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## Responsibility and other dangerous ideas: who cares, who can, and who should in higher education

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### ABSTRACT

Universities are increasingly expected to assume greater responsibility for student mental health, with recent debates in the UK questioning whether institutions should hold a statutory duty of care. This paper critically examines what such responsibility might mean, who within the university is positioned to enact it, and the potential consequences of formalising responsibility through regulation. We distinguish between three overlapping forms of responsibility: a moral drive to care, grounded in empathy and relational connection; a legal duty to do no harm, which remains narrow and reactive; and a preventative responsibility, focused on building safe and supportive environments. Drawing on existing policy and research, we highlight the uneven distribution of responsibility across frontline staff, particularly academics, who often lack adequate training, recognition, and institutional support. We argue that regulation risks displacing authentic care, exacerbating inequalities, and contributing to burnout, while doing little to address structural conditions. Finally, we consider whether increased institutional responsibility serves students' best interests, warning that it may undermine opportunities for students to develop autonomy and agency. We conclude that rather than expanding regulation, universities should prioritise time, resources, and authentic relationships that enable both staff and students to share responsibility for community wellbeing.

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Mental health; duty of care; institutional responsibility; university policy; regulation

## Introduction

Universities describe themselves as academic communities. They do not currently appear to be happy communities. Students report high levels of anxiety and low levels of life satisfaction (Baik et al., 2019; Hauschildt et al., 2021; Lipson et al., 2019; Neves &

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Stephenson, 2023), while academics report high levels of stress and burnout (Urbina-Garcia, 2020).

Mental health is a state of wellbeing, enabling learning, agency and participation (World Health Organisation, 2014). It is not a fixed medical condition, but a dynamic and socially embedded state that fluctuates across time and context (Keyes, 2002; Patel et al., 2018). It is shaped by social relationships, institutional environments, and structural conditions (Allen et al., 2014; Baik et al., 2019; Brewster et al., 2022; Lund et al., 2018; World Health Organisation, 2014). Poor mental health has educational and pedagogical consequences. Mental distress disrupts the executive functions needed for learning (Wijbenga et al., 2024; Wood et al., 2018) and reduces intrinsic motivation, curtailing persistence and increasing disengagement (Fishman, 2014; Ryan & Deci, 2000b; Vansteenkiste & Ryan, 2013). Indeed, poor mental health is associated with increased likelihood of withdrawing from higher education (Baik et al., 2019; Byrom et al., 2025; Orygen, 2017).

Following a judicial ruling that *‘there is no statute or precedent which establishes the existence of... a duty of care owed by the university to a student’*, (British County Court, 2022) the UK Parliament debated in June 2023 whether to create a statutory duty of care (Hansard, 2023). Parliament noted that a duty of care exists in common law; education providers must not cause harm to their students through their own actions (Halfon, 2023; Parliament, 2023). The Minister for Higher Education urged all universities to adopt a whole university approach to promoting good mental health (Hansard, 2023). Similar discussions are happening beyond the UK, with encouragement to adopt a whole university approach in Australia (Orygen, 2020), Canada (CSA & Mental Health Commission of Canada, 2020) and Europe (European University Association, 2023). In the USA a court ruling noted a special relationship between student and university, giving rise to a duty of care under limited circumstances (“Nguyen v. Massachusetts Institute of Technology,” 2018).

Few would dispute that universities should be places where students thrive. Here, we question the best way of achieving this goal. We examine the notion of a duty of care and what this means in the context of student mental health. We ask whether legal regulation and accountability are likely to be able to foster better student mental health. Our focus is predominantly on the UK, though we expect considerations to be relevant around the world.

## Methods

We have taken an interdisciplinary approach to examine how responsibility for mental health is understood, distributed and enacted within higher education. We draw on higher education research, organisational sociology, the ethics of care, legal analysis, and psychological research on mental health and emerging adulthood. We start with the call for universities to ‘take more responsibility’ for student mental health and interrogate what a ‘duty of care’ might mean. Here we explore how the notion of responsibility might be understood in the context of mental health in higher education. Having set out ways of understanding the duty of care, we turn to consider who holds this duty. Universities are collections of individuals; thus, we start with the premise that for the institution to hold responsibility, presumably individuals in the institution must hold responsibility.

We ask who might be asked to execute a duty of care. Political debates have explored whether universities should hold more legal responsibility, thus we question whether regulation and accountability are well positioned to achieve the goal of supporting better student mental health. Finally, we return to the student, to ask whether it is in the students' interest for the university to hold more responsibility for their mental wellbeing.

## Analysis and discussion

### *In the context of mental health, what does a duty of care mean?*

Responsibility is a layered and contested concept. We distinguish three forms of care: the moral drive to care, a legal duty to do no harm, and institutional responsibility to prevent harm.

#### *Ethical intuitions and ethical institutions: a moral drive to care*

There is a human desire to care for those around us (Noddings, 2013; Ryan & Deci, 2000b; Tronto, 2020). Knowing we are part of a community, we feel drawn to care when the distress of another person is before us. This is related to human empathy; understanding and sharing the feelings of another person, expressing concern, offering support, and trying to alleviate suffering (Cuff et al., 2016; Hall & Schwartz, 2019). Entwined with a desire to help are related intuitions, such as a sense of moral duty or obligation. Taken together, these ethical drivers are a part of how communities thrive (Atkinson et al., 2020). Across sectors, frontline workers' discretion is where genuine, humane responses can emerge (Lipsky, 2010). People want to help and, when allowed, they sometimes find ways to adapt or even contravene rules to find opportunities for compassion (Armstrong & Byrom, 2023).

Many academics report feeling a profound sense of care (Hughes et al., 2018; Hughes & Byrom, 2019). Navigating this is complicated and emotive. A desire to care lacks clearly defined expectations and boundaries and can be beset by practical concerns about how best to help. At times, ethics can conflict with institutional policy. Different stakeholders, students, parents, academics, university administrators, disability advisors and mental health teams, may all claim to have the student's best interests in mind and yet define them differently.

Academics have a frontline role in universities, often being students' first point of contact in distress (Hughes et al., 2018; Hughes & Byrom, 2019). This is a fragile ecosystem. Zacka argues that front-line workers who implement policy, fall into one of three recognisable postures; they might follow rules with a strict adherence to regulations, they might be client-centred tailoring responses to individual needs or they might be adhocatic, flexibly experimenting, innovating and adapting rules (Zacka, 2017). While academics may tend towards being client-centred or adhocatic, Zacka (2017) warns that rules, sanctions or legal liability push workers towards rigid rule-based postures.

Many universities have sought to remind academics that they are not mental health professionals and not expected to take on this role; their role is simply to signpost students in distress on to appropriate services. However, clarification that academics are

not responsible for students' wellbeing does not reduce their drive to care (Hughes et al., 2018; Hughes & Byrom, 2019). Academics might understand that they should be signposting students in distress to other services. Research shows that academics frequently continue to care long after they have signposted a troubled student and fulfilled their statutory responsibilities: as one put it; 'This is somebody's child! I know I don't have a duty of care, but I'm worried about this person and there is nowhere, literally nowhere to go' (Hughes et al., 2018; Hughes & Byrom, 2019). There currently appears to be a dissonance between what academics feel they ought to do, motivated by empathy, worry and relational care, and what the university formally expects or enables them to do.

Moral intuitions are highly prized (Colby, 2003). Arguably, institutional culture should not only support but model civic responsibility (Thornton & Jaeger, 2007). The moral instinct to care is powerful. Greater discretion may enable staff to engage with students more naturally and authentically.

### *A legal responsibility to do no harm*

Institutional policies are often shaped by legal obligations. For employers, these obligations, grounded in tort, equality, and labour law, focus on avoiding harm, rather than enabling care. In this section, we examine the legal standard of 'doing no harm' and question whether it offers meaningful protection for staff or students.

In the UK employers hold a duty of care towards their employees (Almond et al., 2022). This spans tort and contract law, equality law and labour standards, including The Health and Safety at Work Act (Almond et al., 2022). The Health and Safety at Work Act (1974) places a duty on employers to provide employees with safe working conditions. Employers have a legal duty to protect employees from stress at work, defined as the adverse reaction to excessive pressure, by conducting and acting upon risk assessments (Health and Safety Executive, N.d.). However, there is little evidence that existing legislation is preventing work-related stress, with increasing proportions of the work force suffering work-related stress, depression or anxiety (Health and Safety Executive, 2024).

UK Universities also hold a common law duty of care (Hansard, 2023): an obligation to take reasonable care to avoid causing harm. This forms the basis of negligence claims in tort law and has underpinned successful claims by employees (Almond et al., 2022; Lockwood et al., 2017). However, there has never been a prosecution under the Health and Safety Act relating to mental health (Almond et al., 2022). The success rate for negligence claims is also very low, since claimants must prove employers could reasonably foresee harm (Lockwood et al., 2017). Employers may assume employees can withstand the normal job pressures unless aware of specific vulnerabilities (Lockwood et al., 2017). Provision of a confidential advice service or referral to appropriate services usually mitigates liability (Lockwood et al., 2017). The hurdle to be 'not negligent' thus appears very low. As UK universities provide counselling services, they are likely to be seen to be meeting their duty of care.

The UK legal obligations on employers are narrow, deficit focused and reactive. They offer little accountability for creating healthy environments or supporting staff to respond to distress. Scholars have critiqued employment law for being individually focused, unable to take a holistic or preventative approach (Almond et al., 2022). Rather than focusing on preventing harm, institutions should be striving to create the

conditions that promote good mental health. This ethos underpins the settings-based, health-promoting approach instantiated in the University Mental Health Charter (Hughes & Spanner, 2019, 2024; Zile et al., 2024). To meaningfully address mental health, institutions must look beyond compliance with legal minimums and embrace more proactive, relational forms of responsibility.

### *A responsibility to prevent harm.*

If moral intuitions speak to how we feel, and legal responsibility speaks to what we must not do, preventative responsibility concerns what institutions can and should do in advance. It is forward-looking and systemic, concerned not only with reducing risk but with building environments to minimise harm. Here we consider how this responsibility is framed in law, policy, and practice.

Universities in the UK have no duty to protect students from themselves (British County Court, 2022). The UK Care Act 2014 sets out a statutory duty for adult safeguarding. It applies to adults who have care and support needs, are experiencing, or are at risk of abuse or neglect, and, because of their care and support needs, are unable to protect themselves. While the Care Act sets a legal precedent for protecting individuals from themselves, it applies only in narrowly defined circumstances – specifically, where individuals are assessed as having care and support needs that leave them unable to protect themselves. This would rarely include university students.

Although the Care Act recognises that self-neglect is possible, it focuses predominantly on preventing abuse or neglect from care providers. In universities, preventing abuse, often framed as bullying and harassment, provides a starting point. Some forms of bullying and harassment are illegal. Further, discrimination based on protected characteristics is legislated against in the Equality Act 2010. The Office for Students has a statement of expectations for preventing harassment and sexual misconduct (Office for Students, 2024b). Institutions are required to embed their approach across the organisation, with governing bodies ensuring risks are identified and mitigated (Office for Students, 2024b). Universities therefore appear to have a defined responsibility to prevent a specific form of harm. However, while the Office for Students' Statement sets expectations, there is no statutory duty.

Universities are increasingly developing systems and roles aimed at preventing psychological harm, particularly in response to concerns about mental health, harassment and student safety. One such development is the employment of designated safeguarding officers. This reflects a growing commitment to create safe and supportive environments, but also responds to regulatory pressure, particularly around preventing harassment and sexual misconduct (AdvanceHE, 2019).

At an institutional level, universities are using safeguarding processes to identify and respond to students at risk. For example, King's College London has a Students of Concern process through which staff and students can log wellbeing concerns (King's College London, 2024). While not a crisis response, this provides a referral pathway for serious concerns, enabling case management, information sharing, referral to agencies and pastoral support. Similarly, the University of Northumbria developed a data analytics platform with Office for Students funding, to support early intervention. This 'Early Alert Tool' uses routine student data to identify individuals in crisis (Office for Students, 2019).

These developments suggest a growing institutional interest in and capacity to act proactively. However, implementation of preventative systems often falls short, remains uneven, fragmented, and often reactive to regulatory or funding pressures rather than grounded in a coherent strategy. Notably, pedagogy and curriculum design might be a focal point for proactive activity designed to prevent harm. How academics teach and assess students impacts student mental health (Jones et al., 2021; Upsher et al., 2023). In the UK, evidence-informed guidance has been developed to support lecturers and universities to reflect on how curriculum design, assessment practices and everyday teaching interactions influence student mental health, with opportunities to use proactive planning to craft more mentally healthy learning environments (Hughes et al., 2022; Hughes & Spanner, 2024). However, the five-year review of Charter assessments notes that in the UK, while pockets of good practice exist, institutions lack a structured approach to ensuring pedagogy and curriculum support mental wellbeing for all (Zile et al., 2024).

The absence of a statutory duty leaves universities to interpret responsibilities inconsistently, and roles such as safeguarding officers are often overlooked in strategic guidance. Without clearer definitions, preventative work risks becoming procedural rather than relational, focused on managing risk rather than cultivating community.

### *Who is the university and who might be asked to execute a duty of care?*

Calls for universities to hold a duty of care must also consider who is being asked to hold this responsibility. As policy frameworks increasingly promote early intervention and whole-institution approaches, we must consider where the burden of action falls. In practice, frontline staff, particularly academics, are routinely positioned as the first point of contact for students in distress. This section explores how structural and relational dynamics shape support, with implications for equity, preparedness, and institutional coherence.

The UK government's Mental Health in Higher Education Taskforce noted the need for universities to better identify students in need of support and to provide clear access routes to support (Department for Education, 2024). The taskforce argued that many vulnerable students remain invisible and do not receive adequate help (Department for Education, 2024). In this context, frontline staff are recognised as pivotal (Taskforce, 2025).

Academics are often the first to notice when a student is struggling (Hughes et al., 2018; Hughes & Byrom, 2019). This reflects relational and structural factors. Students often have a pre-existing relationship with their academic tutors and may therefore feel more comfortable disclosing concerns. Structurally, universities present the academic tutor as a student's key contact, typically more available than central services.

While personal tutors are usually academics on permanent contracts, teaching assistants are in precarious positions. They are usually PhD students employed on hourly contracts with minimal training make up much of the teaching workforce (Cornell, 2020). Academics in the UK have engaged in industrial action, raising concerns about the widespread use of casual contracts. Almost half of universities use zero-hours contracts to deliver teaching, and 22% of all academics are on fixed-term contracts (HESA, 2024; Jack, 2025; Parr, 2024; UCU, 2023). Frontline staff may be young, inexperienced and precariously connected with the university.

This lack of experience might not matter, if wider support structures held responsibility, but their capacity to do so is limited. The way universities operationalise policies under the Equality Act offers a useful case study. Most UK universities have a disability advisory service that develops study support plans to guide academics in making reasonable adjustments for specific students. On paper, the responsibility for identifying and communicating necessary adjustments sits with these trained professionals. In practice the disability advisory service only works with students who actively disclose a disability and engage with the service. Yet, the legal requirements of the Equality Act, clarified in recent guidance (Equality and Human Rights Commission, 2024), stipulate that if any staff member knows or suspects that a student has a disability, including a mental health condition, the university is deemed to know and should accommodate appropriately.

Many students are unaware that mental health conditions may qualify as disabilities, and few view themselves as eligible for disability-related support (Addis, 2020; Johnson et al., 2019; Pearson & Boskovich, 2019). As a result, academics are often the first to notice when a student is struggling. Students are likely to disclose challenges to frontline teaching staff first. This places responsibility back on those in a frontline role.

Across policies, procedures, and everyday practice, the task of supporting students and adapting practice is frequently delegated, explicitly or implicitly, to frontline academic staff. While universities may present this as part of a wider institutional approach, in practice it is often individual lecturers, teaching fellows, and teaching assistants who are expected to notice distress, initiate referrals, and respond appropriately. These tasks are shaped less by formal role definitions than by availability, visibility, and existing relationships with students.

### ***What are the limitations of regulation?***

Having considered the different ways a duty of care can be understood – as a moral impulse to care, a legal responsibility to do no harm, and a preventive aspiration to protect against harm, we reflect on the limitations of regulating care. While regulation promises clarity and accountability, it risks narrowing the space in which genuine care can occur (Armstrong & Byrom, 2023; Lipsky, 2010; Zacka, 2017). Caring is a relational practice that requires time, emotional investment, and discretion, (Atkinson et al., 2020; Noddings, 2013) yet these resources are already scarce within higher education (Hughes & Byrom, 2019; Morrish & Priaulx, 2020). They are also hard to capture via accountability checklists (Armstrong & Byrom, 2023). When responsibilities are codified without necessary support, they can become burdensome, unevenly distributed, and corrosive to staff and student wellbeing (Ahmed, 2012; Morrish & Priaulx, 2020; O’Keefe & Courtois, 2019; Tunguz, 2016). Regulating a duty of care may be counterproductive: it neglects the time care requires, leaves hidden emotional labour unacknowledged, exacerbates structural inequalities, and contributes to burnout and defensive practices among staff (Lipsky, 2010; Zacka, 2017).

Caring takes time; it cannot be rushed. (Noddings, 2013). Student perceptions of a caring lecturer depend on staff dedicating time to listening, supporting, and being available beyond formal teaching hours (Walker & Gleaves, 2016). Workload allocation

models typically allow personal tutors two to four hours per student per year. Can this realistically capture the time and emotional energy required to foster supportive relationships? The same workload allocation models rarely, if ever, recognise student support as taking up time for a module leader or teaching assistant. With many teaching assistants facing financial and career insecurity (HESA, 2024; Jack, 2025; Parr, 2024; UCU, 2023), it seems unjust to expect support beyond paid teaching hours. Regulation will do little without recognition of the time required to care. With increasing pressures across the sector, time and space to foster relationships seems scarce. More time, rather than more regulation, may be of greater value.

Often the work of care is present, but neither institutionally owned nor resourced. Emotional labour to manage one's own and others' emotions is often invisible, undervalued and uncompensated (Hochschild, 1979). In practice costs fall unevenly, with women and academics from minoritised backgrounds bearing a disproportion share (Ahmed, 2012; Tunguz, 2016). This distribution compounds existing structural inequalities and conflicts with universities professed commitments to equality. Care work is rarely recognised in promotion or appraisal frameworks, creating a misalignment between professed institutional values and reward systems (Morrish & Priaux, 2020; O'Keefe & Courtois, 2019). Staff who invest in student support often have less time for research, making them less competitive for promotion. Better recognition and formal reward structures for emotional labour and care work are vital; but this is not a shift that the higher education sector can easily make alone, this is shaped by much wider societal values and expectations.

For the most part, frontline staff lack the expertise they believe they need to respond effectively (Goel et al., 2024). It takes skill and experience to sit calmly and compassionately with distress and many academics feel ill-prepared (Morrish & Priaux, 2020). Unsurprisingly, there is a focus on better mental and emotional literacy training and support for academics (Department for Education, 2024; Goel et al., 2024; Gulliver et al., 2018; Taskforce, 2025). Although many institutions encourage academic staff to pursue professional recognition, such as accreditation through Advance HE, this does not include explicit training in how to promote student wellbeing or respond to distress. The Advance HE Professional Standards Framework notes that teachers should respect individual learners and diverse groups and promote engagement and equity of opportunity (AdvanceHE, 2023), but the development of skills to listen and to care are lacking. Increasing responsibility without accompanying training and support risks depleting academics' sense of autonomy and competence, fundamental for wellbeing (Dodd et al., 2025; Patrick et al., 2007; Ryan, 1995; Ryan & Deci, 2000a; Schutte & Malouff, 2021; Vansteenkiste & Ryan, 2013).

Increasingly, studies report a high prevalence of mental health problems, including burnout, among academic staff (Urbina-Garcia, 2020). Burnout is conceptualised as an occupational phenomenon, resulting from chronic workplace stress that has not been successfully managed (WHO, 2019). Zacka (2017) warns that external regulation can squeeze out intrinsic motivation to care, leading to burnout. Regulation, rules, sanctions or legal liability, undermine authentic drives to care, leading to cynicism and burnout (Zacka, 2017). Staff burnout is detrimental to students, reducing the care and support that students experience (Brewster et al., 2022; Rakow et al., 2024). Regulation reduces the autonomy needed to care.

There is evidence that policy, structures and rules threaten the moral instinct to care whilst failing to achieve their goal (Armstrong & Byrom, 2023). The consequences are already visible: staff burnout is high (Urbina-Garcia, 2020). Students describe frustration as they are passed from one person or service to the next (Dooley, in press); a defensive practice and a predictable consequence of tightened accountability mechanisms (Lipsky, 2010). Increased standardisation of mitigating circumstances, while designed to ensure accountability, risks eroding the space for care and replacing moral judgment with compliance logistics (Armstrong & Byrom, 2023; Lipsky, 2010). The challenge for the higher education sector is that increased regulation is coming at a time of acute financial strain (Booth & Halterbeck, 2025; Office for Students, 2024a). Lipsky (2010) cautioned that when regulation raises expectations without necessarily providing resources, frontline staff tend to cope by rationing and prioritising, leading staff to adopt harsher gatekeeping strategies to protect scarce resources.

Taken together, these examples demonstrate that regulating a duty of care is not a straightforward solution. When time, training, and institutional recognition are absent, rules and accountability mechanisms risk hollowing out the very relationships they aim to protect. Instead of fostering care, regulation can displace responsibility, deepen inequalities, and accelerate staff burnout, ultimately leaving students less well supported. If universities are to meet their obligations meaningfully, they must move beyond compliance and create the conditions in which care can be exercised safely, sustainably, and with authenticity.

### ***Is it in the student's interest for the university to hold more responsibility for their mental wellbeing?***

Up to this point, we have explored whether universities and their staff are able to take more responsibility for student mental health. But we must also ask a different, and perhaps more uncomfortable, question: is it in the student's interest for universities to do so? In positioning the institution as the primary holder of responsibility, we may risk depriving students of critical opportunities to develop their own capacity for care, self-regulation, and independence. This section considers the developmental implications of institutional responsibility, drawing on psychological and sociological perspectives to explore what students might gain, or lose, when responsibility is held for them, rather than with them.

Most students are emerging adults, navigating significant transitions (Wood et al., 2018). They are learning to hold responsibility for themselves – financially, emotionally, and practically (Tanner et al., 2008). For some, this is overwhelming; for many, it is entirely new. Contemporary adolescence offers few opportunities to practise autonomy before adulthood (Larson, 2000; Schlegel & Barry Iii, 1991). Expecting universities to carry responsibility for student wellbeing shifts it away from students themselves. Yet, the acquisition of responsibility is recognised as essential to adulthood (Arnett, 2000, 2010; Tanner et al., 2008). Many emerging adults are averse to taking responsibility (Arnett, 2000), but developing this capacity is critical. There is broad agreement that adolescents and young adults must learn to take responsibility for managing their own lives (Gordon et al., 2009), and that educational institutions have a role to play in fostering this development (Mameli et al., 2019).

A sense of personal responsibility is associated with positive mental health outcomes, including greater motivation, self-regulation, and perceived control over learning (Fishman, 2014; Higgins et al., 1994). Successfully fulfilling difficult obligations builds both skill and identity, reinforcing an individual's self-conception as someone who can be responsible (Salusky et al., 2014). Societies that cultivate responsibility effectively tend to offer a progression of increasingly challenging roles that prepare young people for adult life (Ochs & Izquierdo, 2009). This means that stressors, risks and experiences of failure cannot simply be seen as harmful or instances of a lack of institutional care or compassion. If students are to gain confidence in holding responsibility, they need real opportunities to practise it and to experience success.

Where universities assume responsibility, they may limit growth opportunities. Yet, expecting students to manage entirely on their own, without support or scaffolding, risks failure and reinforces reluctance to take on responsibility. As with any form of learning, personal responsibility must be developed gradually and with guidance (Belland et al., 2013; Vygotsky, 1978; Zackariasson, 2020). This principle is well established in mental health practice. Therapists and coaches often work explicitly to help clients take responsibility for their own wellbeing. Boundaries in clinical relationships foster empowerment and engagement (BACP, 2023). Effective therapy supports clients to develop confidence in their capacity for self-care, rather than fostering dependence.

If students are to learn how to care for themselves, universities must provide environments where mistakes and learning are possible. A purely reactive model, where academics are expected to notice distress and step in, may crowd out space for students to practise self-regulation. While well-intentioned, such responsiveness may unintentionally limit student agency.

An alternative approach would be to offer students meaningful roles in shaping and supporting community wellbeing (Dodd et al., 2024, 2025). Salusky et al. (2014) argue that social roles help mediate the development of responsibility. Sociologists note that roles come with obligations but also confer agency; the freedom to interpret and perform responsibilities in different ways (Newman & Newman, 2015).

Academics, in this view, may have an important role to play – not by holding responsibility *for* students, but by modelling what it looks like to hold responsibility *well*. This kind of learning depends on relationships. Yet today's universities offer students relatively few opportunities to build meaningful relationships with staff or peers (Byrom et al., 2025; Priestley et al., 2025). This marks a stark contrast with schools, where students often know their teachers personally, and workplaces, where managers usually know and support employees.

These reflections suggest that taking more responsibility for student mental health may not always serve students' best interests. While institutions have a duty to provide support, they must also consider how to foster student autonomy, resilience, and agency. Responsibility, if held too tightly by the university, can crowd out opportunities for students to learn to care for themselves and others. For academics to take responsibility effectively, relationships matter. More importantly, these relationships may offer the very conditions through which students begin to build their own capacity for responsibility. The challenge is not simply how much responsibility the university should hold – but how it holds it, and how that holding supports the development of responsible, capable adults.

## Conclusion

We have traced the evolving and contested landscape of responsibility for mental health in higher education. Starting from the observation that universities are increasingly expected to take more responsibility for student mental wellbeing, we have unpacked what a duty of care means, and importantly, does not mean in a UK context and who is being asked to execute this. We have identified limitations of regulation, both from the perspective of the university and students.

We distinguished between moral, legal, and preventative forms of responsibility, highlighting how each frames the role of the university. While a moral drive to care is grounded in empathy and relational care, legal responsibility tends to be minimal and reactive. Legal force narrows the discretion that allows authentic, caring relationships (Lipsky, 2010). Preventative responsibility, though increasingly invoked in policy, remains inconsistently implemented and often driven by external pressures rather than coherent strategy.

Our analysis shows that, in practice, the duty of care frequently falls to frontline academic staff. These staff often lack the experience, training, clarity, and institutional support needed to care. For many, this creates emotional strain and uncertainty. Regulation governing how to care, and who to share information with may exacerbate burnout, reducing intrinsic motivation to care.

Finally, we considered whether holding more responsibility is always desirable. While support is necessary, universities must also create space for students to develop autonomy and agency. Responsibility, if held too tightly by institutions, can displace rather than support this growth. The challenge is not simply whether universities should hold more responsibility, but how they do so, and how that holding can remain both relational and developmental.

Ultimately, we call for a more honest and grounded conversation about responsibility in higher education – one that recognises not only what is needed, but also what is possible. We doubt that care can be regulated. We doubt that increased accountability will improve the student experience. Care takes time and thrives with the freedom to be authentic.

## Author contributions

Conceptualization: N.C.B., A.D., S.C., P.C.J., and N.A. Funding acquisition: N.C.B. and E.W. Writing - original draft: N.C.B. Writing - review & editing: N.C.B., A.D., S.C., P.C.J., E.W., and N.A.

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