Written Evidence to the Joint Inquiry into Children and Young People's Mental Health

About University Alliance

University Alliance (UA) represents leading professional and technical universities across the UK. Our members specialise in working with industry and employers. Their teaching is hands-on and designed to prepare students for their careers. Their knowledge and research drive industry and the public services to innovate, thrive and meet challenges. Alliance universities are leading the way in innovation and business support in the green, tech, and healthcare industries. They are major educators in healthcare, engineering, the creative arts, social sciences, degree apprenticeships and more.

Our submission is structured around the inquiry's three themes, focusing on the specific questions where Alliance universities have direct evidence and experience to contribute.

Summary

Universities have a critical role to play in supporting the mental health and wellbeing of their students, and Alliance universities take that role extremely seriously. However, evidence from our members paints a consistent and concerning picture: universities are being asked to absorb the consequences of systemic failures in statutory health and care services, without the mandate, resources, or information needed to do so safely.

Across our membership, institutions are reporting sharply rising demand, complexity and crisis in student mental health. Students now routinely present with multiple, overlapping challenges—including trauma, neurodivergence, social isolation, financial stress and acute distress—while student expectations of university mental health provision have escalated beyond what non-clinical institutions can safely deliver.

These pressures are compounded by significant and increasingly dangerous gaps in statutory mental health provision. NHS crisis thresholds have risen; ambulance and crisis teams frequently do not attend serious incidents; students are discharged from hospital without any notification to their university; and the mobility inherent in student life means that young adults routinely lose their place on NHS waiting lists. All too often universities are treated as if they are responsible for clinical risk.

Our members are clear: universities have a crucial preventative and educational role, but they cannot replace NHS, social care or crisis services. Failures in statutory provision are driving unsustainable pressures on universities and exposing their students and staff to unacceptable risk. Current accountability arrangements focus almost exclusively on universities, despite statutory services holding clinical responsibility.

We urge the Committees to recommend three specific reforms:

1. A national template for NHS–university data sharing agreements, with a clear expectation that every Integrated Care Board engages with universities in its area.

2. Clear guidance to statutory services on the boundaries of the university role, and a coherent NHS student pathway that ensures students are not disenfranchised from health services by their transient status.
3. Support for universities to set clear, accountable, non-clinical baselines for what they will provide — not a statutory duty of care that would draw them into quasi-clinical territory.

These reforms are essential to create a safe, coherent and equitable mental health system for students in higher education.

Part 1: The Role of Education and Community Settings

> ***Inquiry question:*** *How effectively are education and community providers identifying and responding to children and young people's mental health needs?*

Rising complexity, not simply rising demand

The most important trend reported by UA members is not simply rising demand for mental health support, but rising complexity. Students are presenting with multiple overlapping issues rather than a single concern: clinical mental health conditions co-occurring with neurodivergence, trauma responses, financial hardship, social isolation, and substance use. Year-on-year increases in priority cases involving suicidal ideation and risk of self-harm were reported consistently across institutions and regions. For example, one member has seen a ninefold increase in student wellbeing appointments since the pandemic. At another UA member institution, the average duration of engagement within university mental health services has reached 37 days, with crisis referrals nearly doubling. Students are also frequently disclosing mental health difficulties very late, or not at all until they reach crisis point, which limits the university's ability to intervene early.

Schools are reporting the same patterns of rising complexity and demand, which means the pipeline of need flowing into universities will continue to grow with each cohort. The current pressures are not a one-off COVID effect; they represent a structural shift in the mental health profile of young people entering higher education.

The pathologising of normal emotional experience

Alongside genuine increases in clinical need, our members report a significant societal shift towards the pathologising of ordinary emotional distress. Clinical terminology – including language relating to self-harm and suicide – has entered everyday student vocabulary, sometimes without full understanding of its implications. As one member put it, where a previous generation might have said "I'm fed up," students now routinely say "I want to kill myself" – even where there is little apparent intent. The university then must respond to that language as though it were clinical, which consumes resources and creates risk.

The language of mental health is being used inconsistently across the sector, conflating clinical conditions, emotional distress, trauma responses and neurodivergence. This ambiguity complicates both the university's response and its relationship with statutory services.

It is important to note that some of the apparent rise in demand reflects better awareness and earlier help-seeking. The sector's decade-long messaging encouraging students to seek

support has surfaced need that previously went undetected. This is welcome, but it creates its own challenge: what happens when students leave the university's supportive environment and must navigate services independently? A strengths-based approach – equipping students with tools to understand and manage their own mental health – is essential to avoid creating a dependency that makes it more difficult for graduates when they enter a world that offers no equivalent support.

The expectations gap

The Student Academic Experience Survey, published in June 2025 by HEPI and Advance HE, found that 40 per cent of students believe universities should provide a comprehensive mental health service for all students, including for severe and complex cases. A roughly equal proportion (41 per cent) believe universities should provide preventative programmes and in-person counselling, but that more severe cases should be treated by the NHS. Students affected by the cost-of-living crisis, those reporting trans identity, and first-year students had even higher expectations of comprehensive university provision.

This data demonstrates that student expectations are running well ahead of what universities can safely or sustainably deliver. If universities are not explicit about what they will and will not provide, the gap between expectation and reality will generate dissatisfaction, complaint, and legal risk. This reinforces the case for clear baselines (Recommendation 3).

Students arriving unprepared

Alliance universities report a marked increase in students arriving without the social skills, resilience, or independence needed for university life. The COVID-19 pandemic remains a significant factor: today's first-year undergraduates were in their early teens during lockdown. Contributors described a generation shaped by economic instability, geopolitical anxiety, social media, and what one academic sociologist termed the "conditions of uncertainty" of a "poly-crisis" world. A rise in parental interference was noted, with universities managing expectations more commonly associated with school settings. The competitive higher education market may be compounding this, with institutions marketing the university experience more intensively than ever.

Growing numbers of students are arriving with ADHD and autism diagnoses but without adequate prior support. One Alliance university reported that it now advises students more cautiously about registering with a local GP, because doing so can mean losing a waiting list place for neurodiversity assessments that students may have waited years to secure.

Students most at risk

The evidence shows that students from disadvantaged backgrounds, international students, mature students, neurodiverse students, and LGBTQ+ students are all at a higher risk (House of Commons Library, April 2025). A KCL/TASO report (2025) found that LGBTQ+ students reported significantly worse mental health outcomes than the student population.

Alliance universities identified international students as a particularly vulnerable group, facing cultural barriers around mental health, geographic isolation, limited external support networks, visa constraints that restrict their options, and limited access to statutory services. The NCISH review (2025) confirmed that international students are at heightened risk.

Healthcare students — who make up a sizable proportion of Alliance university cohorts — face unique pressures, including intensive clinical placements, limited financial support, and

the emotional toll of frontline care, making them disproportionately vulnerable to mental health difficulties.

> ***Inquiry question:*** *What role should staff in universities play in supporting the mental health of children and young people, what support and training do they need?*

The university does not fix the broken leg; it ensures the student gets to the NHS. The same principle should apply to mental illness. Universities are educational institutions, not clinical services. Their role is to support students to succeed, thrive and flourish in their education. University wellbeing teams provide early identification, initial support, signposting, and preventative interventions. Where a student's needs exceed what the university can provide, the university's responsibility is to make that bridge – referring to the NHS or supporting a managed period of leave so that the student can get well and return to succeed.

The difficulty is that those boundaries are being steadily eroded. Universities are increasingly holding students with clinical-level needs within their services because statutory services will not engage. But the more universities step in, the more is expected, and the greater the risk that they will be blamed when things go wrong. As one UA senior leader explained, if a university says it will deliver something and then fails to deliver it, it will be held to account in court. If it is clear about what it will and will not do, and delivers on that commitment, it is on solid legal ground. The case of Feder & McCamish v Royal Welsh College of Music and Drama (2023) confirmed this principle: universities may owe a duty of care where they have assumed responsibility for providing support. This makes it essential that universities are clear and realistic about what they commit to.

What universities can and should do is invest in whole-institution approaches that are genuinely within their control. These include assessment design and timing, the physical and social environment, how communities are fostered, compassionate and joined-up communications with students, and how students are prepared for the transition both into and out of university. Much of this costs little or nothing; it is about culture, systems and consistency. The Higher Education Mental Health Implementation Taskforce's work on compassionate communication – ensuring, for example, that a student in crisis does not simultaneously receive an impersonal email from the finance department threatening eviction – is an example of the kind of practical, achievable improvement that makes a real difference.

> ***Inquiry question:*** *How do inspection and accountability frameworks such as the Office for Students support or hinder education settings in prioritising mental health provision?*

UA members have significant concerns about the OfS's future regulation of mental health and disability. The experience of the E6 conditions on harassment and sexual misconduct is instructive: imposing a new regulatory condition can help institutions secure internal resources, but it does not on its own drive the deeper cultural shifts required. It also risks compounding the problem by placing further obligations on universities while leaving the responsibilities of statutory services entirely unaddressed.

Our strong view is that government should not impose a new regulatory condition or a statutory duty of care for student mental health (Recommendation 3). What we support is a Statement of Expectations that sets clear, principle-based baselines for what universities should provide, using existing regulatory powers to hold institutions to account where

necessary rather than creating new ones. This is the approach being developed by the Higher Education Mental Health Implementation Taskforce: universities adopt an evidence-based whole-institution framework, demonstrate systematic delivery and monitoring, and are accountable — through their Vice-Chancellor and governing body — for the outcomes of what they do. If university services expand beyond these baselines into quasi-clinical territory, they risk triggering CQC oversight — a consequence the sector should be clear-eyed about. The goal should be realistic expectations, consistently met, not an ever-expanding mandate that universities cannot safely fulfil.

> ***Inquiry question:*** *What mental health support should be available through Young Futures Hubs, and how should these hubs connect with other local services?*

Young Futures Hubs have no defined relationship with universities. Government mental health strategy effectively stops at age 18: Mental Health Support Teams are designed for schools and colleges, not universities, and there is no equivalent community-based provision designed with university students in mind. The 18–25 age cohort in higher education has no policy home and students sit in "no man's land". Employees have employment-based duties of care, those not in education or employment may be visible to the NHS, but students fall between systems. If Young Futures Hubs are to serve this age group, their design must account for the transient status of students and establish referral pathways with local universities.

> ***Inquiry question:*** *What regional and local variability is there in provision of open-access mental health support across the country?*

UA members in different regions reported strikingly similar problems, suggesting that the failures described in this submission are systemic rather than local. However, the quality of engagement between universities and statutory services varies enormously depending on geography and local relationships. In large cities with multiple NHS trusts, universities may rarely speak to the same ward twice. Even within a single city, universities and NHS services may be unable to agree on a common risk classification framework, meaning that a student assessed as high-risk by the university may be evaluated as low-risk by the receiving NHS service – and the referral pathway collapses before it starts. A national template for data sharing and common referral protocols would help address this variability (Recommendation 1).

Part 2: The Role of NHS and Specialist Mental Health Services

> ***Inquiry question:*** *What reforms to CAMHS would best support timely, equitable and continued access to specialist mental health care for children and young people?*

The transition cliff-edge

The handover from school-based support and CAMHS into university is a recognised failure point. Students lose access to support upon arrival, often without any handover to the institution. Those who received EHCP-level support in school often arrive expecting the same provision, which universities cannot replicate. The Committees should consider

whether CAMHS reform should include a requirement for structured handover to university support services where a student with an active case transitions to higher education.

> ***Inquiry question:*** *What measures are needed to tackle increasing rates of children and young people deteriorating to the point of A&E attendance or acute admission?*
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> ***Inquiry question:*** *How can transitions from acute services back into community mental health services be improved?*

Rising crisis thresholds and unsafe discharge practices

Thresholds for emergency service attendance at student crisis situations have risen significantly. One Alliance university reported having to develop a specific policy for situations where ambulance crews will not attend. In some areas, police no longer respond to mental health crisis calls. Universities are managing students who may be psychotic, at risk of self-harm, or in acute distress, but who do not meet the threshold for a blue-light response. The university has no clinical authority and often no information about the student's history.

Students are also being discharged from hospital directly into halls of residence with no notification to the university. The first the institution hears is often from halls staff or fellow students. In one case shared with UA, a student discharged from a psychiatric section on a Monday arrived at university and needed re-sectioning within 12 hours; the university had no prior knowledge whatsoever. University accommodation is not a clinical care setting. One Alliance university has taken the stance that it will not accept a student being discharged unless the university is part of the discharge planning process. This should be standard practice (Recommendation 2).

Part 3: Integration Between Education, NHS and Community Provision

> ***Inquiry question:*** *What factors are driving recent trends in children and young people's mental health, and how have changes in service thresholds influenced the presentation of need and access to early support?*

The evidence from UA members points to a combination of interacting factors: the long-term legacy of COVID-19 on adolescent social development; economic instability and the cost-of-living crisis; geopolitical anxiety; the pervasive influence of social media; and a cultural shift towards pathologising normal emotional distress. The affordability crisis is a significant additional pressure. The proportion of full-time undergraduates working during term time has risen from 42 per cent in 2020 to 68 per cent in 2025 (HEPI/Advance HE), reducing opportunities for social connection, independent study, and access to campus-based support.

Crucially, the rising thresholds at which statutory services will engage have directly increased the burden on universities. When NHS services raise referral thresholds, students who would previously have been accepted for treatment are referred back to university support services. This transfers clinical risk to institutions that are not clinically equipped to

manage it. Universities are also absorbing expectations relating to social care, the cost of living, and the consequences of under-resourced police and emergency services.

> ***Inquiry question:*** *How effective are current referral pathways between education, community services and NHS services?*
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> ***Inquiry question:*** *How well do current pathways link to delivery of SEND services?*

Referral pathways between universities and statutory services are described by UA members as inconsistent, fragile, and dependent on individual relationships rather than systemic structures. Even where the will to collaborate exists, practical obstacles make it difficult. In one city, a government-funded initiative linking universities with regional mental health services was unable to reach agreement on a common risk classification framework between the two universities and the NHS. The programme produced little more than another referral pathway onto a different waiting list. This experience underlines a wider lesson: new policy initiatives in this area must be developed collaboratively with the institutions expected to deliver them. Interventions imposed from above will not succeed and risk wasting limited public resources.

The transition from SEND support in schools to higher education is an acute failure point. Students with EHCP-level support arrive expecting universities to replicate intensive provision. This expectations gap does not always relate directly to mental health, but the frustration and unmet need it creates frequently presents as a mental health concern — further blurring the boundaries that universities are trying to manage. GP re-registration can compound the problem, resulting in lost waiting list places for neurodiversity assessments (Recommendation 2).

> ***Inquiry question:*** *What practical barriers affect joint working between education settings, local authorities, NHS services and voluntary and community sector organisations?*

The data sharing gap

The most significant barrier is the absence of systematic data sharing. Universities are supporting students whose full clinical picture they cannot see. They may be managing students just below the threshold for detention under the Mental Health Act, receiving daily visits from a crisis team, with no knowledge of this clinical involvement. The NCISH review (2025) identified problems with information sharing and communication as a recurring theme in student suicide cases.

Bournemouth University's data sharing agreement with Dorset NHS, achieved after five years of negotiation, demonstrates what is possible but also why it cannot be left to individual institutions. Data sharing agreements must be developed locally because the NHS is not one organisation – GPs, hospitals, and mental health trusts are all governed differently. A single national agreement is therefore not structurally feasible. What government can do is provide a national template and set a clear expectation that ICBs engage with universities to establish local agreements (Recommendation 1). Data sharing should operate within appropriate consent frameworks, with students as active parties to agreements about their information. Where there is a risk of self-harm or harm to others, universities and NHS services should have the confidence to share information and act.

Teesside University, which does not yet have a formal data sharing agreement, has nonetheless invested significant time in building relationships with the local Mental Health Trust through regular joint case discussions and clear points of contact. As a result, university Mental Health Advisers are now invited to discharge planning and multidisciplinary meetings and can access timely information for students receiving clinical care. This has been pivotal in coordinating support at transition points. Formalising this partnership through an Information Sharing Agreement would establish clear arrangements for consent, safety planning, and escalation — creating a durable framework that can grow with demand.

> ***Inquiry question:*** *What role should ICBs and local authorities play in joining-up mental health support in health and education settings?*

Students are currently invisible in NHS planning processes. They are not included in local health needs assessments or public health strategies. The only policy lens through which they receive consideration is education regulation via the OfS. ICBs and local authorities should be required to include students in their health needs assessments. University students are residents and citizens of the areas in which they study; their health needs should be planned for accordingly (Recommendation 2).

> ***Inquiry question:*** *Is there sufficient alignment between the strategies and reviews of DHSC and DfE?*

There is a fundamental misalignment. Government mental health strategy effectively stops at age 18. The 18–25 age cohort in higher education falls between the DfE's oversight of universities and DHSC's oversight of NHS services, and neither department has taken clear ownership. The 10 Year Health Plan, SEND reform, the independent review into mental health conditions, ADHD and autism, and the National Youth Strategy should all explicitly address the needs of university students. As the Higher Education Mental Health Implementation Taskforce's discussions have emphasised, DHSC and DfE join-up is crucial (Recommendation 2). This lack of coordination between the two departments is not limited to mental health; in the workforce space, the DfE's withdrawal of funding for Level 7 apprenticeships directly contradicted NHS ambitions for advanced practice roles.

> ***Inquiry question:*** *How can accountability for outcomes be better shared across government?*

The accountability asymmetry

The current accountability framework is one-directional: universities are held to account by the OfS and the courts. The University of Bristol v Abrahart ruling established that institutions cannot rely on a lack of formal notification if the effects of a disability are reasonably apparent and must have systems in place to ensure staff observations and concerns are captured and acted upon consistently. NHS services face no consequences for declining to engage with students, raising referral thresholds, or discharging patients into university settings without notification. Accountability must be shared across the system, not loaded onto universities alone.

Recommendations

Recommendation 1: A national template for local data sharing

Government should develop a national template for data sharing agreements between universities and NHS mental health services and set a clear expectation that Integrated Care Boards engage with universities in their areas to establish local agreements. The template should include guidance on how agreements are to be operationalised at local level, including governance, designated points of contact, and mechanisms for review.

Any template must also recognise that many university students — particularly commuters, distance learners, and those in areas where ICB boundaries do not align with university catchments — may be registered with GPs or receiving care from NHS services outside the ICB in which the university is located. This reinforces the case for a nationally consistent template rather than purely local arrangements.

At present, there is no requirement for ICBs to engage with universities in any capacity — a gap that UA has also identified in the context of healthcare workforce planning. The structural diversity of the NHS – GPs, hospital trusts, mental health trusts, and community services are all governed differently – means that a single national agreement is not feasible. But a national template, combined with an expectation on ICBs, would provide the framework that individual institutions cannot reasonably be expected to negotiate alone. The Bournemouth–Dorset agreement and the Higher Education Mental Health Implementation Taskforce's work on NHS-HE partnerships offer practical models for how these agreements can work. Data sharing should operate within appropriate consent frameworks, with students as active parties to agreements about their information.

Recommendation 2: Clarify the respective responsibilities of universities and the NHS

Government should issue clear guidance to NHS trusts, local authorities and police setting out what universities are and what they can reasonably be expected to do. Universities are not clinical services, not extensions of social care, and not discharge destinations. The current practice of discharging students into university accommodation without notification, referring students back to universities instead of treating them, and declining to attend crisis situations on university premises must be explicitly addressed. Discharge protocols should require engagement with the receiving university as standard.

Students should be explicitly included within NHS planning and commissioning frameworks. ICBs and local authorities should account for student populations in their health needs assessments. The NHS should develop a coherent student pathway ensuring continuity of care across the period of study, so that GP re-registration does not result in lost waiting list places and students do not lose access to health services by their transient status. CAMHS reform should include a requirement for structured handover to university support services where a student with an active case transitions to higher education.

Government strategies – the 10 Year Health Plan, SEND reform, the independent review into mental health conditions, ADHD and autism, and the National Youth Strategy – should all explicitly address the 18–25 higher education cohort, which currently falls between the DfE's oversight of universities and DHSC's oversight of NHS services with no clear departmental ownership.

Recommendation 3: Support clear baselines, not a statutory duty of care

Government should support the approach being developed by the Higher Education Mental Health Implementation Taskforce: outcome-focused, evidence-based baselines for what universities will provide, subject to transparent governance and accountability. Under this model, each university adopts a whole-institution framework (choosing from available evidence-based models), demonstrates systematic delivery and monitoring, and is accountable – through its Vice-Chancellor and governing body – for the outcomes of what it does. The approach is analogous to health and safety: there are baseline expectations, institutions choose how to meet them, and they explain what they are doing and why.

A statutory duty of care would create unrealistic expectations, risk drawing universities into quasi-clinical provision, and expose them to regulatory frameworks designed for healthcare providers. The existing legal framework – including the Equality Act, health and safety duties, and the implications of the University of Bristol v Abrahart ruling – already establishes significant accountability. What is needed is for universities to implement these obligations consistently and transparently, not for a new layer of statutory duty to be added on top.

Within these baselines, universities should invest in the preventative, whole-institution approaches that represent their most valuable contribution: assessment design, community-building, compassionate communications, expectation-setting, and preparing students for independent life both during and after their studies. These align with the 10 Year Health Plan's focus on prevention and community care. Universities should also develop clear frameworks for managed leave and return, so that students whose health needs temporarily exceed what the university can provide are supported to step away, get well, and return to succeed. UWE Bristol's Coordinated Support Approach, in which the student, university services, academic teams and — where appropriate — a trusted contact jointly review a risk assessment and develop a clear support plan, offers a practical model for how these baselines can work in practice.

Conclusion

Alliance universities are deeply committed to the health and wellbeing of the students they serve. Every day, staff across our member institutions support students through difficult experiences – often going well beyond what universities are resourced or mandated to do.

But this commitment carries risk. The more universities step into the gaps left by statutory services, the more is expected of them, and the greater the likelihood that they will be held responsible for failures that properly belong elsewhere. The sector is caught in a dynamic where doing more creates the expectation to do even more, and where the consequences of not meeting those expanding expectations will fall on universities, not on the statutory services that have withdrawn.

We urge the Committees to use this inquiry to help break that cycle. What is needed is more clarity about what universities are and are not; the boundaries between educational support and clinical provision; the respective responsibilities of the education and health systems; and students' entitlements as citizens within the NHS. Accountability must be shared across the system, not loaded onto universities alone.

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Contact

For further information, please contact:

Susanna Kalitowski, Director of Policy, University Alliance
susanna@unialliance.ac.uk