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EDITORIAL

Student mental health: some answers and more questions

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Public concern for the mental health of university students has been rising. University counselling services in the UK and USA are reporting increases in helpseeking, with more students presenting with more severe problems (Avotney, 2014; Flatt, 2013). Several reasons probably explain this increase. Distress among younger people has increased, especially among women (Lessof et al., 2016; Ross et al., 2017). With many more students to university (Bathmaker, 2003) and with classes of over 200 per year on some courses students receive less personalised support. Social media (Jacobsen & Forste, 2011) and financial difficulty resulting from increased tuition fees (Gani, 2017) have both been suggested but have little research evidence.

Most mental health problems develop in early life, with the onset of 75% of lifetime mental disorders occurring by age 25 years (Kessler et al., 2007). These include psychotic problems as well as depression and anxiety. University students form a substantial group of young people, with just under 50% 18–19 year olds applying for university in the UK (UCAS Analysis and Research, 2014). These students are therefore in the high risk period for developing mental health problems so it is vital both to understand and then offer acceptable, effective and accessible support for this potentially vulnerable group.

Counselling is the most consistently offered intervention and positive results have been demonstrated in services offering psychodynamic therapy, structured brief therapy and integrative therapy (Connell et al., 2008; McKenzie et al., 2015). But the capacity of 1:1 counselling services to offer support to large numbers of students is limited and so may not be appropriate as a first-line intervention. Alternative approaches and methods of delivery have therefore been suggested. For instance, recent reviews show evidence of effective interventions using CBT and its modalities (including mindfulness) (Regehr et al., 2013). Computerised interventions, usually offering CBT, offer the potential but their acceptability is problematic as take-up is low and dropout rate high (Musiat et al., 2014).

Despite the increased demand for counselling services, only about a third of students with mental health distress seek formal help from counselling in the UK (Macaskill, 2012) or USA (Eisenberg et al., 2007). They are more likely to seek help from their friends and family than from formal services (Rickwood et al., 2005). Students most commonly talk to friends and family and rarely to the counsellor when they had problems (Oliver et al., 1999).

The most common major obstacle to seeking help has been assumed to be stigma. For instance, medical students feared being stigmatised potentially because of fitness to practise issues (Chew-Graham et al., 2003) but an influential review of stigma and help-seeking across all ages showed that it was only the 4th greatest obstacle to help-seeking (Clement et al., 2015). Key barriers among students with untreated mental health problems in the USA were ''wanting to deal with issues on my own'' and that ''stress is normal in college/graduate school'' (Eisenberg et al., 2012). Similarly, Czyz et al. (2013) found that suicidal students felt treatment was not needed or they did not have time or preferred self-management. Stigma was seldom mentioned. Recent evidence suggests that other factors such as positive mental health concepts like flourishing or languishing might better explain differences in seeking help as well as suicidal tendencies among those with diagnosable mental health problems (Keyes et al., 2012).

The growing demand for formal help is not currently being met by many services. This demand is also probably underestimated as many students do not seek help as they perceive their problems as related to the normal stresses of university life and prefer to manage it themselves. If we are to reduce mental health problems, especially as they are likely to persist or recur, we need effective, scalable interventions that are attractive to students. Given that stigma does not appear to be the key obstacle, awareness raising to reduce stigma would not be effective and might be potentially unhelpful (Arie, 2017; Wessely, 2005).

This special issue highlights important new evidence on student mental health, both by understanding the underlying issues and their implications of poor mental health, in addition to interventions that may be effective to alleviate distress.

What factors are associated with the development and detection of poor student mental health?

McIntyre et al. (2018) carefully examined both academic and non-academic predictors of distress among 1135 UK undergraduates and found different factors associated with different outcomes. Loneliness was the strongest overall predictor of

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Table 1. Adapted WHO model of support for university students.

Level of support	Type of support	Examples	Severity of students' mental health problems
Level 5	External specialist support	Specialist mental health services	Severe problems requiring specialist care
Level 4	University support services	Counselling Disability services Computerised therapy	Students with more severe or diagnosable problems
Level 3	Structured university support	Personal tutors Study and wellbeing skills Peer support or Buddy system	Students with varying levels of distress
Level 2	Informal university/personal support	Friends Social support via university societies with some offering talks on mental health issues Family	Students with varying levels of distress
Level 1	Self-care – or readiness for university	Budgeting and cooking skills Friendship skills Coping with academic demands (e.g. time management, essay skills, sleep) Emotional coping skills	Students with varying levels of distress

distress, academic stress was the strongest for academic outcome, with childhood trauma, a key background risk factor. The findings about loneliness replicate the results of other studies in the UK (Richardson et al., 2017) and the USA (Hefner & Eisenberg, 2009).

Lipson & Eisenberg (2017) concentrated on the effects of mental health problems on academic performance in 4280 American students. They found that those with mental health problems tended to worry more about coping with academic demands, completing the course and particularly whether it was worth the time, effort and money spent on university. Similarly, in a qualitative study of 2nd year UK students comparing those with levels of distress above a clinical threshold and ''Well'' students, Mackaskill (2018) reports similar results. Distressed students worried much more about their course work, careers and student debt compared to the ''well'' group whereas students in the ''Well'' group were generally more proactive about dealing with problems.

It is difficult to identify those students who have poor mental health problems easily although reductions in academic work seem to be related. But one group that would be thought to come quickly to the attention of supervisors and services are those who develop psychosis. The university years are the key vulnerable period for its development, but Hardy et al. (2018) concluded that, although these problems are more quickly detected when compared to the general population of the same age, the rate of detection was still slow.

New factors are also now associated with increases in university students' distress. For example, Mishna et al. (2018) described a high rate of cyberbullying in a Canadian University. Non-consensual sharing of the images raised most concern and nearly 20% of those who had experienced cyber bullying reported stress and anxiety.

All this research assumes that there is little developmental change over the period of being a student, especially in their first year. Longitudinal work is important because it indicates naturalistic changes which may contribute to the over-estimation of mental health problems or suggest different targets for intervention. Knoesen & Naude (2017) in South Africa used a positive psychology approach, of languishing and flourishing in 22 students in their 1st year. Initially, students ''languished'' and felt totally overwhelmed by the experience of being at university, feeling lonely, finding academic work hard and having practical problems. But as they developed confidence with academic tasks, developed social support and felt more confident about being independent, they ''flourished''. This development of coping skills together with social support, will help students move from ''languishing'' to ''flourishing'' and supports work by Ennals et al. (2015) and Labrague et al. (2017). Also using a positive psychology approach, Selvaraj & Bhat (2018) found that ''languishing'' and ''flourishing'' were associated with psychological ''capital'' (or psychological strengths), particularly hope, efficacy and optimism among 338 American undergraduate and postgraduate students.

Are there novel therapies that can be provided in university settings?

This issue contains two papers about canine therapy. Although this approach seems to be extremely popular, evidence about its effectiveness is scarce. In a large Canadian study, Binfet et al. (2017) found good results when a drop-in service was offered to undergraduates and in the UK, Wood et al. (2017) found good psychological and physiological results when a brief canine therapy intervention was offered. Although it is not clear whether this type of therapy is widely applicable, this approach would be scalable and cost-effective as long as larger studies replicate its efficacy.

But not all support needs to be formal. Young people prefer to talk to friends and family and people they know rather than professionals (Rickwood et al., 2005). So Byrom (2018) examined peer support which had promising evidence of effectiveness with 72 students in nine UK universities. But there are some caveats as attrition was relatively high with only 28% completing the six session course.

From Australia, Gulliver et al. (2018) described how lecturers are usually the first port of call for many students but 60% felt under-equipped to provide support. This replicates

UK studies (Hughes et al., 2017; Manthorpe & Stanley, 2001) and suggests a need for training and guidance to aid academic staff.

A model of university student mental health

The World Health Organisation model of informal and formal help (World_Health_Organisation, 2009) could be adapted to students (see Table 1). It describes support in several steps, with the most accessible at the bottom (level 2) and least accessible at the top (levels 4 and 5). Most university services are provided at level 4 but coordination is needed between different levels especially 2 and 3 where we have already seen there could be simple and scalable interventions to support the developmental changes over the university years.

Levels of support, as Table 1 suggests, need to be adaptable and tailored. At the highest levels, we have little understanding of the comparative effectiveness and cost-effectiveness of different interventions for this developmental level, in this sort of setting. Clearly, the most severe problems should be treated by specialist services that are available to the population. But at lower levels many interventions have been suggested and, in this issue, canine therapy and peer support are effective although peer support has attrition problems.

At lower distress levels merely raising awareness may not be generally helpful although this form of intervention may need to be tailored as some groups, e.g. international students, may achieve benefit. So for the majority of students, we should concentrate on those vulnerable groups not seeking help. This can happen indirectly through developing self-confidence to target depressed students (Brown et al., 2004), departmental programmes on study skills and wellbeing for potentially anxious students (Lewis & Davies, 2017) or even including more exercise (Tyson et al., 2010). As we know that loneliness is an important factor, then creating more face-to-face communities in departments, student unions and residence halls might help overcome this problem.

What next for the research community?

Two key changes in the research focus would have a large impact in this area. First, although we have identified some predictive factors most of these have been in cross-sectional studies. Longitudinal cohorts of students entering, and progressing through, university are also essential to begin to identify vulnerable students early. The earlier the identification then the easier it may be to avert crises and the interventions will also be more scalable.

Second, the outcomes from treatment or intervention studies currently do not allow any comparison. While some may target mental health distress (a proximal target) others use distal outcomes, such as flourishing or changes in academic progress. Without overall agreement on a key target there will never be an evidence base to allow a comparative examination of the costs and benefits of the different approaches. Without this agreement on measurement, the field will continue to be confused and confusing and prevent the adoption of key treatments across the university sector.

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Declaration of interest

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