Department for Education

# HE providers' policies and practices to support student mental health

## Research report

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Government Social Research

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# Executive Summary

## Introduction

The proportion of higher education (HE) students reporting a mental health condition to their university has been increasing over recent years[1]. Young people in particular are susceptible to poor mental health as they transition into adulthood. Most mental health disorders first appear before the age of 24[2]. The impact of the coronavirus (COVID-19) pandemic has further emphasised the importance of supporting their wellbeing. The Department for Education's recently published State of the Nation report shows that rates of a probable disorder among 17-19 year olds have risen since 2021[3] but this age group are least likely to declare a mental health condition[4] and less likely to seek help[5]. Among all age groups the consequences can be significant. These students are at greater risk of non-continuation of study and their likelihood of progressing into skilled employment or further study is reduced[6].

All higher education providers (HEPs)[7] have a duty under the Equality Act 2010 to provide reasonable adjustments for students with a mental health condition and they should at the same time be providing the best possible learning environment for those students[8]. They are encouraged to adopt effective practice in relation to mental health and wellbeing and have suicide prevention and intervention strategies in place. There have already been some important strides in this space, and the Department for Education (DfE) supports Universities UK's Stepchange: Mentally Healthy Universities framework[9], the Suicide-Safer Universities guidance[10] and the University Mental Health Charter[11] led by Student Minds, all of which are intended to drive up standards of practice across the HE sector. UUK and Papyrus also produced postvention guidance (actions after a death by suspected suicide) providing practical advice on compassionate, confident, and timely support – this was published in December 2022 and so is not in the

[1] Table 15 - UK domiciled student enrolments by disability and sex 2014/15 to 2021/22 | HESA
[2] Adolescence and mental health - The Lancet
[3] State of the nation 2022: children and young people's wellbeing - GOV.UK (www.gov.uk)
[4] UCAS-report-on-student-mental-health-press-report-June-2021.pdf (shu.ac.uk)
[5] State of the nation 2022: children and young people's wellbeing - GOV.UK (www.gov.uk)
[6] 87% of full-time undergraduate first year students with a mental health condition continued with their study in 2020/21 compared with 89% overall and 68.4% of full-time undergraduates with a mental health condition progressed to further study or a graduate job or other positive outcome 15 months after graduating in 2019/20 compared to 72.3% overall -Access and participation data dashboard - Office for Students
[7] To make a distinction across HEP type to allow for comparisons with the previous report we distinguish between Private Providers (PPs), Further Education Colleges with HE provision (FECs) and universities/HE Institutions (HEIs)
[8] Mental health: Are all students being properly supported? - Office for Students
[9] Stepchange: mentally healthy universities (universitiesuk.ac.uk)
[10] Suicide-Safer Universities Guidance (Universities UK, last updated Jan 2023)
[11] The University Student Mental Health Charter (Student Minds)

scope of this research report. Separately, the Association of Colleges Mental Health and Wellbeing Charter has been developed for Further Education Colleges (FECS)[12].

DfE has also funded effective practice to support university student mental health. The Office for Students (OfS) was asked to allocate £15m in 2022-23 to give additional support for transitions from school and college to university, and to target funding to support partnership working with NHS services to provide students with a pathway of care to local mental health services. The OfS has also invested a total of £9m to fund 28 projects across two Challenge Competitions in 2018 and 2021 to identify innovative approaches to improve mental health in HE.

The DfE commissioned IFF Research to undertake a survey and qualitative follow-up of HE providers to understand the range of institutional policies and practices they use to support student mental health and wellbeing. Questions in this study centred around the extent to which providers have adopted mental health and wellbeing at a strategic level, the practices adopted by HE providers in supporting students' mental health, wellbeing and suicide prevention and how these are designed and evaluated. This study builds upon DfE research in 2019/20[13] which provided an in-depth study of HE institutions' approaches to supporting students including the range of services provided.

For the most part throughout this report findings are reported separately for Higher Education Institutions (HEIs). Further Education Colleges (FECs) and Private Providers (PPs).

## How far have HEPs adopted health and wellbeing at a strategic level?

Survey results  suggest that since 2019, more HEIs are taking a strategic approach to student mental health and wellbeing. The proportion of HEIs with a specific mental health and/or wellbeing strategy increased from 52% in 2019 to 66% in 2022. A large proportion of the remainder (26%) had one in process. Only 3% of HEIs had no strategy and no current plans for one, compared with 9% in 2019. Among FE colleges and Private Providers, 64% and 49% respectively had a strategy in place.  Many were planning one, with only 3% of providers reporting no current plans. Among providers with a strategy, this commonly took the format of a separate strategic document or was part of the institution's overall strategic plan.  HEIs were most likely to have a separate strategic document (62%).

[12] AoC Mental Health & Wellbeing Charter | Association of Colleges
[13] https://www.gov.uk/government/publications/he-student-mental-health-and-wellbeing-sector-insights

In the absence of a specific or overarching strategy, most providers had designated policies to support student mental health and wellbeing.

Most providers designed their mental health and/or wellbeing strategy for both students and staff with just under a quarter of providers with an existing or planned strategy covering students only.

HEIs most commonly referred to UUK's 'Step Change' framework (84%) when developing their strategy, with around two-thirds having referred to the University Mental Health Charter (65%) or UUK and Papyrus' 'Suicide-Safer Universities' framework (67%). Among FECs with a strategy, the vast majority (87%) referred to the AOC's Mental Health and Wellbeing Charter. Private Providers with a strategy used a combination of resources.

In addition to published guidance most providers consulted external organisations or groups on student wellbeing, mental health and/or suicide prevention. Only 5% of HEIs and 3% of FE colleges did not consult externally. Private Providers were least likely to do this. However, all HEIs, and the vast majority of all other provider types consulted internally on their strategy.

## To what extent have HEPs adopted and embedded suicide prevention frameworks and strategies?

The vast majority of HEIs had a suicide prevention strategy or were working towards putting one in place (66% and 32% respectively). Likewise a large proportion, 54% of FE colleges and 42% of Private Providers, had a suicide strategy with 34% and 37% respectively indicating there one was in the planning. Comparisons with the previous survey were not possible on suicide prevention.

Among HEIs with a current or planned suicide prevention strategy, this mostly covered or was being developed to cover prevention (97%), intervention (99%) and postvention[14] (93%), suggesting a comprehensive approach.

HE providers using the frameworks to inform their strategy believed this provided them with clear goals. and that grouping activities into prevention, intervention and postvention provided a useful structure.

[14] Postvention was defined as actions taken after a death has occurred, including communications, support for the bereaved and post-incident review

## What services do HEPs offer to support students?

The majority of HE providers offered multiple services to support student mental health and wellbeing. Almost all HEIs (99%) and the majority of FECs (93%) provided in-house self-help resources, and the majority of HEIs and FECs (97% and 85% respectively) offered in-house psychological support for those experiencing poor mental health, either face-to-face or virtual contact with a counsellor.

Private Providers offered relatively fewer types of support than HEIs or FE colleges and in particular, only a small minority (16%) offered agreed joined-up care pathways between themselves and local NHS services. This compared with 70% of HEIs and 63% of FE colleges

In the qualitative research, some HEIs said that their current focus in improving and developing their services was on wellbeing support and preventative measures such as social prescribing to support students experiencing loneliness and social isolation. Providers also offered a range of self-help resources for students to access which were designed to support them with their mental health or wellbeing and some saw this as a cornerstone of their support strategies. However, others were concerned about the increasing focus on self-help, highlighting that some students will need more intensive, therapeutic support.

## How do HEPs design, deliver and evaluate services to meet the needs of their students?

HEPs consulted widely both internally and externally in the development of services to support student mental health/wellbeing and suicide prevention.

While most respondents consulted stakeholders when developing their mental health and suicide prevention strategies, HEIs had typically consulted a wider range. Over nine in ten HEIs reported that they consulted with their senior leadership team, disability services staff, Student Union representatives, mental health practitioners, and academic teaching staff. Almost eight in ten (78%) HEIs reported that they consulted with current students and with accommodation staff, respectively. Internal consultation was less wide-ranging among other types of HE provider, which is perhaps linked to the nature of HEIs and their students, with more living away from home than in FE colleges and Private Providers.

Almost all HE providers offered training to staff in relation to student mental health and wellbeing. Providers most commonly offered training to student services staff and teaching staff. HE providers with a mental health or wellbeing strategy were more likely to offer training to student services staff, estates staff, and technical staff. HE providers without a strategy were more likely to offer training to none of the listed groups of staff.

Overall, services to support student mental health, wellbeing and suicide prevention are typically evolving and many HE providers are reviewing their services and making changes to strengthen these. Data on service use and outcomes was used to inform service improvement. Three-quarters (73%) of HEIs review their student mental health strategy/ policy at least once a year and two-thirds (68%) review their suicide prevention strategy/ policy. Over nine in ten (92%) HEIs regularly review whether student mental health services are meeting demand and around half (49%) regularly review whether services/ practices are meeting demand for NHS care pathways.

## Service reflections in the context of rising demand

Providers that had experience of supporting students with complex or urgent mental health needs felt that they had been left with no choice but expand their internal support services as quickly as possible and to seek closer working relationships with the NHS. Providers interviewed in the qualitative research typically considered that it was becoming increasingly difficult to meet demand even though many had funded expansion of services such as counselling. Providers said that this pressure was a result of a combination of:

- Students experiencing more, or more complex, problems with their mental health due to a range of factors including Covid restrictions and the cost of living.
- Students being more aware of their mental health and wellbeing and feeling more able or confident to seek support.
- An increase in students believing that they would benefit from counselling.
- Lack of capacity in the NHS to take on longer-term or more complex support needs.

## Conclusions

Overall, HE providers are adopting health and wellbeing at a strategic level within their organisation and reported that this is becoming increasingly important to them. Compared with 2019, the proportion of HEIs with a specific mental health/wellbeing strategy in place has increased from just over half to two-thirds, and a similar proportion have a suicide prevention strategy in place.

Those HE providers with strategies, or those in development, consult with a wide range of internal and external stakeholders and utilise the range of tools and frameworks in place to support them. Internally, consultation with students is particularly common among HEIs. Externally, HEIs (and to a lesser extent, FECs) tend to consult with a wider

range of local stakeholders including NHS services, local third sector organisations and their local authorities, whereas consultation is more limited among Private Providers.

The use of suicide prevention frameworks and strategies, including links with local suicide prevention networks, has been an increasing priority among HEIs in particular. Some providers felt that they would benefit from closer links and greater clarity about how to work with local emergency services.

# Chapter 1: Introduction

In 2022, the Department for Education (DfE) commissioned IFF Research to explore approaches to supporting student mental health, wellbeing, and suicide prevention at Higher Education providers (HEPs) in England. The study was designed to build on initial exploratory research conducted for the DfE in 2019[15].

Fieldwork took place between May and September 2022 and comprised:

- A survey of HE providers about their strategy, policy and practices regarding student mental health, wellbeing and suicide, disseminated across eligible universities/Higher Education Institutions (HEIs), Further Education Colleges (FECs) and Private Providers.
- A series of follow up qualitative interviews among managers and staff at HEPs which took part in the survey and agreed to be recontacted for more in-depth research.

The rest of this chapter sets out the background to this research and provides an overview of the methodology.

## Research background

It is well documented that the developmental transition into adulthood leaves young people especially susceptible to poor mental health and/or wellbeing. Increases in disorders have been observed in recent years. Among 17- 19-year-olds, rates of probable disorder have risen from one in six in 2020 and 2021 to one in four in 2022[16]. Recent research using data from the Longitudinal Study of Young People in England (LSYPE2) points to somewhat greater vulnerability among those in higher education compared to those who took other routes at aged 18/19[17]. Potential explanations are that "alongside the developmental transition to adulthood, young people entering higher education can experience academic pressures, social challenges, separation from their usual support networks, and financial problems[18]."

Covid-19 threw this issue into starker focus, with research such as the Student Academic Experience Survey concluding that "students, staff and institutions have faced bigger challenges than at any point in living memory [and that] picking up the pieces after the

[15] https://www.gov.uk/government/publications/he-student-mental-health-and-wellbeing-sector-insights [16] Mental health of Children and Young People in England, 2021, wave 2 follow up to the 2017 survey (NHS Digital, 2022)

[16] Mental health of Children and Young People in England, 2021, wave 2 follow up to the 2017 survey (NHS Digital, 2022)

[17] Lewis G, McCloud T and Callender C, University College London and Institute of Education, HE and Mental Health: Analyses of the LSYPE Cohorts (DfE, 2021)

[18] Lewis G, McCloud T and Callender C, University College London and Institute of Education, HE and Mental Health: Analyses of the LSYPE Cohorts (DfE, 2021)

crisis will need proper resourcing[19]." DfE's Parent and Pupil Panel (PPP) Survey found that the overall mean score for anxiousness had slightly risen among pupils and learners in 2022, increasing from 3.6 in May 2021 to 4.4 in May 2022, with older learners reporting higher levels of anxiousness compared to younger groups[20].

In the 2021/22 academic year there were 2.86 million students enrolled at UK Higher Education providers[21]. All higher education providers (HEPs) have a duty under the Equality Act 2010 to provide reasonable adjustments for students with a mental health condition and they should at the same time be providing the best possible learning environment for those students[22] There have already been some important strides in this space, and the DfE supports Universities UK's Stepchange: Mentally Healthy Universities Framework[23], the Suicide-Safer Universities guidance[24] and the University Mental Health Charter[25] led by Student Minds, which are intended to drive up standards of practice across universities:

- Stepchange: Mentally Healthy Universities Framework was developed by UUK and calls on HE leaders to adopt mental health as a strategic priority and take a whole-institution approach, embedding it across all policies, cultures, curricula and practice. It recommends that all aspects of university life promote and support student and staff mental health.
- The University Mental Health Charter, led by Student Minds and developed in collaboration with students, staff, and partner organisations. The Charter expands upon the whole-institution approach outlined in Stepchange and is intended to drive up standards of practice across the HE sector. It provides a set of evidence-informed principles to support universities to adopt a whole-university approach to mental health and wellbeing including leadership, early intervention and data collection.
- The Suicide-Safer Universities framework. Led by Universities UK and Papyrus this framework supports university leaders to prevent student suicides and support students and families after the death of a student. The suicide framework has been widely adopted and is one of a number of key components in the University Mental Health Charter led by Student Minds. UUK and Papyrus also produced postvention guidance (actions after a death by suspected suicide) providing

[19] The Student Academic Experience Survey (HEPI, 2021)
[20] IFF, Parent and Pupil Panel Survey, DfE, December 2022
[21] Higher Education Student Statistics: UK 2021/22 released | HESA
[22] Mental health: Are all students being properly supported? - Office for Students
[23] ibid.
[24] Suicide-Safer Universities Guidance (Universities UK, last updated Jan 2023)
[25] The University Student Mental Health Charter (Student Minds)

practical advice on compassionate, confident, and timely support – this was published in December 2022 and so is not in the scope of this research report.

- In 2019, the Association of Colleges (AoC) launched their mental health and wellbeing charter, which commits colleges to creating an environment that promotes and proactively supports student and staff mental health. DfE have also co-developed the educational staff wellbeing charter with the sector, which is open to schools and colleges to commit to protect, promote and enhance the wellbeing of their staff.

DfE has also funded effective practice to support university student mental health. The Office for Students (OfS) was asked to allocate £15m in 2022-23 to give additional support for transitions from school and college to university, and to target funding to support partnership working with NHS services to provide students with a pathway of care to local mental health services. The OfS has also invested a total of £9m to fund 28 projects across two Challenge Competitions in 2018 and 2021 to identify innovative approaches to improve mental health in HE.

In 2019, DfE commissioned exploratory research[26] to understand HE providers' approaches to supporting student mental health and wellbeing, the types of support available, and the collection and use of student mental health and wellbeing data. The research also explored providers' evidence gaps in relation to student mental health and wellbeing. As part of this exploratory research, an online survey was conducted with all publicly funded HEIs, and a sample of FECs and Private Providers. As such, the findings for FECs and Private Providers were indicative only.

## Aims and objectives

This research aimed to build on the findings from the exploratory research conducted in 2019 and contribute to wider effective practice. Specific objectives include exploring:

- How far Higher Education Providers (HEPs) have adopted health and wellbeing at a strategic level in their organisation;
- The extent to which the whole institution approach as referred to in the Universities UK Stepchange: Mentally Healthy Universities framework has been embedded;
- What services are offered to support students and how HEPs design, deliver and evaluate services to meet the needs of their students;

[26] IES and AdvanceHE, HE student mental health and wellbeing: insights from HE providers and sector experts, DfE, June 2021

- The extent to which HEPs have adopted and embedded suicide prevention frameworks and strategies including linking with their local suicide prevention networks.

## Methodology

This section summarises the methodology, with more detail in the Technical Appendix.

### Survey of HE providers

All eligible HE providers in England were invited to take part in a 20 minute survey about their strategies, policies and practices to support student mental health, wellbeing and suicide prevention. All OfS registered HE providers in Spring 2022 were in scope for the research.

The survey questions covered a range of areas related to the research objectives, including strategic development, existing practices and services, and overall service reflections. The questionnaire was developed in collaboration with DfE and key stakeholders including the Office for Students (OfS), Universities UK (UUK), Student Minds, and a small number of university contacts sourced through the Association of Managers of Student Services in Higher Education (AMOSSHE). The questionnaire development was also informed by a cognitive testing phase across HEIs, FECs and Private Providers.

Fieldwork took place between 11th May and 27th July 2022. The in-scope population consisted of 133 HEIs, 157 FECs and 109 Private Providers. The majority of surveys were completed online (161) with a small number (18) completed by phone using Computer Assisted Telephone Interviewing (CATI), following a short chasing exercise. Response rates were lower for FECs and Private Providers relative to HEIs, 38% and 39% respectively. A breakdown of response is shown in Table 1.1.

**Table 1.1: Survey responses by type of HE provider**

| Provider type | In-scope | n | Response rate |
|---|---|---|---|
| Higher Education Institutions (HEIs) | 133 | 77 | 58% |
| Further Education Colleges (FECs) offering HE courses | 157 | 59 | 38% |
| Private Providers | 109 | 43 | 39% |
| **Total** | **399** | **179** | **45%** |

Each HE provider was asked to submit one collated response for their institution. They were encouraged to gather input from other colleagues, where needed. The survey was generally completed and submitted by a senior member of staff, including Vice Chancellors, Principals and Deans of Students as well as Heads or Directors of departments responsible for student services, student experience, student support, mental health or wellbeing, and people in similar roles.

A breakdown of the profile of the survey respondents by provider type, region, size (number of students) and tariff level (for HEIs only), is outlined in Table A1 in the Technical Appendix.

## Qualitative interviews

The qualitative fieldwork consisted of 75 depth interviews conducted across 33 HE providers, from 27th June to 1st September 2022. Participants in the qualitative research included the survey lead and other nominated colleagues at their institution, either in strategic roles or working directly with students. More than one interview was conducted per institution in order to gain a fuller perspective on the topics covered, including operational delivery as well as strategy.

Provider characteristics were monitored to ensure a broad spread by: provider type, broad region[27], tariff (among HEIs), size (in terms of number of students), and the presence of a mental health / wellbeing strategy, as indicated in the survey. The profile of the 33 HE providers who took part in the qualitative phase of the research is shown in Table A3 in the Technical Appendix. This included interviews in 20 HEIs, six FE colleges and seven Private Providers.

The interviews explored the research objectives in more depth, guided by the responses given at the survey stage. Interviews lasted 45 to 60 minutes and were recorded with permission from participants.

## Approach to analysis and reporting

Due to the relatively small sample size for some provider types and the census approach, the survey data are unweighted. Data were analysed using crosstabulations in Excel and SPSS. Throughout the report the survey findings are reported separately in terms of HEIs, FE colleges and Private Providers. This is partly because the largest concentration of HE students is within HEIs, so it is important to explore their results separately and compare these with the 2019 study where possible, and partly because the base sizes

[27] The qualitative research was not designed to be representative, but to provide representation across different provider characteristics. At the broadest regional level there was representation across London, South, Midlands and North, although at more granular level HE providers in the North East and North West were under-represented.

for FE colleges and Private Providers are smaller relative to the size of those populations.

The qualitative data was entered into an Excel-based analysis framework mapped to the research questions, which the research team interrogated to identify themes and subgroup patterns.

The report uses the following conventions when reporting survey findings:

- Throughout, base figures are shown on tables and charts to give an indication of the statistical reliability of the figures.
- As a general convention throughout the report, figures with a base size of fewer than 30 are not reported.
- In some cases, figures in tables and charts may not always add to 100 percent due to rounding (i.e. 99 percent or 101 percent) or multiple responses.

## Report structure

The report is structured as follows:

- Mental health, wellbeing and suicide prevention strategies, including sources used to inform their design and development.
- The extent of internal and external consultation on strategies and services.
- Details around the services and practices adopted, including types of support available, whether they are targeted to specific groups of students and the sorts of organisations that HE providers work with.
- Staff training, including which staff are offered training and the types of training delivered.
- Data collection, including the types of information collected, how frequently and how it is used.
- Service reflections, including the extent to which HE providers consider that their mental health and wellbeing services are meeting student demand, and where the gaps are.
- Conclusions.

# Chapter 2: Mental health, wellbeing and suicide prevention strategies

This chapter outlines the extent to which providers have a specific mental health and/or wellbeing strategy, and a suicide prevention strategy, and explores providers' approaches to strategy development.

The coverage and scope of providers' mental health and wellbeing strategies have been explored previously and are not covered as part of this project. Frequently they are comprehensive documents detailing wide-ranging areas of activity and include an understanding of the context as well as the ambitions of the institution in terms of its goals, activity, channels of support, roles and responsibilities and how they will review and monitor progress. A more descriptive account can be found in the DfE commissioned exploratory 2019/20 study.[28]

In terms of defining mental health and wellbeing, whilst being somewhat separate concepts, they are interrelated. The Mental Health Charter provides a working definition of each but acknowledges that alternative definitions might be used. The DfE 2019/20 study showed that whilst some providers might have working definitions of both mental health and wellbeing, some might use these terms synonymously.

## Mental health and wellbeing strategies

HE providers were asked whether they had a specific mental health and/or wellbeing strategy. The terms 'mental health' and 'wellbeing' were not defined in the survey at this point, to acknowledge that different organisations might understand these terms differently, and to allow for a direct comparison with the approach taken in the 2019 research, where the terms were also not specifically defined.

Amongst the different types of providers, 66% of HEIs had a specific mental health and/or wellbeing strategy, whilst 64% of FE colleges and 49% of private providers had one.

Overall, only 3% of providers said they did not have any current plans for a mental health or wellbeing strategy. Around one in ten (11%) said they had no specific strategy for mental health or wellbeing, but that it was covered in a wider strategy, whilst around one-quarter (26%) said they had no current strategy but that it was in progress.

[28] https://www.gov.uk/government/publications/he-student-mental-health-and-wellbeing-sector-insights

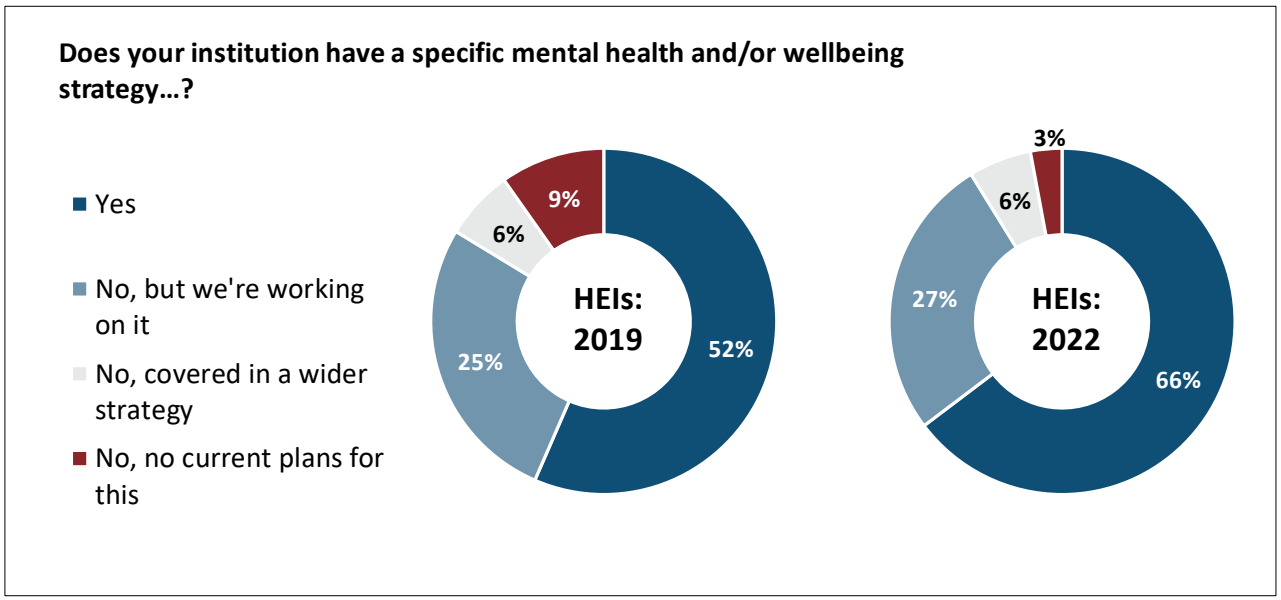
**Table 2.1: Proportion of HE providers with a specific mental health and/or wellbeing strategy**

| | Total | HEI | FEC | Private provider |
|---|---|---|---|---|
| **Net: Dedicated, mental health and/or wellbeing strategy*** | **61%** | 66% | 64% | 49% |
| Yes, combined mental health and wellbeing strategy | **50%** | 56% | 51% | 40% |
| Yes, separate mental health strategy | **6%** | 6% | 7% | 5% |
| Yes, separate wellbeing strategy | **8%** | 4% | 12% | 9%. |
| Covered in a wider strategy** | **11%** | 6% | 12% | 16% |
| No, in progress (not in place yet)** | **26%** | 27% | 22% | 30% |
| No, not planned as yet | **3%** | 3% | 2% | 7% |
| Other | **1%** | 1% | 2% | 0% |

*B1. Does your institution have a specific mental health and/or wellbeing strategy? Base: Base: All (179); HEIs (77), FECs (59), Private Providers (43). *Multiple responses were possible.**Includes 4 providers who responded 'Other' and were back-coded into both categories.*

The proportion of HEIs who said they had a specific mental health and/or wellbeing strategy increased from 52% in 2019 to 66% in 2022 (Figure 2.1). Only 3% of HEIs did not have a strategy and had no current plans for one, compared with 9% in 2019. These changes suggest that since 2019, more HEIs are taking a strategic approach to student mental health and wellbeing.

**Figure 2.1: Proportion of HEIs with a specific mental health and/or wellbeing strategy: comparison 2019 and 2022**




*B1. Does your institution have a specific mental health and/or wellbeing strategy…? Base: 2019: HEIs (81); 2022: HEIs (77).*

## Responsibilities for strategy

Most HE providers allocated strategic responsibility for student mental health and wellbeing to either a mental health specialist (42%), or to senior management of the institution, such as the Principal, Vice Chancellor or Dean (39%). For 33% of providers, responsibility lay with the senior role responsible for student services, such as the Head of Student Experience or Director of Student Services. For 64% of providers, the same role had both strategic and operational responsibility for student mental health and wellbeing.

HE providers most commonly assigned strategic responsibility for suicide prevention to a mental health specialist (47%), followed by the Head of Student Services (32%) or senior leadership such as the Principal or Vice Chancellor (32%). At several providers, responsibility was shared by two or more different roles. For 71% of providers, the same role had both strategic and operational responsibility for suicide prevention. Detailed breakdowns by provider type are included in the Appendix.

## Strategy coverage

All providers with a current or planned mental health and/or wellbeing strategy were asked whether it covers or will cover students only or both staff and students. For the majority of providers with a strategy (72%), this covered both students and staff. Fewer providers had a strategy just covering students (24%). Similarly, among providers who

were planning their mental health and/or wellbeing strategy, the majority (77%) were including students and staff. Fewer (23%) were planning a strategy that just covered students.

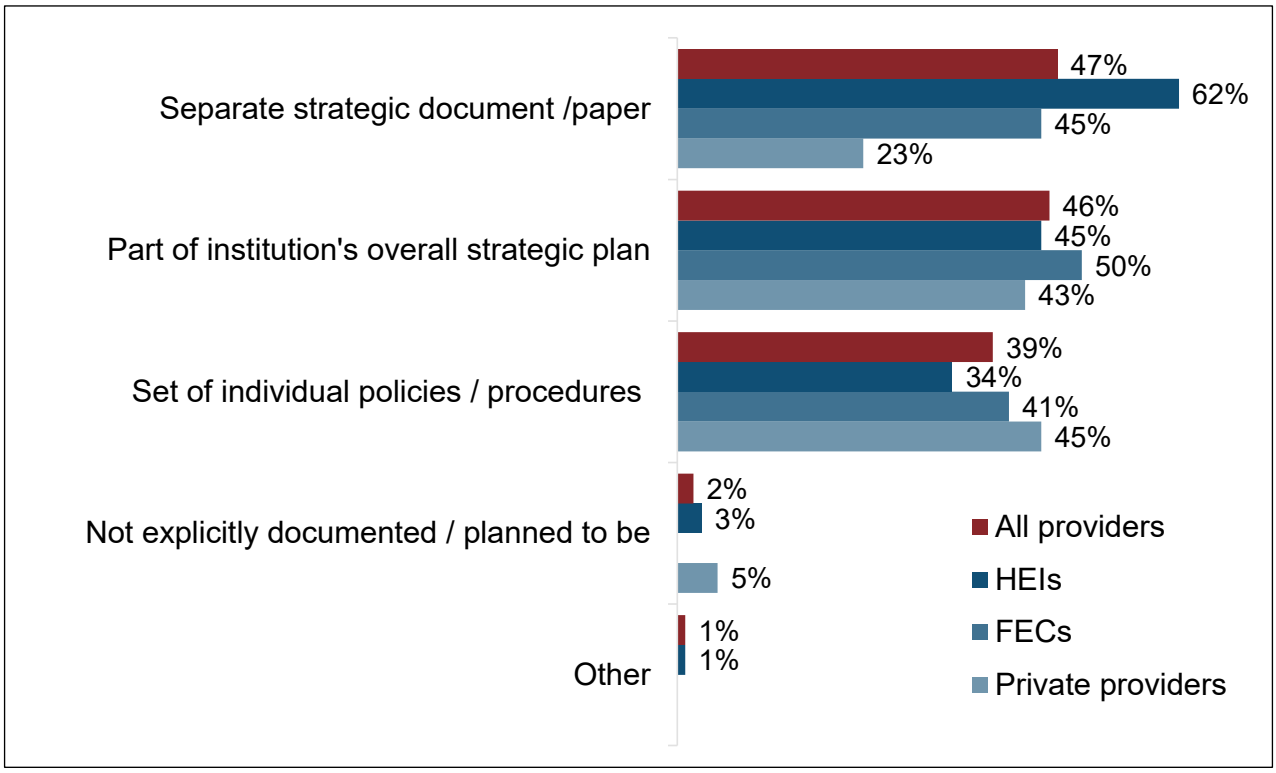
Two-thirds of HEIs with a strategy (66%) said it covered both students and staff, a slight increase from the 2019 survey where this was the case for 62% of HEIs.

FE colleges with a current or planned mental health and/or wellbeing strategy were asked whether it covers or will cover HE students only or both HE and FE students. The vast majority (91%) said that it covered both HE and FE students. Only a small number said that it covered HE students only (4%) or FE students only (4%).

Among providers with a strategy, this commonly took the format of a separate strategic document or was part of the institution's overall strategic plan (Figure 2.2). HEIs were most likely to have a separate strategic document (62%) and private providers were least likely to adopt this format. A strategy represented in a separate set of policies was less common among HEIs compared with FECs and private providers but very few (2%) overall had no documented policies.

Among HEIs with a mental health and/or wellbeing strategy, 62% said this was in the form of a strategic document/paper, whilst 45% said it is part of the institution's overall strategic plan, and 39% said it comprises a set of policies. Only 3% of HEIs said their strategy was not explicitly documented or planned to be. Whilst not directly comparable to the 2019 survey, as providers could select multiple options, the proportion with a strategic document/paper has remained relatively consistent, with 67% of providers who had a strategy stating this in 2019.

**Figure 2.2: Format of current or planned student mental health and/or wellbeing strategy**




*B2a. What form does/will your institution's mental health/wellbeing strategy(ies) take? Multicode. Base: All who have a strategy/ have one planned (174); HEIs (76), FECs (58), Private Providers (40).*

## Mental health and wellbeing policies

Providers without a current mental health and/or wellbeing strategy were asked to state whether they had any policies in place. In the survey, 'policies' was defined as *"set of guiding principles and/or toolkits that inform your practices in these areas."*

Most providers without a current mental health strategy said they had mental health policies in place (46%) or they were working on it (44%), representing 14% and 13% of all providers respectively (Table 2.2). A minority said they had no current plans for a mental health policy (2% of all providers) or that they were unsure (1% of all providers). While the base sizes for each provider type are too low to report on individually[29], this pattern is seen across each provider type: most providers without a mental health strategy either had a mental health policy in place or were working on it.

Similarly, most providers without a wellbeing strategy either had a wellbeing policy (12% of all providers) or were working on it (15% of all providers). A minority of providers (3%

[29] Data is not shown for each provider type due to very low base sizes (HEIs: 24; FECs: 13; Private Providers: 17).

of all providers) without a wellbeing strategy said they had no current plans for a wellbeing policy, and 1% of all providers said they were unsure.

**Table 2.2: Presence of mental health and wellbeing policies amongst providers without a mental health strategy**

| | Mental health policy | | Wellbeing policy | |
|---|---|---|---|---|
| | % of those without strategy | % of all providers | % of those without strategy | % of all providers |
| Yes | **46%** | **14%** | **39%** | **12%** |
| No, but we're working on it | **44%** | **13%** | **50%** | **15%** |
| No, no current plans for this | **7%** | **2%** | **9%** | **3%** |
| Unsure | **2%** | **1%** | **2%** | **1%** |

*B4a_1 / B4a_2. Does [HEP] have any policies in place regarding the following ... Mental health / Wellbeing? Base: Providers without a specific mental health and/or wellbeing strategy (54).*

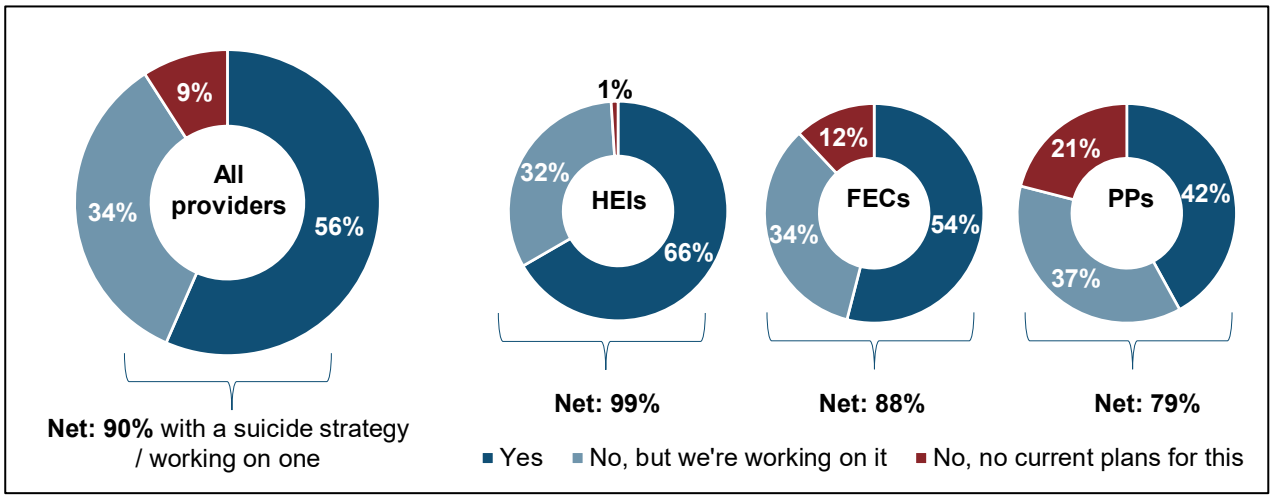
In the qualitative interviews, providers that did not have a specific mental health and/or wellbeing strategy or policy in place said the reason for this was that mental health and wellbeing were covered in existing policies. This included sector-wide policies such as safeguarding and fitness to study as well as provider-specific policies which covered a range of issues relating to mental health and wellbeing, such as sexual harassment and violence.

The absence of a specific strategy does not mean the provider lacks a process for identifying students in need of support. For example, one HEI reported that their safeguarding policy meant that student mental health and wellbeing was monitored through staff observation, that case conferencing was conducted for students of concern, and statutory services were contacted if needed.

## Suicide prevention strategy

Figure 2.3 shows that 66% of HEIs currently had a student suicide prevention strategy. Among the remaining HEIs 32% were working to achieve this. Only 1% of HEIs reported no plans currently to do so. By comparison, 54% of FE colleges and 42% of Private Providers had a suicide prevention strategy with 34% and 37% respectively indicating that one was in the planning. This question was not asked in the 2019/20 exploratory research so comparisons are not possible.

**Figure 2.3: Proportion of providers with a specific suicide prevention strategy**




*B5. Does [HEP] have a suicide prevention strategy? Base: All (179); HEIs (77); FECs (59); Private Providers (43).*

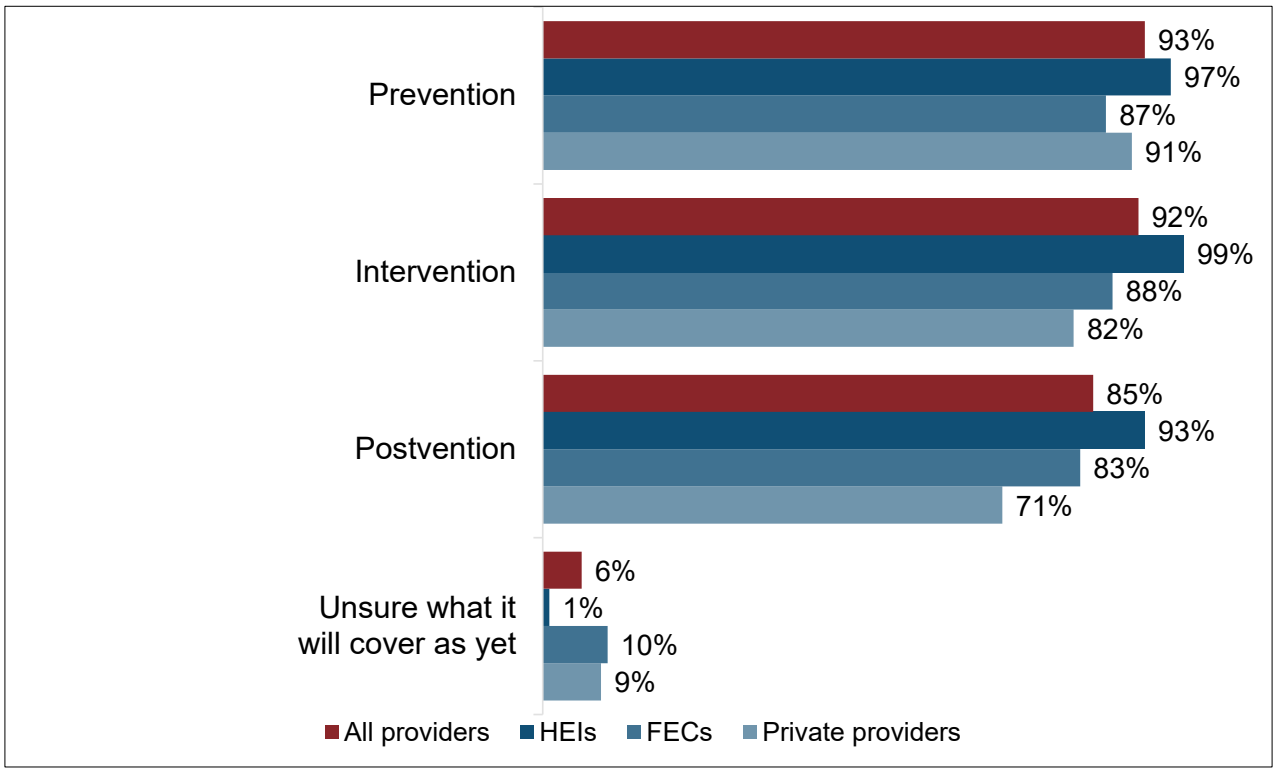
Among HEIs with a current or planned suicide prevention strategy, most stated that this covers or will cover prevention (97%), intervention (99%) and postvention (93%), suggesting a comprehensive approach (Figure 2.4). In the survey, postvention was defined as 'actions taken after a death has occurred, including communications, support for the bereaved and post-incident review'.

While the vast majority of FE colleges and Private Providers with a current or planned suicide prevention strategy reported that this covered prevention (87% and 91% respectively) and intervention (88% and 82%, respectively), it was less common for this to cover postvention (83% and 71%, respectively).

Among providers with a current or planned suicide prevention strategy, half said that the focus and coverage was for students only (50%) and half said it was for both students and staff (49%).

Among FE colleges and Private Providers with a current or planned suicide prevention strategy, the majority (69%) said that it covers or will cover both HE and FE students. Just over one-quarter (29%) said that it covers or will cover HE students only.

**Figure 2.4: The coverage of strategies on suicide prevention, intervention and postvention**




*B9a. Which of the following does/will your suicide prevention strategy cover? Base: Providers with a current or planned suicide prevention strategy (162); HEIs (76); FECs (52); Private Providers (34). Multiple response.*

## Format of current or planned suicide prevention strategy

Table 2.3 shows that just over half of each provider type with a current or planned suicide prevention strategy reported that this was part of their mental health/ wellbeing strategy.

While 45% of HEIs stated that their suicide prevention strategy is or will be a separate strategic document(s), this was only reported by 6% of FECs and 12% of Private Providers.

**Table 2.3: Format of current or planned student suicide prevention strategy**

| | Total | HEI | FEC | Private provider |
|---|---|---|---|---|
| Part of our mental health/wellbeing strategy | **54%** | 54% | 54% | 56% |
| A set of individual policies and procedures that are concerned with suicide prevention | **33%** | 33% | 27% | 41% |
| Separate strategic document(s) | **25%** | 45% | 6% | 12% |
| Part of a different strategy | **19%** | 8% | 29% | 29% |
| Part of the institution's overall strategic plan | **17%** | 18% | 15% | 18% |
| It is not explicitly documented or planned to be explicitly documented | **3%** | 1% | 6% | 3% |
| Other | **1%** | 1% | 0% | 0% |

*B6c. What form does/will your institution's suicide prevention strategy take? Base: Providers with a current or planned suicide prevention strategy (162); HEIs (76), FECs (52), Private Providers (34). This question was 'multicode'; providers were able to select all that applied to their circumstances, with the exception of the response option 'It is not explicitly documented or planned to be explicitly documented'.*

## Suicide prevention policy

The 78 providers without a current suicide prevention strategy were asked if they had any suicide prevention policies in place. The majority of them either had suicide prevention policies in place (28%) or were working on it (53%). A minority (17%) without a suicide prevention strategy said they had no suicide prevention policy and no plans for one (representing 7% of all providers overall – 3% of HEIs, 10% of FECs and 12% of Private Providers).

In the qualitative research, providers without a suicide prevention strategy or prevention policy in place tended to be among those that did not provide student accommodation and/or whose student population typically contained a high proportion of mature students, in particular some Private Providers. These providers gave two main reasons for considering it unnecessary to have a suicide prevention strategy in place:

- The perception among these providers was that their students were generally older, living with their families, and often in the town or city in which they were

assumed to have existing support networks. As a result, these providers regarded their students as being less at risk of suicide, compared to younger students living away from home for the first time.

- There was also the perception that their students spent less time on the provider's site, compared to a student living on campus. As a result, these providers assumed it was less likely that the student would experience a mental health crisis on site. They believed that signs of distress would be recognised earlier by the students' friends, family or possibly work colleagues and that the first sign that the provider would notice is non-attendance.

Such providers tended to encourage students to access NHS services through their GP if needed, rather than try to provide this support themselves. If they did have concerns about a student, they said they would contact their next of kin, rather than take a central role in intervention. However, some of these providers said that they were planning to create a suicide prevention policy, in response to DfE's prompts to ensure that a strategy is in place.

Similarly, where FECs tended not to have a specific suicide prevention strategy or prevention policy, they often covered issues relating to suicide prevention in existing policies such as safeguarding or fitness to study. Again, their main reasoning was that students were mostly living at home with their parents, and were assumed to have existing support networks and access to support through their local GP. One FE college saw their duty as ensuring that the student was safe to be on campus.

> "We have never had a situation with an HE student, but we would conduct an assessment, contact services when needed and use the Fitness to Study policy to decide on whether the student is safe to be on campus." - FEC

## Sources used to inform strategy design and development

Providers with a current mental health, wellbeing or suicide prevention strategy were asked whether they had used the following in its design or development:

- UUK's 'Step Change: Mentally Healthy Universities' framework
- the University Mental Health Charter (led by Student Minds)
- Universities UK and Papyrus' Suicide-Safer Universities framework
- AoC Mental Health and Wellbeing Charter (asked of FECs only).

## Sources used to inform mental health and/or wellbeing strategy

Table 2.4 shows that, by provider type, HEIs had most commonly referred to UUK's 'Step Change' framework (84%), with around two-thirds having referred to the University Mental Health Charter (65%) or UUK and Papyrus' 'Suicide-Safer Universities' framework (67%).

Among FECs, the vast majority (87%) said they had referred to the AOC's Mental Health and Wellbeing Charter. Referring to HE-specific sources was less common: 39% referred to the University Mental Health Charter, 15% referred to UUK's 'Step Change' framework, and 30% referred to UUK and Papyrus' 'Suicide-Safer Universities' framework.

Among Private Providers, 61% had referred to the University Mental Health Charter, 57% referred to UUK's 'Step Change' framework, and 50% referred to UUK and Papyrus' 'Suicide-Safer Universities' framework.

Among the 26% of providers who referred to 'other sources' in the development of their mental health and/or wellbeing strategy, these included[30]:

- Collaboration with other HE providers
- Collaboration with third-sector organisations
- Academic research
- Engaging with staff / students
- Working with local NHS / mental health and wellbeing support services
- Using consultants / training agencies
- Working with local authorities
- Designing / integrating technology solutions in communications e.g. Discord
- Other published guidance online.

[30] Data is not shown for each response due to low base (34 providers in total said they had referred to another source(s)).

**Table 2.4: Sources used to inform mental health and/or wellbeing strategy**

| | Total | HEI | FEC | Private provider |
|---|---|---|---|---|
| **"University Mental Health Charter"** | | | | |
| Yes – used | **55%** | 65% | 39% | 61% |
| No, don't believe it was published at the time | **18%** | 28% | 13% | 7% |
| No, but I think it was published at the time | **11%** | 2% | 22% | 11% |
| Unsure | **16%** | 5% | 26% | 21% |
| **UUK's "Step Change: Mentally Healthy Universities" framework** | | | | |
| Yes – used | **54%** | 84% | 15% | 57% |
| No, don't believe it was published at the time | **11%** | 5% | 22% | 4% |
| No, but I think it was published at the time | **7%** | 2% | 13% | 7% |
| Unsure | **28%** | 9% | 50% | 32% |
| **UUK and Papyrus' "Suicide Safer Universities" framework** | | | | |
| Yes – used | **50%** | 67% | 30% | 50% |
| No, don't believe it was published at the time | **15%** | 12% | 22% | 11% |
| No, but I think it was published at the time | **12%** | 11% | 13% | 14% |
| Unsure | **22%** | 11% | 35% | 25% |
| **FECs only: AOC' "Mental health and Wellbeing Charter"** | | | | |
| Yes – used | **87%** | - | 87% | - |
| No, don't believe it was published at the time | **4%** | - | 4% | - |
| No, but I think it was published at the time | **0%** | - | 0% | - |
| Unsure | **9%** | - | 9% | - |

*B4. Did [HEP] access/use [source] in the design and/or development of your mental health and/or wellbeing strategy? Base: Providers with a mental health and/or wellbeing strategy (131); HEIs (57), FECs (46), Private Providers (28* Caution low base).*

UUK's Step Change framework had been used by many HEIs and private providers that took part in in the qualitative interviews. Providers that used this framework were very positive about it. It was seen as clear, easy to follow, and allowed them to check it against their existing policies to find gaps. Providers also found the framework flexible enough to fit the specific needs of their institution.

> "It was really good; you could draw on it and adapt it." - HEI

While providers were generally happy with the Step Change framework, some said that it had been superseded by the University Mental Health Charter and was no longer used.

> "We were working on that before, it was really helpful but now Student Minds' University Mental Health Charter has taken over, I thought the framework was fantastic, it felt definitive." - HEI

The University Mental Health Charter was commonly used by HEIs and Private Providers that took part in the in the qualitative interviews. Many of these were in the process of working for charter assessment, so it tended to be top of mind, and it was also viewed as the currently favoured framework for the sector. Providers that were working on their mental health/wellbeing strategy at the time of the research were generally using the University Mental Health Charter as their basis. Views on the Charter were mixed. Providers were positive about the use of the student voice, and many liked the level of detail in the Charter, which could help to ensure they had the right processes and policies in place.

> "There is more of a student voice, what students want rather than what we think they need." - HEI

> "What we're doing at the moment is we're working towards achieving the Student Minds' Mental Health Charter and we've already identified that a whole institution mental health strategy will be one of our outputs of the work that we're doing." - HEI

Conversely, some providers deemed that the Charter was too prescriptive, and it did not allow for differences between providers. For example, it was viewed as being less relevant for providers that did not offer on-site accommodation or for those working with large volumes of part-time or mature students, and therefore they saw it as more difficult to comply with.

There was also some criticism that providers are charged to be assessed against the Charter. Some providers felt that if the Charter is going to be used a basis for the policies, processes, and support across the sector, then it should not involve payment. These felt that as they struggled to provide enough mental health and wellbeing services to meet the needs of students, their budgets were already stretched and that assessment against the Charter was not the best use of funds.

> "I was all up for it, thought it was great for benchmarking, but you had to pay, and our budget is too tight. The rich universities can pay for it and wear it as a badge of honour but if I had that budget, I would spend it on student services. Should this really be a money-making scheme?" - HEI

In the qualitative interviews, some FECs that had used the AOC Mental Health Charter regarded it as a useful starting point for developing policies, but deemed that it was not detailed or challenging enough to base an entire strategy on. Some providers described this as a foundation or basis which they had moved beyond, and that they needed a more challenging framework to work with.

> "We have been working to AOC for 2 years, it's not saying anything radical, it's fine as a starting point, we just use it as a baseline commitment." - FEC

## Sources used to inform suicide prevention strategy if separate to mental health/wellbeing strategy/policies

Providers with a current suicide prevention strategy that sits outside of their institution's wider strategic plan or overall mental health/wellbeing policy (36% of all providers surveyed, n = 65) were asked whether they used any of the same sources or frameworks discussed previously.

Overall, two-thirds of these providers had referred to Universities UK and Papyrus' 'Suicide-Safer Universities' framework (rising to 84% among HEIs). Around half (55%) had referred to the 'University Mental Health Charter' (rising to two-thirds among HEIs, 68%) and half (49%) had referred to UUK's 'Step Change' framework (HEIs: 71%)[31]. Among the 17 FECs with a current suicide prevention strategy that sits outside of their institution's overall strategic plan or outside of their mental health/wellbeing policy, ten said they referred to AOC's Mental Health and Wellbeing Charter.

[31] Data for FECs and Private Providers not shown due to low base sizes FECs (n=17) and Private Providers (n=10). The base for HEIs is 38.

Just over one-quarter (28%) of providers in this group (10% of providers surveyed, overall) said they referred to other sources to inform the design or development of their suicide prevention strategy. These included[32]:

- Sector specific documentation / advice / guidance / services
- Public health documentation / advice / guidance / services
- Third sector resources e.g. MIND, Papyrus, CALM, Samaritans etc
- Local authority resources e.g. regional suicide prevention strategies / groups
- National authority resources e.g. preventing suicide in England strategy
- Academic research
- International resources e.g. World Health Organisation (WHO).

In the qualitative research, providers who had worked with the UUK and Papyrus Suicide-Safer framework spoke positively about it. They considered that it had provided them with clear goals to work with and that grouping activities into prevention, intervention and postvention provided a useful and clear structure to work with.

Providers that were working on their suicide prevention policies said that they were using this framework to ensure they had processes and support in place around prevention, intervention and postvention. In some cases, this involved developing the strategy from scratch while others were adapting existing policies.

One issue with the UUK and Papyrus' Suicide-Safer Universities framework was that some providers felt that it did not leave enough space for them to make case by case decisions about whether a student's next of kin should be contacted if there were concerns about the student's mental health.

> "There is an assumption that parental involvement in these situations is always helpful but that isn't the case. There is also the question of informed consent in this. Our students are adults, not children." - HEI

## Prevention, intervention and postvention approaches

Prevention strategies generally focussed on ensuring that students in distress were recognised and supported as early as possible. For example, this encompassed providing training to staff as well as providing clear and accessible referral or self-referral routes for support. Some providers also aimed to raise awareness of suicide among

[32] Data for 'other' sources not shown due to low base size (n=18).

students in the hope that they may recognise someone at risk and report this, but this approach was felt to be less effective than reporting by staff.

> "Making sure that the whole community knows how to recognise somebody in distress, what's available to them and to get them to a safe place as quickly as possible." - HEI

Intervention strategies varied and often depended on the location and built environment of the provider, for example, providers with tall buildings or bridges on site aimed to restrict access to these or put up posters encouraging students to call for help. Intervention also included clear processes for contacting emergency and local mental health crisis services.

Postvention strategies included support for the student and their family, undertaking thorough case reviews to learn lessons, and in supporting other students. HEIs in cities where a cluster of student suicides had taken place also included increased prevention activities here, ensuring that bereavement and mental health support was in place for students who may need it.

> "We are aware of suicide transmission, not just within our own student body but within our city amongst students." - HEI

## Publishing and reviewing mental health and suicide prevention strategies

Providers with a current or planned mental health and/or wellbeing strategy were asked whether it is or will be published. In addition, providers with a suicide prevention strategy that sits outside of their institution's overall strategic plan or mental health/wellbeing policy were also asked whether the detail of this will be published. The survey defined this as: *"By 'published' we mean that it is available to all students and staff, whether this is via a publicly available source, or internal sources e.g., via a staff/student portal etc."*

By provider type, 62% of HEIs said that their mental health and/or wellbeing strategy is published, or will be published (34%) (Table 2.5). Among FECs, 57% said that it is published and 36% said it will be. Among Private Providers, 53% said that their mental health and/or wellbeing strategy was published or will be (38%).

Most providers with a suicide prevention strategy stated that they had published this (45%) or that they were working on it (38%). A minority (17%) said they had no current plans to publish the detail. Among HEIs with a suicide prevention strategy, 50% said that it was published, or will be published (37%).

Regardless of whether or not it was published, three-quarters (73%) of HEIs reviewed their student mental health strategy/ policy at least once a year and two-thirds (68%) reviewed their suicide prevention strategy/ policy. Among FECs, 88% reviewed their student mental health strategy/policy and 63% reviewed their suicide prevention strategy/policy at least once a year. The equivalent figures for Private Providers were 77% (student mental health strategy/policy) and 56% (suicide prevention strategy/policy).

**Table 2.5: Whether mental health/ wellbeing and suicide prevention strategies are or will be published**

| | Mental health/ wellbeing | | | | Suicide prevention | |
|---|---|---|---|---|---|---|
| | **Total** | **HEIs** | **FECs** | **Private Providers** | **Total** | **HEIs** |
| Yes | 58% | 62% | 57% | 53% | 45% | 50% |
| No, but we're working on it | 36% | 34% | 36% | 38% | 38% | 37% |
| No, no current plans for this | 6% | 4% | 7% | 10% | 17% | 13% |

*B3. Is/will your mental health and/or wellbeing strategy be published anywhere? Base: Providers who have a current or planned mental health/wellbeing strategy (174); HEIs (76); FECs (58); Private Providers (40). B6d. Is the detail on your approach to suicide prevention published anywhere? Base: Providers with a current suicide prevention strategy that sits outside of their mental health/wellbeing strategies or policies (65); HEIs (38). Data for FECs and Private Providers not shown due to low base sizes.*

# Chapter 3: Strategic consultation

This chapter explores the extent to which providers carried out internal and external strategic consultation on student wellbeing, mental health and/or suicide prevention.

Providers were asked whether they had carried out strategic consultation with internal and external colleagues, affiliates or organisations on student wellbeing, mental health and/or suicide prevention to explore the extent to which they were working collaboratively both within their institution and with other organisations. Providers were asked to select those they had consulted from a pre-defined list, but they could also mention other consultees. Consultation with internal and external stakeholders was also explored in the qualitative follow-up research.

## Internal consultation

Nearly all providers had consulted at least one internal group. While around one in ten Private Providers had not consulted with anyone internally (12%) this fell to 2% of FE colleges and zero HEIs.

HEIs consulted widely with internal groups, with over nine in ten reporting that they consulted with their senior leadership team, disability services staff, Student Union representatives, mental health practitioners, and academic teaching staff (Table 3.1). Almost eight in ten (78%) HEIs reported that they consulted with current students and with accommodation staff, respectively. These figures are not directly comparable to the 2019 exploratory study which asked specifically about consultation with students on student wellbeing/mental health strategy and policies and did not include suicide prevention. In the 2019 exploratory study, 93% of the HEIs surveyed had said they had carried out consultation with students about 'how the institution can better support their mental health and well-being'.[33]

Internal consultation was less wide-ranging among other types of HE provider, which is perhaps linked to the nature of HEIs and their students, with more living away from home than in FE colleges and private providers. Table 3.1 shows that, among FE colleges, the most common internal consultees were the senior leadership team, followed by mental health practitioners, and the Board of Governors/ Trustees. Among private providers, consultation with the senior leadership team and academic teaching staff were most common.

Overall, just under half of providers (46%) said they had consulted 'other' internal groups or affiliates, outside of the precoded list in the survey. HR / professional services staff

[33] The question asked in the 2019 exploratory study was asked as follows: "Has there been any consultation with students over how the institution can better support their mental health and well-being?"

(31%) received most additional mentions, followed by security-related staff (21%). Other internal groups of staff consulted (mentioned by only a small number of providers) included Special Educational Needs and Disabilities Co-Ordinators (SENCOs) and safeguarding/ welfare staff.

**Table 3.1: Internal groups consulted on student wellbeing, mental health and/or suicide**

| | Total | HEI | FEC | Private provider |
|---|---|---|---|---|
| Senior leadership team | **93%** | 97% | 95% | 84% |
| Teaching/academic staff | **80%** | 92% | 69% | 72% |
| Internal mental health practitioners/advisors e.g., counsellors, therapists etc. | **80%** | 95% | 86% | 44% |
| EDI colleagues (i.e., equality, diversity, inclusion) | **70%** | 84% | 69% | 47% |
| [HEP] Disability services | **68%** | 96% | 44% | 49% |
| Current students | **64%** | 78% | 58% | 49% |
| [HEP] Governors/Board of trustees | **64%** | 65% | 73% | 49% |
| [HEP] Student union representative or equivalent | **61%** | 94% | 44% | 28% |
| Estates/facilities colleagues | **44%** | 65% | 32% | 21% |
| Accommodation staff | **40%** | 78% | 15% | 7% |
| Staff Union representatives | **32%** | 47% | 32% | 5% |
| Other student union staff | **23%** | 43% | 14% | 2% |
| Families of students | **7%** | 9% | 7% | 5% |
| **Net: Other** | **46%** | 58% | 53% | 14% |

*C1. Have any of the following internal colleagues/affiliates been consulted at the strategic level on student wellbeing, mental health and/or suicide? Multiple responses possible. Base: All (179); HEIs (77), FECs (59), Private Providers (43).*

Providers who had consulted any internal groups were asked which, if any, they had consulted specifically on student suicide (Table 3.2). The majority (86%) said they had consulted at least one internal group specifically on student suicide. A substantial

minority of FECs (23%) and Private Providers (22%) said they had not consulted any internal groups on student suicide specifically although they had consulted on student mental health and wellbeing. The equivalent figure for HEIs was just 4% suggesting that HEIs are adopting a more consultative approach within their organisation.

**Table 3.2: Internal groups consulted specifically on student suicide**

| | Total | HEI | FEC | Private provider |
|---|---|---|---|---|
| Senior leadership team | **38%** | 34% | 33% | 56% |
| Teaching/academic staff | **24%** | 23% | 16% | % |
| Internal mental health practitioners/advisors e.g., counsellors, therapists etc. | **38%** | 48% | 35% | 19% |
| EDI colleagues (i.e., equality, diversity, inclusion) | **19%** | 18% | 19% | 22% |
| [HEP] Disability services | **25%** | 34% | 14% | 22% |
| Current students | **15%** | 12% | 14% | 22% |
| [HEP] Governors/Board of trustees | **14%** | 10% | 16% | 19% |
| [HEP] Student union representative or equivalent | **19%** | 32% | 7% | 11% |
| Estates/facilities colleagues | **6%** | 12% | 2% | 3% |
| Accommodation staff | **11%** | 22% | 0% | 3% |
| Staff Union representatives | **3%** | 5% | 2% | 0% |
| Other student union staff | **4%** | 8% | 0% | 0% |
| Families of students | **1%** | 0% | 2% | 3% |
| Net: Other | **36%** | 47% | 33% | 19% |
| **None of the above - we have not consulted anyone internal** | **14%** | 4% | 23% | 22% |

*C2. Which of these, if any, have you consulted on student suicide prevention specifically? Multiple responses possible. Base: Providers who had consulted internal groups on student mental health, wellbeing or student suicide (170); HEIs (77), FECs (57), Private Providers (36).*

Just over one-third (36%) of providers said they consulted 'other' internal groups on student suicide specifically; among HEIs, this figure was 47%. The most common staff

groups mentioned here were security staff (mentioned by 12% of HE providers overall and 21% of HEIs) and HR/ professional services staff (mentioned by 9% of HE providers overall and 13% of HEIs).

## External consultation on student wellbeing, mental health and/or suicide prevention

Overall, most providers (89%) said they had consulted external organisations or groups on student wellbeing, mental health and/or suicide prevention (Table 3.3). A minority (10%) said they had not consulted any external organisations or individuals and this was more common among Private Providers (28%). Just 5% of HEIs and 3% of FE colleges had not done any external consultation.

Table 3.3 shows that HEIs consulted widely with external partners. The most common groups they consulted were local NHS services (77%), suicide prevention, intervention or postvention networks (73%) and other HE providers (70%).

FE colleges often have strong local and community links given that they tend to draw learners from the local area. This is reflected in their main external consultation partners: the Local Authority (71%) and local NHS services (68%).

As discussed earlier, fewer Private Providers did any external consultation and the most common types of organisations they did consult with were other HE providers (44%) and suicide prevention, intervention and postvention networks (37%).

**Table 3.3: External groups consulted on student wellbeing, mental health and/or suicide**

| | Total | HEI | FEC | Private provider |
|---|---|---|---|---|
| Suicide prevention, intervention or postvention networks/partnerships | **57%** | 73% | 51% | 37% |
| Local authority | **55%** | 58% | 71% | 26% |
| Other Higher Education provider(s) | **53%** | 70% | 36% | 44% |
| Local NHS Services | **60%** | 77% | 68% | 21% |
| Third-sector organisations/charities or local/national stakeholders | **50%** | 62% | 53% | 26% |
| Other | **6%** | 9% | 5% | 2% |
| None of the above - we have not consulted any external figures/organisations | **10%** | 5% | 3% | 28% |
| Don't know / can't remember | **1%** | 1% | 0% | 0% |

*C3. Which of the following external organisations/individuals, if any, does [HEP] consult with on student wellbeing, mental health and/or suicide prevention? Multiple responses possible. Base: All (179); HEIs (77), FECs (59), Private Providers (43).*

## External consultation specifically on suicide prevention

Providers that consulted with any external organisation/individuals were asked to state which ones they had specifically consulted on suicide prevention. Most providers (86%) said they had consulted externally about student suicide prevention, with the range of groups shown in Table 3.4.

The most common external consultation partners for HEIs were suicide prevention, intervention or postvention networks (mentioned by 63%) and other higher education providers (mentioned by 51%) suggesting that they are particularly keen to learn from specialist partners and from other institutions. Around half of HEIs (49%) had also consulted with local NHS services on suicide prevention.

The main external consultation partners for FE colleges were their local authority and local NHS services (both mentioned by 42%), followed by third-sector organisations or other local/national stakeholders (39%). Just under one-third of FE colleges had liaised with specialist suicide prevention, intervention or postvention networks (30%).

Among Private Providers, suicide prevention, intervention or postvention networks (47%) and other HE providers (43%) were the most common external consultation partners. Fewer private providers had consulted with local bodies such as their local authority (27%) or local NHS services (20%).

**Table 3.4: External groups consulted on student suicide prevention specifically**

| | Total | HEI | FEC | Private provider |
|---|---|---|---|---|
| Suicide prevention, intervention or postvention networks/partnerships | **48%** | 63% | 30% | 47% |
| Local authority | **36%** | 34% | 42% | 27% |
| Other Higher Education provider(s) | **38%** | 51% | 19% | 43% |
| Local NHS Services | **41%** | 49% | 42% | 20% |
| Third-sector organisations/charities or local/national stakeholders | **39%** | 45% | 39% | 23% |
| Other | **3%** | 3% | 4% | 3% |
| None of the above - we have not consulted any external figures/organisations on student suicide specifically | **14%** | 7% | 21% | 20% |

*C3a. Which of these, if any, have you consulted on suicide prevention specifically? Multiple responses possible. Base: Providers who had consulted external groups on student wellbeing, mental health and/or suicide prevention (160); HEIs (73), FECs (57), Private Providers (30).*

## Strategy development approaches

In the qualitative interviews, providers described a range of starting points from which they had developed their current mental health and wellbeing strategies and policies. Some had existing standalone strategies/ policies which they had recently reviewed, others had existing strategies/ policies which covered mental health and wellbeing and were moving this content to a standalone strategy/ policy, and some had been working on developing all their strategies/ policies from scratch. Regardless of starting point, this work had generally been undertaken in response to DfE's request for increased emphasis on student mental health and suicide prevention, including that HE providers develop a suicide prevention strategy.

> "A lot of it is covered in other existing policies such as safeguarding but we are required to have a specific one in place by 2025 which we are working on now." - FEC

Overall, strategy development and review was generally handled by a small team of internal staff, but the size of this group, and the staff roles covered within it, varied depending on the size of the provider and level of in-house mental health and wellbeing support offered. Among small providers, strategy development was often handled by just a couple of staff, while larger providers were more likely to have a multi-disciplinary group drawing on a range of skills and experiences.

Many providers also worked with external partners to develop their strategies, such as:

- Local NHS partners, for example if the provider part-funded mental health services at an on-site GP practice.
- Local voluntary organisations.
- Working groups at other universities in the city.
- External counselling service providers.

The type and number of partners mainly depended on the size, location, and existing external support provision at the provider. Large HEIs and HEIs located in cities with other HEIs often worked together, along with other local organisations such as the local authority, emergency services and NHS to develop a city-wide approach. In many cases, this level of partnership working had been developed in response to a suicide or cluster of suicides across the city.

Providers that did not have a working relationship with another local provider would sometimes develop these with providers in other areas to learn from each other and share their ideas and approaches. These relationships were sometimes existing ones, or ones developed at sector conferences or events. Other types of external partnerships included mental health or suicide charities which shared ideas and resources with providers to plan their strategies. Providers that had a contract in place with an external counselling service, would also sometimes consult them when developing their strategy.

In the qualitative interviews, providers with mental health and/or wellbeing strategies in place had all consulted students on these in some way. Commonly, this involved giving students, typically Student Union representatives, the opportunity to review and feedback on draft strategies/ policies, or to help sense check them to ensure that they would be understood and accessible for students.

> "We have been very careful to stress that although we have prepared material it is not prescriptive, and students are welcome to tear apart

> what we've done. We're very open to that level of discourse, just to get that genuine voice from the students into the process." - HEI

Many providers in the qualitative research, especially HEIs and some private providers, described an intense recent focus on suicide prevention, and they attributed this to DfE's prompts to ensure that they have a specific strategy in place. Providers that already had a suicide prevention strategy in place or had most aspects of this covered across other policies, said that these had been reviewed to ensure they covered all relevant areas and, where needed, were brought together into a single document.

Providers in the qualitative interviews identified several challenges with developing strategies/ policies, including concerns that that their new approach may:

- Create overlap with statutory services, rather than join up with them.
- Create overlap with other existing policies such as LGBTQ, Sexual Harassment, as well as statutory policies such as Safeguarding and Fitness to Study.
- Have less meaning or impact for staff and students without the context of a specific situation or issue (such as sexual harassment).

Where possible, providers with these concerns tried to mitigate these risks by consulting with relevant staff, students, and external partners but some were not confident that they had avoided these issues.

# Chapter 4: Services to support student mental health and wellbeing

This chapter explores the services and resources providers have in place to support student mental health and wellbeing. It also explores the extent to which providers work with external partners to deliver such support services to their students.

## Overview of services and practices

The majority of HE providers offered multiple services to support student mental health and wellbeing.

Table 4.1 shows that, among HEIs who offered support their students, the top three most common services were:

- In-house 'self-help' resources (e.g. digital apps, reading materials, information) for those experiencing poor mental health: accessible online or in person (99%)
- In-house psychological support for those experiencing poor mental health: face-to-face or virtual contact with counsellors etc.(97%)
- Awareness raising and education around mental health (90%).

Among FECs who offered services, all of them had awareness raising and education around mental health, and around wellbeing/ health information (100% each). Almost all offered early warning systems (97%).

Among Private Providers, the top three services they offered also featured early warning systems (86%), awareness raising and education around mental health (79%) and awareness raising and education around wellbeing/ health information (77%) although they were less widespread than in other types of provider. Private Providers offered less wide-ranging support than HEIs or FE colleges and in particular, only a small minority (16%) offered agreed joined-up care pathways between themselves and local NHS services. This compared with 70% of HEIs and 63% of FE colleges who provided any services.

**Table 4.1: Services available to students by provider type**

| | Total | HEI | FEC | Private provider |
|---|---|---|---|---|
| Awareness raising and education around mental health | **91%** | 90% | 100% | 79% |
| Awareness raising and education around wellbeing/health information | **89%** | 87% | 100% | 77% |
| In-house psychological support for those experiencing poor mental health: Self-help resources accessible online or in person | **86%** | 99% | 93% | 53% |
| Early warning systems for mental health difficulties | **85%** | 77% | 97% | 86% |
| In-house psychological support for those experiencing poor mental health: face-to-face or virtual contact with counsellors etc. | **83%** | 97% | 85% | 53% |
| Open-access sessions/talks on issues such as resilience, mindfulness etc | **77%** | 83% | 85% | 56% |
| Externally available psychological support for those experiencing poor mental health: Self-help resources accessible online or in person | **76%** | 84% | 78% | 58% |
| Externally available psychological support for those experiencing poor mental health: face-to-face or virtual contact with counsellors etc. | **75%** | 79% | 76% | 65% |
| Awareness raising and education around suicide prevention, intervention or postvention | **65%** | 61% | 78% | 53% |
| Agreed joined-up care pathways arranged between [HEP] and local NHS services | **55%** | 70% | 63% | 16% |
| Peer-to-peer support groups for students | **49%** | 51% | 51% | 44% |
| Student Minds / Student Space | **49%** | 60% | 42% | 37% |

*D1: Does [HEP] use/offer any of the following to support their students? Multiple responses possible. Base: All (179); HEIs (77), FECs (59), Private Providers (43).*

HE providers with a mental health or wellbeing strategy, or with a suicide prevention strategy, were more likely to offer a range of services including awareness raising, in-house psychological support and external support, than those which did not have a strategy.

By provider type, Table 4.2 shows that 77% of HEIs who offered internal or external psychological support offered online CBT resources, but it was less common in FECs (51%) and Private Providers (41%). The majority (70%) of HEIs offered online CBT sessions with a qualified therapist or specialist, as did 39% of FECs and 38% of Private Providers.

The percentages for HEIs and FECs are the same when considering the proportions that offered CBT in the overall sample, as all HEIs and FECs answered this question. Among Private Providers overall, 37% offered access to online CBT resources and 35% offered access to a CBT therapist/specialist.

Around two-thirds (69%) of HE providers offering psychological support services provided other types of therapy or resources as part of this.

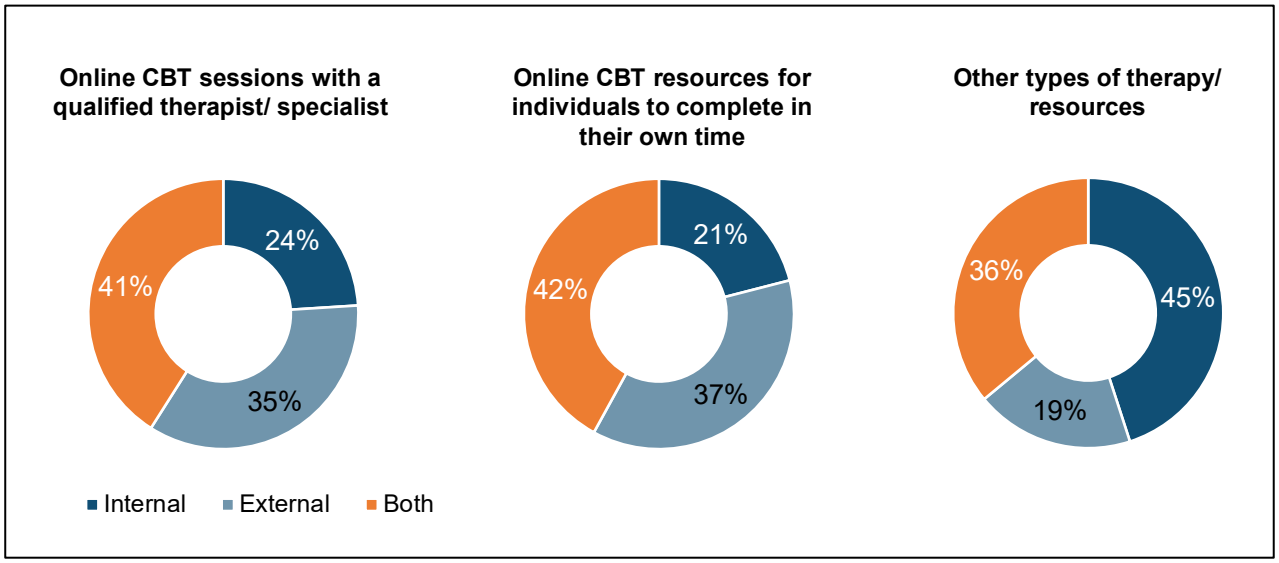
**Table 4.2: CBT and other types of therapy/resources offered by providers offering internal or external psychological support**

| | Total | HEI | FEC | Private provider |
|---|---|---|---|---|
| Online CBT resources for individuals to complete in their own time e.g., diary entries/logs, workbooks/exercises etc. | **60%** | 77% | 51% | 41% |
| Online CBT sessions with a qualified therapist/specialist | **53%** | 70% | 39% | 38% |
| Other types of therapy/resources | **69%** | 77% | 66% | 56% |

*D1a: Do any of these practitioners/resources offer…? Multiple responses possible. Base: HEPs offering internal or external psychological support (175); HEIs (77); FECs (59); Private Providers (39)*

In terms of how this psychological support was delivered, the largest group of providers offered online CBT sessions (41%) and online resources (42%) through both internal and external means. Just over a third offered these through external organisations (35%, 37%), whilst a fifth offered them through internal sources (24%; 21%). The pattern is slightly different for other types of therapy or resources, with HE providers most often providing these internally (45%).

**Figure 4.1: Whether psychological services are offered internally or externally or both**




*D1b: Are these ... offered via the internal or external sources of support that you mentioned, or both? Base: HEPs offering each type of psychological support: Online CBT sessions (92); Online CBT resources (105); other types of therapy/resources (120).*

In the qualitative interviews, providers described a wide range of practices and services to support students with their mental health and wellbeing. This included some, typically FECs and Private Providers, which aimed to meet their statutory obligations under the Equalities Act[34] but, beyond that, signposted to external NHS support. At the other end of the spectrum were other providers, typically HEIs, which offered a wide range of in-house psychological and social prescribing services.

Providers relied on a combination of staff referrals and students self-referring to their support services. Generally, all support services were managed through one team and referrals would be assessed by the team to determine the type, level and immediacy of the support needed. In most cases, referrals were made using an online form, but some providers offered a wide range of options including calls, SMS, online chat, and face-to-face referrals.

Many providers used person or system led monitoring approaches to act as an early warning system, alerting them to students who may be at risk and in need of support. A key early warning system was monitoring attendance. Providers typically did this routinely, mainly by asking academic staff to record this and report high levels of non-attendance to a manager in their Department or to a central student support team.

[34] Under the Equality Act 2010 a person with a disability includes those with a mental impairment that has a 'substantial' and 'long-term' negative effect on their ability to do normal daily activities. An education provider has a duty to make 'reasonable adjustments' to make sure disabled students are not discriminated against. These changes could include providing extra support and aids

Larger providers, typically HEIs, sometimes went further and used student ID card data to monitor student engagement, for example by tracking use of teaching and accommodation buildings as well as facilities such as the library. Some systems also linked to data about the students' academic achievements and whether they may be experiencing financial difficulties. These systems, providers explained, had generally been developed to identify students who may be at risk of not meeting academic expectations, but they realised that data can also indicate that a student is in distress. If a student stops attending lectures, using the library, or seems to not be leaving their room, this will trigger a red flag in the system and a member of staff will contact the student to see if they need support.

> "We developed the algorithm initially to identify students who were at risk of failing but we came to understand the link between academic engagement and mental health was strong so now it is used to identify students at risk." - HEI

Among Private Providers and FECs where student numbers tended to be smaller than HEIs, the staff were encouraged to monitor students through observations as well as direct questions in regular meetings and to report and concerns they may have about a student to a specific person or team.

> "The academic staff are the early warning system. They notice issues with students and are able to call the wellbeing team for advice." – Private Provider

Providers that offered in-house or funded external psychological support reported that students, or staff making referrals generally expected that the student would be offered access to counselling. Most Private Providers in the follow-up interviews, reported that they were able to meet this demand, mainly because it tended to be low, but many HEIs in the follow-up interviews, reported that their counselling services were oversubscribed and that they were not always able to meet demand. This meant that access to counselling often involved a waiting time of several weeks or months, sometimes linked with a formalised triage system which determined who was most in need.

> "They [counselling service] have been totally overwhelmed at times and had to stop taking new students on at the end of the last academic year." - HEI

In the qualitative interviews, providers that offered access to counselling, either in house or through an external provider, typically offered a limited number of sessions and would then signpost to NHS services for further support. However, many providers, mainly HEIs, reported that lack of capacity in NHS services often meant that students who needed

further or more intense support were not able to access this when needed. This meant that the provider needed to offer additional support where they could, often aiming to deal with issues for which their services were not designed.

> "The most a student can get is six sessions of therapeutic support but that is not enough to deal with distress or trauma in most cases. For students who come from difficult backgrounds, they may have a high level of support needs which this university, and no other that I am aware of, is set up to provide." - HEI

Many HEIs said they have been trying to both expand their counselling capacity to deal with demand as well as offer other forms of support for students, which may be more appropriate, and often easier to access that counselling. Examples of other types of support offered include:

- Sports Therapy.
- Peer to peer support (including mentoring and buddying)
- Listening service
- Online and face-to-face forums.

Providers also emphasised the importance of helping the student to identify and tackle the underlying issue(s) impacting their mental health and wellbeing. This meant offering practical support with issues such as debt or supporting them with academic related issues by facilitating conversations with academic staff about extensions or adjustments.

> “Counselling is not the answer to everything. Students may well be experiencing feelings of depression and may feel that counselling is what they need. But if the issue is that they are experiencing financial problems then that needs to be fixed first.” - HEI

Some HEIs said that their current focus in improving and developing their services is on wellbeing support and preventative measures. For example, some were beginning to offer or expand social prescribing to support students experiencing loneliness and social isolation. By working with the Student Union to run social events and encouraging students to engage in these, and with each other, they hope to prevent the need for more intense intervention later.

> "The university is very good at knowing when and how to involve the student union and student reps. I would say that student wellbeing and mental health is one area where we work very well together." - HEI

Providers also offered a range of self-help resources for students to access which were designed to support them with their mental health or wellbeing. These included:

- Internally developed content such as articles and podcasts.
- Access to apps or websites that offer articles, podcasts, worksheets or meditations.
- Links to third sector content, provided by organisations such as MIND or Student Minds.
- Links to NHS resources.

Providers viewed self-help resources as a cornerstone of their support strategies and promoted these heavily. Examples included signs around campus, at Student Union talks, on provider websites or apps and whenever a student is in contact with student support services. Monitoring use and impact of these resources was seen as a challenge, but some providers had identified that support plans for specific issues, for example, dealing with debt or loneliness, could have positive results for students, helping them to resolve issues or seek appropriate practical support.

> "We need to provide more education and resources on issues that can lead to a mental health issue, like finances, relationships." - HEI

Some providers, commonly FECs and Private Providers, that had bought in external self-help services tried to encourage engagement with these by building them into the curriculum. Some providers that were using an external app had built time for this into lesson plans and asked academic staff to encourage students to use their 5 or 10 minutes to engage with their personal plan, which could include forms of CBT or mindfulness.

> “We focus on mental fitness rather than mental illness…try to see looking after your mental health as a positive thing.” - FEC

However, while many providers hoped to expand their self-help resources and encourage further use of these as a means of prevention, and in reducing demand on therapeutic services, not all agreed with this approach. Some providers were concerned about the increasing focus on wellbeing and self-help and were concerned that this may leave students who need more intensive support feeling that they have ‘failed’ by not being able to resolve their negative feelings by themselves.

> "The philosophical policy of the university, and of many others is to label everything as wellbeing which implies that students have control to make themselves better with an app. Most students need actual therapeutic support." - HEI

## Targeted support to specific groups of students

As well as supporting students with a declared mental health condition, other students might need to be targeted for support, particularly if they are in groups recognised to be potentially at risk. Providers were asked in the survey if they had any practices or services targeted specifically to supporting the mental health and wellbeing of students in certain groups. The vast majority (91%) of HE providers had practices or services offering targeted support for at least one specific group of students (Table 4.3).

A small number of HE providers offered targeted support to groups not listed, including:

- Students with safeguarding concerns
- Student carers
- Students with dependents
- Foundation students, and those aged 16-18 (in FECs).

**Table 4.3: Proportion of providers offering practices or services targeted specifically to support the mental health and wellbeing of specific student groups other than those declaring a mental health problem under a disability**

| | Total | HEIs | FECs | Private Providers |
|---|---|---|---|---|
| Students with neurodiverse conditions | **76%** | 83% | 78% | 60% |
| Care Leavers / Estranged students | **67%** | 70% | 83% | 40% |
| Students with a physical disability | **67%** | 75% | 61% | 60% |
| LGBTQ+ students | **61%** | 64% | 75% | 40% |
| Students from ethnic minority backgrounds | **56%** | 58% | 54% | 56% |
| Mature students | **53%** | 49% | 54% | 56% |
| International students | **47%** | 68% | 32% | 33% |
| Asylum seekers & refugees | **45%** | 43% | 61% | 26% |
| Male students | **42%** | 38% | 51% | 37% |
| Postgraduate students | **42%** | 60% | 27% | 30% |
| Commuter students | **27%** | 23% | 29% | 30% |

| | | | | |
|---|---|---|---|---|
| Other groups of students | **12%** | 6% | 25% | 5% |

*D2: Do you have practices or services targeted specifically to supporting the mental health and wellbeing of any students in the following groups ...? Multiple responses possible. Base: All HEPs (179); HEIs (77); FECs (59); Private Providers (43).*

Among HEIs offering targeted support, this was mostly aimed at students with neurodiverse conditions (83%), followed by students with a physical disability (75%) and care leavers or estranged students (70%). Among FECs, support was most likely to be targeted towards care leavers or estranged students (83%), students with neurodiverse conditions (78%) and LGBTQ+ students (75%). Among Private Providers, support was most commonly targeted towards students with neurodiverse conditions (60%), students with a physical disability (60%), and students from ethnic minority backgrounds and mature students (both 56%).

HE providers with a mental health or wellbeing strategy were more likely to have targeted support for male students (74% vs 57% at those without a strategy), students with a physical disability (75% vs 56%), and care leavers and estranged students (74% vs 57%). Providers who had a suicide prevention strategy (who are more likely to be HEIs) were also more likely to offer targeted support for male students (49% vs 33% at those without a strategy), students with a physical disability (73% vs 59%), and postgraduate students (50% vs 32%).

## Supporting students to disclose mental health concerns

In the provider follow-up interviews, providers said they encouraged students to disclose mental health and wellbeing difficulties at specific points during the admissions and enrolment stage, as well as throughout their course.

HEIs said that students could disclose mental health conditions on their UCAS form, by contacting the HEI directly, or face-to-face while visiting the campus or at an admissions interview.  Some providers saw their support offer as a strong selling point and were keen to emphasise this at open days.

> “We became aware it’s something that we don’t want to hide away … from a parent’s point of view, it reassures them.” – HEI

Once a student is offered a place, HEIs and Private Providers said that they again encourage students to disclose in messaging on enrolment documents sent to them by post or email, as well as on their website.

Enrolment was another key stage for encouraging disclosure. Providers used several ways to prompt students including direct emails and messages, academic induction talks,

Student Union induction talks, accommodation induction and with messaging at events run during fresher's week.

Generally, these prompts at admission, pre-enrolment and enrolment stage were to ensure that providers could meet their statutory obligations and to provide support or adjustments for students who need them.

> "They are there to ensure the Equality Act is met and our legal obligations and ensure things like reasonable adjustments are met." - HEI

After enrolment, providers typically used ongoing messaging throughout the academic year to remind students of the support available and how they can access it. Providers emphasised the importance of regular reminders as they felt that students were likely to ignore messaging until it was relevant to them.

> "Messaging needs to be constant because students only tune in when they need it." - HEI

The type and frequency of these ongoing reminders depended on the size and type of provider, as well as the support they offered to students, but included:

- Messaging around the provider's site to ensure that students were aware of support available, e.g., posters in hallways and toilets.
- Pop-ups and events at key times, such as Mental Health or Wellbeing week.
- Direct communications to students at key times, such as exam periods, to remind them of support available and/ or to signpost to external support.

Some providers also targeted information about support services for students who were more likely to be experiencing challenges at specific times, such as exam periods. This included supporting students with:

- the transition to living in the UK (HEIs and Private Providers)
- their first winter term away from home (HEI and Private Providers)
- their transition to an apprenticeship or a work experience placement (all provider types).

While many providers offered different routes for students who wished to disclose difficulties with their mental health or wellbeing, most said that the main two forms were by speaking to staff or by self-referral to support services.

Student-facing staff across all provider types played a central role in supporting students with disclosing difficulties. For many FECs and Private Providers, conversations with

academic or student support staff were the main, or only means of reporting. However, even HEIs and some Private Providers that offered lots of different routes for disclosure said that students were still likely to speak to someone they knew first, usually a member of academic staff. This meant that it was crucial to ensure that staff knew what to do when a student raised a concern.

> "Trying to reel people in through one particular way is never going to be easy because that route might not be comfortable for that particular person. Disclosure happens where people feel comfortable enough to be vulnerable. That may well be with their Personal Tutor, preferred academic member of staff or with a cleaner or porter in the halls of residence.” - HEI

Other disclosure routes usually involved self-referral to the provider’s student support team. This could include contacting the team by phone, SMS, email, through an online form or portal, online chat, or face-to-face.

What happened after a student disclosed a difficulty depended on whether the provider offered any in-house support. Those that did not offer in-house support, which tended to be FECs and some Private Providers, would speak to the students, and signpost them to NHS or third-party mental health and wellbeing services. Any in-house support offered would be focused on providing academic support, for example by speaking to academic staff to agree to an extension or an adjustment.

Within providers that offered support services, including therapeutic support, access to these was generally assessed by a member of the student support team who would determine what kind of support the student might benefit from. This stage was often driven by the number of options available and the level of demand for these services.

There was no common approach taken to sharing details about disclosure with others within the provider or with the student’s family. Internal information sharing processes varied between providers. Some providers, especially Private Providers and FECs, would share information about a student’s mental health with other members of staff, and they would make this clear to the student. The purpose of this was to ensure that the student could be properly supported. This seemed to be less common in HEIs but did happen in some cases.

> "There are no set rules about when I or another member of the team will share information, but we understand how to make those decisions and explain to students that we work with a circle of confidentiality. For example, we may want to speak to the student's tutor about an adjustment." - Private Provider

## Contacting next of kin

The decision to contact the student's next of kin was normally driven by the wishes of students themselves. Many providers asked students to name their next of kin and ask for permission to contact them for a range of reasons, including in cases of concern about a student's mental health or wellbeing. Typically, this consent was checked and regained regularly, such as once a year.

> "Our protocol for contacting parents is using an opt-in basis. We ask students to complete a third-party contact form and update it each year. We ask who we can share information with, including about their academic studies and their wellbeing." - HEI

Whether or not consent to contact their next of kin had been formally collected, providers interviewed for the qualitative research reported that they would still carefully consider disclosure to a student's family. Often, if the provider felt that it would benefit the student, they would discuss this with them and encourage the student to speak to their families themselves.

> "We encourage them to be open with friends and families...community is really important and support from family and friends is often the best support in terms of monitoring not just how you're coping but also getting that additional help." - HEI

Providers were generally very reluctant to share a student's disclosure with their family and they had two reasons for this. The first was the view that that their students are all adults and, as such, have the right to determine who such information is shared with. The second reason was that providers did not believe that it would always be in the student's best interest to contact their next of kin and may even make the situation worse. This is because they had no way of knowing whether the student's next of kin would be supportive.

> "Quite often families can be a source of students' stress and anxiety relating to pressure, whether that's perceived or actual." - HEI

There were exceptions to this. Some Private Providers with a high volume of mature students, and some FECs, said that they would be likely to contact a student's next of kin if they were concerned about them, for example if they had not attended classes and not responded to calls or emails. Also, providers of all types said that, in line with their safeguarding policy, they would consider contacting a student's next of kin if they were concerned for the student's immediate safety, regardless of whether the student had consented to this.

"We will breach confidentiality when there is concern about the safety of that student or others around them. We don't have a blanket agreement to contact parents at the moment." - HEI

Disclosure outside of the provider, and the student's family, was typically only done when there was an immediate concern for the student's safety. In these cases, providers had protocols for accessing support which normally involved contacting emergency services or the local mental health crisis team for assistance.

## Working with external organisations

The vast majority of HE providers worked with other organisations in relation to student mental health and wellbeing (Table 4.4). By provider type, most FECs (97%) worked with Local NHS and care services, as did 94% of HEIs. Just under half (49%) of Private Providers worked with local NHS and care services. Similarly, most FECs (97%) worked with other local authority partnerships. Among HEIs, 75% worked with other local authority partnerships, as did 33% of Private Providers.

**Table 4.4: Proportion of HE providers who partner with each organisation type**

| | Total | HEIs | FECs | Private Providers |
|---|---|---|---|---|
| Local NHS and care services | **84%** | 94% | 97% | 49% |
| Local authority – other partnerships | **72%** | 75% | 97% | 33% |
| Third sector organisations/charities | **69%** | 83% | 73% | 40% |
| Suicide prevention, intervention or postvention partnerships | **66%** | 77% | 81% | 28% |
| Local stakeholders | **44%** | 52% | 46% | 26% |
| National stakeholders | **31%** | 36% | 32% | 21% |
| No – we do not work with any of these | **6%** | 1% | 2% | 21% |
| Don't know | **1%** | 0% | 3% | 0% |

*D3: Does [HEP] work with any of following …? Multiple responses possible. Base: All HEPs (179)*; HEIs (77); FECs (59); Private Providers (43).

Working with third sector organisations or charities varied considerably between different types of provider, ranging from 83% among HEIs and 73% in FECs, to 40% in Private Providers. Among HEIs, MIND (31%), and Student Minds (22%) were most commonly

mentioned. For FECs, 32% had worked with MIND and 19% with Papyrus. Among Private Providers, MIND and Samaritans (both 14%) were most commonly mentioned.

Similarly high proportions of HEIs (77%) and FECs (81%) worked with suicide prevention, intervention or postvention partnerships but this declined to 28% among Private Providers.

Having a strategy was associated with a greater likelihood that HEPs were working with partners on student mental health. HE providers with a mental health or wellbeing strategy (73%) were more likely to work with a suicide prevention, intervention or postvention partnership, than those without such a strategy (56%). Those with a strategy were also more likely to work with local stakeholders (50% vs 32% those without a strategy)  Among HEIs specifically, there was no notable difference in the likelihood of working with a suicide prevention, intervention or postvention partnership among those who had a mental health or wellbeing strategy (75%) compared to those without (80%).

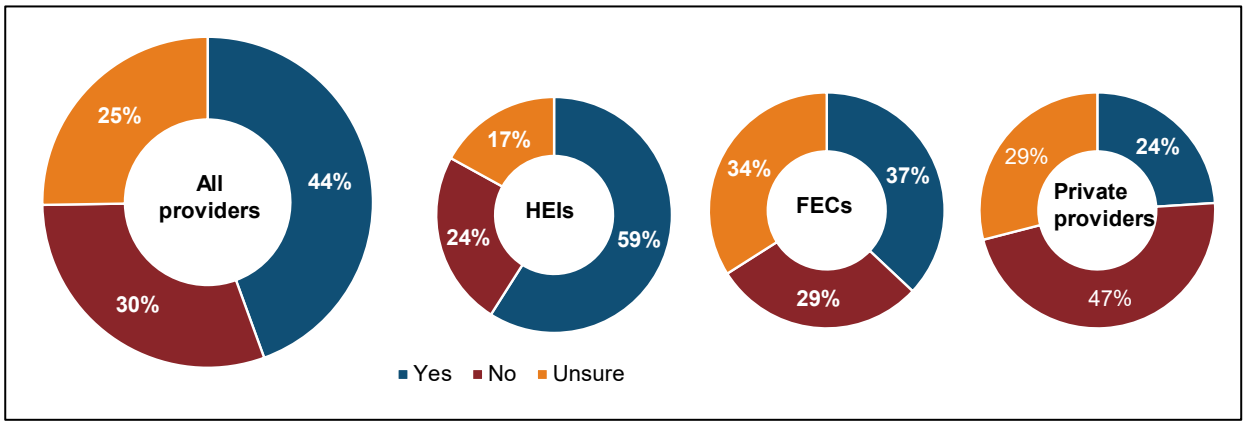
Providers with a suicide prevention strategy were more likely to work with:

- Local NHS and care services (90% vs 76% those without a strategy)
- Suicide prevention, intervention or postvention networks (77% vs 53%)
- Third sector organisations / charities (74% vs 54%)
- Local stakeholders (51% vs 33%).

This pattern was less pronounced amongst HEIs specifically, but HEIs with a suicide prevention strategy were still more likely to work with suicide prevention, intervention or postvention networks (82% vs 65%), and local stakeholders (59% vs 39%) compared to those without.

Of the HE providers working with external services, Figure 4.2 shows that 59% of HEIs had arrangements with external services facilitating NHS care pathways, as did 37% of FECs and 24% of Private Providers.

**Figure 4.2: Whether external services involve facilitating NHS care pathways**




*D4: Do any of the external services you've mentioned involve these organisations facilitating NHS care pathways? Base: HEPs that use external services (169); HEIs (76); FECs (59); Private Providers (34).*

The qualitative interviews explored HE providers' links with partner organisations, and for many of them the NHS was a key focus. For Private Providers and FECs, this partnership tended to involve signposting students to NHS services, including their GP or Improving Access to Psychological Therapies (IAPT). Some of these providers reported that they faced barriers in establishing more formal links with NHS services as their students lived across a large geographic area, meaning that each student may be registered with a different GP.

> "We will signpost them to their GP, but our students could be anywhere. They could be resident in one place but working elsewhere, so they just need to know what is that logical step to the appropriate support." - Private provider

Establishing links with local services was easier for providers whose students lived on, or very close to their site and this meant that they could focus on developing relationships with one or two GP practices that support many or most of their students. The extent and nature of these links varied but the aim of the providers was to establish links which would allow students to be referred into NHS services more quickly, and for support between the provider and the NHS to be more joined up. Examples of these partnerships included:

- Local working groups of teams, including providers and NHS services, to improve joint working approaches.
- Direct links with one or two GP practices to discuss specific cases (if a data sharing agreement is in place), and wider policies and approaches.
- Funding of a mental health nurse at a local GP surgery (on campus) to support the provider with specific cases, wider policies or approaches, and training.

Providers developed partner relationships both to expand and improve the support that they provided, but, more crucially, to get clarity on NHS referral criteria, understand NHS pathways and to reduce the number of steps needed to access support. Many providers, commonly HEIs, reported that they had needed to support students with complex and urgent mental health support needs, which they felt ill equipped to meet. They said that these students had not been able to access NHS support when needed due to complex referral processes, so they aimed to work in partnership to reduce these barriers and smooth the pathway for students who needed to access support.

> “To reduce the amount of steps that students have to take to specialist crisis, mental health support and things of that nature, we want to reduce the burden around that, and make sure that people are being referred into services quickly and getting the support they need.” - HEI

While providers who had made these links had made progress in helping students access support, many of them reported that their students were being negatively impacted by long waiting lists and lack of capacity in NHS services. They said that even when referrals are made, students do not necessarily get the support they need, when they need it. This meant that some providers needed to attempt to provide long-term, complex therapeutic care within services that were only designed to deliver short course therapies.

> "The main issue is the strain the NHS is under, we are seeing complex cases waiting longer for treatment, that feels really precarious sometimes and it means that our team put almost all their time on supporting complex cases and do not have the time to work on prevention." - HEI

In the qualitative interviews, a serious concern for HEIs was that they would not be able to support a student at risk of suicide, or that the resource and focus needed to support them would mean that other students would not be able to access support. Several HEIs which took part in the qualitative interviews reported that students had been discharged into their care less than 48 hours after attempting suicide and they felt ill equipped to handle these cases.

> "The NHS refuse to take students who are at risk. We have cases of students being sectioned but then the hospital will try to discharge them into our care. We are not a care facility. We are not emergency services, we are not set or equipped to deal with this." - HEI

Providers that had experience of supporting students with complex or urgent mental health needs reflected that they had been left with no choice but expand their internal support services as quickly as possible and to seek closer working relationships with the NHS. Some did not think that, as an education provider, they should need to fund NHS services but felt they had been left with no choice in order to support their students.

> "We are co-funding NHS services, and I don't think that is right." - HEI

Providers made several suggestions about how these issues could be addressed, including:

- Reducing referral barriers for NHS services. One suggestion was to assign an NHS psychiatrist to providers who they can contact directly about complex or urgent cases.
- More funding for provider site-based NHS services, including capacity for providing longer-term mental health support.
- Expanding Child and Adolescent Mental Health Services (CAMHS) to cover students below a certain age, rather than referring them to Improving Access to Psychological Therapies (IAPT).

Some providers, again commonly HEIs that had experience of dealing with mental health crisis cases, felt that they would benefit from closer links and greater clarity about how to work with local emergency services. While many of these providers did already have some links with these services, not all had been able to establish these, and this meant they felt less confident about what to do in a crisis. Other providers said that even though they did have relationships with emergency services, there was still uncertainty between different organisations about who should be contacted in specific situations. There was also a concern that services under pressure may not prioritise responding to a call from a HEI, assuming that they may be able to handle the situation themselves.

> "We are trying to reach out to them, but everyone is holding their hands up and going ‘sorry’".– HEI

In addition to local NHS and emergency services, some providers also worked with their local authority and with other providers in the local area, to develop joint working approaches. In most cases these groups were focussed on specific issues or needs which had been identified as a risk in that area, including suicide, sexual harassment or assault and domestic violence. Working together on these issues allowed providers to share best practice and for relevant organisations to develop an area-wide plan for dealing with issues which often presented risks to students, and other residents, outside of the provider’s site.

# Chapter 5: Staff training

This chapter explores the extent that HE providers offer training in student mental health and wellbeing, and suicide prevention, to different types of staff, and what this covers. Drawing on the qualitative interviews, it also examines what drives these decisions and how training is delivered and promoted within institutions.

## Prevalence of training for different groups of staff

Almost all HE providers offered training to staff in relation to student mental health and wellbeing. Providers most commonly offered training to student services staff and teaching staff, with over 9 in 10 offering to these groups (Table 5.1).

By provider type, most HEIs offered training to student services staff (99%), teaching/ academic staff (95%), while the majority offered it to accommodation staff (78%), security staff (75%) and administrative/ clerical staff (74%). Among FECs, 95% offered training to teaching/ academic staff and 93% offered training to student services staff. The vast majority of FECs (85%) offered training to the senior leadership team, and 80% offered training to administrative/ clerical staff. Among Private Providers, training was most offered to teaching/ academic staff (79%), student services staff (72%), and the senior leadership team (70%).

HE providers with a mental health or wellbeing strategy were more likely to offer training to student services staff (95% vs 82% those without), estates staff (71% vs 50%), and technical staff (66% vs 51%). HE providers without a strategy were more likely to offer training to none of the listed groups of staff (7% vs 1%).

**Table 5.1:Staff groups offered training on student mental health, by provider type**

| | Total | HEI | FEC | Private provider |
|---|---|---|---|---|
| Student services staff | **91%** | 99% | 93% | 72% |
| Teaching/ academic staff | **91%** | 95% | 95% | 79% |
| Administrative/ clerical staff | **73%** | 74% | 80% | 60% |
| HEP senior leadership team | **67%** | 52% | 85% | 70% |
| EDI colleagues | **65%** | 69% | 78% | 42% |
| Estates colleagues | **63%** | 70% | 76% | 33% |
| Technical staff | **61%** | 60% | 76% | 42% |
| Security | **60%** | 75% | 75% | 12% |
| HEP student union representatives | **55%** | 68% | 56% | 30% |
| Facilities staff (e.g. porters, security) | **51%** | 57% | 68% | 19% |
| Accommodation staff | **47%** | 78% | 31% | 16% |
| Chaplaincy | **41%** | 70% | 24% | 12% |
| Staff union representatives | **40%** | 38% | 64% | 9% |
| HEP governors/ board of trustees | **40%** | 21% | 73% | 30% |
| Residential life staff | **39%** | 66% | 22% | 14% |
| Ancillary staff (e.g. cleaners, cooks) | **38%** | 42% | 56% | 7% |
| Other student union staff | **36%** | 48% | 39% | 12% |
| Other | **8%** | 12% | 5% | 7% |
| None of the above | **3%** | 1% | 0% | 12% |

*E1. Do you offer training to any of the following groups of staff? Multiple responses possible. Base: All (179): HEIs (77); FECs (59); Private Providers (43).*

Of those providers who offered training to staff, Table 5.2 shows that most HEIs covered each of the following aspects in their staff training:

- Awareness/understanding of issues related to poor mental health and/or wellbeing (97%)
- Escalation procedures for students in crisis (97%)

- Supporting good mental health and wellbeing of others (97%)
- Recognising and supporting students at risk of harm to self/others (95%)
- How to respond to disclosures when they happen (92%).

**Table 5.2: Areas covered in staff training**

| | Total | HEI | FEC | Private provider |
|---|---|---|---|---|
| Awareness/understanding of issues related to poor mental health and/or wellbeing | **96%** | 97% | 100% | 87% |
| Recognising and supporting students at risk of harm to self/others | **91%** | 95% | 93% | 82% |
| How to respond to disclosures when they happen | **90%** | 92% | 93% | 82% |
| Escalation procedures for students in crisis | **87%** | 97% | 88% | 66% |
| Supporting good mental health and wellbeing of others | **87%** | 97% | 88% | 66% |
| Information for staff about how to support our own mental health and wellbeing | **82%** | 80% | 93% | 66% |
| Whole university approaches to mental health and/or wellbeing | **68%** | 75% | 64% | 58% |
| Suicide prevention | **53%** | 57% | 58% | 37% |
| Referral options e.g., to NHS services | **52%** | 49% | 59% | 47% |
| Suicide intervention | **43%** | 47% | 46% | 29% |
| Suicide postvention | **32%** | 29% | 42% | 24% |
| Other | **2%** | 1% | 3% | 0% |

*E2. More specifically, what areas does your staff training cover? Multiple responses possible. Base: All who offer training to staff (173); HEIs (76); FECs (59); Private Providers (38).*

HE providers with a suicide prevention strategy were more likely to offer training for almost all the areas listed. Notably, they were almost twice as likely (67%) to offer training on suicide prevention compared to providers without a strategy (34%), and more than twice as likely to offer training on suicide intervention (57% vs 24% for those without) and postvention (42% vs 19%, respectively).

The qualitative research revealed a varied approach to staff training. A few of the providers reported that they only ran training linked to their statutory obligations or safeguarding training, and did not provide any specific mental health or wellbeing training for their staff.

> “All staff have safeguarding training to try and ensure a level of competency in dealing with sensitive situations.” - HEI

However, other providers, typically HEIs with accommodation, ran specific training on how to handle a mental health crisis to ensure that staff knew what to do in such a situation. This training was often aimed at staff in roles like student support, security and accommodation who would be most likely to be asked to support a student in crisis. This training was focussed on recognising a student in crisis and what the member of staff should do in these situations, including which internal and external services should be contacted.

> “We've trained lots of our frontline teams. So the security team, the night team, the student services teams with suicide intervention training…The way we're approaching that is we developed a matrix that sets out all of the main student facing staff roles.” - HEI

Providers that offered internal support services to students, including counselling, CBT and other therapies also accessed regular, specific training for staff in these roles to ensure that they stayed up to date and could widen their offer for students.

Wider staff training tended to be focussed on mental health and wellbeing awareness, including how to recognise when a student may need support, and how they should be referred or signposted for this, either to internal or external services. Most providers used external course providers for this training, typically the Mental Health First Aid course, or similar, although some did develop their own training, drawing on the skills and experience of their student support team.

The main aim most providers had with this training was to enable staff to identify students who may need support, but to know their limits in such situations, and discourage them from trying to offer support themselves. Many HEI providers spoke of situations where a member of staff, typically academic staff, had attempted to help a student themselves, either practically or emotionally which had resulted in difficult, inappropriate, or unhelpful situations for both the student and staff member.

> “Often, it's because they they're trying to be really kind and supportive and they end up getting in a pickle because they've ... not referred early enough to our team.” - HEI

Some FECs and smaller Private Providers interviewed in the qualitative research offered mental health awareness training to all student-facing staff, with the rationale that a student may approach any member of staff at any time, and all should be prepared for this. Larger providers, including HEIs, were more likely to take a targeted approach, for example by offering a number of places per team or Department, or inviting people in specific roles, such as team or Department managers. The challenge many large providers faced was being able to offer as many training places as possible within a limited training budget.

> “Financially it can be a bit of a challenge. I don't have a very big budget for training. The training budget for my two teams is the same that it was when I started [3yrs ago], but my service is massively bigger.” - HEI

Take up of training was also noted as an issue for some providers, particularly some HEIs who said that even if they were able to offer training to all members of staff, they would struggle to get everyone to attend. This was seen as an attitudinal issue, often on the part of academic staff who may not see student mental health and wellbeing as part of their role, or who may take an interest in the issue, but believe that they do not need training to know how to handle such situations.

> "Take up is low because they are not mandatory. Academics are having conversations that they are not equipped to deal with." - HEI

Some of the providers interviewed in the qualitative research were trying to increase focus (and budget) staff training because they felt that training was key to ensuring that students could be offered support quickly and consistently. Being able to run mandatory mental health awareness training was seen by many as the single change which could have the most impact on their ability to support students.

> "We are focussed on ensuring that all student facing staff are able to recognise when something isn't right and know who to contact. We don't want to staff to dabble in this, it's about signposting to professional support." - Private Provider

# Chapter 6: Data collection

This chapter explores providers' collection and use of mental health and wellbeing data.

Providers were asked whether they collected any data to **monitor** student mental health and/or wellbeing, across the whole student population. They were asked to only consider aggregate population-wide data in their response, as opposed to any data collected about individual students[35]. At this point in the survey, a definition of mental health and wellbeing was provided, to mirror the approach taken in 2019. The definitions provided were as follows:

Mental health: "Mental health was defined as *"Mental health data for a proportion of students with a mental health need (with or without a formal mental health diagnosis) e.g. students experiencing poor mental health such as depression or anxiety."*

*Wellbeing: "Wellbeing data for all students with or without a mental health need e.g. topics relating to stress management / healthy eating / physical exercise / time management."*

## The prevalence of collecting monitoring data

By provider type, 38% of HEIs said they collected data to monitor student mental health among all students, as did 71% of FECs and 30% of Private Providers (Table 6.1). Among HEIs, 22% said they collected mental health data about specific groups of students, as did 17% of FECs and 9% of Private Providers[36]Among HEIs, 9% said they had no current plans to collect student mental health data, as did 7% of FECs and 35% of Private Providers.

In terms of data on student wellbeing, 23% of HEIs said they collected data to monitor this among all students, as did 51% of FECs and 30% of Private Providers. A smaller proportion of providers each said that they collected wellbeing data about specific groups of students: HEIs (17%), FECs (22%), Private Providers (7%). Among HEIs, 19% said they had no current plans to collect student wellbeing data, as did 10% of FECs and 35% of Private Providers.

[35] All institutions collect individual level data on disability due to mental health problems. This question was aimed therefore at aggregate data collected by the institution (note that the estimates cannot be compared to the 2019/20 survey).
[36] In the survey the two options for 'yes, all students' and 'yes, specific groups of students' was multi-code. This means the two groups are not mutually exclusive.

**Table 6.1: Student mental health and wellbeing monitoring data collection**

| | Total | HEI | FEC | Private provider |
|---|---|---|---|---|
| **Mental health data** | | | | |
| Yes, all students | **47%** | 38% | 71% | 30% |
| Yes, specific groups of students | **17%** | 22% | 17% | 9% |
| No, but we're working on it | **22%** | 35% | 5% | 23b% |
| No, no current plans for this | **15%** | 9% | 7% | 35% |
| Don't know | **4%** | 3% | 5% | 5% |
| **Wellbeing data** | | | | |
| Yes, all students | **34%** | 23% | 51% | 30% |
| Yes, specific groups of students | **16%** | 17% | 22% | 7% |
| No, but we're working on it | **27%** | 40% | 12% | 26% |
| No, no current plans for this | **20%** | 19% | 10% | 35% |
| Don't know | **5%** | 3% | 8% | 5% |

*F1_1 / _2. Do you collect any data to monitor student mental health / wellbeing across the whole student population? Base: All (179); HEIs (77); FECs (59); Private Providers (43).*

In the qualitative interviews, there were some providers across all types that did not collect any data on student mental health and wellbeing, apart from statutory data on disability (including a mental health condition) required by HESA, for HEIs and Private Providers, or by the Education and Skills Funding Agency (ESFA), for FE colleges. Providers shared the following reasons for this:

- Not having the skills, systems, or resources in place to collect, manage and analyse data.
- Concerns that it could worsen the distress felt by students.
- Not wanting to collect data that cannot be compared with that of other providers, so deciding to wait for a sector-based approach.
- Being unsure about what data they would collect and what they would do with it.

## Frequency of data collection

In the survey, providers who said they collected mental health and/or wellbeing data were asked how frequently they collected this data (Table 6.2), and at what time points (Table 6.3). By provider type, HEIs most commonly collected student mental health data on registration with a support service (83%), followed by on registration / enrolment with the provider (78%). Among FECs, (86%) collected mental health data on registration / enrolment with the provider, and 63% collected this data on registration with support services.

**Table 6.2: Frequency of student mental health and wellbeing data collection**

| | Total | HEI | FEC |
|---|---|---|---|
| **Mental health data** | | | |
| Less frequently than annually | **5%** | 10% | 2% |
| Annually | **47%** | 49% | 45% |
| More regularly e.g. two or 3 times a year | **47%** | 41% | 53% |
| Don't know | **1%** | 0% | 0% |
| **Wellbeing data** | | | |
| Less frequently than annually | **2%** | 3% | 2% |
| Annually | **39%** | 41% | 34% |
| More regularly e.g. two or 3 times a year | **56%** | 55% | 61% |
| Don't know | **2%** | 0% | 2% |

*F2_1/_2. How often do you collect information on student mental health / student wellbeing? Base: Providers who collect data to monitor student mental health (106); HEIs (41); FECs (49); Private Providers (16 – Data not shown due to low base). Providers who collect data to monitor student wellbeing (85); HEIs (29 – caution low base); FECs (41). *Data by provider type not shown due to insufficient base.*

Table 6.3 shows that, by provider type, 76% of HEIs collected wellbeing data on registration with support services, and 41% collected it on registration / enrolment with the provider. Among FECs, 73% collected wellbeing data on registration / enrolment with the provider, and 68% collected it on registration with support services.

**Table 6.3: Student mental health and wellbeing data collection time points**

| | Total | HEI | FEC |
|---|---|---|---|
| **Mental health data** | | | |
| On registration / enrolment with HEP | **78%** | 78% | 86% |
| On registration with support service | **66%** | 83% | 63% |
| As and when disclosed | **16%** | 7% | 22% |
| In student surveys | **7%** | 15% | 2% |
| Regular / termly updates | **6%** | 7% | 4% |
| Other | **2%** | 0% | 4% |
| Don't know | **3%** | 0% | 2% |
| **Wellbeing data** | | | |
| On registration / enrolment with HEP | **58%** | 41% | 73% |
| On registration with support service | **66%** | 76% | 68% |
| As and when disclosed | **18%** | 10% | 22% |
| In student surveys | **7%** | 17% | 2% |
| Regular / termly updates | **6%** | 3% | 5% |
| Other | **5%** | 0% | 10% |
| Don't know | **7%** | 7% | 5% |

*F2a_1 / _2. When do you collect information on student mental health / wellbeing? Multiple responses possible. Base: Providers who collect data to monitor student mental health (106); HEIs (41); FECs (49); Private Providers (16 – Data not shown due to low base). Providers who collect data to monitor student wellbeing (85); HEIs (29 – caution low base); FECs (41). *Data by Private Providers due to insufficient base.*

## Types of information collected

In the survey, providers who collected mental health and wellbeing data were asked to state which types of information they collected. This was asked as an open-response question and the responses were coded, as shown in Table 6.4

Among HEIs who collected student mental health data, the following types of information were most commonly collected:

- Self-disclosed mental health issues (54%)
- Support activities / services accessed / utilised / required (46%)
- Information sourced from professional or provider databases and/or standardised scales such as the HESA student record, GAD-7 & PHQ-9 scores, interactions with student counselling services (44%).

**Table 6.4: Information collected on student mental health and wellbeing**

| | Providers who collect student mental health data | Providers who collect student wellbeing data |
|---|---|---|
| Self-disclosed mental health issues | 55% | 47% |
| Support activities / services accessed / utilised / required | 48% | 38% |
| Other self-disclosed support needs e.g. disabilities, at risk | 36% | 29% |
| Evidence of formal diagnosis | 26% | 8% |
| Information sourced from professional or provider databases and/or standardised scales e.g., HESA student record, GAD-7 & PHQ-9 scores, interactions with student counselling services etc | 25% | 22% |
| Previous and family history incl. triggers / environmental factors | 22% | 24% |
| Safeguarding concerns flagged / presenting issues | 12% | 18% |
| Details for referrals to services / confirmation of fitness to study | 9% | 6% |

| | | |
|---|---|---|
| Medication - required / used / side effects | 8% | 6% |
| Attendance / academic outcomes / engagement in extra-curricular activities | 6% | 6% |
| Personal support network information | 4% | 1% |
| Other | 5% | 6% |
| None / NA / Unknown | 2% | 6% |

*F2b_1 / _2. What information on student mental health / wellbeing do you collect? Multiple responses possible. Base: Providers who collect data to monitor student mental health (106); Providers who collect data to monitor student wellbeing (85).*

## Data sharing: mental health and wellbeing

In the survey, providers who collected mental health and/or wellbeing data were asked whether they use or share this data internally and externally. These results are not reported by provider type due to relatively small base sizes.

Most providers (95%) said they shared mental health data internally, within specific departments, provided they have permission. The remainder said they do not share mental health data within specific internal departments because they do not have permission (1%) or for other reasons (3%); while 1% said they did not know.

The majority of providers who collected mental health data (80%) said they share the data internally across different departments provided they have permission. The remainder said they do not share the data with different departments because they do not have permission (11%) or for other reasons (8%); while 1% said they did not know.

Among providers who collected mental health data, 63% said they use or share this data externally with outside partners or advisors, provided they have permission. Around one in four (23%) said they do not share mental health data externally because they do not have permission, and 11% said they do not do so for other reasons; while 3% said they did not know.

Most providers who collected data on student mental health said they used this to inform service or policy design (94%), to evaluate existing services or policies (94%), or to target advice or support for students (99%). One-third (32%) said they used student mental health data for other purposes. Among the providers who said they used mental health data for another purpose, the main reasons were:

- Creation / improvement of internal support services / policies (56%)
- Capacity planning (26%)

- Monitoring data trends/ benchmarking (24%)
- KPI measurement and reporting of delivery and performance (21%).

Among providers who collected data to monitor student wellbeing, most (94%) used or shared this data internally, within specific departments, while 4% said they did not, for reasons other than not having permission.

Most (82%) also used or shared wellbeing data internally across different departments, provided they have permission. A minority (8%) said they do not share across different departments because they do not have permission; 8% said they do not do so for other reasons, and 1% said they did not know.

Among providers who collected student wellbeing data, 59% said they shared it externally with outside partners or advisors, provided they have permission. The remainder said they do not share wellbeing data externally because they do not have permission (18%) or for other reasons (20%); while 4% said they did not know.

Almost all providers who collected student wellbeing data said they used it to inform service or policy design (94%), to evaluate existing services or policies (94%), and to target advice or support for students (99%). Just over one-quarter (27%) said they used wellbeing data for other purposes, the main ones being:

- Creation / improvement of internal support services / policies (48%)
- Data trends / benchmarking (26%)
- Capacity planning (22%)
- KPI measurement and reporting of delivery and performance (22%).

In the qualitative interviews, providers explained that the primary 'starting point' for data on student mental health and wellbeing was data they had to collect for HESA, which was obtained through student disclosures during admissions and enrolment. Providers generally prompted students at several points during the admissions, pre-enrolment, and enrolment stages to encourage them to disclose any disabilities or health conditions and what support they may need while studying. Many providers also prompted students to update their information in case of any changes.

> "Students can update their registration, so we do get emails throughout the years saying the student has declared they have a disability." HEI

This data was generally only shared with the student's consent, and with individuals within the provider who needed to know some details about the students' mental health condition so that they could offer appropriate adjustments and support. Generally, this included relevant members of staff within the provider, but some did encourage students

to be more open about their needs, including with other students, if they felt it would help to ensure they are supported.

> “A student might need a student support or inclusion plan, that's contractual data that the student contracts with us. They then consent to who that is shared with. Normally their teaching team, their personal tutor and sometimes they might want their people like their flatmates to have sight of that as well.” - HEI

HESA data was primarily used to ensure that a support plan is put in place for the student, but providers did use anonymised data counts to understand patterns in student need and to help plan their support services. For many providers that did not offer access to any direct or funded mental health support services, HESA data was often the only data they had on student mental health and wellbeing.

Providers that offered access to mental health and wellbeing support all collected data on students who were referred to these services, including demographics, reason for referral, type of support offered or used, and any outcome data available. Providers used this data to understand how their support services were being used and to explore the effectiveness of different types of services they offer.

Wider data collection among all students tended to focus on awareness and satisfaction with support services rather than asking about mental health issues specifically. Student surveys run by providers or the Student Union in some HEIs would ask whether students were aware that the provider offered services, if they knew how to access them, whether they had used them, and levels of satisfaction. Most of these providers said that they did not ask students about their mental health or wellbeing in these surveys as they did not think this information would be useful in supporting students.

> "We ask questions about service awareness, service use and satisfaction but we don't ask "how are you feeling?" and I don't think that we should. What do you do with that data?" - HEI

# Chapter 7: Service reflections

This chapter explores the extent to which HE providers perceive their mental health and wellbeing services are meeting student demand. It also explores the extent to which they think that supporting student mental health and wellbeing is embedded throughout the institution, and the extent to which they feel theirs is a 'compassionate community.' These topics were explored with providers who participated in the qualitative interviews.

Over nine in ten (92%) HEIs regularly review[37] whether student mental health services are meeting demand and around half (49%) regularly review whether services/ practices are meeting demand for NHS care pathways. FECs followed a similar pattern: almost all (98%) regularly review demand for student mental health services while just under half (46%) do so for NHS care pathways. Almost nine in ten Private Providers regularly review demand for student mental health services (86%) but just 9% review demand for NHS care pathways, reflecting the issues discussed earlier in this report around the nature of Private Providers and their student body.

Overall, many HE providers interviewed in the qualitative research reported that they were struggling to meet ever increasing demand for support services. They described growing demand for counselling year-on-year and even though many had funded expansion of these services, they were still only just meeting current demand, and expected to be struggling again soon. Providers said that this pressure resulted from a combination of:

- Students experiencing more, or more complex, problems with their mental health due to a range of factors including Covid restrictions and the cost of living.
- Students being more aware of their mental health and wellbeing and feeling more able or confident to seek support.
- An increase in students believing that they would benefit from counselling.
- Lack of capacity in the NHS to take on longer-term or more complex support needs.

> "We are not meeting demand, especially not for those at high risk. We are seeing numbers creep up and we keep growing and changing our services, but we are struggling to keep up." - HEI

The exception to this was Private Providers which tended to be smaller in size, and had not seen the level of demand for support services that larger providers had experienced.

[37] This was defined in the survey as at least once per year.

These providers generally felt that they did have plenty of capacity to meet demand, which they described as being low and stable in recent years.

> “I think we're meeting demand. I don't see a huge amount of pressure on the support services that we're offering.” - Private Provider

When considering the extent to which student mental health and wellbeing had been embedded throughout their institution, none of the providers that took part in the qualitative research felt that this had been fully achieved yet. They defined embeddedness as being when all students and staff have an awareness of their own, and others’ mental health and wellbeing, and know how to signpost for support.

Some smaller providers, such as specialist HEIs and Private Providers, considered that they were closer to achieving this, but were not there yet. Smaller institutions reported their size to be an advantage when implementing change, as they had to deal with fewer people and processes.

The main gap identified by providers of all types was engaging academic staff in recognising when a student might need support and signposting them correctly, and in embedding awareness of mental health or promoting wellbeing in the curriculum. Many providers who felt their core support offering was strong, said that the inconsistency in behaviour or policy within academic departments was a concern. However, they did think that the situation was improving, and that staff awareness was increasing year on year, mainly due to a greater focus on training.

> "We still have a long way to go in terms of does every member of staff and every student know that support exists, and in what forms?” - HEI

Some providers, commonly smaller Private Providers or FECs, which had more central control over timetabling, had started to embed mental health awareness and positive wellbeing behaviours into the curriculum. Larger HEIs tended to describe making changes to the curriculum as more challenging due to the number of courses they offered and the number of staff they would need to engage to do this.

> “If I went to say Engineering, would it be embedded there? Probably not.” - HEI

Examples of embedding mental health and wellbeing into the curriculum included adding mindfulness sessions to the timetable and using mental health data in a statistics course. Some providers had also sought feedback on the impact of specific courses on student mental health and wellbeing and had implemented changes to these in response.

> “I think our framework is at a place where it's something that's become more part of the curriculum, more part of the discourse, part of the discussion among staff and students.” - Private Provider

Despite the challenges that providers had experienced in embedding mental health and wellbeing, many providers interviewed in the qualitative research said that their institution was a compassionate community for both students and staff. A compassionate community was described as an institution where people care about each other as individuals and put the needs and wellbeing of students and staff at its centre.

> "I genuinely think it is. It's a warm place. Students comment on the sense of community but I think that's down to the ethos rather than policies.” – HEI

In the qualitative research, smaller providers and HEIs made up of several colleges commonly felt that their size or structure enabled them to build a sense of community where everyone knows, and cares about, each other. They saw this as one of the main selling points of their institution. However, even larger HEIs believed that they provided a strong sense of community within their institution, and many attributed this to the positive example set by senior leadership.

> "Yes, absolutely and that comes from the top. The Vice Chancellor is a compassionate guy." - HEI

The importance of leadership in setting the tone and direction for an institution was also discussed by providers that did not describe their institution as being a compassionate community. These providers attributed this to issues relating to staff turnover and staff morale, driven by the values and priorities of senior leadership in the institution. They felt that it was difficult for staff to create a supportive environment for students if they did not feel supported or valued themselves. This view was echoed by many providers who thought that staff mental health and wellbeing must be considered in tandem with that of students.

> “I think there have been lots and lots of problems at [HEI] in the last few years and the morale of staff is on the floor. I think the morale of staff and what can happen in terms of student wellbeing are really closely linked.” - HEI

When considering further support they would benefit from, HE providers typically identified a need for:

- more information and guidance.

- more funding prioritised for student mental health; and,
- greater clarity on relationships with NHS.

Information and guidance needs were focussed on a desire for a clearer sector-wide approach, including a national model for policies, services, and support to ensure that providers know what they need to provide, and how to do it. There was also a desire for more formal sharing of best practice between institutions, and of more sector-wide discussions on issues relating to mental health and wellbeing, including on the intersectionality between this and other issues such as finances and sexual violence. Some HEIs thought that students would benefit from being prepared for the transition to university by their school or college and suggested that DfE could facilitate this work.

The need to provide more types of support and more capacity in support services, as well as an understanding of the importance of staff training, meant that funding for mental health and wellbeing activities was a key concern for many providers. Many said that they needed more money to enable them to meet students' needs. While some Private Providers and HEIs had been able to reallocate finding from other areas to expand or improve support services, some reported that this was not sustainable due to the rate of increase in demand. HEIs and FECs felt that DfE should provide additional funding to support with these costs, including the cost of training staff in mental health awareness.

> "Give us a training budget. You can't stay up to date with the information if you're not training people properly." - HEI

Additionally, FECs said that they faced constraints in how their budgets were structured which prevented them from being able to move funding from other areas to pay for mental health and wellbeing support. They felt that they needed both more funding, and a greater level of flexibility in how funding can be used.

When considering their relationship with external services, providers – particularly HEIs - wanted more clarity on how they should work with local NHS and emergency services. This included clarity on the differing roles and responsibilities of providers and the NHS as well as identifying and dealing with gaps between the two. They also wanted clarity about how they should work with emergency services, including which service to contact in specific situations.

> "In my opinion, is that in terms of an education provider, I think the boundary between what an education provider is now providing and what the health sector is providing isn't in the right place." - HEI

In order for students to avoid long waiting times for NHS support and the risk that they are lost between the gap between provider and NHS services, providers wanted quicker and clearer referral routes into the NHS care pathways. Some suggested that this could

be achieved by linking providers with an NHS psychiatrist so that complex and urgent cases could be discussed, and students could be assessed and referred more quickly.

> “Each time they've got to go through a process, we're more likely to lose them in that process.”- HEI

Finally, providers wanted greater investment in NHS mental health services for students to increase capacity and reduce the number of students with long-term or complex needs relying on their education provider for support. Many suggested that this could be achieved by expanding Child and Adolescent Mental Health Service (CAMHS) to include younger students (for example aged 18 to 21) and ensuring that there is enough capacity within the service to meet the increasing level of demand.

> "Services have been designed on the basis that we can offer some external counselling through our partner but that does not address all mental health concerns. We need to know that NHS services are available for our students when they need them." - Private Provider

# Chapter 8: Conclusions

This research aimed to build on the findings from the exploratory research conducted in 2019 and contribute to wider effective practice. Specific objectives included:

- How far Higher Education providers (HEPs) have adopted health and wellbeing at a strategic level in their organisation;
- The extent to which HEPs have adopted and embedded suicide prevention frameworks and strategies including linking with their local suicide prevention networks.
- What services are offered to support students and how HEPs design, deliver and evaluate services to meet the needs of their students; and
- The extent to which the whole institution approach, as referred to in the Universities UK Stepchange: mentally healthy universities framework has been embedded.

The data shows that HE providers are adopting health and wellbeing at a strategic level within their organisation and that this is becoming increasingly important to them. Compared with 2019, the proportion of HEIs which have a specific mental health/wellbeing strategy in place has increased from just over half to two-thirds, and a similar proportion have a suicide prevention strategy in place. Overall, most HE providers who do not have specific strategies in place are working on developing them, and only a small minority have no strategy and no plans for one.

Those HE providers which have strategies in place, or are developing them, consult with a wide range of internal and external stakeholders and utilise the range of tools and frameworks in place to support them. Internally, consultation with students is particularly common among HEIs. Externally, HEIs (and to a lesser extent, FECs) tended to consult with a wider range of local stakeholders including NHS services, local third sector organisations and their local authorities, whereas consultation was more limited among private providers.

The use of suicide prevention frameworks and strategies, including links with local suicide prevention networks, has been an increasing priority among HEIs in particular. Some providers, again commonly HEIs that had experience of dealing with mental health crisis cases, felt that they would benefit from closer links and greater clarity about how to work with local emergency services. While many of these providers did already have some links with these services, not all had been able to establish these, and this meant they felt less confident about what to do in the event of a crisis. Other providers said that even though they did have relationships with emergency services, there was still

uncertainty between different organisations about who should be contacted in specific situations, and more generally about demand for NHS services outstripping the supply. Providers themselves noted this as a concern about their own mental health support services and some highlighted a more fundamental issue around the role of HE providers and the need for clearer boundaries and referral pathways between HE providers and NHS services.

Services to support student mental health, wellbeing and suicide prevention are evolving and many HEIs in particular were reviewing their services and making changes to strengthen these, either through direct delivery or outsourcing. A wide range of support was available ranging from awareness raising activities, through to self-help resources, counselling and CBT. Awareness raising and early warning systems were viewed as particularly important in order to encourage students to disclose when they were in difficulty, or to have systems in place to identify those at risk such as reduced course attendance or library use, which might suggest disengagement caused by poor mental health. Private providers were less likely to offer various services, which they attributed to differences in their student composition that meant students had less need of support. HE providers who offered services used a range of approaches to evaluate them, including student feedback and monitoring of take up. Some HEIs noted rising demands for support services, and several were introducing a 'no wrong door' type approach where everyone accessed the same system so that they could be 'triaged' and referred more effectively to the most appropriate types of support. Funding for services was of concern to many providers in the face of continuing increases in demand.

The extent of 'embeddedness' was explored in the qualitative research rather than in the survey as HE providers interpreted this in differing ways. A consensus developed around defining embeddedness as being when all students and staff have an awareness of their own, and others' mental health and wellbeing, and know how to signpost for support. In this respect, many of the HE providers interviewed in the qualitative stage regarded 'embeddedness' as still being developed. They identified a range of factors that underpinned this:

- Effective awareness raising and creating an 'open discourse' around mental health. This included encouraging students to disclose any mental health difficulties or conditions at or before enrolment, and reinforcing this through regular monitoring data.
- Mental health awareness training for staff across all parts of the institution, but especially for student-facing staff, and ensuring that signposting routes and escalation processes were clear to staff. Getting buy-in from academic staff and consistency between different academic departments was considered to be especially important.

- Effective leadership, with this ‘setting the tone’ for how mental health and wellbeing was prioritised within HEPs. Some HE providers pointed out that staff mental health and wellbeing must be considered in tandem with that of students, as it was difficult for staff to create a supportive environment if morale was low and they did not feel supported themselves.

Looking to the future, HE providers identified a range of areas where they would welcome more information and guidance on supporting student mental health, wellbeing and suicide prevention. These included a national model for policies, services and support; sharing of best practice across the HE sector; greater clarity of roles regarding HE providers, NHS and emergency services; and better funding for NHS mental health services more generally to ensure a better match between supply and demand.

# Technical Appendix: Methodology

## Survey of HE providers

All eligible HE providers in England were invited to take part in a 20 minute survey about their strategies, policies and practices to support student mental health, wellbeing and suicide prevention. Eligible providers were defined as being within scope for the research if they had degree-awarding powers.

The DfE emailed an introductory letter to eligible HE providers at the start of May 2022, in advance of the survey invitation from IFF Research, in order to alert them about the research and emphasise the importance of taking part.

Fieldwork took place between 11th May and 27th July 2022. The in-scope population consisted of 133 HEIs, 157 FECs and 109 Private Providers. The majority of surveys were completed online (161) with a small number (18) completed over the phone using Computer Assisted Telephone Interviewing (CATI), following a short chasing exercise.

The survey questionnaire covered a range of areas related to the research objectives, from roles and responsibilities to strategic development, existing practices and services and overall service reflections. It was developed in collaboration with DfE and key stakeholders including the Office for Students (OfS), Universities UK (UUK), Student Minds, and a small number of university contacts sourced through the Association of Managers of Student Services in Higher Education (AMOSSHE). The questionnaire development was also informed by a cognitive testing phase across HEIs, FECs and Private Providers. This involved six cognitive interviews, during April 2022.

Contact information was sourced through a combination of desk research and available DfE databases under the appropriate data protection and GDPR permissions. A breakdown of response is shown in Table A1.

**Table A1: Survey responses by type of HE provider**

| Provider type | In-scope | n | Response rate |
|---|---|---|---|
| Higher Education Institutions (HEIs) | 133 | 77 | 58% |
| Further Education Colleges (FECs) offering HE courses | 157 | 59 | 38% |
| Private Providers | 109 | 43 | 39% |
| **Total** | **399** | **179** | **45%** |

Each HE provider was asked to submit one collated response for their institution. They were encouraged to gather input from other colleagues, where needed. The survey was generally completed and submitted by a senior member of staff, including Vice Chancellors, Principals and Deans of Students as well as Heads or Directors of departments responsible for student services, student experience, student support, mental health or wellbeing, and people in similar roles. In a few cases the survey was submitted by a safeguarding lead, or by a person with responsibility for equality, diversity and/or inclusivity.

A full breakdown of the profile of survey responses for each provider type, by region and number of students, is outlined in Table A2. Among HEIs, the response by Office for Students (OfS) tariff level was evenly distributed between HEIs with low, medium and high scores and those which do not have a tariff score.

**Table A2: Profile of HE Providers who took part in the survey**

| | | **HEI** | **HEI %** | **FEC** | **FEC %** | **PP** | **PP %** |
|---|---|---|---|---|---|---|---|
| | ***Total*** | ***77*** | **100%** | ***59*** | **100%** | ***43*** | **100%** |
| Region | East of England | 6 | 8% | 5 | 8% | 2 | 5% |
| | East Midlands | 5 | 6% | 1 | 2% | 1 | 2% |
| | West Midlands | 7 | 9% | 7 | 12% | 3 | 7% |
| | North East | 2 | 3% | 4 | 7% | 1 | 2% |
| | North West | 10 | 13% | 10 | 17% | 0 | 0% |
| | South East | 13 | 17% | 7 | 12% | 5 | 12% |
| | Greater London | 17 | 22% | 6 | 10% | 28 | 65% |
| | South West | 7 | 9% | 8 | 14% | 2 | 5% |
| | Yorkshire & Humber | 10 | 13% | 11 | 19% | 1 | 2% |
| Number of students | <1,000 | 6 | 8% | 36 | 61% | 19 | 44% |
| | 1,000-5,499 | 11 | 14% | 23 | 39% | 8 | 19% |
| | 5,500-9,999 | 12 | 16% | 0 | - | 1 | 2% |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | 10,000-19,999 | 37 | 48% | 0 | - | 0 | - |
| | 20,000+ | 9 | 12% | 0 | - | 0 | - |
| | Unknown | 2 | 3% | 0 | - | 15 | 15 |
| Number of students (condensed) | <10,000 | 29 | 38% | 59 | 100% | 28 | 65% |
| | 10,000+ | 46 | 60% | 0 | - | 0 | - |
| | Unknown | 2 | 3% | 0 | - | 15 | 35% |
| OfS Tariff Group | High | 19 | 25% | - | - | - | - |
| | Medium | 19 | 25% | - | - | - | - |
| | Low | 21 | 27% | - | - | - | - |
| | Specialist HEI | 18 | 23% | - | - | - | - |

**Table A3: Population of HE Providers invited to take part in the survey**

| | | **HEI** | **HEI %** | **FEC** | **FEC %** | **PP** | **PP %** |
|---|---|---|---|---|---|---|---|
| | ***Total*** | ***133*** | **100%** | ***157*** | **100%** | ***109*** | **100%** |
| Region | East of England | 10 | 8% | 14 | 9% | 8 | 7% |
| | East Midlands | 9 | 7% | 12 | 8% | 3 | 3% |
| | West Midlands | 12 | 9% | 17 | 11% | 4 | 4% |
| | North East | 5 | 4% | 8 | 5% | 1 | 1% |
| | North West | 15 | 11% | 31 | 20% | 5 | 5% |
| | South East | 18 | 14% | 27 | 17% | 13 | 12% |
| | Greater London | 38 | 29% | 12 | 8% | 64 | 59% |
| | South West | 14 | 11% | 19 | 12% | 7 | 6% |
| | Yorkshire & Humber | 12 | 9% | 17 | 11% | 4 | 4% |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Number of students | <1,000 | 13 | 10% | 106 | 68% | 60 | 55% |
| | 1,000-5,499 | 21 | 16% | 50 | 32% | 15 | 14% |
| | 5,500-9,999 | 19 | 14% | 1 | 1% | 1 | 1% |
| | 10,000-19,999 | 56 | 42% | 0 | - | 0 | - |
| | 20,000+ | 17 | 13% | 0 | - | 0 | - |
| | Unknown | 7 | 5% | 0 | - | 33 | 30% |
| Number of students (condensed) | <10,000 | 53 | 40% | 157 | 100% | 76 | 70% |
| | 10,000+ | 73 | 55% | 0 | - | - | - |
| | Unknown | 7 | 5% | 0 | - | 33 | 30% |
| OfS Tariff (HEIs only) | High | 31 | 23% | - | - | - | - |
| | Medium | 31 | 23% | - | - | - | - |
| | Low | 31 | 23% | - | - | - | - |
| | Specialist HEI | 38 | 29% | - | - | - | - |

## Qualitative interviews

A total of 75 qualitative interviews were conducted across 33 HE providers, from 27th June to 1st September 2022. More than one interview was conducted at each provider to gain greater breadth and depth, in recognition that the survey respondent may have an overview of student mental health, wellbeing and suicide prevention at their institution but would not necessarily have the depth of knowledge to answer more detailed questions across the full range of topics covered by the interview. For example, respondents could be from a strategic or an operational role, and conducting more than one interview per provider enabled a fuller perspective on that institution, across topics such as strategy development, partnership working and service delivery.

These were a mixture of individual interviews, paired interviews, and – in a handful of cases – triads involving three participants. Where interviews were conducted in a pair or triad within the same provider this was generally because at the point of recruitment, more specialist colleagues were invited to contribute on specific topic areas and it was logistically easier for them to make a joint appointment.  Participants in the qualitative

research included the survey lead and other nominated colleagues at their institution, either in strategic roles or working directly with students 'on the ground'.

Provider characteristics were monitored to ensure a broad spread by: provider type, region, tariff (among HEIs), size (in terms of number of students), and the presence of a mental health / wellbeing strategy, as indicated in the survey. The profile of the 33 HE providers who part in the qualitative phase of the research is shown in Table A4 and Table A5, by provider type.

**Table A4: Profile of the HE providers which took part in the qualitative phase by region and size (number of students)**

| | HEI | FEC | PP |
|---|---|---|---|
| ***Total*** | ***20*** | ***6*** | ***7*** |
| **Region** | | | |
| East of England | 1 | 0 | 0 |
| East Midlands | 4 | 0 | 0 |
| West Midlands | 1 | 3 | 1 |
| North East | 0 | 0 | 0 |
| North West | 0 | 1 | 0 |
| South East | 4 | 0 | 1 |
| Greater London | 2 | 0 | 5 |
| South West | 2 | 0 | 0 |
| Yorkshire & Humber | 6 | 2 | 0 |
| **Size (number of students)** | | | |
| <1,000 | 0 | 4 | 4 |
| 1,000-5,499 | 3 | 2 | 1 |
| 5,500-9,999 | 5 | 0 | 0 |
| 10,000-19,999 | 8 | 0 | 0 |
| 20,000+ | 4 | 0 | 0 |
| Unknown | 0 | 0 | 2 |

**Table A5: Profile of the HE providers which took part in the qualitative phase by OfS tariff (HEIs only) and whether they had a strategy in place**

| | HEI | FEC | PP |
|---|---|---|---|
| ***Total*** | **20** | **6** | **7** |
| **OfS Tariff** | | | |
| HEIs with high scores | 5 | n/a | n/a |
| HEIs with low scores | 8 | n/a | n/a |
| HEIs with medium scores | 4 | n/a | n/a |
| No tariff | 0 | 6 | 7 |
| Specialist HEI | 3 | n/a | n/a |
| **Strategy in place?** | | | |
| Combined | 10 | 2 | 5 |
| Separate MH strategy | 1 | 0 | 0 |
| Separate wellbeing | 1 | 0 | 0 |
| Covered in wider strategy | 0 | 2 | 1 |
| No, in progress | 6 | 2 | 1 |
| No, not planned as yet | 1 | 0 | 0 |
| Other | 1 | 0 | 0 |

The interviews explored the research objectives in more depth, guided by the responses given at the survey stage. Interviews lasted 45 to 60 minutes and were recorded with permission from participants.

## Approach to analysis

Due to the relatively small sample size and the census approach, the data are unweighted. Data was analysed using crosstabulations in Excel and SPSS. Where a relatively high proportion of responses fell into the 'other: specify' category (more than 10%) these were reviewed and back-coded to existing precodes if possible. If this was not possible, and there were sufficient responses to warrant it, new precodes were added.

The report uses the following conventions when reporting survey findings:

- Throughout, base figures are shown on tables and charts to give an indication of the statistical reliability of the figures.
- As a general convention throughout the report, figures with a base size of fewer than 30 are not reported, although on charts and tables these figures have been retained for indicative purposes.

- In some cases, figures in tables and charts may not always add to 100 percent due to rounding (i.e. 99 percent or 101 percent) or where multiple responses were permitted.

The qualitative data was entered into an Excel-based analysis framework. This was structured under headings relating to the research objectives and allowed discussions to be compared and judgements made about the commonality of experiences and views.

# Responsibilities for mental health and wellbeing within HE providers

## Strategic responsibility

Table A6 details who had strategic responsibility for student mental health and wellbeing across the different provider types. In HEIs and FECs this was usually a mental health specialist, senior management of the institution, such as the Principal, Vice Chancellor or Dean, or a senior role responsible for student services, such as the Head of Student Experience or Director of Student Services. The latter was less common in Private Providers. Several HE providers spread strategic responsibility for mental health and wellbeing across multiple roles.

**Table A6: Role(s) with strategic responsibility for mental health and wellbeing**

| | Total | HEI | FEC | Private provider |
|---|---|---|---|---|
| **Mental Health Specialist** e.g. Director of Student Support and Welfare, Student Wellbeing & Counselling Manager / Student Advisor | **42%** | 45% | 41% | 40% |
| **Principal / Vice Chancellor / Dean / President / Provost** (other SLT / board) | **39%** | 38% | 51% | 23% |
| **Director / Head / Manager of Student Experience / Life / Services / Journey / Engagement** (or similar) | **33%** | 43%c | 34% | 14% |
| **Director of Business / College / Academic Services** (or similar) | **12%** | 16% | 7% | 12% |
| **C-Level Executive** e.g. CEO / COO / Chief People Officer / Chief Education Officer | **10%** | 10% | 5% | 16% |

| | | | | |
|---|---|---|---|---|
| **Rector / Registrar / Academic Registrar** | **10%** | 16% | 0% | 14% |
| **Other/ Unspecified Director / Deputy Director / Head** | **4%** | 3% | 3% | 9% |
| **Course / Project Leader / Academic Tutor / Coach** | **1%** | 0% | 0% | 2% |
| **Other** | **4%** | 3% | 5% | 7% |

*A1. Who – in terms of job title/role – has overall strategic responsibility at HEP for the mental health and wellbeing of students at your institution? Base: All providers (179); HEIs (77), FECs (59), Private Providers (43).*

FECs and Private Providers were asked whether they had different leads with strategic responsibility for higher education (HE) and further education (FE) students. Around one-fifth (22%) of FECs had different leads for HE and FE students, with the majority (78%) having the same staff responsible for both groups. The majority of Private Providers (77%) stated that they did not have FE students, but all of those who did said the same staff were responsible for both HE and FE students.

## Operational responsibility

For 64% of providers, the same role was involved in both strategic and operational responsibility for student mental health and wellbeing. Table A7 shows that operational responsibility predominantly sat with a mental health/wellbeing specialist, across all provider types.

**Table A7: Roles with operational responsibility for mental health and wellbeing**

| | **Total** | **HEI** | **FEC** | **Private provider** |
|---|---|---|---|---|
| **Mental Health Specialist** e.g. Director of Student Support and Welfare, Student Wellbeing & Counselling Manager / Student Advisor | **71%** | 79% | 63% | 67% |
| **Principal / Vice Chancellor / Dean / President / Provost** (other SLT / board) | **8%** | 5% | 12% | 9% |
| **Director / Head / Manager of Student Experience / Life / Services / Journey / Engagement** (or similar) | **30%** | 30% | 36% | 21% |
| **Director of Business / College / Academic Services** (or similar) | **6%** | 9% | 3% | 2% |

| | | | | |
|---|---|---|---|---|
| **C-Level Executive** e.g. CEO / COO / Chief People Officer / Chief Education Officer | **1%** | 1% | 0% | 2% |
| **Rector / Registrar / Academic Registrar** | **1%** | 1% | 0% | 2% |
| **Other/ Unspecified Director / Deputy Director / Head** | **7%** | 8% | 2% | 12% |
| **Course / Project Leader / Academic Tutor / Coach** | **5%** | 3% | 2% | 14% |
| **Other** | **9%** | 6% | 8% | 16% |

*A2. Who – in terms of job title/role – holds operational/day-to-day responsibility for the for the mental health and wellbeing of students at your institution? Base: All providers (179); HEIs (77), FECs (59), Private Providers (43).*

FECs and Private Providers were asked whether the same staff members had operational responsibility for both HE and FE students. Most FECs (81%) confirmed that the same staff were responsible with one in five (19%) taking a separate approach to who was responsible for HE and FE students at their college. Of the ten Private Providers that had FE students, nine of them said the same staff members were responsible for both HE and FE students.

# Responsibilities for suicide prevention

## Strategic responsibility

Table A8 shows that HE providers most commonly gave strategic responsibility for suicide prevention to a mental health specialist, followed by the Head of Student Services or senior leadership such as the Principal or Vice Chancellor. At several providers, responsibility was shared by two or more different roles.

**Table A8: Roles with strategic responsibility for suicide prevention**

| | **Total** | **HEI** | **FEC** | **Private provider** |
|---|---|---|---|---|
| **Mental Health Specialist** e.g. Director of Student Support and Welfare, Student Wellbeing & Counselling Manager / Student Advisor | **47%** | 55% | 41% | 44% |
| **Principal / Vice Chancellor / Dean / President / Provost** (other SLT / board) | **32%** | 27% | 44% | 23% |

| | | | | |
|---|---|---|---|---|
| **Director / Head / Manager of Student Experience / Life / Services / Journey / Engagement** (or similar) | **32%** | 39% | 34% | 16% |
| **Director of Business / College / Academic Services** (or similar) | **9%** | 13% | 7% | 7% |
| **C-Level Executive** e.g. CEO / COO / Chief People Officer / Chief Education Officer | **7%** | 10% | 0% | 12% |
| **Rector / Registrar / Academic Registrar** | **11%** | 16% | 0% | 16% |
| **Other/ Unspecified Director / Deputy Director / Head** | **5%** | 6% | 2% | 7% |
| **Course / Project Leader / Academic Tutor / Coach** | **2%** | 0% | 0% | 7% |
| **Other** | **4%** | 3% | 3% | 7% |

*A1. Who – in terms of job title/role – has overall strategic responsibility at HEP for suicide prevention (this might span – prevention, intervention and/or postvention)? Base: All providers (179); HEIs (77), FECs (59), Private Providers (43).*

## Operational responsibility

For 71% of providers, the same role was involved in both strategic and operational responsibility for suicide prevention. This was typically a mental health/ wellbeing specialist (particularly in HEIs) or the Head of Student Services (Table A9). Similar to mental health and wellbeing, operational responsibility for suicide prevention was sometimes shared by more than one role.

**Table A9: Roles with operational responsibility for suicide prevention**

| | **Total** | **HEI** | **FEC** | **Private provider** |
|---|---|---|---|---|
| **Mental Health Specialist** e.g. Director of Student Support and Welfare, Student Wellbeing & Counselling Manager / Student Advisor | **74%** | 86% | 64% | 67% |
| **Principal / Vice Chancellor / Dean / President / Provost** (other SLT / board) | **9%** | 5% | 12% | 12% |

| | | | | |
|---|---|---|---|---|
| **Director / Head / Manager of Student Experience / Life / Services / Journey / Engagement** (or similar) | **28%** | 30% | 32% | 21% |
| **Director of Business / College / Academic Services** (or similar) | **4%** | 6% | 3% | 2% |
| **Rector / Registrar / Academic Registrar** | **2%** | 1% | 0% | 5% |
| **Other/ Unspecified Director / Deputy Director / Head** | **6%** | 6% | 3% | 9% |
| **Course / Project Leader / Academic Tutor / Coach** | **6%** | 5% | 2% | 14% |
| **Other** | **8%** | 4% | 8% | 14% |

*A2. Who – in terms of job title/role – holds operational/day-to-day responsibility for the suicide prevention (this might span (prevention, intervention, postvention)? Base: All providers (179); HEIs (77), FECs (59), Private Providers (43).*

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