



The **Insight** Network

University Student Mental Health Survey 2018

A large scale study into the prevalence of student mental illness within UK universities.

MARCH 2019



TheInsightNetwork

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Dig-In

Christopher Platt and Clare Goodrham

Contents

[Foreword](#)

[Executive Summary](#)

[Key Findings](#)

[Introduction](#)

[Methodology](#)

[Sample](#)

[Results](#)

[Discussion](#)

[References](#)

[Appendix](#)

The Insight Network

The Insight Network is a team of therapists and psychiatrists that provide treatment and therapy for a wide range of mental illnesses. Beyond treating patients, TIN is also involved in research and service delivery work within the field of mental health and wellbeing.

Dig-In

Dig-In was founded in 2014 and is a fast-growing and entrepreneurial business centered on using our extensive reach of students for positive outcomes. Dig-In provides the official student welcome box to over 140 universities and accommodation providers across the UK. We work in partnership with a range of brands that provide information, money-off vouchers, promotional items and free samples for students, to help students save money and kickstart their first few weeks at university. We use our unique ability to reach and gain insights from large numbers of UK students to help improve their environment and wellbeing.

Get involved

If you would like to be part of future surveys, please contact Help@TheInsightNetwork.co.uk to express your interest. We also welcome any questions, feedback and any suggestions for future surveys.

The 2019 Student Survey will take place in September.

Foreword



Dr Stephen Pereira,
Director,
The Insight Network,
Consultant Psychiatrist

Starting university is a major period of transition in the lives of young people, and although many look forward to it as a positive and exciting time in their life, for some, the reality of life as a student does not always mirror expectations.

Mental health conditions are just as common in young people as they are in the general population, and some particular conditions are even more common among this age range. About one in four students experiences a mental illness each year. Students may be at heightened risk for psychological difficulties due to the combination of factors that affect young people in general and university-specific triggers. The stressors that students confront in this period are not trivial – for many, going to university involves moving away from home the first time, finding new networks, forging new identities, being challenged intellectually and dealing with new financial strains. As a society, we need to recognise the stress that students can be under and how this can affect their mental health.

Mental illness can have devastating effects if left unacknowledged and untreated. In order for universities and government agencies to provide effective psychological support it is important to understand the scale and profile of the student mental health crisis in the UK. In 2017, the Insight Network and Dig-In collaborated to produce a large-scale survey of UK students' wellbeing, and were able to investigate risk factors for student mental illness and identify specific at-risk groups.

This year, our aim was to conduct the largest ever survey into UK university student mental health, and to more accurately ascertain the prevalence of mental illness and low wellbeing among the UK student population. We were able to investigate not only prevalence and at-risk groups, but also levels of anxiety, loneliness, substance misuse, and thoughts of self-harm.

The findings of this survey have highlighted the true severity of student mental health crisis and constitute an urgent call to action for universities and government agencies. Mental health issues can be effectively managed if individuals are able to access the right treatment, and more importantly, in good time. These stark results should act as a demonstration of the grave need for more investment into mental health care provision. In a more positive light, the results may be of comfort to those students who are suffering, showing them that they are not alone, that mental illness can affect any person at any time, and that through continued commitment to improving care provision we can work together to alleviate this crisis.

Foreword



Christopher Platt,
Dig-In
Founder & CEO

Hi - I'm Chris, the CEO of Dig-In. Dig-In provides the official student welcome box to over 140 universities and accommodation providers. In 2018, 400,000 students arrived at university to find a Dig-In box waiting for them in their room.

I set up Dig-In in 2014 with the aim of giving students a great welcome on their arrival at university and with the intention to use the privileged access we have into university hall and accommodation providers as a force for good for students.

On a personal level, I have experienced the challenges of having a mental health issue and as a cause close to my heart, we set out in 2017 to conduct the largest ever study into student mental health and secured over 19,000 responses to our first student mental health study.

In 2018, the survey was repeated and on completion of the Dig-In Freshers survey, students were further invited to anonymously take part in our mental health study. Over September and October 2018, we were able to gather responses from over 37,500 students.

By conducting the largest survey in this field for a second year running, we hope to further raise the profile of mental health issues in students and collaborate with key stakeholders across this area to improve support services, the engagement with those services and help every student to reach their full potential.

So as well as working with a range of brands to provide information, money-off vouchers and free samples for students to help them save money and kick start their first few weeks at university, we are also committed to using our unique ability to reach and gain insights from large numbers of UK students to help improve their environment and wellbeing.

Executive Summary

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Over 37,500 students from 140 UK universities.

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1 in 5 students has a current mental health diagnosis.

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1 in 3 has experienced a serious psychological issue for which they felt they needed professional help.

The Insight Network and Dig-In Box aimed to conduct the largest ever survey of UK university students' mental health. To this end, data was collected from over 37,500 students from 140 universities, comprising a range of nationalities, ethnicities, genders and ages, including applicants due to commence university in 2018 through to 5th year+ students. Analysis of this data has produced a comprehensive report of mental health in the student population.

Our findings show that more than one-fifth have a current mental health diagnosis. The most common diagnoses are depression and anxiety disorders, and more than half of those with a current condition have complex diagnoses.

As well as mental illness, it is important to look at psychological distress; our findings show that rates of psychological difficulties in students are relatively high, with more than one-third reporting that they have experienced a serious psychological issue for which they felt they needed professional help. This is up 0.9% from 2017, a rise of close to 1% in only one year.

This research also found reports of thoughts of self-harm to be relatively common, which is a particular concern due to its association with suicide attempts. This is almost twice as high as reported rates in 2017, which is an alarming trend. This rise in thoughts of self-injurious behaviours is not only an issue for universities, but also for accommodation providers, as they need to be equipped to support students who are likely to enact or who are recovering from para-/suicidal behaviours on their premises.

Another alarming finding of the research was the high levels of substance misuse. When students were asked about using alcohol or recreational drugs as a means of coping with difficulties in their lives, almost half admitted that they did so, and 1 in 10 reported that they did this often or always. In a related question, 1 in 15 reported using drugs or alcohol in order to be able to fall asleep at night.

High levels of substance misuse are a cause for alarm for several reasons. Firstly, the fact that students are gravitating to substance misuse in attempts to cope with challenges suggests that they are not equipped with more adaptive strategies. Further, substance use is an extremely maladaptive approach to coping, and tends to significantly worsen mental health overall, and as such it should raise alarm to find that substance misuse is so common among students. High levels of substance misuse are also alarming due to the association with self-injurious behaviours, para/suicidal acts, and accidental death. The current research

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About half of all students report thoughts about self-harm.

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Students in second and third year were at significantly higher risk than first years for feelings of worry and loneliness, substance misuse, and thoughts of self-harm.

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Students who identify their gender as 'other' are at higher risk for psychological difficulties and disorders, and also constitute an increasing proportion of the student population.

suggests that substance misuse continues to pose a serious threat to students.

While many students with a mental health diagnosis reported that their difficulties had commenced at school, almost one-fifth reported that the issue had emerged in their time at university, and more than three-quarters of all those who reported a diagnosis stated that they were currently affected by symptoms associated with their condition.

The research has also identified at-risk sub-populations from within the student population. One of the most interesting discoveries was that second- and third-year students were at significantly higher risk than first years for feelings of worry and loneliness, substance misuse for coping, and thoughts of self-harm. These students are also the most likely to have a diagnosed mental health condition. This may be due to various factors. Perhaps the fact that support initiatives trail off after first year, or that academic pressure intensifies, or a combination of these and other factors are the basis for second- and third-years finding life more difficult. More research into the specific factors affected the wellbeing of student at different stages of university could be enlightening and inform more directed interventions.

A second important finding is that those who identified their gender as 'other' were disproportionately at-risk: about three in five reported a past serious psychological problems for which they needed professional help, and two in five reported a prior mental health diagnosis. This could be due to the fact that many gender dysphoric individuals choose to express their true gender for the first time at the start of university, as it provides a change in their environment and the opportunity for a new beginning. As a result, in addition to the fundamental transitions that all students confront with starting university, students who identify as an 'other' gender are also in the process of navigating a new gender expression. This could potentially put students who identify as an 'other' gender under higher pressure, increasing their risk of low wellbeing. The proportion of students identifying as an 'other' gender has increased by 0.4% from 2017, to 1% of the total sample, and the trend is for this group to continue to grow, meaning they should increasingly be a focus of support initiatives.

There should also be more research conducted in this population in order to clear up some ambiguities in the present research. This research was not directed specifically at the LGBTQ+ community (Lesbian, Gay, Bisexual, Trans*, and other non-cisgender or non-heterosexual individuals), and as such did not probe very deeply into the specific gender identities of the students identifying as an 'other' gender nor ask a specific question about diagnosis of gender dysphoria. As a result, some students who identified as an 'other' gender reported that they had a mental health diagnosis, and then specified that this diagnosis was gender dysphoria. As such, while the results show students identifying as an 'other' gender have higher rates of mental health diagnosis, it is not clear if this means that they are more likely to have mental health conditions in general, or if this is confounded by a gender dysphoria diagnosis. The Insight Network is committed to researching this further in 2019.

Another at risk group identified in the research is those with a prior mental health diagnosis. Often the transition to university means moving away from relatives, doctors,

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More than three-quarters have concealed their symptoms due to fears of stigma.

and service providers that have previously been an essential support to vulnerable students, meaning that students with an extant mental health condition are at risk of a functional decline when they arrive at university unless there is some continuity of provision. Those with a relative with a mental health diagnosis are also at significantly higher risk of both psychological distress and diagnosis.

Those who most often report mental health difficulties identify as female, and are in their first year of university, aged between 18 and 20, from the UK, and ethnically white. However rates at which students report mental health problems can only be used as an approximation of actual prevalence, as there is an issue of differential stigma and non-disclosure. It is possible, for example, that some overseas students are less likely to report psychological difficulties because they are from countries that have more stigmatising attitudes to mental illness, or that students who identify as male underreport their distress due to a perception that mental distress is a sign of weakness and that this is not masculine. Indeed, even from among those that were open to reporting psychological difficulties in this survey, more than three-quarters stated that they had concealed their symptoms from their families and friends due to fears of stigmatisation. This is up 40% from 2017, suggesting that this is a significant and increasing issue in the accurate measurement of psychological problems by means of self-disclosure.

We hope that this report can add further evidence to the prevalence of mental illness and distress in the UK's university student population, as well as providing information about which sub-populations may be most at risk and the character of students' psychological difficulties. We currently have another more detailed survey underway, which, in addition to the topics covered in the present research, investigates overall life satisfaction, sense of purpose, the role of social media in psychological wellbeing, causes of stress, anxiety, and loneliness, and thoughts of suicide.

Key Findings

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33.9% have experienced a serious psychological issue for which they felt they needed professional help.

What is the prevalence of mental health problems in the student population?

More than one-third (33.9%) of respondents had experienced a serious personal, emotional, behavioural or mental health problem for which they needed professional help. This is an increase of just under 1% in only one year. The students who are most likely to report past psychological issues for which they needed professional help identify as female, are in their first-year of university, aged between 18 and 20, from the UK, and ethnically white.

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21.5% of students have a current mental health diagnosis

More than one-fifth (21.5%) had received at least one mental health diagnosis in the past. The students who are most likely to report prior mental health diagnoses also identify as female, are aged between 18 and 20, from the UK, and ethnically white. However, in contrast to those who reported past psychological issues more generally, students in second and third year were the most likely to report at least one mental health diagnosis.

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42.8% of students reported that they were often or always worried.

What is the profile of the student population's mental health problems?

21.5% of the sample had one or more mental health diagnoses, and 11.9% had two or more. The most common diagnoses were depression and anxiety disorders (10.2% and 8.4% of the sample, respectively), followed by bipolar disorder (0.55%), eating disorders (0.54%), borderline personality disorder (0.25%), autism spectrum disorders (0.24%), and attention-related disorders (0.19%).

Students reported high levels of feelings of anxiety, with 42.8% reporting that they were often or always worried, and only 12.3% reporting that they were never or rarely worried. 87.7% reported that they had struggled with feelings of anxiety, an increase of 18.7% from 2017.

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33% of students reported that they were often or always lonely.

Students also reported high levels of loneliness, with one-third (33.0%) reporting that they often or always felt lonely, and only 20.5% reporting that they were never or rarely lonely.

When asked about substance misuse, 44.7% admitted to using alcohol or drugs to cope with problems in their life, with about 1 in 10 (9.5%) stating that they did this often or always. In a related question, 6.9% reported using drugs or alcohol in order to be able to fall asleep at night.

When asked about thoughts of self-harm, 50.3% reported some thoughts of self-harm, and

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44.7% of students admitting to using alcohol or drugs to cope with problems in their life. 9.5% did so often or always.

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50.3% of students reported some thoughts of self-harm. 9.4% thought of self-harm often or always.

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75.6% have concealed their symptoms due to fears of stigma.

about 1 in 10 students (9.4%) admitted that they thought about self-harm often or always. The 2017 report found that only 24% had had thoughts of self-harm, suggesting a two-fold increase in one year.

When asked about substance misuse, 44.7% admitted to using alcohol or drugs to cope with problems in their life, with about 1 in 10 (9.5%) stating that they did this often or always. In a related question, 6.9% reported using drugs or alcohol in order to be able to fall asleep at night.

When asked about thoughts of self-harm, 50.3% reported some thoughts of self-harm, and about 1 in 10 students (9.4%) admitted that they thought about self-harm often or always. The 2017 report found that only 24% had had thoughts of self-harm, suggesting a two-fold increase in one year.

Issues of non-disclosure

Stigma may be a significant factor in obstructing access to psychological support. More than three-quarters (75.6%) reported that they had concealed their symptoms from those around them for fear of stigmatisation. However, the actual rate of concealment is likely to be even higher when we account for those who chose not to participate in the research at all.

Introduction

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We want mental health support for students to be a top priority for the leadership of all our universities. Progress can only be achieved with their support – I expect them to get behind this important agenda as we otherwise risk failing an entire generation of students.”

**S. Gyimah,
Universities Minister, 2018**

Why investigate student mental health?

Levels of mental illness, subclinical distress, and low wellbeing among students in higher education in the UK are on the rise, and are higher than in other sections of the population (Ansari et al., 2011; Brown, 2016). This section of the population is at high risk for mental illness, both due to being in a vulnerable age range and also due to the transitions and specific trials associated with commencing university (Brown, 2016; Cooke et al., 2004; Kessler et al., 2007; Macaskill, 2012; Thorley, 2017).

Our motivation to investigate student mental health is both humane and practical. As care-providers, we have a duty to better understand the crisis of student mental illness and distress. More than one-third of students report that they have been confronted by severe psychological problems, for which they felt they needed professional help, and yet research suggests that only around 5% have received such assistance (Macaskill, 2012). Field research consistently finds high and increasing levels of student mental stress (Nightline, 2013; NUS, 2013, 2015; Unite, 2016; YouGov, 2016; Youthsight, 2013), and a record number of 134 students died as a result of suicide in 2015 (Thorley, 2017). Statistics like this remind us that a critical section of our youth is suffering the effects of mental illness or distress, that current initiatives to support them are insufficient to meet demand, and that we must all do what we can to understand and assuage this crisis.

With funding cuts resulting in decreased access to NHS psychological support, service providers' focus has narrowed to those with the most severe problems, meaning that students with mild to moderate mental health problems tend to not be prioritised for professional help from the NHS (Thorley, 2017; UK Royal College of Psychiatrists, 2011). This means that the psychological support offered by universities to their students is even more critical, as it is likely to be the only professional help these students will be able to access. Therefore, from a humane perspective, it is imperative that universities dedicate significant resources to mental health initiatives.

More practically, low wellbeing is associated with discontinuation of studies (Unite, 2016), which constitutes a loss of potential income for universities, individuals and government (Thorley, 2017). In 2017, the HESA reported that 6.3% of undergraduates dropped out prior to their second year, which is an unprecedented high (HESA, 2017c).

In recognition of these facts, the government is applying increasing pressure on universities to improve the psychological support offered to their students. Universities will have to develop their services in order to comply with the Department of Education's agenda.

We believe the key to designing effective mental health initiatives for students is a good

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More students than ever are disclosing mental illnesses to their universities.

understanding of the prevalence and profile of their psychological problems; this is what we have investigated in our research.

What's different about this survey?

While prior studies have investigated the prevalence of various mental illnesses and distress in the student population, most have been based on relatively small samples. This survey furthers our understanding of the prevalence and profile of mental health difficulties in the student population by analysing data collected from a sample of more than 37,500 students. The sample comprises participants from a range of universities, nationalities, ethnicities, genders and ages, including applicants due to commence university in 2018 through to 5th years+ students, allowing for a comprehensive investigation of mental health in the student population.

What are the key areas covered in this survey?

■ Prevalence Statistics:

More students than ever are disclosing mental illnesses to universities (Thorley, 2017). In 2013, the NUS published the results of an online questionnaire based on 1,285 responses which suggested that 16% of students had a current mental health diagnosis and 26% had experienced mental health difficulties. Of these, 80% of students reported experiencing stress, 66% reported being consistently unhappy, 55% reported feeling anxious, 49% reported feeling depressed, 45% reported feeling anger, and 38% reported experiencing episodes of panic. Similar results were found in the 2016 YouGov poll, which questioned 1,061 students and reported that 26.5% of students experienced mental health difficulties.

Past data about the prevalence of student mental illness and distress has been based on relatively small samples; the present research surveys a far larger sample, aiming to collect critical data on the prevalence of mental illness and distress in the student population.

■ Causal factors:

The pressures associated with this transitional period - including moving out from family homes, having decreased access to old support networks, needing to establish new ones, creating new identities for themselves, acclimatising to a different learning institution, and peer pressure to misuse alcohol or drugs (Scanlon, Rowling & Weber, 2010) - can result in stress that can interact in a diathesis-stress model with genetic, biological, psychological, and cultural vulnerabilities contributing to poor mental health (Macaskill, 2012). For students, these transitions are especially prone to having deleterious effects on mental health as most students are in a vulnerable age range, epidemiologically defined by both

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Students report higher levels of mental distress than their non-student peers.

the onset of conditions like schizophrenia and the progression of conditions that tend to commence in adolescence like mood and eating disorders (Kessler et al., 2007).

Student life itself can be a cause of mental distress, with students reporting higher levels of mental distress than their non-student peers (Unite, 2016). When asked about triggers of their mental distress, students tended to cite university-specific factors, including the amount of work required for their course, academic performance, finance-related issues like student loans and balancing jobs with their studies, struggling to fit into new social groups, and loneliness (NUS, 2013). Cooke et al. (2006) found that mental illness increased monotonically from the point at which students commenced their studies. This research investigates students' loneliness and stress to determine if these products of transition and academic pressure are highly prevalent and likely triggers of mental distress.

A further factor in the rise in student mental illness is increased university participation. The widening of the demographic characteristics of the student population has resulted in mental illness and distress levels rising to become more similar to those in the general population (UK Royal College of Psychiatrists, 2011). In the interests of preventative care, it is important that universities be conscious of the student sub-populations who are most at risk of developing mental health difficulties during their studies. The present research investigates students' demographic, familial, and individual characteristics and their respective associations with future psychological problems as a means to better predict who will need help.

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Suicide in the student population was at an all-time high in 2018.

■ **Suicide Risk:**

The most severe outcome of mental health conditions is suicide. A suicide in a university is not only tragic for the victim, but also has ramifications for other students and staff - who then may need psychological support themselves - further straining the university's mental health services, and it also damages the university's reputation, threatening its future viability. While the rate of suicide is lower for students than for the general population (4.4 per 100,000 students, as compared to 11.6 per 100,000 people in the general population), this year student suicide was at an all-time high (ONS, 2018), so universities cannot be complacent on this front.

These statistics do not include suicide attempts, which may be high in universities. Risk factors for suicide attempts, including feelings of loneliness or isolation, substance misuse (Lamis & Malone, 2011), self-harm, and suicidal ideation, have been found to be relatively prevalent in the student population (Nightline, 2013), and the present research examines rates of loneliness, substance misuse, and thoughts of self-harm with the aim of better predicting students at risk of suicide attempts.

Methodology

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The survey comprised six demographic questions, eleven core questions about mental health, and five conditional follow up questions.

A quantitative online survey was carried out on 37,654 students from 140 universities across England, Scotland and Wales. Invitations were sent to students who had signed up for Dig-In and responses were collected throughout August to October 2018. The survey comprised six demographic questions, eleven core questions about mental health, and five conditional follow up questions. The questions investigated:

- Prior mental illness, mental distress, or low wellbeing
- Current mental difficulties
- Depressed or anxious feelings
- Substance misuse
- Sleep disturbance
- Self-harm
- Stigma and disclosure
- Family history of mental illness
- Knowledge and use of support services

Participants were allowed to pass questions that they did not want to answer. After participation, students were provided an email address at the Insight Network and advised that they could use it if they felt they needed support.

Chi squared tests were conducted to determine any significant associations between demographic characteristics and responses to mental health related questions. Adjusted standardised residuals were used throughout. The survey then asked students about some specific areas known to be of concern in student populations: anxiety, loneliness or isolation, substance misuse, and self-harm. ANOVA was conducted to assess the associations between demographic characteristics and responses to these questions. Where the assumption of homogeneity of variance was violated, Welch's ANOVA was used, and where the assumption of normality was violated, Games-Howell post hoc comparisons were conducted. We also explored correlations between anxiety, loneliness or isolation, substance misuse, and self-harm.

Sample

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15,684 (41.8%) identified as male, 21,478 (57.2%) identified as female, and 382 (1.0%) identified as a gender other than male or female.

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The survey received responses from students originating from 171 different countries. However, the majority of respondents were from the UK. (71.5%).

■ Gender

Of the respondents, 15,684 (41.8%) identified as male, 21,478 (57.2%) identified as female, and 382 (1.0%) identified as a gender other than male or female. These statistics were compared with the HESA census, and were found to be highly representative of the higher education population in general, with the exception that within our sample there were significantly more students who identified as 'Other'. Students who identified as 'Other' were also significantly more represented in the 2018 sample than in the 2017 sample (see Appendix, [Table 4](#)).

■ Age

Respondents ranged in age from '17 or younger' to '23 or older', with more than half of the sample aged 18 (33.2%) or 19 (22.2%). In comparison with the 2017 sample, the 2018 sample included fewer respondents aged 17-19 and more respondents aged 20-23, such that the students in the latter sample tended to be slightly older (see Appendix, [Table 4](#)).

■ University year

The survey was offered to students in all university years, and respondents ranged from first- to fifth- year students. However, the majority of respondents were in their first year (67.2%), and 91.3% of respondents were first to third year students (see Appendix, [Table 4](#)).

■ UK or overseas status

The survey was offered to both UK and international students at universities in the UK, and as such comparisons can be made between these groups. The survey received responses from students originating from 171 different countries. However, the majority of respondents were from the UK. (71.5%). The following seven most represented countries each accounted for less than 3% of responses, and 163 of the countries each accounted for less than 1% of responses, such that the international students in the sample represent a group with highly heterogeneous countries of origin. The proportion of international respondents has decreased 9% from the 2017 sample (37.5%). Comparison with the HESA census statistics indicate that within our sample of international students, students from Europe were significantly overrepresented and students from Asia were significantly underrepresented. Students from North America were also relatively underrepresented, and students from South America and Oceania were relatively overrepresented.

■ Ethnicity

In the sample the largest ethnic group was 'White' (70.3%). When these statistics were compared with the HESA census, the ethnicities of 'White' and 'Asian' were overrepresented in the sample, but 'Black', 'Mixed', and 'Other' were broadly consistent with the higher education population in general. The proportion of 'White' respondents was the same between 2017 and 2018, but the proportion of 'Asian', 'Mixed', and 'Other' respondents has significantly increased (see Appendix, [Table 4](#)).

Results

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Both self-assessed psychological difficulties and mental health diagnoses were significantly associated with gender, ethnicity, age, university year and UK or overseas status.

Psychological wellbeing and mental health diagnosis.

When asked about prior psychological difficulties, more than a third (33.9%) of respondents endorsed that they had had a serious personal, emotional, behavioural or mental health problem for which they needed professional help. This is a higher percentage than endorsed that they had received a mental health diagnosis (21.5%), suggesting that about 1 in 8 students had experienced psychological difficulties for which they needed professional help but did not receive a diagnosis. Both self-assessed psychological difficulties and mental health diagnoses were significantly associated with gender, age, university year, UK or international status and ethnicity (see Appendix, [Tables 1 and 2](#)).

■ Gender:

In terms of gender, students who identified as female were significantly more likely to report mental health difficulties than males ($\chi^2(1) = 881.160, p < 0.001$). Female-identifiers were also significantly more likely to report a prior mental health diagnosis than students who identified as male ($\chi^2(1) = 749.31, p < 0.001$).

**Those who identified as neither male nor female were excluded from this analysis due to the extremely small class membership (383, 1.01% of the total sample). However, of this class 62.8% reported a past serious psychological problems for which they needed professional help, and 43.4% reported a prior mental health diagnosis. This group is therefore of particular interest when investigating mental health in the student population, and future studies should address them.*

■ Ethnicity:

Ethnicity was significantly associated with reports of psychological difficulties ($\chi^2(5) = 633.99, p < 0.001$), such that White and Mixed ethnic categories were more likely to report such issues. Ethnicity was also significantly associated with diagnosis ($\chi^2(5) = 751.40, p < 0.001$), such that White and Mixed ethnic categories were more likely to report mental illness.

■ Age:

Age was significantly associated with reported mental health difficulties ($\chi^2(7) = 453.07, p < 0.001$) such that students aged 17 or younger were least likely to report mental illness, with this likelihood increasing slightly at 18, increasing significantly at 19, and peaking

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Reports of mental health difficulties were lowest in first year, increased significantly in second year, and peaked significantly in third year students.

significantly at 20, and thereafter decreasing with increased age. Age was also significantly associated with diagnosis ($\chi^2(7) = 390.67, p < 0.001$) such that students aged 17 or younger were least likely to report mental illness, with likelihood increasing steadily and significantly up to aged 20, at which age diagnosis rate peaked, and then decreasing slightly with increased age.

■ **University year:**

University year was significantly associated with reports of mental health difficulties ($\chi^2(4) = 243.66, p < 0.001$), such that reports were lowest in first year, increased significantly in second year, and peaked significantly in third year students. University year was also significantly associated with diagnosis ($\chi^2(4) = 138.84, p < 0.001$) such that first years were least likely to report a diagnosis, with diagnosis rates increasing very steeply to peak significantly in second year, decreasing only very slightly to continue significantly elevated in third year students, to then fall dramatically to first-year levels in fourth and fifth years.

In all analyses of the effect of university year, it should be noted that 90% of our sample were from first, second, and third-year students, and the fourth, fifth, and later-years constituted a small cohort. This means that the sample imbalance may also be contributing to the effect of university year observed between the first-to-third year and fourth-to-fifth year cohorts.

■ **UK or overseas status:**

This factor was significantly associated with experiencing psychological difficulties ($\chi^2(1) = 369.12, p < 0.001$), with international students being less likely to report that they had experienced serious personal, emotional, behavioural or mental health problem. Being a UK or international student was also significantly associated with reports of mental health diagnosis ($\chi^2(2) = 604.177, p < 0.001$), such that UK students were more likely to report a prior mental health diagnosis than international students.

Looking specifically at students from outside the UK, 26.2% (2757) of international students had a prior psychological issue that needed professional help. This is a lower rate than in the student population in general. The proportion who reported issues varied with continent of origin: 40.2% of students from North America reported prior psychological problems, as compared to 33.8% of students from South America, 28.2% of students from Oceania, 29.4% of European students, 20.4% of African students, and 20.3% of Asian students.

In terms of diagnoses, 13.1% (1377) of international students endorsed a prior mental health condition, which was also lower than in the student population in general. Again, the proportion reporting diagnoses varied with continent of origin: 24.7% of students from North America reported prior mental health diagnosis, compared to 14.1% of students

from South America, 13.2% of students from Europe, 10.0% of students from Africa, 8.7% of students from Asia, and 8.5% of students from Oceania.

Chi squared tests showed that continent of origin was significantly associated with reports of psychological difficulties, ($\chi^2(6) = 154.768, p < 0.001$). International students from Asian countries were significantly less likely to report a past psychological issue for which they felt they needed professional help, and those from North American countries were significantly more likely to do so. The pattern of association was similar for rates of mental health diagnoses, ($\chi^2(6) = 197.116, p < 0.001$), with students from Asian countries significantly less likely to report a prior diagnosis and those from North American countries significantly more likely to do so.

Of those who endorsed that they had had a serious personal, emotional, behavioural or mental health problem for which they needed professional help, the highest proportions were female (67%), aged 18 (27%), White (78%) and from the UK (78%). Of those who had received a mental health diagnosis in the past, the highest proportions were also female (70%), aged 18 (25%), White (82%), and from the UK (83%).

Another known risk factor for psychological illness and distress is having a relative with a diagnosed mental health condition. Overall, 44.3% (16,758) reported that a member of their family had had a mental health condition. While the overall student population reported mental health difficulties for which they needed professional help at a rate of 21.5% and mental health diagnoses at a rate of 5.2%, those who had a relative with a diagnosed mental health condition reported rates of 49.3% and 20.3%, respectively. Hence this research confirmed that having a relative with a diagnosed mental health condition increases the risk of mental health difficulties and conditions.

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About half of those students who reported a mental health condition reported a complex diagnosis, with 11.9% of the overall sample reporting two or more comorbid disorders.

Complex Diagnoses

Those who reported that they had received a mental health diagnosis were then asked about the number of diagnoses they had received, and 4483 (55.6% of those who reported that they had received a mental health diagnosis and 11.9% of the total sample) reported two or more diagnoses. The most common diagnoses from within those who reported a prior mental health condition were depression (52.8%) and anxiety disorders (43.3%). Within the total sample, these disorders were also relatively common: 10.2% of students reported a diagnosis of depression and 8.4% a diagnosis of anxiety disorders.

A free text response space was provided for those whose diagnosis was not listed to state their diagnosis in their own words. The most commonly reported disorders were Bipolar Disorder (0.55%), eating disorders (0.54%) (including Anorexia Nervosa, Bulimia, and EDNOS), Borderline Personality Disorder (0.25%), Autism Spectrum Disorders (0.25%), Post-Traumatic Stress Disorder (0.20%), and ADHD/Attention Deficit Disorder (0.19%). A word cloud was generated using frequency analysis of all of the disorders mentioned in the

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33% reported that they were often or always lonely.

■ **UK or overseas status:**

This factor was significantly associated with anxiety ($F(1)=616.737$, $p<0.001$). Students from the UK were more likely than international students to report higher levels of anxiety.

■ **Gender:**

Gender was significantly associated with anxiety ($F(2) = 1293.544$, $p<0.001$). Students who identified as male reported significantly lower levels of anxiety than those who identified as either female or 'other', and those who identified as female reported significantly lower levels of anxiety than those who identified as 'other', such that male-identifiers were least anxious and 'other' gender-identifiers were most anxious.

■ **Ethnicity:**

Ethnicity was significantly associated with anxiety ($F(3) = 105.586$, $p<0.001$). White students reported significantly higher levels of anxiety than either Asian or Black students, who reported the lowest levels overall. Mixed ethnicity students also reported significantly higher levels of anxiety than Asian or Black students, although not quite as high as White students. Those who identified as an 'Other ethnic group' reported significantly lower levels of anxiety than both White and Mixed ethnicity students, although not quite as low as Asian or Black students.

Loneliness

Students also reported high levels of loneliness. Students were asked to indicate how often they felt lonely or isolated, again using a 10-point scale. The mean score was 5.26. Only 20.5% reported that they were never or rarely lonely, and one-third (33.0%) reported that they often or always experienced feelings of isolation.

■ **University year:**

University year was significantly associated with loneliness ($F(4)=77.905$, $p<0.001$). Students in their first year reported significantly less loneliness than second and third years. Levels peaked significantly in second year, and remained high in third year. In fourth year, levels decreased to not significantly different from first year, while in fifth year levels decreased to significantly lower than first year (Figure 2). Again, interpretation of the fall in fourth, fifth, and later years should account for class imbalance.

■ **Age:**

Age was also significantly associated with loneliness ($F(6)=45.980$, $p<0.001$). Loneliness

increased significantly between 17 and 19, and peaked significantly at age 20. Levels continued to be elevated at 21, decreasing slightly at 22, and significantly at 23, with 23-year-olds reporting the lowest levels of loneliness overall.

■ **UK or overseas status:**

Loneliness was significantly lower for international students ($F(1)=467.066$, $p<0.001$).

■ **Gender:**

Gender was significantly associated with loneliness ($F(2) = 528.092$, $p<0.001$). Students who identified as male had significantly lower levels of loneliness than those who identified as female or 'other', and those who identified as female reported significantly lower levels of loneliness than those who identified as 'other', such that male-identifiers felt least isolated and 'other' gender-identifiers felt most isolated.

■ **Ethnicity:**

Ethnicity was significantly associated with loneliness ($F(4) = 35.017$, $p<0.001$). The pattern for loneliness was similar to that for anxiety, in that White and mixed ethnicity students reported significantly higher levels of loneliness than Asian, Black, or 'Other ethnic group' students, who reported the lowest levels overall.

Substance misuse as a coping mechanism.

Students were asked about their use of psychoactive substances as a form of coping with distress. The mean score was low (2.6), but 44.7% admitted to using alcohol to cope with problems in their life to some extent, with about 1 in 10 (9.5%) stating that they did this often or always. In a related question, 6.9% reported using drugs or alcohol in order to be able to fall asleep at night.

■ **University year:**

University year was significantly associated with substance misuse ($F(4) = 29.502$, $p<0.001$). Rates increased significantly from first year to peak in second year, and rates remained significantly elevated in third year. From third to fourth year rates fell significantly, and rates continued to decrease to their lowest point in fifth year (Figure 2).

■ **Age:**

Age was also significantly associated with substance misuse ($F(6) = 42.315$, $p<0.001$).

Students aged 17 and 23 reported the lowest levels, and those aged 20 reported the highest levels. Substance misuse increased significantly between 18 and 19, and between 18 and 19, to then peak at 20. Levels decreased slowly between 20 and 22, and then significantly at 23.

■ **UK or overseas status:**

Students from the UK were more likely than international students to report using substances as a method of coping with life's problems, ($F(1) = 908.941, p < 0.001$).

■ **Gender:**

Gender was also significantly associated with substance misuse ($F(2) = 24.595, p < 0.001$). Students who identified as male or female reported similar, overall low rates of substance use, while those who identified as 'other' reported significantly higher rates.

■ **Ethnicity:**

Ethnicity was also significantly associated with substance misuse ($F(4) = 231.865, p < 0.001$). White and mixed ethnicity students reported significantly higher rates of substance misuse than Asian, Black, and 'Other ethnic group' students.

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50.3% of students reported some thoughts of self-harm.

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9.4% thought of self-harm often or always.

Thoughts of Self-harm

Students were asked about how often they had thoughts about self-harm. The mean score was low (2.7), but 50.3% reported some thoughts of self-harm, and about 1 in 10 students (9.4%) admitted that they thought about self-harm often or always.

■ **University year:**

University year was significantly associated with self-harm ($F(4) = 43.530, p < 0.001$). In comparison to first years, second years reported significantly more thoughts of self-harm, and third years also reported elevated levels. These thoughts were significantly less common in fourth and fifth years, with fourth and fifth years reporting the lowest levels overall (Figure 2).

■ **Age:**

Age was also significantly associated with thoughts of self-harm ($F(6) = 31.549, p < 0.001$). Interestingly, this pattern differed from that found for worry, loneliness, and substance misuse: 17, 19, and 21 years olds reported highly similar rates of thoughts of self-harm,

while 20-year-olds reported significantly higher rates and 18-year-olds reported significantly lower rates. The lowest rates were reported by 23-year-olds.

■ **UK or overseas status:**

Thoughts of self-harm were significantly lower for international students, ($F(1) = 413.806$, $p < 0.001$).

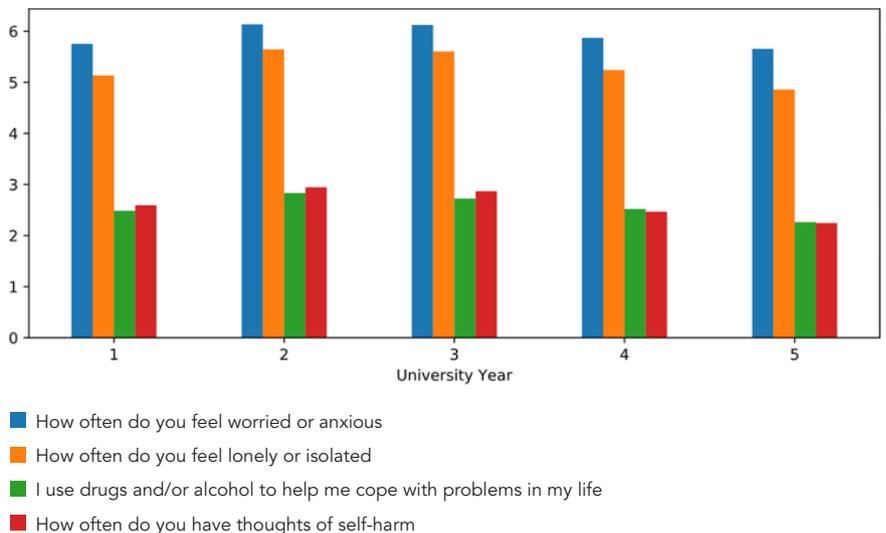
■ **Gender:**

Gender was also significantly associated with thoughts of self-harm ($F(2) = 556.600$, $p < 0.001$). Students who identified as male reported the lowest levels of thoughts of self-harm, significantly lower than students who identified as either female or 'other'. Students who identified as female reported significantly lower levels of thoughts of self-harm than 'other' gendered students, and this latter group reported the most common thoughts of self-harm overall.

■ **Ethnicity:**

Ethnicity was also significantly associated with thoughts of self-harm ($F(4) = 24.702$, $p < 0.001$). Asian students reported significantly higher rates than Black or 'Other ethnic group' students, while white students reported significantly higher rates than Asian, Black, or 'Other ethnic group' students. Mixed ethnicity students reported the highest rates of thoughts of self-harm.

Figure 2: University year plotted against feelings of anxiety, loneliness, substance misuse and self-harm



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Feelings of worry and loneliness were very strongly correlated.

Feelings of worry and loneliness were very strongly correlated ($\rho=.652$, $p<0.001$), such that those students who reported being anxious were likely to also report being lonely, and vice versa. Both worry and loneliness were significantly and strongly correlated with thoughts of self-harm ($\rho=0.476$, $p<0.001$ and $\rho=0.532$, $p<0.001$, respectively). Both were also significantly correlated with substance misuse ($\rho=0.265$, $p<0.001$ and $\rho=0.313$, $p<0.001$, respectively) (Figures 3 and 4).

Figure 3: Self-harm plotted against Anxiety and Loneliness

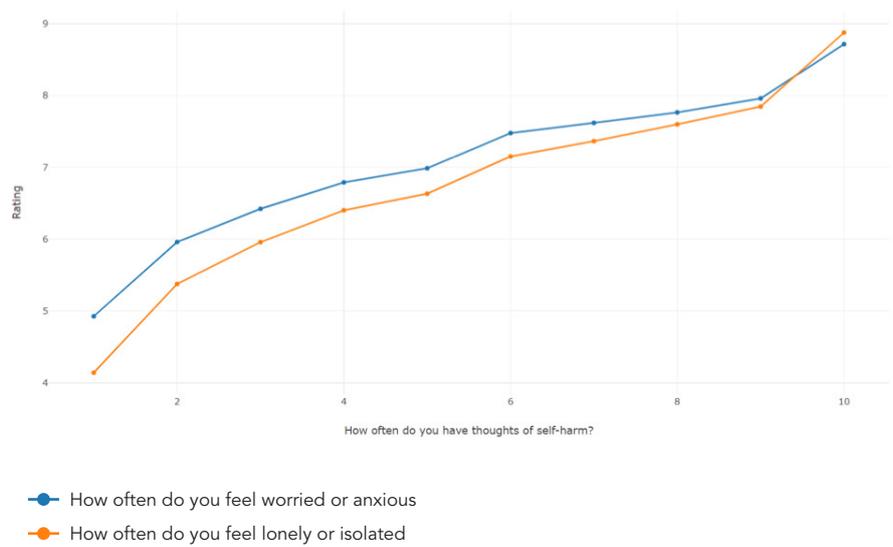
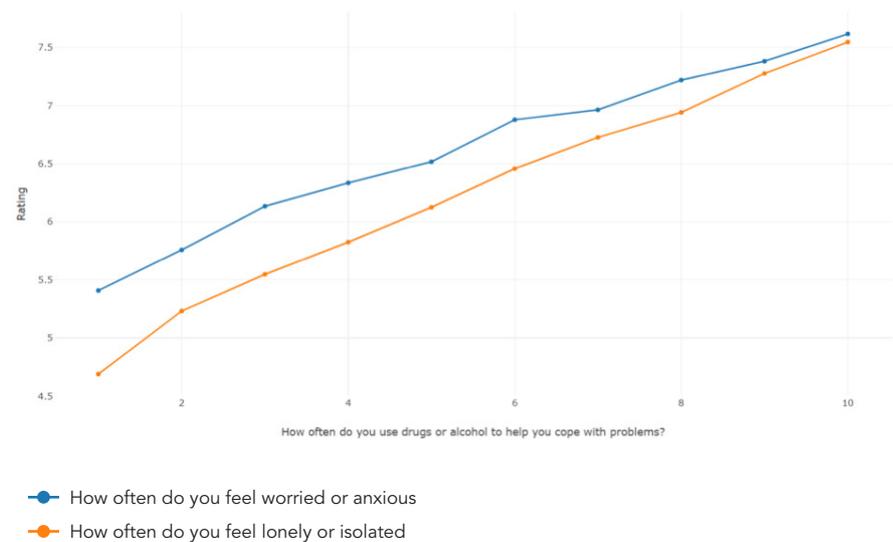


Figure 4: Substance misuse plotted against Anxiety and Loneliness



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75.6% claimed that they had concealed the symptoms of their mental health diagnosis for fear of stigma.

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80.1% reported that they were aware of the psychological support offered by their university. Only 10.2% reported using them.

Stigma and non-disclosure

Students who had reported prior mental illness, either in their own estimation or in the form of a diagnosis, were asked if they had concealed their symptoms due to a fear of stigma. About three-quarters (75.6%) who had answered that they had had a mental health diagnosis claimed that they had concealed their symptoms for this reason. The most common profile of students who reported concealing their symptoms was female, in first-year, aged 18-19, from the UK and from the 'other' ethnic group. This is not to say that this is the profile of students most likely to conceal their symptoms, however, as respondents to this conditional follow-up question were a self-selecting sample of those who had endorsed a psychological issue or diagnosis in a prior question. Other students who had concealed their symptoms from people around them may also have concealed them from us, and therefore not had the opportunity to answer this question.

Support services

Awareness of support services appeared to be high, with 80.1% of students reporting that they were aware of the options provided by their university. Those who were aware tended to identify as female (56.7%), be aged 18 (33.5%), going into first year (66.8%), white (71.9%), and from the UK (72.8%). Most service users also identified as female (66.3%), aged 20 (22.6%), were going into first year (36.9%), white (74.8%), and from the UK (78.4%).

The number of students that reported that they had used the support services was far lower, at only 10.2% (3856). Considering the rate at which students said they had problems for which they needed professional help was over 33%, this means that only one-third of students who felt they needed help actually received it from their universities.

Discussion

At-Risk Groups:

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An interesting finding of this research is that second- and third-years, rather than first-years, report the highest rates of problems with anxiety, loneliness, substance misuse, and thoughts of self-harm.

■ Second and third year students:

An interesting finding of this research is that second- and third-years, rather than first-years, report the highest rates of problems with anxiety, loneliness, substance misuse, and thoughts of self-harm. They also rank highest in terms of mental health diagnosis rate. According to our research, first-year students were most likely to report a prior psychological issue, but were also more likely to be conscious of and use the universities' mental health services, and seemed to be suffering less from mental distress than second- and third-years.

This may be due to various factors. Perhaps the stimulation of new experiences alleviates the loss of the familiar that occurs through life-transitions in first-year but subsides and is no longer a protective factor in second and third year. Or perhaps the 'freshers' activities stave off loneliness in first year but there is less to mitigate isolation in second and third year. Or perhaps there is increasing academic and financial pressure as finals approach and the world of work and loan repayments looms. There are likely to be multiple cofactors. More investigation should be conducted into the changing triggers for mental illness and distress throughout students' time at university, and resources allocated to the specific mental health needs of students in later years.

■ International Students:

International students in general were significantly less likely than UK students to report a prior psychological issue or mental health diagnosis, and were also less likely to report current feelings of anxiety or loneliness, substance misuse related to emotional coping, and thoughts of self-harm.

However, it is not simply that being international is associated with lower rates of psychological issues: when we deconstructed the international group into continents, there was considerable variation among the international students. Specifically, international students from Asian countries were significantly less likely to report a past psychological issue or diagnosis, and those from North American countries were significantly more likely to do so. We may hypothesise that some of the variation in reported rates of mental health difficulties is culturally-based, and that countries with very open discourses about psychiatric morbidity, like the United States, are likely to have students who are willing to disclose their problems in a survey, while countries with more stigmatising attitudes, like China, are likely to have students who are less willing to report that they are affected

by mental health issues. Overall there are significantly more international students from the Asian continent than from the others combined in our sample, which may be part of the reason that the overall statistics for international students show relatively low rates of psychological difficulties.

While we have some interesting data for international students, the Insight Network believes that the international students who participated in this research are likely to be a self-selecting sample of those who both understood English and considered mental health to be of some interest or importance, and a topic that could be discussed. Those who were not able to participate due to the language barrier and those who chose not to participate because they did not consider mental health to be interesting, important, or an acceptable topic for discussion, will not have contributed their data to the sample, which may mean the results are systematically non-representative of the general international student population.

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The increase in students who identified as an 'other' gender is an important trend, as these people constitute a particularly high-risk group in terms of mental illness and distress.

■ **Students who identified as an 'other' gender:**

The increase in students who identified as an 'other' gender is an important trend, as these people constitute a particularly high-risk group in terms of mental illness and distress (62.8% reported a past serious psychological problem for which they needed professional help, and 43.4% reported a prior mental health diagnosis). Higher rates of representation of this group in universities is likely to be accompanied by higher rates of psychological difficulties among the student population and a greater need for support services. These students are also just as likely to use these support services (one in three of those who reported a prior serious mental health problem also reported that they had used the universities' services in the past), so an increase in their representations is likely to produce both higher demand and higher use rates.

The Insight Network believes that 'other' gendered students are likely to be an increasing proportion of the student population in future: since our 2017 survey, the number of students identifying their gender as 'other' has increased from 0.6% (119) to 1.0% (383) of the sample. In 2017, we asked follow-up questions to identify the students' specific gender identity, and found that 40% identified as 'non-binary', 17% as 'agender', 13% as 'genderfluid', and 8% as 'transgender'. This year we did not ask follow-ups about the specific gender identity of those in the 'other' gender group, and so we cannot track changes in the composition of this sub-population at this point, but future research will investigate and see how this is changing with time.

■ **Students who identified as female:**

Our data also confirmed that students who identify as female are more likely than those who identify as male to report mental health problems. This trend was present throughout, from reports of prior psychological difficulties, mental health diagnosis, levels of anxiety and loneliness, to thoughts of self-harm. While students who identified as the 'other' gender scored the highest on all of these indices, female-identifiers scored consistently

higher than male-identifiers.

This trend needs to be pulled apart further, however. The most at-risk group tends to be those who identify as female in data extracted by self-disclosure; those who identify as male tend to be higher-risk in suicide rate data, which does not depend on self-disclosure. For example, ONS statistics indicate that in 2016, the rate of suicide in male-identifying students (6.7 per 100,000) was far higher than in female-identifying students (2.8 per 100,000). So, while our research has identified female students as a particular at-risk group, this may have as much to do with differential levels of self-disclosure, or even with gendered manifestations of mental suffering, as it does with male and female gendered people having different rates of mental health problems.

■ Those with a relative affected by a mental health condition:

Our research also confirmed that there is a strong association between psychological difficulties or mental health diagnosis and having a relative with a mental health condition. Among those who did have such a relative, rates of psychological difficulties and mental health diagnosis were one in two (49.3%) and one in five (20.3%), respectively, while rates in those who did not have such a relative were one in five (21.5%) and one in twenty (5.2%), respectively.

Key concerns:

■ Students are feeling worried and isolated:

Students generally reported high levels of anxious feelings, and 42.8% reported that they were often or always worried. Students also reported high levels of isolation, with 33.0% stating that they experienced feelings of loneliness often or always. These factors were also highly correlated, such that those most affected by anxious feelings were also most affected by loneliness, and constituted a very high-distress group. This is a concern in itself, as these feelings are distressing, but it is also a concern due to the strong correlations shown in our research between these feelings and hazardous thoughts and actions, specifically substance misuse as a means of emotional coping and thoughts of self-harm.

■ Substance Misuse:

In our research we also uncovered a relatively high frequency of students using alcohol or drugs as a form of coping with distress. The mean response indicated that most students did not do this all the time, but 44.7% admitted to using alcohol to cope with problems in their life to some extent, and about 1 in 10 (9.5%) stated that they did this often or always. In a related question, 6.9% reported using drugs or alcohol in order to be able to fall asleep at night. This is worrying, due to the implication that students are not equipped with

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The rise in reports of thoughts of self-harm is a particularly alarming indicator from our study.

more adaptive techniques for emotional coping and the psychologically and physiologically damaging effects of using substances for this purpose, but is also concerning because of how closely associated this risky behaviour is with self-harm.

■ **Self-harm:**

The rise in reports of thoughts of self-harm is a particularly alarming indicator from our study. Research has suggested an upward trend in self-harm in the UK, and it is an increasing focus of concern (Public Health England, 2014). Self-harm is both hazardous in itself and a sign of severe distress, and is also associated with suicide attempts, an even graver concern. A 2017 ONS report revealed that there had been 95 completed suicides in UK universities in a 12-month period, more than in almost all previous years. Epidemiologically self-harm is a very age-specific issue, with most of these people being aged 11-25. Within the most at-risk age range (16-25), a 2018 YouGov poll estimated that the rate of one or more prior acts of self-harm was about 1 in 3 (YouGov, 2018). This most at-risk age range largely overlaps with the student population.

While we did not have figures for how many students had self-harmed, our cross-sectional figures suggested that 1 in 2 (49.7%) students currently had some thoughts of self-harm, and 1 in 10 (9.7%) thought about it often or always. The actual rate is likely to be higher as not all students will disclose that they have these thoughts. The proportion of students who have thoughts of self-harm at some point throughout their course is also likely to be higher than those who had them at the time of data collection, and a longitudinal investigation could be used to get a more accurate gauge of the problem.

■ **Access to services:**

While rates of self-assessed psychological problems demanding professional help were over 33%, only 10% reported that they had used their universities mental health services. This could be due to a range of reasons, including fear of stigmatisation, not knowing that they can get help, or not believing that their problems are sufficiently severe to deserve help (an opinion that prevails evermore in the context of reduced resources and consequent necessary restriction of support to the most severe cases). A possible solution for this could be to reframe the function of psychological support services as a means to increase resilience and keep yourself strong, rather than as a last resort when issues have escalated to a severe level.

■ **Should we be asking these questions?**

There has been some concern expressed in the past that asking students questions about troubling topics like psychological suffering and self-injurious behaviours would be highly distressing to the students and that they would not want to participate because it would make them feel worse. We provide two compelling pieces of evidence that this is not the case and that, in fact, many students do want to talk about their mental health.

Firstly, we did not offer any incentive beyond the utility of our research in the future provision of mental health services, and on this basis we were able to recruit over 37,500 students to participate in this research over a period of only three months. Secondly, only 166 (0.4%) of those who opened the survey webpage did not complete the questions, and the rate of passing or skipping any one question never rose above 400 (1.05%), suggesting that most students who showed an interest in participation by following the link completed all of the questions. The implication is that students were not so distressed by the content of the questions that they chose not to participate. This is not to say that they did not find it distressing, and future research should look into assessing levels of distress associated with participation. But they still thought it was in their interest to continue and to provide all requested information about their mental health.

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This is a critical time to act to intervene in students' mental health.

■ **Call to action:**

This is a critical time to act to intervene in students' mental health. We hope that the findings in the present research will inform universities, accommodation providers, medical and psychological professionals, and government agencies on the principle issues facing students and how we might find effective solutions. The 2018 YouGov poll into the wellbeing of young people in the UK found that every item in the happiness index had fallen in the 12 months prior, and that the 2018 happiness index was the lowest since the research was first commissioned in 2009. It found that young people's main area of concern was their emotional and mental health, and that this was the index that had plummeted the furthest. Our research has corroborated and extended these alarming findings within the largest ever sample of UK students.

We have found that rates of psychological distress and illness among students are on the rise, and that students report alarmingly high levels of anxiety, loneliness, substance misuse, and thoughts of self-harm. In addition to confirming that students' mental health is a pressing issue that calls for immediate action, our research has identified which sub-sections of the student population are particularly likely to struggle with their psychological wellbeing, with the aim of informing effective and directed intervention. The Insight Network is committed to continuing with our large-scale research into the mental health status and needs of the UK student population.

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Appendix

		Gender					U.K. or International status					Ethnicity					
		Male N %	Female N %	Total N %	χ^2	Other N %	U.K. N %	International N %	Total N %	χ^2	White N %	Black N %	Asian N %	Mixed N %	Other N %	Total N %	χ^2
Have had a serious personal, emotional, behavioural or mental health problem for which they needed professional help	2017	1963 (31)	4324 (69)	6287 (32)	$\chi^2(1) = 402.12, p < .001$	83 (1.3)	4396 (69)	1974 (31.0)	6370 (33.0)	$\chi^2(1) = 169.58, p < .001$	4803 (75.0)	290 (4.6)	639 (10.0)	488 (8.0)	6370 (33.0)	$\chi^2(4) = 150.98, p < .001$	
	2018	3930 (31.4)	8563 (68.4)	12522 (33.6)	$\chi^2(1) = 881.16, p < .001$	236 (1.8)	9928 (77.8)	2801 (22.0)	12758 (33.9)	$\chi^2(1) = 369.12, p < .001$	9886 (77.5)**	487 (3.8)	1366 (10.7)**	739 (5.8)	12758 (33.9)	$\chi^2(5) = 633.99, p < .001$	
	Difference (%)	↑ 0.4	↓ 0.6	↑ 1.6		↑ 0.5	↑ 8.8	↓ 9.0	↑ 0.9		↑ 2.5	↓ 0.8	↑ 0.7	↓ 0.2	↑ 0.9		
Diagnosed with a mental health condition	2018	2266 (28.7)	5621 (71.2)	7896 (21.2)	$\chi^2(1) = 749.31, p < .001$	163 (2.0)	1392 (17.3)	6653 (82.6)	8059 (21.4)	$\chi^2(2) = 604.177, p < .001$	6570 (81.5)**	220 (2.7)	664 (8.2)*	458 (5.7)	139 (1.7)	8059 (21.4)	$\chi^2(5) = 751.40, p < .001$
	2018	1522 (25.6)	4403 (74.2)	5934 (15.9)	$\chi^2(2) = 102.84, p < .001$	144 (2.4)	5206 (85.7)	858 (14.1)	6078 (16.1)	$\chi^2(2) = 179.02, p < .001$	5048 (83.1)*	157 (2.6)**	409 (6.7)	354 (5.8)	103 (1.7)	6078 (16.1)	$\chi^2(5) = 84.64, p < .001$
Currently experiences symptoms	2018	468 (32.3)	978 (67.5)	1448 (3.9)	$\chi^2(4) = 770.78, p < .001$	21 (1.4)	1010 (68.8)	453 (30.8)	1469 (3.9)	$\chi^2(4) = 779.03, p < .001$	1019 (69.4)	63 (4.3)*	249 (17.0)	83 (5.7)	52 (3.5)**	1469 (3.9)	$\chi^2(10) = 914.56, p < .001$
	2017	2087 (32)	4420 (68)	6507 (33)	$\chi^2(2) = 450.96, p < .001$	78 (1.2)	4770 (72.0)	1815 (27.6)	6585 (34.0)	$\chi^2(2) = 440.97, p < .001$	5068 (77.0)	287 (4.4)	633 (9.6)	471 (7.0)	6585 (34.0)	$\chi^2(8) = 274.25, p < .001$	
Concealed symptoms in fear there may be stigma attached	2018	1592 (26.7)	4365 (73.2)	5965 (75.4)	$\chi^2(2) = 48.00, p < .001$	130 (2.1)	5096 (83.6)	984 (16.1)	6095 (75.5)	$\chi^2(2) = 26.85, p < .001$	4975 (81.6)*	173 (2.8)	504 (8.3)	343 (5.6)	95 (1.6)**	6095 (75.5)	$\chi^2(5) = 6.52, p = .259$
	2017	12722 (42.6)	17166 (57.2)	30002 (80.5)	$\chi^2(2) = 17.22, p < .001$	283 (0.9)	22039 (72.8)	8200 (27.1)	30285 (80.4)	$\chi^2(2) = 115.38, p < .001$	21781 (71.9)**	1482 (4.9)	4669 (15.4)*	1524 (5.0)	772 (2.5)	30285 (80.4)	$\chi^2(5) = 203.94, p < .001$
	Difference (%)	↓ 4.3	↑ 5.2	↑ 42.4		↑ 1.1	↑ 11.6	↓ 11.5	↑ 41.5		↓ 4.6	↓ 1.6	↓ 1.3	↑ 0.2	↑ 41.5		
Aware of mental health support services at university	2017	2573 (36)	4649 (64)	7222 (37)	$\chi^2(2) = 326.18, p < .001$	70 (1.0)	5202 (71.0)	2090 (28.7)	7292 (37.0)	$\chi^2(2) = 391.45, p < .001$	5567 (76.0)	307 (4.2)	772 (10.6)	513 (7.0)	7292 (37.0)	$\chi^2(8) = 244.48, p < .001$	
	2018	12722 (42.6)	17166 (57.2)	30002 (80.5)	$\chi^2(2) = 17.22, p < .001$	283 (0.9)	22039 (72.8)	8200 (27.1)	30285 (80.4)	$\chi^2(2) = 115.38, p < .001$	21781 (71.9)**	1482 (4.9)	4669 (15.4)*	1524 (5.0)	772 (2.5)	30285 (80.4)	$\chi^2(5) = 203.94, p < .001$
	Difference (%)	↑ 6.6	↓ 6.8	↑ 43.5		↓ 0.1	↑ 1.8	↓ 1.6	↑ 43.4		↓ 4.1	↑ 0.7	↑ 4.8	↑ 0.5	↑ 43.4		
Have used mental health services at university	2018	1210 (82.0)	2537 (67.7)	3776 (10.1)	$\chi^2(2) = 195.36, p < .001$	80 (2.1)	3022 (78.4)	827 (21.4)	3856 (10.2)	$\chi^2(2) = 70.97, p < .001$	2886 (74.8)*	176 (4.6)	482 (12.5)**	215 (5.6)	91 (2.4)	3856 (10.2)	$\chi^2(5) = 33.87, p < .001$
	2017	4324 (37)	7381 (63)	11705 (60)	$\chi^2(1) = 248.42, p < .001$	82 (0.7)	7645 (65.0)	4142 (35.1)	11787 (60.0)	$\chi^2(2) = 68.93, p < .001$	8337 (71.0)	669 (5.7)	1583 (13.4)	917 (8.0)	11787 (60.0)	$\chi^2(4) = 26.57, p < .001$	
Would make use of online expert psychological help	2018	7889 (36.4)	13707 (63.3)	21646 (58.1)	$\chi^2(2) = 676.87, p < .001$	252 (1.2)	15774 (72.0)	6086 (27.8)	21898 (58.2)	$\chi^2(2) = 6.09, p = .048$	15041 (68.7)**	1220 (5.6)	3861 (17.6)*	1148 (5.2)	583 (2.7)	21898 (58.2)	$\chi^2(5) = 92.17, p < .001$
	2017	4324 (37)	7381 (63)	11705 (60)	$\chi^2(1) = 248.42, p < .001$	82 (0.7)	7645 (65.0)	4142 (35.1)	11787 (60.0)	$\chi^2(2) = 68.93, p < .001$	8337 (71.0)	669 (5.7)	1583 (13.4)	917 (8.0)	11787 (60.0)	$\chi^2(4) = 26.57, p < .001$	
	Difference (%)	↓ 0.6	↑ 0.3	↓ 1.9		↑ 0.5	↑ 7.0	↓ 7.3	↓ 1.8		↓ 2.3	↓ 0.1	↑ 4.2	↓ 0.1	↓ 1.8		

▲ Table 1: Gender, international status, and ethnicity analyses.

** Indicates the most significant variance

* Indicates the second most significant variance

		Age								χ ²	University Year						χ ²
		17 or younger	18	19	20	21	22	23 or older	Total		1st	2nd	3rd	4th	5th or higher	Total	
		N %	N %	N %	N %	N %	N %	N %	N %		N %	N %	N %	N %	N %	N %	
Have had a serious personal, emotional, behavioural or mental health problem for which they needed professional help	2017	107 (2.0)	2012 (31.6)	1514 (24.0)	935 (15.0)	602 (10.0)	1200 (18.8)	6370 (33.0)	χ ² (5) = 69.09, p<.001	4061 (63.8)	804 (12.6)	665 (10.0)	840 (13.2)	6370 (33.0)	χ ² (3) = 56.56, p<.001		
	2018	146 (1.1)	3421 (26.8)**	2937 (23.0)	2092 (16.4)*	1447 (11.3)	912 (7.1)	1772 (13.9)	12758 (33.9)	χ ² (7) = 453.07, p<.001	7913 (62.0)**	1862 (14.6)	1781 (14.0)*	640 (5.0)	507 (4.0)	12703 (33.7)	χ ² (4) = 243.66, p<.001
Difference (%)		↓ 0.9	↓ 4.8	↓ 1.0	↑ 1.4	↑ 1.3	↑ 2.2	↑ 0.9		↓ 1.8	↑ 2.0	↑ 4.0	↓ 4.2	↑ 0.7			
Diagnosed with a mental health condition	2018	69 (0.9)	2045 (25.4)**	1883 (23.4)	1363 (16.9)*	974 (12.1)	594 (7.4)	1113 (13.8)	8059 (21.4)	χ ² (7) = 390.67, p<.001	5024 (62.3)**	1218 (15.1)*	1108 (13.7)	379 (4.7)	297 (3.7)	8026 (21.3)	χ ² (4) = 138.84, p<.001
Currently experiences symptoms	2018	46 (0.8)	1577 (25.9)	1467 (24.1)	1054 (17.3)	751 (12.4)	416 (6.8)*	758 (12.5)**	6078 (16.1)	χ ² (7) = 61.22, p<.001	3736 (61.5)	985 (16.2)**	860 (14.1)	274 (4.5)	197 (3.2)*	6052 (16.1)	χ ² (4) = 41.52, p<.001
Developed a mental health condition while at university	2018	9 (0.6)	97 (6.6)**	169 (11.5)	295 (20.1)	275 (18.7)	199 (13.5)	420 (28.6)*	1469 (3.9)	χ ² (14) = 1203.49, p<.001	504 (34.3)**	270 (18.4)	391 (26.6)*	149 (10.1)	142 (9.7)	1456 (3.9)	χ ² (8) = 905.16, p<.001
Concealed symptoms in fear there may be stigma attached	2017	124 (2.0)	2431 (36.9)	1581 (24.0)	876 (13.0)	574 (9.0)	999 (15.2)	6585 (34.0)	χ ² (10) = 97.58, p<.001	4461 (67.7)	769 (11.7)	647 (9.8)	708 (10.8)	7292 (37.0)	χ ² (6) = 63.52, p<.001		
	2018	52 (0.9)	1551 (25.4)	1443 (23.7)*	1043 (17.1)	751 (12.3)	448 (7.4)	795 (13.0)**	6095 (75.5)	χ ² (7) = 14.09, p=.050	3769 (61.8)	937 (15.4)	861 (14.1)**	286 (4.7)	212 (3.5)*	6095 (75.5)	χ ² (4) = 7.25, p=.123
Difference (%)		↓ 1.1	↓ 11.5	↓ 0.3	↑ 4.1	↑ 3.3	↑ 5.2	↑ 41.5		↓ 5.9	↑ 3.7	↑ 4.3	↓ 2.6	↑ 38.5			
Aware of mental health support services at university	2017	104 (1.0)	2555 (35.0)	1700 (23.0)	1058 (15.0)	697 (10.0)	1178 (16.2)	7292 (37.0)	χ ² (5) = 102.42, p<.001	4537 (62.2)	983 (13.5)	829 (11.0)	943 (12.9)	7292 (37.0)	χ ² (6) = 181.10, p<.001		
	2018	456 (1.5)	10143 (33.5)*	6747 (22.3)	4052 (13.4)	2953 (9.8)	1936 (6.4)**	3922 (13.0)	30285 (80.4)	χ ² (7) = 21.21, p=.003	20220 (66.8)*	3790 (12.5)	3467 (11.4)	1536 (5.1)**	1157 (3.8)	30170 (80.1)	χ ² (4) = 4.61, p=.331
Difference (%)		↑ 0.5	↓ 1.5	↓ 0.7	↓ 1.6	↓ 0.2	↑ 3.2	↑ 43.4		↑ 4.6	↓ 1.0	↑ 0.4	↓ 4.0	↑ 43.1			
Have used mental health services at university	2018	20 (0.5)	503 (13.0)**	697 (18.1)	870 (22.6)*	673 (17.5)	406 (10.5)	680 (17.6)	3856 (10.2)	χ ² (7) = 1355.8, p<.001	1423 (36.9)**	898 (23.3)	972 (25.2)*	345 (8.9)	201 (5.2)	3839 (10.2)	χ ² (4) = 1882.76, p<.001
Would make use of online expert psychological help	2017	218 (2.0)	4097 (34.8)	2672 (23.0)	1531 (13.0)	1023 (9.0)	2246 (19.1)	11787 (60.0)	χ ² (5) = 3.88, p=.567	7800 (66.2)	1339 (11.4)	1070 (9.1)	1578 (13.4)	11787 (60.0)	χ ² (3) = 9.27, p=.026		
	2018	297 (1.4)	6904 (31.5)**	4866 (22.2)	3103 (14.2)*	2246 (10.3)	1510 (6.9)	2909 (13.3)	21898 (58.2)	χ ² (7) = 99.23, p<.001	14369 (65.6)**	2823 (12.9)	2674 (12.2)*	1114 (5.1)	825 (3.8)	21805 (57.9)	χ ² (4) = 44.93, p<.001
Difference (%)		↓ 0.6	↓ 3.3	↓ 0.8	↑ 1.2	↑ 1.3	↑ 1.1	↓ 1.8		↓ 0.6	↑ 1.5	↑ 3.1	↓ 4.5	↓ 2.1			

▲ Table 2: Age and university year analyses.

** Indicates the most significant variance

* Indicates the second most significant variance

Appendix

	Age								Total	Results of ANOVA Age*Anxiety
	17 or younger	18	19	20	21	22	23 or older			
	N %	N %	N %	N %	N %	N %	N %	N %	N %	
7/10+ rating for how often do you feel worried or anxious	217 (2.7)	5230 (32.3)	3726 (23.0)	2423 (15.0)	1684 (10.4)	1049 (6.5)	1798 (11.1)	16127 (42.8)		F(6)=38.786, p<.001
7/10+ rating for how often do you feel isolated	165 (1.3)	3778 (30.4)	2943 (23.7)	1961 (15.8)	1390 (11.2)	829 (6.7)	1347 (10.8)	12413 (33.0)		F(6)=45.980, p<.001
7/10+ rating for using drugs or alcohol to solve problems	45 (1.3)	975 (27.2)	925 (25.8)	604 (16.9)	412 (11.5)	231 (6.5)	376 (10.5)	3568 (9.5)		F(6) = 42.315, p<.001
7/10+ rating for how often do you think of self-harm	66 (1.8)	1155 (31.5)	894 (24.4)	605 (16.5)	378 (10.3)	222 (6.1)	336 (9.2)	3656 (9.7)		F(6) = 31.549, p<.001

	U.K. or International			Results of ANOVA International*Anxiety	University Year					Total	Results of ANOVA University Year*Anxiety
	U.K.	International	Total		1st	2nd	3rd	4th	5th or higher		
	N %	N %	N %		N %	N %	N %	N %	N %	N %	
7/10+ rating for how often do you feel worried or anxious	12460 (77.1)	3677 (22.7)	16137 (42.9)	F(1)=616.737, p<.001	10365 (64.1)	2250 (13.9)	2135 (13.2)	791 (4.9)	578 (3.6)	16119 (42.8)	F(4)=49.838, p<.001
7/10+ rating for how often do you feel isolated	9617 (77.3)	2800 (22.5)	12417 (33.0)	F(1)=467.066, p<.001	7787 (62.6)	1900 (15.3)	1728 (13.9)	611 (4.9)	370 (3.0)	12396 (32.9)	F(4)=77.905, p<.001
7/10+ rating for using drugs or alcohol to solve problems	3041 (85.0)	534 (14.9)	3575 (9.5)	F(1) = 908.941, p<.001	2234 (62.1)	571 (16.0)	477 (13.3)	171 (4.8)	108 (3.0)	3561 (9.5)	F(4) = 29.502, p<.001
7/10+ rating for how often do you think of self-harm	3025 (82.5)	630 (17.2)	3655 (9.7)	F(1) = 413.806, p<.001	2349 (64.1)	573 (15.6)	484 (13.2)	153 (4.2)	87 (2.4)	3646 (9.7)	F(4) = 43.530, p<.001

	Male	Female	Total	Results of ANOVA Gender*Anxiety	Other	Ethnicity					Total	Results of ANOVA Ethnicity*Anxiety
	N %	N %	N %			White	Black	Asian	Mixed	Other		
	N %	N %	N %		N %	N %	N %	N %	N %	N %	N %	
7/10+ rating for how often do you feel worried or anxious	4875 (30.1)	11029 (68.2)	15904 (42.2)	F(2) = 1293.544, p<.001	236 (1.5)	12120 (75.0)	660 (4.1)	2158 (13.3)	823 (5.1)	373 (2.3)	16134 (42.8)	F(3) = 105.586, p<.001
7/10+ rating for how often do you feel isolated	4175 (33.6)	8021 (64.5)	12196 (32.4)	F(2) = 528.092, p<.001	220 (2.0)	9105 (73.2)	590 (4.7)	1779 (14.3)	662 (5.3)	285 (2.3)	12421 (33.0)	F(4) = 35.017, p<.001
7/10+ rating for using drugs or alcohol to solve problems	1462 (40.8)	2027 (56.6)	3489 (9.3)	F(2) = 24.595, p<.001	80 (0.3)	2893 (80.8)	133 (3.7)	292 (8.2)	192 (5.4)	61 (1.7)	3571 (9.5)	F(4) = 231.865, p<.001
7/10+ rating for how often do you think of self-harm	957 (26.1)	2593 (70.7)	3550 (9.4)	F(2) = 556.600, p<.001	104 (2.8)	2771 (75.6)	159 (4.3)	452 (12.3)	197 (5.4)	79 (2.2)	3658 (9.7)	F(4) = 24.702, p<.001

▲ Table 3: Anxiety, loneliness, substance misuse, and self-harm analyses.

	Gender %			Age %						
	Male	Female	Other	≥17	18	19	20	21	22	23≤
2017	41	58	0.6	1.9	35.1	22.5	13	8.7	18.8	
2018	42	57	1	1.6	33.2	22.2	13.5	9.8	6.6	13.1
Difference	↑1	↓1	↑0.4	↓0.3	↓1.9	↓0.3	↑0.5	↑1.1	↑0.9	

	University Year %					Ethnicity %				
	1st	2nd	3rd	4th	5th≤	White	Asian / Asian British	Black / African / Caribbean / Black British	Mixed	Other
2017	66.8	10.9	9.2	13.2		70.3	13.6	5.6	1.4	
2018	67.2	12.5	11.6	5.0	3.8	70.3	16.5	5.1	5.0	2.6
Difference	↑0.4	↑1.6	↑2.4	↓4.4		-	↑2.9	↓0.5	↑6.2	

▲ Table 4: Demographic changes 2017-18.