Thesis submitted in accordance with the requirements of Liverpool Hope University for the degree of Doctorate in Education

‘A mental health tsunami’: How are UK higher education student welfare services responding to the perceived ‘crisis’ with student mental wellbeing?

Scott Massie

29 August 2025

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This thesis is being submitted in partial fulfilment of the requirements for the degree of Doctorate in Education.

Signed: _ ____________ (Candidate) Date: 29 August 2025

Dedication

For Rob – I love you.

Also for my dad for inspiring me. RIP Dad (1943-2025).

Acknowledgements

Firstly, I would like to thank the participants who gave up time in their busy schedules to support this project.

I would like to thank my team of supervisors: Dr Erin Pritchard, Dr Naomi Hodgson, Professor Michael Lavalette, and Professor Michael Brennan, for their consistent guidance and valued support over the years. A particular thanks to Dr Erin Pritchard for her patience with me randomly knocking on her office door with questions (or requests for teabags).

I would also like to thank my family, as well as my colleagues at Liverpool Hope University for their friendship and moral support.

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Abstract

In line with the known increase in demand for services, the mental health needs of the university student population have become a focus for attention. Higher education students have specific pressures, including financial concerns; workload expectations; alongside the balancing of studies with family and work commitments. Particular groups of students are known to be at higher risk due to aspects of intersecting identities. The impact of experiencing mental distress while at university has significant short and longer-term consequences.

This thesis examines how university student welfare services are adapting to the increased demand for support. It will consider what may be influencing the upsurge in requests for mental health support, while evaluating the impact of ongoing barriers that limit help-seeking, including the ramifications of stigma. This will be placed within the context of an evolved, neo-liberal higher education sector. In addition, there will be an interrogation of the language and discourse of mental health and distress, including a critique of the growing trend to label student mental health within a ‘crisis narrative’. The analysis will scrutinise national guidance, how these influence the direction of student welfare providers, and how the prevailing barriers are being factored into the response to student need.

The broad orientation of the study is to view mental health as a universal need, one that requires a societal response, rather than sitting purely within the biomedical model. To achieve this, the thesis will be underpinned with a critical mental health lens, informed through several theoretical threads – these include traditional anti-psychiatry perspectives, survivor driven discourse, the related influence of *mad* studies, and the overlap with disability studies. Drawing upon a poststructuralist examination of language, with a focus on Foucauldian interpretations, it will seek to explore how ideas and meaning embedded within traditional psychiatric approaches to mental health and treatment continue to generate stigma and reinforce negative notions of mental distress.

Qualitative data has been gathered through semi-structured interviews with student welfare service leads based in several universities in the Northwest of England. The data was coded, and themes generated utilising Braun and Clarke’s (2022), *reflexive thematic analysis* as the methodological approach. The analysis illustrates that student welfare services are seeking to respond to increased demand through reviewing and adapting their services, enhancing flexibilities, and broadening out the language of mental health and wellbeing. While national guidance and policy can be useful with supporting inventive approaches, bespoke localised responses are critical to meet diverse levels of need. There are mixed experiences of partnerships with local health providers that need addressing to ensure there is a consistency of response to higher level needs. Students, while requesting support from university services more generally, still experience social barriers – not helped by the ‘crisis narrative’ – and so the expansion of alternative means to provide support via a ‘whole university approach’ needs to be encouraged.

List of abbreviations

AI – Artificial Intelligence

AMHP – Approved Mental Health Professional

ASYE – Assessed and Supported Year in Employment

AYPH – Association of Young People's Health

BAME – Black, Asian and Minority Ethnic

BASW – British Association of Social Workers

BBC – British Broadcasting Corporation

CTO – Community Treatment Order

CQC – Care Quality Commission

DfE – Department for Education

DSM – Diagnostic and Statistical Manual

EqA – Equality Act 2010

FiF – First in Family

GAD – Generalised Anxiety Disorder

GDPR – General Data Protection Regulations

HEA – Higher Education Academy

HEI/HEIs – Higher Education Institution(s)

ICD – International Classification of Diseases

LGBTQ+ – Lesbian, Gay, Bisexual, Trans(gendered); Queer, plus[1].

LHU – Liverpool Hope University

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[1] The '+' is an important addition acknowledging that there are varied other identities related to sexuality and gender that also form part of this community.

MHA – Mental Health Act 1983

NHS – National Health Service

NUS – National Union of Students

ONS – Office for National Statistics

OfS – Office for Students

PTSD – Post Traumatic Stress Disorder

RCP – Royal College of Psychiatrists

SWE – Social Work England

SWS – Student Welfare Services

UCAS – Universities and Colleges Administration Service

UMHAN – University Mental Health Advisers Network

UMHC – University Mental Health Charter

UUK – Universities United Kingdom

VLE – Virtual Learning Environment

WHO – World Health Organization

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Chapter 1: Introduction

1.1 Preamble

The introduction will provide the context for this study. Addressing a topic area, *mental health,* that has been described as having ‘more complexity than could be explained in a full history, psychology and medical degree curriculum’ (Hughes and Spanner, 2024, p.9) is a challenge, with key writers in this field acknowledging the diversity of theoretical frameworks that contribute to this subject (Cohen, 2018; Rogers and Pilgrim, 2014). That said, this chapter will provide clarification about my research decisions, how these relate to my own positionality – a social and critical approach – and the overall purpose of the project.

The initial sections will set the scene, beginning with a summary of the overall aims and objective; the research design; the rationale for the study; and the research questions. This is followed by an overview of my own background and how this has influenced my interest in this topic area. Further context will be provided with a brief history of *madness* and the development of modern psychiatry, including the systems of classification. The theoretical underpinning – *poststructuralism* – is summarised, followed by a scrutiny of the complexities of language – this also contains a summary of the terminology that will be used for this thesis – and the interplay with stigma.

The next parts will focus upon the emergence of anti-psychiatry and critical mental health. There will be a concise overview of key critical perspectives of mental health, and how anti-capitalist, postcolonial, and feminist perspectives intersect as well as offering their own distinct frameworks; the overlap with Disability Studies; then ending with more current theoretical frameworks, including service user/survivor movements and Mad Studies. It is important that I make it apparent that critical perspectives do not deny the experience of distress – as my lived experience includes – however sit within a lens that I will frame as *critical mental health* (see Cohen, 2018).

This is all situated within the backdrop of an evolving higher education sector (see *Rationale for the study* below), that, along with a detailed overview of what it means to be a university student will be addressed further in the following chapter – the *Literature Review*. It is important that the introduction places the study within the broader historical, and contemporary context of the evolving discourse and societal meanings of mental health, distress and wellbeing. The later *Analysis* chapter will draw upon these intersecting critical positions to do justice to this topic area highlighting the myriad of complexities and contradictions that permeate this subject.

1.2 Aims and objectives

The overall purpose of this research is to provide a snapshot as to how university student welfare services are responding to the known increase in demand from students for mental health support (Oswalt et al, 2020; Sanders, 2023). While research with students seeks to place this in context (Thorley, 2017; Sampson et al, 2022), there are limited publications that hear from the providers (Osborn et al, 2024), and so this project seeks to address this gap (see 1.4 Rationale for the study for further explanation). The thesis will be presented with given context to both historical and contemporary understandings of what we mean by mental health, distress and wellbeing. The complexities and overlap with language and discourse will feature throughout, supported by a poststructuralist lens and an engagement with the varied strands of critical mental health perspectives. I have intentionally incorporated a direct quote from one of the participants – ‘A mental health tsunami’ –within the title (further explanation is covered within the *General Discussion* chapter). I have done so to illustrate the competing perspectives about the phenomenon, and while the rest of the title suggests a challenge to this perspective – as will be examined drawing upon the highlighted theoretical frameworks – I will not be dismissing any individual viewpoints.

My focus is to examine how university student welfare services are responding to the known increase in demand over recent years. This will be explored with the backdrop of a changed higher education sector, and how SWS are placing their services within marketised, neoliberal provision. In addition, the analysis will highlight the scope of the varied guidance, research and policy frameworks published over recent years. It will explore how HEI student welfare services are adjusting to the increase in help-seeking behaviour, within the broader context of the marketisation of education and the demands this creates – the boundaries of what SWS can and/or should provide will be discussed in later parts. While not seeking to quantify the causation of increased support seeking, it will consider underlying influences, noting the additional pressures placed upon students amidst the evolved HEI sector. The *Literature Review*, will summarise how students are making sense of their identities within an exploration of overlapping intersectional characteristics.

An underpinning feature will critically examine how the language and terminology framing mental health/wellbeing within the HEI sector reflects (or otherwise), the broader societal discourses. Specific attention is paid to the *crisis narrative* that is being applied to the experiences of university students, with an exploration of wider influences – this will feature throughout, rather than being contained within a limited discussion. While increased take-up of provision and self-reported distress is a known trend (Oswalt et al, 2020), it is still unclear whether there is an elevation of actual distress, or whether this relates to other factors, including increased recognition (Knapstad et al, 2019). I will not be taking a fixed position as to whether student mental health is indeed a *crisis*, however I will be expressing some perspectives. The *crisis narrative* adds an important dimension to the broader picture, and as such will be addressed within the literature review (chapter two), analysis and general discussion (chapters four and five), as well as my concluding thoughts (chapter seven).

It is hoped that the findings (see chapter 4: *Analysis*, and 5: General *Discussion*), and the following recommendations (see chapter 6) will have an impact. These may support closer collaboration between providers – within the higher education sector and health provision – both locally or nationally; or at least raise some further awareness of the intricacies of this subject for students seeking support.

1.3 Research design summary

Note: the *Methodology* chapter will expand upon the below, providing a clear justification for the research choices.

I needed to engage with a research design that suited my positionality while enabling a meaningful analysis of the data. The data was gathered through semi-structured interviews with university student welfare leads. This method (see *Methodology*, section 4), underpinned the aims through open dialogue that addressed the research questions. The interviews supported an exploration of the current picture via questions that enquired about both professional and personal thoughts, encouraging participants to illuminate their own meanings and interpretation of the changing dynamic of student help-seeking behaviours.

The data was analysed utilising Braun and Clarke's (2016; 2019, 2022), methodology of Reflexive Thematic Analysis (see *Methodology*, sections 5-7). This approach to data analysis encourages a subjective interpretation of the data, drawing upon researcher positionality and theoretical perspectives. RTA also harmonises with the underpinning poststructuralist framework, in that meaning derived from data is open to interpretation given its time and social context.

1.4 Rationale for the study

This part will introduce the overarching context of the United Kingdom (UK) higher education sector and suggest how these developments have changed the nature of being a university student. It will then introduce research relating to what we currently know about student mental health and wellbeing. Elements of this will be explored further within the *Literature Review* – including a focus upon intersectional aspects of identity – with both of these chapters informing the later *Analysis*.

1.4a The higher education context

There have been discussions in relation to student mental health dating back to the 1940s with many of these correlating to the specific student profile, experience, and environment at the time (Crook, 2020). To place current student mental health in context, there is a need to consider the substantial changes to UK universities that have developed over the previous three decades. The changes to higher education introduced through consecutive governments since the early 1990s (O'Byrne and Bond, 2014), has resulted in significantly higher numbers of young people accessing university, doubling since 1992 (ONS, 2016). Concurrently, the evolution of universities, enforced via the introduction of tuition fees in 1998 (Richardson, 2013; Thompson et al, 2022), has changed the conception of what a university actually is, with the higher education sector now being part of a neoliberal consumer-provider model (O'Byrne and Bond, 2014).

The introduction of student loans as an alternative to maintenance grants by the 1990 Conservative Government represented the early stages of the shift of financial funding for university degrees from central government to the individual student and their families – resulting in the burdening of graduates with substantial debt (Humphrey and McCarthy, 1998). Developments were continued by the New Labour governments' two stage approach to changing the face and experience of higher education, all influenced by the Dearing Report (1997). This report made recommendations for the fundamental reshaping of higher education, that ultimately paved the way for the introduction of tuition fees (Bennett, 1997).

Part of the reformation of higher education involved the expansion of institutions, including all former polytechnics, that were afforded university status during 1992 (Grayson, 2023). This has seen university student numbers more than double in this time, from one million to over two million (ONS, 2016). This was also a driver for widening participation for many people who may not have previously considered going to university, and this included students with existing mental health needs (Bryant et al, 2022). While this came with many positives, over the longer term there is evidence of disparities in experience, including for those students with existing mental health needs, or with students from lower income backgrounds experiencing higher unmet support needs than other students (Cullinan, Walsh and Flannery, 2019).

The introduction of tuition fees (initially set as a £1000 contribution) in 1998 (Denovan and Macaskill, 2017), for many signalled the permanent end of free education for university students. Since this time, funding for universities has continued to transfer from government via the substantial increases in fees, thus leading to higher stress associated with this enhanced financial burden (Richardson, 2013). The changing nature of Higher Education Institutions (HEIs), to an industry that sells degrees as a 'product' that students purchase, is being driven through competition and results-based league standings (Thompson et al, 2022). With HEIs now modelled within the consumer/provider market, their 'offer' also now includes wider student services, including student welfare. This has also been evidenced through the recent increase of ranking student welfare services (SWS) (HUMEN, 2022) – mirroring the well-established national HEI league tables – and with questions relating to HEI mental health support being asked in the National Student Survey (NSS) – the UK wide survey of all undergraduate final year students (NSS, 2024).

1.4b The student context and wellbeing

Young people are identified as a high-risk group for the onset of more significant mental health needs, with 75% of those with life-long wellbeing challenges identifying the emergence of their initial symptoms occurring before the age of 24 (Brown, 2016; Macaskill, 2013). These figures relate to those with more substantial/longer term needs, and this group is identified as only increasing by a small amount (OfS, 2019). However, younger people in general are at increased risk of poor mental health/wellbeing (Bryant et al, 2022), and with two-thirds of higher education students aged 24 or younger, the vulnerabilities of this group of emerging adults, alongside their student specific needs, requires attention (Barden and Caleb, 2019; Student Minds 2024c).

Andrews and Wilding's (2004) study highlighted initial connections between the financial commitment, and stress caused through the expectations of academic performance. With students now potentially graduating from their studies with upwards of £50K in debt (Shackle, 2019), this has, inevitably, changed the student experience overall, with links between debt and distress being identified for some time (Cooke et al, 2004; Macaskill, 2013). If once, going to university was seen as a privilege (Humphrey and McCarthy, 1998), to study subjects of personal interest, many now simply see it as a means to gain the best degree award, and then seek the highest paid employment in order to justify the extensive investment and to be able to repay their debt. With grade achievement being the key motivator, this may then divert students towards prioritising ‘outcomes’ above seeking deeper meaning in what they are studying (Hughes and Spanner, 2024).

There are additional noted broad pressures upon all young people – including the climate crisis and lack of affordable housing – in addition to specific stressors upon the student population (Stones and Glazzard, 2019). Mirroring headlines that young people's mental health is in ‘crisis’, this narrative has also been applied to the HE student population within the media, research, and reports (Bewick and Stallman, 2018; Vogt and Johnson, 2022). The above has clearly contributed to an increased impact upon wellbeing, demonstrated – as will be explored in the *Literature Review* – through various research reports and policy. The substantial increase in demand for support from student welfare services has been noted by the sector and student bodies over recent years (Sanders, 2023). In response, there have been targeted campaigns and guidance to support HEIs to respond to these changes (Hughes and Spanner, 2024; UUK, 2023a).

1.4c The university as mental wellbeing provider

Increases in demand for student mental health support continues to be noted by universities who report that the significant upsurge in needs are stretching resources (King et al, 2024). Research and reports have, for some time, identified and promoted a ‘whole university approach’, with the need to embed a more inclusive, flexible and safe service (Stanley and Manthorpe, 2002; Royal College of Psychiatrists, 2011). More recent texts (Barden and Caleb; 2019; Stones and Glazzard, 2019), and sector-led publications (Hughes and Spanner, 2024; UUK, 2018), highlighted increased concerns and gaps in provision – these include inconsistent responses between shared health providers; disjointed information about what support is available and for whom; and accessibility for those with intersecting aspects of identity (these are all given further attention below) – calling for urgent and positive action. The development of the University Mental Health Charter (Hughes and Spanner, 2019; 2024), has brought this all together with clear evidenced based guidance for the sector to drive forward whole university approaches – see *Literature Review*, section 2.10.

Despite this, there have been identified gaps in research noted for some time. The UMHC (Hughes and Spanner, 2024), continues to identify the limited research in respect of the effectiveness of SWS provision. HEI self-reporting of SWS effectiveness is often based on student surveys at the start and end of intervention, rather than independent studies (Nazari and Ommen, 2019). Osborn, Saunders and Fonagy (2022) suggests that outside of the USA, studies are limited in exploring students' access to services, and details about collaboration between support providers. Some existing studies focused on specific ‘conditions’ and so missed common concerns that are now being given greater attention, such as the impact of loneliness (Oswalt et al, 2020; Wonkhe, 2019) upon students’ wellbeing (see 2.2 for further details). Others have noted that data collection/publications in respect of student mental health and wellbeing remains inconsistent (Francis-Taylor et al, 2023); with limited reports about how students’ are self-reporting their distress (Knapstad et al, 2019); and minimal evidence to compare on-site SWS services with wider community provision (King et al, 2024).

In respect of this project, there is a dearth of research literature that hears the voices from those working in SWS (Osborn et al, 2024); and/or how services are coping with the increased demand (Nazari and Ommen, 2019). While one student mental health report (Pollard et al, 2021), engaged directly with HE providers, and concluded with valuable recommendations – such as the need to develop clearer overall strategies – it had as its focus what HEIs do and can offer, rather than hearing how they are managing the increased demand. This is a significant gap as the literature addresses the need for strategic action from HEI leaders to effectively respond to student mental health needs and broader wellbeing (Stones and Glazzard, 2019; Hughes and Spanner, 2024) – this project will seek to help address this gap. Silverman (2000) stresses the need for a theoretical foundation with research that explores human behaviours, and so while some empirical research examines student help-seeking behaviours, it has been argued (Hunt and Eisenberg, 2010; Osborn et al, 2024), that many of these lack a theoretical foundation to scrutinise what is needed to change on a macro level. The available literature in respect of university provision shall be explored further in the *Literature review*, section 2.8.

1.4d Rationale summary

In response to the above rationale, this project seeks to explore how those that lead SWS services are managing the transforming environment of student mental health and support seeking behaviours. Those that work in SWS are provided with evidence-based direction to evolve their provision in order to be able to meet the needs of students within the changed HEI sector. That this is taking place with the context of additional pressures to be clear about the scope of the limits of their provision, and with an increasing demand to perform well in league tables, this will be enhancing known strains on their services.

The voices of those at the ‘coal-face’ need to be heard, and importantly need to feed into future direction and guidance – both locally and in respect of national strategies. (Note: There are reflections in later chapters – most significantly 3.6b – that clarifies that several of the leaders of SWS are still completing direct support work with students). The interview questions (see *Appendix Three*) were designed to enable both professional and personal perspectives from those leading SWS. They were designed to address some of the areas where there are gaps in research – such as perspectives on collaboration, and newer conversations, including the impact of loneliness (these are given additional explanation within the Methodology and Analysis chapters). The research questions (below) support the case for this project, requiring the inclusion of key aspects of the wider picture – including the influence of national guidance, and also the *crisis narrative* – citing the ongoing impact of stigma, and seeking to pick-apart meaning behind increased demand. The gap noted (in 1.4c) with theoretical perspectives informing student mental health and help-seeking behaviours, will be embedded throughout this and later chapters.

1.5 Research questions

Main research question:

How are UK higher education student welfare services responding to the perceived 'crisis' with student mental wellbeing?

Sub-questions:

- *What are the influential factors in the surge in demand for mental health services from universities?*
- *How do attitudinal barriers, including stigma, continue to manifest?*
- *How may the language and discourse of mental health and illness impact upon provision and help-seeking; How might the framing of this issue as a 'crisis' impact upon support?*
- *How does national guidance, policy and related research promote and/or support SWS responses to the increasing needs of students?*
- *How are HEI student welfare services adapting their provision in light of the above?*

1.6 My background

It is important to discuss both my personal and professional background and how these have influenced this project, including the research design. I have placed this early on as my background has fundamentally informed my interest in this subject area, and therefore my choices – this attention will support the broader context of the aims and objectives.

I began my undergraduate degree aged 18 in 1992. I very much enjoyed both the academic and social aspects of life as a university student, having a network of good friends. However, towards the end of year two and throughout the final year I experienced a change. I was no longer socialising as much, missed a lot of classes, and spent extended periods asleep or in bed.

This low mood and lethargy, coupled with anxiety would almost certainly have been diagnosed as depression, however, I did not seek medical support. I also chose not to talk about this with my friends due to perceived stigma, rather, settling for jokes from them about my ‘laziness’. I was not aware if there were any student support services for wellbeing at this university – probably, at the time reflecting universities more broadly. Concerned about the amount of teaching I had missed, I chose to confide in my personal tutor. While interested, there was no suggestion that they could refer on, or at least provide some information about support services. The tutor basically stated that this must have been a difficult time for me – that is not to say they did not care, it simply reflects the dearth of support services at the time.

I understood what was influencing this change in mood, namely a combination of childhood experiences, and with coming to terms with my identity as a gay man – this was happening at a time prior to the internet; without knowing another openly gay person; a scarcity of positive role models on television; and an openly homophobic Conservative government with many anti-gay laws – including at the time, Section 28 of the Local Government Act 1988 (see Baker, 2022). After ‘coming-out’ with the thankful support of friends and family, my mood improved. This was in the remaining months of my degree, however I know for certain that these experiences impacted negatively upon my final degree award. Despite improvements in legislation and societal acceptance, discrimination based on sexuality and gender identity remains for lesbian, gay, bisexual, trans and queer+ (LGBTQ+) students (Smithies and Byrom, 2018) – further details in the *Literature Review*.

My professional experience in social care began in the following year, with support worker roles across day services and supported housing projects for adults with learning disabilities. I moved to Merseyside (where I remain), in 1998 to complete the MA Social Work. Once qualified, I spent a few years working for local authorities in specialist teams for adults with learning disabilities (LD). In 2005, I qualified as an *approved social worker* converting to an *approved mental health professional* (AMHP), following the changes introduced by the Mental health Act 2007. An opportunity arose to move into a community mental health team, where I remained until I joined Liverpool Hope University (LHU) in 2016. LHU were keen for me to maintain my AMHP role, and so I was seconded to my former local authority to complete shifts on their rota for 1-2 days per month. This continued until 2024, since when I have opted to take a break from this role in order to focus on my studies.

While at times I continued to experience anxiety throughout my professional career, I found ways to manage this. The main problem was more the physical impact of anxiety, in that I experienced significant, sometimes chronic symptoms of fatigue – a response to the body 'coming-down' from being flooded with anxiety related hormones. Following a life event in 2013, I began to have new, and at times, frightening thoughts. This was feeling unmanageable, and so, for the first time, I asked for support from my general practitioner. This resulted, after a fifteen-minute consultation, in a diagnosis of *generalised anxiety disorder* (GAD), with associated depressed mood, and a prescription for antidepressants. I was never comfortable with the diagnosis of GAD – I would not be happy with any – so I choose not to use it, opting to tell the people I wish to, that I can struggle at times with feeling highly anxious. I do not feel I have a 'disorder', rather that my feelings stem from a series of life events that, since childhood, have caused me to worry a lot about many things. The 'generalised' in GAD is supposed to imply a constant state of worry (Foulkes, 2021), however this isn't the case with me and so I do not identify with it.

Despite this, GAD sits on my medical record because, since this time, I have continued to take the antidepressant. While certainly not a cure, it does, at times, dampen the feelings of anxiety, with the main benefit – and the main reason I continue to take it despite some negative side effects – that I no longer have the associated fatigue. I have also had primary care counselling and paid for private therapy, although I have never been open to secondary mental health services.

During my professional career as a social worker, I have witnessed coercion and control playing out in various forms. These have included observing people being told that they will not be discharged until they agree to take anti-psychotic medication; people being prescribed medication without being told what it is, how it may (or may not) help, and which side effects they will have; people being ignored and judged while in hospital, leading them to become passive recipients of care; people attending ward reviews with many other professionals (often student nurses of trainee psychiatrists) without being introduced, while at the same time being discouraged to appeal to the Mental Health Review Tribunal under the false promise that they will be discharged soon. More recently, I have noted the overuse of Community Treatment Orders (CTOs), being applied to people following a first admission, and also as a means to free up beds, contradicting the original intention for CTOs to be considered for a limited number of people to manage known ‘high-risk’ to self or others (DeRidder et al, 2016).

For the past nine years I have been teaching social work at degree level. My interest in the topic of mental health has evolved and developed since working at a university, and, among many other topic areas, I teach various perspectives of mental health, including critical models. It is also important to say, that once I had stepped outside of day-to-day mental health services (despite remaining as an AMHP), and looked back in, I can truly see the power of the dominant psychiatric medical model, and also how at times, I was absorbed and institutionalised into it.

Both my personal and professional background have fundamentally influenced the decision to research this topic area in several ways that will be discussed in further chapters. Within this relatively short period as a lecturer, I have noted an increase in students having a diagnosis that features in their learning support plans. This is backed up through noted increases in declarations on Universities and Colleges Administration Service (UCAS) applications, as well as highlighted in research reports (UCAS, 2023; Cibyl, 2024). It is not apparent who is providing these diagnoses; however, it suggests that some may receive this privately, and others self-diagnose perhaps using online ‘symptom checkers’ (Tse and Haslam, 2024), or indeed using artificial intelligence (Wimbarti, Kairupan and Tallei, 2024). There are current discussions about the growing prevalence of self-identification that adds to the inconsistencies and contradictions with the language of ‘mental health’ – this will be addressed further in 1.7 below.

1.7 A 'very brief' history of *madness*

Meanings of mental *health*, *distress*, and *illness* have been framed and discussed in many ways over the centuries, largely shaped by geographical and cultural factors (Scull, 2015). For example, in parts of Africa and southern Asia, mental distress has generally, and continues to be addressed from a social perspective, whereas Western approaches remain firmly rooted in the biomedical model (Fernando, 1991) – the development of the medical model via the foundations of psychiatry is addressed in 1.8 below.

Prior to the foundations of Western psychiatry during The Enlightenment – spanning the 17th and 18th centuries – (as detailed in the following section), people expressing mental distress would often be considered as having magical or divine powers, usually linked to religion, and were revered in some communities (Stone, 1998). Equally, many others were accused of being possessed by demons, labelled as a witch (see 'Feminist Perspectives' section below), and/or in partnership with the devil, and suffered severely as a result (Porter, 1989). Early, ancient 'treatments' for mental distress would sometimes focus on therapeutic approaches such as music or 'good counsel' (Rogers and Pilgrim, 2014). However, more commonly, treatment concentrated upon the body as the origin of the distress, mirroring early Greek remedies for physical health, such as bloodletting, or purging of the four humours (Scull, 2015). While some aspects of the early Greek approaches were diluted over the centuries, some of the concepts remained for treatments through to the Middle Ages, where religion became the dominant force (Croydon-Smith, 1982). For example, evidence of trepanning – boring a hole in the skull and removing a part of the brain to 'cure' madness – exists from the Reformation (ibid.) This practice can, however, be argued to have remained an accepted operation into the early-mid 20th century under the 'treatment' of lobotomy (Scull, 2015).

People in the sixteenth and seventeenth centuries expressing mental distress were either free and accepted within communities, or contained – alongside criminals, people with various impairments and other people that the societies of the time deemed unworthy such as alcoholics and prostitutes – within workhouses or early forms of asylums (Pilgrim, 2014). Distinctions in law (within the Vagrancy Act 1744 and the Poor Law Amendment Act 1834), were made between the ‘pauper lunatic’ and the ‘dangerous lunatic’, with the result that ‘paupers’ were sent to workhouses and ‘dangerous’ people to asylums (Scull, 1982).

Possibly the best known of these was Bethlehem Hospital (originally founded in 1408), later shortened to ‘Bethlem’, providing the etymology for the term ‘bedlam’ (Porter, 1987). People in distress were often tied in shackles or caged for long periods, and, for some time, Bethlem hospital was treated as a place for tourists to visit, allowing the public access to view people in distress as they would animals in a zoo (Gilman, 2014). One patient, James Norris, who had spent over 12 years in shackles with an iron ring around his neck, was discussed within a parliamentary select committee in 1815, and, along with campaigns from concerned groups, influenced early debate about how to treat distressed individuals (Porter, 1987). This helped shape new legislation, specifically the Lunacy Act 1845, that established compulsory asylums (with clear record keeping), with a view to moving people with mental health needs away from workhouses and prisons, and relabelling people as ‘patients’ (Scull, 1982).

At the time, many regarded these changes as positive, however this new legislation prompted the growth of the Victorian asylum, identified by large-scale structures, with the ability to admit hundreds or thousands of patients, set within an enclosed community (Scull, 1982). Foucault (1967) referred to the substantial rise in people confined to asylums during the 19th century as ‘the great confinement’, with numbers incarcerated increasing from a few thousand to 100,000 over the course of the century. Inpatients within asylums in many ways were treated as prisoners, with locked doors, strict routines, and widespread abuse (Porter, 1987; 1989).

Admission to the Victorian asylums continued to be the standard form of treatment during the early-mid 20th century, becoming (after some debate) part of the new National Health Service (NHS) in 1948 (Pilgrim, 2014). Changes to how society viewed mental health/illness began to shift during the early part of the 20th century, in part through the emergence of psychotherapies refocusing causation towards the ‘social’ and ‘familial’, rather than medical; and with the large numbers of young men returning from World War One expressing severe distress, later labelled as ‘shellshock’ – now termed post-traumatic stress disorder (PTSD) – resulting in this type of distress being more visible, and having commonalities within families and communities (Walker, 2013).

Despite this, the deficiency model predominated, demonstrated through the mid-20th century with inpatients being treated as *guinea pigs* for psychiatrists competing to develop ‘revolutionary’ treatments. So-called ‘breakthrough’ treatments included insulin comas, lobotomies, and the introduction of electro compulsive therapy (ECT), often resulting in life changing trauma (Scull, 2015). The backlash to these practices, helped to drive the emergence of the various thinkers/writers that fall under the umbrella term of ‘anti-psychiatrists’ (see section 1.10 below).

This all influenced further changes in legislation, specifically the Mental Treatments Act 1930, that legislated for available treatment for people as ‘outpatients’, introducing the concept of ‘community care’, and for voluntary admission to hospital. The first version of the current Mental Health Act in 1959 introduced independent safeguards for those being assessed for compulsory detention and treatment (Rogers and Pilgrim, 2014). These legislative developments ran alongside evolving notions of mental health and distress, all amid the heightened stature of psychiatry.

1.8 The development of psychiatry and classification

The early foundations of psychiatry during the 18th century ‘Enlightenment’ period, focused upon replicating the growth and status of medicine for physical health seeking to present itself as a legitimised arm of medical science, with a shifting away from religion as the source of treatment (Stone, 1998). ‘Rational’ approaches to medical treatment mirrored the other societal challenges presented through the ‘age of reason’ by philosophers, writers, and theorists (Kenny, 1998).

Prior to the foundations of the systems of classification used today, 18th century asylum records indicated that the social causes for people’s distress were cited, such as relating to personal trauma, relationship problems and dependency on substances

(Scull, 2015). Phillipe Pinel, an 18th century French physician – who some regard as the founder of modern psychiatry – argued for a more humane treatment for people experiencing mental distress, making connections to social and family causes and away from biology (Porter, 1987). However, while promoting more 'moral' treatments, he remained a strong advocate for the asylum as the place most likely to provide a 'cure' (White in Cohen, 2018).

The roots of the dominant medical discourse of mental health and illness are aligned to the foundations of psychiatry (Scull, 2015). For psychiatry to present itself as equally legitimate as medical diagnoses and treatments for physical health needs, it has had to seek to shore itself up with 'evidence based' practice, resulting in the current systems of classification (Bentall, 2009; Davies, 2013). Pinel (among others) developed an early system of classification, proffering the term 'melancholia', along with the three further categories of 'dementia', 'mania' and 'idiotism' (Stone, 1998). Other taxonomies were developing across Europe, retaining common terms from Greek physicians (Scull, 2015), however there remained sharp divisions in approach between those considering societal influences and the purely bio-neurological advocates (Rogers and Pilgrim, 2014). One of the key exponents of the latter camp, Emil Kraepelin, a German clinician working and studying in asylums, proposed a purely scientific approach with a focus upon genes and the brain as the causes of *pathology* (Davies, 2013). Kraepelin introduced the term 'dementia praecox' – a precursor to schizophrenia – seeking to develop a standardised nosology of types of mental illness (Scull, 2015). Kraepelin's work, including the later splitting of 'dementia praecox' into types, were highly influential for the medical based categorisation of mental *illness*, that is very much reflected in the current diagnostic tools still used today.

The various early versions of the International Classification of Diseases (ICD) were far in advance of mental *illness* classification, with chronicles published through Europe and the United States in the latter parts of the 19th and early 20th century. Following the foundation of the World Health Organisation in 1948, this body was tasked with updating the ICD (to version 6), seeking to standardise practices across the world, and, significantly, for the first time included a chapter dedicated to mental disorder (Scull, 2015). The ICD (WHO, 2021), now in its eleventh revision, is used today as the lead diagnostic tool for psychiatrists to diagnose and label mental disorders. The USA has their own version, the Diagnostic and Statistical Manual (DSM) (APA, 2022), that while in many ways largely mirrors the ICD, contains some key differences. The ICD covers all disease categorisations, while the DSM is for mental *disorders* solely. Despite this, authors of both versions have collaborated during revisions resulting in established commonalities.

Unlike scientific/medical approaches to physical health that are rooted in evidence-based positivist studies, psychiatric practice continues to be based around the diagnostic tools of the DSM (APA, 2022), and ICD (WHO, 2021). Both texts are utilised throughout the world (with some exceptions, such as China having its own version), and both work by applying a diagnostic label based around a list of presenting symptoms – with no scientific foundation to legitimise its supposed positivist facts (Gomory, Cohen and Kirk, 2023). While the aetiology of biological disorders has a foundation in proven science, the application of a mental 'disorder' diagnosis is based solely upon presenting symptoms and a 'matching method'. Research suggests that diagnostic outcomes can vary greatly, up to 42 percent of the time, between psychiatrists (Davies, 2013).

Each revision of these diagnostic tools involves a moving of goalposts (Foulkes, 2021), with some *disorders* removed and others added. While critical mental health, over the past five decades has sought to challenge the structures and practices of psychiatry from various perspectives, there has been no suggestion that the current conventions are under threat, or seeking reform, with the World Health Organisation revising the ICD frequently, continuing to ratify mental disorder diagnostics as equal to physical/biological (WHO, 2021). While critical voices support a social and 'symptom first' approach, the ongoing status of psychiatrists placing themselves above the individual is summarised neatly in this quote,

> 'Without a classification system the necessary economical communication with colleagues to convey information becomes a lengthy description of clinical problems that is self defeating' (Tyrer, 2014, p.280).

1.9 Language and terminology

A starting point is to acknowledge that all terms associated with mental health, wellbeing and distress are contested (Cohen, 2018: Foulkes, 2021). I will be approaching this whole topic area from the perspective that the terms mental *health* and mental *illness*, as well as notions of *wellbeing* are social constructs, dependent upon political, societal, historical and cultural understandings – further details in the *Methodology* chapter. ‘Wellbeing’ itself is clearly subjective and creates irregularities with attempts to measure this within populations – including the student population (Dodd et al, 2021). Medicalised language seeps into everyday usage, such as with a simple example of a person stating they are ‘depressed’ when they have received bad news (Foulkes, 2021).

While acknowledging that many regard mental health and wellbeing as independent constructs (Dodd et al, 2021), I am opting to use the overlapping terms of mental health, wellbeing, mental health needs/struggles, and mental distress where appropriate. Coming from a critical position, I will generally avoid the language of mental disorder and illness; while acknowledging for some, these are important distinctions for their own lived experience. Where these terms do feature, they will relate to applications of the medical model of psychiatry. All terms are subject to debate, and as will thread through the thesis, the tensions between the dominant medical and social/critical models will be addressed. I will also, where it feels apt, use *mad* and *madness* as a poststructuralist response to societal misrepresentations of distress.

Language and discourse, while fluid, are an essential component of this study, as suggested by the title and research questions. During the exploration of this topic area, particular attention will be paid to the *crisis narrative.* It is accepted that terminology boxes people into categories, placing them within a broad framework of power/powerlessness as a ‘mentally ill’ person with all the associated stigma, stereotyping and othering that follows. Despite this, self diagnosis and identification appears to be increasing, and in response there are emerging debates in respect of this.

These include notions of ‘concept creep’ – that increases with public conversations results in people self-diagnosing with medicalised terms (Haslam, 2016; 2024); ‘looping effects’ – with the suggestion that people take on role expectations once given a label (Foulkes, 2021); or ‘prevalence inflation hypothesis’ – a cyclical model that counters the potential benefits of awareness raising, with overinterpretation, and therefore self-labelling of common experiences (Foulkes and Andrews, 2023). Part of this wider development of the expanded conversation relates to how social media, apps, and indeed AI are contributing to the above concepts (Tse and Haslam, 2024; Wimbarti, Kairupan and Tallei, 2024). Not all agree, with counter arguments that the benefits of greater awareness far outweigh potential risks (Cascardi and Brown, 2016); or that models such as ‘prevalence inflation hypothesis’ may minimise beneficial understandings of individual experience (Ning, 2015). To note, addressing these concepts is important as part of the wider discourse, however by doing so does not seek to diminish the individual lived experience of poor wellbeing/distress.

The *Analysis* and General *Discussion* chapters will draw upon the above conflicts and contradictions with mental health language and discourse, not least because these were identified as important influencing factors by the participants. In order to maintain a questioning and reflexive stance about language, and the meaning society gives to expressions of mental health, I have drawn upon *poststructuralism*, and specifically a *Foucauldian* approach to provide a theoretical underpinning.

1.10 Theoretical underpinning: Poststructuralism and Foucault

The research questions have been intentionally developed to appear ‘open’, enabling an analysis of the multiple interpretations of the topic more widely, and also specifically in relation to the current higher education landscape. Broadly, poststructuralism proffers that *meaning* is not fixed (as assumed by structuralists), rather, it is produced and reproduced in-line with evolving language and discourse (Fook, 2016). Poststructuralism can be said to have origins in the civil rights movements, with the seeking of emancipation from oppressive structures based on race, class, gender and sexuality (Easthope, 1991).

Michel Foucault, while not usually grouped together with the other ‘anti-psychiatrists’, was influential in providing a critique of psychiatric practices as part of his wider philosophy regarding power and structural oppression – this informed strands of poststructuralism (Fook, 2016; Smart, 1985). He argued that those subjected to a judgemental ‘inspecting gaze’ will internalise these feelings, performing expected roles to the point where they become normalised without a ‘moral’ oversight (Danaher, Schirato and Webb, 2000). Foucault names psychiatric treatment as a ‘technology (or mode) of power’ arguing that the authority afforded to the profession enables division and oppression of those subjected to these processes (Foucault, 1988). Within one of his key works, *Madness and Civilisation* (1964), Foucault built upon some of his earlier themes with a focus upon how societal discourse constitutes power structures within a given time, specifically through the ‘othering’ of those labelled as mentally ill. This text can be viewed as a merging of social constructionist frameworks, consolidating sociological and historical developments with the growing categorisation and organisation of *madness* (White in Cohen, 2018).

Foucault pursued the notion that psychiatry had sought to function for the benefit of the bourgeois, by removing the ‘problem’ via the segregation of mental ‘illness’ through incarceration into asylums, (Rogers and Pilgrim, 2014) – noting that these were generally built a significant distance away from populated towns (Banton et al, 1985). While Foucault’s focus was that this was driven by a middle-class ‘moral regulation’; others, such as Scull, (1977, cited in Rogers and Pilgrim, 2014), while agreeing this practice served the middle-class, viewed this in merely economic terms via the removal of those who cannot produce capital.

Foucault’s importance to critical mental health is that he identified the regimes of power and technologies of differentiation used to subjugate via the ‘othering’ of people into the binaries of 'well’ and ‘ill’ (Danaher, Schirato and Webb, 2000). Technologies of power in mental health services include the psychiatric diagnostic tools (see 1.6), and more broadly imposed via the assessment and support planning tools, and within the eligibility criteria in the legislation. Foucault (1977) suggested that social workers apply power in their interactions with the people they support, exposing people to the ‘risk management’ surveillance of the state (Barnes and Mercer, 2003; Chambon, Irving and Epstein, 1999).

In his later period – including within his text *Madness and Civilisation: A History of Insanity in the Age of Reason (*1988) – Foucault built upon his foundational work and discussed the need to resist authoritarian structures; that power conversely supports this as a creative force, and that professionals, such as social workers, have a role in this 'social activism' (Irving, 2009). He suggested the need for an ongoing questioning of systems of thought and accepted 'truths', and that this can support resistance (Chambon, Irving and Epstein, 1999). An example of this resistance can be seen in the campaigns, literature, and self-organisation of survivor/user groups, and the reclamation of the meaning of 'recovery' (see 1.11f below) (Beresford, 2016). More recently, Nikolas Rose (1998) has built upon Foucault's earlier work, specifically focusing upon the other 'psy-' professions – namely psychology and the psychotherapies – as apparatus of social intercourses that seek to align 'moral' behaviour with the social and political positions of the therapists (Rogers and Pilgrim, 2014). A poststructuralist/neo-Foucauldian perspective will underpin this thesis, supporting the multifaceted critique of the language and discourse of mental health, distress and wellbeing; and how these factors continue to contribute to stigma.

1.11 Stigma

The etymology of the word 'stigma' can be traced back to the ancient Greeks, associating negative traits with mental distress (Martyn and Thompson in Bolt, 2021). The term developed into common parlance, deriving from 'stigmata', the physical scars on North American slaves delivered through whippings and brandings, often referred to in descriptive posters for escaped slaves by their owners (Tyler, 2020). Its meaning today relates to judgements made towards aspects of a person's identity that do not fit with society's expected norms. This can be observed in the micro – including looks, postures, words – or macro levels through restricted access, controls and reduced human rights (ibid.). The power of stigma relies upon accentuating differences, usually involving a binary perspective with a majority and minority division. This then leads to 'othering' of the minority by those in the majority who seek to secure their privilege (Wilkinson, 2005). Stigmatised attitudes are then produced and reproduced within the self, and in both perceived and actual public or societal forms, including media representations (Carmack et al, 2018; Wahl, 1995). Stigmas also evolve over time depending on contemporary political and societal meanings given to identity, and as such need to be addressed as intricate and complex with an intersectional lens (Coleman-Brown in Davis, 2013).

Early theorists addressing mental health stigma, and how this can impact individual behaviours were developed by Erving Goffman (1963), and Thomas Scheff (1966). Goffman developed the notion of stigma leading to ‘spoiled identities’ and how ‘mental patients’ (his terminology), subjected to these processes have to ‘manage’ these identities both within and outside of services (Foster, 2007). Further, Goffman discussed existing or former patients as experiencing a lifelong ‘career’, within which people face daily negotiations on whether to conceal or disclose this part of their identity (ibid.). Termed as ‘passing’, individuals with stigmatised identities – such as LGBTQ+ people or those with hidden disabilities – play out strategies of concealment depending on the social context of normative expectations, particularly when feeling threatened (Ozbilgin, Erbil and Baykut, 2022). While these actions can be seen as defensive or resistive (ibid.), Goffman’s overview of ‘passing’ has been critiqued for his original inference for those stigmatised not to challenge those enforcing stigma, rather to play-out the assigned role (Tyler, 2020).

Scheff’s (1966) labelling theory has two components, that of the ‘social role’, and ‘societal reaction’. With the social role, the service user takes on the given label and ‘acts’ to the expectations of these representations of the mental patient – this creates a societal reaction, leading to rewards from mental health staff, or, in turn, if the patient rejects the role, they may experience punishment in the form of discrimination or poor treatment. Scheff was influenced by Becker’s (1963) perspectives on ‘deviance’, in that he regarded those experiencing symptoms of poor mental health would be considered as ‘violating social norms’. This approach has been critiqued (Foster, 2007), however Scheff does argue that these are involuntary behaviours in response to their label and associated role playing. This is counter to Szasz’s (1961; 1994) assertions, that those presenting with mental distress should be considered as ‘social deviants’ and be ‘treated’ through the criminal justice route rather than as people in need (see 1.10 for further details).

Elements of these earlier theories are subject to critique, (Foster, 2007; Gove, 1975 cited in Sjöström, 2018), namely that they are placed within their given time and societal context, with a focus on those that were treated as inpatients in large institutions. Therefore, cited user ‘behaviours’ are less relevant to current mental health provision – in that services are more community based, and treatment has expanded to include therapeutic and behavioural approaches. Other critiques seek to challenge these theorists’ proposition that all people will act in similar ways and that ‘patient’ behaviour is often stereotyped in their accounts (Foster, 2007; Rogers and Pilgrim, 2014).

However, the medical, diagnostic based model continues to triumph, with evidence that labelling with the prevailing medicalised psychiatric terminology drives negative personal and public perceptions in relation to mental ill health (Wright, Jorm and Mackinnon, 2011; Pederson and Paves, 2014). In addition, the rising rates of compulsory detentions to hospitals under the MHA 1983 since 2005 (CQC, 2018), was explored by the Independent Review of the Mental Health Act (2018). While the Review concluded and published a report with over 100 recommendations, including increasing funding for community and crisis resources, there was barely mention of the impact of austerity (only two references in a 322-page report), and the consequences of reduced community provision.

Community Treatment Orders (CTOs), introduced through the Mental Health (amendment) Act 2007, enforce compliance through the law, and indeed coerce ‘obedient’ behaviour through the threat of further detention – a Foucauldian example of this micro-level ‘technology of power’ enforcing macro, structural levels of control (Lukes, 2021; Chambon, Irving and Epstein, 1999). The far higher numbers of CTOs in usage, represents the power afforded to psychiatrists. The power ‘over’ the patient granted to treating professionals under the MHA 1983, continues to replicate social divisions, with the construction and ‘othering’ of those subjected to this (Tew, 2005). The long-reported negative experiences of former inpatients reflect this oppression and affirm the role-playing actions as described by the early theorists (Read and Reynolds, 1996; Walker, 2013). Further, this also reveals wider concerns about the Western neoliberal social control of people, evidenced in increases in prison populations, the strengthening of police powers, and reduced rights to free speech (Lukes, 2021; Tyler, 2020).

The dehumanising impact of stigma in its various forms was in part a driver for those seeking to question the authority of mental health service providers, leading to the development of the anti-psychiatry movement (as covered in the following section). Labelling theory, the deviance model, and the overlap with stigma can be traced back to Goffman (Rogers and Pilgrim, 2014). Since this time, these processes have largely transferred from the asylums into the community with the media and successive governments sustaining the deviance model to pursue different agendas – a counter to the initiatives of anti-stigma campaigns (Beresford, 2023).

The impact of stigma is a barrier to disclosure and help-seeking, and influences withdrawal from support services (Clement et al, 2014). Perceptions of public stigma towards mental health/illness include concerns about being labelled as ‘weak’ or even ‘dangerous’, and the potential negative impact this may have upon opportunities for employment, housing, relationships with real effects of isolation or service users concealing this part of their identity (Beresford, 2023). Public perceptions include misunderstandings that poor mental health is often transient, or that notions of ‘recovery’ imply that people no longer need support, rather than being self-determined (Walker, 2014). For those engaging with services, the ongoing impact of austerity of reduced resources and poor responses through NHS provision enhances all of the above (Beresford, 2023).

The relationship between the lived experience of stigma and the tropes that are propagated, creates known barriers to disclosure and help seeking (Robotham, 2008). Campaigns to challenge mental health related stigma have been actioned in different countries, such as the UK’s ‘Time to Change’ (2022) campaign – see below. These strategies have been supported through international associations (Sartorius and Schulze, 2005), seeking to refocus the discourse to one of commonality and the ‘social norms’ of experiencing mental distress (Eisenberg et al, 2019).

Education is often regarded as the most ‘valid’ method of awareness raising; however, this approach has been critiqued, especially when focusing on language that can lead to expressions of ‘pity’, with no real change in discrimination noted (Corrigan, 2016). The push to emphasise mental disorders as biological in cause (prevalent in USA campaigns), can lead to the public responses that it is ‘not their fault’. In turn, an unintended consequence is that the label becomes more permanent, and people do not feel service users can recover — this can increase some stereotypes, such as the association of violence for those labelled with ‘schizophrenia’ (ibid.).

While clearly driven through best intentions, Corrigan (2016) warns of other possible unintended negative impacts of these campaigns. Arguing that the campaigns three key methods of approach are through education; aligning mental illness to biological causation; and contact have various consequences, not all being positive. Direct contact between people with lived experience is widely suggested to improve general attitudes (Corrigan, 2004). However, people with lived experience are more likely to be open with others who have similar circumstances, concealing their mental health histories from others that they do not feel safe with – as suggested by Goffman and Scheff (Foster, 2007). These campaigns have also been accused of having a Eurocentric tone, resulting in further exclusion for Black, Asian and Minority Ethnic (BAME) people (Knifton, 2012).

Time to Change existed in the UK between 2007 and 2021. The campaign had continued in Wales with funding from the Welsh government (Time to Change Wales, 2022), however closed in March 2025. The original approach, in partnership with the mental health charities, Mind (2023) and Rethink Mental Illness (2023) has focused upon enhancing public empathy through education and awareness campaigns. Henderson, Potts and Robinson (2019) have reviewed the progress of the campaign, summarising that while there appears to be a reduction in the misunderstanding of the experience of mental distress, this cannot be directly evidenced to the impact of this campaign. While some propose that stigma can be eliminated (Stones and Glazzard, 2019), service user movements continue to evidence the discrimination, and dehumanisation within services and wider society (Beresford, 2020; Davies, 2013).

Further discussion, alongside how stigma impacts student help-seeking, are addressed further in the *Literature Review*.

1.12 The emergence and influence of ‘anti’ and ‘critical’ psychiatry

The emergence of anti-psychiatry and critical mental health can be traced back to a group of academics, philosophers, psychologists, and psychiatrists, working and writing in the 1960s, and into the 1970s (Cohen, 2018). This group of thinkers, while varying considerably in their philosophical and political positionality, had in common that they critiqued the prevailing societal understandings of, and approaches to mental health and illness (Cummins, 2017). These writers were collectively termed at the time as ‘anti-psychiatrists’ (Chapman, 2016; Coppock and Hopton, 2000), with the commonality between them that they challenged the structures and processes of psychiatry – reframing them as a political issue – including the features of diagnosis, labelling, treatment regimens and, specifically, detention/treatment in hospital (Ingleby, 1980). It is worth noting that two key thinkers associated with this movement, R.D. Laing, and Thomas Szasz rejected the term ‘anti-psychiatry’, and it is still contested within broader critical mental health as marginalising other key critical perspectives (Double cited in Tew, 2005, p.55).

Possibly the most influential figure associated with the anti-psychiatry movement was R.D. Laing (Cummins, 2017), a psychiatrist whose key critique focused on the oppression of people experiencing mental distress through what he regarded as the pseudo-scientific methods of diagnosis. Laing (1960; 1967) did not dispute the lived experience of distress by people struggling with their mental health. Rather, his approach was to focus away from the disease model of treatment, and towards a social understanding with therapeutic interventions. His premise was founded upon the belief that for most people their distress will largely relate to childhood trauma and family dysfunction (Cohen, 2018). For example, Laing did not believe in a condition of schizophrenia, however discussed the label as a social fact with negative consequences – such as for people given this label having the adjective ‘schizophrenic’ applied, that then carries the metanarrative of *dangerousness*. Laing, alongside other anti-psychiatrists (and indeed reflecting Foucault), advocated that psychiatry cannot be objective due to its lack of scientific explanation, and that the functions of psychiatry, and specifically diagnostic procedures and labelling, are socially constructed in order to bolster the power of psychiatry as a legitimised profession, in turn, dehumanising those that need support (Ingleby, 1980).

Goffman, alongside his key works addressing *stigma*, challenged the institutional treatment regimes within his text, *Asylums* (1961), and became an early voice for constructionist approaches (White in Cohen, 2018). His key arguments sought to dispute the accepted regimes of treatment, through arguing that the power imbalance within institutional care results with inpatients acting and behaving in ways to seek 'approval' from the staff in order to avoid poorer treatment, in effect becoming compliant with the apparatus of authority (ibid.) Goffman's premise is critiqued as lacking discussion of more therapeutic environments, and also that community based support has since replaced the dominance of institutional systems of support (Cummins, 2017).

Another key thinker grouped within the anti-psychiatry movement, Thomas Szasz, while having some commonalities with other anti-psychiatrists – in that he critiqued psychiatry as a political process – developed his ideas from a very different perspective to others. Szasz, a staunch libertarian, challenged the very existence of mental illness, believing it to be a 'myth' (Szasz, 1961). He was anti-institutional, arguing that psychiatry is 'wrongfully' afforded powers of compulsory treatments, terming them as apparatus of the 'therapeutic state', and that the criminal justice systems should be sufficient means, for those, he regarded, as deviating from social norms (Cummins, 2017). Writing later, Szasz (1994) continued to advocate personal responsibility over citizen's rights, postulating that people with mental health needs should be regarded as 'non-productive members of society who pose a threat to liberty by virtue of their dependency' (ibid., p.137).

Emboldened by the sixties anti-psychiatrists, others on the 'inside' of psychiatry sought to challenge the profession's claims of objectivity, and its branding of itself as equal to other branches of medicine. David Rosenhan, an early 1970s psychiatrist, inspired after attending a talk by Laing (Bentall, 2009), completed, what many regard as his (in)famous research – sometimes named 'experiment' (Bentall, 2003). This involved himself and other researchers presenting at psychiatric institutions with the same invented symptoms, and then found, once admitted – and when they reported no further symptoms – they would only be discharged if they agreed that they had a mental illness and were observed taking antipsychotics (Rosenhan, 1975). When Rosenhan published his research, the American Psychiatric Association felt under threat, and responded by revising and publishing a newer, enhanced version of the DSM (DSM III), that aimed to remove any apparent *vagueness* through representing *reliable* and formulaic categorisation, aligning mental distress entirely to forms of physical illness (Whooley in Cohen, 2018).

Many of the central propositions from the original ‘group’ of anti-psychiatrists, have been subject to their own reappraisal with criticism from within and outside of the profession (Cummins, 2017). Most notably, Peter Sedgwick, a socialist and activist, provides a counter perspective via a detailed critique of the key ideas of several of the influential ‘anti-psychiatrists’ (including Laing and Foucault), within his text, *Psycho Politics* (1982). While sharing political viewpoints on the left with some, Sedgwick argued that their positioning was often muddled, changing perspectives over the course of their writing (Ferguson, 2017). Sedgwick's core thesis was that their arguments could actually be counterproductive, bolstering the political right’s desire to reduce welfare and support services for those experiencing mental distress. He argued for a left focused civil rights movement, led by survivors and service user groups (ibid.), which has had an influence upon user-led recovery campaigns, and the development of mad studies (as will be covered in the next section).

1.13 Other key critical mental health perspectives

Despite my choice to take anti-depressants, I remain closely aligned to critical perspectives of mental health treatment and services. This can seemingly present as a contradiction, in that I (officially) have a diagnosis, take medication, have engaged with counselling and therapy; yet I am critical and anti-labelling. My own choices reflect my own recovery, and I happily sit within this complex interplay. This also mirrors many of the expressions from SWS participants as they navigate this myriad world (see *Analysis*).

There are many critical mental health perspectives, and as with other key movements – such as feminism and anti-capitalism – some contradict and compete with others. Some suggest that a persistent sociological focus on the term ‘anti-psychiatry’ and its mid-century origins dismisses how strands of critical mental health thinking have developed (Cohen, 2018) – including the collective/experiential knowledge that has advanced Mad Liberation/Studies (Ramon and Williams, 2005). Others have argued that any use of the idiom *mental health* could be considered as vindicating colonialism (Burstow, in Cohen, 2018).

This project will consider the overlap and intersection of several influential critical mental health frameworks (as is set out below), that reflect the purpose and direction of this project. This is important as the literature identifies distinct (and intersecting) aspects of identity and how these may shape student understandings of mental health/wellbeing, and in turn, help seeking behaviours. (Note: the experiences of students with intersecting identities will be explored in further detail in the *Literature Review*, and so the below sets a historical and contemporary overview to support the later analysis).

1.13a Postcolonial/anti-racist perspectives

> ‘Whether he likes it or not, the black man has to wear the livery the white man has fabricated for him.’ (Fanon, 1952, p.17).

The foundations of psychiatry, and indeed psychology, have long been critiqued for seeking to bolster colonialism with a white, westernised approach, that actively dismisses other cultural and geographical approaches to mental health in order to shore up imperial hierarchies (Fanon, 1952; Fernando, 1991). Early *research*, and the classification of races within a hierarchy – including work by Kraepelin on ‘tainted’ gene pools – supported the justification of repressive colonial regimes (Rogers and Pilgrim, 2014). This was alongside the rise of psychotherapies that sought to distinguish between the ‘civility’ of white Europeans and ‘savagery’ of non-Europeans (Mills in

Cohen, 2018, pp.206-207). An example of this can be traced back to the slave trade, with enslaved people being diagnosed with 'drapetomania', a mental health diagnosis from 1851, applied to slaves who sought to escape from their 'owners' (Fernando, 1991). Later – and still manifesting in the 1970s – Black, Asian and minority ethnic (BAME[2]) people were vilified as lacking intellectual abilities, and therefore limited potential, relating to tropes that the IQ of white people was superior to that of their black and brown counterparts (Patel, 2017).

It is known that BAME people continue to have a poorer experience of mental health service provision, (Devonport et al, 2023; Keating in Spandler et al, 2015, p.128). This reflects other structural means of oppression, mirrored through education, housing and the criminal justice system, which has been termed as 'internal colonisation' (Murji, 2003 cited in Patel, 2017, p.126). That BAME people (like with disabled people – see 1.11d below), are commonly viewed as being at fault for their own 'problems' (White, 2018), adds a further layer to macro-level oppression.

The impact of this long-term trend, along with culturally inappropriate responses, creates a mistrust of services, and therefore low levels of help seeking from BAME communities (Bhugra et al, 2023; Sewell, 2009). Recent examples of this impact in practice can be evidenced today through higher rates of BAME people being subjected to compulsory powers under the Mental Health Act 1983 (MHA) (RCPsych, 2018) – specifically, being four times more likely to be detained under the MHA 1983, and nine times more likely to be subjected to Community Treatment Orders under the MHA 1983 than white men (CQC, 2023b). These higher rates apply mostly to Black African Caribbean men, driven by prevailing stereotypes of 'dangerousness', that are also reflected within general custody rates (Heyes et al, 2025).

Keating (in Spandler et al, 2015, p.129) uses the term 'race trauma' to describe the stress induced by the impact of racism and argues for cultural and inclusive approaches

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[2] *I acknowledge that all these terms can be contested, and other options such as 'Global Majority' may be preferred. I will use BAME for consistency, with an understanding that this can be problematic for some people/groups, who may feel that this term limits racialised differences (Lawrence, Fletcher and Kilvington, 2025).*

to mental health support for BAME people. Further, the author argues (ibid, pp.127-128) that while the social model of disability can serve as a useful political platform for change, historically this has marginalised, and reproduced binaries for BAME people with mental health/wellbeing needs. The shift towards considering cultural conceptions of health and wellbeing has to factor in how racist perceptions are endemic, and so cultural contexts need to view notions of ‘normality’ via culturally specific interpretations (Fernando, 1991).

1.13b Gender, sexuality and feminist perspectives

> ‘The pathologisation of femininity and regulation of unhappy or ‘difficult’ women through patriarchal psychiatric nosology has a long history’ (Ussher, in Cohen, 2018, p.72).

Historically, for women expressing mental distress, the causes were linked to their biological sex, and specifically reproductive organs, with the origin of the term *hysteria* being from the Greek for uterus or womb (Scull, 2009). Ancient Greek and Roman societies believed all female illness derived back to the womb, and suggested women who expressed ‘excess emotion’ had a ‘wandering womb’ (Appignanesi, 2008). From the 14th century (across Europe), religious explanations dominated, with possession of demons or the devil, designated to women expressing mental distress (Scull, 2015). The witch hunt trials of the 15th and 16th centuries exemplified how for anyone with an alternative perspective of religion, or indeed seemingly practising forms of sorcery, were targeted, with a suggested 500 women losing their lives due to the trials that conflated *madness* with sexual subversion and evil (Russell, 1995).

While religious dominance, to a point, yielded to science during The Enlightenment, ‘treatment’ for women reflected established patterns of patriarchy, with a focus upon their reduced ‘abilities’ to act in the role of wife and mother (Ussher, 1991). Showalter (1987), discusses how mental distress in women was labelled differently from men, being termed the ‘female malady’ rather than the ‘English malady’ as prescribed to men. For men, the causes of distress focused upon pressures of work; while for women, it was considered they were failing in their family roles. Institutional treatments focused upon ‘re-educating’ women to perform ‘ladylike’ skills, including subservience to men, quietness, and attentiveness to their dress; and where this was not being demonstrated, women were subjected to various abusive regimes (ibid.).

Approaches to women's mental health in the 20th century continued to reflect societal expectations of their gender role, often resulting in long-term trauma, such as in Sylvia Plath's semi-autobiographical account in *The Bell Jar* (1963). Differences in diagnosis and treatment for women continue to repeat, with women much more likely to be diagnosed with a label that relates to gender stereotypes, such as 'emotionally unstable personality disorder' (Appignanesi, 2008; Russell, 1994), along with terms such as being 'dramatic' still applied to women seeking support (Hussen, 2023). In terms of race, notions of *strong Black women* are propagated, inferring that Black women have survival traits which means that they do not experience mental distress – this results in inaccurate guidance and a paucity of outreach to these communities (West, Donovan and Daniel, 2016).

Currently, many more women than men seek support for their mental wellbeing, thus resulting in an imbalance in labelling, particularly with 'depression', despite there being no scientific data to evidence this (White, 2018). This, in turn creates a targeted market for the powerful pharmaceutical industry, with advertisements playing on gender roles and guilt via the notion of the 'failing' mother – as demonstrated within several United States magazine adverts (see Appendix One).

Diagnostic categories continue to refer to both normal biological functions, such as menstruation, and with labels that reference emotional lability in women (Ussher in Cohen 2018, p.75). This is reflected in the higher number of women than men diagnosed with affective disorders, and indeed 75 percent of the time 'emotionally unstable personality disorder', or the DSM equivalent 'borderline personality disorder' (Skodol and Bender, 2003). Medical treatments focus on reproduction, and indeed sexual desire (Jutel and Mintzes in Cohen, 2018), all adding to a policing of gender roles by the psy-professions in order to ensure a conformity to social roles (White in Cohen, 2018).

Patriarchy, while sustaining male privilege, also has a clear negative impact on men's mental wellbeing (Mansfield, Addis and Courteney, 2005). This begins with the indoctrination of young boys into notions of masculinity, with caregivers (including educators), providing rewards for gendered behaviours considered positively male, and equally penalising expressions of what are seen as female traits (Sheehy and Solvason, 2025). This results in lifetime consequences for men's wellbeing, in that they have learned to repress expressions of vulnerability and distress, internalising the stereotypes of masculine strength and power (AkhaviZadegan, 2024; Maeshima and Parent, 2022). It is known that men are less likely to seek support for either physical or mental health symptoms (Mansfield, Addis and Courteney, 2005), creating specific barriers for mental wellbeing help seeking (Mokhwelepa and Sumbane, 2025). Suicide remains the leading cause of death for men (in England and Wales) under 50 (ONS, 2024), with masculine associations of 'weakness' when experiencing mental distress proving a formidable barrier to support-seeking (Bennett et al, 2023).

People who identify within the umbrella terms of LGBTQ+ are known to experience higher rates of mental distress than the general population (Gnan et al, 2019) – a combination of direct discrimination (including increasing rates of violent attacks (Stonewall, 2023)), and internalised psychological pain from societal oppression (Fish, 2012). The removal of anti-gay legislation and the introduction of legal protections has been claimed to ensure equality – this can fall within the notion of 'queer blindfolding' (Smith and Shin, 2014) – however research suggests continued high rates of discrimination and harassment of LGBTQ+ people throughout societies structures, including in the workplace (TUC, 2024).

Those that identify as trans/transgendered/gender-diverse have been systematically targeted by politicians, high-profile figures, and the media over recent years (Connolly, Dewan and Holland, 2025), exemplified by the 2025 UK Supreme Court gender 'ruling' (Human Rights Watch, 2025). This has had significant implications for the safety of trans people, evidenced by rates of hate crime that specifically target trans people increasing by almost 200% in five years (Stonewall, 2023). Fuelling the levels of transphobia have been campaigns led by 'trans exclusionary radical', or 'gender critical' feminists (Finlayson, Jenkins and Worsdale, 2018). Their arguments are built on the premise that trans equality will erase the binary of men and women, whereas most trans rights literature is asking the question as to why gender has to be organised in this way

(Butler, 2024). To note, the experiences of LGBTQ+ students will be given attention in the *Literature Review.*

1.13c Anti-capitalist/Marxist perspectives

> '...capitalism is a 'breeding ground' for mental illnesses because it creates the social conditions in which people require such a label as a coping strategy' (Robinson, 1997 cited in Cohen, 2018, p.47).

Poor mental health can be said to be both a consequence of capitalism, and a driver to increase capital (Ferguson, 2017). From the later 1970s, economies of scale were applied to health services, with service 'efficiencies' reducing the status of service users to a 'throughput' of patients, with quality, expensive treatments (such as specialist psychotherapies) seen as unaffordable luxuries (Haugsgjerd in Ingleby, 1981, p.207).

Ferguson (2017) introduces three key approaches of Marxism and the relationship to mental health and wellbeing:

- Materialist - that restricted access to basic resources will impact both levels of wellbeing and abilities to 'recover' and flourish.
- Historical - that expressions of health and distress exist within the particular socio-economic context of the time, and that minority groups are at specific risks due to structural oppression.
- Dialectic - the avoidance of reductionist theories, and to approach mental health as being, 'shaped above all by [people's] life experiences under capitalism' (ibid., p.21).

The functions of psychiatric diagnosis and medical treatment continue to be legitimised via the *science* of mental health/illness – bolstered through capitalism – and, as such, the power of the profession remains (Davies, 2013). Capital created by the formidable pharmaceutical industry, with prescription medication for mental health generating over $36 billion per year (approximately £27 billion), is predicted to continue to grow (Statista, 2023). In the UK in 2021, 75 million prescriptions for antidepressants were written (Self, 2021). Targeted advertising, and also campaigns directed towards prescribers, involve spending on advertising across the range of antipsychotics, antidepressants, and other anti-anxiety medications, driving the creation of capital, and, in turn legitimising ‘back-to-work’ focused welfare reform (Davies, 2022).

It can be argued that those unable to provide labour due to their mental health needs have been subject to particularly virulent attacks by recent governments, (Hutton, 2012; Mind, 2023). This built upon changes driven by previous governments, such as New Labour’s ‘new deal’ attacking civilian rights (Beresford, 2000), and introducing divisive language, such as ‘the workless class’ and ‘dependency culture’ (Finn, 1997). These terms would become increasingly negative moving through successive Coalition and then Conservative governments, with ministers freely describing welfare claimants as ‘scroungers’ (Jowit, 2016). This, in turn was a catalyst for negative campaigns through the media driving a rise in hate crime against disabled people (Quarmby, 2015) – with some paying the ultimate price with their lives (O’Hara, 2015). Since the implementation of austerity by the 2010 Coalition government, mental health service users have faced the double jeopardy of severe cuts to services, and reduced access to welfare (Moth et al, 2015). The combination of this, alongside the fear caused by work capability assessments; the impact of the ‘bedroom tax’; and the introduction of Universal Credit has greatly increased psychological distress, and early deaths, for many disabled people (Beresford, 2017; Butler, 2013; Wickham et al, 2020). Disabled students were also impacted with reduced access to financial support from the Disabled Student's Allowance (DSA), a cut that disproportionately impacted students from lower income backgrounds (Pring, 2014).

At the time of writing, the incumbent Labour government has shown zero qualms about picking up this baton, with plans for further cuts to benefits (Butler, Inman and Murray, 2025). Additionally, the current Secretary of State for Health, Wes Streeting is building upon the previous Government's rhetoric of ‘sick note culture’ (Gregory and McKiernan, 2024), with direct attacks on disabled people. He is focusing on people with mental health needs, stating that there is ‘overdiagnosis’ that prevents people returning to the labour market to produce capital (Elgot, 2025). That a person with the status of Health Secretary is openly challenging medical diagnoses suggests the lack of scientific rigour behind the functions of the medical model of mental health – as argued by Moncrief in *The Conversation* (2025).

The aligning of paid work with individual *recovery* has been a trope for some time, with the National Health Service commissioned 2016 ‘Five Year Forward View’ strategy proposing that ‘employment and health form a virtuous circle’ (Mental Health Task Force, 2016, p.16). That neoliberal governments view mental ill health as the cause of downward mobility, they can then blame the individual and justify the withdrawal of benefits; whereas the reality is that class, and associated stress from poverty precede mental ill health, as shown by those receiving higher rates of diagnosis (such as schizophrenia) living in more deprived areas (White, 2018). This further suggests that governments’ focus on reducing labelling is misguided, and rather they should be seeking to improve support services, alongside better working conditions for those that wish/are able to return to the labour market (*The Conversation*, 2025).

How mental health professionals – including those working for SWS – are seen in terms of Marxist approaches depends upon perspective. Given less attention by Marx himself within the binaries of wealth *owners* or *producers*, neomarxists generally view professionals as either upholding and colluding with the power of the ruling classes; or, that practitioners that seek to empower and support recovery have had their role eroded via bureaucratised consumer model approaches to care and support (Rogers and Pilgrim, 2014). How university welfare provision is making sense of their role within the neoliberal consumer provider sector, with the additional pressures of targets and being placed within league tables, shall be examined within the *Analysis* chapter.

1.13d The intersection and overlap with disability studies

> ‘It is not individual limitations, of whatever kind, which are the cause of the problem but society’s failure to provide appropriate services and adequately ensure the needs of disabled people are fully taken into account in its social organisation’ (Oliver, 1996, p.32).

It has been argued that early *critical* mental health and anti-psychiatry perspectives in the 1960s and 70s pre-existed critical disability studies, with the former disregarding theoretical applications to disability; and the latter being confined to the longstanding notions of disability relating to the individual and their personal ‘suffering’, (Barnes, Oliver and Barton, 2002). More recently, critical mental health perspectives have been informed by and are more embedded in critical disability writings. Beresford (2000) notes, at the time of his publication, that some leading disability writers were uninterested in the experience of *survivors*[3] of the mental health system. It was the rise in writings by disabled people in the latter part of the 20th Century that heightened change, reframing disability away from the individual, and towards a focus upon the social and environmental factors that oppress (Goodley, 2017). These influenced the development of a range of interdisciplinary perspectives, self-organisation, and campaigns of resistance, with the common thread of ‘the reformulating of disability as a form of social oppression as opposed to a purely medical or welfare concern…’ (Thomas cited in Barnes, Oliver and Barton, 2002, p.39).

Key to this is the separation of the perceptions of *impairment* and *disability*, a concept seen as integral to the social model (Oliver, 1990). The core reasoning is that the experience of having limitations via a biological/psychological/physiological ‘impairment’ does not unconditionally mean that the individual becomes a disabled person. Rather it is the limiting social and environmental barriers imposed upon people with impairments that enforces disability (Barnes and Mercer, 2003). This reordering of models of disability originally emerged through the campaigning organisation UPIAS[4], that demanded the abolishment of ‘capitalist disablement’, in order to reorganise societal approaches to disability (Chis, 2024). Although subject to challenge, the following definitions (drawing upon UPIAS), are from the Disabled People's International (DPI, 1982, cited in Goodley, 2017, p.9),

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[3] As with other terminology, the term ‘survivor(s)’ does not sit comfortably with all, with some noting a resemblance to ‘cure’ (Price in Davis, 2013).

[4] ‘UPIAS stands for Union of the Physically Impaired Against Segregation – an activist collective formed in the early 1970s (UK), through which the social interpretation of disability and the “social model” emerged’ (Chis, 2024, p.26).

> IMPAIRMENT: is the functional limitation within the individual caused by physical, mental or sensory impairment.
>
> DISABILITY: is the loss or limitations of opportunities to take part in the normal life of the community on an equal level with others due to physical and social barriers.

There are alternative perspectives arguing that these terms should not be separated, however a key position for keeping the distinction is that alternatives – such as the biopsychosocial model (more details in later parts), (Borrell-Carrió, Suchman, and Epstein, 2004) – involve a coalescence with the structures of welfare. These arguments focus on the forced merging of the terms ‘disability’ and ‘impairment’ driving the necessity for individuals to prove they are impaired and therefore also disabled, in order to meet eligibility for welfare (Goodley, 2017). The categorisations by the welfare state tend to fuse mental health with other disability for administrative purposes (Beresford, 2000), with the Equality Act 2010 definitions further reflecting bureaucracy with its attempts to box people into standardised definitions of ‘disability’ (Goodley, 2017).

As with critical mental health, varied critical disability perspectives developed, with differences stemming from culture and geography. In places, these intersect and overlap, with alternatives that contest and challenge within the discipline (ibid). Goodley (2017) presents a summary of four key perspectives that emerged within the growing discipline: *The Social Model* – a counterpoint to the dominant medical individualised approach, focusing upon societal and environmental barriers as disabling; *The Minority Model* – civil rights based, challenging ideas of normality and ableism though promoting diversity; *The Cultural Model* – counters the separation of impairment and disability, highlighting that metaphors of disability are embedded within all cultures; and *The Relational Model* – a citizenship and community focused response, influential upon ‘normalisation’/social role valorisation.

Goodley (ibid.) acknowledges the limitations of boxing together perspectives, recognising that theoretical strands will continue to develop. One example is postcolonial global perspectives, where it can be argued that utilising medical model terminology may assist with campaigns for resources, alongside the highlighting of colonial exploitation, and causations of disability (Barker and Murray cited in Davis, 2013). This can also be demonstrated via poststructuralist ideologies, including the influence of Foucault (as above), such as with suggested limitations to the social model. These include debates about expanded definitions of ‘impairment’; that it may discount intersecting identities (including mental distress); or its proposed reliance on the medical model to be diagnosed with an impairment (Davis, 2013). Notably, the *troubling* of the notions of body and disability are being pursued, such as with Crip Theory, to challenge the afforded power immersed within structured discourses (Karlsson and Rydström, 2023). Crip Theory has some overlap with feminisms and Queer Theory, in that *compulsory* able-bodiedness and heterosexuality suggests alternatives are a choice, whereas there is no such choice (McRuer, 2006). Historically and culturally, queer people have been viewed as *disabled* and disabled people as *queer,* as evidenced via portrayals in the arts (Barounis in Davis, 2013), and the tragedy/cure model (McRuer, 2006).

There are several reasons proffered for fusing critical disability/Crip Theory, and critical mental health/Mad Studies, such as with the post-structuralist rewriting of previously accepted notions of medical knowledge and power, specifically challenging the Cartesian divide of mind and body (Barnes and Mercer, 2003). Beresford (2000) focuses on three overlapping strands – that disability and mental health are usually tied together for administrative purposes, specifically for welfare categorisation; that many disabled people also experience mental distress, and vice versa; and finally via the lived experience of oppression, sanism and ableism.

Despite widely accepted similarities, there have been ongoing challenges with forming enduring alliances, with reasons highlighted by Lewis, (2013, p.117):

> ‘Part of this difficulty involves the simple fact that two groups are composed of different subcultures – with different histories, different cultural artefacts, and different networks of association’.

For others, this relates to uneasiness with language, such as with some survivors feeling discomfort with the term ‘impairment’ (Beresford, 2020); and equally, some disability activists are unhappy with being situated alongside notions of *madness*

(Lewis, 2013); with others highlighting conflicting interpretations of the concept of *recovery* (Pilgrim and McRanie, 2013 cited in Rogers and Pilgrim, 2014, p.196). That these positions relate to stigma, or at least perceived additional stigma – reflecting aspects of sanism and ableism – then enhancing the connections between the disciplines should seem logical (Thorneycroft, 2020). As with metanarratives of disability (see Bolt, 2021), stigma-related shame in respect of mental distress and support seeking, may induce feelings of guilt, and therefore a tempered voice when engaging with services/professionals (Martyn and Thompson cited in Bolt, 2021).There are clear arguments as to why coalitions between mental health service users/survivors, and disability rights activists, can only benefit social approaches, to bolster the continued challenges to, and need to 'resist' biomedical dominance (Beresford cited in Spandler et al, 2015).

Crip Theory and Mad Studies have clear commonalities, in that they have been driven and developed through perspectives from those with lived experiences, seeking to move beyond a professional and/or academic basis, and often closed sets of rights based literature (Thorneycroft,2020). The reclamation and redelineation of the 'othering' discourses targets a modern approach to tackling oppression, with the challenging of flawed binaries via creative and anarchic means to disrupt fixed narratives (Goodley, 2017).

1.13e Mad studies

> '...exposing people to the idea that madness is not something outside of "normal" human experience, but rather a continuum of thought, emotion and perception, is good for everyone.' (Shimrat in Beresford and Russo, 2021, p.56).

Crip Theory evolved from the writings of people with lived experience of oppressive structures, including their allies (Reaume, in Beresford and Russo, 2021, p.99). While there are contributors to the Mad Studies extant literature by people who neither identify as mad or have lived experience as users (ibid.), the embedding of the knowledge of lived experience is seen as a necessity to take a sustained challenge to conventional power structures and accepted truths (Pryer, Davies and Hislop, 2023). This places Mad Studies as sharing commonalities and intersecting with Queer Studies, postcolonial frameworks and strands of feminism (Gorman and Lefrançois in Cohen, 2018). The term *Mad* – as with *Queer* – carries a flexible use as a central concept that unifies people with different lived experience within a uniting collective (Price in Davis, 2013).

The foundations of ‘Mad studies’, and indeed ‘mad activism’ can be traced back to 1970s Mad Movements (Price in Davis, 2013). They fundamentally seek to progress all the above critical ideologies, with the drivers to promote inclusive resistance, positive self-images to challenge sanism, and a sense of dignity in identification (Beresford and Russo, 2016; Gorman and Lefrançois in Cohen, 2018). ‘Mad Pride’, a model drawing upon the unity of gay pride marches, developed in the 1990s, seeks to both be a mode of political activism and celebration of identity (Foster, 2007).

While the origins of the word ‘mad’ can be identified within Shakespeare’s plays (Porter, 1989), the term has historically been loaded with negative, often violent associations over the centuries, and thus, rightly open to debate. Therefore, the use of the word ‘Mad’ – as with ‘Queer' in LGBTQ+ movements – is not universally embraced by survivor groups, with some arguing the historical derisive connotations of the word invalidates its usage (Beresford, 2020). Counter to this, it has been argued that the use of the term ‘Mad’ in ‘Mad Studies’ can have sustained benefits, however, it may need to be acknowledged as one focus within the broader need to galvanise campaigning and collective responses within the user and survivor movement (Beresford, 2020).

While Mad Studies can differentiate from the earlier anti-psychiatry thinkers, in that it does not necessarily argue for the abolition of the profession, it can be said to share commonalities with anti-psychiatry and other critical mental health ideologies – in that the power afforded to the pharmaceutical industry and modes of diagnoses are used to coerce people into contemporary treatment regimes (Reaume, in Beresford and Russo, 2021, p.99). Mad Studies has also been seeking to galvanise the push-back to the ‘exportation’ of Western psychiatric approaches – driven in part by the powerful pharmaceutical industry – to other parts of the world (Beresford and Rose, 2023).

One of the consistent key messages via critical perspectives is that the side effects of medications can be as debilitating as living with the symptoms of mental distress (James, 2001). For example, modern anti-depressants can produce numerous side effects, including lethargy, and sexual problems; and certain antipsychotic medications can result in significant weight gain; involuntary drooling; and severely impaired energy levels through its sedating effects (Bentall, 2009). While medication may help minimise symptoms of mental distress in many cases, there is no known ‘cure’ for mental distress through pharmaceuticals alone (Foster, 2007; Davies, 2013). This balancing of seeking to reduce symptoms with managing side effects has been a key component of survivor and service user groups who seek to critique the current structures (James, 2001; Tew, 2005).

1.13f User/survivor movements

> ‘The system did teach me things [,] the main one being how to be a good schizophrenic, I do believe that we learn much about how to be mentally ill in the system’ (Coleman, n.d., no pagination).

As Sedgwick argued (Beresford 2016), the resistance to, and indeed ‘fightback’ to the power afforded psychiatric practices and associated stigma, has been galvanised by service user and survivor networks. Mental health survivor groups, as with other civil rights movements, promote visibility and the reclamation of language and terminology, in order to ‘trouble’ the power of labels, and psychiatry more generally. This includes self-ownership of the concept of ‘recovery’ (Walker, 2014) and service user led campaigns, with the production of insider research, writing and knowledge creation in respect of their lived experiences (Tew, 2005). This has also resulted in the influential development of self-identifying alliances, such as the Hearing Voices Network, Social Perspectives Network and Critical Psychiatry Network (James, 2001; Tew 2005).

While it is perfectly understandable that people seek an explanation for their experiences with a diagnosis delivered by the biomedical model – as we do for physical health symptoms – it needs to be noted that, as stated by Tew (2005, p.1), ‘for many people, it does not always provide the most helpful ‘’pegs” on which to hang their experiences’. Current legislation continues to push people into accepting a diagnosis via the eligibility criteria within the Equality Act 2010, and Care Act 2014; psychiatrists have open leeway with the Mental Health Act (1983) criteria of ‘any disorder or disability of the mind’. Further, the Care Quality Commission (CQC) has responsibility for inspecting mental health inpatient hospitals (CQC, 2023a). The CQC’s 2016/17 report found that around one third of inpatients had not had their care plans discussed with them, or their views considered (CQC, 2018); and the 2021/22 report finds that there are severe gaps in services leading to substantial delays with both admission and discharge (CQC, 2023b).

Today, critical mental health, while informed by the early movements, has a focus upon challenging the structures from within, including insider/survivor movements, campaigns and research, supported by the development of Mad Studies and activism. People with lived experience of being diagnosed and treated through psychiatric systems have retold their stories, which provides an insight into the oppression that the systems produce and reproduce (Foster, 2007; Read and Reynolds, 1996). This has included being dehumanised as inpatients in hospital via varied coercive practices including involuntary medication (Cole et al, 2023; Nyttingnes, Ruud and Rugkåsa, 2016). Powerful drugs come with powerful side effects that many experience as equally disabling as living with the symptoms of distress, often restricting energy levels for social and community activities that should be aiding recovery (Raptopoulos, 2010).

As a response to the above, survivor groups have been instrumental in seeking to reclaim the notion of ‘recovery’ (Tew, 2005). The push for self-determination of what it means to ‘recover’, opposes ‘expert’ definitions, such as a mental health team determining that one has ‘recovered’ through discharge from services; a psychiatrist recording someone as functioning at ‘pre-morbid’ levels (Fox in Walker, 2013, p52); or as defined by Government welfare reforms that returning to the labour market equals recovery (Moth, Greener and Stoll, 2015). Yet, the concept of recovery is not about dismissing the potential support of community professionals, or indeed that medication can aid the impact of symptoms (Fox in Walker, 2013, p49). Rather it is for the individual themselves to define what recovery means for them, as opposed to complying with what others deem to be ‘recovery’. Recovery is often referred to as a journey with various struggles (Deegan in Tew, 2005, p.203), one that is hindered by stigma and internalised self-stigma that restricts social engagement through feelings of exclusion (Mezzina et al, 2006a).

As with all terminology, the terms ‘survivor’ and ‘service user’ can be contested from within (Beresford, 2023), however, there is broad agreement that user/survivor involvement in policy and service development is key to challenging dominant models. User participation has, however, been critiqued as tokenistic, with those invited to participate being subordinated or absorbed, often replicating internalised prejudice from their experiences within the system (Beresford in Tew, 2005, pp.36-37). Effective user-driven responses need to build *upwards* from listening to lived experiences, rather than *downwards* from existing policy and statutes (Lindow in Newnes et al, 1999). Beresford (2023) argues that true citizenship can only be achieved through a societal response – and a shared citizenship responsibility – to mental health, one that simply reflects the universality of what we mean by wellbeing.

The key is to listen to individuals, as for one person, being able to make it to the shops or visit family may represent their recovery (Tew, 2005). The principles of ‘mad studies’ legitimises the knowledge and meaning of lived experience, and that the language associated with this should be owned by each individual – this is a core component to address the stigma of living with mental distress and/or surviving mental health systems (Beresford, 2020).

1.14 Conclusion

As addressed at the beginning of this chapter, this is a topic area with multiple intricacies. The terms ‘complex’ and ‘complexities’ will feature throughout this thesis, however the intention is to highlight these, rather than seeking to unravel them. The interaction with social constructionist perspectives of the power of discourse, and knowledge creation through language demonstrates the need to acknowledge that this is an enigmatic subject, with varied conflicting and contradicting viewpoints. The power within language alongside the intricacies of shifting discourse will feature throughout. This will be addressed further within the following *Literature Review*, as well as dedicated space to explore how aspects of student identity – and intersecting identities – interplay with mental health and support seeking.

To end with a return to discourse, these two quotes, around 370 years apart, exemplify how language has been used to vilify people on the basis of difference by those who wield power. The first (cited in Rabinow, 1984, p.132) is an attributed quote to the Lord Mayor of London circa 1630,

> ‘This vermin that troops around the city, disturbing public order, assaulting carriages, demanding alms with loud cries at the doors of churches and private houses’.

The second, in the foreword to the New Labour Government White Paper, *Modernising Mental health Services* (1998), by the then Health Secretary Frank Dobson,

> ‘Care in the community has failed because, while it improved the treatment of many people who were mentally ill, it left far too many walking the streets, often at risk to themselves and a nuisance to others. A small but significant minority have been a threat to others or themselves’.

Chapter 2: Literature Review

2.1 Introduction

This literature review will build upon the key themes that were presented within the *Introduction*, seeking to summarise the extant literature[5] related to this topic area. The review will explore the current context, while making important connections to developments in the HEI sector. The purpose is to build a *picture*, or 'tell a story' in respect of what is known, while also being curious about the gaps in research (Braun and Clarke, 2022). In addition to peer reviewed articles from journals and authored/edited textbooks, it will draw upon a wider range of sources – these include research reports; national guidance documents; newspaper and magazine articles; websites; government legislation and policy directives; and conference papers (Thomas, 2017). It is important to acknowledge the scope of publications that have been addressing this subject matter over recent years. The review will follow a broad 'narrative' approach (Silverman, 2000), spotlighting nuances and complexities, while also referencing theoretical perspectives.

The literature review will be presented as follows. The initial part will provide a summary of the current context of student mental health/wellbeing; an overview of specific factors impacting upon the student experience – including the needs of specific groups of students; along with the impact of the COVID-19 pandemic. The next section will consider patterns of disclosure for HEI students; how they may or may not seek support from university providers; the barriers to help-seeking – all informed through a broader discussion of the impact of stigma. The following segment focuses upon what is known and not known about the university as a mental health service provider; how SWS are responding to the changing picture; HEI functions, duties and the overlap with policy and guidance; the role of the academic; and a focus upon alternatives to traditional HEI services. Finally, this review will conclude with a drawing together of key themes from

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[5] To note this is an evolving topic area with new research and reports expected.

the literature, with a critical analysis of the prevailing trend to label the phenomenon as a ‘crisis’ (The Tab, 2025; Vogt and Johnson, 2022).

2.2 Student Mental Health and Wellbeing – what we know and what we do not

The current media coverage in relation to student mental health would suggest this matter is a relatively recent phenomenon (Shackle, 2019; Weale, 2019). However, there has been significant writing and research in respect of this topic, particularly since the substantial changes to higher education and the student experience over the past three decades (Humphrey and McCarthy,1998; Ylijoki, 2003; Macaskill, 2012). Some argue that the discourse surrounding student stress and the impact upon wellbeing was rarely considered prior to the developments since the 1990s (Humphrey and McCarthy, 1998).

While this may be the case, the mental health/wellbeing of student populations have been included at national education conferences, since the 1940s, with a noted increase in reports in the 1960s (Crook, 2020). There were some common themes occurring since mid-century that are still reflected today, namely that students could feel undue pressures to perform highly – more so related to family expectations, as the financial debt burden did not exist in the same way (Andrews and Wilding, 2004). These, alongside feelings of homesickness and loneliness resulted in the first university counselling services from the 1950s (Swainson, 1951; Jacobs, 1979, cited in Hughes and Spanner, 2024). Moreover, there were specific concerns noted in relation to international students, namely family pressures and feeling unwelcome in their country of study (Maeshima and Parent, 2022). The mid-century studies also discussed particular impacts upon women, who were at the time far in the minority and underrepresented within academia (Crook, 2020).

While acknowledging some of these historical discourses, there has been a substantial increase in research, policy and guidance in relation to student mental health over the past decade (Student Minds, 2014; 2023a; UUK, 2023b; Sanders, 2023). Guidance and policy have been driven through three key routes – student body led (Student Minds, 2014; 2023a; Student Minds, 2023b; NUS, 2022); sector led (Houghton and Anderson, 2017; Thorley, 2017; UUK, 2018; 2023; Wilson et al, 2022), and government reports (OfS, 2025; UCAS, 2021). These will all be given further attention later in this chapter.

In addition to the student and sector-led guidance, there have been various research studies and reports by the independent sector (Unite Students, 2016; Dig-In, 2020); other key organisations (Royal College of Psychiatrists, 2011); alongside the government (Lewis and Stiebahl, 2024). These documents/reports, alongside those published by the student and sector bodies, while having a slightly different remit, all broadly agree on two key themes.

Firstly, there is significantly higher disclosure of mental health needs – alongside increased demand from students seeking support for their mental wellbeing – that has been on an upward trajectory over recent years (Sanders, 2023; UUK, 2023a). This is further evidenced through UCAS (2021a) who have noted a 450% increase in applicants declaring that they have a mental health need on applications in recent years. UCAS also suggests that disclosure may have previously been considered a negative by students on their applications and so this development likely reflects broader changes to societal attitudes (Bryant et al, 2022). Figures and statistics vary, with worldwide studies suggesting a third of all HEI students experience a mental health need (Balloo et al, 2022; Elnaem et al, 2022), with studies in the US suggesting this is up to half of all students (Blanco et al, 2008, cited in Macaskill, 2016).

As indicated (see *Introduction*), these conversations are happening within the myriad of the complex and often contradictory discourse of mental health/ wellbeing, all enhanced through varied perspectives and elements of self-interpretation (Tse and Haslam, 2024). Subjective interpretations of the terms mental ‘health’, ’distress’ and ‘wellbeing’ inevitably leads to variations in reported findings. In turn, these factors impact attempts to quantify rates of student mental health needs/distress, resulting in considerable variations in reported statistics, published within several key reports (DigIn/Insight Network, 2019; UCAS 2021a; Sanders, 2023; Student Minds, 2023).

Knapsted et al, (2019) within their longitudinal study of trends of self-reported distress, also note that many previous studies that aimed to quantify rates of student distress have been sporadic, mainly USA based, and utilised questionable methodologies – including some that limits the number of ‘conditions’ (Oswalt, 2020) – (Knapsted et al, 2019). While not seeking to argue against the importance of seeking clear data (Dodd et al, 2021), well-publicised research tends to be those that receive more press attention (Jenkins, 2024).

The complex interplay between terminology and self-identification, with conflating notions of mental health, distress and wellbeing (Dodd et al, 2021), suggests a clear influential factor in the disparate findings as shown. The blending of common feelings of poor wellbeing, including experiences of isolation and loneliness (Dinu et al, 2022), with terms such as ‘serious mental illness’ or ‘mental disorder’ has been noted for some time (Storrie, Ahern and Tuckett, 2010). This is argued to be an increasing phenomenon (Foulkes, 2021), and may be being enhanced through such notions – as established within the *Introduction* – as ‘concept creep’ (Haslam, 2016; 2024), or ‘prevalence inflation hypothesis’ (Foulkes and Andrews, 2023). While the *analysis* chapter will draw back to these concepts, this project is not so much concerned with statistical data, rather noting that (as indicated by all key reports), there is an established overall increase in demand for services (whether this can be accurately measured or otherwise).

The second key theme is a broad agreement about the impact upon students of experiencing poor mental health while at university. These are backed by additional studies and include higher dropout rates, with mental health cited as the leading reported factor (Tamin, 2013; Sanders, 2023); lower grades and ultimately degree awards (Markoulakis and Kirsh, 2013; Storrie, Ahern and Tuckett, 2010); higher levels of unhealthy coping mechanisms, including gambling (Nowak, 2018), and drug and alcohol use (Brown, 2016); and, significantly, there are increased risks of self-harm and suicidal intent (Taub and Thompson, 2013; UUK, 2018; Dig-In/Insight, 2019).

The various factors influencing this rise (details below), do get discussed, such as the Association of Young People’s Health (AYPH) (2021) highlighting the (around ten year) gap between the onset of symptoms for young people and access to support; or Wonkhe (2019) foregrounding the very real impact of isolation and loneliness. Regardless of the causation, there is a verified increase in demand for support. It is also now acknowledged that certain groups of students will experience poorer well-being due to aspects of their identities, including factors in relation to class, poverty, disability status and sexuality (further details below).

The trend is clear, however what is not known are the reasons for this, so the broad question remains – is the rise due to increases in mental distress for students; or are students more willing to seek support; or a combination of these and related factors? While the research suggests it is a complex interaction of both, what is known is that there are distinct pressures upon HEI students in the current socio-political context, with an expectation for institutions to continue to respond (Storrie, Ahern and Tuckett, 2010).

2.3 Student Mental Health and Wellbeing – specific factors affecting university students

The costs of attending university also includes increased costs of housing and general living, and there has been a noted recent increase through 2022-23 for students identifying financial concerns as the key reason for dropping out of their courses (Sanders, 2023). Prior research noted the links between financial concerns and lower wellbeing (Cooke et al, 2004; Nissen, Hayward and McManus, 2019), with more recent reports suggesting that around two-thirds of students now worry about money weekly and 40 percent on a daily basis (Cybil, 2023). Most students are now having to work part-time as a minimum in order to be able to meet daily living needs (Denovan and Macaskill, 2017; OFS, 2019). This, in turn adds additional study pressures through limiting time to dedicate to studies, enhanced through those students that have a requirement to complete full time practice placements as part of their degrees (Li, Denson, and Dorstyn, 2018).

The process of transition to become a university student can be viewed as a severe disruption in a young person’s life cycle and may result in feelings of grief and loss for a previous ‘stable’ life (Barden and Caleb, 2019). For many, the pressures to form new friendship networks, and/or adapt to independent living may create critical psychological tensions at a time where many, for the first time, will be responsible for all their daily living needs (Tamin, 2013; Stones and Glazzard, 2019).

Transition itself has been described as ‘multifaceted’, (Stones and Glazzard, 2019), going beyond the initial period of adjustment, involving transition between years, into practice placements in many cases, and indeed the closing period of university/graduation with the erasure of their student identities (Hughes and Spanner, 2024). These peaks of tension can result in severe distress, exacerbated in later years where students are expected to be more independent, resulting in feeling that they should not request help (Hughes and Spanner, 2024; Randell and Bewick, 2016). Student stress levels have been seen to increase across the course of their study (Sanders, 2023), often reaching a spike during the final year with enhanced pressures to perform, and the expectation of future financial hardship (Hughes and Spanner, 2024).

Going to university for the first time can enable students to develop aspects of their identity, providing, for example for LGBTQ+ students, a positive sense of self and belonging (Taulke-Johnson, 2008). Equally, due to ongoing discrimination, this may enhance feelings of loneliness and isolation which can impact students with specific aspects of identities or intersecting identities (Balloo et al, 2010; UCAS, 2021). Studies have also suggested that subjects with fewer options for discussion and socialisation – and therefore a reduced sense of belonging – may enhance feelings of loneliness, specifically for students who may already be vulnerable (Dinu et al, 2022). The lived experience of loneliness has been emerging as a key concern resulting in increased mental distress for students, (Student Minds 2014; Dinu et al, 2022), with the impact upon studies and outcomes being as potentially detrimental as for those with specific mental health diagnoses (Hughes and Spanner, 2024; Wonkhe, 2019). While loneliness can impact any student, there are particular groups at risk of isolation (and therefore loneliness), such as for disabled or international students (Brewer, Urwin and Witham, 2025; Student Minds, 2024a) – (further details in 2.4a and 2.4b below).

2.4 Identity, wellbeing and support seeking

While student mental health research will tend towards either being generalised or having a focus upon a specific aspect of identity, it needs to be noted that students may experience disadvantages across multiple social categories (Balloo et al, 2022). Intersectionality highlights that disadvantage does not simply occur within each aspect of a person’s identity, such as ‘race’ or ‘gender’, rather that the lived experience of discrimination is complex (Crenshaw, 1991). Multiple and intersecting aspects of identity/memberships of social groups can impact on the student experience, and their trajectories of mental health/wellbeing in a number of ways (Balloo et al, 2022). While noting this and not seeking to homogenise groups on the basis of identity, there are key features of student identities that can intersect with wellbeing – these will be summarised, in no particular order, below.

2.4(a) International students

International students have historically regarded the UK as an attractive place to study (Lillyman and Bennett, 2014), and continue to make up a substantial portion of the UK’s total student population (around 22%), with significant higher levels for postgraduate students (39%) (HESA, 2022). At time of writing, the current government is retaining previous restrictions upon international students (Adams, 2024), despite warnings of damage to the sector and beyond (UUK, 2023c). Alongside some fluctuations due to Brexit and COVID-19, numbers at each HEI continue to vary, with some attracting higher levels of students from specific countries, or areas of the world, due types of courses available (UCAS, 2021b)

UCAS (2021a), reports a small rise in international students declaring a health-related need (physical and/or mental), although the proportion is significantly lower (3.9%), compared to UK applicants (13.4%). This variation is believed to relate to international students concerned about being deemed as having a ‘negative’ trait, with perceived judgements that could influence a successful offer of a place (ibid.).

The understanding that university life can be more difficult for international students has been noted since mid-century (Crook, 2020). While seeking to minimise generalisations, the awareness that international students may be more susceptible to wellbeing variables has been highlighted by Student Minds (Frampton, Smith, and Smithies, 2022), with their report suggesting a misalignment — with overall reported better life satisfaction, against descriptions of poor responses to need and overall quality of the student experience. This mirrors long-standing findings about cultural differences and how the conceptualisation and framing of wellbeing and mental health are Eurocentric, and how western services will often miss or misinterpret provision (Bhugra and Bahl, 1999).

For some international students, the impact of leaving their homes and cultures and moving to a new, and often unwelcoming society, will be significant (Unite, 2016; Brown, 2016, Thorley, 2017). International students may also feel isolated through a loss of their own culture (Sawir et al, 2008), alongside feelings that they cannot or do not want to join in with, for example, UK drinking traditions (Singh; 2011). International students are also more likely to experience loneliness, in that they may not feel they either fit into, or are accepted in a different culture, enhancing the experience of isolation following transition (Wonkhe, 2019). The University Mental Health Charter (Hughes and Spanner, 2024), highlights the importance of transition for international students, suggesting the need for detailed preparation to help ensure these students acquire confidence with navigating their new environments. In addition, there are some specific cultural factors relating to the stigma of poor mental health and disclosure (Knifton, 2012). Asian students in particular may be under extended family pressures to perform well, with reported higher levels of stigma associated with seeking mental health support (Eisenberg et al, 2009; Li, Denson, and Dorstyn, 2018).

While noting that there may well be specific cultural factors that impact upon both wellbeing and disclosure/help seeking – such as research suggesting Asian students have enhanced levels of personal and perceived stigma (Maeshima and Parent, 2022) – equally there needs a mindfulness that international students from any specific country, culture, or indeed on grounds of religion, do not necessarily conform to these patterns. For example, Jibeen (2016), suggests that by stereotyping students from Asia as having a close supportive family, or by believing that their religion supports their wellbeing, may result in these students not seeking help or feel ignored, increasing poor wellbeing overall. Further, cultural misrepresentations have been reported by international students who do seek help, with mental health professionals mirroring structural cultural misconceptions (Raya and Fawaz, 2017). Student welfare services (SWS) have identified gaps in cultural awareness and, despite the pressures, need to address this through knowledge creation to be an effective, inclusive service (Lian, Wallace and Fullilove, 2020).

2.4(b) Disability

It needs noting that there are competing positions as to whether mental distress should be framed as disability. For this section, the focus shall be on students with physical impairments and the impact of ableism – defined for this purpose as the othering of people with physical differences against perceived notions of ‘normalcy’ (Lewis in Davis, 2013). Over previous decades the number of disabled students attending university has continued to increase (Heffernan, 2024), with predictions that a third of all home students will have a declared disability by 2033 (Disabled Students UK, 2023). Disability disclosure is nuanced and – as with other aspects of identity – should be a matter for the individual. That said, disabled students are often forced into disclosure through the need to access support due to barriers to learning within the university environment (Brewer, Urwin and Witham, 2025). Reported experiences of disability disclosure to able-bodied people include being ignored; feeling coerced into ‘fitting’ themselves into an existing ‘type’ or category (Lister et al, 2021); or left feeling that they have been reduced to the impairment (Blockmans, 2015). Metanarratives of disability suggest stereotypical tropes are applied through an able-bodied lens, often resulting in patronising and/or over-accommodating responses (Bolt, 2021). This can be a particular dynamic for students with intellectual disabilities, where wellbeing issues are often overlooked creating an additional barrier (Whittle et al, 2018).

Disabled students experience multiple levels of discrimination, occurring both within and beyond the university environment, including obstacles to accessibility, inflexible adjustments for learning resources, and a lack of listening to personal accounts and needs (Morina, Lopez-Gavira, and Molinac, 2017; Brewer, Urwin and Witham, 2025). These compound additional barriers with developing social support networks, again due to restrictive access to social and community spaces, enhancing isolation and loneliness, and therefore poorer overall wellbeing (Minotti et al, 2021). As with other oppressed groups, the impact of a disadvantaged university experience includes lower degree awards, higher drop-out rates, and reduced opportunities for social mobility (Lister et al, 2021). That disabled students have to work harder to complete academic work, often with increased levels of tiredness, in turn enhances loneliness and isolation even when living on campus (Brewer, Urwin and Witham, 2025).

The Disabled Student Commitment (Disabled Students' Commission, 2023) – supported by Advance HE – calls upon the sector to work towards significant changes to improve inclusion for disabled students, focusing on four key areas of: communication, certainty, consistency and choice[6]. They advocate a ‘whole university approach’ both mirroring and citing the UMHC (Student Minds, 2024).

2.4(c) Race and ethnicity

The problematic history of psychiatry, mental health support, and the ramifications of institutional racism (Sewell, 2009), will impact students who define themselves as Black, Asian and Minority Ethnic (BAME) – both for home and international students. Psychiatry’s foundations are wedded to colonialism that preferences white western identities, with a medical, rather than social focus, and a *Cartesian* separation of mind and body (Barnes and Mercer, 2003; Fernando, 1991). Black people specifically, are known to have a poorer experience of mental health services in general (Bhugra et al, 2023: Keating and Robertson, 2004), as evidenced in part by the higher rates of detention for black men under the Mental Health Act 1983 (CQC, 2023b).

Known prejudice within service provision results in many BAME people avoiding seeking support on the basis of expected cultural misunderstandings, or indeed blatant racism (Bhugra et al, 2023; Fernando, 2003). Whether the experience of prejudice is covert or overt, the outcome – a combination of poor experiences of provision and

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[6] Choice is important; however, it needs noting that disabled students being offered virtual learning as an alternative to removing barriers can enhance feelings of isolation and loneliness (Kotera et al, 2021).

genuine fear of abusive treatments – results in a ‘vicious circle’ of avoidance to engage with mental health support services (Keating and Robertson, 2004). Knifton (2012) discusses the impact of stigma and shame that can be experienced by BAME people seeking support, based upon family and community cultures. It is also argued that promotional and anti-stigma campaigns to try and address these factors are often themselves culturally inappropriate (ibid.).

Black students continue to report ‘deep-rooted’ institutional elements within universities that impact upon their wellbeing (Stoll et al, 2022), further evidenced through the degree attainment gap based on ethnicity, that the sector has acknowledged (OfS, 2021) – this is despite higher participation and engagement levels from Black students (Stoll et al, 2022). These factors will also be replicated within HEI welfare provision, with BAME student doubts about the cultural competence of SWS, resulting in missed opportunities for help-seeking, and therefore enhancing further the negative outcomes for these students of higher drop-out rates and lower degree awards (Berry and Locke, 2011; Lipson et al, 2018). It is notable that a chapter in a student mental health textbook (Stones and Glazzard, 2019), that focuses on specific identities and how HEIs need to be aware of and respond to these, omits any discussion around race and ethnicity (ibid, chapter 5).

Seventy-five percent of BAME students report experiences of racism within their institutions – enhancing the associated negative impact upon their wellbeing – (Frampton and Smithies, 2023). Conversely, when they do try to report racism, they often find that they are not listened to (Stoll et al, 2022; Unite Students, 2022). This, alongside the barriers to seek help from SWS (Balloo et al, 2022; Hughes and Spanner, 2024), results in some BAME students seeking psychological support within their peer groups, or returning home to families (Unite Students, 2022). Research suggests that HEIs need to ensure services are both culturally aware and appropriate as a starting point to meet this gap in provision, along with listening to BAME students’ experiences (Stoll et al, 2022; Frampton and Smithies, 2023; OfS, 2021).

2.4(d): Gender and sexuality

Female students are more likely to engage with support services (Balloo et al, 2022; Bryant et al, 2022), despite long-standing gendered notions of mental distress in women being connected to emotional lability (Ussher in Cohen 2018). Research indicates a sustained gender gap with over two times more women than men declaring a mental health condition (Sagar-Ouriaghli et al, 2022; UCAS, 2021a). This data reflects societal patterns of differences in help seeking by gender, with women reporting less stigma associated with common mental health needs, reflected in higher levels of help-seeking (Horwitz et al, 2020).

Men continue to report a higher impact of stigma, based upon stereotypes aligning poor mental health with 'weakness' (Carmack, et al, 2018; Sagar-Ouriaghli et al, 2022). Barriers to men seeking support will also apply to physical health needs (Mansfield, Addis and Courteney, 2005), with a noted difference by gender in reporting sexual assaults (Allen, Ridgeway and Swan, 2015). Of particular concern, and again reflected in wider society, are the levels of completed suicide for men, three times higher for men than women in the 20-24 age range (ONS, 2023). UCAS (2021a) highlighted that more work needs to be done within HEIs to explore support options targeted at male students. There has been some work completed, such as the suggested re-framing of help-seeking behaviours from a negative to a strength (Sagar-Ouriaghli et al, 2022); or with specific men-led projects that focuses on social spaces and networks (Maggs, 2022).

For LGBTQ+ students, university may be the first time that they feel able to explore and form their identities, with earlier school experiences of discrimination resulting in them previously concealing their sexualities/gender identity (Maji and Sarika, 2024; Brown, 2016). This can be a very positive experience for many, including feeling fully accepted, at least within the university environment (Taulke-Johnson, 2008). While most universities ensure issues of sexual diversity are highlighted, and indeed events such as Pride are openly supported, LGBTQ+ students continue to report the experience of homophobia and transphobia while on campus (Smithies and Byrom, 2018). This may result in LGBTQ+ students feeling that they have to hide their identities, perhaps differently from their home environment, and results in 2-3 times LGBTQ+ students considering leaving their courses than those who identify as heterosexual and cisgendered (ibid.).

There are also differences when the homogeneity of this group is separated, so while all LGBTQ+ people experience far higher mental health needs than those who identify as straight, students defining as ‘lesbians’’, bisexuals’, or ‘queer’ report almost double rates of distress as compared to ‘gay men’ (Sanders, 2023). The reasons for this are unclear, however reported hate crimes based upon sexual orientation have quadrupled over the past decade (Statista, 2025), with LGBTQ+ students also being targeted (Baggs, 2021).

For students who identify as trans or non-binary, even if feeling able to be open at university, face an increasingly hostile transphobic society, driven through the media and high-profile politicians, including previous prime ministers, as part of the current ‘culture war’ (Duffy et al, 2021; Walker, 2023). The wellbeing of trans students’ needs particular attention given the rates of self-harm and suicide, alongside significant levels of direct experience of discrimination when accessing healthcare services (TransActual, 2021).

While rates of self-harm and suicide remain much higher for LGBTQ+ young people than the equivalent age group (Gnan et al, 2019), attendance at university has been shown to enhance wellbeing, and, up to half the rates of self-harm for these groups (Balloo et al, 2022). HEIs often intimate that the needs of LGBTQ+ students are being met due to student societies, however many report feeling excluded from these groups, thereby suggesting that universities have significant work to do (including awareness training for all staff), to develop inclusivity across their institutions (Smithies and Byrom, 2018; Hughes and Spanner, 2014).

The lived experience of discrimination; perceived and/or actual stigma; and/or the lack of appropriate understanding of needs within professional services, reflected in wider society, may well enhance barriers to support seeking for LGBTQ+ students (Stonewall, 2018). It is important for HEI SWS to acknowledge that some groups of students may seek help elsewhere due to their identities, with research suggesting that LGBTQ+

students are more likely to seek support from support groups/services outside of campus that are aimed at those with diverse gender and sexualities (Bryant et al, 2022).

2.4(e): Socio-economic status

Aspirations of 'social mobility' for working class people has in turn been seen as a positive, benefitting society, while also suggesting a coercion with capitalism that may divide working class people, rewarding those that 'contribute' to society (and capital production), with a vilification of those that do not (Hanley, 2016). The current expectation of minimal education levels in order to gain well-paid employment in a post manufacturing period has resulted in more working class young people applying to universities (Reay, 2018). For those that cannot access higher education may retain lower expectations of achievement, with a 'resilience model' being triumphed by successive governments as the means to be aspirational and 'escape' poverty (Walkerdine, 2011). 'Respectability' is now redefined for those who have aspirations and will therefore 'work-hard' (in turn, avoiding 'laziness'), (Hanley, 2016).

For working class students attending university, distinctly where they may be the 'first in family' (FiF) – defined as having neither (step)parent(s) having attended university (Pires and Chapin, 2022) – this experience of 'social mobility' can be isolating. Middle- and/or upper-class students may actively partition working class students as 'outsiders on the inside' (Coulson et al, 2018 cited in Reay, 2018, p.534), resulting in a belief that they have to work harder academically to prove that they belong (Hanley, 2016). A lack of social acceptance for FiF students may also result in avoidance of social groups and student societies, enhancing feelings of loneliness (Dinu et al, 2022; Reay, 2018). The realities for FiF students include a lack of preparation or support from schools, due to the expectation that working class pupils will lack aspiration (Pires and Chapin, 2022; Walkerdine, 2011). This is reflected in lower applications from FiF students to 'elite' institutions, and more applications for subjects such as law or business, rather than social sciences (Henderson, Shure and Adamecz-Völgyi, 2020). In addition, FiF-women graduates will earn 7.4 percent less in wages compared to non-FiF women graduates (Adamecz-Völgyi, Henderson and Shure, 2023).

To note, while I was a FiF university student, I had a middle-class upbringing and schooling with full support and preparation from school and family. For students from working class or low-income households, perceived stigma from fellow pupils may enhance the need to demonstrate resilience (Walkerdine, 2011), which can, in turn, be a barrier to mental health support seeking (Billings, 2021). These perceptions of resilience, autonomy, and self-discipline in studies reflect tropes about other groups of students, including international and disabled students (Goodley, 2025). For working class students (as with disabled students), online and virtual studying options may present its own challenges due to lack of personal space or inadequate technologies – see 2.13 below.

2.4(f) Other groups

Important aspects of identity, and indeed intersecting identities of students need to be considered beyond the current nine ‘protected characteristics’ of the Equality Act 2010[7]. Care leavers/care experienced students may have specific needs in relation to trust, and so a named contact with specialised knowledge may help support these students (Stones and Glazzard, 2019). Students who are carers for another (often a family member), may have specific wellbeing needs resulting from guilt or worry for leaving the person they may have been caring for (Kettell, 2020). Likewise, if they are continuing with a caring role, consideration needs to be given to the impact of this upon full-time studies, with HEIs needing to offer additional flexibility to acknowledge their responsibilities, and address known high drop-out rates (Runacres et al, 2021).

Universities themselves have – as with any historical institution – structural foundations of maintaining privilege over equality (Balloo et al, 2022). This can be evidenced (as

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[7] The nine ‘protected characteristics’ within the Equality Act 2010 makes it unlawful to discriminate against someone on the following grounds: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation (Equality and Human Rights Commission, 2021).

discussed in the above sections), through ongoing obstacles – such as the multiple barriers faced by disabled students (Brewer, Urwin and Witham, 2025) – or via deeply embedded systemic discrimination, demonstrated as such by the lower grades and degree awards for BAME students (Berry and Lock, 2011). This suggests that the starting point for HEIs, when considering the wellbeing of all their students, must be that they recognise their own elitist social origins that are informed through patriarchy, capitalism, ableism, and colonialism (Payne, 2013). To effectively address the welfare of all its students, HEIs need to move beyond expressing that they are seeking to be inclusive, expecting students with diverse identities to experience a flawless integration; rather, work to develop truly robust equality and diversity policies (Hughes and Spanner, 2024; NUS, 2022).

2.5: The impact of COVID-19 and lockdowns[8]

The COVID-19 pandemic clearly had an impact on the wellbeing of people across the globe, with the World Health Organisation (2022) reporting a 25 percent increase in anxiety and depression. The causation of this increase is complex, with factors beyond fear of contagion, or actual symptoms for those who caught the virus, including variables, such as the economic impact of lockdowns (Zavlis et al, 2021).

For university students, the restrictions in relation to the lockdown periods were substantial, with unprecedented changes to the student experience (Wieczorek et al, 2021). Most students had to either return home to live with their families or indeed be ‘locked down’ in university accommodation, halls or other student housing (ibid.). A Student Minds report by Frampton and Smithies (2022) indicates that 74 percent of university students reported a negative impact on their mental health and wellbeing due to the pandemic. Several studies have considered the impact of Covid upon university students, reporting an enhanced negative impact upon wellbeing for students on the basis of many variables (Salimi et al, 2023). These include for those with intersecting

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[8] The data collection for this thesis took place in the immediate post-lockdown period, and so it felt crucial to include related research within the literature review. Participants also discussed the impact of Covid (and the lockdowns) upon their student populations.

identities, such as gender, race, being disabled, and sexuality (Dinu et al, 2022); lifestyle and health related matters (Elnaem et al, 2022); financial insecurities (Salimi et al, 2023); environment and safety factors (particularly for women), (Soria and Horgas, 2021; Frampton and Smithies, 2022); and the impact of isolation and loneliness (Wieczorek et al. (2021).

Students also had to adapt to being taught online, a challenge for the tutors as well as those studying – including a noted detrimental impact on wellbeing for early career researchers (Byrom, 2020). While online platforms such as ‘Zoom’ and ‘Microsoft Teams’ provided the means to teach online, the experience of inappropriate study spaces, finite digital skills, and scant technology (Dinu et al, 2022), alongside limitations to engage directly with teaching materials in a classroom setting, and indeed effectively with their peers, clearly had an impact on creative scaffolded learning (Frampton and Smithies, 2022).

Further, many students undertaking vocational programmes had practice placement opportunities cancelled, or at least severely restricted and radically reimagined (McIver and Murphy, 2021; Salimi et al, 2023). Social work students, for example, had to adapt to the processes and experience of undertaking direct practice, moving to online visits and assessments, with the ethical matters of practice with vulnerable children and adults enhanced (BASW, 2020). There was a drive by Social Work England to enable flexibilities, with a recognition that enhanced post-qualification experiences through the Assessed and Supported Year in Employment (ASYE) would have to reflect missed opportunities for direct practice experience during the lockdown period (Pentaris et al, 2021).

SWS also had to significantly modify their services, with the usual counselling and other support being offered only virtually during this period, with the benefits of in person counselling or other advice being unavailable. Take up of online options did increase overall, providing a valuable source of support for those students willing (and able) to engage (Carbone et al, 2021). However large numbers of students report reluctance due to feeling virtual support would be ineffective, as opposed to face-to face input (Li and Leung, 2020). This is in addition to concerns about privacy and confidentiality, with many younger students being in their family homes, with limited guarantee of confidentiality (Frampton and Smithies, 2022).

The initial Covid-related surge in long-arm teaching methods has been reflected post pandemic in the advanced use of technology embedded in teaching methods (Rakow et al, 2023a). Virtual learning environments (VLEs), while benefiting many, have also been seen to have detrimental effects on learning, and indeed wellbeing, where students have not been provided with clear instruction and/or tutors have usage knowledge gaps (ibid.) Further, concerns have been noted about privacy and surveillance afforded by the mandatory use of VLEs (Rakow et al, 2023b). The longer-term impact of the pandemic and associated lockdowns for younger people are still emerging; however it is suggested that those at particular risk at the time – based on identities, financial status, home-related risks, or pre-existing mental health needs – are the students most likely to experience ongoing and serious negative impacts (Sonuga-Barke and Fearon, 2021).

2.6 Stigma and student help-seeking behaviours

The *Introduction* provided a historical and theoretical overview of stigma and how this phenomenon continues to impact people with mental health support needs. It is often assumed that stigma is less prevalent in younger people, however this is not backed up with evidence (Carmack et al, 2018). University students are subject to the same consequences of stigma as with the general population, alongside some additional specific factors relating to life as a student. Driven by negative associations played-out across multiple societal structures, the links between stigma and the ramifications upon disclosure and help-seeking are clear, (Tyler, 2020). Some of these relate to traditional concerns such as the burden of a label, or associations with being seen as ‘weak’, or even ‘dangerous’ (Corrigan, 2007). The lived experience of devaluation and discrimination within services can lead to a mistrust of mental health professionals, enhanced through perceptions of societal oppression amplifying internalised self-stigma (Verharghe and Bracke, 2011).

Self-stigma among students is readily identified as a key barrier to accessing support, relating directly to feelings of shame and expected negative responses (particularly from peers) should they seek support (Carmack et al, 2018; Storrie et al, 2010). Three quarters of students with some level of mental health *need* will conceal this from their friends (Weale, 2019; Dig In, 2019). This is amplified through a lack of awareness about what SWS can provide (Student Minds, 2023b). Others point to perceived stigma through directly associating their needs with the term ‘disability’, and the correlation of this with SWS (Simpson and Ferguson, 2014).

While the impact of stigma can influence help-seeking behaviours for all HEI students, for international students there may be additional barriers relating to cultural determinants of stigma, stemming from differences towards the causes of, and options for treatment of mental distress (Lian, Wallace and Fullilove, 2020). Concerns about cultural stigma can further influence the willingness to seek help due to concerns about confidentiality and perceived shame that this could have on their families (Rayan and Fawaz, 2017). As addressed above, the stereotyping of international students – that they all have supportive family networks – may result in them opting for alternatives to SWS, such as seeking help through friends, or via spiritual/religious means (Li, Denson, and Dorstyn, 2018). Further, the large numbers of international students undertaking professional qualifications in the UK, (specifically health related professions), reflect the known concerns about how they may be viewed by their profession (Elnaem et al., 2022).

Many HEI students would rather disclose to friends, rather than seek university-based support, with noted potentially negative consequences for those that take on a caring role (Byrom, 2017). While open discussion with peers and family about accessing support from any service (including SWS), has not been found to reduce notions of stigma, it may enhance wellbeing overall through a greater awareness of what they are experiencing, and by the act of sharing distress (Carmack et al, 2018).

While stigma takes several forms, for HEI students this has a very real impact on seeking support while studying at university, with the associations of weakness and shame still prevalent (Gagnon, Gelinas and Frieson, 2017). Students continue to state that they are worried about their friends finding out (Carmack et al, 2018; Student Minds, 2014) or may hide their needs either at home or at university, meaning that for half or more of the year they feel they have to conceal their experiences. Further, there are specific concerns for groups of students. One of these is those students studying for a professional degree, such as nursing or social work – preparation for practice placements have been noted as required area of focus (Hughes and Spanner, 2024) – who may have concerns about being deemed ‘unfit’ for practice should they disclose (Moxham et al, 2024; Barden and Caleb, 2019). Despite reassurances about confidentiality, this remains a known factor (Venville, Street and Fossey, 2014). Medical students specifically have reported that their ’professional lives [may be] in jeopardy’ should they seek support for their mental wellbeing (Storrie, Ahern and Tuckett, 2010, p.4). The misconception that stigma can simply be eliminated, as proposed by some (Stones and Glazzard, 2019), does not reflect the reality of lived experience of personal and perceived stigma upon HEI students, that continues to be reported as a key factor in non-disclosure/help-seeking (Student Minds, 2014; Brown, 2016).

While open to criticism, campaigns and education that aims to increase awareness of mental health/distress are considered as having an overall benefit, and are espoused by the guidance (Student Minds, 2023b; UUK, 2023a) – especially when focusing upon open communication, education, and the commonality of lived experiences (Chronister, Chou, and Liao, 2013; Carmack et al, 2018). Equally, these campaigns need to be aware of possible unintended negative outcomes (Corrigan, 2016), such as how targeted interventions that align to the diagnostic/medical model may enhance stigma (Balloo et al, 2022).

The Office for Students (2025), alongside Advance HE (Wilson et al, 2022) requests that universities take action to support open discussion of mental health, encouraging co-production, and full student engagement to develop student centred responses. Peer support and curriculum infusion (see 2.12) are cited as positive pragmatic steps to ensure students feel integrated into the university, with noted outcomes of improved wellbeing (Byrom, 2018).

While not a new conversation (Storrie, Ahern and Tuckett, 2010), the UUK Stepchange framework (UUK, 2023a), and the University Mental Health Charter (Hughes and Spanner, 2024), promote a ‘whole university approach’, that includes addressing the language and discourse of mental health and wellbeing. This guidance encourages both an open culture within institutions and a recognition that student journeys will not all be ‘perfectly smooth’ (Hughes and Spanner, 2024, p.36). As such, HEIs are steered towards approaching the issues from a wellbeing perspective, therefore minimising the impact of stigma that spotlights medical/diagnostic led discourse. UUK and the OfS both endorse and have collaborated with the UMHC, with the OfS (2025) mental health resources being organised around the themes published within the Charter.

2.7: Disclosure, help seeking, and barriers

University students can be considered as having a unique experience, specifically those that are attending a university away from their home base – this can lead to them living a dual life, spending similar parts of their year in two very different settings, with distinct sets of friends and available local resources. Students with longer term or more significant needs who may have already been accessing services at home, can face problems with consistency of support between their settings (Barden and Caleb, 2019). Transition for these students between home and university needs to be prioritised, as 73 percent of students with historical mental health support needs report a period of crisis after transitioning (Bryant et. al, 2022). UUK (2018) suggests the need for careful planning, and, where agreed by the student, sharing of information in order to minimise any disruption to care.

SWS can be a vital bridge here; however, they are unable to provide specialist support for those students with complex needs that may require psychological therapies or input from a crisis team as part of their care plans (UMHAN, 2019). Further, parents who may have been the core support for their children with established needs report frustrations with contact with and between SWS that may lead them to feel fully excluded. This is in part due to unrealistic expectations of what HEIs can provide, and aspects of confidentiality (Boughton et al, 2021).

While demand for support continues to rise – a noted doubling in requests for counselling across United States campuses since the turn of the Century (Storrie, Ahern and Tuckett, 2010) – there are still several barriers to disclosure and help seeking. Stigma, as discussed, is a clear part of this, with the impact of self, perceived and public stigma affecting help-seeking behaviours in numerous ways. This can be particularly acute where the impact of a diagnosis/label brings attached stereotypes (Corrigan, 2007). Even where stigma is managed by the student, or at least they have found a means to bypass this, there are additional barriers that may impact upon disclosure/help-seeking (Bryant et al, 2022).

One apparent obstacle is that very high numbers of students state they are unaware of SWS at all, or that they are unsure of what support can be offered (Brown, 2016), with recent figures from Student Minds (2023) suggesting that 1 in 4 continue to state they do not know where to get help at their universities. Even where there is some knowledge, students may feel that SWS only offer traditional types of support such as counselling that may discourage contact (Barden and Caleb, 2019). The term ‘disability’ itself when used in relation to SWS can also act as a deterrent, reflecting discriminatory notions of what it is to have a disability (Simpson and Ferguson, 2014). Other reasons include that many students will continue to prefer support from family, friends and university peers, before turning to professional services (Byrom, 2017; 2018). In addition, students also favour support from their tutors above SWS (Hughes et al, 2018); and indeed, may opt for the wide variety of online and app-based support (see 2.11).

Hartrey, Denieffe, and Wells (2017, p.216), argue that there are two key features that influence student help seeking behaviour, specifically: ‘1. Factors internal to the person (symptoms, fear of disclosure and knowledge of mental illness); 2. Factors external to the person (knowledge, beliefs and attitudes of the college community’. Help seeking can be influenced through students feeling they have a strong sense of belonging to the university (Bryant et al, 2022), that can be enhanced through non-service driven actions, such as peer support initiatives and curriculum infusion (Barden and Caleb, 2019; Wilson et al, 2022). The UMHC (Hughes and Spanner, 2024), emphasises the importance of co-production at all levels, ensuring there are real outcomes from listening to the student voice, and embedding changes that are long-term and feed into the HEI culture, rather than small-scale, time-limited responses.

2.8 The university as mental health provider

While the student mental health *crisis narrative* is a relatively new conversation (Shackle, 2019; Frawley, 2023), the sector has been supporting their students with their mental wellbeing for decades, indeed back to the 1940s (Crook, 2020). The significant rise in demand over the past decade has impacted upon the types and levels of support on offer (Hughes and Spanner, 2024; Stones and Glazzard, 2019). While counselling services, financial advice, and direct support with access/adjustments for disabled students remains a key offer (Cybil, 2023; Hughes and Spanner, 2024), SWS are reporting that higher numbers of students are presenting with more severe and longer-term needs than previously noted (Priestley et al, 2022; Osborn et al, 2024). SWS continue to revise their offer to respond to more complex needs, including sexual trauma, and/or identity issues (Nazari and Ommen, 2019). This was recognised by UMHAN (2023) who have published clinical guidance for student mental health providers, addressing the need to balance interventions that are responsive, while acknowledging some may add to distress.

Some earlier publications addressing student mental health highlighted such areas as the importance of identifying wellbeing across students' degree journey (Bewick et al, 2010). Indeed, a text providing direction for HEIs to effectively address their student's mental health needs promoted such concepts as a 'whole institutional approach', and the need to identify the range of needs within their cohorts (Stanley and Manthorpe, 2002). It is suggested (Caleb, 2019), that managers at senior level should lead with the development of a localised mental health strategy, involving leaders from across the institution. Equally, texts promoting the importance of involving all HEI staff – including academic and administrative – as an institutional wide response (Barden and Caleb, 2019; Stones and Glazzard, 2019) – mirror the UMHC's 'whole university approach' (Hughes and Spanner, 2024). See '2.11: The role and experiences of the academic tutor' below for further details.

Research findings suggest that receiving support (whatever the preference for the individual student may be), will likely have a positive effect upon outcomes (Upsher et al, 2022; Vescovelli et al, 2017), helping to remedy the negative impact upon students' experiencing distress – including the higher drop-out rates. Positive outcomes from accessing counselling had been found, however the link between this and academic performance was noted as a gap (Lee et al, 2009). Measurements of ‘effectiveness’ is still an area identified as a gap in research – highlighted by the UMHC (Hughes and Spanner, 2024) – frequently based upon standardised questionnaires provided to students by SWS themselves (Nazari and Ommen, 2019).

The publications that have engaged with student users of SWS report mixed responses, with around half reporting a positive outcome, yet one-fifth stating that they did not feel helped (King et al, 2024). Students have reported difficulties with access to services (ibid.), including feeling they had to do the groundwork to find information (Nazari and Ommen, 2019). Some do not relate what they are experiencing as a ‘need’ and so may wait until experiencing a crisis (Osborn, Saunders and Fonagy, 2022). Students have reported dissatisfaction with SWS, that they can feel isolated or abandoned by existing provision (Barnett et al, 2021), or indeed a feeling of simply being placed on a waiting list after a bureaucratic form filling procedure (Priestley et al, 2021).

One of the existing barriers for students has been noted to relate to a lack of understanding as to what SWS can and do provide (Priestley et al, 2021), highlighted as one of the key barriers (alongside stigma), as covered in 2.7. In addition, many students still feel that counselling is the only service that SWS continues to offer despite the diversification of provision (Barden and Caleb, 2019). The lack of knowledge of what SWS can offer leaves many students feeling intimidated by the thought of seeking support, often confused by fragmented services, and left wondering if they ‘deserve’ this help (Osborn et al, 2024). The Department for Education commissioned a report (Pollard et al, 2021) researching areas of student mental health with universities. The report identified variations in strategy across HEIs, and specific gaps in evidence – including the need to further understand student expectations and evidence of effectiveness – that providers highlighted as useful for improving services. This report was valuable, and enhanced why the UMHC (Hughes and Spanner, 2024), is so vital to drive forward both national and localised strategies (see 2.10 below).

Gaps in the research relating to HEI SWS provision include limited findings in relation to collaboration between services (Osborn, Saunders and Fonagy, 2022), and minimal research from student perspectives about barriers to access (King et al, 2024). Others point out that some research only addresses those with a confirmed diagnosis, therefore missing perspectives of those experiencing distress related to common wellbeing factors (Oswalt, et al, 2020); and that overall data collection is low (Francis-Taylor et al, 2023). Conversely, there have been growing studies exploring alternative (or complementary) support options, such as with new technologies, or peer led support (see 2.12 and 2.13 below).

The key purpose of this project is to address the very limited research that has engaged directly with SWS employees and their wider institutions (Osborn et al, 2024). With the transformed landscape of the HEI sector, alongside the known increases in demand and complexity of presentations, it is vital to hear the voices of those delivering services, that, in turn, should have an input into future research, policy and guidance. Some of the points (above paragraph) – collaboration between services; common well-being factors; and new technologies – are covered within the interview questions (see Appendix Three), to hear the perspectives of those leading SWS. Other gaps need to be addressed (see recommendations chapter), to continue to support and guide HEIs through their duties of care and in the context of the guidance (see 2.9 and 2.10 below).

2.9 HEI responses – current policy and directives; duty of care

The transformation of the HEI sector since the early 1990s has resulted in universities requiring a much broader remit beyond the teaching of degrees. However, the specific obligations of HEIs in respect of the welfare and mental wellbeing/health remains blurred. In 2010, it was noted that student mental health was becoming a ‘growing problem’ and that university welfare providers were lacking the knowledge and skills to effectively respond (Storrie, Ahern and Tuckett, 2010, p.5). Since this time, the developing conversations, along with the stream of reports, research and policy have driven HEIs' need to respond.

The Department for Education (DfE) has recently confirmed that HEIs have a ‘general duty of care’ to their students, specifically not to cause harm while carrying out its functions (DfE, 2023). This was part of the government’s response to a petition calling for a statutory legal framework of care for HEIs towards their students (Farrer and Co, 2023). The petition was led by the campaign group ‘For the 100’ (2023) – named after the approximate 100 students per year who take their own lives by suicide. Parliament did debate the petition, concluding that the current general duty of care should be sufficient, with the universities minister pressing HEIs to adopt the UMHC (Hughes and Spanner, 2024), by September 2024 (Blake, 2023). UUK (2023b) supported the outcome, highlighting that protections for student wellbeing are covered through the existing duty of care alongside contractual duties and the protections afforded by the Equality Act 2010. Legal cases regarding alleged failings in HEI ‘duty of care’ can be taken to civil courts, alongside challenges based around the EqA, and the *general data protection regulations* (GDPR), within the Data Protection Act 2018 (Barden and Caleb, 2019).

The Office for Students (OfS) within its regulatory framework (2022), specifies that, ‘support’ does not include other categories of non-academic services, for example, the provision of welfare and counselling services for students’ (ibid. Para. 333J). While the OfS (2025), is clear it does not regulate student welfare services (SWS), their website has guidance in relation to student mental health under its ‘advice and guidance’ section. This has a series of recommendations, broadly reflecting the themes of UUK’s (2023b), ‘mentally healthy universities’; and the UMHC (Hughes and Spanner, 2024) – further details below.

The UK Quality Code for Higher Education (QAA, 2023) references the OfS regulatory framework, then sets out a series of expectations for ‘standards’ and ‘quality’. While there are several references to ensuring there is *support* for students, there is nothing specific in relation to mental health or wellbeing. Beyond the OfS, outside regulators for professional HEI programmes also direct that providers ensure provision for student welfare needs – such as Social Work England’s *education and training standards* (SWE, 2021), for approving and revalidating social work degrees. This includes the expectation that training providers, ‘Ensure that students have access to resources to support their health and wellbeing…’ (ibid., standard 5.1).

There is an expectation for SWS to have clear pathways for students with more complex needs including those that may self-harm or express suicidal ideation (UUK, 2018). The Suicide-Safer Universities guidance (ibid.), advises HEIs to assess risk across key student demographics, and look beyond traditional points of concern (such as academic pressures and financial concerns), into wider risk contexts such as stress created by geopolitical concerns, and cultural factors. A recent coroner’s inquiry following a student suicide criticised a university for not responding effectively to a student in need (Morriss, 2021), influencing the campaign, *Forthe100* (2023). Again, this is an area where boundaries of responsibilities are less clear – further hindered by local variations in partnership arrangements with the NHS (see *Analysis*) – with SWS often managing significant risk, leading to ‘complex ethical challenges’ (Hughes and Spanner, 2024, p.43).

While student suicide rates remain below the average for the general population within a similar age range (OfS, 2022), suicide remains one of the leading causes of death for this age group (Taub and Thompson, 2013). There are varying rates reported by the Office for National Statistics (2021), noting a reduced rate in the four years up to this publication (with a suggested discrepancy in reporting due to Covid-19). More recent analysis indicates that after consistent year on year reductions, there has been (in line with all younger people), an increase (Sanders, 2023), with an ongoing particular concern for the significantly higher rates for young men (Sagar-Ouriaghli et al, 2022; OfS, 2022).

While known influences upon suicidal behaviours – such as adverse childhood experiences or a relationship break-up – equally affect the student cohort, there are also noted university environment related factors, such as struggles with academic performance and expectations (Kabir et al, 2024). Equally, a more balanced approach has been suggested, with a recognition that the ‘crisis narrative’ may actually be increasing risk (Bantjes, Hunt and Stein, 2023). HEIs clearly take this concern seriously, and promote different means to support students in crisis, such as advertising Papyrus

(2023) and other relevant organisations. Higher risk groups such as young men and LGBTQ+ students may need directing to specific resources (OfS, 2019). There also needs to be an acknowledgement of the impact student suicide can have upon tutors, and the personal distress they will also be experiencing (Barden and Caleb, 2019).

While universities have parameters of the level of support they can offer, it remains vague as to how far the university or NHS provision should be the first line of contact for students in significant crises, an issue addressed by UMHAN (2019). Sampson et al (2022) noted the lack of research about collaboration between the NHS and HEIs, with the UMHC highlighting the detrimental impact of early discharge from services, or as they describe a continuous ‘hand-off’ between the NHS and SWS, rather than seeking ongoing cooperation to support students (Hughes and Spanner, 2024, p.49).

2.10 Guidance and reports

Despite evidence about some historical sector-driven discussion about student wellbeing, Macaskill (2013) asserts that the issue is a current one. From a student-led perspective, various bodies have developed and published guidance over the past decade (Dig-In, 2019; Student Minds, 2014; 2023a; Wonkhe, 2019). Back in 2018, UUK published their ‘starting a conversation about mental health’, with language mirrored by UCAS in their 2021 report, indicating that, at least for the sector, this is judged as a current topic. The work of the NUS (2022), and Student Minds has been two-fold – firstly seeking to raise awareness of the issues through publishing reports with research discussing the rise in demand; and secondly, with taking a lead to support HEIs to respond to the impact of low wellbeing upon their students.

Most significantly – originating with students sharing their own experiences with peers, and then evolving over a decade with various collaborators, alongside endorsements from the Office for Students and UUK – Students Minds launched the ‘University Mental Health Charter’ (UMHC) in 2019 (Hughes and Spanner, 2019). Research (Priestley et al, 2021) that sought student views about SWS, noted that the participants endorsed a ‘whole university approach’ reflecting the principles of good practice within the UMHC. The UMHC Framework outlined a set of eighteen key themes grouped across four domains (see Appendix Two), and invited HEIs to sign up to the programme and seek to achieve the framework award (ibid). Despite the launch time and associated impact of Covid-19, three universities signed up to be part of the pilot programme (Hughes and Spanner, 2024). Since this time, the UMHC has been updated in 2024 (with funding from the Department for Education and Office for Students (Hughes and Spanner, 2024), to continue wider collaboration with universities to acquire the Charter award via meeting their *principles of good practice* (Student Minds, 2024b).

The impetus behind the UMHC is to support HEIs to develop a *whole university* response to mental wellbeing, considering the needs of students across their studies, in addition to fully acknowledging the importance of staff mental health. Student Minds (2024c), in their 2024 *Manifesto* call upon the government for urgent funding to not only support universities to be able to adequately address the mental health needs of their students, but also highlight the serious underfunding of related services within health care and housing. While membership of the UMHC remains voluntary at the time of writing, 113 HEIs have now signed up, with Student Minds being supported by the funding boost (OfS, 2024c) to support this broader engagement. To note, at the time participants were interviewed for this project, only one of the five contributing HEIs were engaging with the Charter, and at time of writing this has now increased to four out of five – this includes my own university.

The sector-led response has been driven by Universities UK, who introduced the ‘Stepchange’ framework, (developed in 2017) endorsing a ‘whole university' approach alongside other co-publications (Thorley, 2017; UUK, 2023). ‘Stepchange’ has since evolved into ‘mentally healthy universities’ and continues to advocate for embedding wellbeing for all students and staff, through a ‘shared vision’ actively mirroring and endorsing (via co-production), of the UMHC’s premise (ibid.). These proposals are supported through other bodies, such as UCAS (2021), and Advance HE (Wilson et al, 2022), with their ‘toolkits’ for HEIs seeking to embed wellbeing in the curriculum.

The focus is very much upon broadening the issue and infusing wellbeing throughout the institution, including a focus upon ideas such as co-production; embedding wellbeing into the curriculum (Houghton and Anderson, 2017), and other ‘proactive, rather than ‘reactive’ measures (Hughes and Spanner, 2024). Seeking a balance between addressing the themes within the UMHC Framework's four domains, the 'Charter' is clear that responses should not be overly prescriptive, highlighting the need for HEIs to be able to develop bespoke, localised responses, as also argued by others (Nunez-Mulder, 2018).

2.11 The role and experiences of the academic tutor

The wellbeing of their students is clearly a concern to university tutors, and supporting students with personal issues is seen as falling within the expectations of their wider pastoral care role (Stones and Glazzard, 2016). Earlier research (Macaskill, 2013; Storrie, Ahern and Tuckett, 2010), suggested that HEIs were lax with developing expectations for staff, leading to knowledge gaps where some tutors regarded student mental health needs as 'behavioural', or simply disregarded the concerns.

Despite this, it has been noted for some time that students will turn to their personal tutors above any other routes for support outside of their friends and family (Bryant et al, 2022; Stanley and Manthorpe, 2002). Equally, tutors continue to feel unskilled with these matters, leaving them feeling vulnerable when a student has directly disclosed a concern to them (Hughes et al, 2018; Spear, Moray and Steen, 2021). This, in turn, can have serious implications for the wellbeing of academics, with anxiety caused through worrying about their student's mental distress, and whether or not they have done enough to support them within expected professional boundaries (Hughes and Byrom, 2019). This can have a serious impact upon morale, should tutors not receive adequate guidance and support (Barden and Caleb, 2019).

University staff already report high levels of mental distress, mostly related to pressures of the role, with the consequences of a poor work-life balance and ultimately, the experience of 'burnout' (Wray and Kinman, 2021). This intensified during the first stages of the Covid-19 pandemic, with all teaching staff having to adapt and take responsibilities for teaching their students online (Carr et al, 2021). In addition, neoliberalism has driven changes to academic research as the market for 'externally funded, problem-oriented transdisciplinary research projects' (Ylijoki, 2003, p.308), has been replacing traditional values-based research. Tutors are, at time of writing, experiencing intense pressures about their future careers due to the financial crisis in the HE sector and the looming spectre of compulsory redundancies (Standley, 2025; Times Higher Education, 2025).

There are clear discrepancies within HEIs as to how the wellbeing of their staff is addressed and what support is made available — this seems to relate to individual HEI cultures, despite the guidance requesting that HEIs should be promoting staff wellbeing as equally aligned to those of its students (Hughes and Spanner, 2024; UUK, 2023). Tutors also face barriers to help seeking, including the impact of stigma, and concerns about being considered unsuitable for their role by employers (Wray and Kinman, 2021). The UMHC and UUK Stepchange framework in both their original and current formats highlight the equal importance of staff wellbeing as a key factor for seeking 'mentally healthy universities'. It is argued that without ensuring staff wellbeing, within a 'whole university approach' then this will filter down and impact negatively upon student wellbeing. The UMHC dedicate one of their four framework *domains* to staff development and wellbeing, describing the interplay between staff and student wellbeing as 'inextricably linked and supportive of one another' (ibid. p.56).

Should students continue to face barriers to disclosure and help-seeking from either SWS or wider services, then the only guaranteed communication/contacts are embedded within the curriculum, and/or with their tutors (Hughes and Spanner, 2024). As discussed, research suggests that many students will have a preference to disclose concerns with tutors/personal tutors, rather than seeking help through services (Bryant et al, 2022; Hughes et al, 2018). This then places a clear responsibility for staff to feel prepared and equipped with supporting students in need. However, with tutors' knowledge base of mental health reflecting broader notions of socially constructed understandings (Carette, De Schauwer and Van Hove, 2018), then responses will vary tutor to tutor and between institutions, leaving both staff and students with inconsistent responses (Hughes et al, 2018).

Universities need to ensure staff are aware of all the services (and the limitations) that SWS offer, alongside discussion around the complexities that may surround issues of disclosure and confidentiality, and professional boundaries (Hughes et al, 2018). Personal tutors specifically need support to safely respond in crisis situations and/or where self-harm or suicide is a noted risk (UUK, 2019). Providing the tools for tutors to respond effectively is regarded as essential, which may involve internal support and training, alongside the provision of space and time for tutor peer reflection, and the sharing of advice and learning should also be encouraged (Walker, Tait-McCutcheon and Gilbert, 2023; Stones and Glazzard).

Embedding positive wellbeing in the curriculum has been promoted by the former Higher Education Academy, (now Advance HE), (Houghton and Anderson, 2017), focusing upon the universal language of mental health, and a move away from the medical discourse of psychiatry, and the binaries of mental ‘mentally well’ or ‘mentally ill’. Their proposals (as with UUK’s, and Student Minds’ approaches), gives significant weight to the experiences and wellbeing of staff as well as students. While acknowledging the difficulties, there are suggested frameworks that place ‘curriculum infusion’ as the core of whole university wellbeing (Barden and Caleb, 2019), supported through ‘toolkits’ published by Advance HE (Wilson et al, 2022).

There are many suggested positives from enabling students to feel a sense of belonging during their studies (Bryant et al, 2022). HEIs can support this through varied means, such as enhanced student voice (Brooman, Darwent and Pimor, 2015), or enabling peer support interventions, acknowledging the impact of ‘experiential knowledge’ (Byrom, 2018; Ramon and Williams, 2005). Supporting students to develop a sense of ownership of the curriculum can support deeper learning that has been noted to have a positive impact upon wellbeing (Hughes and Spanner, 2024). The sector-led guidance has been promoting the potential positive outcomes through the embedding of wellbeing into the curriculum, and this has been backed up with research outcomes that suggest a multi-layered approach beyond direct teaching practices, including reviewing assessment and feedback (Upsher et al, 2022; 2023).

While these, and other proactive strategies need to be considered within individual HEI plans to develop a whole university approach (Barden and Caleb, 2019), academics on the front-line of student support continue to report increasing class sizes and therefore reduced time to offer individual pastoral care to their students (Hughes et al, 2018). This, in line with growing risks from market pressures and financial sustainability (Foster, Gross and Borrott, 2023), all noted by the office for Students (2023), will only add to the existing pressures being felt by tutors, (Wray and Kinman, 2021), that will, in turn, have negative consequences for their students.

2.12 Alternatives to student welfare support

Irrespective of SWS' varied and flexible offer to students, the impact of the known barriers, mean that some will not want to use university services, with figures suggesting that low numbers of students who may need support, seek help within their HEI (Sanders, 2023; Student Minds, 2023). As examined, this relates to various reasons, including stigma; what their perception of what SWS is for and what they can provide (Student Minds, 2024b); the benefits of accessing these services; and their own attitudes and self-evaluation of the acts of disclosure and help-seeking (Li, Denson, and Dorstyn, 2018).

Some students may already have a network of support based around their home environment, including their own GP and/or other primary or secondary mental health services (Stones and Glazzard, 2019). Other students may feel that their family and home friend groups may be sufficient to meet their needs (Grant, 2002), and so these students may opt to keep this separate from their student lives, choosing to avoid discussing their mental wellbeing with their university friendship groups (Carette, De Schauwer, and Van Hove, 2018). Family support will depend upon the scope of the parent-child relationship and other variables based upon identity and class; however, seeking support from family and friends continues to be the main route students choose, far above HEI or other professional resources (Boughton et al, 2021).

Peers continue to be highlighted as the first point of disclosure for students, with up to two-thirds seeking initial support from a friend (Pointon-Haas et al, 2024). Friends may find an unofficial caring role rewarding, however, in turn, this can significantly impact their own wellbeing, including upon their own academic performance (Byrom, 2017).

Acknowledging the above, the UMHC notes the promising effectiveness of student or peer-led interventions – suggested to be as effective as professional offers (Byrom, 2018) – while also acknowledging the potential detrimental impact of leading with a caring role upon the individual (Hughes and Spanner, 2024). There are potential risks where this is not fully underpinned through robust support from the HEI (Pointon-Haas et al, 2024), and so carefully managed, and integrated peer-led interventions require support. These can be particularly positive to address experiences of loneliness (Byrom, 2018), with studies suggesting this may effectively mitigate negative influences upon wellbeing (Goselin and Rickert, 2022).

Students identifying as BAME and/or international students may seek support for their wellbeing via avenues associated with their cultures, including religion or other means to meet spiritual need (Knifton, 2012). As stated, it remains important for universities and SWS not to stereotype and/or assume that international or BAME students either do not want to engage due to cultural stigmas, or that their families/wider cultural networks will be sufficient to meet need (as discussed in 1.3c). Black students can benefit from peer support groups delivered by Black students where they may feel safe addressing the lived experiences of racism and associated isolation (Stoll et al, 2023). Students also report that they find their own positive resources for their wellbeing through aspects of their identity and cultural interests such as films, sport, and novels (Carette, De Schauwer, and Van Hove, 2018). Finally, while open to critique, students may well seek support individually via the range of websites and apps available for mental health and wellbeing.

2.13 Apps and websites

The use of websites, apps, and more recently artificial intelligence (Lister et al, 2021), to provide information, and in many cases alternatives to seeking in-person mental health support have existed for some time, with a noted surge in usage during the COVID-19 pandemic (Iwaya et al, 2023). The growing availability of apps providing mental health support is evident, with current estimates that there are around 300,000 active apps relating to mental health worldwide (Chiazzui and Newell, 2019).

It is recognised that the use of mental health apps globally, sometimes termed ‘mhealth’ (Kenny et al, 2020), can at least provide a service to those from countries where the financial ability to access health support is a major issue (Chiazzui and Newell, 2019). Apps can also provide a means to address barriers to disclosure and help seeking driven by self and perceived public stigma (Lee and Jung, 2018). Indeed, some go further to suggest that the ‘digital tools they select may be the difference between improvement and decompensation or even life and death’ (Chiazzui and Newell, 2019, p.1).

There is some evidence of effectiveness, such as an internet-based cognitive behavioural therapy programme enhancing wellbeing for adolescents (Eisenberg et al, 2009); or at least for short-term improvements in anxiety (Lee and Jung, 2018). For some students, these resources may help address additional barriers, such as bridging support between home and university support options (Hughes and Spanner, 2019); and a level of confidentiality for those students on professional qualifications, concerned about being considered unfit to practise (Lee and Jung, 2018). Soria and Horgas (2021) argue that those students who may be more likely to be experiencing isolation on the grounds of identity, could benefit most from the expansion and promotion of apps. Much of this also depends upon the ‘digital capabilities’ of students, access to appropriate IT resources – with links to socio-economic status – and matters of privacy within their homes (Dinu et al, 2022).

Student Minds (2025) have been a dedicated information and support hub for students since 2013, rebranding from the original 2009 founding organisation, *Student Run Self Help*; while the *Big White Wall*, now *Togetherall* (2023) presents as an online ‘community’ with 24-hour access. This latter platform is commissioned by over 200 education establishments in the UK (ibid.), self-promoting its features of accessibility and flexible usage for young people, while attracting multi-million pound investments as it expands worldwide (PR Newswire, 2020). Despite this, there are difficulties with measuring outcomes (Marinova, Rogers and MacBeth, 2022), alongside – as with other mental health apps – suggestions that sustained engagement rates are low, falling below 20 percent from those originally subscribing (Melcher et al, 2022).

While apps can credibly be regarded as a viable alternative tool for help-seeking for those concerned about social stigma, there has been limited research to gauge their effectiveness, and indeed safe usage (Anthes, 2016). This is, in part, due to the reliability of testing efficacy beyond analytic data (Chiazzui and Newell, 2019). There have also been concerns raised about data privacy (Iwaya et al, 2023), with mental health apps often sharing user analytics. In addition, apps could be seen as driving a diagnostic/ medicalised response to poor wellbeing that for many they are experiencing an expected reaction to stress or feeling anxious (Parker, et al, 2018).

In addition to apps, there are now various private companies seeking to market themselves to universities as a means to help their services 'improve', and meet the gaps identified in services. Some of these, such as *Solution Path* (2023) focus upon the use of analytical data and/or artificial intelligence to suggest their effectiveness in meeting gaps in provision; or *Meee* (2023), proffering that their approach to finding the 'magic' in staff and students will change education.

While apps and other web-based support are an inevitable growth factor, SWS need to be mindful of an over-reliance due to the limited account of effectiveness; minimal guarantees of a 'safety net' for users; and indicators of enhanced isolation (Hughes and Spanner, 2024; Lee and Jung, 2018; Kotera et al, 2021). Which apps HEIs, and specifically which SWS seek to promote also have the potential to increase poor wellbeing due to reports of the ineffectiveness of many apps as an alternative to in person provision (Carette, De Schauwer, and Van Hove, 2018; Byron, 2019). Usability is reported to be a barrier, with some not responding well to complex features (Chiazzui and Newell, 2019); and many young people seeking their own preferred apps, rather than being directed to one associated with an institution/programme (Byron, 2019). Research suggests that overall app use continues to increase, reflecting the wider picture that people experiencing mental distress will continue to seek their own preferred ways to meet their wellbeing needs, (Carette, De Schauwer, and Van Hove, 2018).

2.14 Conclusion 1 – is this a crisis?

The *crisis narrative* is being applied with reference to the perceived increasing mental health needs across all populations. At times this can be focused upon the general population (BMA, 2022); or key components of a population, such as women, where stereotyping still influences support outcomes (Hussen, 2023); or to men, often with the focus upon suicide rates (Mental Health Foundation, 2021). More commonly seen, are reports and surveys framing the mental health needs of children and young people as a 'crisis*'* (Gregory, 2023; Hub4Leaders, 2017), alongside the notion that most teachers of school age children feel ill-equipped and/or unsupported to be able to effectively respond (Lowry et al, 2022). Some reports focus on the longer-term outcomes of this *crisis* for young people upon their life opportunities, and for the future impact on the overall economy (Centre for Mental Health, 2025).

Internationally, college-age student mental health has been increasingly aligned to the *crisis narrative*, advocating a critical response in line with other global emergencies (Bantjes, Hunt and Stein, 2023). This term is often employed through the media (Bewick and Stallman, 2018), that increased both during, and post, the COVID-19 pandemic (Hall, 2022). The labelling of the situation as a 'crisis' is echoed within some of the reports, surveys, and guidance that has been published over the past decade, such as with the National Union of Students in its current mental health policy (2022) applying the term freely; and the Dig In/Insight Network report (2019, p.4), describes the situation as a 'crisis*'* within its foreword.

In addition, the sector has been utilising the term for discussion within conferences (Open Forum Events, 2022), and symposiums (Colleges & Universities of the Anglican Communion, 2019), seeking to address responses to student mental health needs. Research papers have also been noted to use the terms 'crisis' or 'epidemic' within their studies (Usher, 2022; Vogt and Johnson, 2022); with others questioning the terminology (Dinu et al, 2022). The University Mental Health Advisors Network (UMHAN, 2019) published a considered response to Shackle's (2019) article that focussed upon 'poor' university responses to the 'crisis', through refocusing the debate upon gaps in NHS provision, that has resulted in enhanced dependence from students upon their HEIs for often complex and acute needs.

Understandably the use of this term – defined in the Cambridge Dictionary (2023), as ‘a time of great disagreement, confusion, or suffering’ – is being used intentionally to raise awareness of the concern with a seemingly benevolent cause (The Tab, 2023). However, there has also been criticism of the application of this term, such as Crook’s (2020) suggestion that the current claims of a ‘crisis’ need to be placed within a historical timeline stretching back many decades. Likewise, Frawley (2023) argues that the perceived ‘student mental health crisis’ is a ‘myth’, being driven through a combination of private sector intervention, media ‘hysteria’, and a push for the medicalisation (and therefore treatment options), for what may be regarded as *common* patterns of positive, and indeed negative wellbeing. Others (AYPH, 2021) acknowledge that statistical data can be misleading and suggest a refocus away from the *crisis narrative*, and towards flexible responses, with a particular focus upon gender.

Further, it’s been argued that through making claims, such as *most* student’s mental health is in ‘crisis’, or media suggestions that student life is *unsustainable*, may make many feel and think that this applies to them (Perry, 2014; Brown, 2016). This term may also drive students towards the medicalised/diagnostic discourses of mental health, and, therefore, encourage a move away from universal concepts of wellbeing, with the outcomes of enhanced stigma and reinforcing patterns of less disclosure and help seeking behaviours, (Tamin, 2013, Simpson and Ferguson, 2014). Bantjes, Hunt and Stein (2023) reflect these concerns, and while advocating for student mental wellbeing to be given greater attention, they suggest that the *crisis narrative* can have several unintended negative consequences, including the potential to enhance suicide ideation (mirroring the above perspectives). They assert that students may avoid support seeking as they are seen as being expected to feel ‘anxious, depressed and suicidal’ (ibid. p.1).

Returning to the UMHC, the authors acknowledge that there is a ‘felt state of crisis’ (Hughes and Spanner, 2024, p.22), however, argue that espousing this term may impede positive progress. Further, the UUK Stepchange guidance (2023) is also cautious with language use, avoiding generalised terms such as the idea of a current or impending crisis, maintaining its focus upon universal wellbeing across the student (and staff) experience.

2.15 Conclusion 2 - summary

While there have been some longer-term concerns noted in relation to student mental health and wellbeing, the growth in reports, publications and guidance over the past 10 years in particular, does suggest that this is a relatively recent public conversation. The developments in higher education have, without doubt changed the experience of being a university student, not least due to the status of student as a consumer, with the university as a provider of a service. It is known that there is a significant increase in student declarations of mental health needs, and this has been clearly reflected in quantified demand for support from university student welfare services. The difficulties with conflicting measures of student mental health and wellbeing reflect the broader complexities and contradictions with language and meaning within this topic area.

Alongside broader stresses for younger people, there are many specific factors that impact on the wellbeing of students. In turn, it is known that those students who are struggling will likely experience detrimental outcomes during their student journey, and indeed longer-term life opportunities. Additionally, it is clear that students facing oppression due to aspects of identity, or intersecting aspects of identity, will have higher levels of reported distress, requiring SWS to have a broad knowledge base, as well as the need to develop bespoke responses.

While demand for services has been rising, there are multifaceted barriers to help-seeking behaviours. Stigma is clearly an incessant and significant factor in disclosure and support seeking – again, more so for certain groups of students, including international students. Anti-stigma campaigns have shown to be limited, and at times detrimental, reflected within the UMHC that awareness raising will likely have minimal impact upon behaviours and outcomes. Additional barriers have been identified, including that students still often feel confused about what SWS can offer, or indeed whether their distress merits support; finding the pathways to access confusing and/or daunting; and for some, once engaging, are left feeling abandoned.

Responding to the known increase in need, the sector and student led bodies (specifically, Student Minds and UUK), have actively developed approaches based upon a comprehensive ‘whole university approach’ – led by the UMHC (Hughes and Spanner, 2024) – directing HEIs to embed wellbeing throughout the university ecosystem, specifically endorsing the need to address the wellbeing of their staff on an equal basis. While the guidance highlights the need to be flexible to account for the individual makeup and locality of the institution, it is also identified that many students will seek alternative means to seek support, including via peers; self-identified support structures; or new technologies. Several gaps in research have been identified, including the need for further student perspectives about access; evidence to capture ‘effectiveness’; and (key to this project) a dearth of research that speaks directly to those working and leading within student welfare services.

The narrative that the mental health of students is in a *crisis* seems unlikely to be helping overall, despite the benevolent intentions towards improving young people’s wellbeing. It remains unclear whether the rise reflects an increase in general levels of distress in young people; and/or being influenced through a growing societal discourse, with more open discussion about mental wellbeing (Knapstad et al, 2019); and/or via such notions ‘concept creep’ (Haslam, 2016; 2024), and ‘prevalence inflation hypothesis’ (Foulkes and Andrews, 2023). These concepts will be probed further within the analysis and discussion sections. The methodological choices (see next chapter), enable a reflexive interpretation that will draw back upon the theoretical influences, the extant literature, along with my own identity and subjectivity to further examine the existing situation.

Chapter 3: Methodology

3.1 Introduction

This chapter will explore, explain, and justify the methodological choices for this research project. It includes a synopsis of the theoretical and ideological positioning (as outlined in the *Introduction*); the relationship of these to my ontological and epistemological research stances; and how these have informed the research questions and the motivation to explore this subject area.

There will be an overview of the method of data collection – semi-structured interviews – making connections as to how this research tool supported addressing the research questions and a reflection upon the processes involved. The decision to recruit participants from university student welfare services (SWS) will be explored, with reflexive discussion about working with the participants, and integrating a review of ethical considerations. It will then discuss Braun and Clarke's (2020) development of their *thematic analysis* approach, with an emphasis on the *reflexive thematic analysis* (RTA) model that is the chosen methodology for this thesis. Following this, it will detail my engagement with RTA that informed the theme development; the processes of exploring the data that identified the final themes; incorporating reflections upon the stages woven into each section. In addition, it will review ethical considerations and the notions of *subjectivity* and *reflexivity* in the research process. Reflecting upon reflexivity will support the links between the research objectives, methodological choices, and aspects of my own identity, aiming to clarify the decisions made as below (Finlay, 2002).

3.2 A brief recap

To begin, I will provide a brief recap of the purpose of this project, with a reminder of the research questions. The broad topic is student mental health with a focus upon how university student welfare services are responding to the known expansion in demand.

The research, while not seeking to quantify the reasons behind the rise in support seeking, will consider potential reasons and meanings behind the increase, including factors suggested by the reports and research, in addition to those identified by participants. The language of the current policy, guidance and directions for practice will support the examination as to how service providers are responding – all with context to the changed face of the higher education (HE) sector. There will be an underpinning poststructuralist lens applied, informed through various critical mental health perspectives, in order to examine prevailing discourses.

The *literature review* identified the current landscape of this topic area, referencing the socio-political changes in higher education over the previous decades. The literature establishes the interacting complexities/contradictions with language and the broader discourse of mental health, while acknowledging specific factors that impact HEI students, including matters of identity. The review highlighted areas of both national and localised responses as HEIs seek to respond to the increased demand for help-seeking, with a specific interrogation of the *crisis narrative*.

The (below) research questions were developed in response to matters determined by the extant research, policy and wider frameworks. The main question seeks to address the limited existing research – see *Introduction* and *Literature Review* chapters – that directly speaks to those on the 'coalface' of meeting student welfare needs. The first three sub-questions recognise the interplay of language and stigma, and how these enforce barriers to help seeking behaviours. It felt important, given the enhanced guidance and media attention being directed at this topic area, to have a specific research question in relation to this, and then finally to draw it all together with studying how student welfare services (SWS) are adjusting their provision to what is known. The methodological choices – as covered in detail below – will explain how these assisted to respond to the research questions.

3.3 Research questions

Main research question:

- *How are UK higher education student welfare services responding to the perceived 'crisis' with student mental wellbeing?*

Sub-questions:

- *What are the influential factors in the surge in demand for mental health services from universities?*
- *How do attitudinal barriers, including stigma, continue to manifest?*
- *How may the language and discourse of mental health and illness impact upon provision and help-seeking; How might the framing of this issue as a 'crisis' impact upon support?*
- *How does national guidance, policy and related research promote and/or support SWS responses to the increasing needs of students?*
- *How are HEI student welfare services adapting their provision in light of the above?*

3.4 Choices

The *Introduction* and *Literature Review* indicate the complexities involved with attempting to quantify/measure rates of mental health, distress, and wellbeing, as well as determining what counts as 'improved wellbeing'. These difficulties reflect the intricacies and contradictions with the language of *mental health*, informed through factors such as evolving social perceptions, and notions of 'concept creep' and 'looping' (Foulkes, 2021; Haslam, 2016). With a reflective awareness of these elements, I was moved to engage with a methodology where subjective interpretations of phenomenon are encouraged.

This section provides an overview of my research design and decisions, and how these choices supported me to address the research questions. It will explore the links between my own positionality; research paradigms; theoretical underpinning; and how these influenced the choices of methodology and research method. D'Cruz and Jones (2004, p.29) describe research as a 'social process', existing in a 'cultural and professional community of 'knowers'', and so the reflexivity that weaves through this thesis will refer to these social processes.

3.4a Choices: Personal

Having a personal interest in a topic is said to encourage creative research (Ransome, 2013), and where the subject has a focus on 'marginalised' people/communities, a lived experience can be seen as an asset (Hill and Doe, 2021). Opting for 'reflexive thematic analysis' (RTA) as the approach to analyse the data and support theme development (as detailed below) has been shaped by my personal and professional background, as well as my positionality.

Having observed the power of psychiatry throughout my professional practice, it is apparent how these processes oppress those at the receiving end (see *Introduction*). Further knowledge and awareness informed through my education journey have enhanced my critical perspectives of the discourse and functions of mental health services. As someone who has experienced oppression due to aspects of my own identity, I am aware of the power of binary labelling and how structured patriarchy, postcolonialism and capitalism continue to manifest and constrain individuals. Further, witnessing and experiencing stigma has again reinforced the notion of how labels can be disempowering, while accepting that many covet a diagnostic category.

Swain (2017) maintains that most doctoral students choose a topic to study that is of personal interest to them. This clearly mirrors my decisions – that my multiple identities as social worker, educator, and approved mental health professional, along with my lived experiences (including as a university student – see *Introduction*), have all clearly informed my passion for the topic of mental health. Embedding notions of self within the research design and development supports an interpretivist approach (see below), acknowledging how the researcher's perceptions of reality will impact the project outcomes (Pring, 2004; Brancati, 2018).

3.4b Choices: Research Positionality

I would describe myself ontologically as a *relativist*, in that I view the world as having multiple constructed realities with everything being relative to its context, thus challenging accepted *truths* (Silverman, 2000). This opposes the *realist* position of there being existing certainties awaiting discovery (Cromby and Nightingale, 1999). Epistemologically, I regard myself as a *social constructivist*, in that I believe meaning and knowledge are open to subjective interpretation, rather than there being fixed discourses or metanarratives waiting to be uncovered (Burr, 2003; Flick, 2020). These support critical mental health perspectives, viewing the broader notions of mental health, distress and wellbeing (see *Introduction*), as social constructs with different interpretations over time, place, culture and context.

It has long been questioned as to whether any qualitative research can claim to be objective (Holloway and Biley, 2011; Gough and Madill, 2012). These arguments are usually based around the premise that any individual (or team of) researcher(s) who actively interpret data sets, will inevitably bring aspects of themselves, including their own voice, into the process of constructing meaning (Bourke, 2014; Finlay, 2002). Braun and Clarke (2022) highlight the benefits of subjective interpretation as a challenge to qualitative researchers who seek objection, what they (ibid.) suggest can be termed 'quantitative envy'. Holloway and Biley (2011) suggest that qualitative researchers are both scientists and artists, being prepared to find (or actively seek) alternative outcomes to research enquiries.

In fields where traditional objective approaches dominate (such as *psychology*), certain theoretical positions – as with feminist poststructuralism – argue for flexible methodological approaches, with the need for an exploration and incorporation of the researcher's lived experience (Gavey, 2011). Scates (1935) critiqued those seeking to dismiss the impact of research assumptions within scientific research; with Pring (2004) suggesting that claims of objectivity in any research still requires a reflective commentary to consider how researcher positions will impact the processes and presentation of findings. Diaconu, (2014) takes this further, asserting that any research (including quantitative) staking claims of *truth-telling*, may be critiqued as *vague,* when reviewed through a postmodern lens.

Critical mental health perspectives view the diagnostic tools of psychiatry as part of a broader framework of what they contend to be a *pseudoscience* (Bentall, 2009; Sjöström, 2018). With the acknowledgment that for many, a medical diagnosis with an accompanying label may provide some people with reassurance and even validation (Beresford, 2023), psychiatry's claim of 'objective knowledge' has been consistently challenged from constructivist perspectives (see *Introduction*). Critical mental health positions profess that people are disempowered by the accepted 'realities', thus disputing wider claims of therapeutic benefit (Bentall, 2009; Moncrieff, 2009). The literature review suggests that for many students, the draw towards medicalised understandings – whether this relates to notions such as 'concept creep' or otherwise – of their experience continues to be a significant factor. Critical mental health perspectives help to place this in a context, and the methodological choices have enabled an interpretive exploration as to how this dynamic informs SWS practice.

3.4c Choices: Theoretical influences

Underpinning the research aims and objectives is a questioning of how student mental health is being framed within a *crisis narrative* and how this is influencing the broader discourse – including the neoliberal higher education sector – surrounding the topic. This will be addressed with a poststructuralist lens to question this prevailing hypothesis (Finlay, 2002), supported through Foucauldian ideas about discursivity – that *what* is said, reflects the historical and social contexts of particular discourse (Barrett, 1991). This also complements the overall constructivist/interpretivist paradigm in that language and meaning are fluid social phenomena (Burr, 2003), and so the researcher will explore what meanings may be interpreted in the context of their data and their own subjectivity.

More broadly, claims of truth within mental health systems and discourse will be addressed in respect of questioning the assertion of scientific rationality afforded to psychiatry (Diaconu, 2014; White, 2018). It will also draw upon key strands of critical mental health– as summarised in the *Introduction* – with these supporting an interpretation of the data, addressing the research questions, with all informing the analysis. Further, there will be dedicated attention to the universal experience of being a university student within a changed HE sector. This is important, as a constructionist lens requires a wider societal understanding, and as such the student experience can only be examined within its current environmental, political, and historical context.

The current context is also required to examine specific aspects of identity (as summarised in the *Literature Review*), and how these all impact both wellbeing and help-seeking behaviours – this analysis will engage with theoretical influences throughout. Embedding theoretical or conceptual ideas within the analysis bolsters the challenge to research claiming objectivity (Nakkeeran, 2010) and helps to place qualitative research within its specific time and place (Brancati, 2018). Through an open and honest dialogue of the researcher's positionality, suggesting how assumptions can influence data analysis, can counter accusations of unreliability (Mesel, 2013).

3.4d Choices: Summary and Justification

The above demonstrates the connections between the theoretical underpinning and educational philosophy that supports my decisions. There is a thread that weaves through my positionality; that meaning and language are relative to the socio-political contexts, and therefore open to construction and interpretation.

The choice of data collection tool and interview design (as set out below), being semi structured, enables participants to express meaning about a current phenomenon within their own professional context and personal understanding (Walliman, 2020). The interview questions (see Appendix Three) demonstrate how the wording of the questions sought the participant's interpretation of current events placed within a wider societal discourse. Kvale and Brinkmann (2009) suggest a quality interview question will both be clear on its theme while encouraging the dynamic within the dialogue – in practice being clear, concise, and without hidden meanings.

The methodological framework of RTA (as detailed in 3.6 and 3.7), for the data analysis encourages a subjective engagement with the data, informed through political and theoretical perspectives, alongside researcher lived experience. Effective RTA has expectations of researcher's deep engagement with the data, exploring and developing themes with an active creative, imaginative lens – this, therefore, encourages subjectivity as a positive contributor to the analysis (Finlay, 2021). The extensive examination of the data set, with a rigorous questioning/reviewing of theme patternation, are requirements for effective RTA (see 3.10), and should also inspect the motivations and the subjective passions of the researcher (Braun and Clarke, 2013). This is why the 'R' in RTA is so essential for researchers to embrace.

3.5 R=Reflexivity

The profession of social work prioritises the importance of critical reflection, both within education and ongoing professional development to help inform, support and justify our practice decisions (see Schön,1983; Fook, 2016). Both Social Work England (the profession's regulatory body), in their professional standards (SWE, 2019); and the British Association of Social Workers (the professional association of registered social workers), within their mandatory 'professional capabilities framework' (BASW, 2018), direct social work students and practitioners to embrace critical reflection.

Reflection can be regarded as the process of thoughtful consideration about what has been going well; what could have gone better; and how these conclusions may influence future practice (Moon, 1999). Often using a cyclical model, such as Kolb (1984) or Gibbs (1988), these reflective principles can apply to any professional practice including social work (Knott and Scragg, 2009), and, equally to research practice (Trainor and Bundon, 2021).

Reflexivity – in the research context – can be described as a sensitive self-awareness of how the researcher's worldviews (social, political and ideological) will influence and 'produce' knowledge throughout the research process (Bryman, 2016); or, as sometimes described, the process of 'bend[ing] back upon oneself' (Sparkes and Smith, 2014, cited in Trainor and Bundon, 2021, p.706), to interrogate how the researcher's self has informed the process and outcomes. So, while clearly the practice of reflection and reflexivity overlap and interact (Bolton and Delderfield, 2018), there are distinctions in research practice (Finlay, 2002). Infusing reflexivity into research has been critiqued as presenting a seemingly *superior* approach, compared to methods that exclude reflexivity (Lynch, 2020), and so Bryman (2016) argues for a clear attentiveness to its use across certain methodologies.

Incorporating reflexivity into research, as required with RTA, requires the researcher to have an enhanced awareness of self (Berger, 2015). This should go beyond theoretical positionality (Trainor and Bundon, 2021), and may include (but not exclusively) the researcher's own world view; political and ideological positions; professional and lived experience; and value base. Researchers will need to consider the complex and often contradictory aspects of themselves as part of active reflexivity, with enhanced consideration about what assumptions they will be bringing into their analysis of data, and with respect to their research goals (Hill and Doe, 2021).

Reflexivity can be incorporated into a specific stage of the research process, such as with Etherington (2004), or Dodgson (2019), suggesting a focus on interrogating the ‘dynamic interplay’ between researcher and participant, and how this may influence the findings. Others (Braun and Clarke; 2022), suggest reflexivity can or should be involved at every stage – a decision I made. While some (D’Cruz and Jones, 2004), propose that reflexivity will help to minimise the impact of self into the research process, Braun and Clarke (2019) argue that the influences the researcher imports into the process is actually a positive for the RTA approach. Through viewing the researcher as an active participant in the process, this supports each stage of RTA, with the expectations of actively revisiting the data, codes and theme development (see 3.10).

This multi-staged process is an expectation of RTA, seeking to critique and renegotiate early coding and theme identification, revisiting how life experience and broader values will inform thematic analysis (Braun and Clarke, 2013). This key function of deep, reflexive engagement with the data supports RTA’s purpose of imaginative theme generation – an active participation of theme development, rather than enabling them to passively emerge.

3.6. Research framework

3.6a Methodological decisions

While there are many perspectives of, and approaches to qualitative research, there are clear distinctions to quantitative research (Bryman, 2016; Coe et al, 2017). In general, these differences relate to how qualitative research engages with ideological and sociological perspectives and how notions of subjectivity within the design, application, and interpretation within the research differs from the quantitative desire for objectivity. Qualitative researchers are seeking meaning about phenomena, rather than testing an established proposition, alongside the position that there is not a fixed way to understand and interpret the world (Braun and Clarke, 2013). To note, research falling within the *pragmatic* paradigm, primarily utilising mixed methods, has its own sets of expectations and required explanations (Creswell and Plano Clarke, 2007).

Some present a research framework as a hierarchy, firstly through establishing ontological and epistemological positioning, followed by justifying the methodology, and the research tools (Crotty, 1998 in Welford, Murphy and Casey, 2011). Others (White, 2017), argue that you can begin with the method and then identify the other features; or, alternatively, view each aspect with equal importance, proposing that they interact throughout (Sidell, 1993). My ontological and epistemological positions (as discussed above), are clear, informed through my own experiences.

The chosen research tools influenced the methodological approach, resulting in a change to the overall direction. The original plan, to utilise a mixed methods approach, having a two-part approach to data collection, namely, to complete student surveys, alongside interviews with SWS, then using a convergent approach to triangulate the data (Poth, 2018). This would have placed the methodology within a *pragmatic* paradigm, informed through a critical realist lens (Bhaskar, 2008). However, after reflection, I decided to change my approach, in that I would not pursue surveys with students. This was driven by several factors. Firstly, asking students to complete anonymous surveys raised additional ethical concerns – while much has been written about minimising possible harm in data collection with in-person interaction, there is relatively little in relation to a negative impact through anonymised data collection (such as surveys) (Bryman, 2016). Indeed, even anonymised surveys do not guarantee risks to identity disclosure (Couper et al, 2010). In addition, as with any discussion addressing mental health/distress, there were no means to guarantee that the students' wellbeing would not be adversely affected despite the original attention given to desensitising questions (Brancati, 2018). Secondly, that asking HEIs to distribute a survey to their students in relation to mental health from an outside source would have likely faced many barriers, with responsibility for wellbeing falling back to the HEIs. Thirdly, while surveys can generate a large volume of data (Teater et al, 2017), the extant research detailing knowledge and awareness of resources offered via HEI SWS already exists (see *literature review*), and so I felt satisfied to build upon this when addressing the research questions. Once this decision had been made, it felt that the project overall had a clearer focus and that the research aims/questions could be fully supported through the interview data.

With the chosen methodology of reflexive thematic analysis (RTA), the cohesion between the design and application is to justify how this approach best meets the research aims and objectives (Finlay, 2021). It is reasoned that effective RTA incorporates aspects of the researcher positionality, seeking to tell a story grounded in 'meaning', rather than present a set of 'truths' (Holloway and Biley, 2011). Braun and Clarke (2013, p.36) suggest that qualitative research approaches should be complex*,* being openly subjective and bringing our 'own histories, values, assumptions, perspectives, politics and mannerisms into the research'. They go on to state that this recognition, alongside reflective awareness will strengthen its validity; and that more simplistic models can result in questionable outcomes.

A frequent critique of thematic analysis (TA), and specifically RTA, espouses that a limited influence of a theory-based methodological framework will curb objectivity, and therefore reliability and validity (Finlay, 2021). However, Braun and Clarke (2022) situate their guidelines within a framework that embraces researcher subjectivity – in fact, this is a core notion that underpins effective RTA (examined further in 3.8 and 3.9). For compelling use of TA, Braun and Clarke (2019) argue that their approach is not 'atheoretical', rather it is theoretically flexible. Working on the basis that both researcher and participants are functioning within specific political and social backdrops, this then places the data within such contexts (Gavey, 2011). Where the intention of a researcher's aims and questions are discussing an ideological phenomenon, Braun and Clarke (2019) suggest this is both a justifiable use of RTA; and that researchers should actively include some discussion of themselves within their work – a recognition that individual interpretation leaves a *signature* through the research (Bourke, 2014). A core objective of this project is to question notions of a societal position on mental health, specifically the hypothesis that student mental health is in 'crisis'. This, therefore, lends itself to a poststructuralist interrogation of the prevailing discourse, alongside influences from my experience and position when addressing the subject.

While some critiques of TA/RTA focus on notions of validity, Braun and Clarke (2013) emphasise that it is the recognition of researcher subjectivity, with a reflexive engagement, that effectively shape and justify the theme development. They (Braun and Clarke, 2020), argue that RTA could sit between what are often considered a clear distinction of what may be regarded as standard methodological frameworks and research tools. However, for the purpose of my analysis, I will be addressing both the division, and complementary aspects of my approaches, in that RTA is my chosen methodology, while the method (research tool) is the use of semi structured interviews as detailed below.

3.6b Methods – participants and recruitment

The aims and objectives of this project seeks to provide a snapshot of the current situation, specifically with scrutiny as to how SWS are responding. The decision to interview university leads for student welfare service (SWS) for the data collection was made early on. Given the expansion of policy, guidance, media attention, and research with respect to this topic area (see *Literature Review*) – alongside their first-hand experience with students – I judged that SWS leads would be best placed to support an investigation of the research questions. That said, being 'leaders' for the service does place them in a social position that could be argued to be hierarchical or even potentially 'elite'. While all participants appeared to respond openly, those in elite positions may prepare, what Kvale and Brinkmann (2009) call 'talk-tracks' in order to champion the institutions they represent. Equally, studies (Anyan, 2013; Vähäsantanen and Saarinen, 2012), have suggested that research participants who hold privileged positions may – either inadvertently or deliberately – employ countermeasures in order to protect the brand of their own institution – these matters will be given further attention in 3.6d below. Equally, it is important to note that for three participants – those working at HEIs with smaller student populations – their role, in addition to leadership responsibilities, continues to involve direct support to individual students using their services. One other discussed how they had worked in SWS for over a decade.

It was always the intention to focus upon the Greater Merseyside footprint, in part due to the commonality of community resources, and the relatively dense availability of HEIs (six) within this area. The reality with difficulties to recruit (as detailed below) expanded the footprint slightly wider to include the Northwest region of England. While this did have an impact on responses – specifically with distinctions in localised resources – there remained some commonalities with shared networks and understandings within the chosen area. The final footprint covered an area of Northwest England, within which fifteen HEIs exist, and of these, I was able to recruit from five.

Challenges with recruiting suitable numbers of participants can threaten a whole project and may be a particular issue for early-stage researchers due to their more limited resources, or with gaining interest (Joseph, Keller and Ainsworth, 2016). For some, the research design may require higher participation rates (such as for quantitative statistical research, or using surveys in qualitative projects), to support valid representation (Cohen, Manion and Morrison, 2007). For RTA, Braun and Clarke (2015) emphasise that the sample size is less relevant, stating that ‘bigger isn’t necessarily better’ (ibid, p. 5). Depending on the needs of the project, they suggest samples of anywhere between 2 to over 400 (Braun and Clarke, 2013), with a caveat that a high sample size could result in the omission of key nuances within the data, with the consequence of missed meanings.

The initial round of recruitment focused upon seeking to secure participants via email (see Appendix Four for sample email), contacts within their HEI internet websites (albeit, having a named contact in my own HEI was the exception – this was the first confirmed participant). HEI website SWS contact details are, understandably vague, encouraging students (their demographic) towards a general access site, where they will then be forwarded on to appropriate support. As expected, initial inquiries would be directed towards a screening admin team, that, as likely occurred, would prioritise student contacts against outside requests. While the research information sheet and consent forms (see Appendices Five and Six), did provide details about anonymised participation, it is not known how much detail was read by gatekeepers, and so matters – such as concerns about confidentiality – may have impeded any further consideration. This early approach only succeeded in one further collaborator.

This 'gatekeeping' for people in positions of authority can add to difficulties in navigating the recruitment processes, whatever the motivation, or direction given to such monitors (Nir, 2018). As such, I had to reconsider my approach to enlisting potential contributors. From this, I was supported by colleagues to engage directly with known academic associates in the target HEIs, requesting that they identify a named individual, and to forward the research information sheet (Appendix Five). An identified colleague within the targeted participant can help to overcome gatekeeping barriers, often giving advice as to the most appropriate means to make contact (Coe et al, 2017). Having been given some named contacts, this method successfully recruited one further participant.

Attendance at a conference, where HEI SWS leads were presenting, provided a direct link, and so this contact resulted in the fourth participant agreeing. Finally, following a decision to expand the geographical footprint, I was able to secure one further contributor (out of five more attempts with other HEIs) – via the original format of emailing directly – resulting in a final total of five participants.

There was discussion in supervision about 'cut-off' times for participants to respond, finding the balance between pursuing individuals, while also acknowledging that there may be varied reasons why they do not wish to participate – see below. I did send a gentle reminder email after one month; however, I did not see that there was anything to gain following non-responses to these. This resulted in recruitment taking longer than expected, at times leading to frustration – a noted part of this stage (Walliman, 2020). While the recruitment was ultimately successful, researchers can face difficulties with enlisting participants from hard to reach or ‘hidden’ populations. These can stem from a number of factors, such as personal identity (for example gaining trust from the LGBTQ+ communities (Fish, 1999)), or differences in ethnicity between researcher and target participants (Alexander and Diefenbeck, 2020). Reassurances about trust and confidentiality may create barriers, such as seeking to recruit from those in elite positions (Nir, 2018); or from groups who may be subjected to social ridicule, such as in Hilario et al’s (2023) reflexive account of recruiting Covid vaccine-hesitant parents. In all these circumstances, additional measures including allowing for time, using several engagement tools, and providing pre-interview reassurances may help (Nir, 2018).

Identifying the specific reasons for non-responses from the several HEIs that were contacted is not known. It may relate to resource availability, or that they did not receive the requests at all through the various channels attempted – either generic or specific named emails. There may be other factors which could relate to the more recent public scrutiny of HEI SWS (Morris, 2022), and/or the broader issues with protecting university status and reputation, linked to the growing trend of ‘ranking’ universities according to their welfare provision (Lane, 2021; HUMEN, 2022). It is possible that SWS leads were concerned about the nature of the research and perhaps were denied permission to participate. In addition, my status as a student and novice researcher, or indeed as a lecturer (with a professional ‘gap’), may have had an impact upon perceived legitimacy compared to established researchers (Nir, 2018). To note, the details (names and emails) of my supervisors were included in the initial contact emails, however it is unknown if this impacted willingness to contribute.

The findings suggest that individual responses to demand by HEIs largely do not rely upon immediate location (with some exceptions), however there are some clear localised factors (as discussed in the *analysis* section). With reflection, a wider field of participants (beyond the chosen footprint) may not have impacted upon the findings, noting that local knowledge has benefited researcher understanding overall. The overview of successfully recruited participants is summarised in the table below.

Table: Summary of participants

Code	**Type**	**Student numbers**	**Participant**
HEI A	Post 1992 (previously accredited by another HEI)	Over 5000	Overall lead for student welfare.
HEI B	Post 1992 (former college)	Over 10,000	Lead for counselling services.
HEI C	Post 1992 (former college)	Over 10,000	Overall lead for student welfare.
HEI D	Russell Group	Over 20,000	Overall lead for student welfare.
HEI E	Post 1992 (former polytechnic)	Over 20,000	Overall lead for student welfare.

3.6c Methods – data collection

\i/ Why semi-structured interviews?

The decision to use face-to-face semi-structured interviews as the method of data collection was straightforward. It is a method that I felt comfortable with, having completed one-to-one assessments with people throughout my social work career. The experience of working through a set of open-ended questions, seeking both to clarify responses and elicit additional details, while also offering reassurance to the interviewee benefitted the process. While other types of interview methods – such as *narrative* interviews that encourage personal story telling (Kvale and Brinkmann, 2009) – were considered, the semi-structured approach was the best match. This enabled responses that were both professional (external realities), and personal (internal understandings), permitting a fluid conversation, while also ensuring each question was addressed (Silverman, 2000).

While there are some commonalities between a social work assessment and a research interview, there are also distinctions, each sitting in their respective fields with a specific purpose. The use of semi-structured interviews as the method of data collection is recommended for certain types of projects, such as where the researcher is seeking to understand an individual’s interpretation of a phenomenon and/or conception of their lived experiences (Coe et al, 2017). Alternative methods – such as surveys – may have resulted in a higher sample size, however the detail of the responses would not have been suitable for my research questions. Focus groups may have resulted in valuable data, with collaborators being able to share commonalities, validate ideas and also highlight distinctions (Coe et al, 2017). However, focus groups can be difficult to arrange, and may result in limited participant engagement, such as where a dominant voice controls the discussion, requiring careful intervention from the researcher to seek redirection (Brancati, 2018). Furthermore, I planned to enquire about personal opinions (as well as professional), that I felt would have been more difficult to explore in a group, where there may have been a dynamic of professional constraint.

With interviews, scripted questions provide a framework for the process, with the semi structured approach allowing pre-prepared sub-questions, and other verbal unprepared additional questions (Bryman, 2016). This method best supports research that is seeking to gain the participants' understanding and sense-making about a topic – rather than seeking to test a hypothesis (Brancati, 2018) – which reflects the purpose of the research title and questions.

The interview design and choice of questions (see Appendix Three) were developed to seek a balance of achieving relevant responses in line with the project title and aims, while also ensuring the questions would be of interest to the participants, and therefore enabling confident responses (Bazeley, 2013). Questions were designed to encourage personal responses as well as organisational, supporting participants to view the topic both from an individual viewpoint, and as an ‘expert’ in their institutions – this supported broad perspectives (Flick, 2020). The initial set of questions were framed around reported data, before inquiring as to potential influences, and then moving onto specific responses from their own institution. The semi-structured approach enabled further probing through improvising additional questions where a response seemed crucial; and also, a review of the wording where early participants seemed unclear (Brancati, 2018).

The word *crisis* was not used in the interview questions, in part as this may have been perceived to be ‘leading’ towards a particular perspective – this was borne out in the data (see *Analysis*), with a range of viewpoints addressing the current situation. Equally, my own perspective of mental health/wellbeing as a universal experience, along with my subjective critical mental health position, did influence the design of the questions. So, for example, I specifically avoided medicalised language or references to mental ‘disorder’, ‘illness’ or ‘diagnoses. This resulted in the participants speaking about student ‘wellbeing’ at a broad level, rather than a narrow focus – an outcome I was aiming for. While Freire (2000) suggests research interviews exist in a space between objectivity and subjectivity, I aimed to support detailed responses through encouraging conversation beyond the standard set of questions, in effect co-constructing the meaning with the participants (Braun and Clarke, 2013).

Speaking directly to HEI student welfare leads resulted in a detailed and rich dataset, minimising the implications of having a small sample size. In relation to the research questions, semi structured interviews supported the participants to explore the topic in detail and proffer their own interpretations. The conversational manner of semi structured interviews allows the interviewer to prompt, seek clarity, and/or return to earlier points (Opie and Brown, 2019), and equally supports the participant to expand or clarify their responses.

While semi structured interviews felt the natural choice for this type of research, resulting in a deep and relevant dataset, there are also, as with all methods, limitations to the approach. These may relate to the sample size; that they can take significant time for recruitment; agreement for times and places for the interview to take place; and completion of the transcripts (Braun and Clarke, 2013). Interviews, as with other qualitative methods, can face additional suggestions of interviewer interpretation and therefore bias, leading to claims of these methods having limited reliability and validity (Cohen, Manion and Morrison, 2007). However, interviewer subjectivity within the broader processes, and specifically data interpretation, are active parts of the chosen methodological tool of *thematic analysis*, and specifically *reflexive thematic analysis*.

\ii/ Doing Interviews: working with participants

Prior to the start of each interview, I reiterated the purpose of my research, offering the opportunity for participants to ask any general questions or raise specific concerns (Brancati, 2018). I was keen to provide reassurance that I was not planning to critique their services in any way, given what has been discussed about the growing sensitivities of HEI SWS (see previous section). I also suggested an approximate time that the interview would last for, repeating what had been said in the initial email contacts – I was aware that the participants were all very busy and that they had taken time out of their schedule. Finally, I sought to reassure participants about anonymisation, offering to send them copies of the transcript once completed. This enabled them to feel some control over their input and rights to privacy (Walliman, 2020). With qualitative research, specifically with interviews, the transcripts can be returned to the subject if certain details need explanation (Kvale, 1996) – however I did not need to do so.

Building a rapport in a time limited context can be difficult, however the preparation work, and reassurances at the opening of the interview supported this (Braun and Clarke, 2013). In addition, using a relaxed conversational style – drawing upon my professional experience – assisted the semi-structured approach. I maintained an awareness that wording can be misinterpreted and so checked regularly that they were happy with the questions, aiding the partners to feel in control (Coe et al, 2017).

\iii/ Doing Interviews: power

A one to one interview carries its own power dynamic – which has been termed as a 'dance of forms of power' (Nunkoosing, 2005, p.699) – being an interaction between two people in a particular setting and time (Swain, 2017). The relationship between the identities of participants and researchers can impact outcomes either positively or negatively, with each having multiple intersecting aspects of self (Bourke, 2014; D'Cruz and Jones, 2004). The researcher needs to be aware of how their identity, verbal approach, provision of information, and given reassurances can all help place the participant at ease.

There can be problematic elements within the interviewer-interviewee dynamic, including factors such as the participant showing discomfort with being recorded, or being unwilling to elaborate upon questions when prompted (Roulston, 2014). I did not experience this, which I believe was in part due to careful preparation work and the given reassurances throughout. While I offered the option to complete the interviews virtually (these all took place post 2020-21 COVID-19 lockdown restrictions), when asked for my preference, I suggested that, if possible, I would lean towards in-person completion – this was to limit restrictions with rapport building and also possible technological faults, or other logistical issues (Sah, Singh, and Sah, 2020).

Introductory emails (see Appendix Four) to potential participants confirmed my professional background, and named my supervisors, that I hoped would support recruitment. Considering 'insider/outsider' research (Berger, 2015; Hill and Doe, 2021), with 'insider research' described as lived experience or commonalities of identity with the participants, may result in benefits such as having established knowledge of social group identity (Hill and Doe, 2021). For myself, I would argue that I fall somewhere in the middle, with aspects of lived and professional experience having clear connections to the research topic, and that my employment within the HEI sector has commonality with the participants. However, I remained aware that the specific professional role of the partners, while having some aspects of experience in this ‘field’ of practice (working in the mental health provider services), there was a clear distinction in that I am a tutor, who has not worked in student welfare services.

\iv/ Doing Interviews: flexibility

One participant requested information about the other contributors, specifically in relation to their role in the service – I explained that three of the four other participants were in an equivalent position, with the other having a more distinct remit (as detailed in the above table), and this seemed to provide reassurance. One interview was repeated in its entirety (see 3.7iii) at the participants request, with all previous data being deleted. I felt each interviewee engaged very well with the process, in part due to the questions being so relevant to their profession. It was key that the participants were in their own place of work, choosing the setting for the interview, supporting them to feel in control, and enabling a cooperative atmosphere (Kvale and Brinkman, 2009).

The audio recordings were each listened to from start through to completion, prior to being transcribed by myself. Coe et al (2017) suggest transcribing each interview before the next, helping to identify where discussion points may have been left incomplete. While I did not do this, each one was listened back to fully, and this did help address areas of focus and encourage elaboration for future interviews. During the process of the data collection, I noted some themes were being repeated, or in several cases displaying distinct responses. While this was interesting to note, I was cautious not to divert too much from the scripted questions in order to support consistency with the analysis. Semi structured interviews should allow the researcher to *probe* or seek to *unpack* responses (Silverman, 2024). While this did assist in practice, I was also conscious to keep to the framing of the key questions to enable a variety of perspectives as to their own understanding of their experiences of this social phenomenon.

3.6d Reflexive thoughts in respect of engaging with participants

This section will develop the above commentary (within 3.6) in relation to the chosen research methods and focus upon the status of, and engagement with the participants. It will provide some additional perspectives about the sample size; positionality of the participants; the researcher-participant power dynamic; with some embedded reflexive thoughts.

The decision to only interview one person from each institution was justified on the basis that the aim is to explore changes at provider level, and therefore targeting service leads for recruitment felt logical. The intention was to gain an oversight as to how student welfare services (SWS) have altered over recent years, seeking insights from those with overall responsibility for provision and influence upon institutional policy and practices. While I could have sought to engage with other SWS employees – such as qualified counsellors, who would have contributed a meaningful appreciation of current student concerns – this would have limited responses to the broader aims/questions that focused upon the changing context of SWS at institutional level. A more significant range of professionals would have provided a more expansive picture overall, and this certainly would be valuable research for projects with differing aims and objectives.

In terms of service remit, four out of the five participants identified themselves as the overall lead for student services with the other holding responsibility for counselling services. While I did not ask specific questions about their professional histories, most identified that they had worked in student welfare services for some time, with some pointing out the differences in demand over the time they have been there – see *Analysis* chapter. The student demographic (specifically numbers of total registered student population) of each individual HEI influenced the boundaries of their role, with three out of the five reporting that they continue to provide 1-1 support to students.

I also chose not to ask about their own personal identities, beyond their professional status. While this could have added some insights into the responses to the interview questions that relate to student identities, (see Appendix Three, question 10), I felt it may also have added an additional dynamic that I wanted to protect against. The initial contact correctly framed the research as seeking to explore how providers are responding (see Appendix Five). Acknowledging that the interviewees had given up their professional time to engage with an interview that was primarily about their service provision, I did not want to potentially impact the nuances of the interviews through asking unexpected personal questions – this felt important to support my confidence as a novice researcher with a keenness to appear open and honest, with their expectations previously identified as a university representative. The final sample size – while open to debate, as below – of five was sufficient to meet the research aims, as interrogated within the remaining chapters.

A smaller sample size is seen as a positive for RTA (Braun and Clarke, 2022), however smaller samples are still often seen to require justification as opposed to larger sample sizes (Fugard and Potts, 2015). Malterud, Siersma and Guassora (2016) highlight differences with the need for quantitative data to report ‘valid calculations’ of sample sizes, against qualitative data that generally does not, despite smaller samples continuing to be critiqued as lacking generasability (Maxwell and Chimiel, 2014). Malterud, Siersma and Guassora (2016) suggest a shift from the terminology of *saturation* and introduce a model of *Information Power* to support qualitative researchers with guidance to justify adequate sample sizes – the authors (ibid.) introduce a five part ‘Information Power’ model, indicating where a smaller sample may be preferable:

1. Study aim – a smaller sample can be considered useful for a focused aim(s).
2. Sample specificity – smaller samples are appropriate when participants hold specific knowledge about the subject matter.
3. Established theory – projects that engage with relevant and/or several theories can incorporate a smaller size.
4. Quality of dialogue – while the authors acknowledge this is difficult to predict, where communication in the interview is flowing and meaningful, the smaller sample can be pertinent.
5. Analysis strategy – in-depth analysis supports smaller strategies.

I can see how my aim(s) could be argued to appear narrow in some, and broader in others, however the overall purpose has a clear focus – as covered within the Introduction chapter, specifically section 1.2 – indicating this reflects part 1 in the above model. Parts 2 and 4 of the model clearly support the smaller sample size, as the participants were specifically targeted for holding specific knowledge about the topic area, further merited due to the depth and quality of the data collated. The underpinning theory of poststructuralism, alongside the integration of a range of critical mental health perspectives legitimises the smaller sample, reflecting part 3 above. As Braun and Clarke (2020; 2021; 2022) consistently argue, it is the richness, rather than quantity of the data that adds value to RTA, with this approach reflecting part 5 of the model. This information power model supports justification of the limited sample size with the authors (ibid.) arguing that these components together create a dynamic interplay.

I have commented upon the positive rapport that I felt was there with all participants during the interviews. I felt this stemmed from the commonality of working in a university environment and direct engagement with the student populations. With reflection, there were some differences in how the researcher-participant dynamic played out. As previously suggested, it is difficult to ascertain – certainly for the non-personal opinion questions – how far the service leads may have felt restrained by the responsibilities of their role, being keen not to be seen as negative; concerned about the institution's reputation; and/or potentially asked to be cautious by their respected line managers. That one participant asked me to repeat the interview at the request of their line manager – due to confidentiality concerns – indicates that it is likely that most, if not all, had to seek permission to engage.

The service leads may not be considered as senior 'elites', such as politicians or others in 'higher' office that hold significant influence (Mbohou and Tomkinson, 2022). However, by nature of having privilege over service design, and delivery, they could project power in the sense of choosing what to disclose to the researcher or keep protected. This social engagement with potential 'elites' can create uncomfortable power dynamics, however, as Mbohou and Tomkinson (2022) argue, this inequality does not necessarily play out in practice, and assumptions of the researcher may actually create these perspectives.

Kvale (2006), while not questioning the usefulness of the interview as a research tool, was an early advocate of considering the impact of power dimensions within the interview space. Acknowledging that the relationship is often far from an assumed equal alliance, and rather that researcher rapport-building and empathy may ultimately be a mask, enticing the subject to disclose further details (ibid.). Having been referred to as 'the power dance' (Vähäsantanen and Saarinen, 2012, p.493), this interplay between researchers and their participants can play out in numerous forms, and from each party. Participants can withdraw, divert or refuse to answer (Anyan, 2013); or utilise their identity based on status, class or gender – such as with Vähäsantanen and Saarinen's (2012) account of an older male academic (as participant) asserting his male privilege by sexualising the younger, female researcher. There are further intricate factors at play – including setting, time and context – such as with Wortham et al's (2011) summary of an interview taking place within a church, with the subject pressing the researcher into joining the congregation.

From the researcher's perspective, they seemingly hold the 'cards of power' including leading with the questions, perhaps controlling *setting* (this wasn't the case for my interviews), and *time* (Vähäsantanen and Saarinen, 2012). Kvale (2006) assessed that the interview is different from a naturally occurring *dialogue* where there is generally more freedom/equality in social exchanges. Acknowledging the diversity of power on both sides, and at all stages of the process can support meaning, and while much is left open to potential subjective interpretations – such as with the power returning to the researcher at the data analysis stage (Anyan, 2013) – this understanding can be seen to support the process as a whole, adding validity to qualitative research (Power, 2004).

A reflexive questioning of the interviewer-interviewee relationship can help interrogate perceptions of power considering a postmodern lens of multiple and intersecting identities (Mbohou and Tomkinson, 2022). Taking a reflexive stance, despite leaving each interview feeling positive that I had collected meaningful data, I recognise that each interview dynamic was unique, and that the participants had varied approaches that were projected to me in different ways.

With one of these, I felt very welcomed, with the participant seeming relaxed and happy, while another appeared quite hurried and, if honest, less personable. The responses from each of these, once the interviews had been transcribed, highlighted a clear difference, with the 'happy' participant providing all positive responses about their service design and future plans; and the 'hurried' participant projecting significant negative thoughts relating to the changes, at times blaming the increases in complex needs upon parents and schools. Reflecting back to these, it may well have been the case that the 'happy' positive responses were actually a screen in order to place their HEI solely in a positive light, whereas the 'hurried' participant may well have been more truthful. Bourdieu, (1996, cited in Power, 2004), promotes a postmodern perspective of the interview dynamic, to encourage a reflection upon the varied potential constructed truths. This encourages the researcher to place themselves in the participants' position. Considering this, alongside my own emotions upon leaving the interviews, feeling very positive after engaging with 'happy' and less so with 'hurried' this may initially have blurred my vision and indeed, the initial stages of the data analysis.

It cannot be known how far the participant responses were guided by outside factors, including their own professional status and institutional reputation, however with reflection and reflexion, these potential influences have been incorporated into the story of the analysis. It has been argued that ultimately, the balance of power may consistently return to the researcher as they engage with and interpret the data, with this editing ability seen as an active construction of knowledge (Anyan, 2013). The analysis stage supports reflexivity about potential influences with the manoeuvrings of power within the data collection, (Anyan, 2013), and RTA (Braun and Clarke, 2022), encourages this subjectivity, in line with my positionality that has been highlighted throughout. Regardless of what is or is not known, any primary research with human participants requires careful ethical considerations (BERA, 2024).

3.7 Ethics

An ongoing reflection upon personal and professional *values,* and how these inform *ethical practice* are fully embedded in the social work profession (Akhtar and Tompsett, 2012), with the professional and regulatory bodies (BASW, 2013; SWE, 2019), standardising these into compulsory elements of assessed practice. These components of the profession – related to harm-minimisation via self-awareness of power – are very much mirrored in ethical research practice. While the social work professions' ethical frameworks continue to inform my practice, for this research project, I adopted the British Education Research Association's (BERA) Ethical Guidelines for Educational Research. In its fourth edition (2018) at the time of data collection, the revised, fifth edition (2024) has also been sourced.

D'Cruz and Jones (2004, p.29) argue that research does not 'take place in a vacuum', rather it is a complex interface involving stakeholders and community members (whether a single professional or group), and, as such, there will be differing perspectives of subject knowledge and lived experience intersecting at the point of interaction. As such, aiming to be an ethical researcher requires reflective consideration about how we wish to achieve the goals of the project, with the balance of protecting self and all involved (Braun and Clarke, 2013).

Value standpoints in research activity may be argued differently from positivist and interpretivist perspectives, with the former focusing upon how to seek to ensure objectivity, and the latter grappling with the notions of subjective influence (Ransome, 2013). Either way, the conduct of the researcher in their practice may be subject to moral challenges, and as such researcher reflexivity is highlighted as a core feature to balance values and ethical concerns (Guillemin, 2004; Ransome, 2013).

Ethical approval was granted in May 2022 through Liverpool Hope University's processes, having referenced universal principles (BERA, 2018), and was endorsed via the research ethics committee (REC). A number of revisions and additional information were required – specifically about the approach to data collection, ensuring harm minimisation, and matters of confidentiality – prior to final approval being granted. RECs have been critiqued as practising inconsistently, with some over emphasising researcher plans over deeper ethical concerns (Barrios, Garcia and Tapia, 2017). However, the approval process, governed by standardised principles (BERA, 2024), is seen as a key safeguard for partners, and also a means to support and protect all (and particularly novice) researchers in their work (Petillion et al, 2017).

Swain (2017, p.80) discusses ‘six key ethical areas’, that I will use to examine how ethics were considered.

1. Explanation about the research.
2. Informed consent.
3. Voluntary participation.
4. Right to privacy.
5. Avoidance of harm.
6. Data stewardship and security. (ibid.).

\i/ Explanation about the research

The standard university research information sheet and participant consent forms (see Appendices Five and Six) were attached to all initial emails to potential participants. I believe my subjective position informing my research was covered in the initial information, however I took time to verbally repeat the purpose of my research prior to each interview – along with reassurances that my aim was not to be critical of individual services/HEIs. Alongside confirmation about the purpose of the research, I emphasised that the consent forms clarified their right to withdraw at any point. Following completion of the interviews, there have been tweaks to the thesis title and research questions, and so while these may not have changed any willingness to participate given the overall aims and objectives remain as detailed – and as communicated to participants (see Appendix Four) – this cannot be known for certain.

\ii/ Informed consent

The notion of truly ‘informed’ consent from research participants has been subject to debate (Swain, 2017), with some (Malone, 2003) suggesting this is impossible to ascertain in social science research. In addition to sending the ‘research information sheet' and ‘consent to research’ forms (Appendices Five and Six), at the initial contact, this was followed up with the provision of additional information – both by email and on the date of interviews. Where seeking consent, it is key for the participants to be aware of the nature of the research, how it may be used, reassurances about data management, as well as any implications for further use of the data (BERA, 2024). Open and transparent explanation of the purpose and aims, as well as reassurances around anonymity and confidentiality – that I repeated in detail prior to the start of each individual interview – all supported voluntary participation (Flick, 2020).

\iii/ Voluntary participation

This can be difficult to ascertain in larger scale projects, or where observation of a group dynamic is taking place, for example with ethnographic studies, or larger focus groups (Ransome, 2013). For the semi-structured interviews, the voluntary nature of this included providing reassurances of the right to withdraw before, during or after the interview; to view completed transcripts; or request the transcripts not be included post interview. I was asked by one participant to redo the interview which was based upon their manager’s concerns that they had referenced a not yet launched co-project with another HEI. This highlighted a wider consideration about who is rubber-stamping consent (Cohen, Mannion and Morrison, 2007), with the likelihood that all participants had to seek permission from their employers. I did offer the option of removing all references to the project from the transcripts that they could then check, however they confirmed their wish to repeat the interview which was honoured (with the original data being deleted).

\iv/ Right to privacy

As with ‘informed consent’, notions of confidentiality and anonymity can be contested (Ransome, 2013). While aware I was essentially intruding upon their professional time, I was willing to minimise this through encouraging participant choices of date, time and interview surroundings. Responding to their preferred choices, (this was also my favoured option), the interviews took place in the contributor's work offices (aside from one who had booked a different room), supporting them to feel comfortable in their own space. Prior to the start of the interviews, I reiterated to the participants that their institution would be anonymised by a code, and that any identifiable information that arises within the transcripts would be redacted. In addition, I explained that the audio recording will only be kept on the password protected device – my phone – until transcribed, at which point the recordings would be deleted. I also confirmed that the anonymised transcriptions would be stored on a password protected work computer that only I have access to.

Through transcribing the interviews, I was careful to redact any personally identifiable details, such as specific projects, names, and geographical details – the later widening of the regional catchment area supported this further. While it remains possible that the participants would recognise some of their own responses in the findings section, they should not, however, be able to identify other collaborators. I have also since edited the summary of participants (see above table), making each individual HEI's details more abstract.

A further consideration here is that participants were asked questions about both institutional matters, and personal opinion in relation to the topic. While being careful to acknowledge that any individual perspectives would be subject to the same anonymity, there was an awareness that these participants were acting on behalf of their employers, and as such may have been over cautious about what they regard as 'permissible' in the balance of private or public knowledge (Cohen, Mannion and Morrison, 2007). I note that this may have further shaped the responses from the one contributor employed by the same institution as myself.

\v/ Avoidance of harm

Both researchers and participants are susceptible to harm during the interview process, despite how much preparation and further considerations have taken place (Ransome, 2013). Contributing institutions – in this case the university that the contributors are employed by – should also be protected from potential harm via the possibility of sensitive data being made public (BERA, 2024). Individual distress can be experienced by both parties, such as feeling oppressed due to status or identity, or with the discussion of delicate topics, such as experiencing trauma from responses, or accusations of the researcher misleading participants (Braun and Clarke, 2013). The research topic is also personal to me, however my experiences through working in this field enabled a professional distance.

The topic of mental health, while obviously extremely broad and subjective, can clearly be a challenging subject of discussion. Professionals working in this field are not immune from any aspect of poor mental wellbeing, whatever their knowledge base and experience. I sought to reassure participants that the interview questions were based on their organisational responses or their professional opinions – in turn clarifying that they would not be asked about their own wellbeing.

While these reassurances were repeated before the start of each interview, there was still no guarantee that participants would not experience distress, and as such I reiterated the right to withdraw at any stage. The participants hold significant responsibilities for student welfare, and they may have been experiencing levels of stress relating to the role, or had experiences with students coming to harm, therefore the questions could have had negative psychological consequences. As far as I am aware, this did not occur, however had it, I would have acknowledged the distress and then checked if they wished to continue (Braun and Clarke, 2013). Following each interview, I followed up with an email to each participant thanking them for their engagement, to which I received warm responses, providing further reassurance that the overall experience was positive.

\vi/ Data stewardship and security

The consent form was clear about how the recorded interview transcript will be stored – on a password protected work computer – as well as confirming that participants can request withdrawal of their participation and data. These assurances were also repeated orally before each interview began, with opportunities for participants to clarify these details, as best practice advocates (Flick, 2020). BERA (2024) emphasises the right to privacy for participants, and that measures to mask identification should be addressed across all matters of data stewardship, including where data may be shared in additional publications or at conferences.

3.8 Thematic analysis

Identifying themes from a data set has been a long-established component of qualitative research methodology (Finlay, 2021). Traditionally, initial sets of coding, followed by theme identification would have been seen as part of the process, while being directed via an established methodological framework such as *interpretive phenomenological analysis* (IPA), or *grounded theory* (GT), (Bazeley, 2013).

The development and growth of TA as a methodology in its own right is largely down to the work and promotion of this enhanced process by Virginia Braun and Victoria Clarke (Silverman, 2024). Following the publication of their initial paper (Braun and Clarke, 2006), they have since sought to address the gaps between the widening use of TA, and (at the time), a limited methodological underpinning for its application. This original paper introduces the notions of the researcher’s deep engagement with data to establish themes, alongside the components of researcher flexibility and subjectivity, as key elements to TA. Since this time, Braun and Clarke have developed, revised, and expanded their models of TA, resulting in the method becoming one of the most commonly cited approaches for qualitative research (Dust and Stevens, 2023).

Braun and Clarke suggest that their ‘brand’ of TA (2013) is actually an umbrella term, composed of three key types that they name as: Coding Reliability; Codebook; and Reflexive Thematic Analysis.

- Coding Reliability (for example, Boyatzis, 1998, cited in Dust and Stevens, 2023) approaches will tend to be used where researcher(s) are testing a hypothesis, usually with more than one researcher involved in the coding stage, seeking themes that are already present.

- The Codebook method is often used with template or framework analysis, involving multiple coders with an agreement to identify codes with a rigorous shared approach (Braun and Clarke, 2022; Roberts, Dowell and Nie, 2019).

- Reflexive Thematic Analysis (covered in detail below) focuses upon the researcher's own engagement with the data, supported by a deep immersion and a creative approach to identifying themes (Braun and Clarke, 2022).

All three key models remove the need to place the processes of theme development within a historically established methodological literature and/or thematic framework (Trainer and Bunden, 2021). Due to this, an assorted range of perspectives can inform the data analysis: 'theory-driven, research-driven, data-driven, or a combination (hybrid) of deductive and inductive approaches' (Stevens, 2023, p.295). Rather, TA more generally, and certainly with the RTA approach will be informed through the ontological and epistemological positions of the researcher, with its use producing sophisticated and nuanced outcomes (Finlay, 2021).

The lack of a methodological rulebook for TA, has led to some researcher anxiety in its practice, specifically coming from subjects with more prescribed research patterns, such as psychology (Braun and Clarke, 2013). Common critiques of TA usually relate to its lack of theoretical underpinning, and inconsistencies with its use in practice, leading to suggestions of unreliability (Trainer and Bundon, 2021; Finlay, 2021). Braun and Clarke note themselves that their original paper in 2006 did leave some questions about TA that resulted in misinterpretations of its use (Byrne, 2022), and so they have since published several further reflections and revisions as to its use and purpose (see Braun and Clarke, 2013; 2016; 2019; 2020).

Braun and Clarke (2019) assert that misunderstandings of the principles of TA may result in misapplication in research practice. They argue that this is often related to researchers following what they believe are 'fixed' processes in its application, thereby neglecting the key elements of researcher subjectivity and reflexivity, leading to a rigidity and/or lack of creativity with theme generation (Braun and Clarke, 2015). Further, researchers arguing for a minimum sample size (Fugard and Potts, 2015), may miss the point that TA is about the richness of data, rather than numbers to ‘back-up’ validity (Braun and Clarke 2015). Finlay (2021) provides examples of what ‘good’ TA may look like, focusing on Braun and Clarke’s model of a deep relationship with, and ‘painstaking extraction’ (ibid, p.104) of the themes.

There have also been concerns raised in the limited reporting of researcher positionality and their processes of reflexive engagement, that have led to disquiet about the quality of use of TA (Trainer and Bunden, 2021). The process requires an interaction of both the researchers’ and participants' social and cultural contexts in order to achieve rich and relevant themes – this is where the RTA approach and focus on reflexivity has become the key version for Braun and Clarke (2022).

3.9 TA to RTA - Reflexive Thematic Analysis

The version of TA that Braun and Clarke have dedicated the focus of their work to is reflexive thematic analysis (RTA). The foundation of RTA was introduced within their 2006 publication, that referenced the need for ‘an ongoing reflexive dialogue on the part of the researcher’ (Braun and Clarke, 2006, p.82). Since then, they have sought to revise their initial ideas and suggest where its use may best suit specific types of research (Braun and Clarke, 2022). Despite introducing a recommended order of analysis (see *theme development* section), the authors have always highlighted that a rigidity of approach may actually be removing the researcher away from the need for creativity in its use (Braun and Clarke, 2022; 2022).

Braun and Clarke (2020) are keen to promote RTA as situated between a traditional method and methodology, and while they do suggest commonalities with other frameworks, they also espouse its uniqueness. They propose that RTA is likely to have developed from *qualitative content analysis* (QCA), with some commonalities with other theme generating approaches, specifically *interpretive phenomenological analysis* (IPA), and *grounded theory* (*GT).* However, they take time to foreground the main differences. It can be argued that both IPA and GT traditionally have a more standardised theoretical base, with IPA having a clear focus on the individual participants and their interpretation of the world; and GT having less distinction between codes and themes, with its driving purpose to develop theory (Chamberlain, 2011).

With QCA likely to share most in common with RTA, what makes RTA distinct is the distancing from an analytical theoretical framework. TA more broadly is critiqued as being unsophisticated due to its lack of theoretical grounding (Braun and Clarke, 2020), however the counterargument is the reverse, in that its use can be so flexible that this becomes its strength (Finlay, 2021). The emphasis upon the versatility of RTA is championed by others, such as Trainer and Bundon (2021, p.705) describing RTA as, 'a complex and beautiful method with oh so many options'.

The role of the researcher is key to RTA's effective use, and there should be connections made between the researcher's ontology, research questions and their own subjectivity (see *reflexivity* and *subjectivity* sections). Beyond this, there can be varied approaches including a more deductive (driven by existing concepts); more inductive (data driven); more semantic (surface level coding); or more latent (deeper level coding), with Braun and Clarke (2022) again spotlighting that all these different approaches are feasible.

Further, while Braun and Clarke (2021; 2022) emphasise the lack of methodological theory in RTA's foundations, they are keen to stress that the researcher's ontological positioning can (and should), be drawn upon while working with RTA, such as acknowledging social constructionism and/or a postmodernist perspective while generating the themes. The embracing of positionality, alongside the subjectivity of the researcher, is key to Braun and Clarke's arguments that RTA sits in the 'BigQ' family of techniques, rather than 'smallq' (Kidder and Fine, 1987). For 'BigQ' research, the importance of fluidity, or organic components of the method are key (Hayes, 2000; Trainer and Bundon, 2021). This, alongside the notion of researcher subjectivity and that meaning is contextual (Braun and Clarke, 2020).

The decision to use RTA as the methodology for the data analysis is in part due to the research questions, and my own identity and positionality. My ontological position (that knowledge and meaning are socially constructed), alongside the purpose of the research (to interrogate a promoted 'truth' with a critical lens); my approach to the subject area of mental health (a critical, poststructuralist lens); subjectivity through my personal and professional experience; familiarity with reflection and reflexion; along with my value base, all sit comfortably alongside the key principles of RTA. In practice, I found utilising RTA was user-friendly that suited my style and experience.

3.10 Coding and theme generation - shared meanings

Compared to other commonly used qualitative methodologies, thematic analysis does not have a clear historical development (Bryman, 2016). Braun and Clarke (2019; 2020) share this view, however, they do discuss likely close relatives such as *content analysis*. The principles of utilising thematic analysis in an effective way relies heavily on the creativity of the researcher, and their openness about their own subjectivity in order to justify the themes (Bryman, 2016; Silverman, 2024). There remain critics of TA, usually based on arguments relating to a misunderstanding of the essence of the approach, or a lack of explanation from the researcher as to how they developed the themes (Bazeley, 2013).

With RTA, the key is to avoid seeking to ‘discover’ existing themes within the data, rather that themes will be generated through active engagement with the data by the researcher (Braun and Clarke, 2019). While Braun and Clarke (2022) intentionally avoid advancing a rigid framework for RTA, they do suggest broadly following the six stages, as below:

1. Familiarisation with the data,
2. Coding the data,
3. Generating initial themes,
4. Reviewing and developing themes,
5. Refining, defining and naming themes,
6. Producing the report.

This staged approach is not a fixed model, and Braun and Clarke (2022) do stress that the researcher can revisit several of these stages depending on their own needs, so long as the researcher is looking for shared ‘meanings’ rather than ‘topics’ within the data. For effective theme development, these processes are expected to be labour intensive (Braun and Clarke, 2019). Being comfortable with my subjective position and with the notion of reflexivity, I began, as a novice researcher, to code the data. While it is accepted in qualitative research there is no fixed way to approach coding, choices will, nevertheless, be influenced by the research purpose (Walliman, 2020).

I started with a line-by-line approach (Bazeley, 2013), building a set of 42 codes – using short phrases rather than single words (Saldaña, 2025) – from the five transcripts, across an 82-page document. I found in this first attempt that many responses/partial responses fitted into several different codes. This first attempt, reflected in the names of the codes, was certainly more semantic than latent – a common experience as Braun and Clarke (2022) suggest. This first attempt did feel ‘participant’ rather than ‘researcher’ driven, (Braun and Clarke, 2015), producing more ‘ad hoc’ codes, rather than those steeped in meaning (Silverman, 2000).

The second line of coding sought to reduce the number of codes through combining alike features and reviewing/renaming several codes. Following this stage, I began to suggest initial themes, however when reviewing these, they still had a feel of ‘domain’ themes, that of grouping together familiar discussion points, rather than ‘organic, exploratory and inherently subjective’ (Braun and Clarke, 2015, p.3). Following a break from the data, I returned and carefully reread all transcripts, looking for meanings within a particular expression in the content of the transcripts, developing the context behind the discussion (Kvale and Brinkman, 2009). This felt different, reducing the need to pull out every line, and therefore producing a much smaller yet more meaningful set of codes – this supported a second attempt at identifying early themes.

This phase resulted in four initial themes. Following a further short break from the data, I reviewed these initial themes, noting that two had overlaps with meaning. With further active engagement and reflection, I was then able to revise these into what became the final three themes – these are set out below and then explored in detail in the following chapter. I felt satisfied with the three theme names – which are supported with subthemes (see Analysis) – in that they have a ‘meaning’, rather than simply being a ‘topic’ (Braun and Clarke, 2022). They also address the purpose of this project, reflecting the research questions, the extant literature, and have a thread running through them regarding the multi-layered complexities of this topic area. See Appendix Seven for a summary of the connections between the research questions, interview questions, and theme development.

These are the themes:

1. Changing narratives.
2. Complex barriers.
3. Creative solutions.

Theme one explores context, providing an overall picture of the backdrop of the current situation; theme two addresses the multifaceted dynamics with help-seeking; and theme three addresses responses. The following chapter provides an abstract of each theme, before moving onto the data analysis.

3.11 Conclusion

It felt important from the outset to embrace a methodology that complements my existing position and experience of the topic area. While critical, I am not fixed to one perspective, and so RTA enabled me to draw upon several theoretical threads, supported by ongoing reflexivity. Through reflecting upon the need for my subjective positionality to be key to the analysis, I retained an awareness that the perceptions and experiences of the participants needed to shine through. While RTA is not the only framework that encourages subjective and personal engagement with data sets, I feel that others – such as IPA or GT – may have limited the analysis through having more predetermined expectations of their use. Therefore, I feel RTA has supported a reflexive and successful engagement with the data that other approaches may not have done.

The analysis of the data in the following chapter engages with the complexities of language and meaning, with the findings implying that the conflicting macro dynamics of this subject area are played out on microlevels – within the context of university structures. The use of RTA, incorporating a poststructuralist lens has enabled meaning to be both sought and challenged, while also building towards recommendations.

Chapter four: Analysis

4.1 Final themes and subthemes

Theme one: Changing narratives *(or providing context)*

1.1 Surging demand - complexities; language - universality (loneliness)

1.2 Marketisation - student as consumer; financial stress

Theme two: Complex barriers *(or realities)*

2.1 Fluctuating terminology - positives and barriers

2.2 Frustrations - media; awareness; limitations - services

2.3 Stigma - conflicting impact; intersectionality

Theme three: Creative solutions *(or responses)*

3.1 Local variations - geography; bespoke approaches - communication

3.2 Developing responses - apps/websites; peer led; staff development

3.3 Collaboration - other HEIs; local resources; working to guidance

4.2 Introduction

As the methodology is *reflexive thematic analysis* (RTA) I have intentionally titled this chapter ‘analysis’ as opposed to ‘findings’ or ‘results’. This, and other decisions for this chapter, have been directly influenced by Braun and Clarke’s (2022) RTA guidance for presenting results. They suggest that where there is a strong component of interpretation, alongside a significant influence of theory and research, then the term ‘analysis’ is more fitting. There will be a general discussion section at the end of this chapter that will pull everything together.

There are various ways to present findings from qualitative research (Silverman, 2000). RTA does not necessarily deviate from some of the standard expectations – such as discussing the findings with context to the extant research and literature (Bryman, 2016) – however, RTA does underscore the need for the researcher to interpret meaning from the data and relate this to the patternation of the themes (Braun and Clarke, 2022). The RTA approach to presenting findings shares some similarities with Interpretative Phenomenological Analysis, in that there is an element of telling a story through the presentation of the data, rather than solely allowing the data to speak for itself (Alase, 2017).

The analysis has been driven through a more ‘latent’ and ‘deductive’ approach, integrating reflexive thoughts with the interpretation of the data, while making connections to theoretical perspectives with links to the wider context (Braun and Clarke, 2022). This approach is not consistent throughout, as some of the analysis leans more towards ‘semantic’ and ‘inductive’ interpretation. This is most apparent in theme one as detailed below. Mixing these approaches is considered acceptable with this version of RTA, so long as it suits the presentation of the findings (ibid.).

I will begin with an overview of the three themes, exploring the boundaries of each while also highlighting where they overlap and inevitably ‘bleed’ into each other. These will be presented as ‘mini’ abstracts, again a recommendation from Braun and Clarke (2022). Following this, I will address each theme in detail, probing the meanings interpreted from the data and aligning them to both the large (see *Methodology*), and smaller theoretical influences (see *Introduction*). The RTA ‘storytelling’ approach will be written in both first and third person, again a recommendation for this type of RTA (Braun and Clarke, 2018; 2020).

The subthemes as outlined in 4.1 above, will be utilised as subheadings within the analysis of each of their related overarching themes. The narrative within each of the subthemes, while having a distinct focus, are not considered static or having a closed boundary, so there are inevitable overlaps – reflected within the three main themes. The engagement with the data continues to develop with the writing of this chapter; with my reflexive thoughts supporting ongoing interpretation – again, this is considered best practice for this type of critical, constructionist RTA (Braun and Clarke, 2022).

I need to consider the assumptions that I bring to the analysis, so I will aim to incorporate these, (with further focus in the following *General Discussion* chapter), seeking to balance the co-creation of the analysis between researcher and data to justify any generalisation, and later recommendations (Braun and Clarke, 2020; 2022). There will be frequent illustrative data extracts, alongside the focused analytic interpretation (ibid.). Illustrative extracts are most prevalent in theme one, *changing narratives,* as it feels important to build a clear picture of the current context, and how this is being interpreted by participants. Themes two and three involve more overlapping of illustrative and analytical discussion of the findings, with the following *General Discussion* chapter further embedding theory, research and reflexive thoughts.

Data extracts have been selected to embrace and add depth to the analysis, chosen not by prevalence of occurrence across the participants' responses, rather through the ‘quality’ of what the extract adds to the interpretation. Braun and Clarke (2022, p.141), discuss the notion of ‘quantitative envy’, where qualitative researchers seek to count high occurrences of similar data to emphasise validity and quality. However, as noted through the methodology section, numbers of participants, or recurring data patternation, are not considered relevant for RTA where the data is rich with meaning (ibid.). Despite this, I will make references to where a meaningful discussion point was noted by a number of participants. For this I shall refer to ‘some’ for where two-three participants reflect a similar thought; and the terms ‘several’, or ‘most’, where there are more than three.

The *General Discussion* chapter will pull together some overall reflexive thoughts, considering how my positionality and critical lens will have guided the interpretation, and indeed what tensions this has created. I will discuss how the claims may have wider applicability, incorporating a social justice lens. This part will also highlight how the themes/subthemes respond to my research questions. Finally, there are, as with any qualitative methodology, limitations and ethical considerations with the use of RTA, that will also be discussed in the following chapter.

Abstract Theme One: Changing Narratives

I have titled this theme 'changing narratives' to reflect the importance of discourse in relation to student mental health, and 'wellbeing' more broadly. Language is key, with developments in how we discuss, explain, and define mental health and wellbeing having implications for the student experience. This theme will provide a broad context as to the current situation, exploring some potential influences as to why this position has arisen. Within this, there will be a critical analysis of the complex and multifaceted factors driving increased demand upon student welfare services (SWS); with discussion of how the broadening of universal approaches to wellbeing may be informing help seeking behaviours. This theme will also address how the narrative of being a university student has changed with a critical examination of the marketisation of HEIs, and the remodelling of students as consumers of a service. I will discuss how this process has enhanced specific stressors for students, and the impact this is having on university providers.

Abstract Theme Two: Complex Barriers

The title for this theme, 'complex barriers' aims to build on the context provided within theme one, exploring the ramifications shaping the current situation. I will again be addressing language here, however with a distinct focus upon the terminology of mental health/wellbeing; how HEIs are individually and collectively reviewing the ways that they frame mental health/wellbeing; with consideration of the positive outcomes, and also barriers created as a result. I will analyse the impact of stigma, how this interacts with language, and how intersecting identities can influence help-seeking behaviours. This theme will also break down what I will term *frustrations* for HEI providers, the various internal and external determinants that limit progress, or indeed enhance barriers.

Abstract Theme Three: Creative Solutions

The third and final theme, 'creative solutions' will build upon the presented context with an overview of the complex influences identified within themes one and two. Solution seeking and tangible responses to the changes will suggest how creative and flexible approaches are key to meeting the needs of each HEI cohort. Again, I will incorporate perspectives of language, with a focus here upon communication. This will include a critical overview of how SWS-student interface methods have been adapted, and also how new technologies are being embraced to help meet demand. Collaboration with other HEIs and agencies, as well as barriers to this, will be referenced, along with the notion of the internal 'whole university' approach. I will explore this term, which is drawn from the key published guidance (Hughes and Spanner, 2024; UUK, 2023b), suggesting the benefits and also potential limitations from HEIs engaging with these directives.

4.3 Summary

Each of the three themes has a boundary, with the three potentially being subtitled, 'context', 'realities', and 'responses'. They will build upon and feed into each other as the narrative of the data analysis is explored. The subthemes identified in 4.1 have been utilised as subheadings to highlight that there are unique and specific aspects to each of the three overarching themes.

Despite each theme having a boundary, an explanation of language and discourse has a clear repeating component within each. There are distinct approaches to the analysis of language – so within theme one the focus is on changes as to how we discuss mental health/wellbeing; theme two examines choices of terminology with connections to stigma; and theme three emphasises current and creative approaches to communication and meeting need – there are inevitable and important overlaps.

I felt it was essential to embed an analysis of language and discourse throughout this chapter to reflect the importance of the two references to terminology in the thesis title, and within the research questions. The underpinning poststructuralist and critical mental health lenses (as addressed within previous chapters), feed into the following analysis with a clear correlation to my relativist and constructivist paradigms (see *Methodology* chapter). This will be most apparent within the General Discussion section.

I have identified extracts that best represent and endorse the themes that emerged, while keeping in mind Braun and Clarke's (2022) assertion for RTA researchers to avoid emotionally hanging on to topic threads within the data that may take the researcher too far away from central meanings. They use a metaphor here of trying to hang on to each 'dandelion head', rather than letting some float away. This enhances the aim to produce a robust interpretation of the data while keeping a central focus upon what the researcher is aiming to achieve.

I feel – perhaps due to the relatively small sample size, or that the interest from participants was so relevant and focused – that there was minimal detail rejected through the coding and theme development process. Nevertheless, I have chosen to exclude some details from the data, such as how each HEI engages with a local (or university based) general practitioner (GP) service. All the HEIs have a long-established process for registering students with a GP, a practice that has been entrenched for decades, and so while there are specific and relevant topics referred to about local resources, I chose (aside from a brief reference) to omit most of this.

This is the story.

4.4 Theme One: Changing Narratives (or *providing context*)

The analysis of theme one will be explored within the two subthemes, *surging demand* and *marketisation*. With seeking to provide a context for the present situation, I needed to place the experiences of participants within the wider changed nature of the higher education sector, and, as below, this was clearly recognised by the participants.

4.4a Surging Demand

> ‘The narrative around mental health has changed a lot, so I think the positive of that is absolutely those that maybe once wouldn’t think to seek help, do seek help…’ (HEI C).

I have chosen this quote to summarise what all participants expressed, in that the language and discourse of mental health/wellbeing has changed and is directly influencing the upsurge in demand. This is further emphasised below, connecting the conventionalisation of mental health discourse with support seeking:

> ‘mental health has been normalised it’s seen a lot more of the younger people come through seem to be a lot more aware of their mental health, erm, which is a really good thing […] so people as I say are able to recognise it a little bit more and kind of come through our doors and come seeking help and support.’ (HEI B).

Note: The claim that mental health has been ‘normalised’ will be explored further in the *General Discussion* chapter. Despite this subjective expression, the increase in demand for SWS has been documented in several recent policy and research reports (UUK, 2018; Hughes and Spanner, 2024; Sanders, 2023), despite the variations in measures, and inconsistencies with definitions. While some discussed this as more matter of fact, others expressed the challenging side:

> ‘it’s just the demand and the need for this service is increasing, increasing, increasing […] it’s a really difficult, challenging time’ (HEI B).

The changing discourse may have influenced demand; however, research suggests there are multifaceted reasons as to why help seeking behaviours have increased, with most reflecting specific stress demands upon the student population (Barden and Caleb, 2019; Knapstad et al, 2019). I chose to ask the participants directly about what they feel may lie behind the upsurge in demand for their services. This was, as I expected, taken as a difficult question, with one respondent expressing:

> ‘That’s a big question, that is a big question’ (HEI C).

The responses overall were varied, with some participants looking at a broader picture, indicating that pressures on younger people start at a much earlier age, or that life in general is more stressful for this group, such as:

> ‘Western life is hard for our students, I think constantly under pressure from school age onwards to be the best, perform, be examined to death, and that pressure I think is held when they get here’ (HEI C).

These thoughts were echoed by another participant who also focused on very specific reasons:

> ‘…social media, the internet […], every move young people make now seems to be broadcast over social media […] the sexualisation of young people, they just seem to be maturing much quicker, and TV and media seems to be speeding up the sort of maturation of young people’ (HEI A).

Other responses suggested external factors such as higher expectations of what HEIs can or should provide from parents and external agencies. One participant suggested that there are simply more students being supported to university with existing needs who would have struggled to attend in the past. This suggests that while it is known that higher numbers of disabled students are attending university (Zhang et al, 2020; Access Insights, 2023), barriers continue to exist. This enhances the negative impact on the student experience for disabled people (Heffernan, 2024), with particular disregard for those with hidden impairments including those with mental health needs (Encuentra and Gregori, 2021).

While one participant was more positive – focusing on developments in their provision and referral routes that has resulted in clearer access – none of the above was too surprising and these potential influences are noted as a part of the recent picture (Macaskill, 2017; Sanders, 2023). However, it was interesting to note that the key pressures upon students resulting from financial concerns – with the building of debt year on year, while having to complete paid work alongside studies to manage day to day – was barely referenced. The expansion of universities through the 1990’s, alongside the introduction of tuition fees triggered the business model of HE, with providers competing in a market of enterprise and competition.

4.4b Marketisation

The debt burden for students upon completion of their degrees is now above £50K, (Shackle, 2019), with this clearly identified as a core pressure on the student experience (Richardson, 2013; Brown, 2016) – this will again be discussed further in the *General Discussion*.

Only one participant spoke directly about finances, and seemed to underplay, or at least query the detrimental impact of financial concerns:

> ‘...they might feel this pressure about getting into debt, about it being value for money and have I made the right choice for that kind of money […] I’m undecided whether students really view it as money in the same way a loan might be seen as a massive debt that they’re getting into, or whether it’s actually kind of not playing as big a part as we may think’ (HEI C).

It is interesting that financial pressures were only discussed by one participant. I feel this is perhaps due to the expectation of debt becoming so accustomed to the lived experience of being a university student since the late 1990s (Humphrey and McCarthy, 1998; Andrews and Wilding, 2004). This demonstrates that the connection between financial concerns and the relatively much more recent increase in students seeking support for their wellbeing is not seen as particularly significant. While research and policy (Denovan and Macaskill, 2017; Sanders, 2023; OFS, 2019), continue to spotlight financial strains as a contributing factor to poor wellbeing, that this was not raised by most participants suggests that this is not being reported to them by their own cohorts.

To stay with the point raised in the previous quote about ‘value for money’, I will consider the changed narrative of students becoming a ‘consumer’ of the university experience, with them purchasing a ‘product’ of education with their tuition fees. This notion has really existed since the introduction of tuition fees; however, it has been intensified in recent years via government neoliberal ideology, and regulation by the

Office for Students (Filippakou and Williams, 2014; Foster, Gross and Borrot, 2023; Office for Students, 2022a; 2023a).

With enhanced competition between HEIs in a marketplace of higher education, universities focus on the *whole* experience, much beyond teaching, and this includes student welfare services (Hughes and Spanner, 2024; UUK, 2023). Participants referenced this in different ways, with one describing the additional pressures this has placed on their service:

> '…they come wanting a cure [...] that their feelings of anxiety will disappear and it's really difficult because we have to be realists to them and then sometimes, they're dissatisfied and then they might tell an awful questionnaire that goes out to an awful ranking system' (HEI C).

Alongside university ranking charts, (HUMEN, 2022), the National Student Survey (Office for Students, 2024), now asks students specific questions about their awareness of SWS, and satisfaction with the provision on offer. This all reflects the neoliberal drive and further commercialisation of the HEI sector, with mental wellbeing becoming part of the product for sale in exchange for tuition fees:

> '...this is probably not news to you, but now it's all about the student experience, and that, personally, is code for student as customer, but the student experience, but what does it mean…' (HEI C).

Returning to the opening extract, the use of wider, more universal language applied to mental health/wellbeing has certainly been factored into how SWS have been reviewing and developing their services. The impact of terminology will be discussed in more detail in theme two, however, I did ask a specific question in relation to loneliness in the interviews (see Appendix Three). This decision was influenced by research and reports (WONKHE, 2019; Minotti et al, 2021), that have highlighted how the impact of loneliness for university students can be as detrimental to students' wellbeing as any long term mental health struggles. All participant responses to this suggested that they are very much aware of this as a key issue and are taking it very seriously:

> 'Loneliness is a massive, massive concern to be honest, an issue and a concern and I don't think it's going away and there's plenty of evidence to suggest that

> loneliness is a contributing factor to suicide risk, and I don’t know how we can fully crack that’ (HEI C).

One participant focused on the word ‘lonely’ as itself being potentially problematic and an active barrier:

> ‘...for people at that age to admit they’re lonely when actually that is considered generally as being a period of time in your life when you’ve got lots of friends and you’re going out and you're socialising […] I think it’s very difficult for people to connect or want to connect with that idea of being lonely because it’s not socially acceptable’ (HEI E).

Loneliness and homesickness are accepted concerns – regardless of whether students have an established group of friends – and this has become more prevalent in discussions on this topic (Stones and Glazzard, 2019). It was interesting that connections were made between potential stigma associated with loneliness, which reinforces the notions that stigma can impact all, and in varied, fluid representations, not just those with protected characteristics (Tyrer, 2020). The experience of loneliness connects to the broader changing narratives for students, such as with the pressure to work long hours for financial survival, therefore limiting options for socialisation or other fulfilling activities. Loneliness is also a particular concern for specific groups of students based on aspects of identity, such as for disabled students, (Morina, Lopez-Gavira, and Molinac, 2017), and indeed students with intersecting aspects of identity. This will be addressed further in the later themes, incorporating the impact of stigma.

The changing narratives of mental health, distress, and wellbeing, along with the recognised additional pressures for university students (and younger people more broadly), have clearly contributed to the increased demand for support. How HEI SWS are responding will be explored in the following themes, with these two extracts summarising the differences in recent years and the impact of this:

> ‘... a massive change within the sector if you think back over the last 15 to 20 years it’s a significant change, where we used to get sort of declarations in the single figures of mental health’ (HEI D).

> ‘It will probably need another thousand practitioners. It’s yeah, it’s difficult […] each year we talk about trying to be proactive with the work we do and we often just get swallowed up firefighting’ (HEI B).

4.4c Theme one: Changing Narratives summary

The theme of *changing narratives* has provided a snapshot of the current situation, with a clear recognition of, and agreement from all, that there has been a surge in demand for wellbeing services over recent years. While the reasons for this cannot be quantified, there are a number of suggestions as to why life is more challenging for students (the complexities of these will be explored further in theme two).

The changed status of universities as a provider of a purchased service, driven through neoliberal reforms, has altered the narrative of the student to that of a consumer – with SWS becoming a part of the broader product being procured. This has also affected the relationship between SWS as the provider, and the students that they seek to support, with an additional awareness that they can be viewed as a commodity, and as such need to consider this within their ‘offer’.

The everyday language of feeling lonely, and the negative impact of this is being given clear recognition. The causes of loneliness – including isolation and/or missing friends or other wellbeing support structures from home (Stones and Glazer, 2019) – and homesickness, are influenced by the above, in that the financial pressures upon students leave them with less time for socialisation and/or any activities that can enhance wellbeing. That loneliness is high on the agenda for all HEIs demonstrates the broadening of the language of wellbeing and the move beyond traditional binaries of ‘ill’ or ‘well’, or for the expectation of a diagnosis (again, the complexities and contradictions within this shall be explored below).

However students frame their wellbeing, the impact of distress will be expressed in varied ways by different students, all depending upon what language they feel most comfortable with. This final extract summarises this theme:

> ‘So, it has its plus and minuses talking about mental health, but certainly I think people are more open to talking about mental health and therefore more likely to seek help’ (HEI C).

4.5 Theme Two: Complex Barriers (or *realities*)

This theme will build upon the context examined in theme one, and addresses the multifaceted complexities that intersect within this topic. The broader context via the upsurge in demand and marketisation of HE has created a need for student welfare services to review, adjust and expand their provision. How they are doing this is addressed in theme three, however there are additional intricate factors at play that need consideration.

These will be examined using the three subthemes (as subheadings) from theme two (see 4.1): *fluctuating terminology*; *frustrations*; *stigma*.

4.5a Fluctuating Terminology

> ‘I think it’s really difficult to get the right language, ‘cos what some people find empowering, others find a barrier, so I think that we have to find ways of positioning our services and the offer through a variety of routes.’ (HEI D).

This opening extract highlights the importance of, and difficulties with identifying the language that students can both relate to, and do not find an obstacle. The complexities with this are made clear by the participants, and there seems to be a stand-off between SWS reaching out to all students experiencing any element of distress – such as with the discussion of loneliness in the previous section – and expectations to endorse existing medicalised mental health provision. This is further expressed in the below extracts:

> ‘I think they’re talking a lot more openly about how they’re feeling and this is where I start questioning whether mental health language is seeping into

> nonmedical wellbeing related issues, so we have a lot more students who seem to use medical language to talk about their symptoms' (HEI C).
>
> '...it was a them and us kind of language. I think language is really important. I think it's something that should be shown that we can all have poor mental health in times of our life, no matter who we are, no matter what our position is…' (HEI B).

These extracts demonstrate the frustrations with conflicting terminology, with students, on the one hand often wanting a diagnosis – the desire for a label that they feel explains their experiences – while also reinforcing a barrier to help-seeking. Critical mental health perspectives, including research with service user/survivor groups (Beresford, 2020; Walker, 2014), argue that the 'othering' that labels create can clearly have negative outcomes. In addition, the drive for medicalised terminology by NHS providers can create barriers for students requiring NHS local resources, such as crisis teams, with obstacles to this resulting in SWS managing risk – a challenge noted within the University Mental Health Charter (Hughes and Spanner, 2024).

The pressure to receive and embrace a label is understandable – as with physical health needs, we desire to have a context of what we are experiencing. A 'diagnosis' can have additional benefits, such as meeting statutory eligibility criteria to receive additional support in the community. This is reflected in the student experience, in that a diagnosed condition may result in receiving a 'learning support plan' or indeed access to financial support for their studies. Conversely, labels also carry potentially negative consequences, such as with the categorisations of learning disability, resulting in inflexible boundaries to individual achievement (Ho, 2004). The medicalisation of distress continues to perpetuate the discourse of mental health and wellbeing, and the above extracts suggest this is something that SWS, within their microsystem, are struggling to challenge.

Seeking to move away from medicalised, and towards more ubiquitous discussions is promoted within the current guidance (UUK, 2023) and advocated within publications more broadly (Hughes and Spanner, 2024). In response, SWS are actively incorporating more universal terminology in their provision, with some positive examples:

> '...try not to think of it as depression, as in a labelled term, and just view it as low mood, which is a normal thing that you can feel from time to time...' (HEI C),

> 'we're spending a lot of time talking to students about the difference between things like feeling anxious and having anxiety, and that feeling anxious is not a mental health condition, that's a part of life...' (HEI D).

While I felt empathy with SWS' in how they are grappling to unravel these terms to provide for all, it feels positive that HEIs are having these internal conversations, and actively embracing broader language. While this is not and cannot be a perfect answer, their approaches feel constructive, and reflect progressive thinking (Houghton and Anderson, 2017; Simpson and Ferguson, 2014). Phraseology is contested, as are alternative perspectives of changing discourses, such as with Haslam's (2016) – also see Haslam and Tse (2024) – proposition of 'concept creep', in that greater public discussion of mental distress, while having some positive outcomes, has also resulted in increased self-diagnosis, embracing medicalised definitions. A direct counter to the notion of 'concept creep', while not dismissing aspects of its key premise, is that it minimises the positives that can be gained through enhanced public awareness, and therefore meaningful dialogue (Cascardi and Brown, 2016). The contradictions within terminology will continue to challenge and feed frustrations for those seeking to unpick it, as this extract sums up:

> '..I think almost all words associated with mental health and wellbeing services have now become problematic, you know, 'wellbeing' is a term that covers everything from reiki to significant mental health difficulties' (HEI D).

4.5b Frustrations

This next section will explore what I have termed as additional 'frustrations', with these being expressed by several participants. To note, there was one participant, HEI E, that indicated positive responses throughout – this did stand out as unusual, with all others expressing a number of discouraging factors. I was expecting to hear some frustrations about the complex current situation that their services find themselves in, and this was communicated in different ways. Some participants focused on the student cohort directly:

> ‘...we’ll have students who are reluctant to make a change or register locally with a GP…’ (HEI B).
>
> ‘...lots of students think they need counselling, and you go ‘do you know what counselling is?’ and here’s some really good psycho-education that may be more useful for you. But we do find people saying, ‘no, but I still want the counselling…’ (HEI D).
>
> ‘...there’s plenty that don’t even know we exist three years into their degree […] they don’t read emails, they don’t like this medium, they don’t like that medium, but we somehow fail because we didn’t sell it to them enough.’ (HEI C).

These extracts, while highlighting different themes, demonstrate the broader picture of the nuances with regard to the conflicting definitions and meanings of mental health, further reflecting the complexities as to how society addresses them more broadly (Tew, 2005). The contradictions with terminology suggest that students, (as with all), can be unclear about what their experiences actually mean, and what they feel they may need from support services.

Along with SWS struggling to identify exactly what their services can offer to students, the varied manifestations of distress further adds to the complexities. In addition to this, several reports continue to identify that many students are not aware of their HEI’s SWS, or if they are, then they do not understand what they can offer (Brown, 2016; Hughes and Spanner, 2024). It is important to note that these frustrations with the student cohort did not appear to deflect the passion of the participants' willingness, and indeed propensity to care, and to seek creative solutions – as will be covered in the third theme.

Other frustrations related to their own institution with one discussing an ‘archaic records system’; and that the ‘powers that be think you have it under control’ (HEI C). Again, this is not unexpected, with HEIs receiving inconsistent support internally, with some investing significant resources into the UMHC (see theme three). To note, three out of the five participants reported only positives about the support their services receive from their own HEIs.

Another frustration related to broader concerns outside of the institution. Some discussed the links to consumerism (as discussed in theme one), while others referenced how the media is not helping with their reporting:

> 'It doesn't help that the media etc are trying to portray students in a certain way, or trying to portray, you know we keep referring to mental health crisis, I struggle with that terminology, because you know, in a way, it's just more people have come forward with things that they would have suffered from and never told anyone about, so it's not a crisis, it's just people talking about it..' (HEI C).

Finally, there are frustrations that relate to relationships with external providers, and more broadly what students, parents, and these external agencies believe that SWS can and/or should be providing:

> '...biggest concern is, are we doing enough proactive work within NHS services etc, and it leaves us feeling very vulnerable if you pass it to other professionals and they say, well it's a waiting list of two years. Who's holding them, who's holding those students? It's difficult and it's not a nice answer…' (HEI C).

> 'I think, externally, services are so busy and we find a lot of our students are being referred by their GP […] they say go to the university, not go to university, go seek mental health support from university, it's quicker...' (HEI B).

Another spoke about external NHS providers being resistive to services that reflects two points about the current picture. Firstly, there is a direct correlation between previous governments' austerity measures and welfare reform that has driven increases in distress, while services have been significantly reduced (Moth, Greener and Stoll, 2015). With the Care Act 2014 introducing a legal duty for local authorities to provide preventative services, the reality of budget cuts via austerity has created a situation where the opposite occurs or at least results in inconsistencies across social services

(Marczak, Wistow and Fernandez, 2024). To note, three participants discussed very positive relationships with external services that largely reflect geography (discussed further in theme three).

The above extracts further emphasise the changed narrative of universities being a purchased service, providing a range of facilities, beyond the expectations of the provision of education. The gaps in understanding about the parameters of what HEIs can provide has been reflected by outside services (UMHAN, 2019), parents, (Boughton et al, 2021), the media (Shackle, 2019), and students themselves:

> '... young people who are very unwell are brought to university by their families with an expectation that the university will look after them […] but what is reasonable and realistic for institutions to provide is a whole different area' (HEI D).

The above dilemma mirrors some of the more recent discourse about the 'duty of care' that universities have for their cohorts (DfE, 2023; Office for Students, 2022). Recent cases in relation to student suicides (Farrer and Co, 2023; Morriss, 2021), alongside the identified recent increase in suicide rates for the student population (Sanders, 2023), has placed this debate into the public domain (Forthe100, 2023); provoking responses from the Office for Students (2022), and Universities UK (2023b). The participants discussed this matter, highlighting their engagement with specialist agencies, such as Papyrus (2023) – a young person's suicide prevention charity. This further builds upon the complex boundaries of their responsibilities, raising dilemmas about the limitations of their provision.

In relation to the above, some participants discussed changes in 'needs' being presented by students relating to specific manifestations of distress, and also the problems with identifying this:

> 'I do think there is an increase in complexity […] talking to some of my colleagues in the NHS, personality disorders massively increasing, and we're seeing that' (HEI D).

> ‘…we have seen an increase in suicidal ideation, self-harm related cases […] an increase in psychosis and students experiencing psychotic episodes, we’ve seen an increase in that […] one thing we haven’t been able to do yet is really prove that complexity through data, how do you present complexity?’ (HEI C).

This further demonstrates the ‘pull’ between seeking to broaden out services, and the expectations of what SWS should be able to manage. The diagnosis of ‘personality disorder’ is contested, and critiqued as enhancing stereotypes, specifically for women via the highlighting of tropes of emotional dysregulation (Appignanesi, 2008; Russell, 1994). There remain ongoing debates within psychiatry about the impact of this label on younger people, with some arguing for increased application (Tyrer, 2022), while social and critical perspectives focus upon the potential burden that this label can place on young people – that it constricts personal and creative development through medicalising distress rather than focusing upon past trauma and holistic intervention (Koehne et al, 2012). This mirrors outdated perspectives within disability studies of individuality and personal ‘suffering’ (Barnes, Oliver and Barton, 2002), rather than seeking to address how these notions multiply experiences of oppression.

However, the challenge to this particular label is not to question the validity of what people are expressing, and there are indications that those with this diagnosis are prone to higher levels of loneliness and associated risks (Liebke et al, 2017). This may all reflect what was suggested earlier, in that increasing numbers of younger people are seeking support earlier (pre university ages) and thereby developing a bespoke support structure that enables them to be able to attend university.

The meaning from the second above extract again highlights the complexities with boxing people into categories, and how SWS should challenge their part of these processes. What is complex for one individual may not be for another, whether you have a diagnosed psychosis, or are experiencing poor wellbeing through loneliness, leaving SWS working out how best to respond to all. This again adds to the frustrations reported by SWS, who, while seeking to place their provision within more universal approaches to wellbeing, many students are wanting a label, or indeed, self-diagnosing, reflecting elements of the notions of ‘concept creep’, or ‘prevalence inflation hypothesis’, (Foulkes and Andrews, 2023; Haslam and Tse, 2024):

> ‘They may never have been diagnosed with depression but they’re talking about being depressed’ (HEI C).

These complexities and contradictions with language and self-identification can become more acute when it comes to students with specific or multiple identities. International students can have very specific needs in relation to their own identities, and may require culturally sensitive support (Unite, 2016; Brown, 2016, Thorley, 2017). One of the interview questions (see Appendix Three) asked specifically about international students (and those with other diverse identities), with some noting this as a key area of focus due to their own HEI attracting large numbers of international students:

> ‘..we have a lot of international students […] you know mental health might not be talked about as openly there as what it is here so you know we have a lot of students who come from [country redacted] and we know that like the rest of the population we’ve all got our mental health and they can struggle but it’s very different how they describe it and also in terms of how that manifests itself when they are struggling and they’re not as forthcoming in terms of seeking support’ (HEI E).

The use of ‘there’ in the previous extract was referenced by the participant to a specific part of the world where this HEI has a large cohort of students. It is clearly important not to stereotype a student by country of origin and culture, as that in itself can prove to be a barrier (Raya and Fawaz, 2017). However, this does demonstrate the need to find a balance with research that highlights cultural differences in interpretation and meaning of mental health and distress (Eisenberg et al, 2009; Li, Denson, and Dorstyn, 2018). One participant focused upon the higher risk indicators associated with international students and potential cultural barriers to help seeking:

> ‘We have a large international cohort, they might be bringing very different attitudes towards mental health […] including how student services are positioned in their home countries as well, so in some international institutions

> you are sent to student services if your academic performance is not good' (HEI D).

These two extracts further represent the nuances of language and discourse that can be obstacles to engagement. Looking deeper, these also reflect the Westernised history of mental health diagnosis and treatment. It has long been acknowledged that the establishing foundations of psychiatry historically favoured white Western colonial ideals, (Fernando, 1991), demonstrated in the foundations of early versions of the published diagnostic tools (APA, 2022; WHO, 2021). This also built upon psychological *research* aiming to separate ethnicities by racial groupings, with the framing of non-whites as below human in order to advance white supremacy (Mills in Chen, 2018).

There's a clear thread that runs through the history that demonstrates psychiatry with deeply embedded racism in its structures, (Bhugra and Bahl, 1999; Fernando, 2003). Postcolonial critiques such as Fanon (1952), and Fernando (1991), refer to Western psychiatry as focusing on the separation of mind and body, and therefore ignoring cultural conceptions of mental health wellbeing and distress. This is borne out today with a suspiciousness of services from BAME people (Sewell, 2009) and evidenced through the significantly higher numbers of Black men being detained under the MHA compared to white men (CQC, 2021).

For international students, whether identifying as BAME or otherwise, the difficulties accessing support for their wellbeing is reflected in the research suggesting a complex interaction of culture, stigma, racism, and stereotyping (Singh; 2011; Jibeen, 2016). Participants with fewer numbers overall of international students acknowledge the risk and that this is 'something that's on our radar' (HEI B), however research suggests (Keating and Robertson, 2004), that these gaps in cultural knowledge can drive a cycle of avoidance of support seeking.

The push to make services as flexible and approachable as possible was clear in all responses, however they also recognised the intricate barriers at play. Some participants focused on specific aspects of identity:

> ‘We recognise it’s there we recognise risk involved and we also recognise they’re less reluctant to […] we’re doing a lot of work around BAME students at the moment, we’re doing our own research’ (HEI B).
>
> ‘I don’t think we’ve cracked it yet, I think there’s more we can do […] We have options for students, such as BME students, should they want to speak with someone who is also BME’ (HEI C).

This again demonstrates the tension between traditional provision, and the acknowledgment that things have changed, suggesting that SWS are very much aware of the need to expand and adapt their services. Certainly, for BAME students, the lived experience of racism can be as acute and present on university campuses as within wider society (Frampton and Smithies, 2023). BAME students also report that when concerns are raised they are not taken seriously (Stoll et al, 2022), again being reflected in lower uptake of support provision (Ballo et al, 2022). The lived experience of oppression enforces poorer wellbeing, and so BAME students are likely to have a higher need for support. However, the existing barriers suggest this is not an easily resolvable issue, and one which participants acknowledged that further work is needed (see *Recommendations*).

For LGBTQ+ students, as with BAME students, the lived experience of being a university student does not mean protection from discrimination or hate crime, both on and off campus (Baggs, 2021; Smithies and Byrom, 2018). The general rise in LGBTQ+ hate crime (Stonewall, 2023), and more acutely, transphobic attacks (Duffy et al, 2021), will clearly enhance distress levels, and the need for support. Moving to university may also be the first time that students feel they can freely explore their sexual orientation and/or gender identities (Taulke-Johnson, 2008). While this may be on the one hand a very positive experience, this can also involve increased levels of stress and also fears about tensions with family (Smithies and Byrom, 2018). I asked about LGBTQ+ student needs. What came through is reflected within the research/reports (Bryant et al, 2022; Sanders 2023), that many may prefer to use an LGBTQ+ specific service outside of the university due to feeling more comfortable with this:

> '…if at the time they're struggling we get a referral through if they wanted that from inclusive support, we do have there's an external agency […] specifically around LGBTQ+ support, so we advertise that...' (HEI E).

Equally, some universities acknowledge that they could improve how they deliver support to LGBTQ+ students:

> '...when they look for a place if they're from an LGBT community, is do they promote, you know, a proper website, not the kind of whitewashing kind of approach […] but genuinely do they have a website that allays concerns for someone from that community, and I feel we should go down that route a lot more' (HEI C).

It is interesting to note, like with BAME and international students, there is a general recognition that students with specific identities will have a unique lived experience, and therefore SWS have a need to recognise this and respond with tailored services. That gaps are noted as areas to improve is positive. I did get an impression that there were knowledge and awareness imbalances that need to be addressed further, beyond having representation within SWS staffing (see *Recommendations*).

Likewise, for disabled students, going to university may present the same barriers with access as in wider society (Minotti et al, 2021). Delays in accessing equipment, reasonable adjustments, or indeed funding for learning support can result in not only poorer wellbeing, but actual real impact on the educational experience, such as higher drop-out rates and lower degree grades than non-disabled students (Morina, LopezGavira, and Molinac, 2017). As with other aspects of identity, disabled students spotlight knowledge gaps and misunderstandings about their lived experience that will prove a barrier to access for mental health support (Stanley and Manthorpe, 2002), and therefore HEIs need to focus on the whole institution if they wish to improve inclusive education (TASO, 2023). Whether students with mental health challenges identify as disabled or not, the lived experience of structured barriers, both on macro levels, and within the microcosm of the university – played out through both physical barriers and erroneous responses from those administering support (Blockmans, 2015) — reflects aspects of both saneism and ableism, and indeed the overlap between them (Thorneycroft, 2020).

Some participants, while accepting that students have specific needs based on identity, note that they have scope to improve – ‘I think we can always strengthen’ (HEI D). While giving the impression overall that they are both acknowledging this and that it is feeding developments, it does feel that a lot more can be done. Expanding conversations and collaboration with those with lived experience would be a starting point, as suggested in various guidance (Hughes and Spanner, 2024; Wilson et al, 2022). Interestingly, some also expressed frustration about the limitations, or perceived limitations of their service in respect of distinct characteristics:

> ‘...you get into some interesting discussions again about that representation thing, because what we hear from students as well, we want, you should employ more, yeah, gay, black, disabled, physically disabled people, and that’s quite difficult, because obviously staff also have a right to choose whether to disclose their characteristics or not’ (HEI D).
>
> ‘It’s a barrier I don’t know how you can resolve in some ways, unless you had the most diverse staffing body going, it’s a really difficult one to meet the needs of such a diverse community’ (HEI C).

I have chosen to discuss some common aspects of student identity; however, it is important to acknowledge that there are many other aspects of identity, beyond the protected characteristics from the Equality Act 2010, that can impact the student experience and also wellbeing. These include, being a carer, with the additional responsibilities of the caring role potentially affecting academic performance and attendance (Runacres et al, 2021); or being a care leaver, who may have less family or networks and may be more vulnerable at key periods such as Christmas (Stones and Glazer, 2019).

Overall, the impression from the data suggests that while SWS have very good intentions and readily acknowledge that there are specific needs based on student identities, this is an area that they are struggling to resolve, and one that is causing frustrations. While I have addressed some specific aspects of identity, however, students may have multiple intersecting aspects to their ‘self’, resulting in a nuanced, individualised lived experience that may enhance existing known barriers. Intersectionality can no longer be considered a ‘new’ term, (Crenshaw, 1991), and so it was interesting to note that this word was not used by any participant. This may actually reflect a more deeply embedded notion that there are some gaps in knowledge, in part due to more recent conversations. An example of this would be for trans students, and the fear that can be created from misgendering, or lack of understanding about the lived experiences of trans people (TransActual, 2021), resulting in an additional barrier for both the student and support service. This notion was considered by one participant:

> ‘...I think there are some really interesting and quite nuanced conversations […] there’s probably also some really interesting generational things going on between students and staff and that’s a, that’s always a challenge I think because we need to listen and respond to students, and recognise that sometimes those things change over time as well and so working out where we want to change in response...’ (HEI D).

5.4c Stigma

A discussion of complex barriers, in particular with relation to identity, also needs an analysis of the impact of stigma. Stigma threads through all of the above discussion, and, as known, can take various forms, including both self- and perceived-stigma (Carmack et al, 2018). The research and reports highlight the ongoing impact of stigma (Billings, 2021; Carmack et al, 2018), including Student Minds’ (2014) report spotlighting the key reasons for students not seeking support for their mental health – these include not wanting their friends to find out or worries about being seen as ‘weak’. The association of mental distress with supposed character ‘defects’ reflects the power of stigma, and the ongoing relevance of early theories, such as with Goffman’s (1963) discussion of ‘spoiled identities’, and Scheff’s (1966) analysis of labelling and the adopting of a ‘social role’.

Due to this known influence, one of my research questions aims to assess the ongoing impact of stigma upon help seeking behaviours. The responses suggested that SWS have given time to address this within the ways that they seek to reach out to students. Interestingly, the range of responses were quite varied, firstly that there is a feeling that stigma is reducing overall:

> ‘I think there is something about reducing stigma, I think that has made an impact, erm, again over time, I’ve been in this sector a long time and I initially think people were worried that they wouldn’t get a place if they declared on a UCAS form, so I think we’ve done a good job of reducing stigma, there’s always more to do’ (HEI D).
>
> ‘...we very much advertise in a number of ways what we do, [...] it’s reducing that stigma and that barrier to people coming forward, and I think year on year that message is getting through.’ (HEI E).

These extracts suggest a couple of things. Firstly, that stigma overall *may* be having a reduced impact, potentially being influenced through more open societal conversations. This could certainly be a causal factor behind the increase in demand for SWS support.

This also suggests that universities and their SWS are taking positive actions to promote wellbeing more broadly. As shown, part of this may be a result due to carefulness with terminology, such as breaking down and normalising the terms for feeling anxious and/or experiencing low mood.

Acknowledging the continued influence of stigma feels realistic, as it is a complex dynamic that cannot be addressed without ongoing work, and certainly will not be easily eradicated, as some, such as Stones and Glazzard (2019), suggest it can be. Campaigns, (Mind, 2023; Rethink Mental Illness, 2023), may help, yet the public impact of these can be said to be limited where media and governments continue to pathologise those in need of support as a ‘burden’ (Beresford, 2023). It feels important, as reported by the participants, that stigma is recognised as a barrier for various reasons, rather than assuming its influence is limited – this feels more realistic with attempts to reach out to students.

There was a general feeling in the responses that stigma has a reduced impact, while continuing to accept that stereotypes in relation to distress, and perceptions of how others may judge them persist. Other participants recognise how stigma for people struggling with their mental health is embedded within society, and that students can bring preconceived notions to university:

> ‘...the sort of visible signs and symptoms of poor mental health, people do feel stigmatised if they present those […] I really am not aware of why, it’s still maybe an embarrassing thing for people to open up and talk about…’ (HEI A).
>
> ‘…a lot of people see poor mental health as a weakness because there’s no physical thing […] I was reading something the other week about people with poor mental health, ‘they are this’ and it was kind of very much around, it was a them and us kind of language’ (HEI B).

These stereotypes are widely recognised, and play out as many false notions, from aligning mental distress to shortcomings in character, or even connecting poor mental health to deviance and dangerousness (Corrigan, 2007; Dobson and Rose, 2022). There was also a point made about the connection with the term ‘disability’, and that some students may feel stigmatised about this association. While this seems to be counter to the increase in students seeking a label (as addressed earlier), this has been reflected in some research (Simpson and Ferguson, 2014). That students may associate *disability* as something different and even more stigmatising, likely represents the ableist stereotyping of disabled people being seen as unable to contribute to society (Hammer and Stutts, 2024). This is also enhanced through the neoliberal governments agendas of constructing disabled people as ‘scroungers’ and therefore a burden to the taxpayer (Beresford, 2023). The aligning of mental health with disability has varied perspectives (as covered in the *Introduction*), however all suggest that further conversations about stigma need ongoing analysis on a wider scale. This nuanced interplay with language and terminology within the microcosm of the university, demonstrates that this is played out throughout society’s institutions and structures.

It was noted that groups of students with distinct identities will have specific stigmas. One participant noted that men still feel enhanced levels of stigma in relation to help seeking:

> '...we think about males, maybe that's kind of a cultural, err a deep rooted cultural stigma in terms of this stereotypical idea that, you know, men you know don't cry or get upset or don't talk about their feelings so I think those things are difficult to break down…' (HEI E).

This gendered barrier to support seeking is well known and continues to be reflected in the research (Carmack, et al, 2018), and with the statistics that suggest men's suicide rates remain very high (ONS, 2019). The additional barriers with engaging international students, and some BAME students was covered by most participants acknowledging the impact of some cultural stigmas, as summarised here:

> '...they might be bringing very different attitudes towards mental health and the level of shame that is associated with mental health difficulties in some cultures just makes it very difficult for those students to get through the doors...' (HEI D).

Caution is rightly needed when considering how cultural factors may impact international students, such as avoiding stereotypes that students from some countries will turn to religion or family for support (Jibeen, 2016). However, the research does refer to notions of shame or feelings of being a 'failure' for many international students should they seek support, (Knifton, 2012). The importance of addressing this and finding means to reach out is proffered by the guidance, such as UUK (2023a). There was evidence of this awareness within the responses, with some actively finding routes through:

> 'We liaise closely with the international service [name redacted], they have their own welfare manager in there […] so international students are very clearly signposted into university support services' (HEI A).

While this will not necessarily resolve all the known barriers for some international students, it is a positive action. More importantly the awareness across HEIs, particularly those that have large international cohorts suggests the conversations are ongoing, and, through listening to these groups of students can only improve matters (Thorley, 2017; Unite, 2016).

There is one further specific group of students that it is important to highlight, that is those on professional courses such as education, nursing, and indeed my own subject, social work. The research and reports (Barden and Caleb, 2019; Lee and Jung, 2018), indicate that students on these courses have an additional barrier, that through disclosing a mental health need, they may be judged as unsuitable or indeed 'unfit to practice' in their field. One HEI did refer to this dynamic:

> '...it's certainly dependent upon what course they're doing, particularly those vocational resources, we know that medical students for example will potentially struggle to come forward if they are battling with anything because they worry that it will impact on their career and their studies...' (HEI E).

This is particularly telling, given that the nature of most of these professions involve a caring role and advocate for anti-oppression and social justice, (BASW, 2021; SWE, 2019). That these students perceive this as a barrier, suggests the pervading influence of stereotypes about mental health struggles, reflecting societal judgemental attitudes.

Stigma is complex and nuanced, driven through historical and multi-faceted structures (Tyler, 2020), thereby impacting individuals in a variety of ways – with additional layers of meanings for groups of students with specific identities. This suggests that intersectional approaches to student support are likely to be most effective where addressing need through various means (see theme three). What is clear is that SWS recognise these complexities, and, while not dismissing the impact of stigma, they are building this into their conversations with many positive actions. It does appear that evolving language has had a direct correlation with the increased numbers seeking support, and so I will conclude this part with the following extract:

> 'I'm not seeing as much evidence to suggest that students don't access our service because they feel they'll be judged, or they feel we won't listen, or it's an unknown service, or it's scary. I'm seeing less evidence of that from even ten years ago' (HEI C).

4.5a Theme two: Complex Barriers summary

This theme has focused upon the intricate and multiple barriers to support seeking. There are complex, interacting, and overlapping dynamics that can create various frustrations for the support providers. Some of these are at micro levels, such as within the university set-up; however most discussed broader macro level influences relating to societal expectations and indeed expressions of mental health.

Once again, the nuances of language, and how the discourse and terminology of mental health/wellbeing evolves is a key consideration. Overall, there is a feeling that SWS are trying to push back against medicalised and category-based language, despite facing historical and deeply institutionalised structures, particularly where there are overlaps with outside agencies.

The impact of stigma – while participants expressed a range of views – was noted by all, and while HEI’s are all taking positive actions, there was not an impression that this is being disregarded or underplayed. In respect of student identities, again there was a recognition throughout of the potential barriers for support seeking, and all expressed this was an area that needed further attention.

While the frustrations are understandable, there was also a general feeling of positivity, with each SWS seeking to be creative in their responses. This will be considered in theme three.

4.6 Theme Three: Creative Solutions (or *responses*)

Within theme one, *changing narratives*, I have considered some of the shared perspectives about the current context, such as the noted increase in demand across all providers – with some common viewpoints as to what may be driving this, such as the additional pressures upon young people. I have also discussed some differences in position about what may be driving the increase, with some focusing on the changes to societal conversations, and others suggesting more direct factors such as drug use or body image.

With theme two, *complex barriers*, again, there are some similarities about how barriers continue to manifest, with all agreeing that stigma continues to perpetuate, albeit in different ways according to the responses. Equally, there are differences in how barriers are perceived, with frustrations expressed about external expectations, or indeed at the student body itself.

With theme three, *creative solutions*, the story develops to focus upon how student welfare services are recognising the need to change, and some of the ways they are seeking to do so. It will also examine the expanding market for the use of self-help apps and websites, in addition to recognising alternative means – supported by research – to support collaborative means to move towards a ‘whole university approach’. The narrative will again be addressed, utilising the three subthemes (see 4.1), within the following subheadings: local variations; collaboration; developing responses.

4.6a Local Variations

Taking the current position, and bearing in mind the barriers, this third theme, *creative solutions*, will focus upon how university SWS are actually responding to meet the increased demand. This theme more directly addresses the thesis title, in addition to the research subquestions.

These opening extracts for this theme provide examples of how SWS are having to ‘differentiate’ their services in order to respond. This was reflected by all other participants:

> ‘...we have had a big restructure about how we work with wellbeing and counselling services together as well as the wider university. We are looking at a big resilience piece of work that’s going to be threaded right the way through for all students...’ (HEI B).
>
> ‘...I mean our service, like in any other service, in any other university I gather has kind of evolved and got bigger and bigger as times gone on, but it’s about that, looking at that kind of, but it’s the least intensive first time and getting the right support at the right time...’ HEI E).

> ‘The traditional ways of delivering services are massively resource intensive, so I think one of the things we’ve started to do is have a much more differentiated offer, so trying to work out what is the need, and what’s the appropriate intervention...’ (HEI D).

These responses are not surprising, and the impression gained is that reviewing and adapting provision is both relatively recent and ongoing. This was suggested by all, with those that have worked within their SWS for a significant time, keen to point out the changes, ‘...when I started here there wasn’t a mental health provision.’ (HEI A).

The ways they are seeking to adapt is clearly a measured response to increasing numbers requesting support, however this also demonstrates how the changed vernacular of mental health more broadly has influenced how providers are reshaping their services. For example, enhancing referral routes using the universal language of wellbeing and reframing needs within everyday parlance such as ‘not feeling yourself’ or having ‘struggles’ is being used within HEI awareness campaigns – this is also reflected in the national online alternatives (Togetherall, 2025).

How SWS are responding appears to be influenced through a number of factors that include: the geographical HEI location; the particular makeup of the student body; and relationships within and beyond the campus. Distinct measures have also been considered, including the routes to access support:

> ‘...in terms of the referral routes, we’ve got a number of ways that students refer in whether it’s self-referral, academics making a referral, erm they can do it via (name redacted) which is a reporting platform, erm friends and family make referrals, we’ve got a drop-in here [...] so that’s not an appointment needed...’ (HEI E).

The above participant very much presented this in a positive way, in that their communication and expansion of pathways to receiving help is proving effective. Another participant expressed frustrations about how ‘young people’ communicate, and how they are feeling disheartened about how their message may not be reaching students:

> '...the young students, the 18/19 year olds don't have messenger as a thing that comes up, you know it's buried, and when they get round to it they'll say they've got seven messages, so even, it's all SnapChat and things, and I don't, not there yet, I don't think I can do TikTok dances to get our message across' (HEI C).

While this does reflect a generational concern (as suggested in theme two), the messages must still be getting through as the increase in demand implies, this is despite some students continuing to report they are unaware of SWS. This indicates that SWS will always be limited in seeking to reach all cohorts of students, such as with LGBTQ+ students often seeking a bespoke community resource.

4.6b Developing Responses

The use of online platforms and/or apps as newer, accessible options for younger people was discussed by several participants, with, again, a mixture of viewpoints:

> '...we curate some resources online, we direct students to the NHS list of digital resources, I think it's actually really challenging to keep up in that space at the moment, so we tend to direct to NHS approved resources because there's so much out there...' (HEI D).

> '...when there's that many self-help apps and it's really difficult for us promoting, because how do we pick, we tend to go off if it's NHS endorsed [...] but you know I get mixed on whether they actually are useful for people or they're a bit faddy and you do it for a month and you forget to do the things you're meant to do on it.' (HEI C).

This demonstrates the need for services to engage with alternative options. However, the difficulties with encouraging this while also seeking to manage the responsibilities to maintain student safety within their remit, is again understandably complex. The use of apps for mental health support is continuing to grow with an estimated worldwide number of available mental health related apps at around 300,000 (Chiazzui and Newell, 2019). The comment above questioning 'usefulness' is explored by some research, suggesting that people often find them limited or meaningless (Byron, 2019;

Parker et al, 2019); and also, that there are clear difficulties with measuring effectiveness (Melcher et al, 2022).

That universities are buying in external services (two referred to a specific website provider), suggests that there is a genuine need to back up in-person support, or at least resource an optional alternative. There are questions about the uptake of these, with some suggesting this could benefit those students feeling isolated (Soria and Horgas, 2021), with other research (Byron, 2019) finding that many students will prefer to use their own favoured app, rather than a university endorsed one.

There is a growing market for mental health provision, shown through national and international providers marketing their products, such as Solution Path (2023). That HEIs are endorsing profit driven companies suggests that they are needing to seek alternatives to manage numbers, however it also raises questions about the integrity of these services. This further signifies the commodification of education, as well as the pressures to be financially sustainable (Foster, Gross and Borrott, 2023). Mental health support apps have been critiqued as being ineffectual and lacking a safety net (Anthes, 2016), in addition to concerns about data protection (Iwaya et al, 2023). Despite these critiques, apps and websites have been shown to be effective in some cases, (Eisenberg et al, 2009; Lee and Jung, 2018). However, where SWS are trying to balance overall student risk management with what capabilities they have in their service, questions remain as to how to moderate these external resources and student engagement with them.

The concept of a university wide safety net fits with the notion of embedding wellbeing through all university structures, and some discussed how this is being implemented:

> '...the university has compulsory mental health training now for all staff, so we're trying to create a very wide safety net, so that students are signposted over to support services [...] especially if they haven't sort of approached us themselves [...] as long as many people, sort of, in the university community are aware of where students need to be signposted if they experience difficulty.' (HEI A).

Academics were referenced in a previous extract, and several referred to mental health training for academics as part of their whole system approach, with a particular emphasis upon staff awareness of how to refer:

> ‘Staff training as well across the university for academic departments and things like that as well, they’re becoming a lot more aware, so they are signposting a lot.’ (HEI B).

Outside of this, there was very little discussion about academics and their role. This was quite surprising, given that students identify their tutors often as the first line of contact for support seeking, ahead of SWS (Bryant et al, 2022; Hughes et al, 2018). Academics themselves express high levels of concern that they are being left to carry the burden of student wellbeing, and face conflicting scenarios due to confidentiality and information sharing (Barden and Caleb, 2019). While some academics report ‘moderate’ levels of confidence with negotiating this area of support, up to two-thirds report feeling ill equipped (Gulliver et al, 2018), with significant disquiet about managing the boundaries of their role, especially for those teaching on professional courses (Hughes and Byrom, 2019).

Any mental health awareness training is likely to be beneficial, along with clearer pathways for signposting – this is also recommended in the UMHC framework guidance (Student Minds, 2024b). However, for universities to state that compulsory training in and of itself is enough to support staff with their concerns is misunderstanding the reported disquiet (Hughes et al, 2018). This training is often an online course that usually involves videos of a number of scenarios, suggesting how academics should respond. These are commonly based around diagnostic terms, so ‘this student is presenting with anxiety’, ‘this student is displaying symptoms of psychosis’, and this is how you should respond. Having over twenty years’ experience as a mental health professional, I am very aware that each individual has a unique experience due to a myriad of factors, and as such there is not a scripted way to engage, outside of some obvious red flags for risk. This is not to suggest that support with awareness raising or broad training is a negative, and in fact some HEIs are actively promoting this:

> '...so we do a lot of training with like the personal tutors, we've got toolkits available, we're supporting staff to support students that can be accessed by any member of the team with a number of different kinds of titles and headings around mental health...' (HEI B).

National guidance, including UUK's (2023a) Stepchange Framework, and the UMHC (Hughes and Spanner, 2024), both foreground the importance of staff mental wellbeing, making it clear that you cannot improve students' wellbeing without considering the health of staff. The UMHC spotlights staff wellbeing within one of the Framework's compulsory *domains* (Domain 3: Work), in order to meet the Charter's requirements. This makes it additionally interesting to note the limited discussion of this by the participants and perhaps suggests that this is not on their radar beyond provision of basic training. In some respects, this makes sense, as SWS' purpose is to be a wellbeing amenity, and given the additional pressures they are clearly under, they have to keep focus on the student body as they juggle time and resource constraints.

Returning to recent and creative approaches, there was some emphasis about embedding notions of wellbeing beyond standardised SWS provision, to expand within wider university structures, including within the curriculum:

> '...in terms of the mental health charter, that will be really key in terms of embedding wellbeing into the curriculum, in terms of accommodation as well, that whole system approach...' (HEI E).

This has been recommended in several publications (Houghton and Andreson, 2017; Upsher et al, 2022), with some specific direction about how this can be done, including toolkits, such as those provided by Advance HE (Wilson et al, 2022). Equally, there has been critique about the potential effectiveness of this upon student wellbeing more broadly (Upsher, et al, 2022), and the additional pressures upon tutors needs to be acknowledged (Stones and Glazzard, 2019).

Student-led and/or co-produced responses are broadly seen as a positive, being a pragmatic means to bridge gaps between the institution and their cohorts (Byrom, 2018). All participants spoke about relationships with their respective student unions, and further engagement with the wider student body are highlighted as key actions through the UUK (2023) Stepchange framework, and the UMHC (Hughes and Spanner, 2024). Equally, various models of peer support is another route, with noted positive outcomes where this is supported through the existing university structures, despite challenges reported by staff leading these approaches (Byrom, 2018; Pointon-Haas et al, 2023). While this is part of the whole system approach, there needs to be caution in respect of risk management and the potential caregiving burden upon peers with taking a lead for the wellbeing support for their friends, especially where this is outside of a university driven network (Byrom, 2017). The following extract sums up some of the key points discussed:

> '...the sector is becoming much smarter effectively about how we use our resources, what do we do as whole cohort interventions?; where can we put peer support in place?; how do we do that safely?, because there are real challenges around doing that, we don't want all of our most vulnerable students supporting one another and creating potentially quite negative feedback loops between themselves...' (HEI D).

All participants spoke about more recent methods to expand the boundaries of previous provision. Examples of this include reaching out to new students before they arrive to try to bridge a gap if they have existing support or are anxious about the move:

> '...we're communicating with prospective students before they start so if they may be experiencing any sort of anxiety about this, about transition […] so we're making awareness raising about the potentiality of students experiencing feelings of isolation, homesickness in the first few weeks, separation trauma from those they love back home.' (HEI A).

This all suggests that there is a recognition to build creativity into the responses to recognised needs. It is known that the transition to becoming a university student, especially where a young person moves out of the family home for the first time and to a new environment (or indeed a different part of the country), can be traumatic, (Barden and Caleb, 2019). Moving away from an established network of friends and family can be considerably isolating, enhancing feelings of loneliness and homesickness (Stones and Glazer, 2019). There may also be feelings of guilt should they be leaving a family carer role (Runacres et al, 2021). For international students moving to a new country, and one that feels unwelcoming to them, these experiences can be multiplied (Crook, 2020).

One participant had a notable focus upon moving beyond fixed or expected responses to improve wellbeing:

> ‘..I quite like social prescribing , so this whole idea of not everything mental health related has to be medical intervention and let’s find ways of just getting into the local karate club and that might help your wellbeing and not once have we talked about it aiding depression or supporting anxiety, it’s just the symptoms you’re feeling could be allayed somewhat by engaging with this community event or club.’ (HEI C).

This felt really refreshing and further suggests the importance of moving the discourse away from the established forms of *treatment*, and towards flexible and creative responses. The idea of social prescribing highlights the long-recognised impact of positive socialisation and community access for any individual’s self-determined ‘recovery’ (Mezzina et al, 2006b). A focus upon basic needs such as sleep, diet, and socialisation has been highlighted within the UMHC (Hughes and Spanner, 2024), with these approaches aligned to universality within the broader discourse.

4.6c Collaboration

Discussing cooperation with others covers a broad scope, and so I did ask specific questions about this in relation to working with other HEIs, local health providers and third party services (see Appendix three). The responses were quite varied and really told a story of the impact of location, as these two opposing extracts suggest:

> ‘...we’re part of a partnership with a number of other local universities, so that came out of an Office for Students funded project […] we’ve expanded to all the other local HEI providers in the area and the local NHS […] an opportunity to share and network, we’re looking to build ourselves as a centre of good practice, where we can trial different ideas for student mental health…’ (HEI D).

> ‘...places like [redacted] where they’ve got three or four universities they’ve been able to come together […] we aren’t in the same position because we are standalone here, we’d like to do possible a bit more linking in with the likes of [redacted] but we have different populations…’ (HEI E).

This further demonstrates the importance of geography, and so knowledge of their individual student populations will support the development of localised creative solutions. This was also reflected in the participants’ responses to relationships with the third sector, with all speaking about positive services that students can be signposted to – these included bespoke services for substance use or domestic violence, and where identity needs may be better met, such as LGBTQ+ specific services. This all sounded useful, however there remain noted differences with availability due to geography – again, highlighted within the UMHC (Hughes and Spanner, 2024).

Relationships and cooperation with GP practices and NHS mental health providers more broadly are certainly key for students who move between home and university for long periods of the year. For students who have pre-established support, transition is vital to avoid gaps in these systems (Stones Glazzard, 2019), in addition to proactive provision across services (Barden and Caleb, 2019; UUK, 2018). One participant was keen to emphasise they feel more students are starting university having had, or have, ongoing input from mental health services:

> ‘...a trend we’re noticing is more and more, this is from childhood […] these are mental health conditions and issues that haven’t emerged while studying at the university but actually have been held before […] I would say fewer and fewer students have an issue that triggers only at university and leads them to have wellbeing concerns.’ [HEI C].

This extract is extremely telling and reflects the broader context of this research and the question that cannot be qualified, in that are the mental health needs of young people increasing or is the expanding discourse and awareness enabling more to seek help – or indeed a combination of both? This will be reflected upon further in later sections.

This *trend* as referred to above, alongside other participants' comments in respect of more complex needs overall, adds to the current context within theme one. What this also demonstrates is that cooperation and positive relationships with local NHS providers is essential to meeting broader needs that would be considered beyond the expectations of university SWS.

For the question about links to the NHS, participants reported excellent and long-established relationships with GP services, with some having onsite GP surgeries. This was not surprising as this is a prevailing provision by HEIs, reflected in my own experience as an undergraduate in the early 1990s. There were contrasting responses relating to wider connections with NHS mental health provision that the following two extracts highlight:

> ‘Brilliant links, probably very telling, but brilliant links with our NHS services, so lots of mental health teams, home treatment teams, psychiatric liaison teams, early intervention teams. We’ve built some great links, but that’s purely because of the complexity of the cases we’re seeing.’ (HEI C).
>
> ‘Some of the kind of NHS services […] I’ll be completely honest it depends on the practitioner, so that can be difficult at times when the crisis teams in particular can be quite hard when we are liaising and saying this person is in crisis […] and sometimes we’re really, really pushing to get them an appointment […] obviously it impacts on their service, but there seems to be some resistance for referrals at times […] they push back a lot.’ (HEI B).

Other participants spoke reasonably highly about their relationships with the NHS, with one focusing on making connections to the services in students' home areas where needed; and another discussing a specific local project they have co-developed with the NHS. That there were significant contrasts, notably within a relatively small geographical area was not surprising, as this is something I have experienced in my practice as a mental health social worker. Previously close collaboration between NHS and social services, particularly so within community mental health teams – a recommendation within the original Care Programme Approach, and its updated position (NHS England, 2022) – and related co-developed policies, such as the ‘Ten Essential Shared Capabilities’ (Department of Health, 2004), have been reversed in practice due to cutbacks and self-protection imposed through financial pressures via austerity (Moth, Greener and Stoll, 2015).

A rationale for differences and potential problems reported by participants is a feeling that NHS providers do not really understand the structures of individual HEIs or the expectations of university SWS more broadly – summarised in these two extracts from HEI D:

> ‘I think education is positioned as a therapeutic intervention by some health providers, which is challenging for education because I'm not sure that’s quite how we would see ourselves [...] I think expectations of what institutions should provide have increased.’ (HEI D)
>
> ‘…I think the challenge for the NHS in working with universities is we’re all quite different, we sort of look the same, and then you get underneath the covers, we’re really not, and trying to navigate university systems is quite challenging...’ (HEI D).

This really demonstrates two key points. Firstly, that both geography and HEI specific identities are key to meeting student needs, again necessitating a localised flexible approach. Secondly, that there is a lack of knowledge from the HEIs about the NHS and vice versa, and that while both are struggling to meet demands with limited resources, without improving this, there will potentially be negative, or at least inconsistent outcomes for students (see *Recommendations*). Seeking to build positive working relationships with outside providers is one of the recommendations in the guidance and associated policy as essential for a holistic response to student wellbeing.

The two key guidance documents of UUK’s (2023) *Stepchange* framework, and the UMHC (Hughes and Spanner, 2024), have many overlaps and indeed have codeveloped aspects of their guidance with each other. While the sector-led UUK framework asks HEIs to ‘adopt mental health as a strategic priority, to see it as foundational to all aspects of university life, for all students and all staff’ (ibid, p.4), the UMHC, (at the time of writing), remains based upon voluntary engagement to meet their standards. Only one of the five participants was engaged with the UMHC (at time of interviews) and discussed its progress as very positive with several benefits:

> ‘...in terms of the Mental Health Charter that will be really key in terms of embedding mental health and wellbeing [...] that whole system approach, and I think once we are up and going with that and we’ve mapped our progress against those principles of good practice, seeing where the gaps are [...] I think if we come at it from all angles, which is the premise really of the charter, I think we will hopefully start to address things upstream...’ (HEI E).

While three other participants spoke about the guidance in a generally positive way, suggesting this was in their plans as a future goal. There was one participant, that while certainly not negative about the UMHC, commented on the potentially limited application:

> ‘Being mapped against something as the perfect service because you know, X,Y and Z, sits slightly uneasy with me and it feels like we are potentially moulding our service to an extension of the NHS to support a vulnerable group, so I have issues again with this commodification idea of everything (HEI C).

The need for caution with embracing a potentially formulaic, inflexible approach, as expressed above is understandable. This could divert from what appears to be essential localised flexible responses, leading to restrictions with the creativity needed for the bespoke student bodies. This also suggests that standardisation could be echoed within league tables and ranking systems, with perhaps those HEIs that are signed up to the UMHC receiving bonus points, whereas prioritising local resources and solutions should be foregrounded. This possibility is acknowledged within the UMHC (Hughes and Spanner, 2024), and they specify that the ‘Charter’ has been designed to reflect localised dynamics. The above could also be said to be feeding the marketisation of student welfare and education more broadly, with those having the UMHC accreditation on its promotional materials, serving to attract more custom.

Despite these cautions, there are clearly positives with the overall purpose and philosophy of this guidance – they are, after all, seeking to be part of the broader responses to improve wellbeing. That all participants are actively reviewing and expanding their provision, taking account of language, and enhancing creative methods to meet need feels positive.

To end this theme, this final extract suggests the importance of finding the balance in responses, while considering changing language and keeping a note of caution – this will be analysed further in the ‘general discussion’.

> ‘Problem is sometimes the language puts people off for what it actually is, which is, what it actually is, is what wellbeing was ten years ago, it’s almost like they’ve had to reinvent it under a new name [...] I think these things are cyclical and I think we’re reaching a point where we’re over talking mental health and we will pull back a little bit to get that balance right.’ (HEI C).

4.6d Theme three: Creative Solutions summary

This theme, *creative solutions,* has built upon the previous two, *changing narratives* and *complex barriers*, with the intention of analysing how university SWS are responding to both the current context, and the varied challenges impacting their provision. There is certainly lots of positive work being done, despite the relatively short timescale that the increased demand has occurred within. It really feels that each SWS is very aware that their ‘offer’ has had to change in response, and that they are doing so through being motivated with the best intentions.

The variations between how HEIs are responding is very localised, using what resources are available to them within broader university and community services. This is also being pressed through a clear understanding of their specific student body. The range of developments in provision is being informed through deep consideration about language and discourse, with a clear move away from the medicalised, diagnostic models – despite this leading to potential conflicts with student, parental and NHS expectations. The expansion of alternatives, such as with apps and outside providers feels an inevitable consequence of changed narratives and growing markets, however, while there are noted concerns, these may be positive choices for many students.

Relationships with others on the whole appear positive, ranging from bespoke partnerships, such as developing a bridge service with the NHS, through to clear links to specialist providers, with consideration of transition. The mixed relationship with the NHS is understandable, and not easily resolvable.

The variations to working to the guidance was interesting and actually changed my perspective. I am generally positive about the purpose and principles of a ‘whole university’ approach, including concepts such as curriculum infusion; however, I can also see the need to heed caution with the potential restrictions on creativity that this could bring.

The following *General Discussion* chapter will develop the narrative further, drawing upon key findings and then engaging back with the research aims and gaps.

Chapter 5: General Discussion

5.1 Introduction

A distinct ‘general discussion’ section that follows the analysis is considered useful where the researcher has engaged with reflexive thematic analysis (RTA), as this helps to pull together the strands of interpretation (Braun and Clarke 2022). This part will begin with a reminder of the research questions. In response to the overlapping themes within the analysis, I have chosen to summarise key threads that address a number of the research questions, rather than being constricted – and to minimise repetition – by responding to each in turn. It will explore these threads with a particular emphasis on the relationship to the research aims, integrating strands from the theoretical influences, as well as incorporating my own reflexive thoughts.

Research questions:

Main research question:

How are UK higher education student welfare services responding to the perceived ‘crisis’ with student mental wellbeing?

Sub-questions:

- *What are the influential factors in the surge in demand for mental health services from universities?*
- *How do attitudinal barriers, including stigma, continue to manifest?*
- *How may the language and discourse of mental health and illness impact upon provision and help-seeking; How might the framing of this issue as a ‘crisis’ impact upon support?*
- *How does national guidance, policy and related research promote and/or support SWS responses to the increasing needs of students?*

- *How are HEI student welfare services adapting their provision in light of the above?*

5.2 Shifting discourse

As discussed throughout the thesis, there are varied complex and overlapping perspectives as to the meaning and social construction of *mental health*. One participant suggests that mental health has been ‘normalised’ and that due to this more people are seeking support. While this suggests that a wider inclusive approach is being factored into the conversations – as advocated by key writers such as Beresford (2020; 2023) – however, (as will be covered below), the competing elements of the drive towards self-diagnosis within a backdrop of anti-stigma awareness seems to have created a conflicting message overall. While I have outlined my own position (see *Introduction* chapter), this project does not attempt to stipulate what cannot be defined, in that there is a universal understanding of what we mean by mental health and wellbeing outside of what psychiatry informs us. Despite this, the participants’ interpretations and reflections of mental health have inevitably shaped their service responses.

The contributors referenced a shifting discourse, with some discussing a more public and open discussion that has had positive outcomes, while others spoke more directly to psychiatry and medicalised diagnoses. What was consistent is that all were attempting to deconstruct the language with a view to blurring the boundaries of wellness and illness. Examples here included directly addressing with students the common and expected experience of feeling ‘anxious’ to differentiate from having an anxiety ‘condition’; with another shifting towards innovative ‘treatment’ options, such as social prescribing. This feels promising as this will help to frame the provision from SWS as accessible for those not seeking a label, while also serving to bridge the gap to harder to reach students

Despite these creative approaches, there was also talk about how students are increasingly embracing medicalised approaches, applying these to both their own explanation of their experiences, and with seeking options for support (Frawley, 2023;

Parker, et al, 2018). Some of this relates to the restricted societal conversations in respect of the social model, with the medical model continuing to dominate as the standard, accepted approach (Davis, 2013) – a position challenged via service user/survivor movements and embedded within Mad Studies (Beresford, 2020; Gorman and Lefrançois, 2018).

While acknowledging that many students may benefit from medication and/or therapeutic interventions, participants discussed student expectations and self-diagnosis; or even demands for traditional interventions such as counselling, even where SWS felt alternatives would be more beneficial. While some of this may reflect notions such as 'prevalence inflation hypothesis' (Foulkes and Andrews, 2023), or 'concept creep', (Haslam and Tse, 2024); other viewpoints remain critical or at least argue for caution in respect of these propositions (Cascardi and Brown, 2016; Ning, 2025). I agree with the principle to be cautious here. I feel that these terms are an important component of the evolving conversations, however, could also be interpreted by those experiencing distress as undermining – or even disregarding – their anguish. Furthermore, notions such as 'concept creep' may add weight to broader political motivations to reduce welfare spending, such as with (at time of writing), the current Health Secretary's assertions that mental health needs are being over diagnosed (Elgot, 2025). There is a delicate balance here (reflecting my own positionality), that critical mental health frameworks (more below), are key to challenging the dominant, and what are regarded as oppressive, features of the medical model, while equally extolling the need to validate all lived experience (including for those that self-diagnose), in order to encourage support seeking.

The work being done by HEIs to move beyond binaries and indeed the restrictions within the medical discourse reflects aspects of Mad Studies (Beresford and Russo, 2021) and indeed Crip Theory (Thorneycroft, 2020). These argue for self-ownership of lived experience, and the concept of recovery, both incorporating critical disability and critical mental health lenses. Focusing on the social and environmental influences for health and wellbeing is also highlighted within the UMHC (Hughes and Spanner, 2024; Student Minds, 2024). There are other perspectives, with one participant speaking about 'revolving' language, and that the term *wellbeing* can have multiple interpretations. The focus on ‘wellbeing’ by HEIs has been suggested to mask barriers for disabled students through presenting HEIs as wellbeing utopias (Orchard and Jones, 2024). Despite this, the challenging and flexible approaches by SWS to break away from the boundaries of the medical model aligns with a broader universal approach, and indeed creative and individual expressions of self – that Foucault referred to as a potential individual ‘freeing’ tool in his later work, while not suggesting this will destabilise structural power (Irving, 2009).

Laing (1960; 1967), supported self-expression as valid lived experience rather than focusing upon symptoms. As with other aspects of identity, such as with sexuality – that queer theory endorses malleable identities – experience of mental distress can be fluid, given many key variables. The varied critical mental health perspectives can be traced back to the works of several key figures, including Laing and Foucault (Double, 2022), who all challenged the control and dominance of psychiatry, and its modes of power, while not denying lived experience of distress.

More recently, Sedgwick (1982), alongside influences from the user/survivor movements (Tew, 2005; Beresford, 2016; 2023), call for a more societal and citizenship focused approach to care. While mental health practitioners embrace more recent concepts such as the *biopsychosocial* model – in this respect meaning the general acknowledgement that there are multiple ways to understanding each individual’s unique experience, requiring references to their own context (Borrell-Carrió, Suchman and Epstein, 2004). While the *biopsychosocial* model may suggest support providers are moving beyond a strict medical model, this approach has been argued to validate the pathologisation of the individual as being responsible for their physical illnesses, in turn feeding stigma (Kennedy, 2017). SWS are very much focusing on the ‘social’, with one contributor extolling the virtues of ‘social prescribing’ as an alternative to traditional treatments, and so it felt there were positive moves that can be built upon.

SWS are seemingly juggling these multifaceted and intricate complexities and contradictions. This is illustrated in how they are seeking to diversify their provision within their broader institutions, rather than being framed only as a specialist resource for a small group of students with high level needs. Participants spoke about how their services have developed and they see themselves as proponents for wellbeing, a proactive service, rather than simply reacting to when students reach crisis. Despite this, they are also facing a conflict here while trying to differentiate their offer to become more universal, however equally, as discussed by several participants, find their service being pulled back to focus their resources on those presenting with more complex needs. Some of this relates to the inconsistent relationships with partners, specifically NHS services, and how the responses both SWS and students receive are reflected by postcode – see *Recommendations* for further details.

5.3 Stigma and devaluation

While the above section addressed evolving conversations and the relationship to help seeking behaviours, the analysis stressed that complicated barriers to support remain. As discussed, stigma, both actual and perceived, continues to impact upon support seeking behaviours for students (Carmack et al, 2018) – with the limitations of anti-stigma campaigns being noted (Knifton, 2012; Dobson and Rose, 2022; Beresford, 2023). The negative impact of stereotyping and oppression more generally will hinder the student's journey of recovery, even more so for students with diverse and intersecting aspects of identity (Fox in Walker, 2013).

There were varied responses to the question relating to stigma, with some indicating that while they are aware of the influence of stigma, they do feel there is more open discussion around wellbeing more generally. This may, as some report, be shaping the change in demand in a positive way, while others acknowledged the ongoing impact for certain groups of students – these included men and international students. The links between stigma and loneliness was acknowledged by one participant who recognised the extent of this and that it is a feature that they are struggling to address. Overall, it felt important that the participants are considering stigma within their creative approaches to reaching out to students. Clearly, the language they are using is intentionally distancing itself from medicalised terminology, despite the realities that many students are being drawn towards these.

While earlier chapters addressed students with physical impairments as experiencing specific features of oppression, there are clear overlaps with the lived experience of students with mental health needs that can fall under the umbrella of *disability*. Disabled students facing barriers to access university may opt for online courses, and while this may remove some physical (or anxiety inducing) blockades, this may also enhance loneliness and isolation, therefore further impacting poor wellbeing (Encuentra and Gregori, 2021). The increased number of students declaring a disability – either physical, mental health related, or both – (Sagar-Ouriaghli et al, 2022; UCAS, 2023), does not imply that these students have a positive experience (Heffernan, 2023), with HEI statistics relating to successful degree completion masking the realities of significant struggles due to ableist barriers (Student Minds, 2024). The institution of the university reflects others through society, such as with disabled students facing limitations with access, both physical and social, often resulting in them feeling at fault (Encuentra and Gregori, 2021). A critical lens of the biopsychosocial model would suggest that the 'psycho' element affiliates with deviance and pathology, as explanations for physical illnesses (Kennedy, 2017). I did not seek to draw the participants into the debates about the alignment of mental health needs with disability; however, they did not appear to determine any difference, in fact several referred to mental health as just one aspect of their disability services. While there are ongoing debates about the crossover between *madness* and disability – and indeed sanism and ableism (Thorneycroft, 2020) – it felt important that SWS did not place importance on differentiating between students who may need input.

For students with intersecting aspects of identity –specifically those covered in earlier chapters that include, among others, gender, race, class and disability – the experiences of oppression will be multi-layered. The participants acknowledged gaps in terms of representation, and there was a general feeling that they could do more. Some focused upon limitations with visible resemblances, referring to hidden aspects of identity, including disability and sexuality. International, BAME, and LGBTQ+ students report the limitations within services to address their specific needs (Stoll et al, 2022), which can result in these students seeking bespoke services in the community (Bryant et al, 2022). For BAME students, health services more generally have a history of inadequate support (Keating and Robertson, 2004), with Western psychiatry continuing to stereotype and restrict access (Sewell, 2009).

It was interesting to hear that participants felt that the way to meet the needs of a diverse student body was to have physical representation within their actual services. The reality, as the research suggests, is the lack of awareness or acknowledgement of the needs of specific groups of students, that in practice will be presented as insufficient or even incompetence responses. A Foucauldian lens would suggest that those in the position of power (in this case SWS), will be replicating preconceived aspects of identity, and may habitually be reinforcing assumed ‘knowledge’, and therefore implying meanings upon those seeking support. That this may be occurring unconsciously, the implication from the research suggests negative outcomes for diverse students needing support. The above is not suggesting that SWS do not care or accept some of this, and the impression from the analysis is that it is something they are thinking about – there were several comments made about their own unique cohorts. That said, it did feel that solely focusing on actual staff representation seemed limiting, as there are known other ways to address these gaps - see *Recommendations* in the following chapter.

5.4 The Crisis Narrative

I opted to incorporate the quote from one participant, ‘...a mental health tsunami…’ within the title as I felt this represented the common iteration being used by media and research alike (Bewick and Stallman, 2018; Dig-In, 2019) – that we are within a student mental health *crisis*. The term ‘tsunami’ itself suggests a danger, and an event that is unpredictable and unmanageable, and so there was an overall feeling from the contributors that they know challenges will continue to increase and as such are trying to prepare in order to sustain an effective provision.

The participants discussed this in various ways. Some referred to the word *crisis* itself, acknowledging that the media is driving this and that this is not helping, with one being very clear that more people disclosing their mental health challenges does not make it a crisis. Other participants felt that the situation relates to more students coming to university or being encouraged to come to university with pre-existing significant mental health needs. While this could be the case – numbers declaring a disability (whether mental, physical or cognitive) have continued to increase (Zhang et al, 2020; UCAS, 2023) – that responsibility is being cast back upon these students reflects ableist/sanist notions of individual responsibility (Goodley, 2017). This also disregards the responsibility of the sector to remove their barriers to achievement, demonstrated through lower degree attainment and higher drop-out rates for disabled students (Student Minds, 2024).

Other discussions focused on aspects of 'Western life' being more challenging for younger people generally and so enhancing levels of poor wellbeing. These responses were accompanied with examples of how, with several focusing on social media – research suggests that there are benefits as well as potential harm (Dodemaide et al, 2022) – and others referring to things such as pressures of body image, substance use, or that expectations of high performance have been carried over from school age. A counter to some of this could be that young people and students have had access to alcohol and drugs for many decades, with some evidence that, specifically with alcohol intake, there has been a reduction in use by younger people over the past two decades (Oldham et al, 2017). In terms of body image, idolising notions of beauty, controlled by the male gaze has been consistent over time, and this continues to be driven through patriarchy (Abbott, 2013). Regardless that some of the above could be argued to be longer term stress-factors for young people, the combination of both societal pressures (such as the climate or housing crises), along with student specific factors (such as balancing study with work and family commitments), has resulted in multiple pressures for university students. While I do not feel the crisis narrative will disappear, I equally do believe that using this label only results in further aggravating the situation – see *Final Reflexive Thoughts*.

While I will argue against the term 'crisis' in respect of student mental health, I feel there's a much clearer rationale for suggesting the higher education sector is in crisis. The sector has been evolving since the early 1990s, with universities now actively competing for student tuition fees within a competitive purchaser-provider market

(Bennett, 1997). This neoliberal model appears to have reached a point where the flaws in this template of funding are being exposed. The many years of funding deficits and risky investment decisions have resulted in the sector facing crucial dilemmas, with many now reducing staff as a means to balance budgets (Foster, Gross and Borrott, 2023).

The changed face of higher education since the introduction of tuition fees has, in turn, altered the experience of going to university in ways beyond growing a large debt balance with the pressures to perform and achieve the best return on their 'investment' (Richardson, 2013). One outcome of this is that more students have to earn money, often in poorly paid and unstable jobs to be able to meet their basic needs (Denovan and Macaskill, 2017; OFS, 2019). I have witnessed students falling asleep during class – with explanations that they have to work nights in order to fund their living costs – that is clearly impacting on their abilities to engage in the classroom (Macaskill, 2013; Sanders, 2023). Priestley et al (2021) found that student perspectives about changes to HEI mental health services 'was indissociably framed alongside wider changes to the university culture and environment' (ibid., p.199). That students report several areas of dissatisfaction with services (see Literature Review, section 2.8), suggests the need for ongoing and meaningful collaboration.

Relatively new pressures upon the sector, such as performance in the National Student Survey and other ranking systems; managing budget deficits; professional courses facing OfSTED and Social Work England inspections, all result in further challenges to the business model of higher education (Thompson et al, 2022). This has had consequences for many institutions, including cost-cutting via widespread redundancies (Times Higher Education, 2025), or even potential closure (OfS, 2024a). The reliance on tuition fees, with the current government agreeing to an increase (UUK, 2024), adds to the financial burden on students, with little change expected for HEIs for their financial sustainability. That SWS are now being drawn into the commodification of education via ranking systems (HUMEN, 2022); and questions asked in the NSS (Office for Students, 2024b), suggests that they may feel pressure to homogenise their offers to be able to compete. Despite HUMEN's methodology and analysis being argued to be unsound (Student Minds, 2022), it is unknown how far students' (and indeed their parents) are factoring this information into their choices. That students are now purchasing higher education, the HEI 'offer' is significantly beyond knowledge delivery in the classroom and now embodies welfare support – a tension that participants readily noted as one likely to only develop.

5.5 Managing difficult pressures and expectations

The *Analysis* outlines the various ways that SWS recognise limitations within their provision that I grouped under the term 'frustrations'. These included connections with other health services, and 'unrealistic' expectations from parents. Referencing students themselves, participants discussed barriers to communication, relating some of this to generational knowledge of social media; that students do not understand what they can provide, and so either do not reach out, or attend with expectations for a specific type of support. That said, there remains a need to recognise the enduring limitations with their provision – these include the impact of stigma (Bantjes, Hunt and Stein, 2023); that many students will remain unaware of the offer from SWS (Brown, 2016); that others will seek support via other means (Byrom, 2017; 2018) – despite the dedicated work continuing to be delivered by SWS. Addressing the main research question, SWS are responding – as theme three: *Creative Solutions* within the *Analysis* suggests – with organic, versatile approaches, largely based upon their knowledge of their unique settings and cohorts.

There remains a concern, as prompted by one participant, that standardised approaches can curtail imaginative responses. So, while purposeful and considerate guidance, such as the UMHC promotes flexibility (Hughes and Spanner, 2024), that HEIs are under pressure to rank highly within national league tables makes them very cautious about their public profile, which, in turn, may hinder creativity. In addition, there have been high-profile student suicides leading to a response from parents, the media, and the government (Farrer and Co, 2023). These campaigns resulted in some clarity about the scope of duty of care towards students (more below), (DfE, 2023), however due to the need to 'sell' their courses, HEIs will still be very wary of potential damage to its public image. Taken together, these two factors could make universities draw back from creative responses due to nervousness about the boundaries of their remit, and in turn move more towards standardised ‘tick-boxing’ provision. Participants expressed that they felt these additional pressures, making reference to the wider commodification of mental health.

The boundaries of universities’ duty of care have been up for debate in recent years with court judgements suggesting that there is no statutory duty, however, there remains a more general duty not to cause harm (Lewis and Stiebahl, 2024). Media attention relating to student death inquest outcomes that held specific universities accountable (Morris, 2022; 2024), has continued the debates about whether the ‘general’ duty of care needs to be made more robust via additional 'statutory' duties (UUK, 2023b). There remains a sense of vagueness about the margins of care responsibilities, with participants feeling that there is a growing expectation of loco parentis, and that both students and parents believe this should be provided as a part of their tuition fees. Experienced mental health professionals have expressed concerns around these boundaries, such as with Osborn et al (2024) reporting that practitioners can feel unclear if they are supporting a dependent young person or an independent adult. It feels like these debates will continue over the coming years, and requires further clarity, whether or not ‘duties’ become statutory.

Students are known to frequently approach their tutors before SWS, as the initial point of support seeking (Hughes et al, 2018). This may create additional levels of stress for tutors who can feel overwhelmed with the dilemma of wishing to provide pastoral care, while feeling unskilled and unsupported in this area (Spear, Moray and Steen, 2021). While HEIs – as referred to by several participants – do provide (often compulsory) awareness training, this is often an online course, usually involving videos about a number of case scenarios – usually with a focus upon a specific diagnosis –suggesting how academics should respond. While awareness raising/general wellbeing education may help, tutors need full guidance and support (including for their own pastoral care), beyond HEIs seeking to tick the box that all staff have completed the course (see *Recommendations*).

For universities to fully embed a ‘whole university approach’ additional options outside of direct SWS provision should be developed for those students who do not wish to seek support from SWS, or to enhance existing choices. It is known that significant numbers of students will turn to friends or peers for support before even considering professional input (Byrom, 2017). Peer-led support, where overseen internally is highlighted as having positive outcomes within some of the guidance (Wilson et al, 2022). Despite this, there are noted concerns about managing risks – to both those accessing and those providing the support (Pointon-Haas et al, 2023) – a point noted by one participant.

Further, the growing market for apps and independent websites is being reflected as an alternative option to manage demand. While there is evidence that some students will prefer this due to anonymity, minimising stigma, and usability (Lee and Jung, 2018), there are associated risks (Parker et al, 2019), as well as limited knowledge of their efficacy (Anthes, 2016). One participant addressed these with a sense of cynicism about their effectiveness as an alternative, describing them as ‘a bit faddy’.

The participants’ responses implied a sense of creativity and flexibility as to how SWS are responding to the change in demand, and this included some of the options discussed above. This all very much depended upon location; their own unique institution; relationships with others (including a strong sense of collaboration with student unions); and specific student cohorts. They all identified that they want students to have a sense of belonging to their universities, while recognising the barriers to these coming from the purchaser-provider business model of higher education. While all spoke about the importance of the ‘whole university’ approach to wellbeing (UUK, 2023a), they were all at different stages (some not yet at all at time of data collection), with engaging with the UMHC. One participant, at the final stages of embedding the Charter’s Framework, spoke freely about its benefits. Another referred to caution about the potential limitations of standardised approaches. While I feel this was a fair point, given the noted importance of bespoke localised responses, however, it needs reminding that the charter does expound the ideas of flexibility and creativity.

5.6 Summary of the findings

The analysis drew out three interacting themes – ‘changing narratives’; ‘complex barriers’; and ‘creative solutions’. I was expecting these to overlap and intersect, and so the picture that emerges is one of complexity, with competing, and at times contradictory understandings of the language and discourse of mental health. Poststructuralism posits that language has to be understood within its particular time and socio-political context, and due to this, can be subject to varied interpretations. That the medical model continues to dominate seems to be limiting the creative work that SWS are seeking to do through their flexible and imaginative approaches. *Mad Studies* literature (Beresford and Russo, 2021; Thorneycroft, 2020) would suggest continued reflexivity with self-identified choices for support (and indeed definitions of recovery) – these themes were broadly acknowledged by the participants.

The neoliberal consumerist model of education – that some have referred to as the rise of the McUniversity (O’Byrne and Bond, 2014) – has shifted the context of student welfare to one where financial investment in a degree carries expectations for certain extra-curricular support. The participants, alongside their understandable frustrations, openly expressed their incentives to care and that they want their students to have a sense of belonging. The complexities they are facing with delivering their services to the best effect is mired in a lack of easy answers. Despite this, the motivation to care and support was consistent and there are areas suggesting a positive future, as will be outlined in the recommendations.

5.7 Limitations

It is important to acknowledge limitations directed via each part of the research process. This part will reflect on potential limitations through the methodological choices (covered in more detail in the *methodology* chapter); and through how the data has been analysed and presented.

The method of data collection through semi-structured interviews with professionals within student welfare services proved valuable for this project. However, the selected HEIs were all within a specific geographical area, and, as such, a broader scope of participants from other parts of the country may have resulted in some further variations within the responses. That said, and as discussed, the participating HEIs did report specific aspects of their provision in relation to their locality – this included relationships with outside providers and availability of specialist services. In addition, both numbers of, and the make-up of each HEI student cohort, did vary considerably across the contributing HEIs. Therefore, while it could be argued that geography may have limited the findings, this could well be countered through the differences within the participating institutions.

Engaging with SWS leaders, rather than those providing more direct support to students – such as counsellors – could be argued to have produced a narrow data set. While accepting that other practitioners would have contributed some valuable insights into the concerns that students' are reporting (and that this would be beneficial), in order to address the aims of this project – examining HEI responses to the evolved student mental health landscape – it required the perspectives of those with service oversight.

That I completed five interviews may lead some to question the generalisability of the findings, arguing that a higher number of participants is necessary for reliability (Maxwell and Chmiel, 2014; Bryman, 2016). However, this is countered through the use of reflexive thematic analysis, with which Braun and Clarke (2022) clearly suggest it is not about numbers, but the richness of the data itself, and therefore as little as two participants may be enough to meet research aims. The 'information power' model (Malterud, Siersma and Guassora, 2016) also supports the smaller sample size, specifically due to participants holding specific knowledge about the subject; the incorporation of established theory; and the quality of the dialogue. Semi structured interviews as the method of data collection brings its own limitations, as discussed within the *Methodology* chapter.

Not hearing directly from student or academic voices (see *Recommendations*), *may* be argued to limit the research findings, after all, this research is exploring student mental health in various ways. While not seeking/interpreting meaning directly from academics, I have taken time to incorporate what the literature and guidance finds about the role and impact upon tutors – this also references the current tensions within the sector more broadly. The decision to not engage directly with students is covered in the methodology chapter, however there could have been valuable contributions from the position of those with lived experience that may have suited a similar project. In terms of the findings, I have intentionally addressed students with both specific and intersecting aspects of identity, and how the impact of oppression may in turn influence help seeking behaviours. While these findings are presented through being informed by research and theory, I am unable to speak with personal knowledge of various aspects of identity. In addition, I did not request personal details about the participants identity, and while I could suggest their gender and race, I do not know this for certain.

Finally, as with all social science research, data analysis and presentation of the findings will be influenced through the researcher's own history, identity, and political and social perspectives (Bourke, 2014; Dodgson, 2019). I have been forthright about my position, both personal, political and ideological from the outset, and referenced these through each stage. It is also a requirement for justifying the use of RTA as the research tool, with Braun and Clarke (2019; 2021) citing this as an essential component with this methodological approach. That said, there is a significant incorporation of theoretical components with the interpretation, namely the range of critical mental health frameworks, along with an underpinning poststructuralist lens. The social constructionist approach has enabled an engagement with discourse, however 'realist' critiques of a poststructuralist approach to language and research may question the validity of this thesis overall (Gergen, 2009).

6 Recommendations

6.1 Introduction

The following recommendations have been drawn out from the analysis with influence from the extant literature and guidance. I have grouped them together under subheadings, however, some inevitably – as with all themes within this topic area – overlap. I also want to note, given the ongoing evolving narrative with respect to this subject, that some of the following may progress or be refocused should further research and guidance be published.

6.2 Internal processes: Representation

There were mixed responses in respect of internal institutional support for student welfare services (SWS). These were on the whole positive, however limitations within their provision was identified as a reason as to why their resources are being diverted to those presenting with more serious concerns – in turn limiting access to those with more common experiences. Additional staff may always help, however there are other factors (as below), which together may prove more useful.

Representation, specifically towards students with distinct and/or intersecting aspects of identity, is an area that SWS all seem to be giving consideration. While some expressed frustrations here – reporting that they cannot employ enough people to mirror all student identities – there was also a valid point made about hidden features of identity and staff privacy. That said, the literature highlights that historical gaps in knowledge and awareness continue. This is evidenced by research that indicates a lack of cultural competence for BAME and/or international students (Bhugra et al, 2023); that disabled students face structural barriers to access (Brewer, Urwin and Witham, 2025); or that LGBTQ+ students choose to find their own community resources (Bryant et al, 2022). Employing sufficient staff to seek to be fully 'representative' is not the recommendation here. Rather, enhancing staff diversity awareness, based on what the research tells us would benefit all. This training should be provided by those with specialist knowledge areas/lived experience and needs to address the range of matters that will help diverse students feel more welcome – often, knowledge bases can be relatively straightforward to improve, for example, understanding the importance of pronouns for trans students.

6.3 Internal processes: Supporting academics

It is known that students will often opt to confide wellbeing concerns to their tutors in the first instance, before considering support from SWS (Hughes et al, 2018). This can add an additional layer of stress, with many tutors reporting that they feel unskilled in this area and have concerns about risk-management (Spear, Moray and Steen, 2021). Awareness training can help; however short e-learning sessions will always be limited in effectiveness. Staff need support to understand the impact of the range of wellbeing matters, from those students who may have established longer term needs, through to those experiencing common factors such as loneliness and homesickness (Dinu et al, 2022). Tutors need to feel confident to identify warning signs, manage disclosure, and to feel safe to discuss these concepts within student spaces.

The recommendation here is for universities to take the lead. Wraparound support to staff is crucial and this can be achieved through various means. Clear routes to seek guidance for concerns about students are needed (some participants discussed how this works within their HEIs), and tutors should not feel hesitant about requesting advice. A bespoke institutional (and perhaps sector wide) agreement in relation to when to share/seek advice with clarity about confidentiality management (and parental contact), should help (Hughes et al, 2018). In addition, the university should provide dedicated space for peer support between tutors to enable sharing and learning from each other, such as with communities of practice type arrangements.

Academics are facing many pressures while undertaking their duties (Wray and Kinman, 2021), all being enhanced through the funding crisis in the HE sector, that includes potential job losses (Foster, Gross and Borrott, 2023). The differences in numbers of HEIs that are engaging with the University Mental Health Charter (Hughes and Spanner, 2024), since I began this project, is telling. This framework (alongside others, such as UUK, 2023a), places staff mental wellbeing as equally important to students with the logical notion that you cannot have one without the other. It will be compelling to see how the many institutions now working to the UMHC domains will be able to evidence this given how the neoliberal capitalist sector is currently treating its workforce (Standley, 2025).

6.4 External partnerships

I found it unsurprising, given my practice experience, that there were significant variations as to how universities partner with NHS services. These ranged from codeveloped, localised agreements with positive outcomes; right through to poor practice whereby cooperation seems to be based around which professional happened to be on duty that day – this latter issue at times resulting in SWS having to manage high risk student presentations, far beyond their expected remit.

The Universities UK (2022) briefing addresses NHS-university partnerships directly, sharing a number of ‘best practice’ case studies. While there are several positive examples, these are either being driven by individual HEI motivation; or reliant upon being successful in funding bids, such as with the Office for Students (OfS) (2019) Challenge Competition. The recommendation here is for some national direction to ensure a safety-first, and largely consistent response for those students that need additional input. A starting point would be enhancing co-understanding of the remit and boundaries of the roles of the HEI and local NHS partners. This also needs to go beyond voluntary guidance or ‘best practice’ regional case examples (OfS, 2025), rather it requires a properly funded long term strategy, co-produced by the Department for Health and Social Care, and the Office for Students as the regulator.

6.5 Holistic responses

The third theme that emerged via the reflexive thematic analysis (RTA) (Braun and Clarke, 2022), approach to data interpretation is titled ‘creative solutions’. All participants referred to revamping their methods for promoting their messages and for delivering support. They all discussed the need to expand to meet the demand, and equally all are instigating measures with respect to their own student make-ups – these included utilising new technologies for communication. It was refreshing to hear the levels of flexibility, including how localised partnerships with other HEIs and/or third-party providers are proving worthwhile. The overall recommendation here is that universities need to continue to encourage and bolster these creative approaches. They (HEIs, rather than SWS specifically), need to accept and respond to the reality that many students are still unaware of what SWS can provide – a point that needs spotlighting given poor wellbeing is the number one reason provided by students who have dropped out of their courses (Sanders, 2023).

The next recommendation is for HEIs to commit to work towards a fully holistic ‘whole university approach’ (Hughes and Spanner, 2024; UUK 2023a). This includes consideration about embedding wellbeing within the curriculum; collaboration with students to develop resources; and a review of all institutional structures and support services. The notion of mental health ‘curriculum infusion’ has been gaining traction (Wilson et al, 2022), supported by research (Upsher et al, 2022), over recent years. This concept carries potential benefits; however, this again needs full backing from the institution. Academic staff need clarity about what may be meant by this term; what is reasonable to achieve; what boundaries may be required within the classroom; and to be given opportunities to grow and develop these ideas within the academic community (Barden and Caleb, 2019). This requires specialist resources, dedicated time and careful planning by HEIs and the sector more broadly.

Peer support is another alternative provision that indicates positive outcomes (Byrom, 2018). However, caution is needed as there are concerns about sufficient safety-nets – a point highlighted by a contributor – via properly supportive and resourced direction for both the students engaging with these options, and for those peers offering input (Byrom, 2017). Universities need to take a lead, collaborating with students with lived experience, to effectively develop these potentially valuable alternatives with comprehensive design based on research.

The use of mental health apps and websites, alongside the more recent expansion of AI continues to grow (Iwaya et al, 2023), despite concerns raised about their effectiveness, privacy issues, and potential barriers (Byron, 2019; Melcher et al, 2022). That SWS are having to utilise and promote alternatives to direct in-person support represents an inevitable outcome of the increased demand. Some students will have a preference for these tools (such as those undertaking professional degrees (Lee and Jung, 2018)), and there are reports of useful outcomes – at least in the short term (ibid.). However, the recommendation here is that universities do not consider apps or websites as a replacement for (or equivalent to) their own provision. Apps and websites can certainly be useful, but in order to credibly manage risk, they should only be promoted only as an additional resource, rather than the frontline of support.

Organic and creative approaches were covered by all participants, and while many are still developing these, there was universal agreement that they are a key means to expand student awareness within their own establishments. It is also important to note that fluid responses, due to locality and other factors, are very much encouraged within the key guidance, including the UMHC (Hughes and Spanner, 2024). While noting that there are external pressures upon HEIs to protect their public image – such as with league table standings, and media/government attention following student deaths – embracing only standardised, tick-box approaches may curtail local creativity. As such, universities need to be mindful of the limited potential of regimented approaches, and balance this with fully supporting localised flexible design.

6.6 Language and discourse

This next part of this chapter returns to language, discourse and terminology. As covered throughout, the fluidity with the interpretation and application of the language of mental health creates multiple nuances and incongruities. These can have positive results such as the focus upon more universal experiences of loneliness, or emphasising the commonness of feeling anxious or stressed. However, in turn it is known that for many students the embracing of psychiatric terminology is something they will continue to covet (Beresford, 2020; Eisenberg et al, 2019). While the underpinning poststructuralist lens has enabled a deeper examination of the meanings behind this, the participants reflected much of the current conversations with relevant and very interesting examples from their direct experience. This recommendation is to endorse what SWS are currently doing – specifically that they are promoting more universal terminology as a means to seem available to all.

To expand upon this recommendation, there should not be a move towards a standardised approach to terminology that may impede the help-seeking behaviours of any student who requires support. SWS are clearly exploring a range of ways to address need, with some spotlighting concepts such as social prescribing, and others driving forward bespoke innovative approaches. The potential benefits from the (creative) scope of available services may both enhance the student journey, and minimise potentially negative longer-term outcomes.

6.7 Future research

It was refreshing (and at times exhausting), to explore the myriad of publications relating to university student mental health; how matters of identity recreate wider societal responses; the internal and external conversations; stigma; and positive responses. As this remains an evolving topic area, all aspects need ongoing research. The expansion of alternatives to direct support – including the impact of A.I, and innovative approaches such as peer support or curriculum infusion – would benefit from additional dedicated studies. Listening to the voices of students, while not directly addressed in this project, is crucial to future research, with policy makers and regulators needing to integrate these within any subsequent policy guidance/directives.

Given where we are in terms of HEIs collaborating with the UMHC, it will be compelling to see research addressing the longer term impact of this. While I am sure these discussions are happening, it will be particularly interesting to those placed within the current (and likely ongoing) crisis within the HE sector. It is also vital to continue to hear the voice of the academic, both how they are continuing to address the needs of their own students, and how they are managing their own wellbeing in these demanding times.

Finally, this project sought to help address the gap with the missing voices of SWS employees, crucially hearing from leaders with strategic responsibilities, within the extant research. While the benign intentions of guidance reports and research findings are there to promote the ‘whole university approach’ and ultimately support the welfare of students, it is important that SWS employees and leaders are heard as they contribute a distinct and vital insight, and so future research should seek to incorporate these.

7. Final reflexive thoughts

The recommendations consider both localised and national responses. While it seems unfair to rank them in any order of importance, I return to my own experiences as a student in the mid-1990s. I very much would have welcomed knowledge of any type of support at the time, despite the then limitations of current technologies, and I am sure I would have reached out (albeit, without telling my friends). What SWS are doing in terms of widening their profile and differentiating their offer feels pivotal as this may ultimately lead to helping those students who do not feel comfortable accessing support through more traditional means.

When I began this research, a colleague commented that this (*student mental health*) is a 'hot topic'. I was aware of the extent of the (mostly) recent research, reports and guidance, and so it has not been surprising, given the attention this subject has continued to garner, that there have been ongoing new publications and/or revisions to existing guidance. Student Minds (2023; 2024a; 2024b; 2024c), have been particularly prolific. Some elements have remained static, such as the crisis narrative, or media attention – although the latter has been focusing more on HEI duties of care, an area that is likely to develop.

There are, however, some more recent and growing conversations that have expanded during the course of this project. Some of these relate to the significant increase in the availability of apps, and private, profit-making websites – and more recently A.I – as alternatives to direct provision. These very much reflect both the extent of the market for meeting wellbeing needs, and how HEIs are simply struggling to meet demand. The recent growth in ranking mental health provision mirroring national league tables will certainly result in SWS becoming subject to further internal and external scrutiny. The evolved HE sector has altered the experience for institutions, academics, professional staff (including SWS), and students alike and it is difficult to see the above factors diverting from an upward trajectory.

The phenomenon of evolving societal conversations, while not new in itself, has introduced novel means to frame mental health discourse. The dynamic of the heightening attraction towards the medical model, has been proposed by notions such as ‘looping’, ‘concept creep’ and ‘prevalence inflation hypothesis’ – these may help explain growing trends in self-diagnoses (in turn, supported by online options to diagnose) – however, as discussed, these should be treated with a note of caution. Having a diagnosis may well result in positive tangible outcomes such as additional access to financial support or academic adjustments within a learning support plan, and so the motivation to embrace a medical label is understandable. However, counter to this is the research that suggests more students (and particular groups of students), are recognising the impact of common, non-medicalised experiences impacting their wellbeing – factors such as loneliness and homesickness – and SWS are rightly addressing these matters within their expanding offer.

Addressing the language and discourse of mental health and wellbeing has threaded through this research project. The SWS leads recognised all the above as part of the current conversation. While several are trying to directly address the limitations of medical language, they are not in any way closing the loops to support. Rather, for those students without existing longer-term support needs there is a meaningful focus upon social responses (such as social prescribing), a trend that needs supporting.

Notwithstanding the known barriers that influence student help-seeking – including the repercussions of stigma – demand, at time of writing, appears to be continuing to increase. How SWS will continue to place itself within their institutions will depend upon how far guidance calling for a ‘whole university approach’ (WUA) is driven forward by each HEI. That most are now committing to some engagement with the UMHC and its endorsement of the WUA, this would suggest institution-wide considerations will develop. This could result in SWS becoming a specialist support service for those with more significant needs – a route that many participants referred to as already taking place – while other elements of the university (such as academic tutors being tasked to develop curriculum infusion), will be expected to meet wider wellbeing needs. It was crucial to hear the perspectives of those on the frontline of student welfare services – a noted gap in research – and to highlight how they are responding to the developing landscape. They are clearly having to develop in line with expectations of the higher education sector neoliberal model, and broader societal expectations, while also seeking to meet the needs of their increasingly diverse student populations.

It is hard to say whether the levels of demand will continue at the same rates, stagnate, or even begin to reduce. Should the student mental health ‘tsunami’ come to fruition or not, what SWS are doing in seeking to dilute medicalised terminology – in turn challenging the deficit model – via the universality of experience feels crucial, and a perspective I hope will continue. The history and expansion of critical mental health perspectives has not resulted in any sustained challenge to the dominance of psychiatry’s biomedical model. This may in part be due to several of the critical frameworks – from the foundations of anti-psychiatry, through to feminist, anti-capitalist and post-colonial positions – having been constrained within the profession itself or internalised within academia. Growing social movements, building upon service user/survivor groups alongside expanding Mad Studies (with its allegiances to critical disability studies), may help bring these perspectives into more societal meanings. Broadening this out to encompass the lived experiences of students – including a focus on those with intersecting identities – will support this further.

To return to the crisis narrative, it does not feel that this will diminish. Media reports that young people’s mental health is in ‘crisis’ continue to be published and are therefore likely to persist with mirroring this discourse. I acknowledge that there are growing struggles for students (and younger people more generally), and so demand for support is likely to continue. However, framing this as a ‘crisis’ does not help anybody – a point emphasised by one participant – not least students. While I do not feel there is a crisis with student mental health, I do feel that there is a crisis within the HE sector. This will drive forward demand for help-seeking as students will experience the knock-on impact of reduced budgets; increased pressure on tutors; staff cuts; and the inevitable tightening of additional resources.

To end, I would like to emphasise the dedication that all the participants showed when discussing their students. Despite the myriad of frustrations that they expressed, there was a clear sense of care, a willingness to explore and expand upon creative, differentiated approaches, with an overall sense that they are driven to provide the best support available.

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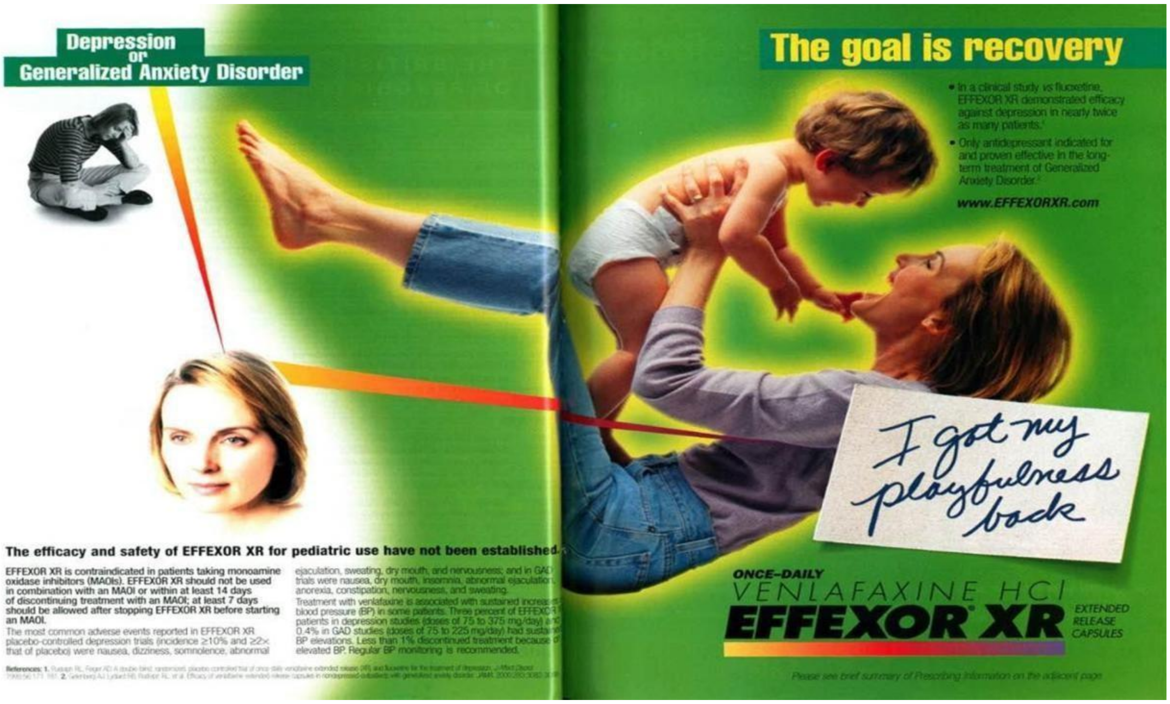
Appendix One: A selection of American mental health pharmaceutical adverts that demonstrate gendered representations of women and motherhood



Depression or Generalized Anxiety Disorder

The goal is recovery

- In a clinical study vs fluoxetine, EFFEXOR XR demonstrated efficacy against depression in nearly twice as many patients.[1]
- Only antidepressant indicated for and proven effective in the long-term treatment of Generalized Anxiety Disorder.[2]

www.EFFEXORXR.com

The efficacy and safety of EFFEXOR XR for pediatric use have not been established.

EFFEXOR XR is contraindicated in patients taking monoamine oxidase inhibitors (MAOIs). EFFEXOR XR should not be used in combination with an MAOI or within at least 14 days of discontinuing treatment with an MAOI; at least 7 days should be allowed after stopping EFFEXOR XR before starting an MAOI.

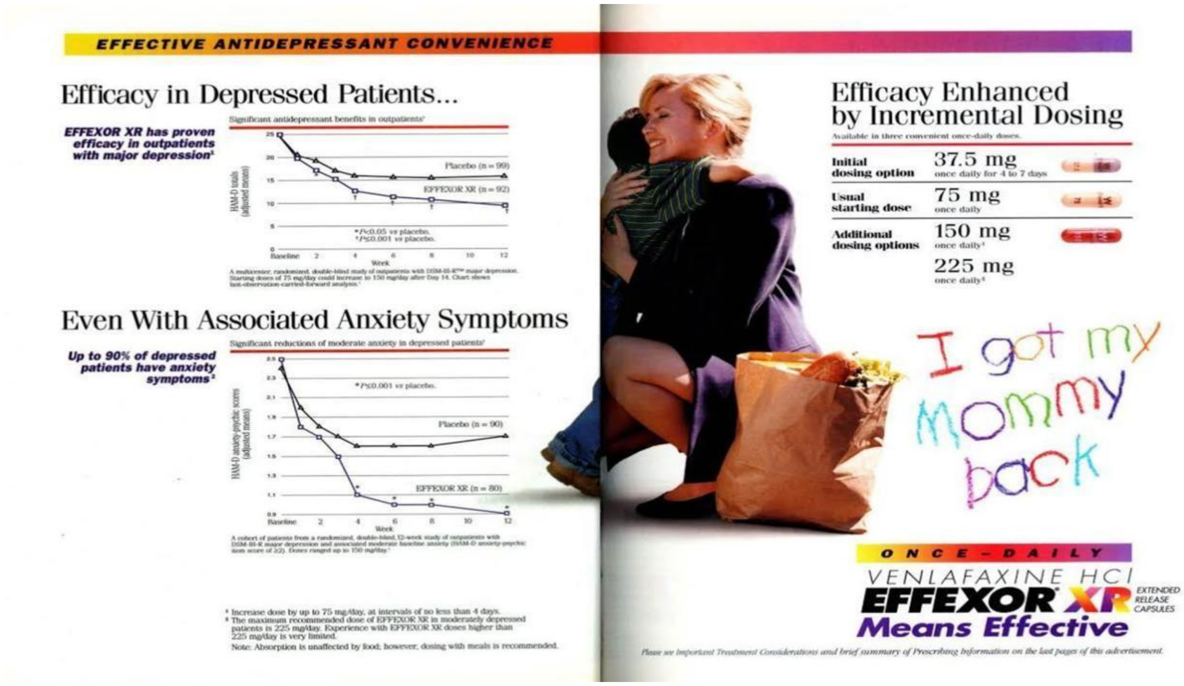
The most common adverse events reported in EFFEXOR XR placebo-controlled depression trials (incidence ≥10% and ≥2× that of placebo) were nausea, dizziness, somnolence, abnormal ejaculation, sweating, dry mouth, and nervousness; and in GAD trials were nausea, dry mouth, insomnia, abnormal ejaculation, anorexia, constipation, nervousness, and sweating.

Treatment with venlafaxine is associated with sustained increases in blood pressure (BP) in some patients. Three percent of EFFEXOR XR patients in depression studies (doses of 75 to 375 mg/day) and 0.4% in GAD studies (doses of 75 to 225 mg/day) had sustained BP elevations. Less than 1% discontinued treatment because of elevated BP. Regular BP monitoring is recommended.

References: 1. [illegible] 2. [illegible]

ONCE-DAILY
VENLAFAXINE HCl
EFFEXOR® XR EXTENDED RELEASE CAPSULES

Please see brief summary of Prescribing Information on the adjacent page



EFFECTIVE ANTIDEPRESSANT CONVENIENCE

Efficacy in Depressed Patients...

EFFEXOR XR has proven efficacy in outpatients with major depression[1]

Significant antidepressant benefits in outpatients[1]

A multicenter, randomized, double-blind study of outpatients with DSM-III-R™ major depression. Starting doses of 75 mg/day could increase to 150 mg/day after Day 14. Chart shows last-observation-carried-forward analysis.[1]

Even With Associated Anxiety Symptoms

Up to 90% of depressed patients have anxiety symptoms[2]

Significant reductions of moderate anxiety in depressed patients[1]

A cohort of patients from a randomized, double-blind, 12-week study of outpatients with DSM-III-R major depression and associated moderate baseline anxiety (HAM-D anxiety-psychic item score of ≥2). Doses ranged up to 150 mg/day.[1]

[*] Increase dose by up to 75 mg/day, at intervals of no less than 4 days.
[†] The maximum recommended dose of EFFEXOR XR in moderately depressed patients is 225 mg/day. Experience with EFFEXOR XR doses higher than 225 mg/day is very limited.

Note: Absorption is unaffected by food; however, dosing with meals is recommended.

Efficacy Enhanced by Incremental Dosing

Available in three convenient once-daily doses.

Initial dosing option	37.5 mg once daily for 4 to 7 days
Usual starting dose	75 mg once daily
Additional dosing options	150 mg once daily[*] 225 mg once daily[†]

ONCE-DAILY
VENLAFAXINE HCl
EFFEXOR® XR EXTENDED RELEASE CAPSULES
Means Effective

Please see Important Treatment Considerations and brief summary of Prescribing Information on the last pages of this advertisement.


Sue's playing with her kids again…
just like normal.
Proven Profile Helps
Restore Normal Functioning
PROZAC
fluoxetine hydrochloride

Appendix Two: Summary of the University Mental Health Charter Framework’s four domains and domain section themes – adapted from Hughes and Spanner (2024)

Number and section title	**Themes within this section**
Domain One: Learn	• **Transition into university – this covers:** 1. Pre-application communication and outreach activity. 2. Pre-entry support and preparation for university. Recruitment and admissions processes. 3. The transition into university. 4. Induction\orientation. 5. The first year, *for all starters* (my italics). • **Learning, teaching and assessment – this covers:** 1. Curriculum design. 2. Pedagogy. 3. Assessment strategies. 4. Support for learning. 5. Inclusivity and academic integration.

	6. The role of *all* (my italics) academic staff. • **Progression – this covers:** 1. Progression from each academic year to the next and/or between academic levels. 2. Progression to time out on placement and back in. 3. Progression back through breaks in study. 4. Progression and transition to life beyond university.
Domain Two: Support	• **Support services – this covers:** 1. Services to respond to students experiencing mental health problems. 2. Support for long term mental illness. 3. Services to support students with issues that may impact on mental health and wellbeing e.g. finance, disability, faith etc. • **Risk – this covers:** 1. Risk related to suicide. 2. Risk related to mental health crisis. 3. Risk to wellbeing from others

	• **External partnerships and pathways – this covers:** 1. Relationships with primary and secondary health care. Relationships with social care. 2. Relationships with third sector providers. 3. Relationships with Disabled Students’ Allowance (DSA)-funded private suppliers • **Information sharing – this covers:** 1. Sharing information with families, guardians, spouses or relevant people in the lives of students. 2. Sharing information with statutory service.
Domain Three: Work	• **Staff wellbeing – this covers:** 1. Workplace culture. 2. Working conditions. 3. Interventions to support good staff wellbeing. 4. Support for staff when experiencing problems with their mental health. • **Staff development – this covers:** 1. Staff training and development on wellbeing and mental health.

	2. Role-specific training on responding to student presentations of psychological distress and poor mental health. 3. The importance of supporting staff to clarify and maintain boundaries. 4. Ongoing development of staff in mental health roles. 5. Training managers to support staff in supporting students. 6. Training managers to support good wellbeing within their teams and respond appropriately to staff experiencing poor mental health.
Domain Four: Live	• **Proactive interventions and a mentally healthy environment – this covers:** 1. Ensuring a culture and environment that supports good mental health. 2. Proactive interventions to improve the mental health of the whole community. 3. Proactive interventions targeted at the mental health of specific groups of students • **Residential accommodation – this covers:** 1. University halls of residence. 2. University arrangements with private halls of residence.

	3. Supporting students in private accommodation (houses & flats etc.). **• Social integration and belonging – this covers:** 1. Ensuring students become socially integrated into university. 2. Creating a safe, inclusive community. 3. Tackling isolation. **• Physical environment – this covers:** 1. Design and maintenance of work, learning and living spaces within the university. 2. Provision and use of green spaces and nature. Movement between buildings and wayfinding. 3. Reducing risk through the physical environment.

Appendix Three: Interview questions

1. It has been reported that there is a national increase with students accessing student support services in relation to their mental health (both pre and post Covid). Has this trend been reflected within your service?

(subs: Do you collect data in relation to this? How have you responded to this increase in demand?)

2. If this is the case, have you any thoughts about the reasons behind this increase in demand?

(subs: Do you feel there is a general rise in mental distress or are students more willing to present for support? Or both?)

3. There is research that suggests that many students feel stigma in relation to accessing student support services for their mental health – why do you think this is?

(subs: Language of ‘disability’? How does your service seek to engage with the student population and encourage them to seek support if needed?)

4. Recent research has concluded that a student's experience of loneliness can be as detrimental to their mental well-being as commonly diagnosed mental health conditions, such as depression and anxiety – do you feel the language used surrounding mental health and well-being causes any problems with disclosure and support seeking?

5. Do you follow/work with any national guidance in relation to student mental health – such as Universities UK, The University Mental Health Charter?

(subs: If not, how is your service supported/developed?).

6. Do you link in with any of the other local universities/colleges to share information or jointly develop support ideas?

7. How does your service link in with GP services and other NHS health providers in terms of support for mental health?

(subs: Do you feel there is room for improvement here? How about transition to and from university?).

8. Have you made any connections with other local mental health support providers?

(subs: Consider groups, specialist resources).

9. If students don't wish to disclose MH needs or seek support from university services, how might you promote other avenues of support?

(subs: Consider internet resources; apps; national services – student minds).

10. The research suggests that students from minority groups, LGBTQ, BAME, disability, international students, experience both higher levels of mental distress and are less likely to seek support – how does your service seek to promote support to these groups?

(subs: Does anything help with this at university level perhaps).

11. Looking forward, the increase in students seeking support looks set to continue – what can support your service to meet this growing need?

(Consider financial and others)

Appendix Four: sample introductory email to potential participants

Dear (*university name* - my italics) student wellbeing services

I am a Senior Professional Tutor, teaching on the BA and MA Social Work programmes at Liverpool Hope University. I'm also an Education Doctorate student and will be completing my research in relation to student mental health.

The initial stage of my data collection is to interview higher education student welfare services. I have interviews completed with four HEIs in the Northwest region and I am hoping that your institution can also be a key participant.

Attached is the research information sheet, along with the consent form for further information. The research information sheet outlines the purpose of my research and confirms your service rights as a potential participant, in addition to matters of confidentiality

I'm writing to ask if you, or a nominated colleague in your service, would be willing to participate. The interview would likely last under 60 minutes and this can take place at a venue of your (or your colleague's) choice, or, if preferred, via Zoom or MS Teams.

I have been granted ethical clearance by my institution to begin my data collection and so I am hoping to get these completed before the end of this academic year. I'd be very grateful if you are able to help.

I have availability during April and May. If your service can participate, (whether this is you or a colleague) please let me know any preferred dates and in what format you would like the interview to take place.

Also, please ask if you need any further details prior to making a decision.

I'm grateful to you for considering this request. These are the details of my supervisory team: (*redacted* - my italics)

Best wishes

Scott

Scott Massie (*Pronouns: He/Him)*

LIVERPOOL HOPE UNIVERSITY

RESEARCH INFORMATION SHEET

Outline of the research (a couple of sentences in non-specialist language)

This research will examine the perceived increase in student mental health needs, in respect of this being labelled as a ‘crisis’; how the language of mental health and wellbeing may continue to stigmatise and act as a barrier to help seeking; and how student welfare providers can respond to increased demand in the context of national policy and guidance.

This part of the research looks at how university student welfare providers are responding to and managing the increase in demand for services.

Who is the researcher?

Name: Scott Massie

Institution: Liverpool Hope University

Researcher’s University email address: massies@hope.ac.uk

What will my participation in the research involve?

You are invited to participate in a one-to-one interview, expected to last about one hour, in a location of your choice, (such as your work office), or, if preferred, via an online platform (Zoom or MS Teams).

Questions will have a focus upon your service’s knowledge and awareness of resources/services for students with mental health needs; possible barriers for students who may need support; and how your service is responding to increased demand.

Will there be any benefits to me to taking part?

It is hoped that this will form one of several interviews completed with HEI student welfare/support services within the Northwest footprint.

A potential benefit may lead to closer sharing and collaboration knowledge to improve outcomes for students in line with Universities UK, Stepchange 'whole university' approach.

A summary of the key findings can be provided to you.

Will there be any risks to me in taking part?

Risks should be minimal. No personal or identifiable questions will be requested, and all data will be kept confidential and be fully anonymised, including the use of a code for your institution.

Questions will be focused upon knowledge of mental health resources. These could have an emotional impact should you have used these providers at some point. The interview can be ended at any time or paused for a break if required.

What happens if I decide that I don't want to take part during the actual research study, or decide that the information given should not be used?

You have the right to withdraw participation at any stage of the research or choose to not respond to any questions without the need for an explanation.

You also have the right to withdraw your data within four weeks of participation, again, without the need to provide an explanation.

How will you ensure that my contribution is anonymous?

All data will be stored on a password protected recording device. This data will be deleted once the interviews are transcribed. Transcribed interviews will be stored on a password protected computer.

No personally identifiable information will be included in the write-up. This includes no names; job description or HEI name (a code will be used for this).

Please note that your confidentiality and anonymity cannot be assured if, during the research, it comes to light that you are involved in illegal or harmful behaviours which I may need to disclose to the appropriate authorities.

LIVERPOOL HOPE UNIVERSITY

RESEARCH CONSENT FORM

Title of research project: How are higher education student welfare services responding to the perceived student ‘crisis’ in mental health?

Name of researcher: Scott Massie

I confirm that I have read and understand the information sheet for the above research project and have had the opportunity to ask questions.	Yes	No
I understand that my participation is voluntary and that I am free to withdraw my data until the time specified, without giving any reason.	Yes	No
I agree to take part in this research project and for the anonymised data to be used as the researcher sees fit, including publication.	Yes	No
I agree for the interview/ observations to be recorded (delete as appropriate).	Yes	No

Name of participant:

Signature:

Date:

Appendix Seven: Connections between research questions, interview questions, and the development of themes

Research sub questions	Link to interview questions by number	Connections to initial themes	Final themes
What do HEI SWS suggest has influenced the surge in demand for mental health services from universities?	1, 2,10,11	● Changing narratives ● Complex barriers	● Changing narratives ● Complex barriers ● Creative solutions
How do barriers, including stigma, continue to manifest?	3, 6,7,8, 9,10,11	● Seeking solutions' ● Local creativity, ● Complex barriers	● Changing narratives ● Complex barriers ● Creative solutions
How may the language and discourse of mental health and illness impact upon provision and helpseeking; How might the framing of this issue as a 'crisis' impact upon support?	2,4,8,9,10,11	● Changing narratives, ● Local creativity, ● Complex barriers	● Changing narratives ● Complex barriers ● Creative solutions

How does national guidance, policy and related research promote and/or support SWS responses to the increasing needs of students?	5,6,7,8,9,10,11	• Seeking solutions, • Local creativity, • Complex barriers	• Changing narratives • Complex barriers • Creative solutions
How are HEI student welfare services responding to growing demand in light of the above?	1,5,6,7,8,9,10,11	• Changing narratives, • Seeking solutions, • Local creativity, • Complex barriers	• Changing narratives • Complex barriers • Creative solutions