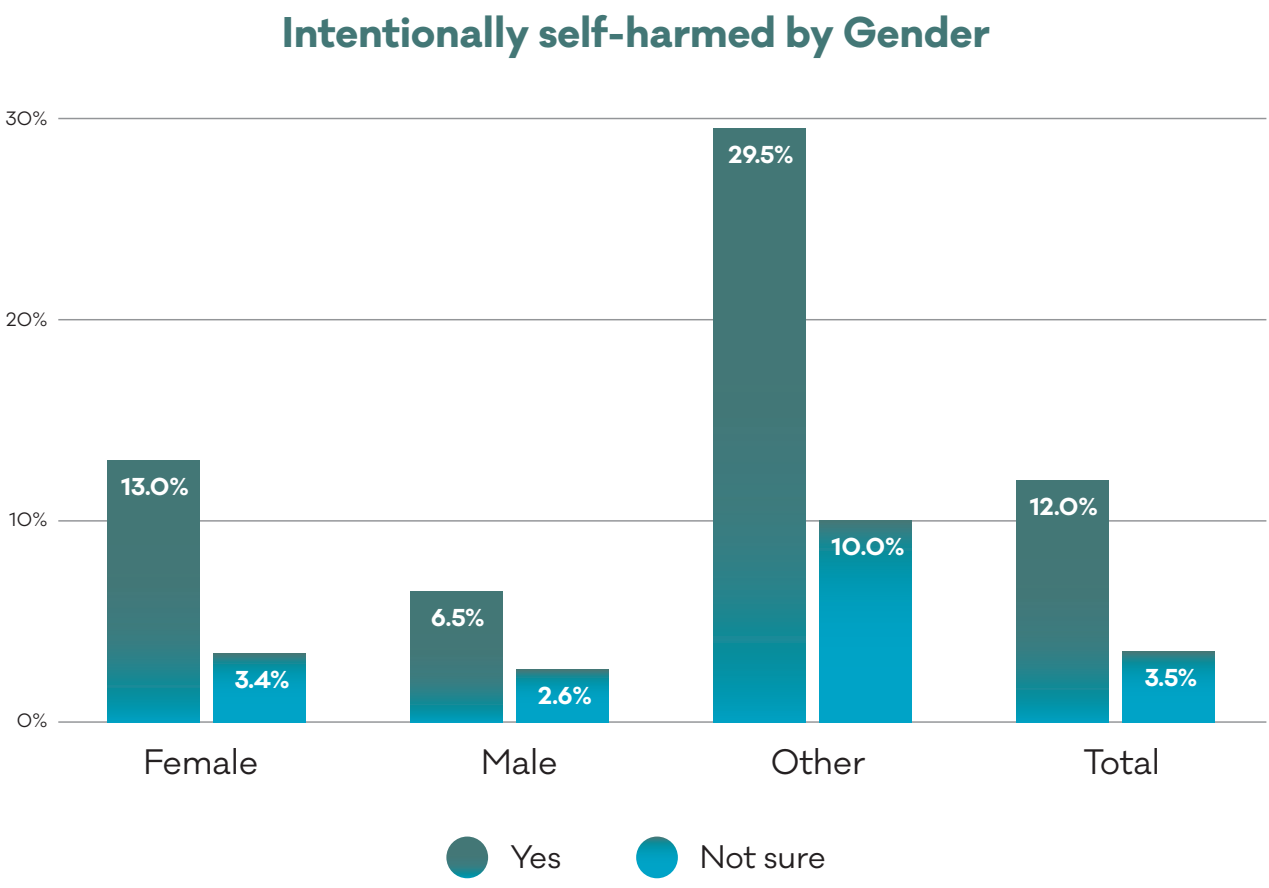
Graph 39. Intentionally self-harmed by Age

n (age) = 13018 n (total) = 13128

Self-harm by Gender

Females (13.0%) and other genders (29.5%) have noticeably higher rates of having intentionally self-harmed than males (6.5%). Other genders (10.0%) have higher rates of not being sure whether they had intentionally self-harmed than both males (2.6%) and females (3.4%).

A Kruskal-Wallis test showed that there was a significant difference across groups, $H(2) = 338.49$, $p < .001$). Bonferroni corrected post-hoc Mann Whitney U tests explored this effect. All groups were significantly different from all other groups (all $p < .001$), indicating that other genders reported higher levels of self-harm than females, who in turn reported higher levels than males.



Graph 40. Intentionally self-harmed by Gender

n (gender) = 13018 n (total) = 13128

Suicidal Ideation or attempt to kill yourself

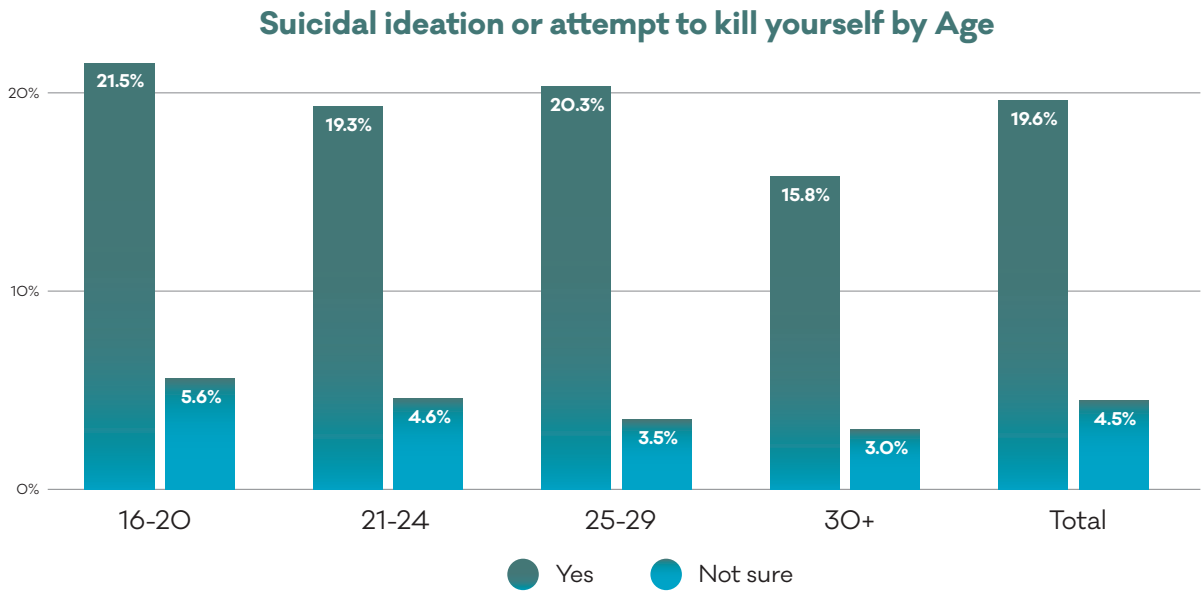
Nearly a fifth (19.6%) reported having either suicidal ideation or attempting to kill themselves within the previous six months and a further 4.5% were not sure whether they had either suicidal ideation or attempted to kill themselves within the previous six months. Those who reported that they had experienced suicidal ideation or had attempted to kill themselves were asked a follow-up question about whether they sought medical assistance due to injuries sustained from self-harming. Less than a tenth (6.8% (n=)) of those who had either had suicidal ideation or attempted to kill themselves in the previous six months had sought medical attention due to injuries sustained from attempting to kill themselves.

Suicidal ideation and attempting to kill yourself were asked together in the same question, meaning it is not possible to extract levels of either, individually, from this question. These figures are the response to both statements.

Suicidal ideation or attempt to kill yourself by Age

Levels of suicidal ideation or attempts to kill yourself are relatively consistent across the 16-20 (21.5%), and the 25-29 (20.3%) age groups. They drop slightly for the 21-24 (19.3%) and the 30+ age group (15.8%).

A Kruskal-Wallis test showed there was a significant difference across age groups, $H(3) = 64.18$, $p < .001$). Bonferroni corrected post-hoc Mann Whitney U tests explored this effect. All groups were significantly different from all other groups (all $p < .001$ except for 16-20 and 25-29 ($p=.036$)). There was no significance between 21-24 and 25-29 ($p>.05$).



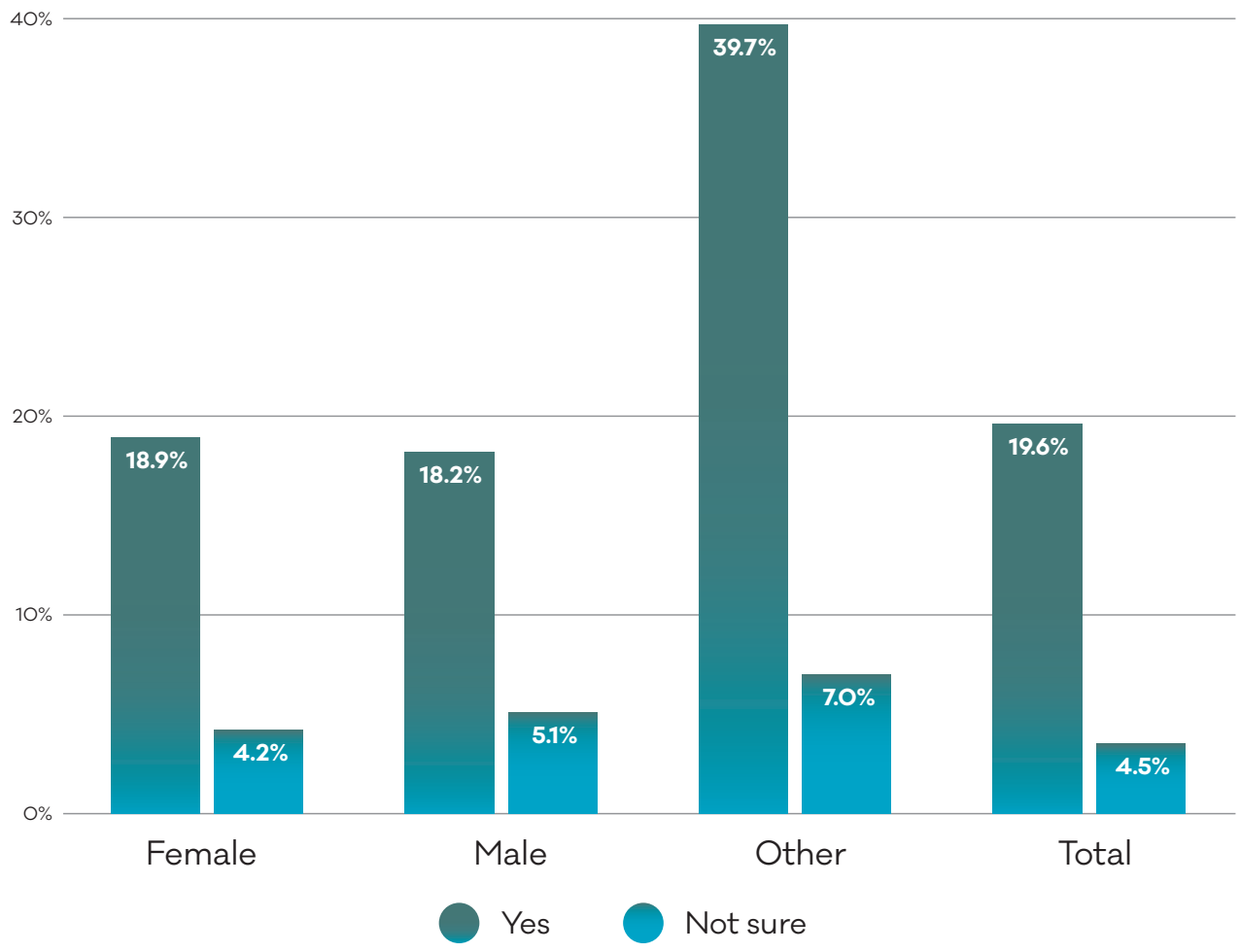
Graph 41. Suicidal ideation or attempt to kill yourself by Age n (age) = 13007 n (total) = 13117

Suicidal ideation or attempt to kill yourself by Gender

Nearly two-fifths (39.7%) of other genders reported either having suicidal ideation or having attempted to kill themselves and a further 7.0% were not sure. Compared with females (18.9%) and males (18.2%). Slightly more males (5.1%) were not sure if they had had ideation or attempted to kill themselves than females (4.2%).

A Kruskal-Wallis test showed that there was a significant difference across groups, H (2) = 172.92, p < .001). Bonferroni corrected post-hoc Mann Whitney U tests explored this effect. Other genders were significantly different from males and females (p < .001). There was no significant difference between male and female.

Suicidal ideation or attempt to kill yourself by Gender



Graph 42. Suicidal ideation or attempt to kill yourself by Gender

n (gender) = 13096 n (total) = 13117

University Experiences

University Experiences

This section reports on the questions the survey asked concerning university experiences.

Respondents were asked questions about university services, membership of student groups and the impact of the pandemic on their university experience. The section will provide some context to national data sources, where available and comparable, and then show a summary of the key findings. Following that it will show each response to a question, then a summary of the breakdown by age and then by gender, followed by graphs showing this information. Additional information can be found in the Appendices.

Context

Pandemic

- YouGov[33] found that four in five (81%) of students said that the pandemic had impacted on their ability to make friends. Two-thirds (67%) felt that the pandemic had a negative impact on their mental health and over half (58%) felt that their university handled student safety and wellbeing well during the pandemic.
- Similarly, a Student Minds[34] survey found that 74% of students felt that the pandemic had a negative impact on their mental health and wellbeing at university.

Summary

In general, awareness of university services is high but usage is relatively low.

Over two-fifths (41.7%) were dissatisfied with their university compared with 38.8% being satisfied.

- Older age groups, 30+ (51.4%) were more satisfied with services than younger age groups, 16-20 (34.4%).
- Males (39.4%) and females (39.0%) were more satisfied with services than other genders (27.8%).

A third (33.4%) of respondents were members of a student group.

- Younger age groups, 16-20 (44.5%) had higher rates of membership than older age groups, 30+ (16.6%).
- Other genders (43.3%) had higher rates of membership than females (34.4%) and males (33.8%).

Of the respondents who were members of a student group this helped:

- 71.9% engage with student life
- 65.9% make friends
- 39.2% manage during the pandemic
- 36.5% keep fit
- 18.8% keep on top of their studies

In general younger age groups, 16-20 and 21-24, felt being a member helped them engage with university life, make friends, manage during the pandemic and keep fit more than the older age groups (25-29 and 30+).

The only significant difference across genders was fewer other genders (26.9%) felt that being a member helped them keep fit than males and females.

The majority of respondents felt that the pandemic had had an impact on their experience of university life: over four-fifths (82.8%) felt that they had

not benefitted from the full student experience due to the pandemic and nearly four-fifths (78.6%) felt that the pandemic had negatively impacted their studies. Half (50.6%) of respondents felt that their university coped as well as it could have in the current situation and nearly half (48.1%) of respondents felt that their university introduced new measures that they would like to see remain.

- In general, younger students felt that the pandemic had impacted both their studies and their experience of university more than older students had. Furthermore, older students felt that their university had coped as well it could have in the pandemic more than younger students did.
- Other genders felt that their studies had been impacted more than females and males. Other genders also felt that their university had not coped as well as it could have in the current situation more than females and males; however, they also felt that their university had introduced new measures that they would like to see remain more than females and males.

More students disagreed (35.8%) that their university had the balance right between academic performance and personal life than agreed (30.8%).

- Older age groups, 25-29 (35.8%) and 30+ (37.3%), felt that their university had the balance right between academic performance and personal life than younger age groups, 16-20(27.1%) and 21-24 (29.0%).
- Just under a third (32.9%) of males felt that their university had the balance right between academic performance and personal life compared with 30.5% of females and just over a fifth of those who identify as other genders (22.5%).

Awareness, usage and satisfaction with services

In general, awareness of services and supports are quite high, particularly so Wellbeing Services (83.8%), Student Services (78.6%) and Clubs & Societies Support Services (71.1%). Fewer students had used services and supports with the most commonly used service being Wellbeing Services (24.2%) followed by Student Services (17.3%).

Graph 43. Awareness and Usage of Services

SERVICE / SUPPORT	AWARENESS	USED
Wellbeing Services	83.8%	24.2%
Student Services Clubs & Societies	78.6%	17.3%
Support Services	71.1%	19.3%
Reasonable Adjustments	64.9%	14.9%
Local MH/Wellbeing Services	62.4%	7.9%
Helpline Support Services	62.4%	4.6%
Disability Services	57.4%	13.0%
Student Association Support Services	54.1%	3.1%
Peer Support Services	49.2%	7.6%
University Health Centres	44.9%	6.6%
MH/Wellbeing Campaigns	43.8%	2.2%
MH/Wellbeing Workshops	42.9%	4.5%
Out of Hours Support Services	35.5%	3.3%
Online University Support Services	31.2%	4.7%
Opportunity to engage with MH/WB issues as part of course	26.7%	3.5%
Quiet Rooms	17.8%	1.9%
Other Supports	8.1%	0.9%

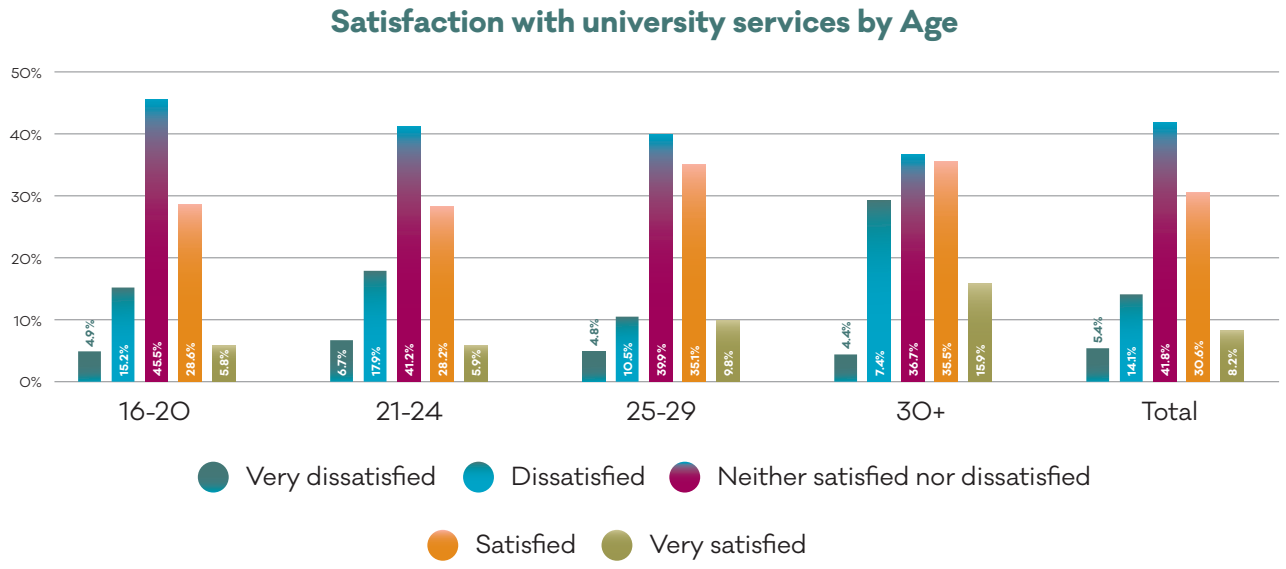
Satisfaction with support

All respondents were asked about their satisfaction with university services. Nearly two-fifths (38.8%) were either Satisfied or Very Satisfied with their university's services and nearly a fifth (19.5%) were either Dissatisfied or Very Dissatisfied with their university's service.

Satisfaction with support by Age

Levels of satisfaction increased through the age groups with those aged 30+ (51.4%) and 25-29 (35.5%) being more satisfied than those aged 16-20 (34.4%) and 21-24 (34.1%).

A Kruskal-Wallis test showed that there was a significant difference across groups, H (3) = 350.32, p < .001). Bonferroni corrected post-hoc Mann Whitney U tests explored this effect. All groups were significantly different from all other groups (all p < .05).



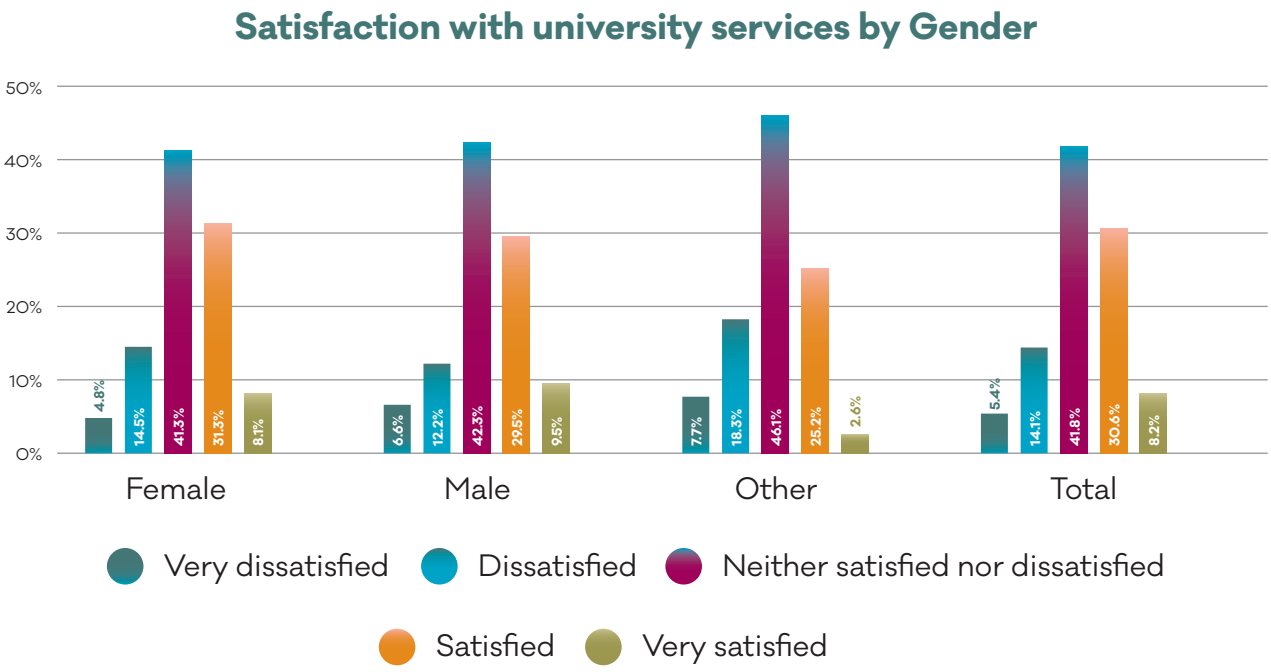
Graph 44. Satisfaction with University Services by Age

n (age) = 12740 n (total) = 12832

Satisfaction with support by Gender

Other genders (27.8%) were less satisfied with university services compared to males (39.4%) and females (39.0%).

A Kruskal-Wallis test showed that there was a significant difference across groups, H (3) = 35.03, p < .001). Bonferroni corrected post-hoc Mann Whitney U tests explored this effect. Other genders were significantly different from males and females (all p < .001) but males and females did not differ from each other (p >.05).



Graph 45. Satisfaction with University Services by Gender

n (gender) = 12820 n (total) = 12832

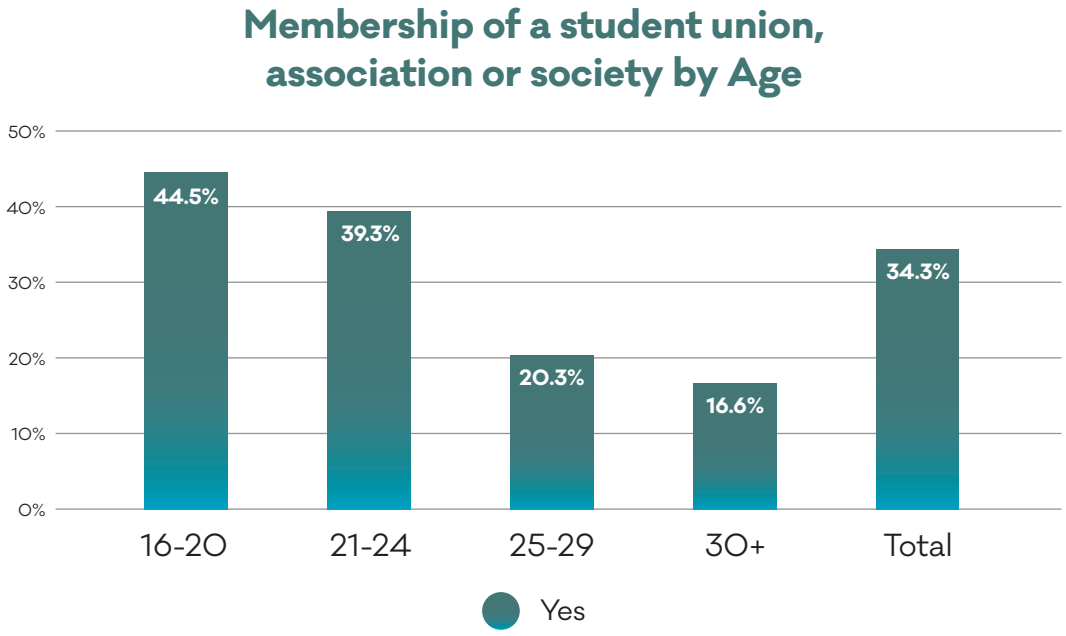
Student Union/Association/ Society Membership

Just over a third of respondents (34.3%) stated that they were a member of either a student society, association or union.

Student Union/Association/Society Membership by Age

Those in the younger age groups were more likely to be a member of a student group with nearly half (44.5%) of those aged 16-20 and 39.3% of those aged 21-24 being members of a student group compared with 20.3% of those aged 25-29 and 16.6% of those aged 30+.

A Chi-square test revealed a significant association between age and membership of student groups ($\chi 2$ (3) = 734.00, p < .001).



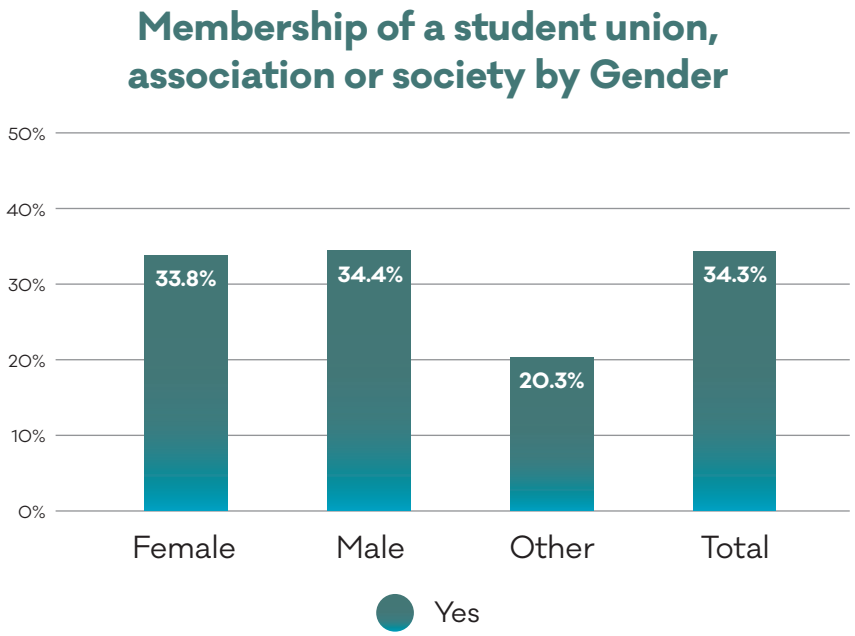
Graph 46. Membership of a Student Group by Age

n (age) = 12813 n (total) = 12917

Student Union/Association/Society Membership by Gender

Other genders (20.3%) had lower rates of being a member of a student group compared to males (33.8%) and females (34.4%).

A Chi-square test revealed a significant association between gender and membership of student groups ($\chi 2$ (2) = 19.125, p < .001).



Graph 47. Membership of a Student Group by Gender

n (gender) = 12898 n (total) = 12917

Being a member of a student group

The following questions were only asked to those respondents who indicated that they were a member of a student group. Nearly three-quarters (71.9%) of respondents said that being a member of a group helped them engage with university life and two-thirds (65.9%) said that it helped them make friends. Nearly two-fifths (39.2%) said that being a member of a group helped them manage during the pandemic and over a third (36.5%) said that it helped them keep fit. Just under a fifth (18.8%) of respondents said that being a member of a group helped them keep on top of their studies.

Being a member of a student group by Age

Overall, younger students reported feeling the benefits of being a member of a student group more than older students did.

Kruskal-Wallis tests showed that there was a significant difference across age groups for each question except 'helped me keep on top of my studies' (p=.074). Bonferroni corrected post-hoc Mann Whitney U tests explored these effects. See Table 5.1 in Appendix 5 for more detail.

Engage with university life by Age

All groups were significantly different from all other groups (all p= < .002) except for 16-20 and 25-29 (p=.056). Younger ages groups, 16-20 (70.9%) and 21-24 (79.5%), felt that being a member of a student group helped them engage more with university life than older age groups, 25-29 (64.3%) and 30+ (52.6%).

Make friends by Age

All groups were significantly different from all other groups (all p= < .001) except for 25-29 and 30+ (p=.054). Younger age groups, 16-20 (64.8%) and 21-24 (75.2%), felt that being a member of a student group helped them make friends more than older age groups, 25-29 (54.0%) and 30+ (44.0%).

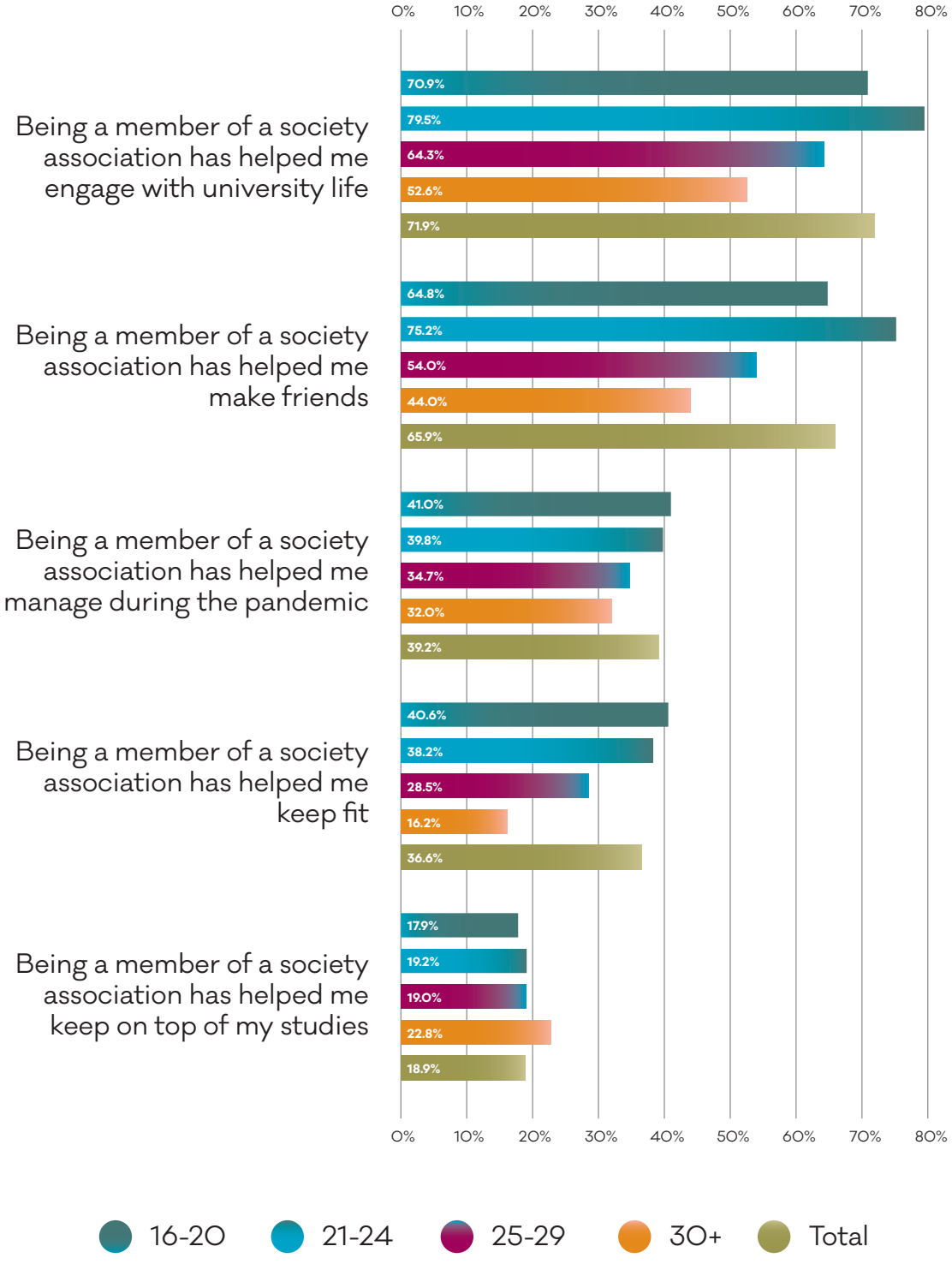
Manage during pandemic by Age

Only the 16-20 and 30+ groups were significantly different from each other (p=.026). Feeling that being a member of a student group helped them manage during the pandemic decreased through the age groups, over two-fifths (41.0%) of those aged 16-20 younger compared with less than a third (32.0%) of those aged 30+.

Keep fit by Age

All groups were significantly different from all other groups (all p= < .008) except for 16-20 and 21-24 groups (p=.878). Younger ages groups, 16-20 (40.6%) and 21-24 (38.2%), felt that being a member of a student group helped them keep fit more than older age groups, 25-29 (28.5%) and 30+ (16.2%).

Benefits of Membership by Age



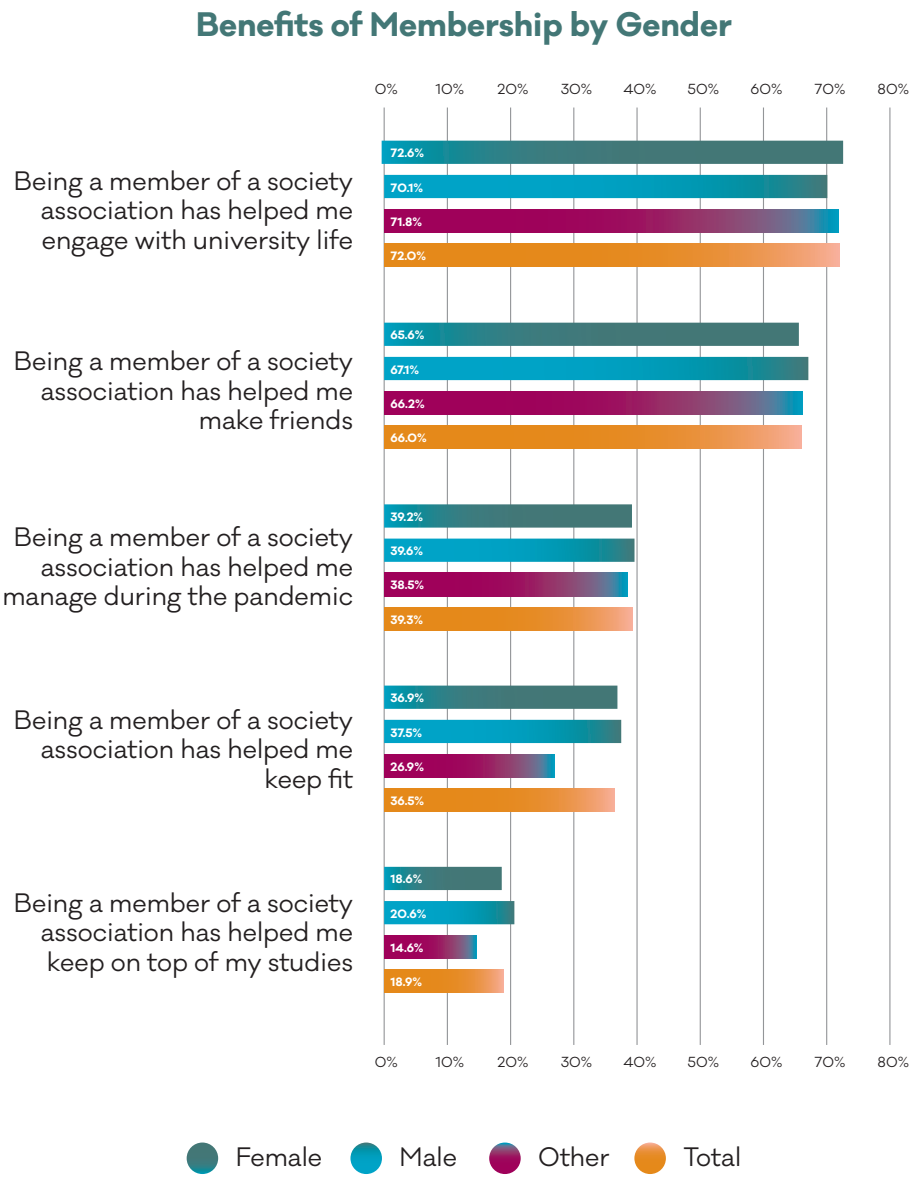
Graph 48. Benefits of Student Group Membership by Age
This graph displays the positive responses ('Yes') to the question on the y-axis.

n (age) = 4368 n (total) = 4392

Being a group member By Gender

There was very little difference in the benefits of membership of a student group by gender with the exception of helping to keep fit in which other genders (26.9%) agreed less that being a member of a student group helped them keep fit than males (36.9%) or females (37.5%).

Kruskal-Wallis tests showed that there was only significant difference across genders for the 'helped me keep fit' question (H(2) =6.79, p=.033). Bonferroni corrected post-hoc Mann Whitney U tests explored these effects. The only group significantly different was Female-Other (p=.028). All other groups (Female-Male and Male-Other) showed no significant relationship (p> .05).



Graph 49. Benefits of Student Group Membership by Gender
This graph displays the positive responses ('Yes') to the question on the y-axis.

n (gender) = 4387 n (total) = 4392

Pandemic

The majority of respondents felt that the pandemic had had an impact on their experience of university life: over four-fifths (82.8%) felt that they had not benefitted from the full student experience due to the pandemic and nearly four-fifths (78.6%) felt that the pandemic had negatively impacted their studies. Half (50.6%) of respondents felt that their university coped as well as it could have in the current situation and nearly half (48.1%) of respondents felt that their university introduced new measures that they would like to see remain.

Pandemic by Age

In general, younger students felt that the pandemic had impacted both their studies and their experience of university more than older students had. Furthermore, older students felt that their university had coped as well it could it have in the pandemic more than younger students did.

Kruskal-Wallis tests showed that there was a significant difference across age groups for each question (all p<.001). Bonferroni corrected post-hoc Mann Whitney U tests explored these effects. See Table 5.2 in Appendix 5 for more detail.

Negatively impacted studies by Age

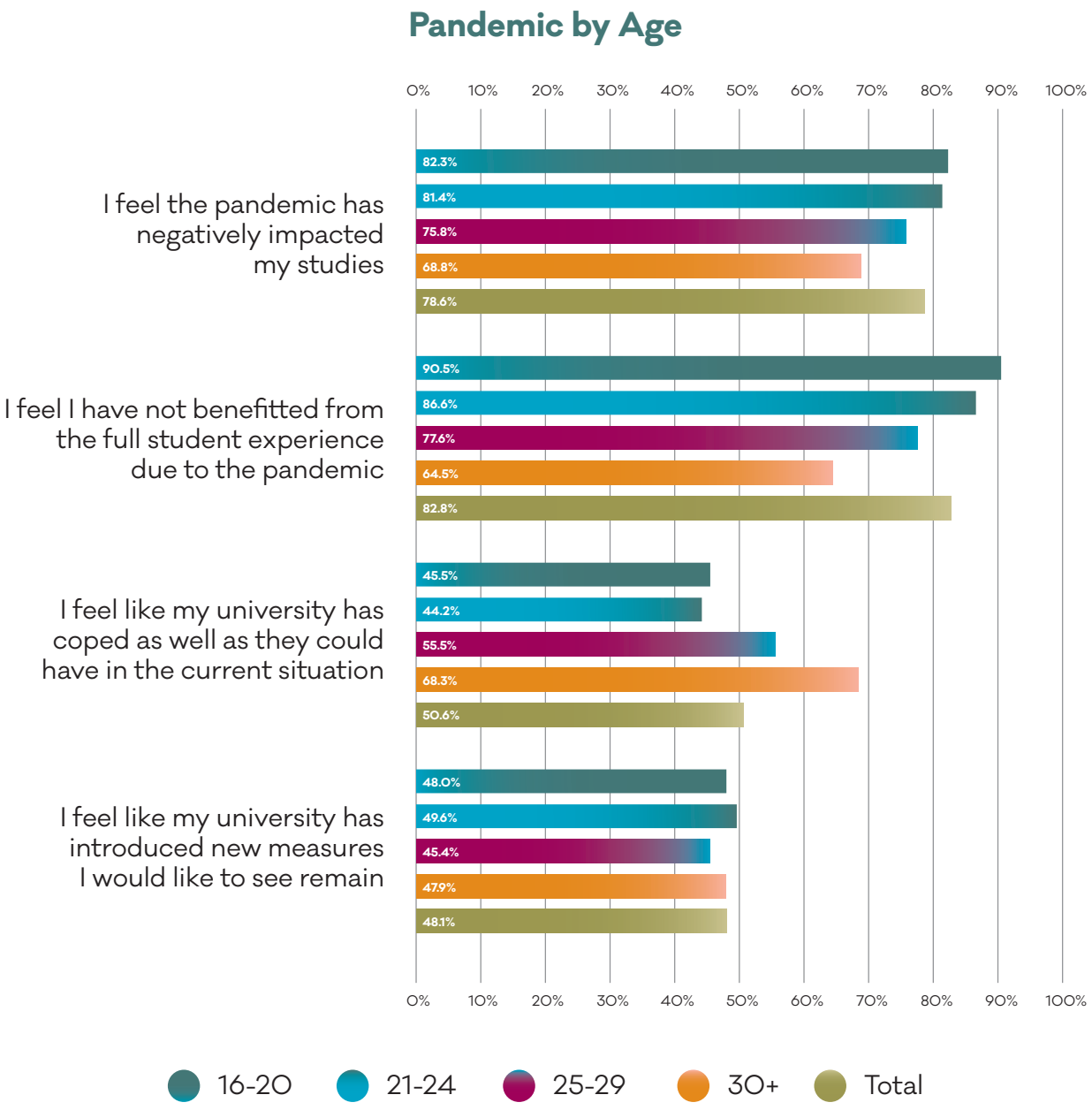
All groups were significantly different from all other groups (all p < .001) except for the comparison between the 16-20 and 21-24 age groups (p = .922). This suggests that younger age groups (16-20 and 21-24) were more negatively impacted in their studies than older age groups (25-29 and 30+).

Not benefiting from the full student experience by Age

All groups were significantly different from all other groups (all p < .001). The younger age groups felt more strongly that they had not benefitted from the full student experience and this dropped through the age groups. Over four-fifths (82.3%) of those aged 16-20 felt they had not benefited from the full student experience compared with just over two-thirds (68.8%) of those aged 30+.

University has coped as well as it could have by Age

All groups were significantly different from all other groups (all p < .001) except for 16-20 and 21-24 (p=.152). Feelings that their university had coped as well as it could have during the pandemic broadly increased through the age groups except for slightly more of those aged 16-20 (45.5%) agreed with this than of those aged 21-24 (44.2%). Over two-thirds (68.8%) of those aged 30+ agreed that their university had coped as well it could have.



Graph 50. Pandemic by Age

This graph shows the collective Agree or Strongly Agree responses per Age group for each question

n (age) = 12624 n (total) = 12717

Pandemic by Gender

Other genders felt that their studies had been impacted more than females and males. Other genders also felt that they their university had not coped as well as it could have in the current situation more than females and males; however, they also felt that their university had introduced new measures that they would like to see remain more than females and males.

Kruskal-Wallis tests showed that there was a significant difference across gender groups for each question (all p=<.009). Bonferroni corrected post-hoc Mann Whitney U tests explored these effects. See Table 5.3 in Appendix 5 for more detail.

Negatively impacted studies by Gender

Other genders were significantly different from males and females (all p =< .002) but there was no difference between male and female groups (p = .656). This suggests other genders (83.0%) felt their studies were more negatively impacted by the pandemic than males (76.7%) and females (79.0%).

Not benefiting from the full student experience by Gender

Only males and females were significantly different from each other (p=.014). There were no significant differences other genders and either males or females (all p>=0.05). Females (83.4%) and other genders (83.8%) felt that they had not benefitted from the full student experience due to the pandemic more than males (80.8%).

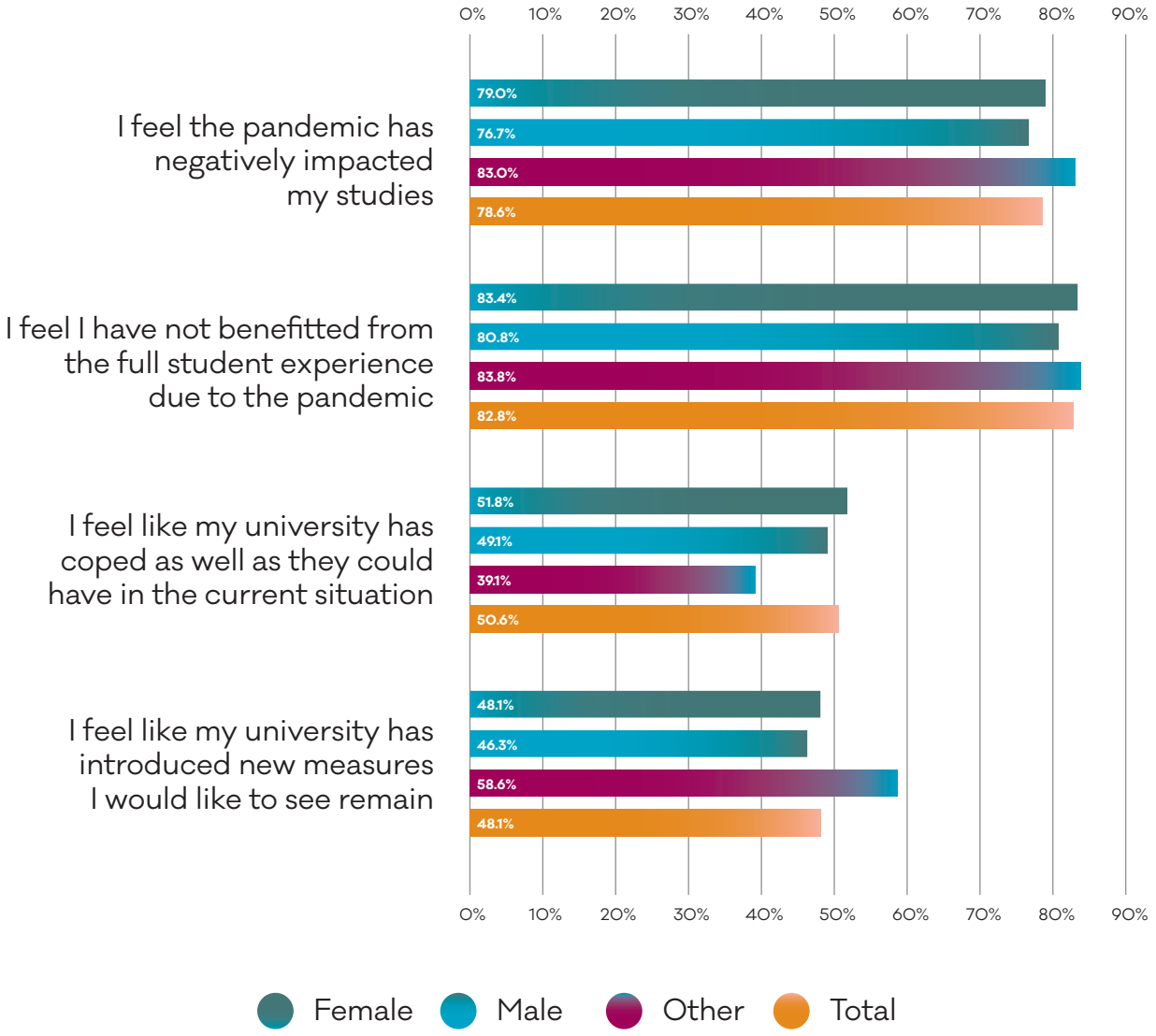
University has coped as well as it could have by Gender

All groups were significantly different from all other groups (all p =< .001). More than half (51.8%) of females felt their university had coped as well as it could have. Just under half of males (49.1%) felt their university had coped as well as it could have and under two-fifths (39.1%) of other genders felt that their university had coped as well as it could have.

New measures by Gender

All groups were significantly different from all other groups (all p =< .004). Nearly 6 in 10 (58.6%) of those who identify as other genders felt their university had introduced new measures they would like to see remain. Under half of both males (46.3%) and females (48.1%) felt that their university had introduced new measures they would like to see remain.

Pandemic by Gender



Graph 51. Pandemic by Gender
This graph shows the collective Agree or Strongly Agree responses per Age group for each question
n (age) = 12706 n (total) = 12717

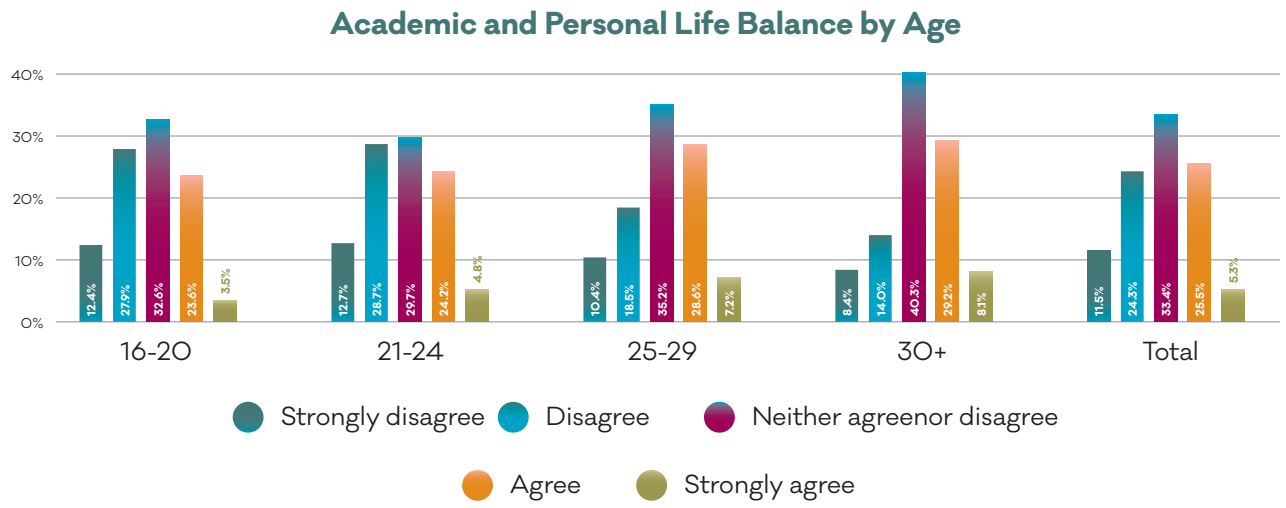
Academic and personal life balance

More students disagreed (35.8%) that their university had the balance right between academic performance and personal life than agreed (30.8%).

Academic and personal life balance by Age

Older age groups, 25-29 (35.8%) and 30+ (37.3%), felt that their university had the balance right between academic performance and personal life than younger age groups, 16-20(27.1%) and 21-24 (29.0%).

A Kruskal-Wallis test showed that there was a significant difference across groups, H (3) = 248.91, p < .001). Bonferroni corrected post-hoc Mann Whitney U tests explored this effect. All groups were significantly different from all other groups (all p =< .007) except for 16-20 and 21-24 (p>.05).



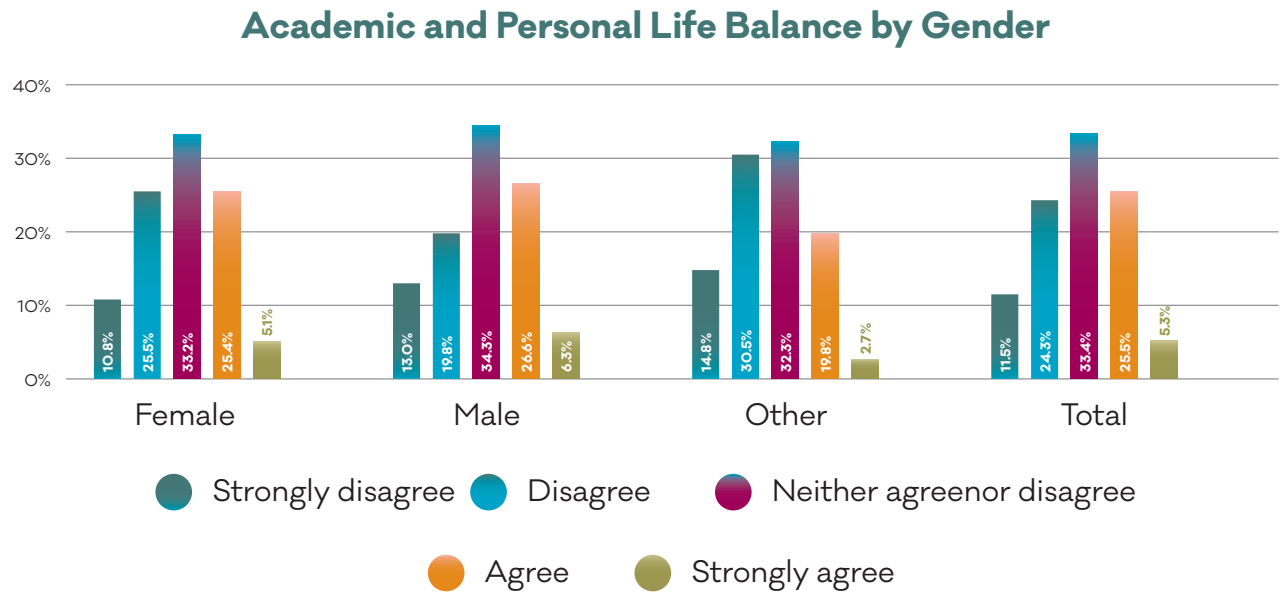
Graph 52. Academic and Personal Life Balance by Age

n (age) = 12638 n (total) = 12731

Academic and personal life balance by Gender

Just under a third (32.9%) of males felt that their university had the balance right between academic performance and personal life compared with 30.5% of females and just over a fifth of other genders (22.5%).

A Kruskal-Wallis test showed that there was a significant difference across groups, H (2) = 31.39, p < .001). Bonferroni corrected post-hoc Mann Whitney U tests explored this effect. All groups were significantly different from all other groups (all p =< .035), with more males agreeing than females, who in turn agreed more than other genders.



Graph 53. Academic and Personal Life Balance by Gender

n (gender) = 12720 n (total) = 12731

Personal and Social Experiences

Personal and Social Experiences

This section reports on the questions the survey asked concerning personal and social experiences.

Respondents were asked questions about friendships and relationships, coping with pressure and online activity. The section shows a summary of the key findings. Following that it will show each response to a question, then a summary of the breakdown by age with a graph and then by gender and a graph. Additional information can be found in the Appendices.

Summary

Over half (55.8%) of respondents had friends at university they could speak to about worries or concerns.

- This was higher for younger age groups, 16-20 (62.5%) compared with older age groups, 30+ (38.2%).
- This was higher for females (57.8%) than other genders (53.1%) and males (50.05%).

Nearly four-fifths (78.7%) had friends at home they could speak to about worries or concerns.

- The oldest age group, 30+, reported lower levels of friends at home

they could speak to about worries or concerns than the other age groups.

- Females (80.6%) reported higher levels of friends at home they could speak to than other genders (75.5%) and males (73.7%).

Over two-thirds (70.6%) had family they could speak to about worries or concerns.

- Those aged 21-24 reported higher levels of having family they could speak to than the other age groups.
- Females (72.1%) reported higher levels of having family they could speak to than males (69.6%) and other genders (49.6%).

Under half (47.2%) had a partner they could speak to about worries or concerns.

- Older age groups (25-29, 57.2% and 30+, 60.1%) reported higher levels of having a partner they could speak to than younger age groups (16-20, 35.3% and 21-24, 48.3%).
- Females (49.5%) reported higher levels of having a partner they could speak to than males (42.2%) and other genders (37.4%).

The harmful coping mechanisms most commonly reported were eating too much to cope with pressure (48.1%), avoiding friends to cope with pressure (39.4%), eating too little to cope with pressure (38.6%).

- There were not any general overall trends across age groups for harmful coping mechanisms.
- In general, other genders and females reported higher levels of harmful coping mechanisms to cope with pressure than males.

The positive coping mechanisms most commonly reported were going to a green space more (45.3%), doing exercise (35.4%) and contacting family (34.5%) and friends (33.6%) more. Although respondents indicated they were more likely to do these activities similar numbers

also reported doing some of these activities less re. exercising less (38.7%), contacting friends less (32.6%) and engaging with hobbies less (40.1%).

- In general, younger age groups reported higher levels of utilising positive coping mechanisms to cope with pressure.
- Overall, females reported higher levels of utilising positive coping mechanisms to cope with pressures than other genders and males, with some exceptions.

Most respondents used social media to keep in contact with friends (84.0%) and distract themselves or procrastinate (82.6%). Over half (52.6%) compared themselves to people on social media and just under a third (28.4%) found their use of social media helpful. Nearly two-fifths (39.2%) used social media to help with their studies. Furthermore, 1 in 10 respondents (10.3%) felt that they did not have adequate internet access where they lived to engage with university and friends online.

- Overall, younger age groups reported higher levels across all social media questions, with the exception of adequate internet access.
- Females and other genders reported higher levels across all social media questions, with the exception of adequate internet access.

Friendships and Relationships

Over half (55.8%) of respondents Agreed or Strongly Agreed that they had friends at university that they could speak to and nearly four-fifths (78.7%) Agreed or Strongly Agreed that they had friends at home they could speak to. Seven in ten (70.6%) Agreed or Strongly Agreed that they had family they could speak to and nearly half (47.2%) Agreed or Strongly Agreed that they had a partner they could speak to.

Friendships and Relationships by Age

Kruskal-Wallis tests showed that there was a significant difference across age groups for each question (all p<=.029). Bonferroni corrected post-hoc Mann Whitney U tests explored these effects. See Table 6.1 in Appendix 6 for details of tests.

Friends at university by Age

All groups were significantly different from all other groups (all p< .001) except for 16-20 and 21-24 (p>.05). Nearly two-thirds of the younger age groups, 16-20 (62.5%) and 21-24 (62.9%), had friends at university they felt they could speak to about worries or concerns compared to less than half (45.7%) of those aged 25-29 and just under two-fifths (38.2%) of those aged 30+.

Friends at home by Age

Three age groups were significantly different from other groups, 16-20 and 30+, 21-24 and 30+ and 25-29 and 30+ (all p= < .002). The other groups did not have a significant relationship (p>0.05). Those aged 30+ were less likely to have friends at home they could speak to about worries or concerns than those in the other age groups.

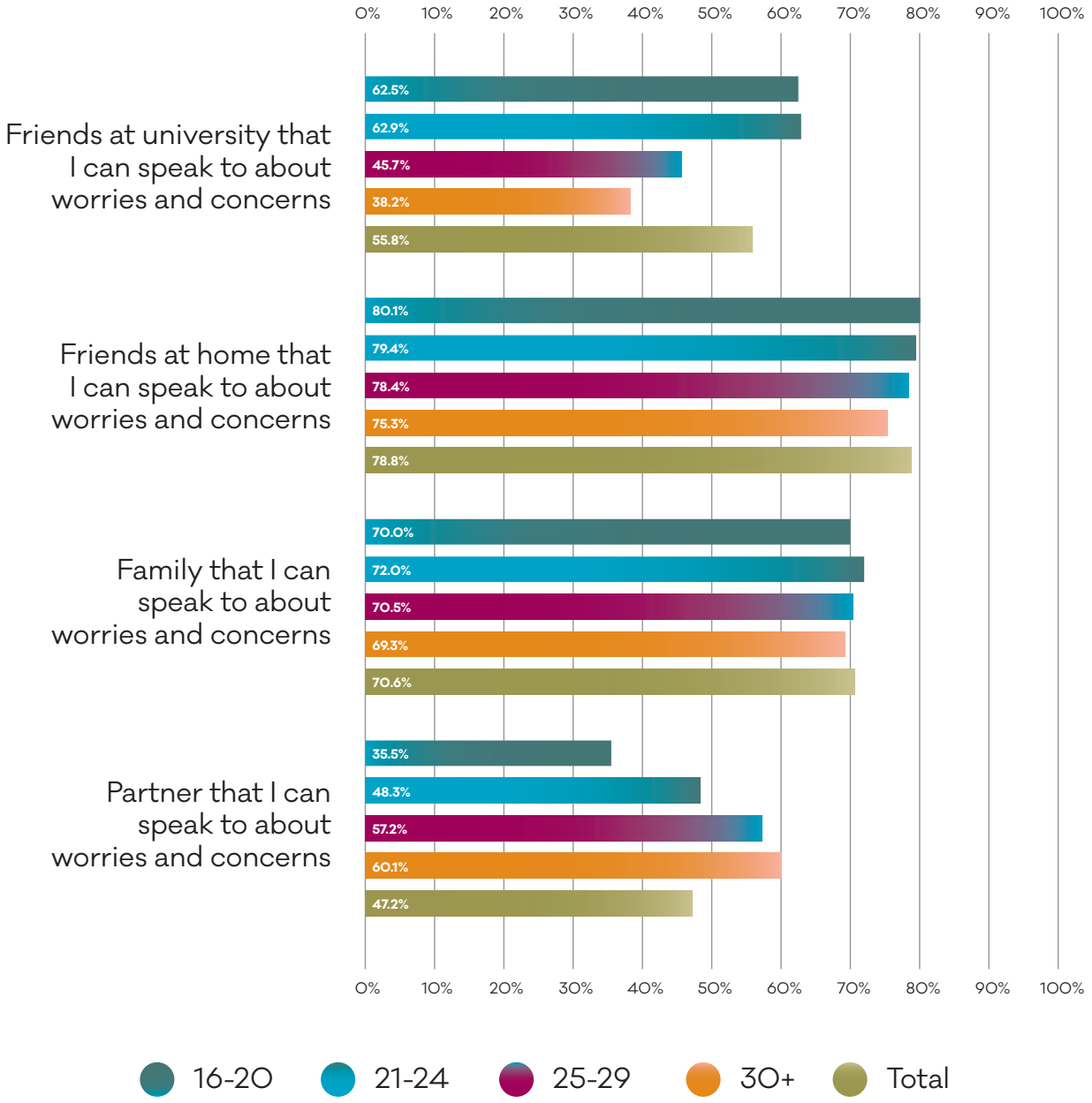
Family by Age

Only one group was significantly different 21-24 and 30+ (p=.02). There was no significant difference between the other groups (all p>.05). Those aged 30+ were slightly less likely to have family that they could speak to about worries or concerns compared with those in other age groups. Those aged 21-24 were slightly more likely to have family they could talk to about worries or concerns.

Partner by Age

All groups were significantly different from all other groups (all p< .001) except for 25-29 and 30+ (p>.05). Those in the older age groups 25-29 (57.2%) and 30+ (60.1%) were more likely to have a partner that they could talk to about worries or concerns than those aged 16-20 (35.5%) and 21-24 (48.3%).

Friendships and Relationships by Age



Graph 54. Friendships and Relationships by Age
This graph shows the collective Agree or Strongly Agree responses per Gender group for each question
n (age) = 12625 n (total) = 12717

Friendships and Relationships by Gender

Kruskal-Wallis tests showed that there was a significant difference across age groups for each question (all p<.001). Bonferroni corrected post-hoc Mann Whitney U tests explored these effects. See Table 6.2 in Appendix 6 for details of tests.

Friends at university by Gender

Females were significantly different from both males and other genders (all p =< .004) but males and other gender did not differ (p>.05). Females (57.8%) were more likely to have friends at university that they could speak to about worries or concerns than males (50.5%) or other genders (53.1%).

Friends at home by Gender

Females were significantly different from both males and other genders (all p =< .014) but males and other genders did not differ (p>.05). Females (80.6%) were more likely to have friends at university that they could speak to about worries or concerns than males (73.7%) or other genders (75.7%).

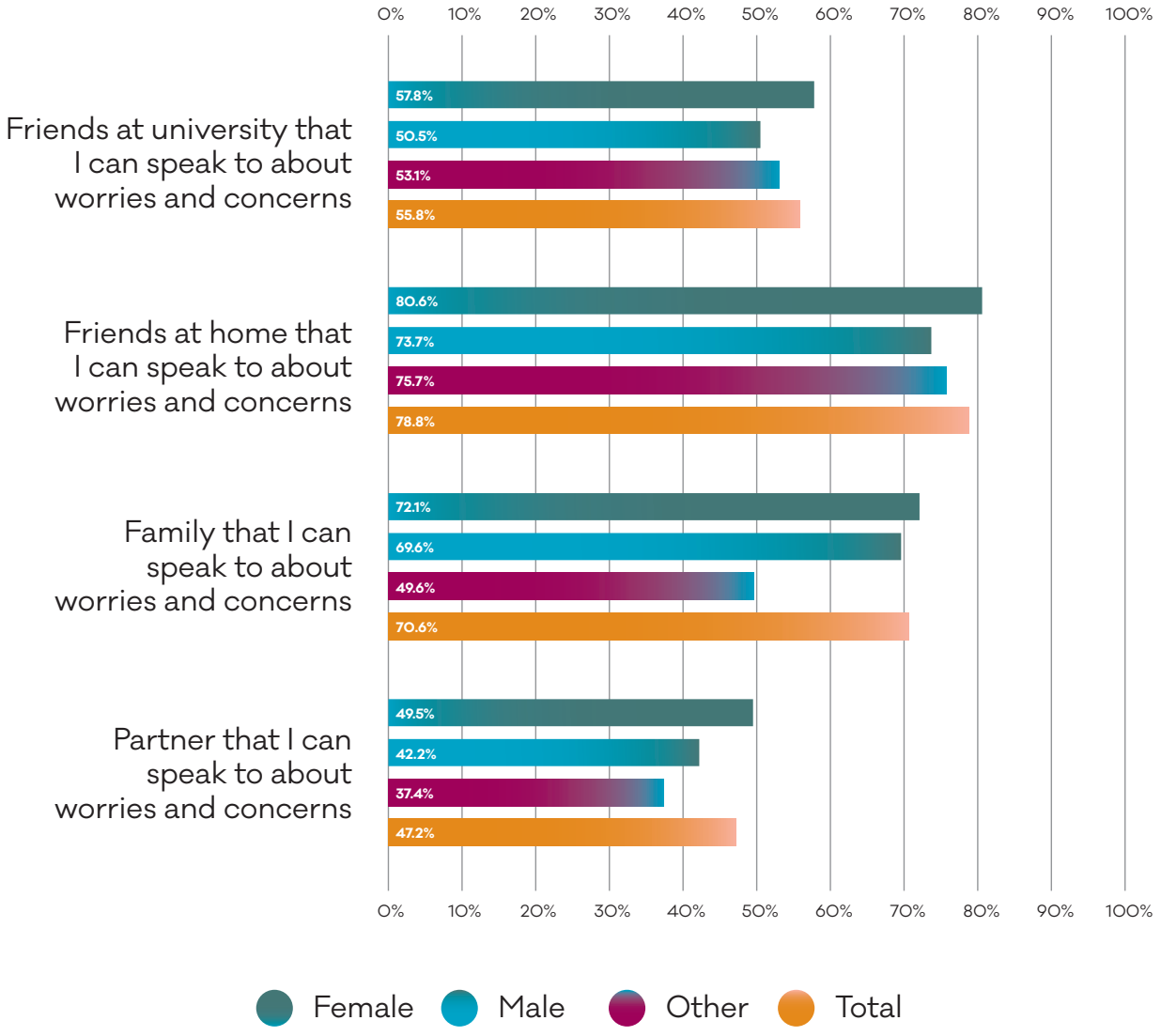
Family by Gender

All groups were significantly different from all other groups (all p =< .047). Other genders (49.6%) were less likely to have family they could speak to about worries or concerns than ales (69.6%) and females (72.1%).

Partner by Gender

All groups were significantly different from all other groups (all p =< .014). Just under half of females (49.5%) had a partner they could speak to about worries or concerns, compared with just over two-fifths (42.5%) of males and under two-fifths (37.3%) of other genders.

Friendships and Relationships by Gender

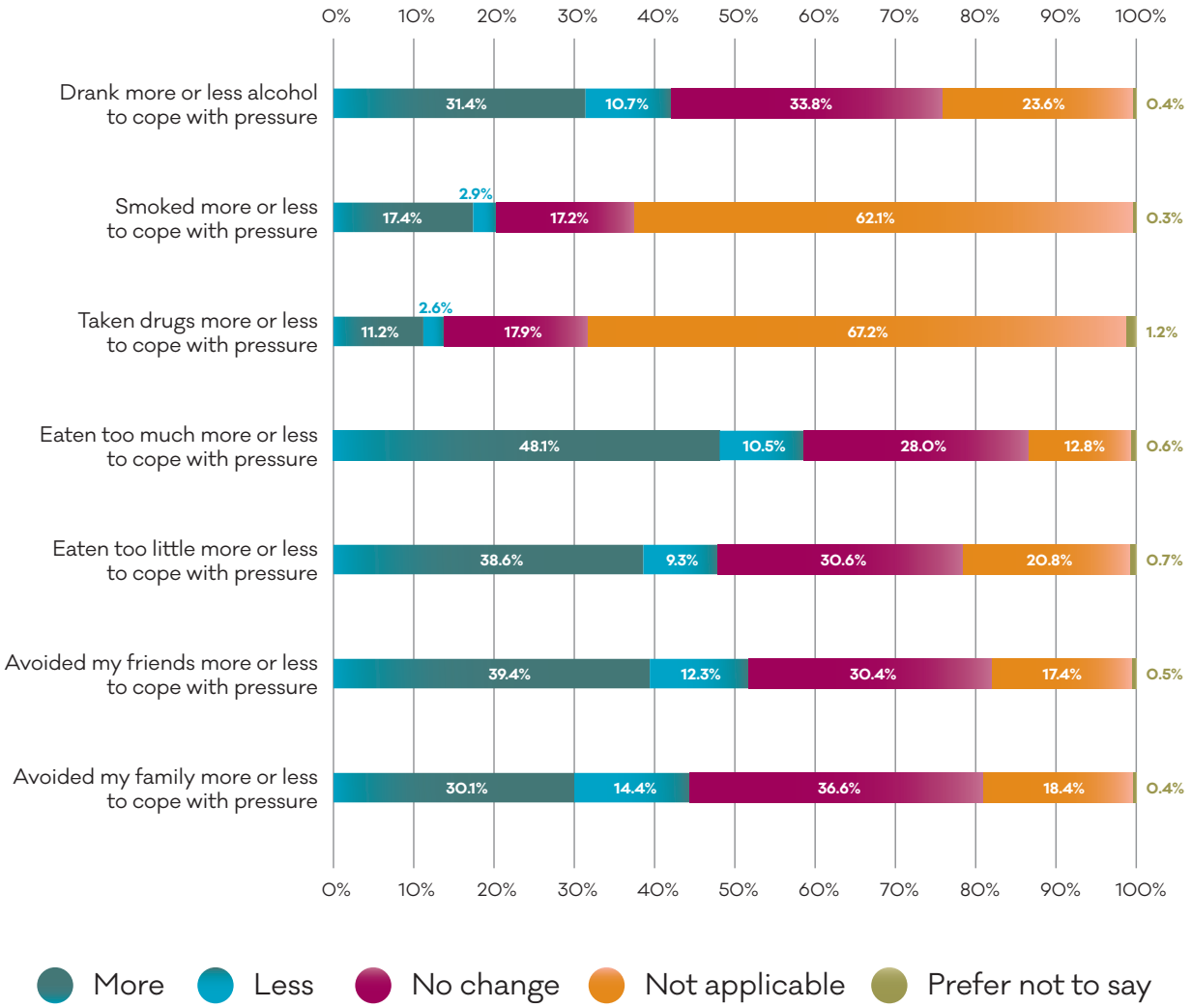


Graph 55. Friendships and Relationships by Gender
This graph shows the collective Agree or Strongly Agree responses per Gender group for each question
n (gender) = 12706 n (total) = 12717

Coping Mechanisms

The harmful coping mechanisms most commonly reported were eating too much to cope with pressure (48.1%), avoiding friends to cope with pressure (39.4%), eating too little to cope with pressure (38.6%).

Harmful Coping Mechanisms



Graph 56. Harmful Coping Mechanisms

n = 12681

Harmful coping mechanisms by Age

There were not any general overall trends across age groups for harmful coping mechanisms. Younger students drank more and ate too little to cope with pressure more than other age groups, but those questions aside the remaining harmful copings mechanisms varied across the age groups.

Kruskal-Wallis tests showed that there was a significant difference across age groups for each question (all p<=.001). Bonferroni corrected post-hoc Mann Whitney U tests explored these effects. See Table 6.5 in Appendix 6 for details of tests.

Alcohol by Age

All groups were significantly different from all other groups (all p<= .007) except for 25-29 and 30+ (p>.05). Younger age groups, 16-20 (46.3%) and 21-24 (44.5%), drank more alcohol to cope with pressure than the older age groups, 25-29 (34.3%) and 30+ (28.6%).

Smoking by Age

Only two groups, 21-24 and 25-29 (p=.012) and 21-24 and 30+ (p=.001), were significantly different from the other groups (all p>0.05). Those aged 21-24 (50.6%) smoked more to cope with pressure than the other age groups, particularly the older age groups.

Drugs by Age

All groups were significantly different from all other groups (all p< .001) except for 16-20 and 21-24 and 25-29 and 30+ (both p>.05). Younger age groups, 16-20 (36.8%) and 21-24 (40.9%) took more drugs to cope with pressure than older age groups, 25-29 (25.5%) and 30+ (21.9%).

Eaten too much by Age

Only two groups, 16-20 and 21-24 (p<.001) and 16-20 and 30+ (p<.001), were significantly different from the other groups (all p>0.05). Those aged 21-24 (58.5%) and 30+ (57.6%) ate too much to cope with pressure than those aged 16-20 (52.2%) and 25-29 (55.1%).

Eaten too little by Age

All groups were significantly different from all other groups (all p< .001). There was a noticeable decrease through the age groups for eating too little to cope with pressure. Over half (56.9%) of 16-20 ate too little to cope with pressure compared with just over a quarter (27.9%) of those aged 30+.

Avoided friends by Age

Three age groups were significantly different from each other, 16-20 and 21-24 (p<.001), 21-24 and 25-29 (p=.02) and 21-24 and 30+ (p<.001). There was no significant difference between the other age groups (p>.05). Those aged 21-24 avoided their friends more to cope with

pressure than any other age group, with over half doing so (53.0%).

Avoided family by Age

Three age groups were significantly different from each other, 16-20 and 21-24 (p<.001) and 21-24 and 25-29 (p=.005) and 21-24 and 30+ (p=.031). There was no significant difference between the other age groups (p>.05). Those aged 21-24 avoided their families more to cope with pressure than any other age group, with more than 4 in 10 doing so (41.6%).

Harmful coping mechanisms by Gender

In general, other genders and females reported higher levels of harmful coping mechanisms to cope with pressure than males. Other genders and females ate too much, ate too little and avoided friends more than males did to cope with pressure. Other genders also drank more and avoided their family more to cope with pressure than females or males.

Kruskal-Wallis tests showed that there was a significant difference across gender groups for each question (all p<=.001) except for the smoking question (p=.082). Bonferroni corrected post-hoc Mann Whitney U tests explored these effects. See Table 6.8 in Appendix 6 for details of tests.

Alcohol by Gender

Other genders were significantly different from males and females (all p < .001) but males and females did not differ (p>.05). Other genders (53.3%) drank more than males (40.9%) or females (40.9%) to cope with pressure.

Drugs by Gender

Other genders were significantly different from males and females (all p <= .025) but males and females did not differ (p = .838). Other genders (45.5%) took drugs more to cope with pressure than males (37.4%) or females (33.7%).

Eaten too much by Gender

Males were significantly different from females and other genders (all p < .001) but females and other genders did not differ (p >.05). Males (44.7%) were less impacted by eating too much to cope with pressure compared with females (58.7%) and other genders (59.6%).

Eaten too little by Gender

All groups were significantly different from all other groups (all p < .001). Nearly two-thirds (65.6%) of other genders ate less to cope with pressure. Over half of females (52.0%) ate less to cope with pressure. Between a third and two-fifths (37.0%) of males ate less to cope with pressure.

Avoided friends by Gender

Males were significantly different from females and other genders (all p < .001) but females and other genders did not differ (p=.486). Males avoided friends less to cope with pressure, with just under 4 in 10

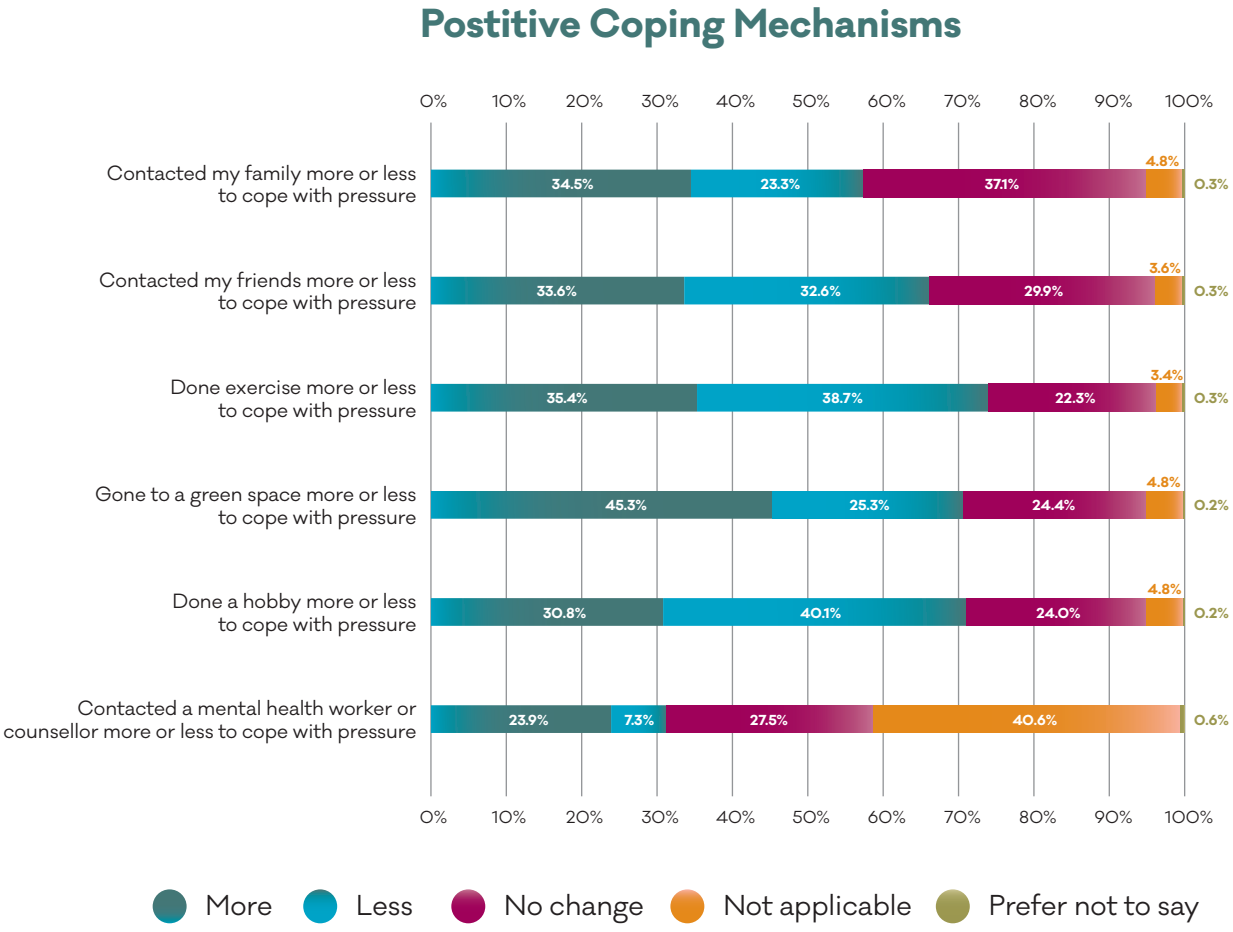
(39.5%) doing so, compared with over half of both other genders (53.7%) and females (50.4%).

Avoided family by Gender

All groups were significantly different from all other groups (all $p < .001$). Over half (54.8%) of other genders avoided their families to cope with pressure, compared with nearly 4 in 10 females (37.6%) and under a third (32.5%) of males.

Positive Coping Mechanisms

The positive coping mechanisms most commonly reported were going to a green space more (45.3%), doing exercise (35.4%) and contacting family (34.5%) and friends more (33.6%). Although respondents indicated they were more likely to do these activities similar numbers also reported doing some of these activities less re. exercising less (38.7%), contacting friends less (32.6%) and engaging with hobbies less (40.1%).



Graph 57. Positive Coping Mechanisms

n = 12667

Positive coping mechanisms by Age

In general, younger age groups reported higher levels of utilising positive coping mechanisms to cope with pressure. This was the case across, contacting family, contacting friends, exercise and going to a green space more to cope with pressure. The middle two age groups (21-24 and 25-29) reported higher levels of doing a hobby and contacting a mental health worker or counsellor more to cope with pressure than either the youngest or oldest age groups.

Kruskal-Wallis tests showed that there was a significant difference across age groups for each question (all p<=.014). Bonferroni corrected post-hoc Mann Whitney U tests explored these effects. See Table 6.11 in Appendix 6 for details of tests.

Contacted family by Age

Only three groups were significantly different from each other, 16-20 and 25-29 (p=.009), 16-20 and 30+ (p<.001) and 21-24 and 30+ (p<.001). There was no significant difference between other groups (all p>.05). Contacting your family to help cope with pressure decreased through the age groups with just under 4 in 10 (39.9%) of those aged 16-20 doing so compared with a quarter (25.8%) of those aged 30+.

Contacted friends by Age

Only three groups were significantly different from each other, 16-20 and 30+ (p<.001), 21-24 and 25-29 (p=.047) and 21-24 and 30+ (p<.001). There was no significant difference between other groups (all p>.05). Broadly contacting friends to cope with pressure decreased through the age groups with just under 4 in 10 of both those aged 16-20 (38.1%) and 21-24 (38.2%) doing so, compared with under a quarter of those aged 30+ (24.5%).

Exercise by Age

Only two groups were significantly different from each other, 16-20 and 30+ (p=.035) and 21-24 and 30+ (p=.012). There was no significant difference between other groups (all p>.05). Those aged 30+ exercised less than the other age groups to cope with pressure, with under a third (30.1%) of them doing so, compared with approaching 4 in 10 of all the other age groups (16-20 – 37.9%, 21-24 – 39.0% and 25-29 – 37.0%).

Green Space by Age

All groups were significantly different from each other (p<=.003) except for 16-20 and 25-29 (p=.077) and 21-24 and 25-29 (p=.968). Broadly, those in younger age groups went to green spaces more to cope with pressure, with over half (52.5%) of those aged 21-24 doing so and approaching half of both those aged 16-20 (46.7%) and 25-29 (49.6%). Compared with under 4 in 10 of those aged 30+ (39.3%).

Hobby by Age

Only three groups were significantly different from each other, 16-20 and

21-24 (p=.001), 21-24 and 30+ (p<.001) and 25-29 and 30+ (p=.010). There was no significant difference between other groups (all p>.05). The middle age groups, 21-24 (35.6%) and 25-29 (33.9%), did a hobby more to cope with pressure than the youngest, 16-20 (32.4%), and oldest, 30+ (25.4%), age groups.

Contacted Mental Health worker or Counsellor by Age

Only three groups were significantly different from each other, 16-20 and 21-24 (p<.001), 16-20 and 25-29 (p=.011) and 21-24 and 30+ (p=.001). There was no significant difference between other groups (all p>.05). The middle age groups, 21-24 (46.1%) and 25-29 (42.3%), contacted a mental health worker or Counsellor more to cope with pressure than the youngest, 16-20 (37.0%), and oldest, 30+ (35.8%), age groups.

Positive coping mechanisms by Gender

Overall, females reported higher levels of utilising positive coping mechanisms to cope with pressures than other genders and males, with some exceptions. Females contacted family more and went to green spaces more to cope with pressure than other genders or males. Females and males exercised more to cope with pressure than other genders and males and females and other genders contacted a mental health worker or counsellor more to cope with pressure than males. Doing a hobby more to cope with pressure was the only mechanism that other genders and males reported higher levels of than females.

Kruskal-Wallis tests showed that there was a significant difference across gender groups for each question (all p<=.002) except for contacting friends more which had no significant difference across genders (p=989). Bonferroni corrected post-hoc Mann Whitney U tests explored these effects. See Table 6.14 in Appendix 6 for details of tests.

Contacted family by Gender

Females were significantly different from males and other genders (all p<.001) but males and other genders did not differ (p=.518). Females (38.2%) contacted their family to cope with pressure more than males (31.3%) or other genders (31.1%).

Exercise by Gender

Other genders were significantly different from males and females (all p<.001) but males and females did not differ (p=.441). Just over a quarter of Other genders (27.8%) exercised more to cope with pressure compared with approaching 4 in 10 (37.4%) of females and over a third of males (35.9%).

Green space by Gender

Only males and females (p=.004), were significantly different from each other.

There was no significant difference between other genders and either males or females (all p>.05). Females (48.8%) went to a green space to cope with pressure more than males (44.7%) and other genders (43.5%).

Hobby by Gender

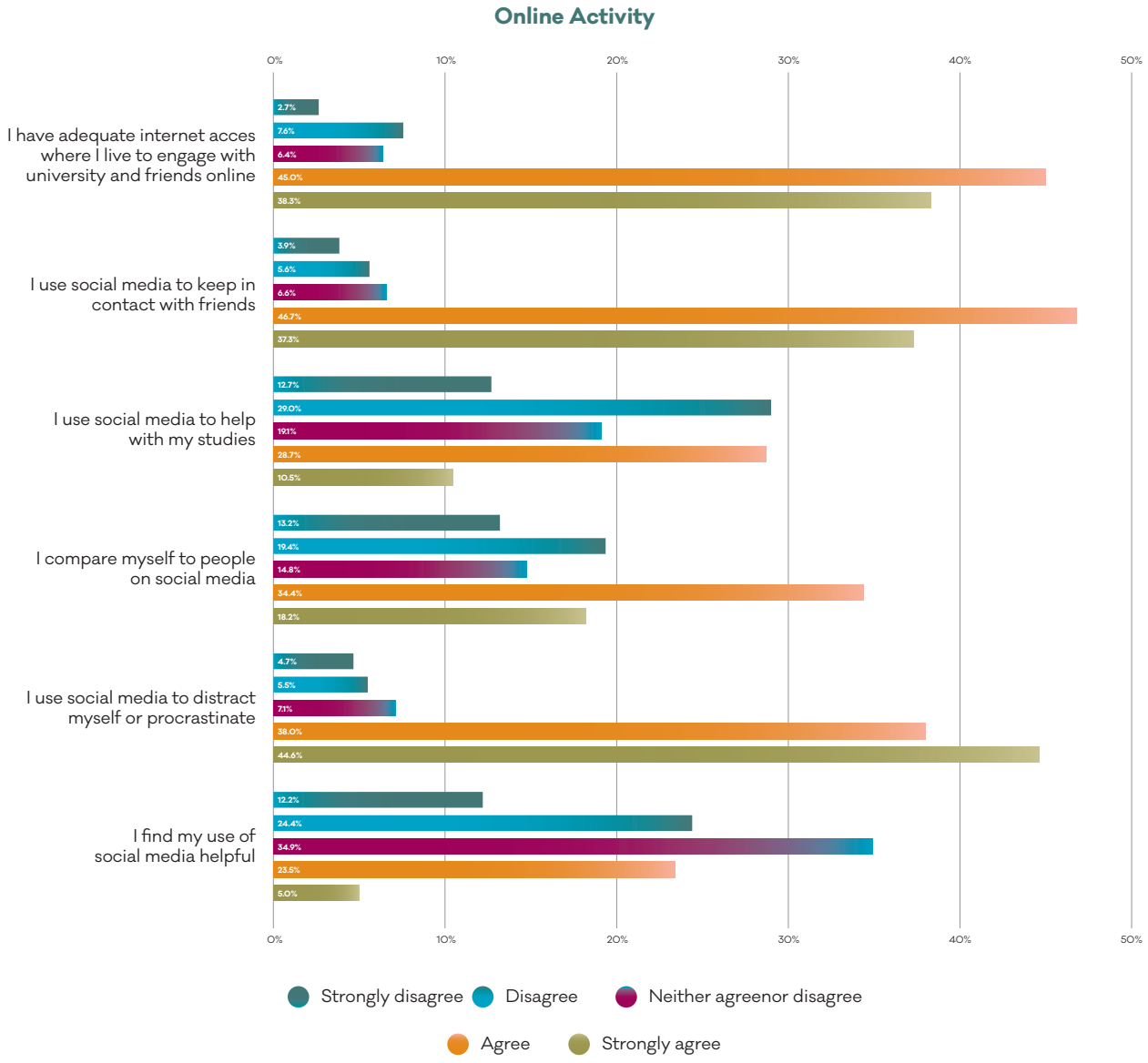
Only males and females (p<.001), were significantly different from each other. There was no significant difference between other genders and either males or females (all p>.05). Females (31.4%) did a hobby less than males (34.8%) or other genders (37.6%) to cope with pressure.

Contacted a Mental Health worker or Counsellor by Gender

All groups were significantly different from each other (all p<.001). More than half (52.3%) of those who identify as other genders contacted a Mental Health worker or Counsellor more to cope with pressure. Over 4 in 10 (42.5%) females contacted a Mental Health worker or Counsellor more to cope with pressure. Less than a third (32.0%) of males contacted a Mental Health worker or Counsellor more to cope with pressure.

Online Activity

Most respondents used social media to keep in contact with friends (84.0%) and distract themselves or procrastinate (82.6%). Over half (52.6%) compared themselves to people on social media and just under a third (28.4%) found their use of social media helpful. Nearly two-fifths (39.2%) used social media to help with their studies. Furthermore, 1 in 10 respondents (10.3%) felt that they did not have adequate internet access where they lived to engage with university and friends online.



Graph 58. Online Activity

n = 12708

Online Activity by Age

Overall, younger age groups reported higher use of social media for keeping in contact with friends, helping with their studies and to distract themselves or procrastinate than older age groups. Younger age groups also reported higher rates of comparing themselves to others on social media than older age groups but also found their use of social media more helpful than older age groups as well.

Kruskal-Wallis tests showed that there was a significant difference across age groups for each question (all p=<.001) except for 'I have adequate internet access...' (p=.669). Bonferroni corrected post-hoc Mann Whitney U tests explored these effects. See Table 6.15 in Appendix 6 for details of tests.

Using social media to keep in contact with friends by Age

All groups were significantly different from all other groups (all p =< .001). Younger age groups used social media to keep in contact with friends more than older age groups, with a drop of 9 in 10 (90.7%) of those aged 16-20 compared to 69.1% of those aged 30+.

Using social media to help with my studies by Age

All groups were significantly different from all other groups (all p =< .001) except for 25-29 and 30+ (p>.05). Younger age groups, 16-20 (42.6%) and 21-24 (39.8%), used social media to help with their studies more than older age groups, 25-29 (35.0%) and 30+ (34.4%).

Comparing yourself to people on social media by Age

All groups were significantly different from all other groups (all p =< .001). Comparing yourself to others on social media dropped noticeably through the age groups, starting with nearly two-thirds (63.1%) of those aged 16-20 and dropping to just over a quarter (26.4%) of those aged 30+.

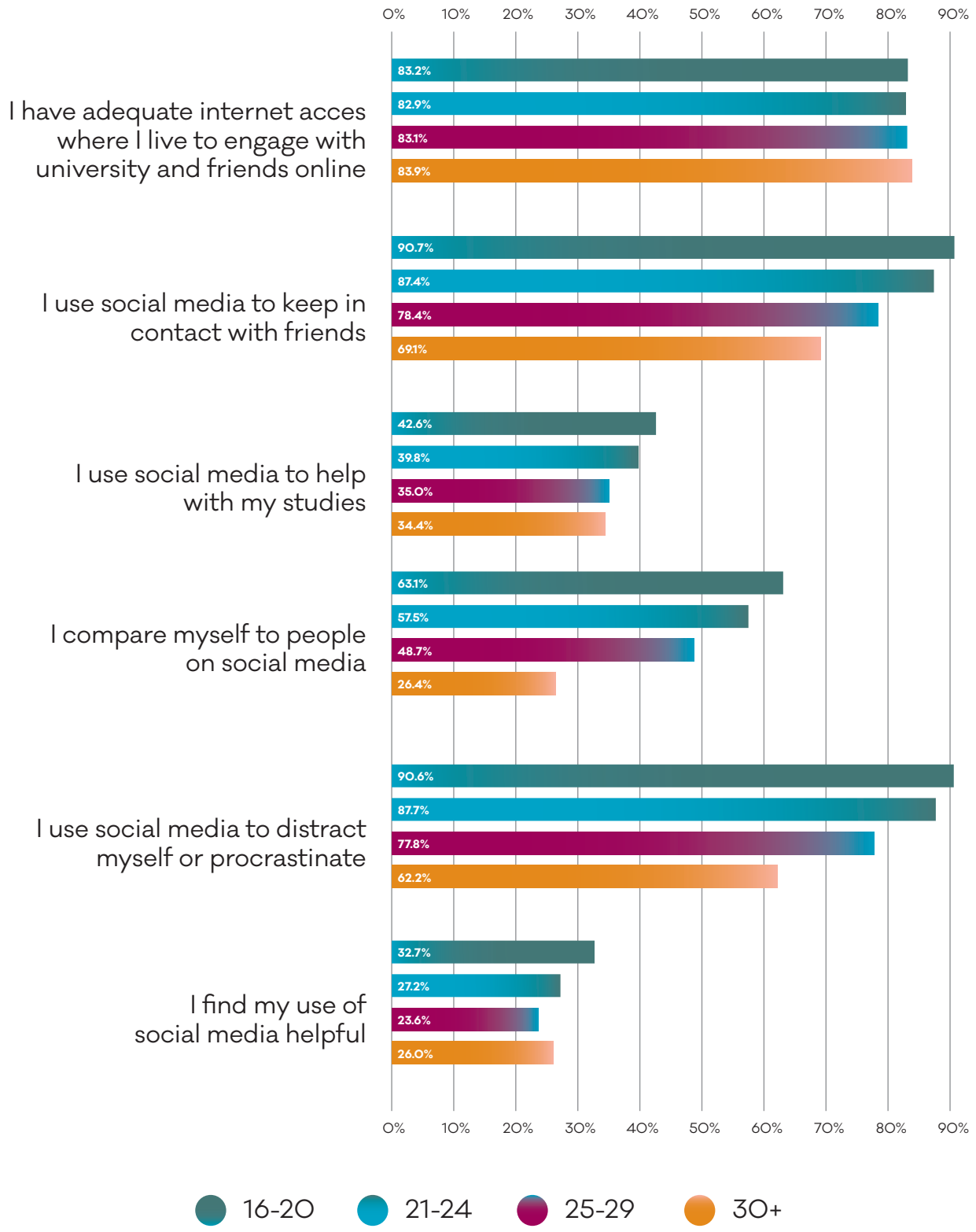
Using social media to distract yourself or procrastinate by Age

All groups were significantly different from all other groups (all p =< .001). Using social media to distract yourself or procrastinate dropped noticeably through the age groups, starting with over 9 in 10 (90.6%) of those aged 16-20 and dropping to just under two-thirds (62.2%) of those aged 30+.

Finding use of social media helpful by Age

Four groups were significantly different from each other, 16-20 and 21-24 (p<.001), 16-20 and 25-29 (p<.001), 16-20 and 30+ (p<.001) and 21-24 and 25-29 (p=.006). The remaining groups were not significantly different from each other (all p>.05). The youngest age group (16-20) generally found their use of social media more helpful than the older age groups with just under a third (32.7%) agreeing compared with just over a quarter (26.0%) of those aged 30+.

Online Activity by Age



Graph 59. Online Activity by Age

This graph shows the collective Agree or Strongly Agree responses per Age group for each question

n = 12615

Online Activity by Gender

Females compared themselves to others on social media more than other genders and males did, they also used social media to help with their studies more than other genders and males. For all but one the remaining questions, keeping in contact with friends, distraction or procrastination and finding use of social media helpful, females and other genders reported higher levels than males. Males reported higher levels of adequate internet access than both females and other genders.

Kruskal-Wallis tests showed that there was a significant difference across age groups for each question (all p=<.001). Bonferroni corrected post-hoc Mann Whitney U tests explored these effects. See Table 6.16 in Appendix 6 for details of tests.

Adequate internet access to engage with university and friends by Gender

Only males and females were significantly different from each other (p<.001). There were no significant differences between other genders and either males or females (all p>=0.05). More males 'Strongly agreed' that they had adequate internet access (42.5%) compared with females (37.0%) and other genders (37.0%).

Using social media to keep in contact with friends by Gender

Males were significantly different from females and other genders (all p < .001) but females and other genders did not differ (p>.05). Males (76.8%) used social media less to keep in contact with friends than females (86.5%) and other genders (82.6%).

Using social media to help with studies by Gender

All groups were significantly different from all other groups (all p <= .026). Over two-fifths (41.7%) of females used social media to help with their studies compared with just over a third of other genders (36.3%) and just under a third of males (32.3%).

Comparing yourself to people on social media by Gender

All groups were significantly different from all other groups (all p < .001). Females were more likely to compare themselves with people on social media with nearly 6 in 10 (58.4%) reporting that they do so, compared with just under half (48.5%) of other genders and just over a third (36.2%) of males.

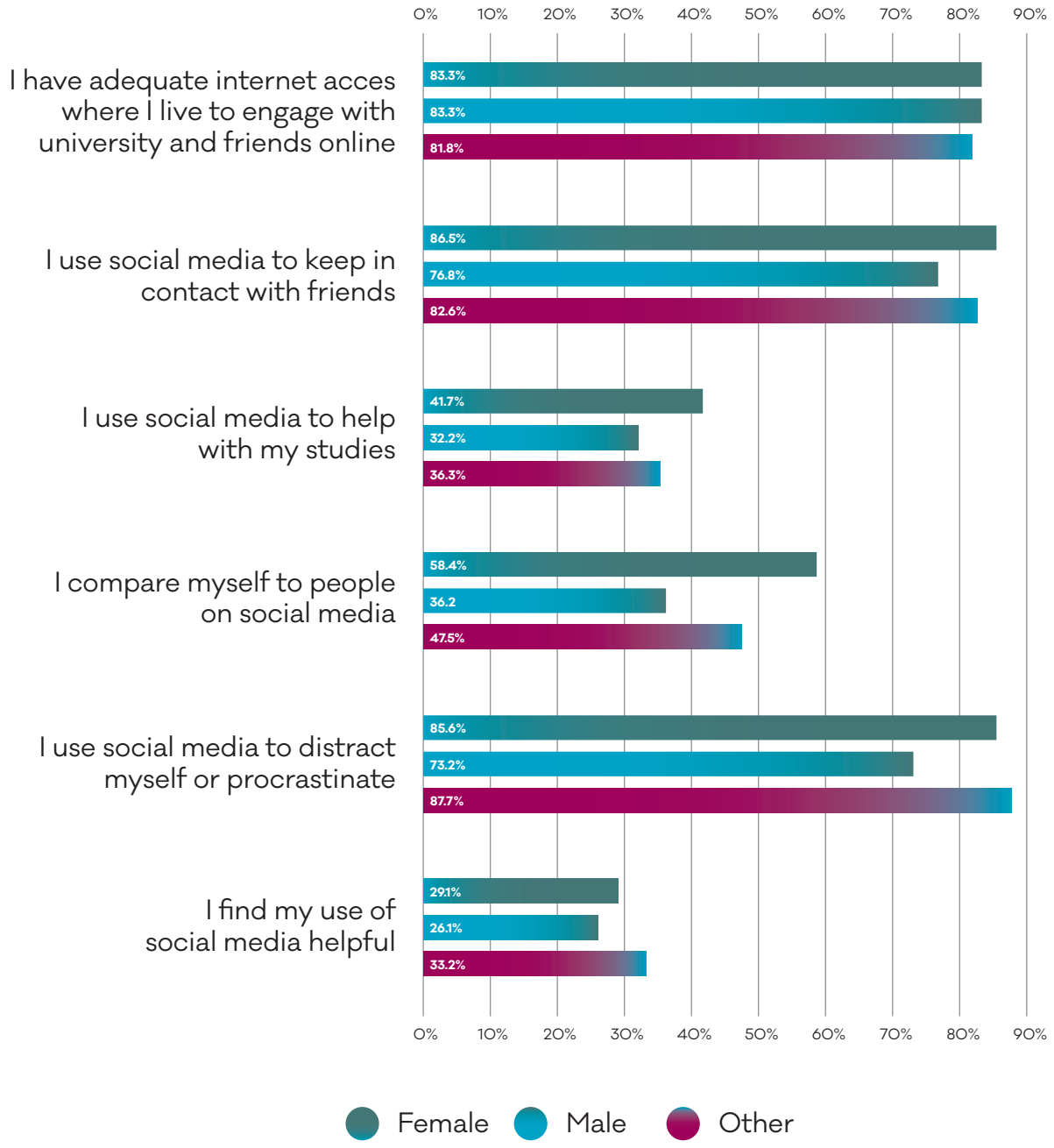
Using social media to distract yourself or procrastinate by Gender

Males were significantly different from females and other genders (all p < .001) but females and other genders did not differ (p=.158). Males (73.2%) were less likely to use social media to distract themselves than other genders (87.7%) and females (85.6%).

Finding use of social media helpful by Gender

Males were significantly different from females and other genders (all p < .001) but females and other genders did not differ (p=.285). Males (26.1%) were less likely to find their use of social media helpful than other genders (33.2%) and females (29.1%).

Online Activity by Gender



Graph 60. Online Activity by Gender
This graph shows the collective Agree or Strongly Agree responses per Age group for each question
n = 12697

Protective and risk factors

Protective and Risk Factors

This section first reviews the correlation between three validated measures used in the survey, ACEs, PHQ-9 and SWEMWBS. Following that is gives an overview of the five factors (questions) that had the strongest association with both the PHQ-9 and SWEMWBS, respectively.

Summary

- There was a strong, negative, correlation between SWEMWBS and PHQ-9 - as the SWEMWBS score went up, the PHQ-9 score went down and vice versa. There was a very weak, negative, correlation between SWEMWBS and ACEs – as experiences of ACEs went down, SWEMWBS scores went up slightly. There was a weak, positive, correlation between PHQ-9 and ACEs – as experiences of ACEs went up, PHQ-9 scores went up slightly.
- The factors (questions) most strongly associated with high PHQ-9 scores (re. Severe symptoms of depression) were General Health scores, experience of suicidal ideation or had attempted to kill themselves, whether they had concealed a mental health problem for fear of stigmatisation or not, experience of a psychological issue that they felt they needed psychological support and current mental health diagnosis.
- The factors (questions) most strongly associated with positive wellbeing (SWEMWBS) scores were General Health scores, experience of suicidal

ideation or had attempted to kill themselves, whether students had family they could speak with about worries or concerns, whether they had concealed a mental health problem for fear of stigmatisation or not and feeling like the pandemic had negatively impact on their studies.

Correlation between Validated Measures

Spearmen's Rank Order tests were used to assess the correlation between the three validated measures (ACEs, PHQ-9 and SWEMWBS) used in the survey.

There was a strong, negative, correlation between SWEMWBS and PHQ-9 (Rs = -.727, p <.001) - as the SWEMWBS score went up, the PHQ-9 score went down and vice versa. There was a very weak, negative, correlation between SWEMWBS and ACEs (Rs = -.193, p <.001) – as experiences of ACEs went down, SWEMWBS scores went up slightly. There was a weak, positive, correlation between PHQ-9 and ACEs (Rs= .300, p<.001) – as experiences of ACEs went up, PHQ-9 scores went up slightly.

Generally, the impact of ACEs did not appear to have much impact on either wellbeing or symptoms of depression, however there was a strong relationship between wellbeing and symptoms of depression.

Correlations

			CONVERTED SWEMWBS SCORE	PHQ-9 Full	ACEs Full
Spearman's Rank Order	Converted SWEMWBS Score	Correlation Coefficient	1.000	-.727**	-.193**
		Sig. (2-tailed)		.000	.000
		N	13941	12604	13195
	PHQ-9 Full	Correlation Coefficient	-.727**	1.000	.300**
		Sig. (2-tailed)	.000		.000
		N	12604	12604	12367
	ACEs Full	Correlation Coefficient	-.193**	.300**	1.000
		Sig. (2-tailed)	.000	.000	
		N	13195	12367	13195

** Correlation is significant at the 0.01 level (2-tailed)

Graph 61. Correlation between Validated Measures

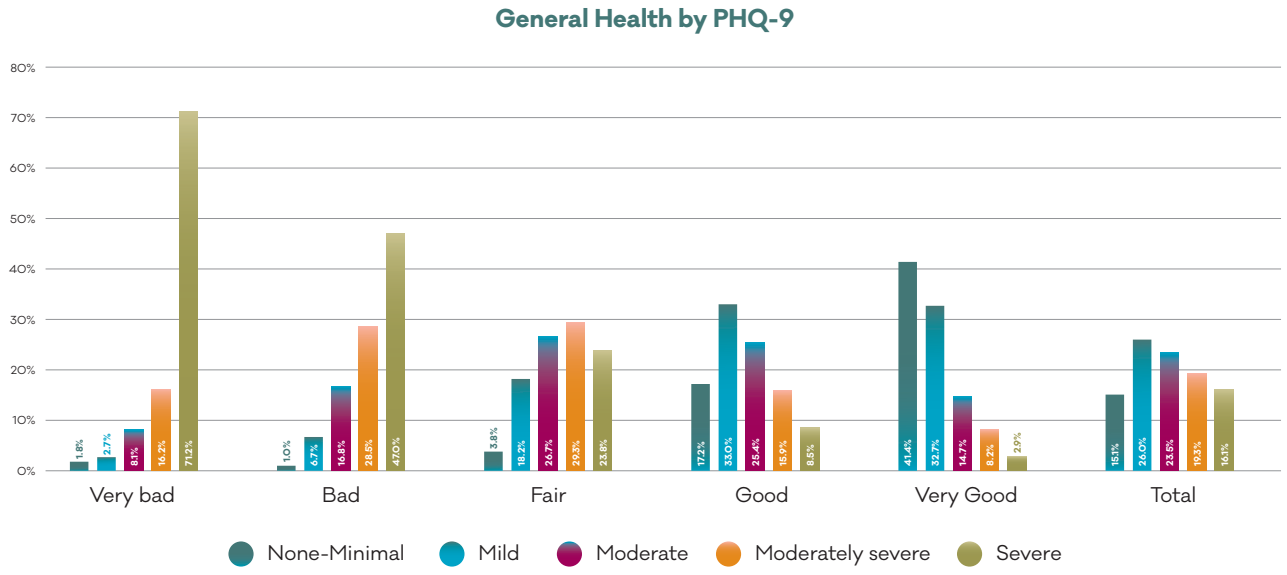
Factors influencing PHQ-9

Kruskal-Wallis and Mann-Whitney U tests were run for all questions in the survey against the PHQ-9 scores to ascertain which factors had the strongest association with PHQ-9 scores. Following this Effect Sizes were calculated for each Kruskal-Wallis and Mann-Whitney U test to establish how strong the association between the factor and PHQ-9 was. This section will discuss the five factors that had the strongest association with PHQ-9 scores. The Effect Sizes of all other questions on PHQ-9 can be found in Tables 4.1 and 4.2 in Appendix 4.

General Health

In general, as self-reported General Health increased, symptoms of depression decreased. Nearly three-quarters (71.2%) of those reporting Very Bad health had Severe symptoms of depression. The figure for Severe symptoms of depression decreases markedly as self-reported health gets closer to Good (8.5%) and Very Good (2.9%). Conversely, None-Minimal symptoms increase from 1.8% of those reporting Very Bad health to 41.1% of those reporting Very Good health.

A Kruskal-Wallis test showed that there was a significant difference across groups, H (4) = 3110.341, p < .001, with a large effect size (0.25). Bonferroni corrected post-hoc Mann Whitney U tests explored this effect. All groups were significantly different from all other groups (all p < .001) except for Very Bad and Bad (p=.011).



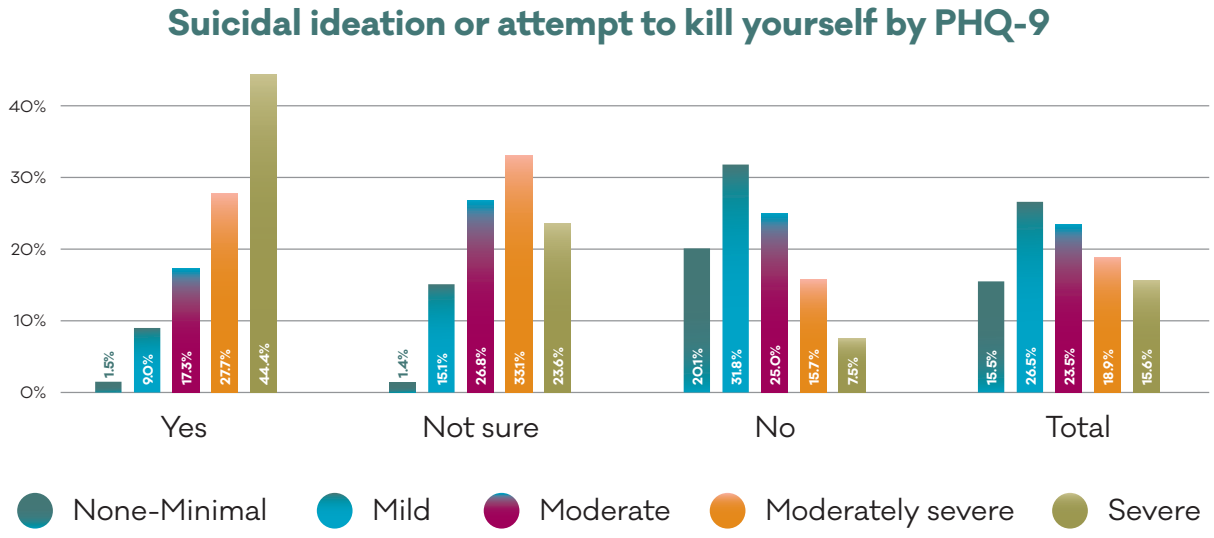
Graph 62. General Health by PHQ-9

n = 12595

Ideation or attempt to kill yourself

Those who had either experienced suicidal ideation or attempted to kill themselves had much higher rates of Severe symptoms (44.4%) than those who had not experienced ideation or attempted to kill themselves (7.5%). Conversely, None-Minimal symptoms were much higher for those who had not experienced ideation or attempted to kill themselves (20.1%) than for those who had experienced ideation or attempted to kill themselves (1.5%).

A Kruskal-Wallis test showed that there was a significant difference across groups, H (2) = 2613.758, p < .001, with a large effect size (0.22). Bonferroni corrected post-hoc Mann Whitney U tests explored this effect. All groups were significantly different from all other groups (all p < .001).



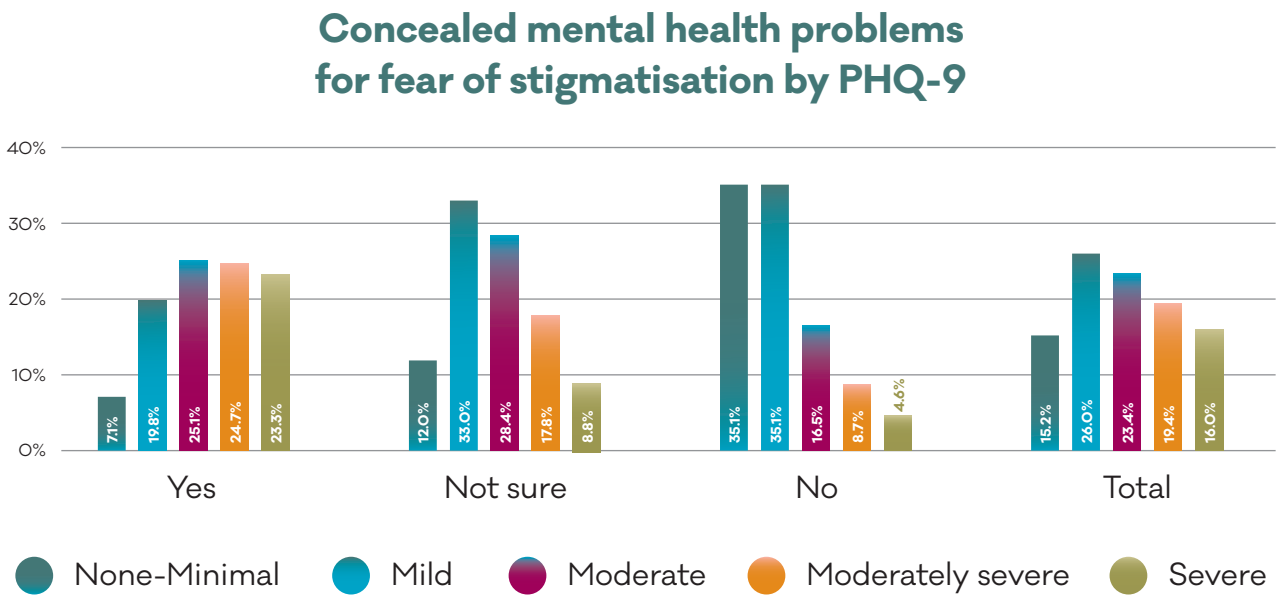
Graph 63. Suicidal Ideation or Attempt to Kill Yourself by PHQ-9

n = 12098

Concealed a mental health problem for fear of stigmatisation

Those who had experiences of concealing a mental health problem for fear of stigmatisation had higher rates of Severe symptoms of depression (23.3%) than those who had no experiences of concealing a mental health problem for fear of stigmatisation (4.6%). 7 in 10 (70.2%) of those with no experiences of concealing a mental health problem for fear of stigmatisation had None-Minimal or Mild symptoms of depression, compared with a quarter (26.9%) of those who had concealed a mental health problem for fear of stigmatisation and just under a half (45%) of those who were not sure whether they had concealed a mental health problem for fear of stigmatisation.

A Kruskal-Wallis test showed that there was a significant difference across groups, H (2) = 2262.600, p < .001, with a large effect size (0.18). Bonferroni corrected post-hoc Mann Whitney U tests explored this effect. All groups were significantly different from all other groups (all p < .001).



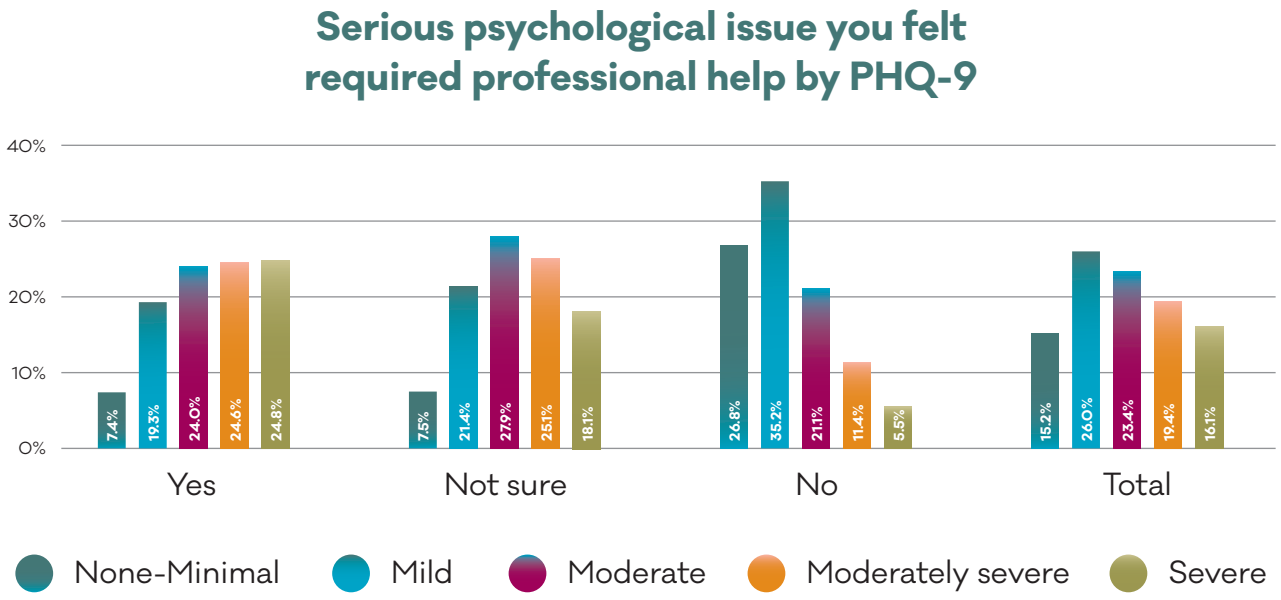
Graph 64. Concealed mental health problems for fear of stigmatisation by PHQ-9

n = 12450

Experienced a Serious Psychological issue that you felt needed professional help

Nearly half (49.4%) of those who had experienced a serious psychological issue that they felt required professional help had either Moderately-Severe or Severe symptoms of depression – compared with 16.9% of those who had not experienced a serious psychological issue they felt required professional help.

A Kruskal-Wallis test showed that there was a significant difference across groups, H (2) = 1962.449, p < .001, with a large effect size (0.16). Bonferroni corrected post-hoc Mann Whitney U tests explored this effect. All groups were significantly different from all other groups (all p < .001).



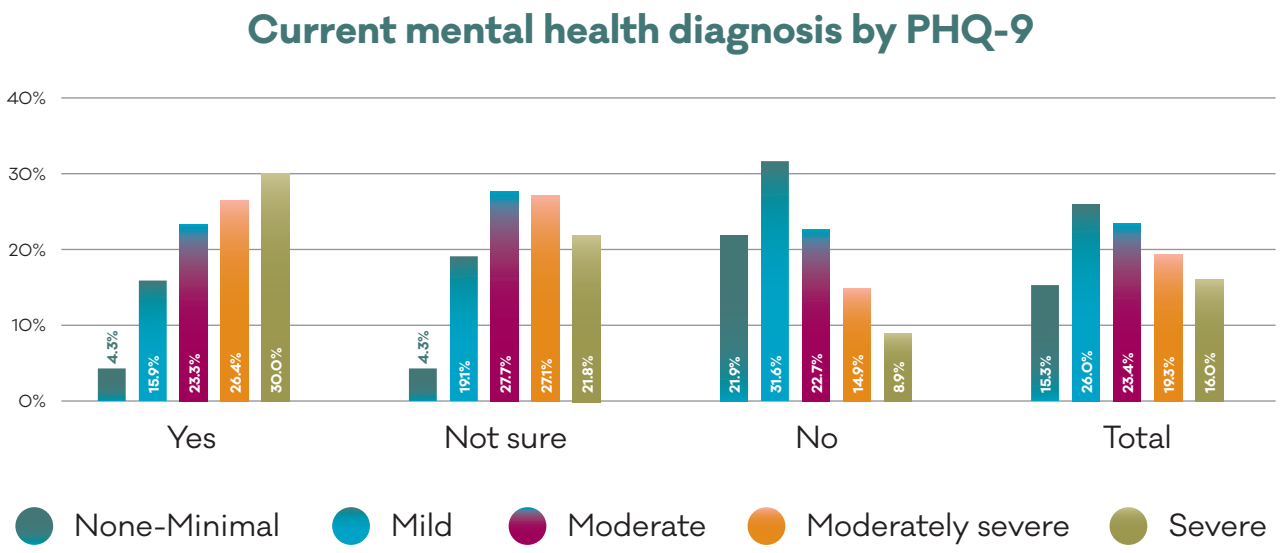
Graph 65. Serious Psychological Issue by PHQ-9

n = 13222

Current Mental Health diagnosis

Over half (56.4%) of those with a current mental health diagnosis had either Moderately-Severe or Severe symptoms of depression and only 4.3% displayed None-Minimal symptoms of depression. Nearly a quarter (23.8%) of those who did not have a current mental health diagnosis had either Moderately-Severe or Severe symptoms of depression. Nearly half (48.9%) of those who were not sure if they had a current mental health diagnosis had either Moderately-Severe or Severe symptoms of depression.

A Kruskal-Wallis test showed that there was a significant difference across groups, H (2) = 1780.787, p < .001, with a large effect size (0.14). Bonferroni corrected post-hoc Mann Whitney U tests explored this effect. All groups were significantly different from all other groups (all p < .001).



Graph 66. Current Mental Health Diagnosis by PHQ-9

n = 12389

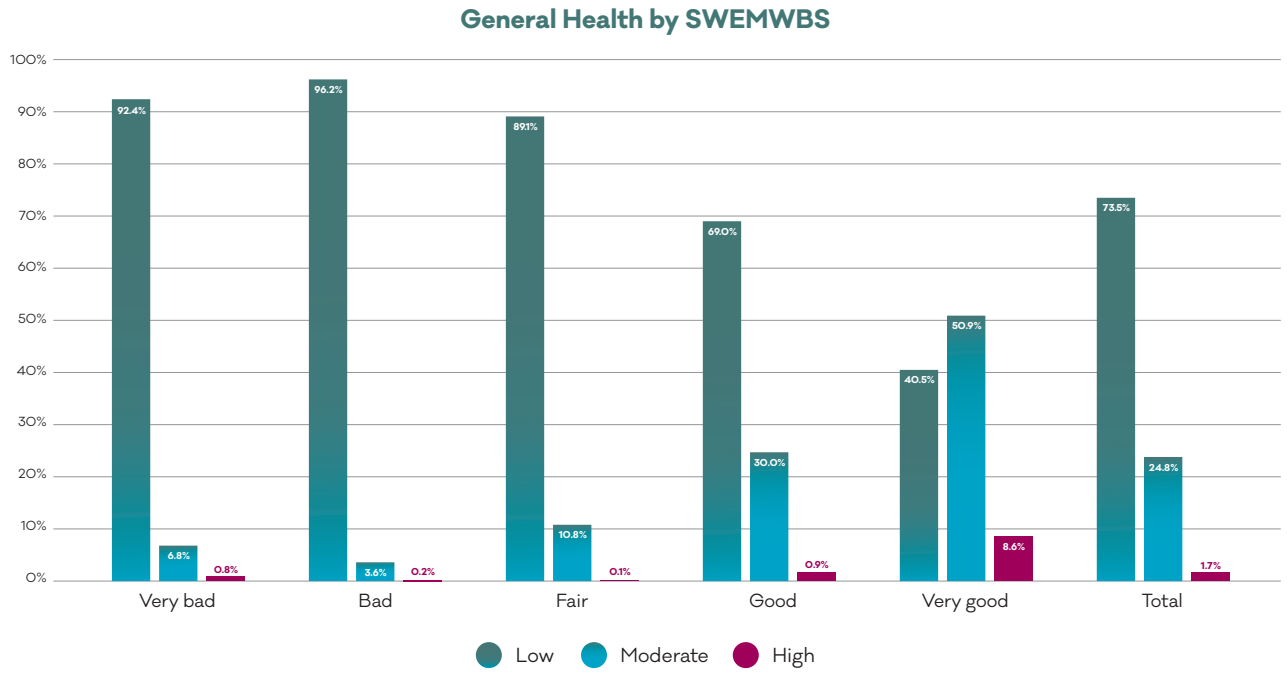
Factors influencing SWEMWBS

Kruskal-Wallis and Mann-Whitney U tests were run for all questions in the survey against the SWEMWBS scores to ascertain which factors had the strongest association with SWEMWBS scores. Following this Effect Sizes were calculated for each Kruskal-Wallis and Mann-Whitney U test to establish how strong the association between the factor and SWEMWBS was. This section will discuss the five factors that had the strongest association with SWEMWBS scores. The Effect Sizes of all other questions on SWEWBS can be found in Tables 4.3 and 4.4 in Appendix 4.

General Health

In general, as self-reported health increased so too did wellbeing. Levels of Moderate and High wellbeing increased from 7.6% of those with self-reported Very Bad health to 59.5% of those with self-reported Very Good health.

A Kruskal-Wallis test showed that there was a significant difference across groups, H (4) = 3008.975, p < .001, with a large effect size (0.22). Bonferroni corrected post-hoc Mann Whitney U tests explored this effect. All groups were significantly different from all other groups (all p < .001) except for Very Bad and Bad (p=.051).



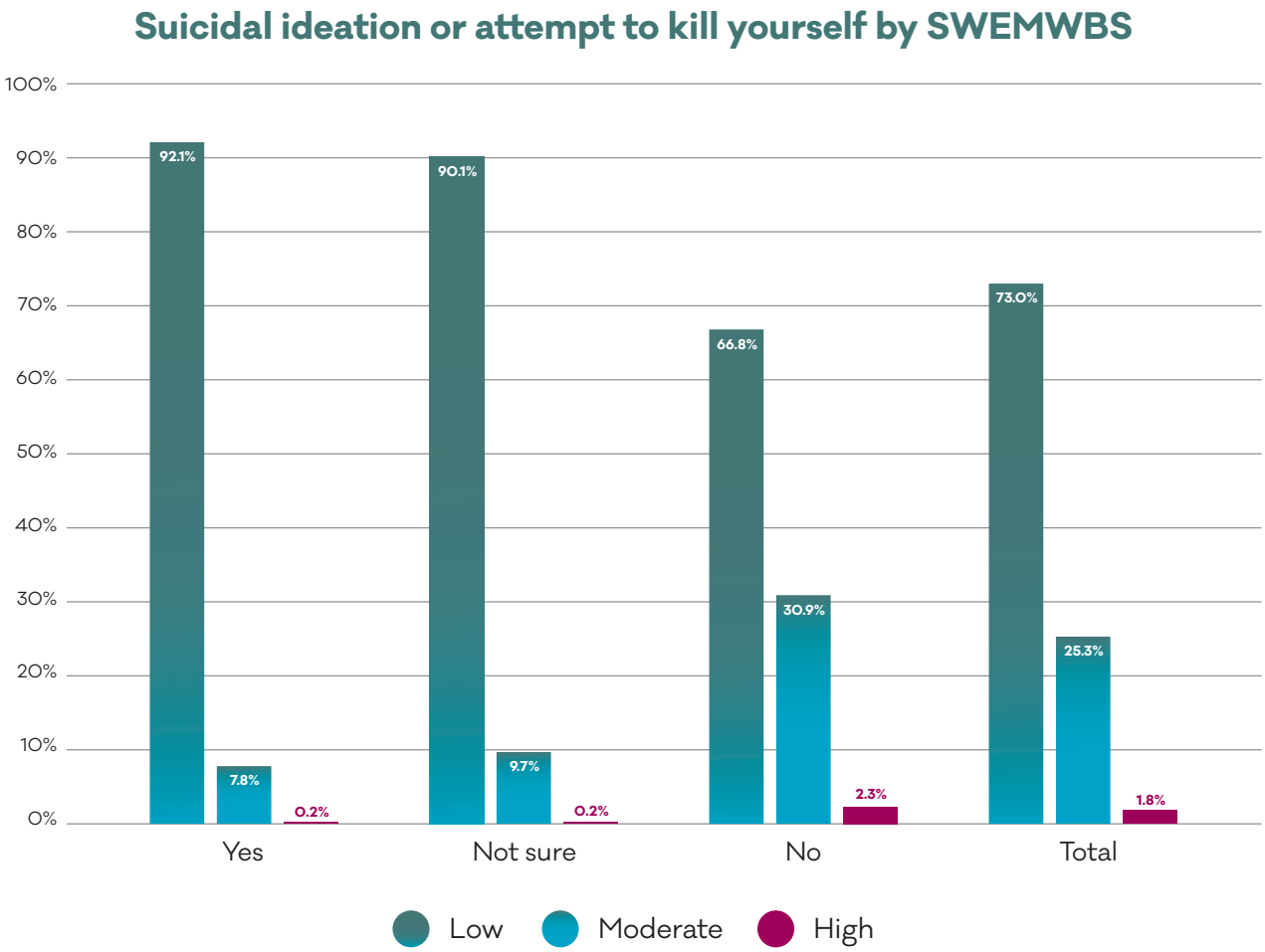
Graph 67. General Health by SWEMWBS

n = 13807

Ideation or attempt to kill yourself

Those who had either experienced suicidal ideation or attempted to kill themselves (92.1%) or were not sure whether they had experienced suicidal ideation or attempted to kill themselves (90.1%) had lower wellbeing scores than those who had not experienced suicidal ideation or attempted to kill themselves (66.8%).

A Kruskal-Wallis test showed that there was a significant difference across groups, H (2) = 1641.096, p < .001, with a moderate effect size (0.13). Bonferroni corrected post-hoc Mann Whitney U tests explored this effect. All groups were significantly different from all other groups (all p < .001).



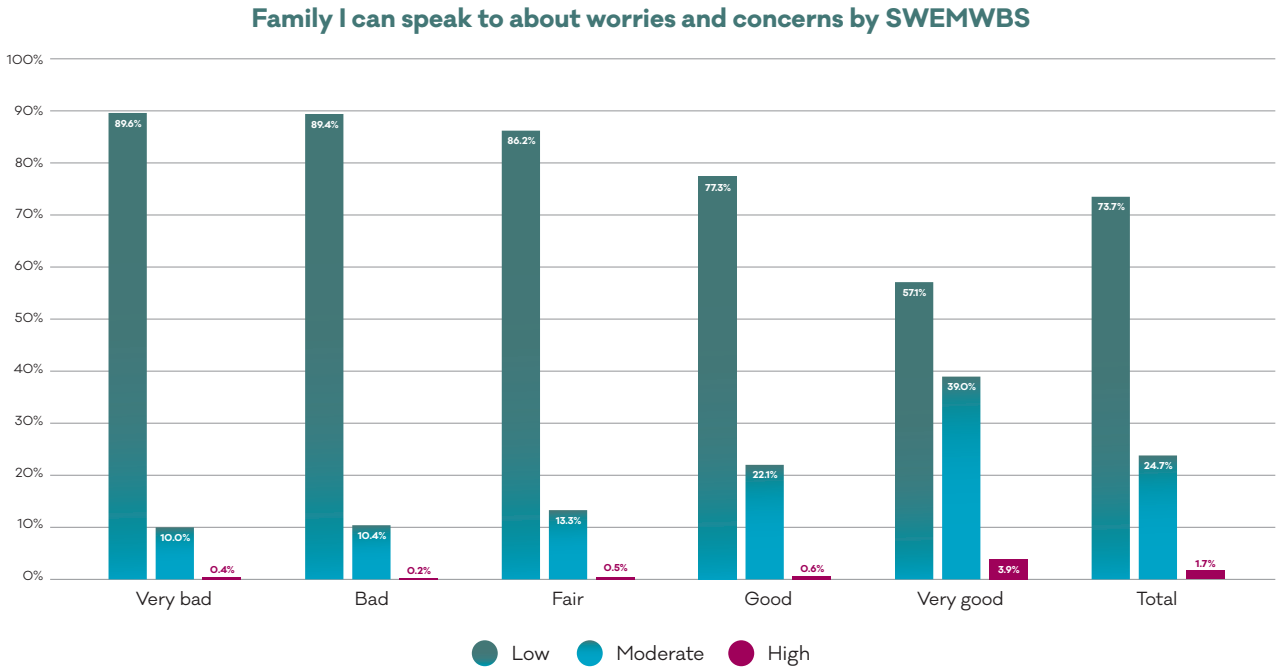
Graph 68. Suicidal Ideation or Attempt to Kill Yourself by SWEWMBS

n = 12654

Family that you can speak to about worries or concerns

Levels of Moderate and High wellbeing increase as agreement with having family you can speak to about worries and concerns increases – 1 in 10 (10.4%) of those Strongly Disagree that they have family they can speak to about worries and concerns have Moderate or High wellbeing, compared with nearly a third (32.9%) of those who Strongly Agree that they have family they can speak to about worries and concerns.

A Kruskal-Wallis test showed that there was a significant difference across groups, H (4) = 1635.860, p < .001, with a moderate effect size (0.13). Bonferroni corrected post-hoc Mann Whitney U tests explored this effect. All groups were significantly different from all other groups (all p < .001) except from Strongly Disagree and Disagree (p=.009).

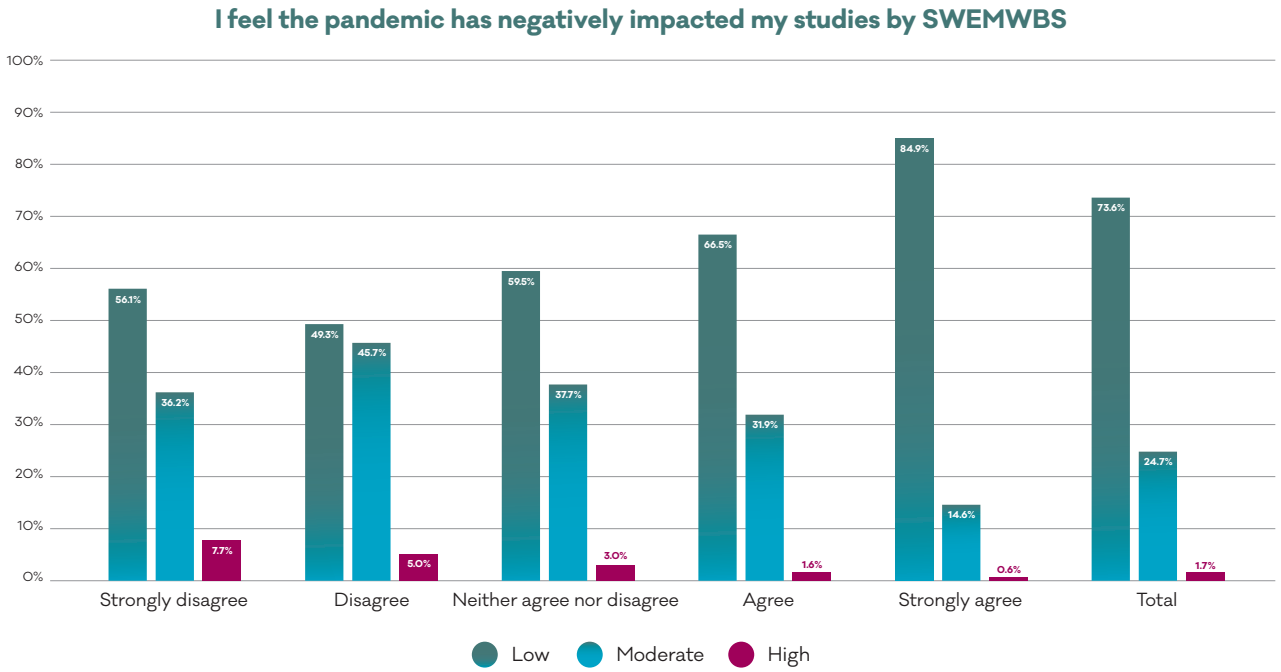


Graph 69. Family I Can Speak to About Worries or Concerns by SWEWMBS

n = 12717

Feeling that the pandemic had negatively impacted your studies

A Kruskal-Wallis test showed that there was a significant difference across groups, H (4) = 1506.188, p < .001, with a moderate effect size (0.12). Bonferroni corrected post-hoc Mann Whitney U tests explored this effect. Eight groups were significantly different from all other groups (all p < .005), two groups were not significantly different, Agree and Strongly disagree, and Strongly disagree and Neither agree nor disagree (both p>.05).



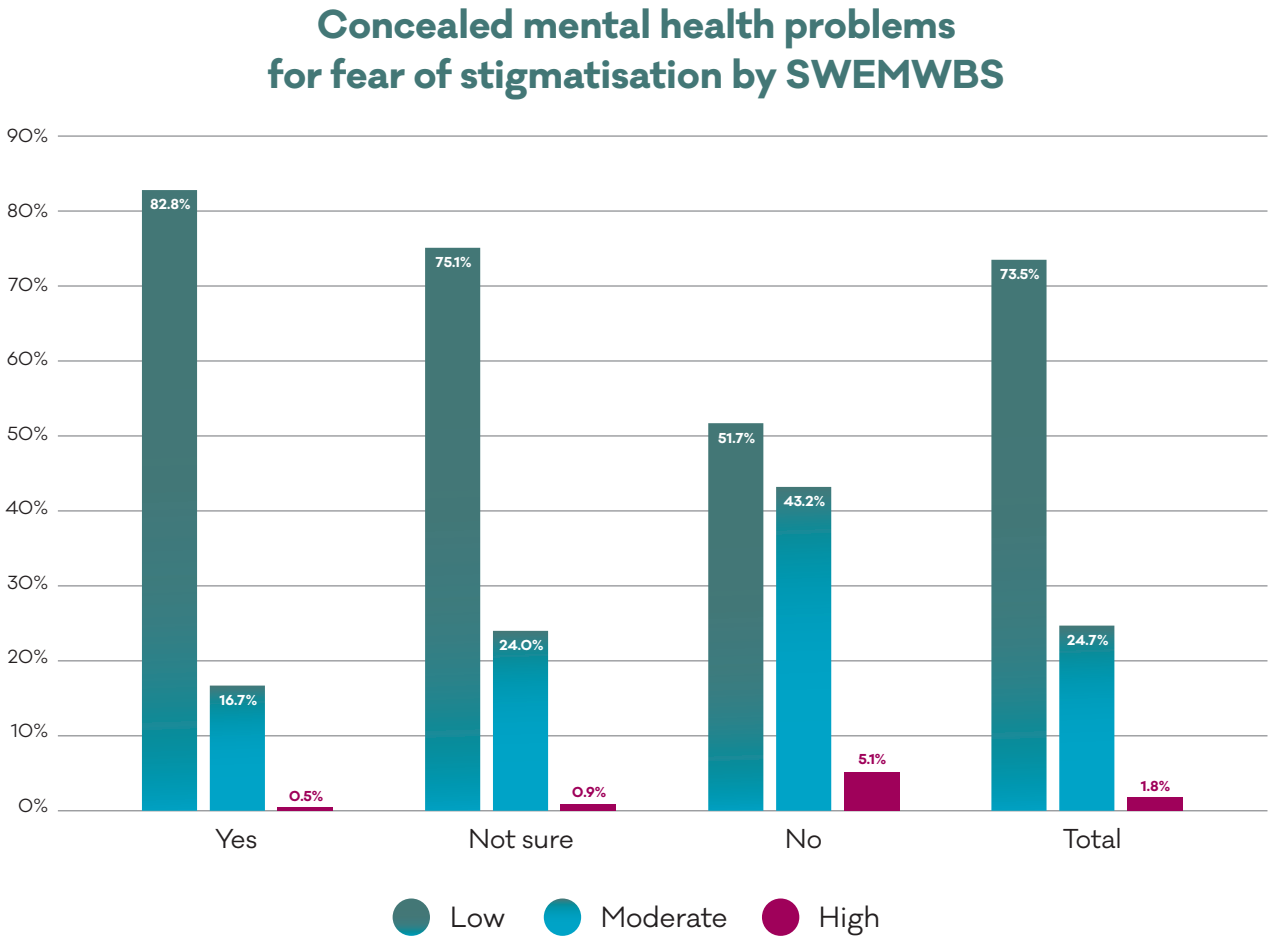
Graph 70. Pandemic negatively impacted studies by SWEMWBS

n = 12742

Concealed a mental health problem for fear of stigmatisation

Those who had not concealed mental health problems for fear of stigmatisation had higher levels of Moderate and High wellbeing (48.3%) than those who had concealed mental health problems for fear of stigmatisation (17.2%) and those who were unsure whether they had concealed a mental health problem for fear of stigmatisation (24.9%).

A Kruskal-Wallis test showed that there was a significant difference across groups, H (2) = 1503.058, p < .001, with a moderate effect size (0.12). Bonferroni corrected post-hoc Mann Whitney U tests explored this effect. All groups were significantly different from all other groups (all p < .001).



Graph 71. Concealed Mental Health Problems for Fear of Stigmatisation by SWEMWBS

n = 13010

Qualitative Findings

Qualitative Findings

In this section we report on the key themes that have emerged from 35 interviewees who took part in individual and group-based interviews. This included a range of professional stakeholders involved in student mental health and wellbeing. The methodology section outlines the process for the interviews and the range of perspectives that were engaged.

The interviewees were asked questions around the student academic journey to allow us to gain insight into the information flow to students around support available; how students disclose when they need support for their mental health and wellbeing; the type of supports; and preventative interventions available to students in addition to staff training. Other questions included the interface between higher education institutions, the NHS and third sector organisations and the wider role of student unions, associations, and societies in supporting mental health and wellbeing. From these questions interviewees were given the opportunity to discuss areas of success within the system as well as gaps and areas for improvement. In the paragraphs below we draw out the key themes that have emerged. The section also provides examples of practice; these were examples given by our interviewees and exemplify the type of activity taking place within the sector. They are not an exhaustive list of all activity taking place within the HEI sector.

Summary

- There is a significant amount of activity taking place within HEIs to support student mental health and wellbeing. However, it can be a confusing picture and difficult to navigate support structures.
- Most of the support is focused on the provision of counselling however wide-spread agreement this is not the appropriate response to many situations.
- Students often come with high expectations of university supports and in many cases a lack of knowledge and understanding of the interface between HEIs and the NHS. The latter point is particularly true for overseas students.
- Increasing numbers of students are disclosing their mental health status at the outset of their university journey however, there continues to be barriers to disclosure including this being asked within the context of having a disability . Which, although there is some understanding as to why mental health status is classified as a disability, it remains a barrier for some.
- There was some consensus around the increase in complexity of cases and an increase in demand overall. This generally was felt to be exacerbated by COVID-19. HEIs quickly adapted to provide a continuous service during lockdowns via phone and online support, but some students experienced barriers to accessing support through these mediums.
- Key gaps across provision identified were around specific support for wellbeing, the need for a trauma informed approach and support for those with long term and enduring mental health problems. For the latter this was aligned to discussion about the problematic interface between university support systems and the NHS. There was consensus that student support as provided by universities should not be viewed as an alternative to NHS mental health teams.

- There were widespread reflections on the risks posed by a wider societal issue of the medicalisation of emotions of sadness and distress and a concern that this may be disempowering young people and undermining their individual resilience, as a coping mechanism. If the medicalisation narrative is internalised by individuals it can lead to a situation whereby anything less than a clinical response is regarded as dismissive with the resultant strain on clinical services.

Information flow

All interviewees discussed the wide array of approaches taken to provide students with information on services available to support mental health and wellbeing. This includes student disability services, counselling, chaplaincy, accommodation support, broader student services and study support, unions, societies and clubs, and in some universities, wellbeing advisors and/or discreet on campus health services or information on how to register with a local GP. Interviewees highlighted the different routes used to inform students about mental health supports through registration and welcome packs, on websites and newsletters, via talks at induction/welcome days and fresher events, via social media output such as

Examples from practice:

Manchester model

Greater Manchester NHS Foundation Trust (GMMH) has developed a new Greater Manchester Universities Student Mental Health Service in partnership with the region's five universities (University of Bolton, University of Salford, University of Manchester and Manchester Metropolitan University and the Royal Northern College of Music) and supported by the Greater Manchester Health and Social Care Partnership and Clinical Commissioning Group

The aim of the service is to provide mental health assessment, support and interventions to students to enable them to fulfil their university ambitions and experience. Students with pre-existing mental health problems or those whose mental health problems emerge whilst at university will be supported to manage their mental health via this service.

The services can be accessed via a referral from the existing universities' counselling and wellbeing services. Referrals will be via these existing university services, not an open referral system. This is to support the management of demand and capacity of the GM Universities Student Mental Health Service, and enable a 'step up/step down' process to operate effectively.

Further information: https://www.gmmh.nhs.uk/download.cfm?doc=docm93jijm4n5899.pdf&ver=8369

short animations, videos and orientation apps, as well as having onsite first point of contact 'hubs' or advice centres.

Despite this, many interviewees emphasised that providing a timely information flow, co-ordinated messages, and clarity on how to navigate the range of services on offer was an ongoing challenge. For some this was due to the size and scale of their university, the vast number of students they work with, and the increasing complexity and variety in the types of services available sometimes leading to a sense of disjointedness.

> *"The information that's given out tends to vary from school to school. Our schools and colleges, you think of a university as being one ... machine, but it very much isn't. We're actually lots of little separate businesses, so there is a real variation in the way that students are communicated with." TL 6*

Into this mix was added the needs of students themselves who were described as coming with varying expectations. It was flagged that students have no understanding of the relationship between the university and the NHS and, especially for international students, no previous knowledge of what the NHS is and where the pressure points within it are.

Insights into the reason for the challenges included a lack of uniformity in the information flow to students as often this was led by individual schools within the institution. Also, the increasing complexity around the structure of mental health and wellbeing supports and where it fits within broader student services. It was evident across the interviews that there is very little consistency across institutions around how student support services are structured or in the language (including job titles and names of departments) used to describe forms of support. This was felt to be a confusing picture for staff and students meaning people aren't sure where to refer or which service to approach when support is required. Although the importance of individual institutions developing services to best meet the needs of their own student population was acknowledged the challenge this creates was raised frequently. Not only for students and staff but also external partners and stakeholders who may work with more than one institution.

> *"We need to work better at promoting and communicating messages where support is because I don't think enough students really are aware. That's a hard nut to crack. With everything that we do, we find communication and promotion hard." TL 21*

> *"I think the key thing is that we're going to need to be integrated in the way we deliver services and make it as simple as possible for the students to access." TL 13*

Examples from practice:

Mind, Body, Boost project

The Mind, Body, Boost project is a European collaboration of partners, with funding from the EU Commission's Erasmus+ Sport 2020 programme. The aim of the 'Mind, Body, Boost' project is to encourage inclusivity and equality through sport by creating a safe health and fitness environment for students who need physical and mental health support.

Mind, Body, Boost is a practical intervention programme delivered by experts in sport and student counselling services. The programme uses the proven anti-depressant effects of exercise to prevent the development of serious mental health issues. The 6-week custom designed fitness and mental programme includes mindfulness skills training, group inclusivity work, challenging physical activities and psychological support tools while also addressing societal issues of social isolation and stress management.

Further information: https://www.enas-sport.net/members-projects/project-one-y8rh4

It was also felt that no matter how good the information flow to students, it often only resonates at the point when the students need it. At this point the student may not have the motivation to navigate some of the structures or engage with the information available.

Disclosure

Interviewees provided insight into the different points in the system when students can disclose a mental health problem for which they require support. This starts at registration, in many instances when completing a UCAS form, when students are encouraged to tick a box asking if they have a disability. This sits alongside a clarification that disability encompasses a mental health condition. If students flag a support need this is passed to disability services who then proactively contact the student and work with them to develop a support plan and put into place reasonable adjustments/funding support as required.

This was an interesting area of discussion in that many of the interviewees stated that mental health is now one of the most common disability classifications being

flagged within this process, overtaking learning difficulties. However, alongside this was a recognition that the framing of mental health as a disability is challenging for some. It was felt that for some students this is a barrier to disclosure as they don't identify with the term disability.

> *"Most students don't tick that box on the UCAS form." TL 1*

"Most students don't tick that box on the UCAS form." TL 1

There was recognition that the formal disclosure process is often used in cases where a student has a long term or enduring mental health condition, but for many students the point of disclosure or reaching out for support comes during their academic journey and this can be to a wide range of people. This includes academic advisors and other academic staff, residential wardens/estate staff, union and society teams (staff or volunteers) among others. Sometimes it is friends or family that are worried and reach out, or issues will be flagged by the student themselves when looking for an extension or letter of support around mitigating circumstances.

Interviewees felt that this raises several issues for the implementation of a Whole System Approach with the need to embed skills, knowledge and confidence around mental health and wellbeing in this broader workforce. This must be done in a way that is appropriate and not overly burdensome. Whilst some institutions have training available to the broader workforce often this is ad hoc. There were concerns raised by some interviewees that in some instances academic staff take on too much in terms of their pastoral

Examples from practice:

SilverCloud

SilverCloud works with universities to help address mental health and wellbeing needs among students. They use clinically-proven digital mental health tools and focus on the full range of student mental health issues, from depression and anxiety to stress, including exam stress, and resilience. They have programmes for Mental Health, Wellbeing and Chronic Conditions, including dedicated apps for Mental Health and Wellbeing, and their services are 24/7.

Further information: https://www.silvercloudhealth.com/uk/higher-education

Examples from practice:

Togetherall

Togetherall is a safe, online community where people support each other anonymously to improve mental health and wellbeing. Joining the community empowers people to seek and provide support for their mental health and wellbeing in a safe and welcoming environment. People can take assessments, complete courses, journal and learn more to understand their mental health.

Further information: https://togetherall.com/en-gb/

role and that this is a source of stress. Other interviewees felt that the response to a disclosure at times is guided by risk management concerns rather than the right person offering an appropriate response. It was felt that concerns around risk can lead to high levels of referral into counselling services even if young people are raising concerns about a social or academic issue.

> *"We have done quite a bit of work with the personal tutors and the academics really just to try and encourage them to refer students on with regards to wellbeing, because I think a lot of the academics are sometimes taking on too much of that responsibility or they have a sense of, I need to sort out every student problem." TL 8*

When discussing disclosure some interviews flagged a barrier among some students due to cultural background. This was part of a discussion around cultural interpretations of mental health and specific barriers to the disclosure of mental health problems when these are viewed culturally as a personal failing. Universities are trying to navigate this complexity and challenge stigma to ensure mental health is something students can openly talk about.

> *"We did a bit of work with international students around how you get information to them and what format you put it in with destigmatising, mental health literacy...It's a massive job." TL 22*

Impact of COVID-19

From the interviews it emerged that there has been no consistent pattern around demand on mental health supports as a result of COVID-19. Some interviewees described some initial reduction in demand in some areas of

support as students returned home or preferred not to engage online, whilst demand in other areas (accommodation services, international student support) significantly increased. However, overall, there was some consensus around the increase in complexity of cases and from 2021 an increase in demand overall. A number of learning points emerged from how the universities responded to the pandemic, particularly the move from face-to-face support to online/telephone support.

It was evident that institutions quickly adapted to enable online engagement and phone support. Interviewees discussed some of the barriers to this form of support such as digital exclusion (poor wifi, etc.) and lack of a safe/private space for students to talk openly. However, they also flagged how institutions were trying to mitigate these barriers, such as by offering private space within the university for students to engage with phone or online support (whilst still not able to see staff face-to-face). Interviewees also highlighted some of the benefits that have emerged. This included significant reductions in Did Not Attend (DNA) rates, flexibility for students in when they engaged with support and better ability to offer support services to more students. The latter being raised in cases where institutions have more than one campus, but many services located in one campus. The latter being very helpful for institutions that cover more rural areas.

Another positive impact emerging from the pandemic was the view that it has shown universities that new ways of learning, more inclusive ways of learning, are possible and may be beneficial to mental health in that they remove some of the pressure points for many students. It was hoped that this learning would be built upon moving forward.

> *[as a result of COVID-19...} "they're able to attend lectures actually in the morning if they want to, or they can watch all their lectures from a week in one day if that's a really good day for them and the other days haven't been so good." TL 17*

Other suggestions given by interviewees on how to build on the lessons learned from the pandemic include the provision of a hybrid model that offers face-to-face support as well as online and telephone support. In addition to potential to further explore the use of technology, including internal flagging systems, to initiate welfare responses moving beyond its current use largely for student retention.

Responding to student's mental health and wellbeing (MH&W) needs

All institutions are working hard to improve and respond to the changing

mental health support needs of students. The models of MH&W support provided by each institution differs depending on this need and the resources available to the institution. The interviewees referred to the welcome additional funding for counselling support, as a result of the pandemic, which enabled them to respond to increasing demand and the increasing complexity of support needs. It was felt that the counselling support provided was often used by students dealing with lower-level mental health problems such as anxiety, low mood and feelings of stress, often as a result of wider social experiences such as concerns around finance, a bereavement, and/or relationship breakdowns. Despite this there was also a sense from interviewees that there has been an increase in the complexity of issues being brought by students and this in itself was a challenge.

> *"What we are finding is that the issues that students are presenting are much more complex and the frequency of some of the things that we're dealing with; extreme financial hardship, domestic abuse, homelessness, gender-based violence, the numbers of suicidal ideation that has substantially increased and also just the number of students at risk of presenting in crisis or at risk that has significantly increased." TL 19*

Some raised that counselling service time can be taken up with administrative activities such as writing letters to support mitigating circumstances. Approaches being trialled to reduce pressure on counselling services included the implementation of self-referral routes and in one institution a self-certification process for mitigating circumstances.

Discussion on counselling provision accompanied broader conversation around the challenge of counselling support becoming the 'front line' service or first port of call for students and staff alike even in situations where counselling was unlikely to be the best response.

> *"We keep saying that to our academic staff because when they encounter a student who's crying their first thing is right, student counselling, let's make a referral and that's really not a good response." TL 10*

> *"It's interesting because university counselling services generally offer a certain service and there [are] an awful lot of people [who] seem to think counselling is the place to go to send people for help. Well, it's an important aspect of it but there's a whole range of services and counselling is not necessarily the appropriate place for most people." TL 3*

There was a definite view from interviewees that counselling was not the answer to all problems. This concern

Examples from practice:

Abundant Academy

The Abundant Academy programme is designed to enhance students perspective, and train them in habits of replenishment, reflection and collaboration, so they can move from overwhelm, freneticism, and feeling stuck, to refreshed and thoughtful momentum and fruitfulness. The programme has been developed out of 9-years work with University of Edinburgh students and staff, on the 'What's the University for?' Series, our 'Slow University' initiative, and collaborations with universities around the world on bringing compassion into the structures and ethos of Higher Education. The programme is led by chaplaincy.

Further information: https://www.ed.ac.uk/chaplaincy/abundant-academy

aligned into some of the wider gaps in the system that were highlighted by interviewees. These are outlined below.

Wellbeing support

A re-occurring gap raised consistently was the need for an increased focus on wellbeing supports within a broader preventative approach. This was framed as the need for a whole system model that aims in the first instance to empower students and provide them with the skills to manage the challenges they will face in their academic journey. To develop these skills within a broader environment of creating positive connections and a sense of community. This aligned into the concern that counselling was viewed as the answer to all students support needs. Many interviewees felt this was part of a wider societal problem where young people are continually disempowered through the medicalisation of emotions especially distress and sadness. It was felt that young people from a young age are drip-fed messages that they can't cope with the ups and downs of life. This in turn becomes internalised with the consequence of young people feeling that anything other than a clinical response is a dismissal of their needs.

> *"I think there are far too many messages from government, from media, from everybody else that young people can't cope with things, and that if they have a bereavement, if they experience any distressing emotions*

they will need professional support. I think that just disempowers them." TL 2

The medicalisation of emotion was linked by some to a lack of understanding on the difference between mental health and mental health problems or illness. The consequence of this was felt to be the disempowerment of young people and the reason, felt by some, that student support services take a deficit model or 'paternalistic' approach that aims to 'fix' young people.

"Some things that are normal parts of leaving home, normal parts of young people's development all gets pulled up into mental health." TL 22

Some interviewees discussed a wellbeing approach needing to start with curriculum design. For schools and departments to work together to identify the pressure points for students and explore ways to mitigate them. This included avoiding same week deadlines for course work across courses, having different ways for students to engage with course work – in person and online – and being proactive where content within the curriculum either provides opportunities to discuss wellbeing strategies or conversely covers issues that could be triggering. This latter point was also raised in relation to implementing a trauma informed approach within universities.

"There needs to be a huge emphasis on support and awareness within the context of the academic curriculum because otherwise it's just going to continue with... we need more resources, we need more counsellors, we need more...." TL 19

The importance of providing training to a range of staff was also highlighted as being core to the successful implementation of a preventative approach with wellbeing at its heart. This includes training for academic staff and professional services as well as staff and volunteers involved in societies, unions and clubs. Although many interviewees provided examples of staff training programmes being underway, including mental health first aid (MHFA), it was the lack of consistency across institutions and the sector as a whole that was often raised. It was felt that a significant barrier to the implementation of training was the need for specific funding for this as well as recognition of the time this takes among already stretched staff.

This pro-active model for wellbeing enhancement was aligned to the increasing strategic approach taken within institutions around student mental health and wellbeing. Where universities had a mental health strategy this was viewed positively and seen as a public declaration of the importance that institution places on the mental health and wellbeing of staff and students alike.

However, although it was felt that the policies in this area were generally good and supportive there was a sense that the vision for a preventative model using a Whole System Approach had not yet translated into practice. In addition to the gaps flagged above regarding curriculum design, consistent and appropriate staff and volunteer training and the need for an empowerment model, a final gap flagged was around how 'success' within universities is measured. Here the need for a consistent measure around wellbeing was highlighted and for this to be given similar prominence to wider success measures such as retention, future positive destinations and quality of academic teaching.

Many interviewees referenced significant areas of work their institutions are doing to fill the wellbeing gap. This includes the creation of wellbeing advisors, increased emphasis on peer support, buddying and coaching, provision of self-help information and courses (online and face-to-face), staff and volunteer training. In addition, initiatives led by student services themselves as well as those led by the societies, unions and clubs. Among the latter there was discussion on the developing role of wellbeing champions – often volunteers – and the need to offer consistent support and training to these roles. One interviewee explained how many students want 1-2-1 counselling support and aren't taking up group-based supports and peer-led interventions. They were not sure if this was due to these supports not being explained clearly enough or is part of a wider issue around students wanting a clinical response

Examples from practice:

12S project

The 12S project was an initiative led by NHS Lothian and 12 universities and colleges across the Lothian area. Within initial funding from a Charlie Waller Grant the project aimed to promote mental health and wellbeing with colleges and universities and encourage partnership working with 3rd and public sector. Small grants were made available to the colleges and universities to enable mental health and wellbeing focused activity including developing expertise to deliver training and education within the sectors. The programme is now supported under the Thrive Edinburgh consortium.

Further information: https://www.edinburghthrive.com/

to social problems, as this was seen as validation of their experience.

Responding to Trauma

Interviewees highlighted that for some students their experiences of university can trigger previous experiences of trauma. That this could emerge from seeming innocuous situations linked to the new experiences of being at university such as making new friends, sharing flats or other examples given were students being triggered due to course content, particularly around adverse childhood experiences, domestic abuse and sexual assault and abuse. Generally, it was felt that the university support structure is not well equipped to adequately respond to trauma. As a result, some interviewees gave examples of students falling through the net. With students presenting with experiences too complex for university supports but not quite meeting the increasingly high threshold for NHS mental health services.

Some suggested solutions were linked to a Whole System Approach with a co-ordinated piece of work to support institutions, and specifically individual schools and colleges that have courses with topics more likely to trigger students, to build in ways to highlight this to students and provide consistent information on what to do should this be triggering.

Discussion on the need for universities to respond to trauma more effectively was often placed within the context of the widening access agenda and responses to societal movements such as #metoo and #BlackLivesMatter. It was raised that significant investment has been given to drive access to higher education and widen participation, including free tuition. Although this was recognised as positive it was felt that there had not been enough consideration around the wider resources needed when increased numbers of students come from backgrounds where there is potentially increased experiences of trauma and/or less family support. Others raised that the response to some of the social movements such as #metoo although potentially triggering had also led to positive examples of joint working across campus and across universities. This included examples of projects around consent, gender-based violence and creating safer cities.

> *"It feels a little bit like you have a widening access route to universities. Why do you not have mental health provision that takes account of the poor mental health of young people? ....young people who come from really low-income backgrounds, who experience poverty, who experience trauma." TL 4*

Students with pre-existing

mental health condition/ complex mental health needs

Another consistent gap that emerged was meeting the support needs of students that come to university with pre-existing mental health conditions or who develop more complex mental health needs during their academic journey. For the former group challenges raised were often around students who move away from home to attend university finding themselves stuck between two systems. For the latter it was around their needs being too complex for the university mental health service to effectively manage but not meeting the threshold for NHS mental health support.

For those with a pre-existing mental health condition there was concern raised by some interviewees that some students may feel reluctant to disclose to the university at the point of registration.

> *"I think that there's still a lot of work to be done in terms of encouraging students to disclose earlier on in terms of how that will be perceived by the university and how it won't have an impact negatively on the way that they're treated." TL 17*

However, there was also recognition that many students with enduring mental health needs come with high levels of resilience in that they were felt to often have good insight into how to manage their mental health and recognise warning signs that they might not be managing as well as they could.

Discussion on support for students with a pre-existing mental health condition aligned into points made around the challenges of working effectively with the NHS. However, for this group of students it was felt that having prior knowledge that they come with a mental health condition should mean that supports and processes can be put in place in advance but that this isn't happening. As a result, many of these students are being failed if their mental health deteriorates.

> *"If come with [a] mental health diagnosis it's difficult to set up new support in [a] new area as [they] need local postcode to register with GP." TL 8*

A recommendation from some interviewees was to take a sector wide approach to agree what information students from across the UK and internationally need to bring with them when they have a pre-existing mental health condition to enable transfer of care to local NHS systems.

Relationship with NHS

All interviewees raised the importance of having close collaboration with the NHS. There was a unanimous view that mental health support structures within universities are not and should not be

Examples from practice:

Oxford University Peer support model

The Peer Support Programme was developed in recognition of the essential role students play in supporting and encouraging one another on a day-to-day basis throughout their time at university. Peer supporters are undergraduate and graduate students who have formally applied for the role and who are trained. These applications require permission from tutors or supervisors. They receive 24 hours of training and attend fortnightly supervision through the Counselling Service to consolidate their training.

https://academic.admin.ox.ac.uk/college-peer-support-programme

a replacement for NHS community mental health teams and specialist provision. Some interviewees expressed exasperation at, in their view, the increasing expectation on university mental health services to pick up gaps that exist within the NHS system. This was viewed as an uncomfortable and unwelcome direction of travel.

> *"The first thing that happens when there's a crisis or the very worst-case scenario happens and the news comes out universities are not doing enough. Well, actually, in many cases we're doing more than a workplace would do for its employees but because we're talking about young people there's this expectation that we have this quasi-health service. When actually, the NHS are often the ones who are failing our students or have gaps in their provision." TL 17*

Interviewees discussed very mixed relationships with the NHS with some having very good relationships and others describing tension. The former was often where universities have a smaller number of GP practices close to campus with whom they have established relationships. The latter was often where this has been more difficult to establish due to the high number of GP surgeries available or where university campuses span more than one health board area. Challenges also arise when a student's mental health quickly deteriorates but they remain registered with their GP at home. In these instances, the local GP near the institution won't see them as registered elsewhere and their home GP can be reluctant as they are residing elsewhere. In these cases, it was felt that students needed to hit crisis before they could access support.

There were examples of the relationship with the NHS being improved as a result of staff employed within the university being registered nurses and an institution funding mental health nurses within a local GP surgery. The benefits of this was felt to be due to these staff members being 'in the system' thus offering a level of reassurance to GPs and wider NHS staff around issues such as duty of care and information sharing.

> *"If you send a GP a message by nhs.net they automatically know that you're covered by NHS confidentiality, whereas if you don't ...sometimes they're a bit like, 'Well, who are you again?' So it really does help." TL 2*

However, it was accessing more specialist mental health support across the sector that interviewees often flagged as a significant gap. It was felt that this means a lack of consistency or clarity on the boundary around what the sector as a whole should provide in way of mental health support without it becoming a 'de-facto NHS for students'. There was recognition that some universities are having strategic discussions with local NHS boards to improve ways of working. The challenges of these discussions were recognised with some institutions working across more than one health board area and a nervousness within the NHS to take on the needs of a large transient population. It was for these reasons that interviewees expressed the need for sector led discussions with the NHS to put in place consistent provision particularly in response to more acute needs.

> *"Your local NHS provision may be very good or really very poor. It's a bit of a lottery to be honest from a student perspective what kind of support you're going to get through NHS and through your institution." TL 5*

Creating Communities

A consistent theme that emerged from the interviews was the need for university to feel like being part of a community where people look out for one another and are part of something together. A smaller number of interviewees provided examples of being part of local area networks with third sector organisations. Here examples were given of this being very helpful in understanding local supports but also in creating opportunities for the student population to feel connected to the university and to the local community.

The importance of feeling connected and part of a community was flagged as being crucial for supporting mental health and wellbeing. Within this the role of all staff and extended services including student associations, unions, societies and clubs was viewed as crucial. Examples of the significant role played

by estate staff through their informal discussions and chats which create the sense that someone is looking out for you thus helping to reduce feelings of isolation. This discussion was often in relation to the crucial role of student associations, unions and societies, and how they help students feel connected and included. In particular, for students who due to aspects of their identity may feel marginalised in other aspects or areas of their life. Some interviewees were honest and frank in the challenge faced to help create a sense of connection to the university. This included the size and scope of the university or feelings of isolation as a result of students from particular backgrounds not fitting the mould or sharing the experiences of the majority. There was also recognition that many students don't connect with student led initiatives through unions or associations and that more work needs to be done to help students understand the scope of what is offered.

[We have ...] a cross-university group looking at students and staff wellbeing and trying to promote and suggest activities that will allow people to do stuff that will also bring people together as a community. It is a cross-university thing. Or we are trying to take a university-wide view of wellbeing and this notion of a community that cares about its members and is connected. That's the approach we try to take so that way we try and catch people before they become too unwell." TL 3

"The culture that the university promotes around mental health,

Examples from practice:

Student Mental Health Agreement (SMHA)

NUS hosts the Student Mental Health Agreement project as part of the Think Positive Campaign. The project brings together the student association and university to work jointly on mental health initiatives on campus. The SMHA collates everything the institution is doing to improve student mental ill health in one clear, easy-to-read-document. The document can focus on a variety of topics, which are determined by representatives from the student association and institution leading on the project.

Further information: https://www.thinkpositive.scot/smha/

mental illness, trans students, gender-based violence, I think, in the end, if an institution can do anything strategically, it's around culture for me." TL 20

The themes highlighted above were the most common areas raised by interviewees. These points are expanded upon further, along with the student experiences raised through the survey findings, in the final discussion and recommendation section.

Discussion and Recommendations

Discussion and Recommendations

This report provides a difficult insight into the challenges being experienced by students attending Scottish HEIs.

It is important to acknowledge the wider contextual issues taking place in the timeframe of this study. The primary factor being the unprecedented pandemic which led to national lockdowns and restrictions of social interactions and face-to-face delivery of services. This resulted in many students having a highly unusual university experience which was predominately online whilst living at home.

However, it is also important to recognise that it would be unwise to wholly attribute the findings within this report to those wider contextualising factors. We know that young peoples' mental health, and students as a specific group, has for several years been an area of concern. This is reflected in previous studies into student mental health (Douglas Oloyede et al (2020); Pereira et al (2019); Thorley, C (2017)), HESA (2021) data which has shown a tenfold increase for declared mental health difficulties in students from 2007 to 2020 and the ongoing commitment and investment from the Scottish Government to support student mental health and wellbeing. This most recently seen in the Programme for Government commitment to a Student Mental Health Plan.

Student Wellbeing

Across a number of the key health measures that were used in this study students reported more worse outcomes than the general population. This can be seen in general health, with 60% of respondents reporting 'Good' or 'Very good' health compared with the latest Scottish national figure of 71%. In addition within wellbeing ratings with the mean of respondents sitting within the 'Low' wellbeing level compared with national mean that sits within the 'Moderate' wellbeing level.

There are no clear insights into the reason for this, however, the national pandemic and bias that is introduced through self-reporting must be considered. This includes the fact that many 'health' enhancing behaviours were curbed during lock down with gyms being closed and socialisation being restricted, as well as access to primary health care being limited. However, as with all findings within this report, the authors would caution against the findings being fully attributed to these factors. Within the qualitative findings all stakeholders interviewed highlighted that many of the challenges experienced within services and supports had existed pre-pandemic. The first gap the stakeholders highlighted as existing across the sector was around wellbeing supports. This was whilst acknowledging the ongoing efforts within individual institutions to enhance these supports. The qualitative section in this report provides some insight into the activities taking place.

This section provides insight into the services and supports for wellbeing being part of a broader, often confusing, landscape. Within this, stakeholders cautioned against what they felt was the current situation of counselling becoming the default pathway for all wellbeing support. Even when this was not the intended design of services. This was set within a broader context of interviewees feeling that young people are more generally, from pre-university, being disempowered to feel that they aren't able and don't have the skills to cope with everyday stresses of life. This was felt to be as a result of societal influences and messaging that pathologise normal emotions such as grief and sadness. This has contributed to the sense of a collective failing of our young people where they are not being provided with the skills to manage challenging emotions but instead are pushed to services thus creating a demand and desire for clinical interventions that cannot be met. Within this it is also important to acknowledge those students who do need additional support for their mental health are impacted by the increased demand from a broader section of students who perhaps would benefit from other inputs. This includes supports for them to feel integrated into their university and part of a wider community.

The results from this study indicate that the wellbeing scores were different across age ranges with younger students (16 to 25 years) having lower scores, therefore lower wellbeing, than older students (25+). The results also indicated that wellbeing scores varied across genders with those who identify as 'other genders' have noticeably lower wellbeing than both females and males.

General health, suicidal ideation/attempt, family that you can speak to about worries and concerns, feeling that the pandemic had negatively impacted your studies and experiences of stigma were the factors that had the closest association with wellbeing scores. Some of these are perhaps unsurprising, general health, experiencing suicidal ideation/attempt and stigma are likely to have an impact on your wellbeing. The strong association of having family you can speak to about worries and concerns with wellbeing may be something that can be contextualised with many students having lived at home in the previous academic year and this strengthening or exacerbating existing familial relations. The pandemic plays a clear role in the remaining association, feeling like the pandemic had negatively impacted your studies, perhaps giving some insight to role that the pandemic had on student wellbeing in the previous academic year.

Whilst not being in the five factors that had the closet association with wellbeing scores, members of student groups had a positive view that this helped them engage with university life and to make friends. Furthermore, other factors that have an impact on wellbeing, whilst having weak associations, include: only just over half of respondents feeling that they had friends at university that they could talk to about worries or concerns; nearly half of respondents reported eating too much to cope with pressure; and going to a green space to cope with pressure.

Overall, it feels important to recognise that the supports required for wellbeing are different from the supports required when a student is experiencing mental health difficulties. At the moment this does not seem to be well understood. In addition, presently it appears there is less value placed on wider wellbeing supports, such as peer-led supports or group-based interventions, from both students and staff alike and this is something that needs to be addressed.

Student Mental Health

The insights provided in this report around student mental health indicates that a high proportion of students are struggling with their mental health. As with wellbeing there is no definitive way to know how much of this is as a result of the pandemic, however the authors would continue to caution against the findings being attributed to this factor alone.

The results state a high proportion of students are displaying symptoms of moderate to severe depression (PHQ-9 results), have higher than national average rates of self-harm and have expected rates of a mental health diagnosis (26% or 1in 4). In addition, nearly half (44.6%) reported that they had experienced a serious psychological issue for which they felt they required support. Of this group just over one third had received support. Although our methodology means we cannot extrapolate rates of suicide ideation from suicide attempt in the past six months the rates given (19.6%) do raise significant cause for concern.

On the whole, the youngest students (16-20 years) reported poorer mental health (higher depression scores, higher self-harm rates, higher rates of suicidal ideation and attempts to kill themselves and experiences of stigma) but had lower levels of diagnosis and having felt like they had experienced a serious psychological issue that they felt required professional help than older students had. It warrants investigation as to whether this could be viewed as evidence of older students having more resilience than younger students.

When exploring mental health by gender it should be noted that those that identify as other gender rated consistently worse than males and females across every measure. This should not disguise that across the majority of measures females also reported worse than males. This should be read within wider recognition of males tending to underreport mental distress and being less likely to seek support whilst having higher rates of suicide. Within this study rates of self-harm were significantly higher for females but the question on suicide ideation or attempt was the same across males and females.

General health, suicidal ideation/attempt, experiences of stigma, experience of a serious psychological issue that you felt needed professional help and a current mental health diagnosis were the factors that had the closest association with depression scores. There are fewer social/environment factors associated with depression scores than there are for wellbeing – on the whole factors associated with depression scores are unsurprising. It is noticeable that general health was the factor that was most strongly associated with both depression and wellbeing and it is worth bearing in mind the previous discussion about the restrictions that were in place around health 'enhancing' activities at the time of data collection. Furthermore, our analyses showed that higher wellbeing correlated to lower symptoms of depression which is, again, likely to be expected.

Worryingly, considering the high rates of mental health problems and distress reported, over half of respondents (56.9%) stated that they had concealed a mental

health problem for fear of stigmatisation with a further 1 in 6 (16.5%) being not sure. Of further concern is the small proportion of respondents who had sought medical assistance from either self-harm or suicide ideation/attempt. A definition of medical assistance was not given within the survey, meaning it was open to interpretation by respondents as to what it meant to them – some may have considered it to mean direct assistance provided by primary care or emergency services and others may have considered it to mean support, potentially ongoing, from psychological services. However, that does not detract from the small numbers of students actually seeking assistance following either of these events.

This aligns with the qualitative findings concerning the increase in presentation of students with severe, complex and enduring mental health needs. This has an impact on university staff who reported having to deal with these cases with limited resources and scope. This was part of a broader discussion about the duty of care of universities to their students. What should and could be the responsibility of universities to respond to very complex needs or should this responsibility sit with the NHS. Within the qualitative section the challenge around this is apparent particularly in light of the different relationships between universities and health boards; with some having very positive pathways and others more challenging ones. This has created a disparity across the sector which requires a sector wide response.

Despite the efforts within the sector to raise the profile of mental health and services available there continues to be a problem around stigma. It potentially warrants investigation to establish if there is any connection between experiences of stigma and the teaching of mental health and wellbeing to young people, in light of the previous discussion around the disempowerment of young people with regards to their feelings and managing challenging emotions.

Experience of Trauma

This study incorporated the adverse childhood experiences questionnaire to provide insight into experiences of trauma and how this relates to student mental health and wellbeing and wider university life. It should be noted that this question related to experiences prior to the age of 18 therefore the impact of the pandemic will be more limited. We also asked about experiences of bullying and food insecurity, the former within the previous semester and the latter the previous 12 months. Therefore, the pandemic may have an increased impact with regards to these questions.

Nearly two-thirds (62.4%) have experience 1 ACE (this is lower than the Scottish

national figure of 71%) and nearly 1 in 6 (15.8%) have experienced 4 or more (similar to the Scottish average 15%). Older age groups (30+) were more likely to have experienced four or more ACEs (25.1%) than younger age groups (16-20, 13.2%). Other genders (26.6%) had experienced four or more ACEs more than both females (16.6%) and males (11.7%).

Our analysis indicates that there is a relationship between depression score (PHQ-9) and ACEs score with both increasing simultaneously but that this is a weak association. The relationship between wellbeing (SWEMBS) and ACEs is weaker still in that a high wellbeing score didn't necessarily reflect a low ACEs score. Generally older students had higher wellbeing scores but also reported higher ACEs score, again raising the question about whether older students have higher levels of resilience and, if so, why this is the case? The weak association between ACEs and depression scores and wellbeing perhaps also indicates that a trauma informed response needs to be separate from mental health and wellbeing responses.

The need for trauma informed responses within the HEI sector was raised by interviewees who provided useful insight into areas of university life that may be trauma triggers – including the design of the curriculum (for example, cumulative deadlines and curriculum content) and the need for academic schools to work together with student representatives to fully implement a trauma informed approach across the curriculum. This was felt to be particularly important given the widening access agenda and the recognition that this may increase the number of students who have experienced trauma.

Just under a fifth (19.5%) reported being emotionally bullied in the previous semester. This was higher for younger age groups than older ages (16-20 years 23.9% and 30+ years 14.2%). Interestingly the difference by gender was less marked than many other questions with other genders (23.6%) and males (21.5%) reporting higher than females (18.6%). This study does not provide insight into whom the respondents feel bullied by, however it does flag that this is an area of concern.

In the previous twelve months over a fifth (21.5%) of students worried about running out of food, nearly a quarter (23.5%) ate less due to a lack of resources or money and 7.2% were in households that ran out of food. Overall food insecurity increased through the age groups. As with other findings within this study it is not clear what impact the pandemic has had on these findings. However, it should be noted that the number of respondents worried about running out of food is significantly higher than the last reported Scottish national figure (9%) which was collated pre-

pandemic. If some of this figure is attributed to the pandemic, then another unknown is whether this will change as restrictions ease or will continue to be a challenge given some of the concerns about the rising costs of living. Overall, it would seem that food insecurity among students, particularly older students, is an under discussed issue likely partly due to the lack of data available on it. It also feels important in light of the widening access agenda which was frequently raised by interviewees.

Recommendations

Recommendation 1.

Increased focus on and funding for wellbeing supports. Specifically for Student Mental Health Agreements to include a dedicated section and funding for wellbeing supports. That the Scottish Government should increase funding for the HEI sector, but this should not be ring fenced for counselling only but rather should include ability to increase capacity and interventions for wider wellbeing support. Additional recommendations to strengthen the wellbeing system within Higher Education Institutions include:

- Need for consistency of language across sector to describe different forms of support – to help students and staff understand and navigate wider student support systems.
- Innovative solutions to increase staff skills, knowledge and confidence to cope with student wellbeing needs
- Individual institutions simplifying existing pathways to wellbeing support and broader supports they offer from the perspective of the student.
- A campaign to raise the profile of wellbeing supports – beyond counselling – and the benefits they can bring.

Recommendation 2.

Higher Education Institutions should incorporate student wellbeing as a measure of success as part of their enhancement model. Individual institutions are likely to require guidance on this from the sector as a whole.

Recommendation 3.

The NHS and HEI sector should undertake a process to agree the parameters on the duty of care of universities. This should be supported by agreement on a streamlined referral pathway for students who need more intensive support than can be provided within the university setting. Once agreed these pathways should be implemented across the sector. This should be done with urgency as some students are currently being failed by both systems.

Recommendation 4.

Universities should undertake consultation and/or research to understand the nature of mental health stigma among students. This should help inform future activity to challenge stigma including enabling staff to address stigma.

Recommendation 5.

Universities should undertake consultation and/or research to gain fuller understanding of the impact of trauma on student mental health and wellbeing and the wider student experience. This should include but not be limited to the areas of exploration within this study regarding adverse childhood experiences, bullying and food insecurity. This should help inform future activity to implement a trauma informed approach across the university sector.

Recommendation 6.

Higher Education Institutions should implement a whole system approach to become fully trauma informed. This is likely to require guidance from the sector and informed stakeholders including to support trauma-informed academic design and content.

Recommendation 7.

A round table discussion between key stakeholders on how to reduce student poverty and the supports required particularly in light of the widening access agenda. This should include discussion on food insecurity. This would enable further exploration of the findings from this study alongside wider evidence. This should include HEI sector representatives, Scottish Government and key poverty charities.

Finally, we would encourage all stakeholders to reflect on the comments and issues raised by the 35 interview participants, captured within our qualitative findings section. This includes key challenges as well as areas of learning; particularly relating to the adaptations required as a result of the pandemic. Furthermore, the intention for the research team is to undertake further analyses of the data which will be published in future journal papers and policy briefings.

Glossary

1. Mental Health

A state of well-being in which every individual realises their own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to their community.

2. Public Mental Health

The art and science of improving mental health and wellbeing and preventing mental health problems through the organised efforts and informed choices of society, organisations, public and private, communities and individuals.

3. Prevention

Action which aims to increase the protective factors for good mental health and wellbeing or reduce the risk of experiencing poor mental health, including supporting people with and without mental health problems to stay well.

There are several different types of preventive approaches, which can be applied together to enable communities to protect everyone as well as give targeted support to those most at-risk. The different kinds of prevention approaches can be defined as:

Primary prevention: stopping mental health problems before they start

Stopping mental health problems before they occur and promoting good mental health for all. Often primary prevention work is 'universal' in that it targets and benefits everyone in a community.

Secondary prevention: supporting those at higher risk of experiencing mental health problems

Supporting those at higher risk of mental health problems (either because of biological characteristics they are born with or experiences they have had) by providing targeted help and support. This type of prevention is often called "selective" or "targeted" prevention. Examples include programmes which support those who have experienced trauma or been victims of hate crime.

Tertiary prevention: helping people living with mental health problems to stay well

Supporting those with high levels of distress or existing mental health problems to stay well and have a good quality of life. These types of programme often focus on those already affected by mental health problems and can aim to reduce symptoms that can be disabling, limit complications, and empower people experiencing problems to manage their own symptoms as much as possible and help to prevent relapse. Tertiary prevention is

seen as distinct, but complementary to treatment for mental health problems and is often carried out in community, rather than clinical, settings.

4. Wellbeing

Wellbeing, put simply, is about 'how we are doing' as individuals, communities and as a nation and how sustainable this is for the future. We define wellbeing as having 10 broad dimensions which have been shown to matter most to people in the UK as identified

through a national debate. The dimensions are: the natural environment, personal wellbeing, our relationships, health, what we do, where we live, personal finance, the economy, education and skills and governance. Personal wellbeing is a particularly important dimension which we define as how satisfied we are with our lives, our sense that what we do in life is worthwhile, our day to day emotional experiences (happiness and anxiety) and our wider mental wellbeing.

5. Whole System Approach

A comprehensive and co-ordinated series of actions that positively influences entire populations. Usually involves engaging all stakeholders, providing leadership, providing opportunities for all involved to be heard, supported, educated and developed, and establishing a culture, ethos and environment that is aligned with the desired outcome.

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