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1. Introduction

University counselling and wellbeing services, primary care, NHS mental-health services and voluntary-sector provision are at the students' disposal to seek mental-health support at UK universities (Campbell et al., 2022; Akram et al., 2023). Availability does not equate to access, though. A student should be aware of a need, be willing to accept professional help, find an appropriate service, understand the process of getting into the service and stay in it long enough to get useful help. A barrier can occur at any of these stages. Stigma and self-reliance are still relevant in the UK, as are service fragmentation, confidentiality issues, poor information and mistrust (Sheldon et al., 2024).

It's crucial to differentiate between seeking help and accessing help. A student might express interest in accessing professional support, but find it difficult to get timely support or find limited pathways. The opposite can also be true, as students who aren't planning to use formal services can instead turn to friends, family or peers. For instance, Begum et al. (2024) identified significant differences between students from first-in-family and other UK families in how they prefer to get help: first-in-family students said they trusted friendships more as a source of help, while other students said they trusted adults more.

There's also an inequality between student groups with respect to access. Medical students may be concerned about a negative impact on their careers due to disclosure, international students may be concerned about a lack of familiarity with the UK healthcare system, and racially minoritised students may fear cultural stigma, discrimination or a lack of confidence in culturally competent care provision (Hardy, West and Fisher, 2025; Kolinska, Piers and Karadzhov, 2025). Such disparities will make it difficult to eliminate all barriers with a single university-wide awareness campaign.

The question to be addressed in the review is:

Which factors affect the availability and uptake of mental-health services by people at university in the UK?

The aims are to: identify personal, social and structural barriers to help-seeking; compare the findings of five peer-reviewed studies carried out in the UK; explore comparisons between student groups; collate themes using thematic analysis; and identify implications for university, NHS and health and social care practice in the UK.

2. Background

The Office for Students (2023) identifies mental-health issues as a barrier to continuation, completion and progression and some groups as having specific barriers to the provision of appropriate support. As part of its analysis, it highlights that university records rely on students' disclosure. This means that

institutional data on the prevalence of declared mental-health conditions might underestimate rates of need, rather than underestimate rates of low prevalence.

The inequality problem is a particular example of this disclosure problem. In addition to overarching issues like stigma and self-reliance, Hardy, West and Fisher (2025) identified cultural issues, discrimination, family attitudes and perceptions of a lack of cultural competence by service providers as factors affecting students' help-seeking attitudes when they were racially minoritised. The review, therefore, recommends that services which have been declared to be universal may still be less acceptable to some groups, while being formally available.

The context for medical education is another specific one. Students go into clinical placements and enter into a regulated profession. Confidence in fitness-to-practise procedures, confidentiality and professional consequences were all cited as factors that may impact on decisions across the help-seeking pathway by Sheldon et al. (2024). This barrier is not simply addressed by teaching students more about depression and/or anxiety; it demands information about what disclosure is and is not from the institutional and professional perspective (Hawsawi et al., 2024).

For an international student, there's another issue. Participants in Scotland had problems with primary care in their country of origin and also found it difficult to navigate primary care in the UK, whilst at the same time connecting their treatment with healthcare systems in their country of origin (Kolinska, Piers and Karadzhov, 2025). GP interactions impacted on subsequent willingness to seek help. Thus, access was not only based on attitudes, but also on relations and organisations.

3. Methods

3.1 Review Design

The question is not about the effectiveness of one intervention but rather the general access pathway, for which a scoping review design was used. Heterogeneous evidence can be mapped, compared and synthesised using a scoping review, and gaps in knowledge can be identified. Pollock et al. (2023; 2024) provide recent methodological guidance on the use of explicit eligibility criteria, transparent searching procedures, systematic data charting and synthesis, which must be directly connected with the review question.

3.2 Search Strategy

Peer-reviewed literature relevant to UK university students and mental-health help-seeking was the focus of the searches. Sources were located via PubMed, EBSCOhost, SAGE Journals and UWTSD Library, and reference lists were checked to locate additional relevant sources.

Search concepts were combined using Boolean operators. This was a representative search:

("university students" OR "higher education students") AND ("mental health" OR depression OR anxiety OR distress) AND ("help seeking" OR "service access" OR counselling OR support) AND (barrier OR stigma OR accessibility) AND (UK OR "United Kingdom" OR England OR Scotland)

To ensure the literature is relevant to current UK practice, the review has been limited to literature published between 2021 and August 2026.

3.3 Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
Peer-reviewed journal research	Editorials and commentaries
Published 2021–August 2026	Publications outside the date range
University or higher-education students	School-only populations
UK, England, Scotland, Wales or UK-wide relevance	Core studies conducted outside the UK
Mental-health help-seeking, access or service use	Studies measuring mental health without access relevance
Primary or eligible secondary research	Policy documents as core studies
English language	Non-English publications

Policy and professional guidance were used in the Background and Discussion but were not included as core studies.

3.4 Study Selection

Studies were filtered to ensure relevance to the review question. Five were chosen for detailed analysis as they had different coverage of the access pathway and different student groups, including general UK students, first-in-family students, medical students and international students.

It was not the intent of the authors to suggest that these five studies represented all UK students. The limited sample allowed for in-depth comparisons, however, as the assessment requirement was to analyse 3–5 peer-reviewed studies.

3.5 Data Extraction and Analysis

Information for each study was obtained relating to population, research design, sample, help-seeking measure, reported barriers, main findings and methodological limitations.

The data were then coded and analysed thematically. A thematic approach was implemented to transcend the individual reporting of each article. Braun and Clarke (2023) remind students that themes are meaningful patterns that they are analysing and not just words that they count. Three themes emerged: help-seeking does not always lead to help received; services may be barriers to help-seeking; and access is not equal across student groups.

3.6 Ethical Considerations

There was no direct recruitment or identifiable information collected in this study as it was a secondary study using published data. The importance of ethical responsibility was not forgotten, however. Findings were not presented as causal, differences among subgroups were not assumed to be stable and universal, and negative experiences with services were not generalised to other subgroups. Citations were used throughout in a proper manner.

4. Results

4.1 Summary of Core Studies

Study	Design and Participants	Key Findings Relevant to Access	Main Limitation
Priestley et al. (2022)	Thematic analysis of six student co-creation panels	Students identified problems with awareness, accessibility, coordination and inclusivity of university support	Consultation participants may be more engaged with mental-health issues than the wider population
Burns, Dagnall and Denovan (2023)	Survey of 1,261 UK university students	Actual help-seeking differed by gender, study level, stress and circumstances; females and postgraduates were more likely to report seeking help	Pandemic context limits transferability to normal university conditions
Begum et al. (2024)	Mixed-method study; 194 first-in-family and 134 non-first-in-family students	Trust, stigma, burdensomeness and social background shaped preferred sources of support	Convenience-based recruitment limits representativeness

Sheldon et al. (2024)	Survey of 103 Sheffield medical students; interviews with 20 students and 10 professionals	Fitness-to-practise fears, confidentiality concerns, stigma and fragmented services obstructed access	Single medical school and low survey response
Kolinska, Piers and Karadzhov (2025)	Interviews with nine female international students in Scotland	Navigating healthcare systems, cultural attitudes and GP interactions shaped continued help-seeking	Very small, female-only sample

4.2 Theme One: Recognising Need Does Not Ensure Disclosure or Formal Help-Seeking

The first theme is that of the disconnect between distress and formal services. In this study, Burns et al. (2023) conducted a survey of 1,261 UK university students during the pandemic to determine the distribution of help-seeking. The students who had sought help were more likely to be female and also postgraduate students, and had reported worse stress and fear of COVID-19. The implications of this are that some students may need support because of its severity, but that their behaviour is not necessarily driven by their distress, with evidence that there are differences between students' demographic characteristics and their levels of distress.

An important social dimension is added by Begum et al. (2024). First-in-family students more strongly indicated that they would consult their friends for assistance than non-first-in-family students among 328 students. Stigma and perceived burdensomeness were negative factors for students, whereas trust was particularly important for first-in-family participants. So there is a competition in place between the formal services and the existing informal services.

These findings refute the single message of service promotion interventions. A student may have heard about counselling and have a preference for a trusted friend as professional disclosure is perceived as risky, burdensome or culturally unfamiliar. Awareness is needed when the students are not aware of what is available, but without addressing the issue of mistrust, awareness would not solve the problem.

4.3 Theme Two: Barriers Continue After a Student Decides to Seek Help

The second theme moves from students' attitudes to the design of the service. Sheldon et al. (2024) identified barriers at each phase of the candidacy pathway of medical students in Sheffield. These comprised uncertainty around services available, lack of consistency in service provision, concerns

around confidentiality and confusion around fitness-to-practise procedures. Students with higher psychological symptoms had increased odds of reporting access concerns.

A similar finding was identified by Priestley et al. (2022): the support students were looking for was more coordinated, clear and inclusive rather than isolated services. The service reform was integrated into a whole-university approach in their co-creation panels. Access issues were thus linked to institutional communication and culture, not just counselling capacity.

Barriers can extend beyond the university, as Kolinska, Piers and Karadzhov (2025) show. International students reported problems accessing health services within their own country and in the United Kingdom. Subsequent help-seeking was then informed by positive or negative GP interactions. It is therefore possible for there to be a referral pathway even if it is not being used.

4.4 Theme Three: Access Barriers Are Not Equally Distributed

The third theme relates to inequality. Begum et al. (2024) demonstrate how family upbringing has an impact on trust and preferred support. Sheldon et al. (2024) show profession-specific fears for medical students, and Kolinska, Piers and Karadzhov (2025) indicate that other factors include migration and familiarity with the healthcare system.

This conclusion is reinforced by more evidence. Among racially minoritised students, cultural stigma, family attitudes, self-reliance, discrimination, microaggressions and perceived cultural incompetence were identified as barriers by Hardy, West and Fisher (2025). The results suggest a service may be available for all users but may be easier to use for some groups of users than others.

5. Discussion

All five studies suggest that barriers to student mental-health support exist as a series of decisions rather than as one decision. It is important to recognise distress as a need for assistance before it can be helped. They then determine if it is okay to share, select a source, determine a path, access it, and evaluate whether the interaction that takes place is safe and useful. Meaningful care can never be realised because of failure at any step.

This is why stigma is important, but it is not enough. The current findings support those of Begum et al. (2024), in which stigma and perceived burdensomeness were observed in all student groups, while a broader synthesis by Lui, Sagar-Ouriaghli and Brown (2024) identified self-reliance, stigma and mental-health literacy as common barriers across all countries. But Sheldon et al. (2024) demonstrate that students who surmount those initial obstacles can then face “discontinuities” and “uncertainty.” The evidence thus refutes the concept that is sometimes used in modelling the nature of non-use as student unwillingness.

It is helpful to contrast the methodological approaches of Burns, Dagnall and Denovan (2023) with the qualitative studies. The survey identifies predictors for 1,261 participants and so serves as a broader survey statistically. It also found that females and postgraduate students were more likely to report help-seeking, which suggests that males and undergraduate students may be less likely to seek help. But the survey doesn't tell us all the reasons for these differences. Further, data were gathered during pandemic conditions, with normal access to services and student life being disrupted.

Begum et al. (2024) further explain by using a mixture of questionnaire and open-ended evidence. They distinguish between first-in-family students and other students and demonstrate that different social networks can be used for help-seeking by apparently similar students. However, first-in-family status should not be considered as a direct determinant of less formal help-seeking behaviour. There may be a correlation between family experience of higher education and socioeconomic background, cultural expectations and integration at university. The study is based on a pattern, but not a single mechanism.

Sheldon et al. (2024) provide the best evidence of the possibility of actively influencing access through institutional practices. They have a mixed-method design, which triangulates student surveys, student interviews and professional perspectives. The candidacy framework can also be used to explore barriers in stages of care, not as a checklist. The main problem with the setting is that it represents just one medical school, not UK higher education as a whole. Fitness-to-practise concerns are experienced by medical students, but not most students. However, confidentiality, fragmentation of pathways and lack of identification of appropriate support are more broadly applicable.

Kolinska, Piers and Karadzhov (2025) are on the other side of the methodological spectrum. Nine respondents are too few to justify an estimate of the prevalence of a barrier, and an all-female sample cannot represent male international students. But IPA allows for detail that large surveys would miss. This is an interesting finding, as participants' expectations about health care in the university and their GP experiences were found to influence their subsequent help-seeking, highlighting the need to take a more nuanced approach than just making service information available in an international student's home language.

The evidence also challenges the idea that all responsibility for student mental health is the responsibility of university counselling. Students transition between universities, GPs, the NHS, private provision and informal networks. A serious or ongoing problem may fall outside of the scope of a short-term university counselling session. On the other hand, students could be kept longer than expected in university services because NHS thresholds or waiting times are not adhered to. Sheldon et al. (2024) specifically highlighted fragmentation between local services and greater connections between the university and the NHS. Evidence from UK service redesign also suggests that the organisation of wellbeing provision can influence student help-seeking behaviour (Bennett et al., 2024).

Special focus is needed on inequality. Drawing on the research of other scholars, Hardy, West and Fisher (2025) synthesised the general barriers that racially minoritised students face, along with culture-specific and systemic barriers, such as concerns about cultural competence and discrimination. Stoll et al. (2022) also found relevance to institutional and social context in a study of mental-health experiences of Black students attending UK universities. As such, a one-size-fits-all approach to providing services to students is not necessarily equitable. Equity may take different forms, with the need for adaptation in communication and services for different groups.

Caution should be taken with informal support as well. Vicary et al. (2025) polled 287 undergraduates at 68 universities in the UK and revealed that higher levels of perceived support were correlated with fewer reports of depression and anxiety and that students who perceived that they had more support were more likely to seek informal help than formal help. Networks of peers can thus be protective and decrease formal service use. This is not necessarily an issue if help is provided informally by friends and that help is sufficient, but peers should not be substitutes for professional care where risk or clinical need is higher than what peers can safely provide.

The results have implications for practice. First, it is important that universities make access to the routes easy to use in times of psychological distress. Students shouldn't have to learn a lot of institutional structures to find the appropriate service. Keeping a central access point for students with easy triage is more defensible than asking them to identify whether their difficulty relates to counselling, disability, wellbeing or external NHS provision.

Second, universities must have clear confidentiality information. This is particularly relevant for students in medicine and other professions regulated by professionals. Sheldon et al. (2024) propose that uncertainty in fitness-to-practise processes can affect the whole pathway of help-seeking. Fear could be addressed more directly than with generic anti-stigma messaging by explaining circumstances in which information is 'confidential' and when it may be shared, and what the possible professional consequences are.

Thirdly, accessibility should be considered on a subgroup basis. Average numbers of service use may mask low engagement rates for international, racially minoritised, male or first-in-family students. The Office for Students already stresses the importance of targeted approaches and an intersectional approach, and the University Mental Health Charter calls for a whole-university approach as opposed to a one-service solution (Office for Students, 2023; Student Minds, 2024).

Fourth, it is important to have clear transition and escalation plans in place within the university and NHS partnership. Students should be aware of what to do if they do not receive support from the university, the process of referral to a GP/the NHS, and who will remain responsible for them whilst they are waiting. Partnership working with external organisations is included in a wider student-health strategy,

according to Universities UK (2024). This is especially important since students can change geographical locations during school breaks (Department for Education, 2025).

5.1 Limitations of the Scoping Review

The review is focussed and there are five core studies. This allows for in-depth comparison but does not take into account all groups of students or all UK institutions. Barriers to the profession may be overrepresented because of two core studies involving medical students.

The presentation of the evidence is also very diverse. Predictors of survey results can't be directly compared with qualitative descriptions of actual experience. Some studies assess intentions; others assess the experience of seeking help or the service experience. These outcomes are not to be used as synonyms.

Some evidence was impacted by COVID-19, such as Burns, Dagnall and Denovan (2023), which has meant that certainty about all findings in current conditions is reduced. Others employed convenience or self-selected samples, which may have resulted in sampling bias in that the students who participated may have been those with a stronger interest in mental health.

Lastly, higher education in the UK is not a single service system. There is a wide range of institutional resources, local NHS provision and student populations. Recommendations should thus be implemented and assessed at the local level as opposed to taking place in a manner that would be expected to be equivalent across different universities.

6. Conclusion and Recommendations

This review finds that barriers to accessing mental-health support among UK university students occur at personal, social and service levels. Unmet need is not solely attributable to stigma, self-reliance and fear of burdening others, as these are factors that can delay disclosure. Even if students choose to access support, they might still find that there are unclear pathways to support, a lack of services, confidentiality issues and challenges accessing the right kind of support.

Access is also unequal. First-in-family students may rely on trusted social networks more than others; medical students may be worried about the consequences of their studies; international students may have difficulties navigating unfamiliar healthcare systems; and racially minoritised students may face cultural and discriminatory barriers. A universal service offer does not guarantee equitable access.

Based on this evidence, there are four recommendations.

First, universities need to have one clearly communicated entry point into mental-health support, followed by triage to get the right kind of help. Students who are distressed should not be required to recognise their own degree of need and make their way through the various disconnected teams.

Second, universities should make available explicit guidelines for confidentiality and the sharing of information, especially for professionally regulated courses. The issues around fitness-to-practise should be tackled directly to avoid misunderstanding.

Third, student groups must be considered when looking at access data. Universities should investigate the differences in referral, attendance, waiting, disengagement and outcome rates for international, first-in-family and racially minoritised students. The assumption of low need should be based on high utilisation, not low utilisation.

Fourthly, for those students who do need specialist or longer-term care, universities and NHS services should have clear pathways to help escalate these needs. During transitions, responsibility needs to be clear so that students are not left between university and NHS provision.

Longitudinal studies with multiple universities that assess service use and outcomes rather than intentions for use should be a priority for future research. There is a need for further evidence from male learners, racially minoritised students, disabled students, postgraduate students and from those who attempted to access support but dropped out. Studies also need to analyse whether service redesign will lead to less inequality or more inequality in addition to the overall increase in service contact.

The main message is that increasing students' access to mental-health services goes beyond urging students to seek assistance. Support should also be clear and credible, culturally sensitive and easily accessed following their request.

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