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Academics' perceptions and experiences of working with students with mental health problems: insights from across the UK higher education sector

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ABSTRACT

Mental health problems (MHPs) amongst university students are increasing in the UK and internationally. Academic staff have a potentially important role in supporting students with MHPs, but the literature indicates that most lack the knowledge and skills to do so. Studies on academics' experiences of working with students with MHPs have generally focused on one or two institutions/faculties, meaning there is a lack of understanding of any differences across the wider higher education sector. In order to address this gap, a mixed methods study involving a survey ($N = 130$) and semi-structured interviews ($N = 11$) was undertaken with academics in 27 institutions across the UK, divided into Russell Group, other pre-1992, and post-1992 universities, across 5 broad subject areas. Nearly all respondents had encountered student MHPs, but although awareness of student MHPs was high, preparedness to support these students was low. These findings were consistent across all types of institution and subject areas, and we therefore recommend that all academic staff should have compulsory basic training in mental health. Although the response rate does not allow us to generalise the findings to all UK universities, the findings indicate that all types of university and subject area face the same issues around student mental health. Our research also builds on studies of academics' experiences of student MHPs in the US, Canada, and Australia, and offers insight for the higher education sector internationally. Overall, this study emphasises that academic staff should be an integral part of any institution's strategy for enhancing student mental health.

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Introduction

Mental health problems (MHPs) amongst university students in the UK are increasing, and their incidence is high in comparison to the general population (Royal College of Psychiatrists, 2011; Thorley, 2017). Studies in other countries have similarly reported on the increasing prevalence of MHPs amongst students (see for example headspace & National Union of Students, 2017, in Australia, and Oswald et al., 2018, in the US).

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It is recommended that academic staff should be able to support students with MHPs (Baik, Larcombe, & Brooker, 2019; Wynaden, Wichmann, & Murray, 2013). However, the literature indicates that many, if not most, academics lack the necessary knowledge and skills to do so (for example, Huyton, 2009; Laws & Fielder, 2012). Contrary to reports of the prevalence of student MHPs, Macaskill (2013) found that many course leaders in the UK believed MHPs were not an issue for their students, and she posits that lecturers may not be sufficiently familiar with MHPs. Similarly, Brockelman and Scheyett (2015) found that although faculty members at a US university tended to believe they were familiar with MHPs, they infrequently noted symptoms of problems in their students. Brockelman and Scheyett (2015) suggest that faculty may not have been recognising symptoms, and therefore not providing support to students. They subsequently call for training for academic staff aimed at increasing their awareness and recognition of MHPs amongst students.

Student MHPs in different subject areas

Studies have indicated differences between subject areas in student and staff experiences of MHPs. McKerrow, Carney, Caretta-Weyer, Furnari, and Miller Juve (2020) and Mousa, Dhamoon, Lander, and Dhamoon (2016) highlight high rates of MHPs amongst medical students, and Skead and Rogers (2015) propose that law students have higher levels of psychological distress than students in other professions. The US study by Lipson, Zhou, Wagner, Beck, and Eisenberg (2016) found that students in humanities and art and design were most likely to have MHPs, whilst students in nursing, business, and public health were least likely. Margrove, Gustowska, and Grove (2014) surveyed staff in the Health and Social Care Schools of two UK universities, and found that staff in this faculty were more likely to be aware of MHPs than staff in other faculties due to the nature of the subjects taught, but whilst a large proportion provided mental health support to students (63%), most (>70%) were not trained to do so. Margrove et al. (2014) emphasise that staff should be trained in distinguishing MHPs from the 'usual trials and tribulations of being a student' (p. 101), and that the support required by students experiencing MHPs is different from the support required for these usual stresses.

The impact of subject area on academic staff's mental health awareness and support skills is similarly highlighted by Gulliver, Farrer, Bennett, and Griffiths (2017), who found that academics from health and behavioural science disciplines in one Australian university were more likely to demonstrate higher depression literacy. Academics with higher depression literacy were more likely to be approached by students with MHPs, potentially because students perceived these staff to have greater understanding of MHPs, and because these staff felt more able to respond to students experiencing MHPs. In a comparative study by Laws and Fielder (2012) within one Australian university, none of the interviewees from the School of Commerce had mental health literacy skills, whereas interviewees from the Nursing and Midwifery School had this as part of their teaching role. However, even staff with a degree in Mental Health felt that assessing students with MHPs was outside their role as a lecturer. Another challenge for academics in health and care disciplines is raised by Hughes and Byrom (2019), who found in semi-structured interviews with academics on healthcare programmes in the UK that supporting students with MHPs had to be balanced with their duty to protect patients in professional practice. These studies indicate that different cultures around mental health may develop within different subject areas. This

could affect the likelihood of students developing problems, students' willingness to disclose problems, and responses from academic staff.

Student MHPs in different types of university

Within the UK, as in many other countries, there are different groups of universities (Filipakou et al., 2012). In particular, there is a major separation between 'old' and 'new' universities, with the latter awarded university status through the Further and Higher Education Act 1992, hence named post-1992 institutions. This divide has traditionally been associated with 'high' and 'low' institutional status, although this is increasingly challenged, particularly in relation to teaching and undergraduate student experience, with Boliver (2015) finding that 'old' and 'new' universities have similar levels of teaching quality. Pre-1992 universities tend to be more research active and have more academically successful and socio-economically advantaged student intakes, compared to post-1992 institutions (Boliver, 2015), which tend to have a higher proportion of 'non-traditional' students, in terms of class, maturity, and ethnicity (Anders, 2012). Also within the pre-1992 institutions are the 'Russell Group', who promote themselves as 'leading', 'research-intensive, world-class universities' (Russell Group, n.d.), and whose students are least likely to be from disadvantaged and other widening participation backgrounds (Barkat, 2019; Boliver, 2013).

The extent to which institutions are accessible for students from a range of backgrounds has a potential link to the prevalence of MHPs amongst students, as Turner, Hammond, Gilchrist, and Barlow (2007) found that non-traditional students are more likely to experience MHPs, and these students may have more of the risk factors for MHPs, such as being from a lower socio-economic or minority ethnic group, family breakdown, diminished family support, and financial hardship (Royal College of Psychiatrists, 2011). This raises the question of whether there are differences in academics' perceptions of and experiences with MHPs amongst students in different types of institution.

Existing studies on academics' experiences of working with students with MHPs have generally been focused on one or two institutions/faculties, and particularly within health and care disciplines (such as Gulliver et al., 2017; Hughes & Byrom, 2019; Laws & Fielder, 2012; Margrove et al., 2014). These authors have acknowledged that their findings are likely to be specific to these staff and students. This means there is a gap in understanding any differences in academics' perspectives and experiences of student MHPs across the wider higher education sector. This study therefore sought to explore: how do academics in different types of institution and subject areas in the UK perceive MHPs amongst students, and how have they experienced working with students with MHPs? This is important, in order to potentially tailor the mental health support and training provided for academic staff in different types of institution and subject area, and enhance the university experience for students.

Methods

Design

An exploratory mixed methods study was undertaken to address these questions, employing a cross-sectional design in two phases – a predominantly quantitative first phase

(online survey), followed by a qualitative second phase (semi-structured interviews). This combination of methods is common in mixed methods studies (Bryman, 2006), and both have been used individually in previous studies on MHPs amongst students, for examples surveys were used by Margrove et al. (2014), Brockelman and Scheyett (2015), and Gulliver et al. (2017), and semi-structured interviews by Laws and Fielder (2012).

Combining qualitative and quantitative research enabled us to draw upon the strengths of both methods and offset their weaknesses, and gain a more comprehensive understanding of the area of enquiry (Bryman, 2006; Greene, Caracelli, & Graham, 1989). Specifically, an online survey enabled us to reach academics across the UK in order to compare types of institution and subject areas, but the data lacked detail about people's personal experiences of working with students with MHPs. The time intensity of conducting and analysing semi-structured interviews meant our sample was small, but this approach enabled us to gain rich, in-depth data and detailed understanding of participants' personal experiences (Johnson & Onwuegbuzie, 2004). Conducting the interviews after the quantitative data collection and analysis meant that this phase of the study could be used to clarify and validate the quantitative results (Johnson, Onwuegbuzie, & Turner, 2007).

Procedure

Ethical approval was obtained prior to the start of the study from the first author's university ethics committee. An information sheet was provided on the online survey access page, where respondents were advised that participation was voluntary, that their responses would be anonymous and kept confidential, and that they had the right to withdraw prior to submitting their survey form. Implied consent to participate was taken if the survey was submitted. Respondents were asked to separately submit their contact details at the end of the survey if they would be willing to participate in a follow up interview. Potential interview participants were contacted via email and provided with an information sheet, which included guarantees of anonymity and confidentiality, and that their data could be withdrawn up until two weeks after the interview had taken place. Confirmation of participants' informed consent was audio recorded before the start of the interview.

All 135 universities whose Vice-Chancellors belonged to Universities UK when the study commenced ('Our members', n.d.) were invited to take part, as this membership body provided the most comprehensive accessible list of UK universities. An email address for an individual or team with responsibility for internal/corporate communication was obtained from each university's website, and an email was sent with details of the study and the survey invitation, requesting that this could be forwarded to academic staff. Reminders were sent after two weeks if no response was received. The survey invitation was sent out by the participating institutions to academic staff via channels including the staff intranet, e-newsletters, e-bulletins, Twitter feeds, and weekly emails.

Measures

The survey was developed for the project, based on the literature and sector reports, with two main sections to address the research questions; firstly, academics' perceptions of MHPs, and signs of MHPs, amongst students, and secondly, academics' experiences and practices in supporting students with MHPs. We adapted measures from studies in

the literature where suitable measures existed, as using previously tested measures strengthened the validity of the survey (Bryman, 2015). For the first section, questions on the signs and prevalence of MHPs amongst students were adapted from the National Union of Students (NUS) Mental Distress Survey (Kerr, 2013) (these were self-report questions in the NUS survey, and we adapted these to instead ask for academics' perceptions of MHPs amongst their students). For the second section, measures were developed based on the study by Laws and Fielder (2012) and the Student Mental Health in Higher Education: Good Practice Guide (Universities UK, 2015), for example in asking academics about their own emotions and practices when working with students with MHPs. Respondents were asked what type of institution (Russell Group, other post-1992, or pre-1992), and subject area they currently worked in, so that the data analysis could explore whether there was any correlation between these (independent) variables and the other (dependent) variables in the study, such as academics' perceptions of MHPs amongst their students and practices when working with students with MHPs.

We provided an operational definition of MHPs at the start of the survey, due to multiple terms in the literature and in common use, as 'mental health problems range from the worries we all experience as part of everyday life to serious long-term conditions' (Mental Health Foundation, 2015). We did not refer specifically to undergraduate or postgraduate students in the questions, in order to encompass academics' experiences at all levels. Free text boxes were included to enable participants to expand on their responses, which provided qualitative data in addition to the quantitative data from the rest of the survey. We pre-tested the survey with six academic staff in teaching and supervisory roles before undertaking the full study, to ensure the face validity of the survey in measuring the concepts of interest in the study (Bryman, 2015).

A semi-structured interview schedule was developed based on the survey findings, in order to explore key issues in greater depth. Using an interview schedule ensured that the topics of interest were covered in each interview (Newby, 2010) and enhanced the reliability of the study by facilitating consistency in, and future replication of, the data collection process (LeCompte & Goez, 1982). At the same time, the semi-structured approach retained enough flexibility for the interviewer to clarify answers, ask follow-up questions, and explore issues as they arose (Newby, 2010). This was important for the interpretive validity of the study (Maxwell, 2002), in order to ensure that inferences made from both the survey and interview data reflected participants' actual experiences of working with students with MHPs.

Participants

Of the 135 institutions contacted, four declined to promote the study to their academic staff, 104 did not respond, and 27 agreed. The eligibility criteria for participants was that they were academic staff with teaching/supervision responsibilities, and this was confirmed at the start of the survey. There were 130 responses to the survey.

Interview participants were purposively selected from the pool of survey respondents who provided their details to include academics from different types of institution and subject areas. Eleven semi-structured interviews (six women and five men) were conducted via Skype or telephone, due to the geographical spread of participants. Although attempts were made to obtain a stratified sample of interviewees from Russell Group,

Table 1. Characteristics of achieved samples.

Type of institution	Survey	Interviews
Russell Group	38	1
Other pre-1992	34	4
Post-1992	58	6
	130	11
<i>Subject</i>		
Arts and humanities (A&H)	28	4
Business and law (B&L)	22	1
Engineering, technology and natural sciences (ET&NS)	22	3
Medical and health sciences (M&HS)	16	2
Social sciences (SS)	42	1
	130	11

pre-1992, and post-1992 institutions, the final sample was determined by the availability of respondents (shown in Table 1).

Analyses

The survey data were quantified where possible and analysed using SPSS version 24. For example, some categorical variables were quantified by creating a total score of numbers, which enabled frequencies and descriptive statistics to be calculated, and non-parametric tests to be conducted. Likert scales were considered continuous variables for which means and standard deviations could be calculated, and parametric tests could be conducted. The quantitative data were analysed according to type of institution and subject area, and these variables were also considered in the qualitative data analysis.

Thematic analysis was used in analysing the qualitative data, as this enabled the identification of patterns in the data in relation to participants' perspectives and experiences (Clarke & Braun, 2017) in working with students with MHPs. The free text survey comments and interview transcripts were input into NVivo 11, to facilitate this analysis, following the process outlined by Braun and Clarke (2006): 1. Data familiarisation; 2. Coding data to deductively and inductively defined codes; 3. Collating codes into potential themes and sub-themes; 4. Reviewing themes in relation to the coded extracts and entire data set; 5. Defining and naming themes. The research team worked independently to code the data, and then met to discuss and agree on the themes and sub-themes. A combination of deductive and inductive approaches to the coding was undertaken, with some codes based on the quantitative survey findings, and others developed from the qualitative data itself (detailed in Table 2).

The quantitative survey results and qualitative survey and interview results are presented below, with illustrative quotes from survey respondents (SR) and interview participants (P1, etc.) from different types of institution and subject area, to highlight the views from across these groups.

Quantitative results

The quantitative analysis was undertaken to explore how academic staff perceived MHPs amongst students, and how they had experienced working with students with MHPs. The findings firstly illustrate the widespread prevalence of MHPs amongst students, perceived

Table 2. Coding scheme for qualitative data.

Theme	Sub-themes
<i>Prevalence of MHPs amongst students</i>	<i>Widespread prevalence of MHPs amongst students</i> Prevalence of depression and anxiety Distinguishing between MHPs and normal emotions
<i>Role of academics in supporting students with MHPs</i>	Providing general support for students experiencing academic or personal difficulties Unqualified to provide specialist mental health support Unclear boundaries between the role of academics and student services in supporting students
<i>Difficulties in supporting students with MHPs</i>	<i>Lack of institutional training</i> <i>Dealing with challenging student behaviour</i> <i>Impact on wider academic role</i> <i>Impact on staff own wellbeing</i> Lack of disclosure from students

Note: Deductively derived codes in italic font, inductively derived codes in normal font.

by academics in all types of institution and subject area. Secondly, the findings reveal tensions in the willingness of staff to support students with MHPs, versus difficulties in doing so.

Widespread prevalence of MHPs

Nearly all staff responding to the survey had encountered MHPs amongst their students (96%), and this was true across each type of institution: Russell Group – 92% (35 out of 38 respondents), other pre-1992 – 97% (33 out of 34), and post-1992 – 98% (57 out of 58). The most common signs of MHPs that respondents perceived were anxiety, stress, and depressed feeling (all noted by over 90% of respondents). Over half of respondents had worked with students who they perceived had thoughts of self-harm/suicidal thoughts. **Table 3** presents full details of the signs of MHPs perceived by respondents in each type of institution.

A one-way ANOVA showed that there were no significant differences in the total number of signs of MHPs noted by respondents from Russell Group ($M = 9.39$, $SD =$

Table 3. MHPs perceived amongst students.

MHP	Total	Russell group (N = 36)	Pre-1992 (N = 33)	Post-1992 (N = 57)	Pearson Chi square	df	p
Anxiety	96%	92%	94%	100%	4.534	2	0.10
Stress	94%	94%	91%	95%	0.568	2	0.75
Depressed feeling	93%	94%	88%	95%	1.673	2	0.43
Feeling unhappy/down	83%	86%	79%	83%	0.641	2	0.73
Lack of energy/motivation	80%	83%	88%	74%	2.967	2	0.23
Panic	71%	75%	79%	63%	2.925	2	0.23
Feelings of hopelessness/worthlessness	65%	64%	70%	63%	0.425	2	0.81
Insomnia/Trouble sleeping	63%	64%	61%	63%	0.089	2	0.96
Suicidal thoughts	54%	53%	42%	61%	3.059	2	0.22
Thoughts of self-harm	53%	58%	42%	56%	2.118	2	0.35
Irritability or anger	52%	39%	58%	58%	3.679	2	0.16
Hypersensitivity to others	50%	36%	58%	54%	3.974	2	0.14
Paranoia	38%	31%	33%	46%	2.551	2	0.28
Sudden mood changes	38%	28%	42%	42%	2.276	2	0.32
Numbness/lack of emotion	29%	31%	33%	26%	0.531	2	0.77
Other	12%	11%	12%	12%	0.031	2	0.99

4.02, $N = 36$), other pre-1992 ($M = 9.70$, $SD = 3.76$, $N = 33$), or post-1992 institutions ($M = 9.91$, $SD = 4.06$, $N = 57$), ($F(2, 123) = 0.19$, $p = .83$, $\eta p^2 = .003$). Pairwise comparisons confirmed the absence of significant effects and meaningful effect sizes (all $p > .80$, d ranging from 0.05 to 0.13). Fear for the safety of students with MHPs was also consistent across types of institutions (noted by 71% of respondents). This high incidence of perceived signs of MHPs contrasts with the studies by Brockelman and Scheyett (2015) and Macaskill (2013), where academics lacked awareness of MHPs amongst their students.

A two-factor ANOVA was run to test possible differences in the number of signs of MHPs reported, and fear for the safety of students perceived to have MHPs, and no main effect of subject area was found ($F(4) = 1.23$, $p = .30$, $\eta p^2 = .04$). This contrasts with the studies by Lipson et al. (2016), who found higher rates of MHPs amongst students in humanities and art and design, and Margrove et al. (2014) who proposed there is higher awareness of student MHPs in health and social care faculties.

Willingness to support students with MHPs versus difficulties in doing so

Most respondents were comfortable working with students with MHPs (mean response 2.14, where 1 = strongly agree and 5 = strongly disagree) and discussing students' MHPs with them ($M = 2.07$). However, only 31% of respondents agreed that their current institution had adequately prepared them for working with students with MHPs, and over half (56%) had not received training in working with students with MHPs. Of those respondents who had not received training (64 people), 56% would attend training if it was offered and 38% would maybe attend training. There were no significant differences in the above according to respondents' type of institution or subject area (all p n.s. after correcting for multiple comparisons). The overall level of training received by academic staff is higher than what was found by Margrove et al. (2014), where 71.4% of respondents in two UK universities reported never having attended any mental health training, but is still inadequate considering that the study indicates most (if not all) academics will work with students with MHPs.

Many staff had experienced difficulties in working with students with MHPs. Half of respondents (51%) had encountered disruption to other students, just under half had experienced inappropriate communication (45%) and behaviour (42%), and 38% had experienced unreasonable complaints. A smaller number had experienced threatening behaviour (16%). This echoes the study by Laws and Fielder (2012), where academic staff reported troublesome behaviour from students with MHPs. There were no significant differences in the number of problems experienced according to participants' type of institution or subject area (all $p > .058$).

Supporting students with MHPs impacted academics' wider roles and potentially their own mental health. Respondents disagreed that they had sufficient time to support students with MHPs (mean response 3.54, where 1 = strongly agree and 5 = strongly disagree) and agreed that they were supporting students with MHPs when they should be doing other work-related activities ($M = 2.47$). Many respondents found themselves worrying about students who they believed to have MHPs, outside of their contact time with these students ($M = 2.23$). The majority of respondents had felt distressed during or after contact with a student they believed to have MHPs ($M = 2.41$). This again supports Laws and Fielder (2012), who noted that supporting students with MHPs detracted from

academics' teaching and research work, and took an emotional toll on staff. There were no significant differences in any of the above according to type of institution or subject area (all $p > .112$), indicating that academics' lack of knowledge and skills in supporting students with MHPs is a sector-wide issue.

Qualitative results

The qualitative analysis sought to bring further insight into the key areas highlighted by the quantitative analysis, namely the prevalence of MHPs amongst students, and the difficulties in supporting students with MHPs.

Prevalence of depression and anxiety amongst students

Interview participants referred to a range of MHPs they perceived amongst their students, with varying degrees of severity, but participants across all types of institution and in different subject areas particularly noted the prevalence of depression and anxiety:

Anxiety and depression are the main ones, students worried about performing. (P11 – Russell Group, ET&NS)

The overwhelming issues that students are presenting with are varying degrees of depression and anxiety ... the big issue that's emerging is students diagnosed with social anxiety ... some students find it almost overwhelming to sit in a large lecture theatre. (P7 – other pre-1992, A&H)

Students with depression and anxiety is the most common ... we have a lot of mature students ... quite a few of them have already been diagnosed ... for the younger ones, the change when they get to university is often the trigger. (P9 – post-1992, M&HS)

The increasing prevalence of depression and anxiety has been noted by Cooper, Downing, and Brownell (2018) and Lipson et al. (2016) amongst students in US universities, and the findings here indicate that this issue is also common within the UK.

Comments in the survey and from interview participants noted the need to differentiate between MHPs and normal emotions:

There is a difference between stress and mental health problems that needs to be relayed to both staff and students. (SR – Russell Group, ET&NS)

Everyone gets anxious ... this is different to a clinical diagnosis of anxiety. (P2 – other pre-1992, ET&NS)

I don't think there's been enough discussion about what are normal levels of anxiety, especially when you're new to a place ... rather than seeing anxiety as meaning you don't have to do things. (P8 – post-1992, A&H)

Helping students to recognise these as the “normal” psychological demands associated with higher education' (Wynaden et al., 2013), and deal with them appropriately, was seen by respondents as part of the university's role in supporting students. This raises an issue though around who should determine whether students are experiencing 'normal' or 'clinical' anxiety (or other problems) – Margrove et al. (2014), for example, propose that university staff should receive training in order to distinguish between

MHPs and everyday stresses. Respondents in the current study were not confident in making these distinctions, however. This indicates the onus is generally on students themselves to recognise when they need professional help, which may not be realistic, and/or on mental health professional staff in universities, who are often over-subscribed and have long wait times.

Unclear role boundaries

Respondents from all types of institution were willing to provide general support to students:

I am happy to talk with students, be with them during difficult times, and sort out practical problems. (SR – Russell Group, ET&NS)

I tend to call them in and have a conversation with them and monitor them for the duration of the academic year ... I think increasingly the university presents itself as having a duty of care which previously perhaps it didn't. (P7 – other pre-1992, A&H)

I like to provide time and space for my students where they feel secure to share difficulties, including those related to mental health. (SR – post-1992, A&H)

However, there was little agreement or guidance available on what an academic's role should be in supporting students with MHPs:

I am not a medical doctor or a social worker or a carer, it is not my job to support people with mental health issues. (SR – Russell Group, A&H)

Students and staff do not know where to find help which is why some academics become very involved with supporting individuals. (SR – other-pre-1992, SS)

[Support for students with MHPs in the institution] ranges from one lecturer happy for students to send her texts every hour throughout the night ... acting more like the Samaritans, to one saying 'I'm not trained, I'm not a professional, I'm not qualified, but I'll do what I can' ... to another one who will really not engage at all. (P6 – post-1992, A&H)

This indicates that students with MHPs are likely to have inconsistent experiences and support depending on the staff they interact with. This is particularly concerning as variable experiences with staff can lead to potential feelings of discrimination or disadvantage by students with MHPs (Martin, 2010).

Dealing with students with MHPs could have a negative impact on academic staff:

It is a terrifying feeling responsible for a suicidal student and worrying if you have given the right advice ... it is also incredibly time consuming and disruptive to work. (SR – other pre-1992, M&HS)

If you're dealing with students who are experiencing paranoia or depression, then managing that student in the classroom ... is going to have an impact on your own mental health and sense of wellbeing and confidence. (P1 – post-1992, SS)

This supports the studies by Huyton (2009) and Laws and Fielder (2012), who found that supporting students with MHPs was time-consuming and stressful for academics, exacerbated by lack of training and support for staff to develop their skills in supporting students with MHPs.

Discussion

Previous studies on academics' perspectives of working with students with MHPs have tended to focus on one or two universities/faculties, and lack insight into the wider higher education sector. We have sought to address this gap by exploring academics' perceptions and experiences of MHPs amongst students across different types of institution and subject areas in the UK, and our study makes two key contributions. Firstly, we found that there is a widespread prevalence of MHPs amongst students across the sector, with academics in Russell Group, other pre-1992, and post-1992 institutions, across five broad subject groupings, all reporting a range of MHPs amongst their students. The lower number of 'non-traditional' students in Russell Group and other pre-1992 institutions therefore does not mean a lower incidence of MHPs amongst their students. Although there has been particular focus in the literature on MHPs amongst students in health and care subjects (for example, McKerrow et al., 2020; Mousa et al., 2016), MHPs amongst students are common across all subject areas. This finding also indicates that, contrary to the studies by Brockelman and Scheyett (2015) and Macaskill (2013), academics have high awareness of the signs and symptoms of MHPs amongst their students.

Secondly, although academics' awareness of MHPs amongst students appears high, preparedness to support students with MHPs is low. Academics' concerns about their role and responsibilities in supporting students with MHPs have been reported in previous studies, particularly in health and care subject areas (such as Hughes & Byrom, 2019; Laws & Fielder, 2012) but our findings evidence that this is a common issues across all types of institutions and subject areas. There is a conflict between academics' general willingness to work with and talk to students about MHPs, versus a lack of information, time, and skills to do so. Academics are generally not trained in making assessments about mental health, and even those who are trained are not expected to do this in their academic role. This indicates then that concerns about a student's mental health should be referred onto specialist mental health services. In reality though, students' preference to talk to someone that they know and trust, alongside long wait times for mental health support services inside and outside university, often places academic staff on the front line in dealing with student MHPs.

In light of this, we recommend that all academic staff should have compulsory basic training in mental health, in order to be prepared to deal with crisis situations and provide a limited amount of support, either alongside, or whilst students wait, for professional help. The Mental Health First Aid (MFHA) programme has been adopted by some institutions in order to build staff capacity in this way – the training is delivered as a 12 h course, including lectures, group activities, role playing, and videos, which aims to give participants the knowledge and skills to identify and support a person in a mental health crisis (Massey, Brooks, & Burrow, 2014). Massey et al. (2014) found that student affairs staff at a Canadian university increased their knowledge, sensitivity, and confidence on issues of mental health after completing the programme, and Ashoorian et al. (2019) found that it gave staff and students at an Australian university confidence to help someone in need, with 65% of people who had completed the training having applied their skills. Currently mental health training in universities tends to be optional, and so individuals with an interest in mental health are generally the ones who take this up (DiPlacito-DeRango, 2016). Therefore, making this training

compulsory for all academic staff would be one way to reach individuals with lower awareness of/interest in mental health, and ensure that mental health support is provided more consistently to students. Further training could then be offered to staff at a local level as required, for example tailored around particular MHPs common in certain cohorts of students.

Adopting this approach to training requires universities to recognise that it is often academic staff that students will turn to for initial and ongoing support, as these are the staff with whom they have most contact with and feel they can trust. Further to this, universities should also ensure that there is access available to mental health support services for academics themselves, acknowledging the impact that supporting students can have on academics' own mental health.

Limitations and future research

The limited number of respondents and self-selecting nature of the survey makes it likely that respondents already had some interest in student mental health, as noted by Gulliver et al. (2017). This is supported by the interview data, as many participants discussed their own experiences with MHPs (either personally or family/friends), whereas other academics may have less awareness of and experience with student MHPs. Reaching potentially less engaged staff would give a more comprehensive understanding of academics' perceptions and experiences of student MHPs in future research. This study sought the views of academics with any teaching/supervision responsibilities, whereas a targeted study focused on academics working with particular student demographics could provide greater insight into the MHPs common to different groups. For example, Waight and Giordano (2018) note particular concerns about the mental health of doctoral students, and the need for further research into support for this group.

The low response rate from institutions and academics means that this is not a representative sample of academics in UK universities, and so the findings cannot be generalised to all UK universities. The findings do indicate though that all types of university face the same issues around student mental health. Therefore, future research conducted in any type of institution is likely to have implications across the sector. Common to most existing studies on student MHPs, this study focused on one national context. However, concerns about student mental health and the role of academic staff in supporting students with MHPs have been raised across the world. Our findings build upon those from studies conducted in particular institutions and faculties in countries such as the US, Canada, and Australia, and offer insight into these issues for the higher education sector internationally. Overall, this study has emphasised that no institution can afford to be complacent about student mental health, and that academics will be a key part of the 'whole-university approach' to student mental health and wellbeing recommended by Thorley (2017). All universities should therefore make academic staff an integral part of any strategy for enhancing student mental health.

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