

Transforming mental health in post-18 education: a place-based approach to care and wellbeing

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nous



Contents

What are HE and FE sectors doing to improve student mental health and wellbeing? 4

Post-18 education must coordinate, not become the NHS 6

Protect prevention from the pull of crisis 7

Build a system that follows the student 8

The future: A place-based approach 10

A: London network for mobile and international learners

B. A regional, West-Midlands ecosystem built around shared relationships

C. Inclusive support for diverse post-18 learners

The test is whether support survives change 14



Why we need to adopt a place-based approach to student mental health support

Responding to student mental health needs in post-18 education is as much a challenge of system design as of resource. Responsibility for a student in difficulty can depend on registration status, nationality or postcode. A student taking mental health leave may fall outside both university and NHS provision. An international student may be ineligible for the Disabled Students' Allowance. Someone judged too well for specialist care, but too unwell for university counselling, may be left to find a local charity - if one exists and has capacity. Non-traditional learners in further education (FE) colleges often experience heightened pressures including financial hardship, housing instability and caring responsibilities. In a system straining under the pressures of budget constraints, those with layered needs like these are frequently left with inadequate support. Underlying each of these cases is a fragmented system in which responsibility for care becomes blurred between providers as students move between institutions, services, places and stages of education.

These examples of students falling through the cracks reflect a structural weakness in how responsibility for support is organised and allocated. The system currently follows provider boundaries, while students move between home and term-time addresses, NHS areas, courses, placements and countries. But student needs continue across these transitions.

Nous highlights that place-based approaches can successfully help bridge these boundaries by organising support around the student journey across education, health and community services.

As student needs become more complex, compounded by the cost of living, employability struggles, and social isolation, the post-18 education sector as well as health and social care services face a practical and moral choice:

1. continue to refine separate services and expect students to navigate between them
2. build better local systems in which organisations share responsibility and collaborate more closely to provide timely, continuous support.

This means local education, health, government and community partners must agree how responsibility, information, and support will follow the student. The latter path is harder, but it is the only one capable of matching the complexity of students' lives.



What are HE and FE sectors doing to improve student mental health and wellbeing?

To explore this question and how different settings are acting to improve student wellbeing across the sector, we recently engaged with several mental health practitioners across universities, further education, the NHS and partner organisations across England to understand the most significant barriers to, and opportunities for, supporting students better.

We focused our inquiry on prevention and early intervention, with particular attention to the transition into further and higher education.[1] This is a critical period when students encounter new academic, financial and personal pressures, often while moving between places, services and established support networks.[2]

1 Student Minds, The University Mental Health Charter Framework, 2nd edn (Student Minds, 2026), 'Theme 1: Transition into university' and 'Theme 10: Proactive interventions and a mentally healthy environment', available at: Student Minds, University Mental Health Charter Framework (accessed 6 November 2026). The framework explicitly treats transition into university and proactive intervention as core components of a whole-university approach to mental health. Pp. 32-34, pp. 75-77.

2 Gareth Hughes and Leigh Spanner, The University Mental Health Charter, 2nd edn (Leeds: Student Minds, 2024), pp. 32–33, available at: University Mental Health Charter (accessed 6 November 2026). The underlying evidence identifies transition into higher education as a significant period for wellbeing and includes evidence of psychological distress, anxiety, depression, sleep disturbance, reduced self-esteem and isolation during this period. Pp. 32-33.

We examined how post-18 institutions and their partners can identify and respond to emerging needs promptly, before they escalate.[3] Our inquiry explored the responsibilities of different providers, the sharing of information, the coordination and continuity of care as highlighted by the Higher Education and Mental Health Implementation Taskforce[4] , and the ways in which location and geography shapes both student needs and the support available.[5] These are our key takeaways.

Complex systems and competing priorities

Formal disclosure of a mental health condition to a university rose from under 1 per cent in 2010/11 to 5.8 per cent in 2022/23. Analysis by TASO found that 17.9% (nearly 1 in 5, or roughly 300,000 UK undergraduates) reported experiencing a mental health difficulty in 2024—tripling over seven years.[6]

The recently released, final report of the independent review into mental health conditions, ADHD and autism reinforces this distinction: mental distress and common mental health conditions have increased substantially, particularly among children and young people, while neurodevelopmental conditions require distinct understanding and support[7].

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3 Department for Education, Higher Education Mental Health Implementation Taskforce (Department for Education, 2026), available at: GOV.UK, Higher Education Mental Health Implementation Taskforce (accessed 6 November 2026); Department for Education, promoting and supporting mental health and wellbeing in schools and colleges (Department for Education, updated 28 April 2026), available at: GOV.UK, mental health and wellbeing in schools and colleges (accessed 6 November 2026). These sources support identification of need, appropriate referral and clearer pathways into specialist support.

4 Higher Education Mental Health Implementation Taskforce, Improving Student Mental Health through Higher Education-NHS Partnerships (Department for Education, January 2026), pp. 12–23, available at: Department for Education, HE-NHS partnerships report (accessed 6 November 2026). The report identifies gaps between higher education and NHS provision, limited data sharing and informal partnership arrangements, and recommends agreed data-sharing practices and stronger governance

5 Universities UK, NHS-University Partnerships: Working Together for Student Mental Health (Universities UK, July 2022), pp. 2 – 4, available at: Universities UK, NHS-University Partnerships (accessed 6 November 2026); Office for Students, Case studies and resources for higher education providers: Joint working between providers and the NHS to support student mental health (Office for Students, n.d.), available at: Office for Students, joint working and local partnerships (accessed 6 November 2026). The evidence includes place-based partnerships in Greater Manchester, Liverpool, North London, Sheffield and Bristol designed to improve local care pathways and coordination between universities and NHS services.

6 TASO. Student mental health in 2024 (2025). Retrieved from: https://cdn.taso.org.uk/wp-content/uploads/2025-02-20_Student-mental-health-in-2024-How-the-situation-is-changing-for-LGBTQ-students_TASO.pdf

7 Independent review into mental health conditions, ADHD and autism: final report. Retrieved from: https://www.gov.uk/government/publications/independent-review-into-mental-health-conditions-adhd-and-autism-final-report

Treating the challenge as a lengthening queue for counselling leads to a narrow response: add capacity at the point of crisis and wait for pressure to return.

Confidential surveys suggest much higher levels of poor mental health. Yet demand, diagnosis, distress, and underlying need aren't interchangeable measures. Treating the challenge as a lengthening queue for counselling leads to a narrow response: add capacity at the point of crisis and wait for pressure to return.

Practitioners report that delayed diagnosis and limited early support mean students increasingly present with multiple, interconnected needs at first contact - poor mental health frequently sits alongside disability, neurodiversity, housing insecurity, family breakdown, or financial pressure. Academic demands and the loss of familiar networks can intensify those pressures, while complex institutional processes can add avoidable stress of their own. The case for collaboration is often widely accepted; the difficulty is that organisations operate with different budgets, accountabilities and incentives.

The challenge is that responsibility for these interconnected needs is fragmented across institutions and services. Organisations hold different budgets, thresholds and accountabilities, often ring-fenced around particular needs. This can create incentives to refer responsibility elsewhere, instead of responding collectively to the person in front of them. Students can then be repeatedly assessed, referred and redirected, increasing the risk that underlying needs go unrecognised and scarce resources are used inefficiently.

Responding well requires services to see the whole person. An international student repeatedly describing homesickness, for example, may be communicating significant anxiety, while another student facing difficult circumstances may need practical support rather than a clinical diagnosis. Education institutions and NHS services need shared responsibility for identifying and responding to need, so support follows the student instead of the boundaries between budgets and services.

Post-18 education must coordinate, not become the NHS

Education can be protective. It creates purpose, belonging and opportunities to develop capabilities that students carry into later life. Universities and colleges can identify emerging difficulty early because they see changes in attendance, engagement or behaviour. They can remove unnecessary stress from curriculum and assessment. They can also make accessing help easier.

In colleges, trusted relationships with teaching and support staff provide a route into help before a learner approaches a formal service. This gives early identification a relational foundation: noticing difficulty, opening a conversation and connecting the learner with appropriate support.

But proximity doesn't make an education provider a clinical service. As one university mental health lead put it, universities are "not the NHS, nor should [they] be replacing NHS services". Specialist diagnosis and treatment remain NHS responsibilities. The contribution of education providers is different: identify risk, provide proportionate support early and compassionate support, help students navigate services and convene partners when needs cross boundaries.

That boundary must be explicit. Without it, staff absorb responsibilities for which they are neither commissioned nor equipped, while students receive an improvised service shaped by institutional capacity. Clear roles protect both. A leading London-based, research-intensive university emphasises a "no wrong door" approach to ensure that any disclosure begins a supported journey. Equally, they recognise that this should not mean that the first organisation contacted must meet every need.

For FE, this boundary must also distinguish safeguarding action from clinical treatment. We heard colleges need clear arrangements to recognise concerns, escalate risk and coordinate with appropriate partners, alongside proportionate support for continued participation. On the other hand, their trusted relationships with learners and local communities create opportunities to identify difficulties early and play a more active role in coordinating with community-based, social care and support services.

Universities are "not the NHS, nor should [they] be replacing NHS services"

University mental health lead

Treat transitions as interventions

Our inquiry highlights that the most dangerous gaps appear when circumstances change: entry into post-18 education, movement between home and campus, leave and return to study, transfer between child and adult services, discharge from hospital and graduation. At these moments, eligibility can change overnight, information can disappear and students can be asked to retell difficult experiences to a new set of professionals.

Fewer than 5 per cent of young people transferring from child to adult mental health services received adequate planning, good information transfer, joint working and continuity of care.[8] The same structural weakness appears across education. A student on leave may no longer qualify for university support, while an NHS case-management system may not record that they are a student. A person discharged from hospital may return to halls without appropriate disclosure, particularly where support is required. At graduation, support can end with little more than a letter.

Transition should therefore be treated as a planned intervention, not an administrative event.

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8 Singh et al (2018). Process, outcome and experience of transition from child to adult mental healthcare: multiperspective study. The British Journal of Psychiatry. Retrieved from: https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/article/process-outcome-and-experience-of-transition-from-child-to-adult-mental-healthcare-multiperspective-study/7E7201DFDB1C81F467B9C679080870A5

Almost every institution wants to intervene earlier. Yet safeguarding duties, acute presentations and gaps in external provision keep pulling staff back towards crisis management.

Protect prevention from the pull of crisis

Almost every institution wants to intervene earlier. Yet safeguarding duties, acute presentations and gaps in external provision keep pulling staff back towards crisis management. One head of service reported doing less early intervention as safeguarding demand grew. In the West Midlands, an Office for Students-funded drop-in service offering low-stigma, non-clinical support was decommissioned and replaced by a traditional, clinically focused triage model. When pressure rises, the part of the system intended to stop escalation is often the first to be squeezed.

Prevention needs more than good intentions. It requires protected leadership, recurrent funding and measures that recognise progress before a clinical outcome is visible. Curriculum design, assessment timing, peer connection and a sense of belonging are factors that all influence wellbeing. The independent review affirms the importance of prevention and earlier support, strengthening the case for action before needs escalate.

Institutions can also remove avoidable barriers. The Disabled Students' Allowance application runs to around 15 pages, which can itself deter neurodivergent students. On the other hand, one university screens for autism and specific learning difficulties in-house and accepts school-based exam adjustments as interim evidence while diagnosis is pending. This kind of pragmatic adaptation does not lower standards. It prevents bureaucracy from becoming another source of harm. This also responds to the review's warning that waiting for diagnosis can delay help: practical support should respond to need while appropriate assessment and specialist care is sourced.

Build a system that follows the student

The reform agenda is clear.

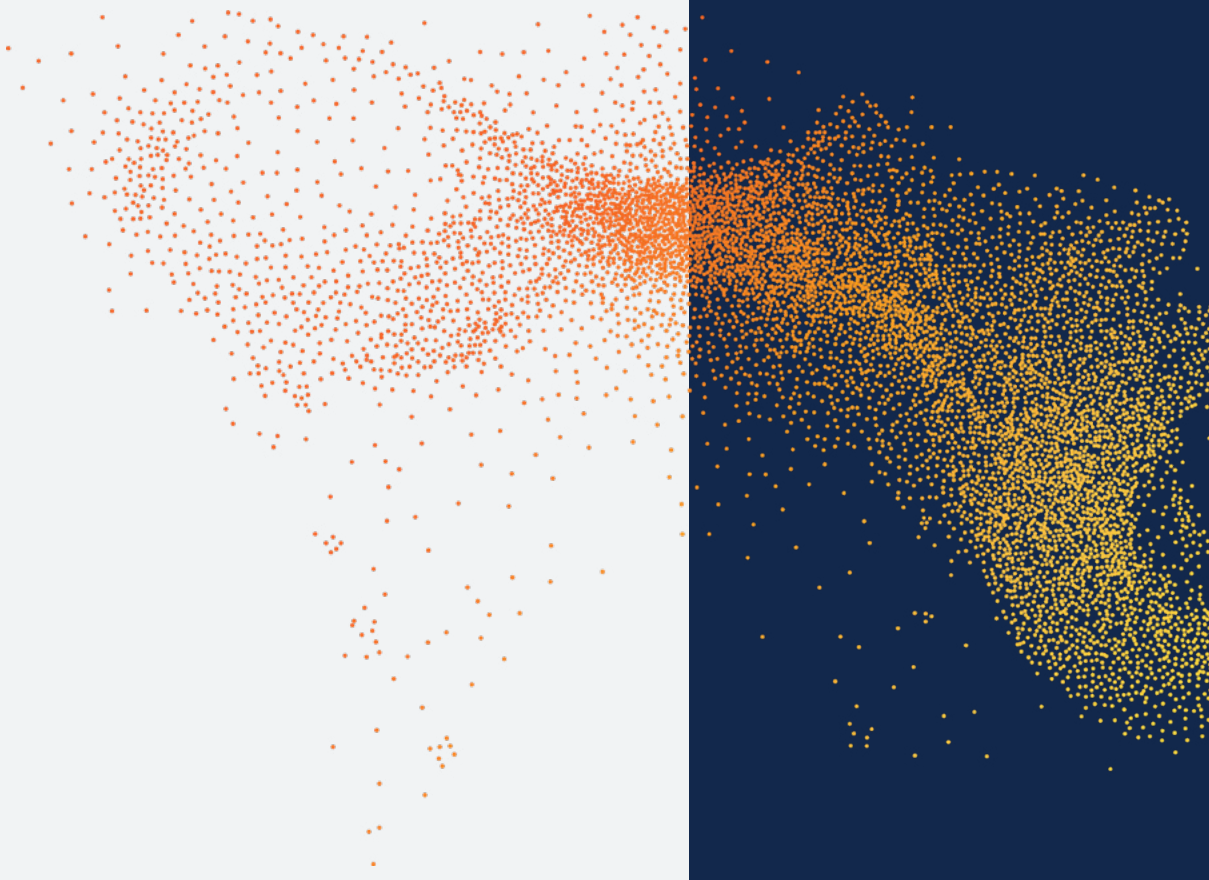
First, every place needs a formal student mental health partnership bringing together education, health, local government and community organisations. It should agree shared outcomes, governance and a route for resolving gaps.

Second, partners should publish a 'Responsibilities and Pathways Framework' that tells students and staff what support exists, who is eligible and what happens during a wait.

Third, transition protocols should cover arrival, movement between services, leave, return to study and graduation. Fourth, prevention should have dedicated capacity rather than depend on what remains after crisis response. Fifth, outcomes should capture access, continuity, student experience, participation, avoided escalation and clinical change where relevant. National and regional bodies should fund the core infrastructure for coordination, data and evaluation while allowing delivery to reflect local populations.

Existing practice shows what is possible. The Greater Manchester Universities Student Mental Health Service offers a single referral pathway across five universities and identifies needs that traditional criteria-based models can miss. In Birmingham, university mental health leads meet with the local NHS trust, while community organisations support needs that fall outside statutory and institutional provision.

Relationships remain critical infrastructure. Trust between students and staff supports earlier disclosure, while named contacts enable faster problem-solving across organisations. But relationships need processes behind them. A resilient system cannot collapse when a committed individual changes role or at the end of a short-term grant.





THE FUTURE A PLACE-BASED APPROACH

A place-based approach starts with a simple insight: a city or region can hold relationships and shared infrastructure that no single institution can sustain alone. Education providers, NHS bodies, local authorities, and community organisations serve overlapping populations. Their support should connect in practice, not merely coexist on an organisational chart. We illustrate three different scenarios:

A

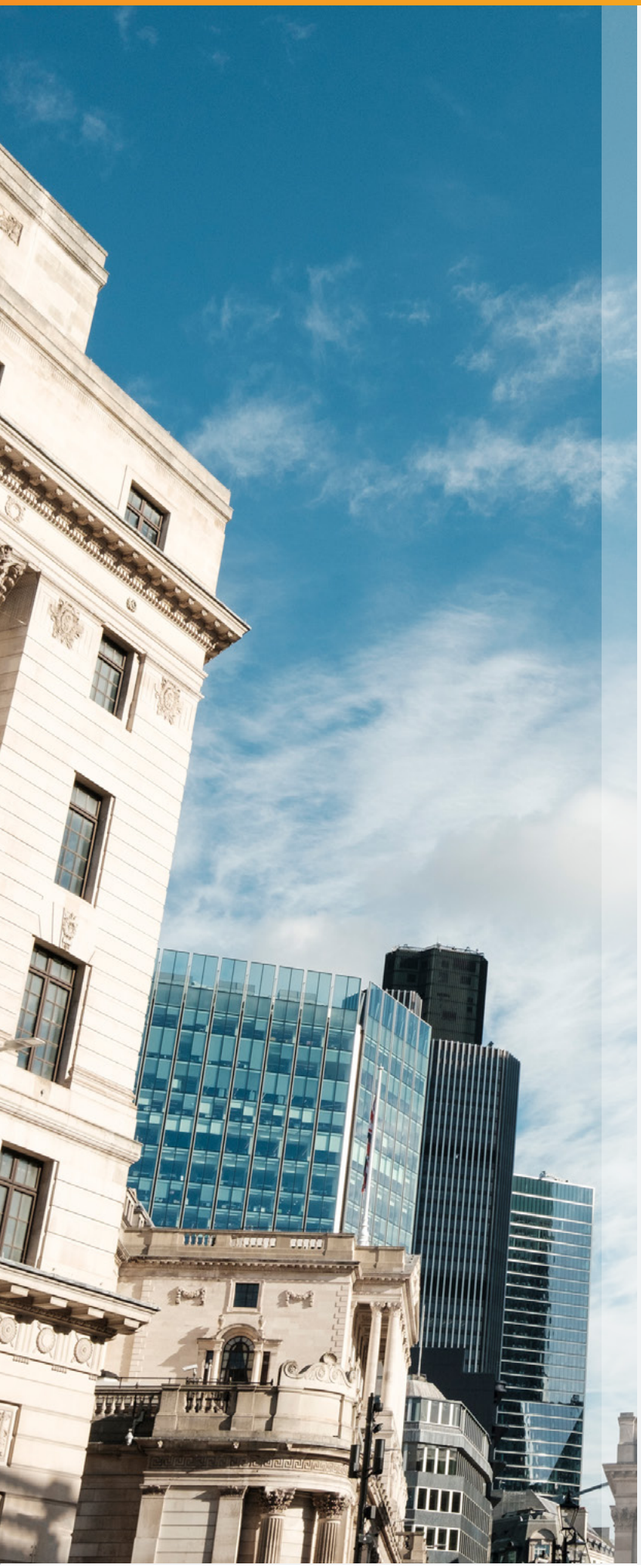
LONDON NETWORK FOR MOBILE AND INTERNATIONAL LEARNERS

B

A REGIONAL, WEST MIDLANDS ECOSYSTEM BUILT AROUND SHARED RELATIONSHIPS

C

INCLUSIVE SUPPORT FOR DIVERSE POST-18 LEARNERS



A

London network for mobile and international learners

Context

Learners may study in one borough, live in another and use health services elsewhere. Many arrive from overseas or move frequently. The city has many providers, but the system can be difficult to navigate. At one London university, more than 60 per cent of students are international and therefore ineligible for DSA.

Emerging response

A shared transition and navigation offer provides pre-arrival information, culturally responsive mental health literacy and clear explanations of NHS access. Institutions maintain named contacts with health and community partners. With consent, learners with established needs receive a structured handover rather than starting again. Institutions help learners register with a GP on arrival and, with consent, obtain notes from clinicians overseas. A pan-London forum of universities and NHS England agrees common expectations for information sharing.



B

A regional, West Midlands ecosystem built around shared relationships

Context

The West Midlands has several universities, colleges, NHS trusts and community organisations serving overlapping populations. Existing relationships are valuable but can depend on individuals and short-term funding. In Birmingham, heads of mental health and wellbeing at several universities already meet regularly with the NHS mental health trust, while charities such as Birmingham Mind absorb needs that neither universities nor the NHS meet.

Emerging response

Partners establish a compact that defines responsibilities, referral routes and governance. A small coordination hub with a named host and recurrent funding maintains the network. Shared outreach and peer support offer less stigmatising routes into help. NHS peer workers embedded in clinical teams support students through leave of absence and return to study. Institutions pool selected capabilities where scale improves access.



C

Inclusive support for diverse post-18 learners

Context

Further education, commuter, mature and care-experienced learners may face practical pressures alongside poor mental health. Many do not identify with a traditional residential student model.

Emerging response

Partners establish a compact that defines responsibilities, referral routes and governance. A small coordination hub with a named host and recurrent funding maintains the network. Shared outreach and peer support offer less stigmatising routes into help. NHS peer workers embedded in clinical teams support students through leave of absence and return to study. Institutions pool selected capabilities where scale improves access. For FE, this should connect trusted staff, safeguarding leads and external services, alongside practical help and enrichment that sustain participation. Referral pathways should clarify support during waits and changes in service eligibility.



London's mobile and international student population needs a different response from a regional city with a smaller group of institutions, or an area serving large numbers of commuter, mature and care-experienced students. Local variation is necessary. A postcode lottery for essential support isn't.

The opportunity is not to copy either model everywhere. It is to make coordination a funded function rather than an informal favour. And crucially, it should be underpinned by common, consistent standards to care and support.

The test is whether support survives change

The hardest problems in student mental health sit between organisations and across different parts of a student's life. They become most visible when circumstances shift and familiar support falls away.

The ultimate measure of success is whether a student can move through their education without losing support, constantly repeating their story and being told they belong elsewhere. Enabling this joined-up care requires clear, strong local partnerships and a shared commitment to act before difficulty becomes crisis.

Education providers have a distinctive role, but not an unlimited one. Health services retain responsibility for clinical care. Community organisations contribute trust and local knowledge.

Place-based partnerships help those contributions add up to a coherent system. Students are already living whole lives. It is time that the systems around them caught up.

About Nous Group

Nous Group is an international management consultancy, working with leaders in the private, public and community sectors across a range of industries including education, health, human services, financial services, safety and security and sustainable development.

With an international network of 600 people, Nous partners with leaders on complex strategic challenges and transformational change programs.

A leader in higher education with global expertise

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Our expertise is complemented by that of Nous Data Insights, our education solutions business, that equips higher education leaders with the data and insights they need to improve performance and achieve their academic mission.

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A bigger idea of success