## LETTER TO THE EDITOR

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# PREVENTION IS BETTER THAN CURE: ADDRESSING POOR MENTAL HEALTH & WELLBEING IN FINNISH UNIVERSITIES AFTER 50 YEARS OF TREADING WATER

*ABSTRACT*

*Mental health and wellbeing in Finnish Universities has been an issue of concern since the 1960s. Since then, conditions have steadily declined on par with other Western countries, and Finland's general population rates of poor mental health and suicide are among the highest in Europe. National reporting on university student mental health offers an incomplete and somewhat deceptive picture of current conditions, which fails to recognise that university students experience an unexplained 52.6% greater incidence of diagnosable poor mental health than that seen in the general population, and even twice that seen in military veterans in many European countries. Mental health professionals come into contact with only a small proportion of the overall body of university students, and the majority of poor mental health is not seen or diagnosed, including that of those who are driven to take their own lives. Moreover, wellbeing management and counselling is now acknowledged as not being enough to protect university students, yet continues to be the main strategic approach to demonstrating care. Some 1.5 million people in Finland aged 25-64 will have been proportionally affected by the continued historic incidence of poor mental health in Finnish universities, and carry their experiences into their future lives. This likely represents the largest demography for mental health study and intervention, and given the high unexplained incidences for age and sector; government departments, mental health professions, health services and higher education bodies should take urgent steps to investigate the causation of student poor mental health, aiming at prevention over access and cure.*

KEYWORDS: UNIVERSITY STUDENT MENTAL HEALTH, FINLAND, STUDENT SUICIDALITY, WELLBEING MANAGEMENT, CAUSATION, PREVENTION, EPIDEMIOLOGY OF MENTAL HEALTH

Reports of poor mental health (PMH) and wellbeing in Finnish universities began in the 1960s. In 1965, 1.2% of the students at the University of Helsinki consulted psychiatrists of the Students' Health Service, and in 1968, '*signs of mental disturbance were found in 23% of the students*' (1), with subsequent incidences consistently ranking with the upper levels of international reports. This early study concluded that '*the facilities for psychiatric treatment available for university students are not adequate at present. It would also be important to develop the mental health counselling services further*', setting the strategic path for addressing PMH in this sector. But mental health conditions have steadily declined on par with other Western countries, and Finland's current rates of poor mental health and suicide are among the highest in Europe (2,3). This is also true for university students and staff, and the EUROSTUDENT VIII report (4) sees Finnish students reporting a steady decline in life satisfaction and a higher prevalence of long-term mental health problems than the EU average. The Finnish Student Health Service (as the sole provider for higher education students in Finland) explicitly defines its primary treatment model around short-term counselling (5). However, a recent admission by US mental health professionals (6) has declared that '*wellbeing management and counselling is not enough to protect university students*'. In the UK, Universities UK and the charity Student Minds have officially declared that student mental health is not just a 'clinical' or 'support' issue, but a 'core strategic' one (7). Furthermore, the National University Mental Health Framework in Australia (8) has stated that the traditional counselling model is reactive and fails to address the structural determinants of mental health.

In 2024, the National Union of Students in Finnish Universities of Applied Sciences SAMOK and the National Union of University Students in Finland (SYL) jointly demanded that the European Union make tackling the mental health crisis among students and young people a priority in its health programme (9). Drawing from basic reported incidences (instigated in conjunction with KELA), in 2000 14–18% of students suffered from mental problems, with 26% experiencing considerable stress, and 12% severe stress (10). In subsequent reports, mental health is measured and reported inconsistently, with different terms and conditions being focused on (11). But incidences of PMH rose to 33% in 2021 and 29% in 2024 which is again consistent with the upper incidences reported in international studies.

## WHAT LIES BEHIND THE PERCENTAGES?

National reporting on student mental health offers a somewhat deceptive picture of current conditions, dwelling on 'young person's issues', an awareness of diagnosed conditions and offering shallow observations on care and wellbeing. Behind the small fluctuations of statistics is an unacknowledged situation where university students experience an unexplained 52.6% greater incidence of diagnosable poor mental health compared to the general population (see e.g. 12). In reality, university graduates cover some 39.2% of Finland's population aged 25–34, and 43% of the population aged 25–64 (13), with many more having left university studies for reasons that include mental health issues (estimated at 9.6–25%: see 14,15). Applying comparable international data in the absence of Finnish studies, the following conditions can be seen:

1. Based on comparative student populations for the time (315,600 higher education students), the 2021 reported incidence of 33% of students in universities and colleges in Finland suffering from anxiety and depression (see 16) theoretically entails 104,149 individuals with general PMH symptoms (measured with e.g. Mental Health Inventory scale-type items), and up to 55,440 with Moderate to Severe Anxiety/Depression, representing those who have progressed past 'distress' into territory where clinical intervention or medication would typically be prescribed (measured with GAD-7 (Anxiety) and PHQ-9 (Depression) type tools which look for moderate to severe clinical symptoms).
2. International studies show that the incidences of moderate-to-severe depression and anxiety among *postgraduate students* are likely to be 10-times greater than seen in the general world population (17,18). In Sweden (19), the need for medication for poor mental health increased by 40% from the year before studies to the 5th year of PhD, with no predisposition –– in Finland, this may account for 39,720 students per 4-year cycle, and more with undiagnosed/unreported cases.
3. Incidences of moderate-to-severe depression and anxiety are double those seen in military veterans in many European countries (e.g. 20). In general, untreated episodes of clinical depression can last six to 12 months, with a likelihood of recurrence (21). About two-thirds of people with clinical depression think about suicide and only 25% or fewer may report their condition (22) –– in Finland, this may account for 104,148 unknown students per 4-year cycle
4. 40% of *postgraduate students* experience moderate-to-severe depression and have a 40% increased risk of suicide (23). In the UK: 75% of colleges recorded >5 attempted suicides within the previous 12 months, and 13% over 30 attempts (24). In Sweden over 18 years, suicide accounted for 36.4% of deaths while studying (25). The WHO predict that for every completed suicide, there are 20 attempted suicides (26), and the 2016 KOTT survey (27) found that 5.7% of students had planned for suicide, 3.8% contemplated suicide occasionally, and 1.9% sometimes or often. UK studies (28) have shown 50% of students to have thoughts of self-harm with 42.2% of students having contemplated suicide at least once within the past twelve months (29), and US studies report 7.3% having suicidal thoughts, and 2.3% having plans for suicide (30).

## THE COST OF STUDENT POOR MENTAL HEALTH

Loneliness and isolation are key elements of depression across studies, and major global and EU authorities have recently shifted their focus toward loneliness and social isolation as a primary driver of the current student mental health crisis. These reports distinguish between physical isolation (living alone or remote learning) and subjective loneliness (the feeling of being disconnected). The WHO Commission on Social Connection flagship report (2025) explicitly cites that lonely individuals are twice as likely to experience depression compared to those

with strong social ties (31), and the EU Joint Research Centre report on Loneliness Prevalence in the EU (2023-2025) found that young adults (18–25) were more likely to be lonely than the elderly, and highlights a vicious cycle where loneliness triggers depression, and depression further increases social withdrawal (32).

Recent findings on the deteriorating mental health of students in the EU have focused on the combined pressure of academic stress and social isolation (33), and Finnish students have been noted as feeling significantly more isolated from fellow students in their study programme than students in other EU countries (34). Simply saying that '*students feel lonely*' runs a risk of trivialization in the face of more emotionally triggering issues such as violence or terminal disease. But applying WHO data (35) brings home the seriousness of loneliness as a component of PMH: a single average duration episode of major depressive disorder may equate to a mortality risk of smoking 15 cigarettes per day, and smoking one cigarette has been broadly estimated to reduce life expectancy by 11–20 minutes (36). If applied, then relative to duration, general depression with loneliness as a recognised contributory factor may shorten the lives of university students by anywhere from 250 hours (following a 3-month general level incidence) to 1000 hours (24-month duration), and be conservatively estimated to reduce overall life expectancy by 10 to 41 days — in Finland, this may amount to 3,040–12,470 lost years of life.

If the global burden (37) of poor mental health is measured in Disability-Adjusted Life Years (DALYs), it is only surpassed by cardiovascular diseases, respiratory infections, cancers, neonatal disorders and musculoskeletal disorders, and surpasses well-funded and researched health domains such as diabetes, neurological disorders, nutritional deficiencies, HIV/AIDS and STIs, substance abuse, interpersonal violence, conflict and terrorism and natural disasters. The majority of this burden comes from Years Lived with Disability, urging mental health professionals and commentators to reconsider the impact that student experiences (especially those of moderate-to-severe and chronic depression) may have on life beyond university.

## STUDENTS ARE NOT JUST YOUNG PEOPLE HAVING A HARD TIME

The oversight and reporting of university student mental health in Finland (and elsewhere) shows a strong degree of paternalism that diminishes the severity of the university student situation. In effect, PMH in this setting is portrayed as something naturally occurring and transient, which is strongly challenged by the evidence of published research. Students are placed as being 'young people' in need of care and guidance, whereas in reality, Finnish students are working-age adults with an average age of 27.3 years on graduation (26.6 EU; 26.7 UK) exceeding international 'young person' classification criteria (UN, WHO, UNICEF and UNESCO have upper thresholds of 24 years old, although OECD extends to 29 years). The vast amount (number of cases) of PMH and suicidality occurs in working-age people aged 19–64, and in the university sector, the most severe PMH is seen in older, competitively selected and more experienced students with a track record of high academic achievement (also visible but unrecognised in the 2024 KOTT report). Against this background, the focus on healthy lifestyle promotion in reports and studies effectually denies the legitimate suffering of those who suffer most.

## WHO HAS A DUTY OF CARE, AND WHERE IS PREVENTATIVE MEDICINE?

In the definitions of the World Health Organization (38), anxiety disorders and depression are characterised by '*clinically significant disturbance in an individual's cognition, emotional regulation, or behaviour* [...]' usually associated with distress or impairment in important areas of functioning. Anxiety features '*excessive fear and worry*', and generalised anxiety disorder would account for the majority of experiences recounted in university settings as opposed to panic disorder, social anxiety disorder and separation anxiety disorder implied by 'young person' reporting. Depression is characterized as being '*different from usual mood fluctuations and short-lived emotional responses to challenges in everyday life*', and yet the diagnostic examinations of reports often list incidences of *symptoms* such as feeling sad, loss of pleasure or interest in activities, disrupted sleep, changes in appetite or weight, time spent online, etc., with no attempt to find out the specific triggers that cause more worrying conditions of fear, excessive guilt and low self-worth – feelings that lead to more severe points of hopelessness about the future (which might contribute to reduced performance or withdrawal from studies), or ultimately thoughts about dying or suicide. If unaddressed, these feelings and experiences can influence perspectives of self, worth and ability, and impact many facets of later life (e.g. relationships, employment, health, etc.), as evidenced by the estimations of the impact of poor mental health in terms of Disability-Adjusted Life Years.

Reducing PMH in non-clinical contexts requires the practical reduction/removal of the triggers that cause it. While

attempted suicide is a predictor of suicidality, the actual trigger is likely to be unreported poor mental health in the form of chronic/severe depression and anxiety, with a history indicating a causative and persisting event/condition. This may possibly involve the thoughts of suicide that have been reported in Finnish studies, but even more widely in international literature. But without knowing what these events and conditions are and reducing their occurrence to the lowest possible level, we cannot hope to effectively address mental health and suicide in this population. Of note: most academic papers on student PMH follow wellbeing and percentage incidence reporting patterns (possibly in alignment with funding opportunities), whereas reports into student suicide or endemic PMH in particular, institutions and settings often reveal cases of grave mistreatment and oppressive conditions that have led to the case in question. However, in Finland there has been little to no reporting of university suicides, and PMH in specific institutions is often attributed to 'performance-driven culture' or 'professional training crises' that avoid specific criticism. It is also noticeable that the Finnish media often include an interview with a Finnish Student Health Service (YTHS) psychologist or refer to YTHS statistics to provide a national clinical perspective, reinforcing the idea that this is a public health issue rather than an institutional one.

The belief that an effective management of presented cases through psychotherapeutic counselling and psychiatric intervention will reduce suffering has been shown to be misplaced through worsening situations and statistics outside the clinical domain, and these are seen to be congruent and long-standing in many Western countries. Yet there are few interventions genuinely aimed at prevention in an otherwise healthy student population that extend beyond awareness and voluntary pledges to safeguard mental health. It is also widely acknowledged that mental health professionals come into contact with only a small proportion of university students, and the majority of poor mental health goes unreported or undiagnosed, including among those who are driven to take their own lives. Accordingly, while expert in clinical management and treatment, mental health professionals are not well placed as the sole directors of policy and strategy in this sector, and should seek multi-sectorial assistance from other fields and professions if prevention is considered to be a key obligation of their respective professions.

## WORKING TOGETHER

The WHO has been a leading voice in promoting a multi-sectoral approach to PMH, emphasising the need for a whole-of-government and whole-of-society response (39). They advocate for collaboration between health, education, social services, justice and labour sectors to address the social determinants of mental health. Furthermore, the UN Sustainable Development Goals (40) also reflect this approach in SDG 3 which focuses on good health and wellbeing, and includes a target (SDG 3.4) to "*reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and wellbeing*". Roughly estimated, some 1.5 million people in Finland's adult population aged 25-64 have a university-level education, and so will have been proportionally affected by the historic incidence of poor mental health in Finnish universities. This likely represents the largest demography for study and intervention, especially given the high above-population incidences of poor mental health and suicidality for age and sector. Accordingly, even in a country with a comparatively small population, positive reductions in PMH and improvements in overall wellbeing are worth pursuing. The National Mental Health Strategy and Programme for Suicide Prevention 2020-2030 (41) guides decision-making and resource allocation in this field. But although there is an expressed aim to pursue multi-sectorial collaboration, published statements and visible activities still centre on registry reporting and management approaches to PMH, led and guided by mental health professionals, with input from bodies concerned with service provision and cost. Additionally, the emphasis in both elements of the programme is still towards 'young people' and service access/provision.

As an indicator of how invested resources might perform relative to expenditure: the benefit-to-cost forecast in published literature amounts to 2.3/3.0 to 1 when only economic benefits are considered when addressing poor mental health, and 3.3/5.7 to 1 when the value of health returns is also included (42). Given that the WHO cite a global economic cost of US$1 trillion per year from depression and anxiety alone (43), this advisory letter and other reports serve as a continuous call to action for increased investment and revised action in this sector, and highlights the real-world impact of poor mental health in university students.

Offers of further discussion on this important issue would be welcomed.

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