Mental Health Wellbeing at University: Student Survey exploring mental health wellbeing and access to support in UK Universities.

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Study Title:	Mental Health Wellbeing at University: Student Survey exploring mental health wellbeing and access to support in UK Universities.	
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Contents

Study Title	Mental Health Wellbeing at University: Student Survey exploring mental health wellbeing and access to support in UK Universities.	
Internal ref. no. / short title	Student Mental Health Wellbeing Survey	
Study Design	Longitudinal self-report questionnaire	
Study Participants	Undergraduate and post graduate students at participating Higher Education institutions.	
Planned Sample Size	Up to 5,000 per annum	
Planned Study Period	Project: February 2020 – December 2026 Per Participant: approx. 15 minutes	
	Objectives	**Measures**
Primary	This study aims to explore the reasons behind undergraduate and postgraduate student's difficulties with mental health across the years of their study to allow for greater understanding of difficulties and protective factors to inform targeted approaches.	
Secondary	To test whether access to student wellbeing services and usage of mental health resources and mental health information are associated with loneliness and perceived social support, wellbeing, and their experience and satisfaction.	The Short Loneliness Scale (Hughes, Waite, Hawkley & Cacioppo, 2004) Multidimensional Scale of Perceived Social support (MSPSS) (Zimet, Dahlem, Zimet & Farley, 1988) Patient experience and satisfaction (PEQ, IAPT) The 7-item Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS, Stewart Brown et al., 2009). Patient Health Questionnaire (PHQ-9, Kroenke et al., 2001) Generalised Anxiety Disorder Assessment (GAD-7, Spitzer et al., 2006)

1 Abstract

There has been a marked increase of 12-20% in the rates of students experiencing mental health conditions reported over the past few years (NUS, 2013; Unite, 2016). According to a 2012 report student mental health rates in that year equalled that of general population (Macaskill, 2012).

Aim: This study aims to explore the reasons behind undergraduate and postgraduate student's difficulties with mental health across the years of their study to allow for greater understanding of difficulties and protective factors to inform targeted approaches.

Methods/ Design: An online questionnaire survey will be distributed to undergraduate and post graduate students at participating Higher Education institutions every year for 5 years. We aim to recruit up to 5,000 students to the study across academic institutions in the UK. The survey will generate both quantitative and qualitative in regards to demographic information of the sample as well as access to student wellbeing services and usage of mental health resources, mental health information, association of this with loneliness and perceived social support, and their experience and satisfaction with university wellbeing services in supporting their mental health wellbeing.

Results: The findings will inform current initiatives and identify key themes for prioritising in further developing robust approaches to support student mental health wellbeing.

Keywords: students, mental health, wellbeing

2 Background

2.1 University transition

Starting university can be a rewarding yet stressful time for young people both in the United Kingdom and globally (Broglia, Millings, & Barkham, 2017; Guney, Kalafat, Boyson, 2010; Macaskill, 2018; Stallman, 2008). High rates of student mental health have been reported over the past few years (Thorley 2017). Alongside starting university at a vulnerable age, the transitions and stressors associated with this exacerbate high risks for mental illness, increased distress, and low wellbeing in this population (Brown, 2016; Kessler, Berglund,

Demler, Jin, Merikangas & Walters, 2005; Neves & Hillman, 2018; Unite, 2016). Furthermore cuts to funding and support services offered to students makes it is critical to understand mental health within this population.

2.2 ***Prevalence***

A large proportion of research has focused on the mental health of undergraduates especially first year students (Denovan & Macaskill, 2013, 2017; Thorley, 2017). However, a study by Macaskill (2012) showed that anxiety levels stayed consistent in first year but peaked in second year, and were significantly higher in third year compared to first year. Similarly, problems reported by second years differed to those reported by first year students, relating to transition to university including homesickness, living independently, teaching styles, and communal living (Denovan & Macaskill, 2013). In contrast, for final year students being closer to the end of their degree brought about uncertainty about future careers and accommodation with a greater risk of social isolation (Ibrahim, Kelly, & Glazebrook, 2013). This was echoed by Pereira, Reay, Bottell, Walker & Dzikiti, Platt & Goodrham (2018) that found students transitioning into their second and third years of study reported highest rates of anxiety, loneliness, substance use, and thoughts of self-harm.

Regarding sexual orientation, prevalence of mental health among the LGBT student population has been reported by Smithies & Byrom, n.d., and Gooch & Bachmann (2018). Whereas levels of mental health in the LGBT general UK population are high (King et al., 2008; Semlyen, King, Varney & Hagger-Johnson, 2016; Weeks, 2017) within the student population, the LGBT levels are also indicated to be high according to the Government Equalities Office (2018). Therefore, it is not unexpected that LGBT student mental health rates would also be on the increase. Moreover, several survey studies investigating LGBT student populations have reported that a large number of individuals have experienced bullying and harassment for how they identify (NUS, 2014). According to Gooch & Bachmann (2018) around a third have related not feeling confident to report these incidents. This can have a significant impact on an individual's mental health (Smithies & Byrom, n.d.) therefore it is important to understand the experiences of students who identify as LGBT.

Although there appears to be vast research into the prevalence of student mental health in higher education, arguably robust data is limited with sources often failing to appropriately define terminology (Brown, 2016). Additionally, source data usually relies on self-reported

measures meaning that responses given may be more socially desirable due to the stigma associated with mental health difficulties. Finally, as most prevalence research is based on surveys that people choose to take part in, there may be a bias in the samples of students that respond (Smithies & Byrom, n.d.). For example, women are more likely than men to respond and talk about mental health both in the student population (Wu, Kalibatseva, Leong, Bathje, Sung & Collins-Eaglin, 2017; Yousaf, Popet & Hunter, 2015) and the general public (Yousaf, Grunfeld & Hunter, 2015; Yousaf, Popet & Hunter, 2015) which means the reported rates could be underrepresented. Additionally, those with a keen interest in mental health may be more likely to respond than others (Smithies & Byrom, n.d.), thus questioning the generalisability of some reports.

2.3 Help seeking behaviours

2.3.1 Seeking support

Increased demand for support services in higher education has been argued to support the reported increase in student mental health rates (Brown, 2016). Accordingly, Thorley (2017) reported a 94% increase in higher education support service demand over the past five years. Additionally, a Freedom of Information (FOI) request by the Times (2016) demonstrated a 68% increase since 2011 in counselling use in the Russel Group Universities (Sandeman, 2016). Broglia, Millings and Barkham (2018) reported that a large number of students who get referred were for high-intensity support, which they argued suggested that their mental health was affecting their ability to cope.

However, despite this increase in demand for support services Macaskill (2012) reported that only 5.1% of those with mental health difficulties are receiving support. Additionally, in 2018 a student mental health report documented that 75.6% of students concealed their symptoms from others due to fear of stigma, with it being argued this percentage could be higher due to not taking account of those that did not respond to the survey (Pereira et al., 2019). Alongside funding and support service cuts (Royal College of Psychiatrists, 2011) stigma and fear of discrimination is one of the primary reasons reported for not disclosing mental health difficulties (Martin, 2010). It would be important to explore the reasons behind such large numbers of the student population concealing their difficulties and not accessing support, and what could be done to aid disclosure and engagement with services.

Seeking informal support (e.g. friends) was more popular than seeking formal (e.g. psychiatrist) support (Goodwin, Behan, Kelly, McCarthy, & Horgan, 2016). However, Davies, Wardlaw, Morriss & Glazebrook (2016) study found that students, especially those enrolled in topics with no mental health first aid content included, may not be fully equipped to support friends/housemates who are suffering from depression, and most do not assess risk.

2.3.2 Self-harm and Suicide risk

Research has suggested an increasing trend in the reports of thoughts of self-harm in the UK population (Public Health England, 2014). In comparison to their 2017 report, an increase of nearly two fold was reported in the student population experiencing thoughts of self-harm (Pereira et al., 2018). This is concerning as it can not only be significantly distressing for the individual, but also poses the risk to evolve towards suicidal attempts (Grandclerc, De Labrouhe, Spondenkiewicz, Lachal & Moro, 2016).

The Office of National Statistics (ONS; 2018) report that although the rate of suicide in the student population is lower (4.4 per 100,000) than that of the general population (11.6 per 100,000) it is still at an all-time high. In 2015 a staggering number of 134 students died as a result of suicide (Thorley, 2017). Suicide in a university setting is not only traumatic for the individual and their loved ones, but it can also have a significant impact on the student and staff community around them which may strain already under resourced university support services (Pereira et al., 2019). Substance use, loneliness and isolation, self-harm, and suicidal ideation are risk factors associated with suicide attempts and have been documented to be relatively high in the student population (Lamis & Malone, 2011; Lamis, Malone & Langhinrichsen-Rohling, 2012; Nightline, 2013; O'Neill et al., 2018; Pereira et al., 2019) making students high risk.

Most studies that look into the prevalence of self-harm and suicide often ask about thoughts more so than behaviours. However, this does not always result in the individual acting on the thoughts, with other factors at play that might increase the chance of acting on self-harm and suicidal thoughts (Hawton, Saunders & O'Connor, 2012; O'Connor, Rasmussen & Hawton, 2012). Mars, Heron, Klonsky, Moran, O'Connor, Tilling, Wilkinson, & Gunnell (2019) reported that they did not find self-harm to be a strong predictor of future suicide attempts, rather the association was only found when suicidal ideation was present.

2.4 Substance use

Within the culture of university, there is a high presence of substances, including both alcohol and illicit drugs with increased peer pressure for misuse (Scanlon, Rowling & Weber, 2010). Research has suggested that students drink more now with increasing emphasis on binge drinking than ever before (Carey, Scott-Sheldon, Carey & DeMartini, 2007; Davoren, Shiely, Byrne & Perry, 2015; Hebden, Lyons, Goodwin & McCreanor, 2015; McCabel, 2002; O'Malley & Johnston, 2002). Substance use can result in mental health difficulties; however it can also be a maladaptive way that people cope with mental health difficulties (Mental Health Foundation, 2006; NUS, 2018). Within the student population an alarming number of just fewer than 45% of students reported using drugs or alcohol to cope with problems in their life, with just under 10% reporting this was a regular occurrence (Pereira et al., 2019). Additionally a study by the NUS (2018) found that 56% of respondents had used substances, including both licit and illicit substances, with 31% doing so to help deal with stress and 22% to self-treat an existing mental health difficulty.

This high rate of substance use within the university environment is concerning because of association to increased risky behaviour including sexual behaviours (Khadr, et al., 2016), self-harm (Moller, Trait & Byrne, 2013; Pereria et al., 2019) and criminal activity (Bennett & Holloway, 2018), and declines in academic performance (El Ansari, Stock & Mills, 2013)

3 Methods/Design

3.1 Type of study

This study is a longitudinal quantitative online self-report survey. Quantitative data will be collected via the online Qualtrics XM platform yearly for 5 years. The survey link will be distributed to students via their respective university student offices or informally via social media. Qualitative data will be collected from a small number of optional open-ended questions within the survey that invite the participant to recount a recent encounter accessing support for their mental health wellbeing at campus.

3.2 Study Participants

The participants will be undergraduate or postgraduate students enrolled at Universities across the UK.

Inclusion criteria: All students enrolled at university in undergraduate years 1-6 and postgraduate students will be eligible. All full-time, part-time and distance learning postgraduate taught students are eligible to complete the survey (including but not limited to MA, MSc, PGCE, PGCert, PGDip courses, or credits at PGT level).

Exclusion criteria: Participants who do not consent to the study.

We aim to invite up to 5,000 students across UK universities during the study period.

3.3 Study Procedures

3.3.1 Recruitment and consent methods

Students will be invited to participate in the study via e-mails, online student newsletter sent by the university press office and student office of the participating institutions. Additional recruitment methods will include distribution of a flyers and posters using the communication platforms within the participating academic departments and NUS and notices on social media. Recruitment methods will include the distribution of a poster and flyer as well as email invites using University communication platforms within each institution.

Informed consent will be recorded as part of an electronically completed questionnaire. The participant must personally tick and date the latest approved version of the Informed Consent form before any study specific procedures are performed. To maintain confidentiality for participants the consent form will not include any personal information (signature or names).

The participant will be allowed as much time as wished to consider the information, and the opportunity to question the Investigator or other independent parties to decide whether they will participate in the study.

The survey will include a participant information sheet, detailing all the relevant information regarding the study as well as include a question on consenting to participate in the study right at the beginning.

Participants have the right to withdraw from participating in the survey before submitting it. Once a participant has submitted the completed survey, it would not be possible to withdraw their responses; as the survey would not include personal details, it would be impossible to identify which survey a certain individual has completed.

3.4 Questionnaire Design

The questionnaire is designed to be completed online using the Qualtrics XM platform, a cloud based survey development tool. The survey will assess the following:

Participant demographics, this section will ascertain participant characteristics such as age, gender, nationality, ethnicity, identification of sexuality, formal mental health diagnosis, level of education, employment status and accommodation. The core questions about mental health, access to mental health support, loneliness, wellbeing, and perceived support will utilise validated measures adapted for this survey. Participants will be allowed to omit questions they do not want to complete. Participants will be provided with their university student support contact details should they require support. The survey consists of 64 questions divided into six parts. Part A consists of demographic information with 18 questions in total. Part B, about your health consists of 29 questions including the Patient Health Questionnaire (PHQ-9, Kroenke et al., 2001) and Generalised Anxiety Disorder Assessment (GAD-7, Spitzer et al., 2006). Part C focuses on loneliness questions and consists of three questions. Part D, Perceived social support, utilises Zimet et al. (1988) validated questionnaire with 12 item statements. Part E will measure wellbeing using the validated 7-item Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS, Stewart Brown, 2009). Part F, experience and satisfaction asks participants to rate how satisfied they were in general with support they received when they contacted their well- being services. Part E, provides an incentive for students participating in the online survey. At the end of the survey students will have the option to enter into a prize draw by providing their email address in order to participate in a prize draw. The survey is anonymous and taking part in the draw will maintain anonymity. They will be a chance to win one of 10, twenty-pound Amazon vouchers.

The survey will take approximately 15 minutes to complete.

3.5 Primary & Secondary Outcome Measures

Primary measures:

Mental health problem as primary outcome measure, an attempt will be made to explain mental health problems in terms of demographic characteristics and also social support and loneliness.

Secondary measures

The following standardised measures will be used within the survey:

The Short Loneliness Scale (Hughes, Waite, Hawkley & Cacioppo, 2004*)*

The Loneliness Scale comprises three items loneliness scale and a simplified set of response categories which aims to measure how an individual feels about different aspects of their life. Items are rated on a three point Likert scale (1 being, Hardly ever; 2- Some of the Time and 3 –Often). Each individual's scores are summed, with higher scores indicative of greater levels of loneliness.

Multidimensional Scale of Perceived Social support (MSPSS) (Zimet, Dahlem, Zimet & Farley, 1988)

The MSPSS is a 12-item scale designed to measure perceptions of social support from three sources, namely, family, friends and a significant other. The scale comprises a total of 12 items with 4 items for each subscale. Items are rated on a 7-point Likert scale (1being very strongly disagree' and 7 being, very strongly agree (Zimet et al., 1988).

Short Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS) (Stewart Brown, 2009)

This shortened version of the original 14-item scale (WEMWBS; Tennant et al., 2007), consists of seven positively worded statements, scored according to a five point Likert scale from "none of the time" to "all of the time". The responses are summed to provide an overall score (between 7-35) reflecting the individual's state of mental well-being over the previous two weeks.

Patient experience questionnaire (PEQ, IAPT)

This has been adapted for use here to identify participant experience and satisfaction with support received at university.

Patient Health Questionnaire (PHQ-9, Kroenke et al., 2001)

This is a 9-item scale used to assess severity of depression as well as monitor responses to treatment (Kroenke et al., 2001). For this study, questions have been selected to assess suicidality and difficulties with sleep.

Generalised Anxiety Disorder Assessment (GAD-7, Spitzer et al., 2006)

This is a 7-item scale which screens for anxiety and assesses the severity. Each item is scored on a scale of 0 to 3, with 0 being 'not at all' and 3 being 'nearly every day'. Score cut-offs relating to severity of anxiety are 5 (mild), 10 (moderate), and 15 (severe).

4 Data Management & Analysis

4.1 Summary of the Types of Data

- Quantitative data will be generated from the completion of the semi-structured questions and validated measures adapted for use in this online survey. The data will be exported from Qualtrics XM platform into SPSS and STATA for analysis.

- A few open-ended questions in the questionnaire will generate qualitative data that will be used to generate themes.

4.2 Planned data analysis

- Descriptive statistics will be presented as either means (SD) or median (IQR) for continuous variables according to the distribution of data
- Parametric or non-parametric statistics will be chosen depending on the distribution of the data.
- Data will be analysed using one-way analysis of variance (ANOVA) and t-tests to assess associations between demographic characteristics and variables such as loneliness, perceived social support, self -harm etc. Where data is not normally distributed, non-parametric techniques (Kruskal-Wallis test and Mann-Whitney U-test) will be utilised.
- Chi-square or Fisher's exact test for categorical variables and any associations between demographic data and responses related to mental health wellbeing questions.
- Statistical significance is assumed at $p<0.05$.
- Pearson's correlation analysis to measure strength of linear relationship between variables.

- Multiple regression analysis will be carried out for continuous dependent variables with adjustment for appropriate confounders / covariates.
- Logistic regression analysis will be carried out for categorical dependent variables with adjustment for appropriate confounders / covariates.
- The statistical software packages SPSS and STATA will be used for graphical presentation and data analysis. Additionally statistical package R will be considered for graphical output if appropriate.
- Analysis will be carried out using listwise method; however if the extent of missing data is not acceptable multiple imputation would be employed.

Sample size

The sample size of up to 5000 across the course of the study will ensure the representation of the student groups is generalizable across the nation. Furthermore, post-hoc power analysis would be reported for main analysis of primary and secondary outcome variables.

4.3 Data collection

Dr Lizi Graves will be the data manager for the Qualtrics XM platform. Dr Peter Phiri will provide supervision and oversight.

Survey data will be collected using Qualtrics XM platform, an online cloud based platform. The data will be exported from Qualtrics XM platform straight to an SPSS file which will be used within SPSS and STATA for further analysis.

Qualitative data from the open-ended questions will be exported into Excel, Word and NVivo software for further analysis and generate emergent themes.

4.4 Potential bias

A potential bias in self-reported measures is that of social desirability which promotes over-reporting of socially appropriate responses and under-reporting of socially undesirable behaviours (Beebe et al., 2007). This will be mitigated by the design of the survey which is anonymous in nature. Any emergent themes generated from the qualitative questions will be supported by verbatim statements.

4.5 Data custodian and data ownership

Name of data custodian: Dr Peter Phiri

Name of data owner: Southern Health NHS Foundation Trust

4.6 ***Data quality and Standards***

All collection, storage, processing and disclosure of personal information will be performed in compliance with the Data Protection Act (2018).

All research will be carried out under the above standards and will be reviewed by:

Southern Health NHS Foundation Trust through the Sponsorship, feasibility and capability process and the Health Research Authority.

All members of the research team and any other individuals from collaborating Universities involved in collecting, inputting, processing, using and sharing data will have had Information Governance Training.

4.7 ***Data security***

No personal data will be collected. All data will be collected in a secure password protected Qualtrics XM online university platform, Access to systems is severely restricted to specific individuals, whose access is monitored and audited for compliance.

Data exported from Qualtrics XM platform will be anonymous, stored and managed in password protected files in a password protected computer. Only members of the research team will know the passwords and will therefore be able to access the electronic data. Study documentation will be archived in accordance with guidelines for Good Clinical Practice and in a NHS approved, secure and adequate archiving facility. Research personnel will keep information relevant to the study for up to 15 years, and then will be destroyed.

4.8 ***Data sharing***

Data will not be shared with anyone outside of the project team and organisations hosting the research. Research outputs and outcomes might be shared with the NIHR (Senior Investigator award) that is the funding organisation.

5 Project management

Dr Peter Phiri and Dr Elizabeth Graves will have overall responsibility for the co-ordination and management of the study. Their specific roles will include liaison between sites will be assisted by the Mental Health Research Delivery Lead from Southern Health NHS Foundation Trust.

Professor Lucy Yardley will be responsible for the recruitment within University of Southampton and analysis of data.

Dr Alyson Norman, MSc Clinical Programme Lead, Lecturer in Clinical and Health Psychology will be responsible for University of Plymouth site.

Dr Jen Thomas, Data Research and Insight Officer, and Dr Nils Swindell, Data and Insight Officer will be responsible for University of Swansea site.

6 Quality Assurance Procedures

The study may be monitored, or audited in accordance with the current approved protocol, GCP, relevant regulations and standard operating procedures. All researchers involved in the study will have up to date GCP training.

7 Ethical and regulatory considerations

7.1 ***Declaration of Helsinki***

The Investigator will ensure that this study is conducted in accordance with the principles of the Declaration of Helsinki.

7.2 ***Guidelines for Good Clinical Practice***

The Investigator will ensure that this study is conducted in accordance with relevant regulations and with Good Clinical Practice.

7.3 ***Reporting***

The CI shall submit once a year throughout the study or on request, an Annual Progress report to the REC Committee, host organisation and Sponsor. In addition, an End of Study notification and final report will be submitted to the same parties. The study findings will be disseminated to peer reviewed journals, conferences and to participant organisations so that implications and recommendations can be considered and inform ongoing engagement with student health wellbeing as well as future strategies.

Patient and Public Involvement

In designing this study, we have taken into account student and service user opinions on previous similar studies. Former students were consulted on the design of the questionnaire.

7.4 ***Participant Confidentiality***

The study staff will ensure that the participants' anonymity is maintained. No identifiable data will be collected. All documents will be stored securely and only accessible by study staff and authorised personnel. The study will comply with the Data Protection Act 2018. At the end of the survey students will have the option to enter into a prize draw by providing their email address in order to participate in a prize draw. The survey is anonymous and taking part in the draw will maintain anonymity.

Data will remain confidential and not be shared with anyone outside of the research team and will be stored securely as per the General Data Protection Regulation (GDPR) and the Data Protection Act (2018).

Personal email addresses collected for the purpose of entering in the prize draw will be downloaded electronically and stored completely separately from the questionnaire data, in a separate password protected excel spreadsheet. This will only be accessed for the purposes of contacting the prize draw winners. Once the prize draw has taken place, all email addresses will be destroyed.

7.5 ***Approvals***

The protocol, participant information sheet, questionnaires and any proposed advertising material will be submitted to an NHS Health Research Authority (HRA) for a favourable

opinion, and host institution for written approval. As the study will only include students it may then be eligible for proportionate review. The Investigator will submit and, where necessary, obtain approval from the above parties for all substantial amendments to the original approved documents.

7.6 Risk, burden, and benefits

Participants will be informed of their right to terminate their participation at any time without having to give a reason. The information sheet will suggest that in the event of any distress they should seek support through university student services or to contact their GP or NHS 111 services. The survey will take approximately 15 minutes; therefore this will be of minimum burden to participants. Access to online survey means that the participants will be able to complete the questionnaires in their own time without the added responsibility of returning their responses to the researcher. It is anticipated that by not having direct contact with the researcher and clear emphasis and reiteration that the survey is anonymous and no personal data will be collected, this will hopefully facilitate participants to provide open and honest responses to the survey questions.

Participants will be informed of the anonymity of their responses. This will be emphasised in order to reassure students that any information they give will not be shared within their institution.

Participants will be informed that the research will contribute to further understanding their experiences and access to support services at university in order for improvements to be suggested.

Peer review

This protocol has been reviewed internally by investigators at Southern Health NHS Foundation Trust and also been subjected to external independent reviews from Bournemouth University, University of Winchester and University of Plymouth.

This protocol has also been submitted for review to the Sothern Health NHS Foundation Trust R&D department.

8 Finance and Insurance

The study is funded by the NIHR Senior Investigator award (RCF).

Insurance
Southern Health NHS Foundation Trust has a specialist insurance policy in place which would operate in the event of any participant suffering harm as a result of their involvement in the research.

9 Project timetable

This project should be completed in 5 years

10 Publication Policy

The outcomes of the project will be written-up for submission to a peer-reviewed journal. Papers for presentation will be targeted at the annual meetings and conferences.

A summary of findings will be written up for participants distributed through the University communication platforms.

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