TASO Transforming Access and Student Outcomes in Higher Education

The current landscape of the delivery and evaluation of student mental health interventions

Tatjana Damjanovic, TASO

With thanks to Jo Ward, King's College London/SMaRteN

February 2024

TASO Transforming Access and Student Outcomes in Higher Education

Contents

Executive summary

Overview

This report presents the perspectives of practitioners and stakeholders involved in the delivery and evaluation of student mental health interventions in the UK. Drawing on a qualitative study of 40 interviews, the report considers the underlying resources, assumptions and relationships that shape a mental health intervention in a higher education setting. The report draws parallels between the challenges of implementation and those of evaluation, suggesting that a holistic approach might help remove the current barriers faced by students in receiving appropriate and timely mental health support.

The Student Mental Health Evidence Hub

This study informed the development of the Student Mental Health Evidence Hub, a free resource developed as part of the Student Mental Health Project. Many of the challenges to evaluation are addressed in the Hub. For example, the need for a set of outcome measures for a non-clinical setting can be found in the Hub's evaluation guidance, while the challenge of deciding where to allocate limited resources is addressed in the Hub's evidence-based toolkit.

Findings

The study draws out four key themes:

1. **Resourcing needs in student mental healthcare**

This study found that the student body seems to be changing in terms of demographic composition and student expectations, putting unprecedented pressures on student services. The pressures that practitioners face are complicated further by short-term funding structures that restrict not only the timely delivery of interventions but the possibility of evaluating and embedding them into the wider university or college system. There are concerns that short-term funding structures lead to brief interventions that sometimes act as a 'plaster' over deeper issues of systemic injustice or institutional practices and impede the possibility of long-term evaluation and sustainable practices.

2. **Co-existing medical and social models of mental health**

When it comes to the design and delivery of interventions, there is a difference in opinion regarding how it is best to refer to mental health difficulties. Indeed, the debate regarding the use of clinical models and the medicalisation of negative feelings has no immediate or clear resolution. The debate about whether to use clinical or social models affects how interventions are designed and how they are promoted to students. The differences between clinical and social models of mental health also determine how an intervention intends to make change, and, therefore, which outcomes are used to measure its impact. As practitioners struggle to find the appropriate outcomes, there seems to be a need for guidance on evaluation methods and outcome measures that are appropriate to the context of higher education.

3. **Developing networks of care**

This study found a network of relationships that are key to upholding the structures that make a student mental health intervention work. The relationships between different teams and departments as well as those between higher education providers and external organisations need nurturing. We found that common ground is the most fertile. The

relationships between higher education providers and external organisations work best when they find commonality: common problems, common goals and a common language.

4. **Collecting, managing and sharing data on student mental health**

Data collection and management practices are central to each stage of an intervention's development, from design and delivery to evaluation. The extent to which a higher education provider can ensure that they collect, manage, share and analyse data on student mental health is dependent on the resources available as well as the relationships between departments or organisations. There is also a concern that inaccurate demographic segmentation could be homogenising vastly different experiences. An awareness of cultural nuances emerged as an important factor in collecting reliable data because different student groups experience mental health stigma differently, prompting disparities in disclosure rates.

Next steps

Further research is needed in a UK context. In particular, more research is needed on interventions that do not name mental health in their promotional materials and are delivered therefore by 'stealth'. It is also recommended to build on existing evaluation of whole university approaches as well as NHS partnership working projects.

Introduction

There is an increasing need for more student mental health support. The unprecedented challenges of COVID-19 (Fancourt, Steptoe and Bradbury, 2022) and the subsequent period of financial instability put pressure on already over-stretched services. A recent study found that the percentage of UK students in higher education reporting mental health difficulties rose by almost threefold in the last six years, rising from 6% in 2017 to 16% in 2023 (Sanders, 2023). This study looks at the context within which student mental health interventions are delivered and evaluated. It considers a broad range of interventions and practices that work towards keeping students safe and well as well as helping students if they face mental health difficulties. The report provides a valuable snapshot of the experiences of practitioners and stakeholders with a view of encouraging a holistic approach to solving the challenges faced by student mental health services. It finds that the challenges of implementation and evaluation of student mental health interventions are closely intertwined, as are the relationships and systems that support them.

We have adopted a non-clinical understanding of mental health and wellbeing. At its core, this is the understanding that mental health and wellbeing is a spectrum that is not necessarily determined by a medical diagnosis. We refer to ‘mental health’ when referring to a person’s emotional and mental state and ‘wellbeing’ when referring to a broader spectrum of experience, including a person’s physical, social and economic context. For this reason, we have preferred using terms such as ‘mental health difficulties’ and ‘poor mental health’ and referring to persons experiencing a diagnosis as ‘living with’ a diagnosis. However, there are instances in which clinical references are used for clarity. For example, clinical language may be necessary when referring to ‘serious mental illness’ where the term is commonly used within primary and secondary care services and therefore higher education providers (HEPs) may need to align their terminology with that of external healthcare providers.

Mental health is important for everyone and mental health difficulties may affect any student in their journey through higher education (HE). However, research has shown that some groups of students are more at risk of experiencing poor mental health than others. In a review of the evidence, we found that students from lower socio-economic backgrounds, students from Black, Asian and minority ethnic backgrounds, mature students, lesbian, gay, bisexual, transgender, queer/questioning, asexual and other (LGBTQA+) and care-experienced students all are at a greater risk of suffering from poor mental health (Robertson, Mulcahy and Baars, 2022). Poor mental health can affect student outcomes including attainment, entry rates and progression into employment. Addressing the disparities in student mental health is therefore a way of tackling broader issues of inequality in HE.

Sector wide, there has been a flurry of activity aimed at addressing the rising need for student mental health support via funding competitions, policy changes and publications of new guidance. Funding opportunities such as the Office for Students Mental Health Challenge Competition (2020) and Mental Health Funding Competition (2021) have established new projects that address a variety of student groups and new guidance and frameworks such as the Mental Health Charter (Hughes and Spanner, 2019) and the StepChange report (UUK, 2023) have provided support for HEPs to develop a whole university approach to student mental health care. Most recently, we have also seen involvement of the UK government through the establishment of the Higher Education Mental Health Implementation Taskforce (GOV UK, 2023).

There are, however, often subtle differences between research, policy and practice. As the landscape for student mental health changes, it can be easy to lose sight of the details. This study asks how practitioners and stakeholders that work with students or support those who

work with students understand the changing landscape. By rooting our questioning in current practice, we look at the inhibitors and enablers, the tools and the challenges that HEPs are equipped with to tackle student mental health support. We look at how different HEPs have approached the design, implementation and evaluation of mental health interventions.

The study is based on semi-structured interviews with 40 practitioners and stakeholders currently working within student mental health. It was conducted as part of the Student Mental Health Project, an Office for Students funded project that aims to help HEPs develop their student mental health interventions. Please see Annex A for more information on the Student Mental Health Project. We found a very wide variety of practices in designing, implementing and evaluating interventions and valued participants as experts in adapting interventions to the particular contexts in which they work. Throughout the report, distinctions between practitioner and stakeholder perspectives are mentioned where relevant.

Methodology

This study was conducted as part of The Student Mental Health Project, an Office for Students funded project that aims to help HEPs develop their student mental health interventions. The study was used to provide a contextual background that informed the development of the Student Mental Health Evidence Hub (TASO, 2023) and the guidance within it. For more information regarding how this study has informed the Student Mental Health Evidence Hub, please see Annex A. The Student Mental Health Evidence Hub (TASO, 2023), is a free resource consisting of an evidence-based toolkit, evaluation guidance, examples of current practice and results of our sector engagement and student panel work. The project has been led by the Centre for Transforming Access and Student Outcomes in Higher Education (TASO) in consortium with What Works Wellbeing, SMaRteN, Student Minds and AMOSSHE, the Student Services Organisation.

Semi-structured interviews were held from December 2022 to February 2023. The interviews were held online, and were recorded and anonymised. Ethical approval was sought and gained from TASO's external ethics board, Nottingham Trent University. Ethical guidelines were followed and participants were informed about the use of their data that confidentiality would be ensured and that they could withdraw from the research process at any time.

Rationale and research questions

Guided by the findings of the *What works to tackle mental health inequalities in higher education report* (Robertson, Mulcahy and Baars, 2022), we conducted a series of semi-structured interviews with practitioners and stakeholders working within mental health in HE. As a component part of the Student Mental Health Project which sought to gain a better understanding of what works for student mental health, this study sought first to understand how student mental health interventions work. The study followed an exploratory approach, seeking to understand more about the current landscape of student mental health provision, delivery and evaluation. Our primary research questions were:

- What are the inhibiting and enabling factors that influence the provision and delivery of a student mental health intervention?
- How are student mental health interventions evaluated, and what contextual factors affect evaluation practice?
- What are the key relationships involved in the development of student mental health interventions?

The interview questions were designed to delve deeper into the underlying structures, difficulties, protective factors and nuances that determine how an intervention works. Though current policies were mentioned by participants, they were not explicitly asked about. For this reason, the report does not look at specific debates and policies such as the debate around the statutory duty of care in HE (HC Deb, 5 June 2023). This study was exploratory, and therefore captures the context of student mental health support and the everyday workings of institutional or regulatory policy.

For the full interview schedule, please see Annex B.

Analytical strategy

The interviews were conducted by two researchers and audio-recorded. The recordings were transcribed using Nvivo Transcription. The data was then analysed by two researchers using inductive thematic analysis following the process of 'thematic induction' as proposed by Braun and Clarke (2006). This involved attributing initial codes to segments of data following an initial familiarisation with the entire data set. As analysis was conducted by two researchers, an initial five transcripts were analysed by both researchers so that an initial codebook based on agreed understandings of codes was established. Following that, codes were refined and then clustered into coherent themes.

This was a reflexive process for both researchers and involved regular meetings to discuss interpretations, codebook changes and development of themes to ensure intercoder reliability. For example, we had recurring discussions regarding how student mental health needs are talked about. We found that one researcher had a more student focused approach and the other a more institutionally focused approach to understanding student needs. This not only reminded us to work within our different positionings with awareness and care, but alerted us to a key issue that informed the development of a theme. Please see Annex E for a full list of nodes, sub-nodes and the number of utterances coded to them.

Through thematic analysis, the themes that emerged reflected the ways in which practitioners and stakeholders understand what students need and how they should be supported. The themes also tackle the practicalities of developing interventions and address the approaches, methods and resources available to HEPs.

Four key themes and 12 sub-themes emerged. Please see Annex E for the final codebook.

- **Resourcing needs in student mental health support**
  - Changing student body
  - Underfunding of crisis support
  - Short-term funding
- **Co-existing medical and social models of mental health**
  - Conceptualising mental health
  - Approaches to evaluation
  - Stigma and 'stealth'
- **Developing networks of care**
  - Siloed structures
  - Community building
  - Shared problems and shared solutions
- **Collecting, managing and sharing data on student mental health**
  - Cultural differences and data collection
  - Managing and sharing data
  - Adapting evaluation practices

Sample

Our sample consisted of 40 practitioners and stakeholders working within student mental health. We interviewed 26 practitioners and 14 stakeholders in total. We approached a wide range of practitioners and stakeholders from a variety of HEPs and external organisations engaging in a variety of interventions. Participants were primarily from HEPs in England, with the exception of one from Scotland.

Participants have been anonymised and are referred to by their status as a practitioner or stakeholder and their institution or organisation type, followed by a randomly allocated number. For example, Pr_P92_36 refers to a participant who is a practitioner working on an active psychoeducation intervention in a Post-92 institution[1]. All abbreviations of institution types are listed in the table below.

The definitions of practitioners and stakeholders were set as follows:

Practitioners (Pr):

- Mental health and wellbeing practitioners delivering interventions (such as support workers, mentors and therapists)
- Academics designing and evaluating interventions
- Project managers of student mental health and wellbeing interventions (within a HEP)

Stakeholders (St):

- Psychologists and therapeutic practitioners (from NHS or third sector organisations)
- Deans and Vice Chancellors
- Third sector representatives (such as CEOs, managers or mental health professionals employed by charities)
- Senior leaders in associated organisations
- Government or policy figures and advisors

For a breakdown of the variety of practitioners and stakeholders interviewed per institution type please see the table below.

Institution/Organisation Type	Abbreviation	Practitioner	Stakeholder
Russell Group	RG	5	
Oxbridge	RG[2]	2	
Post-92	P92	13	
Small and Specialist	SS	2	
Further Education	FE	1	
Public Research University	PRU	4	
Corporation	C		1
Mental Health Charity	MHC		9
Higher Education Body	HEB		1

[1] 'Post-1992 institutions' are former polytechnics, central institutions or colleges of higher education that were given university status by the UK Government in 1992.
[2] Please note, for confidentiality purposes, interviewees from Oxbridge are recorded as Russell Group universities.

Research Body	RB		1
Governmental Body	GB		1

Participants were selected if they fulfilled three or more of the following selection criteria:

- Works with/in interventions that are targeted towards specific student groups. For example, students who identify as LGBTQA+, students from Black, Asian and minority ethnic backgrounds, disabled students or students with experiences of care.
- Works with/in interventions targeted towards students with intersectional identities.
- Works with/in intersystem collaboration interventions.
- Works with/in settings-based interventions.
- Works with/in interventions that are innovative (such as using new technologies, new partnerships or new ways of working).[3]
- Has conducted some prior evaluation.
- [For practitioners, an additional category:] Has additional connections in the sector network (such as trusteeships, committee members, round table participants etc.).

For further details on the selection criteria methodology, please see Annex C.

Limitations

Due to availability, we were not able to ensure a completely even cross-section of participants and stakeholders from all types of HEPs and representing all types of interventions. As participation was voluntary, the participants who wished to be involved in our research were, to some extent, already those engaged in the changing tides of the student mental health landscape.

Furthermore, our focus on innovative work did mean that some participants were working on interventions that had only been recently established. While they provided insight into the most current ways of working, this made it more difficult to get a complete picture of the longer term inhibitors, enablers and effects at play.

A final limitation to this research is the limited involvement of student voice. Despite this research being part of a larger project involving a Student Panel, they were not involved in the design or development of the qualitative research. To mitigate this limitation, some later focus groups with students were conducted as a separate piece of research.[4]

Findings

Overview of themes

Our findings are condensed into four overarching themes.

The first theme, ***Resourcing needs in student mental support***, addresses the way student support services are having to meet the demands of the changing student body in the face of limited financial resources. There is a particular focus on the effect these strains have on producing a disparity between preventative and crisis support.

[3] For more details regarding the focus on innovative practice, see Annex C.
[4] Insights from the student focus groups can be found on the Student Mental Health Hub, accessible on https://taso.org.uk/student-mental-health-hub/student-panel/insights-from-the-student-panel/

Delving further into the conceptual tensions behind student mental health support, the theme ***Co-existing medical and social models of mental health*** considers the way different definitions of mental health shape an intervention, from assessing need, to implementation and evaluation.

Another underlying structure to developing interventions is addressed in the third theme, ***Developing networks of care*** where the key relationships and dynamics that underpin an intervention are discussed. In particular, navigating siloed structures, community building and finding shared problems and solutions are drawn out as helpful ways to manage interventions in partnership with external organisations and across departments.

The final theme, ***Collecting, managing and sharing data on student mental health*** considers the way data collection and management are entangled in questions of staff capacity, cultural sensitivity and the complex relationships between departments.

Resourcing needs in student mental health support

In the main, participants described current student mental support as an uneven and changing landscape. Both practitioners working within HEPs and stakeholders from external organisations articulated difficulties in providing appropriate provision for students in the face of limited financial resources and the perceived changes in the student body.

A changing student body

Many participants expressed an awareness that the student body is changing. As one participant noted, this is a crucial factor determining the kind of support that is put in place: 'we needed to have an understanding of what was in the student body to have an understanding of how to enable them and our students to succeed' (Pr_P92_36). Some participants described the changing student body as one that was changing in terms of demographic composition, noting an increase in international students, students from lower socio-economic backgrounds and students with other responsibilities such as caring responsibilities or work. Other participants, on the other hand, highlighted generational differences such as incoming students being 'digital natives' (Pr_PRU_8) and finishing secondary education during COVID-19. Many participants also observed a decline in both staff and student wellbeing caused by the rise in the cost of living from 2021. The observations around the changing student body were made predominantly, but not exclusively, by practitioners from post-92 institutions and public research institutions. In particular, the impression of the declining student and staff wellbeing was a common observation by participants regardless of where they worked.

These changes in student circumstances also impact the levels of demand for mental health support and the way in which mental health support is expected to be delivered. Practitioners noted that students have less time in the day and need out-of-hours care or are now accustomed to studying more online following COVID-19. Conversely, some reported a demand for more in person support in reaction to post-pandemic ways of working. It was also noted by a select but diverse few practitioners and stakeholders that changes related to student fee arrangements, and competitive market practices within HE seem to have contributed to students increasingly placing more demand for higher standards of service and provision as a return on investment.

The changes in the student body have created additional and more nuanced demands on student services to address the complexity of the current need in their provision. Most practitioners and stakeholders cited anxiety and depression as the most common difficulties students face, followed closely by stress and a lack of belonging as well as noting a rise in

serious mental illness and crisis cases. There was, in equal measure, concern that students from Black, Asian and minority ethnic backgrounds, as well as international and postgraduate students, do not disclose mental health difficulties. Practitioners and stakeholders both held a sense of the student mental health landscape as one experiencing unprecedented change. In particular, for those that perceived this changing landscape, it was the scale and diversity of student mental health needs that stood as concerning factors. There is a sense that better data collection is needed to fully understand all the nuanced ways in which the student body is changing (see *Collecting, managing and sharing data on student mental health*).

Short-term funding

Many participants felt restricted by limitations in their 'capacity' to meet the changing needs and demands in student mental health. 'Capacity' was often used to refer to all the types of resourcing needed to implement an intervention successfully; funding, time, training, staff and by extension, staff wellbeing.

When referring to funding difficulties, participants referred to the brevity of funding cycles and the competitiveness of both external funding bids and bids for business cases within HEPs themselves. Considering the time it takes to put together bids and business cases, the brevity of the funding cycle in comparison to the workload involved in putting it together, these difficulties threaten the sustainability of student support services. Many participants discussed the issue of administrative costs in their funding, noting difficulties when funding focuses on meeting 'per head' student costs and does not contain supplementary funding to support the administrative costs of effectively managing and evaluating developments. This was remarked predominantly by participants in receipt of external funding though there were participants who had received funding from their own HEP to run additional or pilot programmes who also noticed this difficulty. Funding structures also meant that many participants were working on interventions that would only last between 12 to 18 months unless refunded. There were many implications of working within condensed timelines such as increased staff stress levels, high staff turnover, limited recruitment and training periods, limited time to develop effective promotional materials and limited evaluation processes.

In four cases, participants associated short-term funding structures as promoting interventions that they termed a 'plaster', that is, providing merely short-term solutions (Pr_P92_24, Pr_PRU_22, St_MHC_16, St_MHC_31). One participant explained that 'This [intervention] is a really good plaster. But ultimately, this isn't a long term sustainable and systems focused solution' (St_MHC_31). In these cases, the participants found that short-term funding cycles lead to a short-sightedness which offers a limited and superficial form of care to students:

> 'There is one [project] on therapy dogs or something. These little things that are great. But to me, that's half of the story and the other half is what's causing this and adding to these stresses in the first place and what can we do about that?' (Pr_P92_24)

For these participants, 'plaster' interventions indicate a lack of capacity to look at the underlying issues in student mental health.

Short-term funding can also limit interventions because there is not enough time to embed them into the wider support system. Many participants were aware that their intervention relied heavily on particularly dedicated individuals working within the team, thereby risking the sustainability of the intervention and lowering staff wellbeing. As one participant put it, 'it's people based. It's not system based' (St_HEB_1). The difficulty of 'people based' systems stretches to limiting evaluation practices. The most rigorously evaluated interventions in this study (that is, those using methods that provide reliable data and were

replicable) had the opportunity to engage academic staff with the interest and expertise to evaluate the intervention. This, most often, was not budgeted or considered to be support-in-kind, meaning that the evaluation process is reliant on staff who are willing to take on extra workload.

Many participants mentioned that the depth and rigour of their evaluation process was deprioritised when faced with limited funding: 'each bit has had some dimension of evaluation, but it's been weak because there isn't the capacity' (Pr_P92_36). In some cases, evaluation plans were written after the project itself began. In others, while data was collected, there was a lack of dedicated staff with the time or skills to analyse the data. There was also a concern about the ways in which short-term funding limited the possibility of measuring the long-term impact of an intervention.

> 'But we just can't do it in the timeframe of this project for something that's [...] something as intangible in some ways as mental well-being, because it varies so much at different times, doesn't it. And just, yeah, I think it needs to be a longer term project really for us to manage that.' (Pr_P92_29)

There was an understanding among participants that measuring both student educational outcomes and mental health outcomes takes time. Without long-term funding, there is a limit to the way an intervention can become embedded within a HEP in a way in which it is rigorously evaluated so that it can address systemic problems that negatively affect student mental health.

Underfunding of crisis support

Participants remarked how financial difficulties have led to reduced student service departments and longer waiting lists. The issues with resource allocation became particularly noticeable when discussing the disparity between preventative support as opposed to crisis support.

> 'There is a resource limit. And because even maybe 15% of our students come in with known mental health issues, but that means 85% will probably never use our service, or well, say, 80% will never use our service. They're cross-subsidising students who need it, which is the right thing to do. But there's a limit to how much that appropriate cross-subsidy is.' (St_P92_3)

Many participants described the challenge of resource allocation as a difficult ethical decision. As the aforementioned participant put it, resource limits mean that decisions about the distribution of care position the universal needs of the student population against the needs of smaller, more vulnerable groups of students. In cases in which crisis care was limited because of a lack of resourcing, participants noted that the disparity in funding impacts students from Black, Asian and minority ethnic communities disproportionately. In one HEP, Black students made up '25% of the students that were seen throughout the years. The Black students were overrepresented in the crisis referral pathways' (Pr_P92_14). As participants found that student disclosure of mental health difficulties was generally lower for Black, Asian and minority ethnic students, and that they accessed preventative support much less, there is a higher proportion of Black, Asian and minority ethnic students who might need support at a point of crisis but might struggle to access it due to funding limitations.

Out-of-hours support and crisis support in particular rely on robust reporting structures, collaborative working, good data management systems and trained staff, all of which require consistent and considerable funding. In most HEPs, these types of support rarely sit within the institution itself. Instead, most HEPs triage to appropriate service providers with whom they have established partnerships, including charities and the National Health Service (NHS). However, caught between different organisations, the delivery of crisis support and out-of-hours services often suffer because of chronic underfunding across all the

organisations involved. As one participant observed, funding restrictions even limit the possibility of understanding the scale of the problem:

> 'But what we're finding now is unrepeatable problems to deal with resource absence or just the kind of chaos that is reigning in A&E. Nobody in A&E will know necessarily that this person is a student. They won't know the protocols for contacting us. They won't have the time to do that' (St_SB_P92_3).

When discussing partnerships with the NHS, participants remarked on the way that funding structures determined the eligibility threshold for care. As one participant explained:

> 'Unfortunately colleagues in the NHS being so under-resourced to kind of meet in the middle, they're finding it very difficult to be managing resources that are around anything that's not probably very high risk. So we can often see students who we feel are at high risk, but actually compared to the risk they're [the NHS] dealing with doesn't quite meet the threshold, which means we still have to then manage young people at risk in the community.' (Pr_PRU_28)

In some cases, this has led to students being denied support because they do not meet the most extreme thresholds for primary or secondary mental health care but simultaneously being considered too unwell to receive adequate care from university or college support systems. One practitioner termed this 'the ping pong effect', where students are continuously referred on to other services (Pr_PG_8), caught in a grey zone of eligibility thresholds between different institutions.

Co-existing medical and social models of mental health

There was a shared awareness that the dilemmas regarding language use to refer to mental health and mental distress informed the way an intervention was designed, implemented and evaluated. However, there were varied opinions regarding the use of medical and social models to define mental health.

Conceptualising mental health

Some participants drew attention to the way student mental health needs are, in themselves, conceptualised. In particular, a third of the participants were concerned about over-medicalising difficult or unwanted feelings:

> 'And then lastly, you've got the medicalisation of normal human feelings and emotions, anxiety, for example, feeling anxious. Any mental health charity, Mind, Mental Health Foundation, any medical organisation, NHS, whoever, will tell you it's normal to encounter issues before an exam or an interview. Stressful situations. But in a survey we did of some of the first year students, 90% said anxiety was a mental health problem. Stress is another one.' (St_MHC_12)

There was a shared sentiment that the 'medicalisation' of unwanted feelings has changed the way the quality and scale of student mental health needs is understood by practitioners, not merely because it impacts how students might answer mental health questionnaires or any other self-reports. It was argued that conceptualising anxiety and stress in particular could pathologise such experiences in a way that blocks students in their studies and is unhelpful.

Underlying the issue of 'medicalisation' is a tension between mental health practitioners, academic staff and students and their seemingly unaligned expectations of what mental health within a university looks like. That is, many practitioners mentioned that they perceived academic staff expecting students to accept more challenges and stress than

students expect to handle. As only academic staff working directly on student mental health interventions were part of this study, we cannot comment on the expectations general academic staff have of students.

While there were reported differences between the way students and staff at HEPs defined mental health difficulties, there were also varied ways in which different departments in the same institution defined and addressed mental health difficulties. In one example where an intervention was co-designed between an academic skills service and a wellbeing service, a participant remembered an early conflict between the two departments regarding the kind of language to use to promote the intervention:

> 'I still think there's a little bit of a battle around where we think the project needs to go and who we think needs to be involved. And I think the language is quite a major issue between the two teams because where academic skills and where wellbeing... and I have to say, I feel that their model is very deficit, whereas our model as a skill centre is quite aspirational.' (Pr_P92_25)

The participant pointed out that following the 'deficit model' (Pr_P92_25) shapes how an intervention intends to create change because it formulates the starting point as a problem that needs to be solved. They pointed out that this also affected how students engaged with the intervention. In this example, the teams addressed these frictions by consulting students in focus groups and shadowing each other's teams for a short period of time. With steering from the students, they settled on language referring to 'boot camps' and 'writing gyms' as the language of fitness and self-improvement was deemed more suitable and familiar to students.

Stigma and 'stealth'

Some practitioners preferred to avoid any language or references to mental health. Based on anecdotal evidence from colleagues and previous work, they found that they could increase student engagement if they did not openly mention mental health. One practitioner termed this a form of delivering support by 'stealth' (Pr_PRU_30). These practitioners had noticed that stigma around mental health prevents some students from accessing interventions. They pointed out that delivering an intervention by 'stealth' was a way of engaging students who would usually be reluctant to be associated with mental health support. Another reason for delivering interventions by 'stealth' was in the case of preventative interventions where the benefit of not using any language related to mental health in the title or promotional materials of an intervention normalised dealing with stressful situations without feeling pathologised (St_MHC_12). In one instance where a practitioner was promoting an intervention that offered a virtual reality (VR) cognitive behavioural therapy (CBT), they focused on promoting the benefits of the intervention such as improving employability and confidence. The reasoning behind it, as they put it, was that this allowed space for more young male students to participate:

> 'You're supporting people without them kind of being actively aware that they're receiving some kind of support. And that's what it allows you to do because it does feel like a gaming experience rather than a therapy.' (Pr_PRU_30)

However, one participant commented on feeling conflicted about the avoidance of openly using language relating to mental health when designing an intervention for postgraduate students. They found that the stigma around seeking support was particularly pronounced at postgraduate level where academic pressures are very high. The dilemma they pointed out was that 'if we're not being more open about these being about mental health in the first place then we're not really tackling that stigma, just trying to sort of just circumvent it' (Pr_P92_24). The ultimate decision to omit mental health language from promotional materials was made based on the conclusion that tackling mental health stigma was outside

the scope of a pilot mental health intervention with short-term funding and 'we just almost have to pick our battles' (Pr_P92_24).

Approaches to evaluation

The coexistence of medical and social models of understanding mental health also has an impact on evaluation practices. Most practitioners used mixed method approaches but found it difficult to find appropriate validated questionnaires and outcomes measures given the non-clinical context they work in.

While many used validated clinical scales such as the Patient Health Questionnaire (PHQ-9) (Löwe et al., 2005) for depression, the Generalised Anxiety Disorder Assessment (GAD-7) (Plummer et al., 2016) for anxiety and the Warwick-Edinburgh Wellbeing Scale (WEMWBS) (University of Warwick, 2006), many found validated scales such as these to be inappropriate. The difficulty, as one participant put it when looking for a validated scale to measure the effectiveness of a suicide prevention retreat, was in finding a way of matching the evaluation process to the model used to design the intervention:

> 'But it's how to not medicalise those measures because what we don't want to do is over-clinicalise. And actually, we're not a clinical service. So it's trying to get that balance of, you know, we're supporting students from a social model, not a medical model. And everyone that we've spoken to wants to give us a medical model.' (Pr_SS_2)

Some practitioners addressed this difficulty by adapting questionnaires to their context, or writing their own questionnaires. In other cases, practitioners chose to use validated questionnaires alongside qualitative methods such as interviews and focus groups in a mixed methods approach.

Though practitioners felt that 'objective measures' (Pr_P92_24) that are both widely accepted and appropriate for a student context are hard to find, many observed a real need for better validated scales that could help them with quantitative evaluations. One participant added that this would greatly help them ensure the project's sustainability:

> 'And I think that's been the biggest challenge... kind of attention. More than anything, if we had a box of metrics and there was one spare, it could go in that very easily and then we'd get a lot of attention.' (Pr_P92_39)

One stakeholder added that a 'nationally recognised subset of outcome measures' would resolve disparity in current evaluation practices where 'everybody's doing random stuff all or nothing at all' (St_HEB_1).

There was a general consensus that qualitative approaches allow for a more nuanced process evaluation. Participants relying on qualitative methods mentioned that they needed to reflect the complexity of student mental health interventions which often address not only difficulties in mental health but the impact this has on students in their studies. 'It's not just the mental health side, it's the studying side' (St_MHC_37), as one participant put it. Many participants noted that despite the development of student analytics on student outcomes such as attainment or retention, mixed method approaches to evaluation allowed them to measure other outcomes such as confidence in new skills or the development of new learning techniques or habits. Many participants also valued the flexibility of qualitative evaluation, some using the process to involve student voice in the development of their interventions with the hope that this would increase student engagement and lower attrition levels in the evaluation.

One project which combined peer support with creative television and radio workshops for discussing mental health in the LGBTQ+ community, found that the creative approach of the intervention lent itself to a more creative approach in the evaluation. While also using

quantitative methods in the form of a wellbeing scale pre and post intervention, they could use their project outputs as part of their evaluation:

> '[W]e've had very, very emotional interviews as part of the … [TV] program and where people have opened up about - who never thought they would do that - but have opened up about their stories, difficulties with families, difficulties with culture. And it's really given us evidence of, you know, what work is still needed and where we can actually help.' [Pr_P92_34]

It was suggested that the activities in the intervention, that of developing a TV program and having honest conversations about mental health, built an emotional context within which the evaluation process produced valuable data. Although this was a unique case in which the outputs of the intervention lent themselves to being combined with the evaluation, the practitioner illustrated what many other practitioners were striving for: to match the evaluation approach to the intervention approach.

Developing networks of care

Participants expressed a consensus that developing student mental health interventions within HEPs and in collaboration with external partners required a careful navigation of siloed departments and under-resourced statutory services. Effective collaborative working built networks involving mental health practitioners, academic staff, representatives of external organisations and students.

Siloed structures

Mental health interventions often require collaboration between different departments within a HEP such as wellbeing services, academic faculties or accommodation support. The kinds of partnership working between departments can vary greatly, from one department simply signposting to another, to data sharing agreements, to completely co-created interventions. There is as much variation in the ways of working as there was in the success of these partnerships. A key difficulty that most participants highlighted was the siloed structures in HE. Many found that inter-departmental working is 'a long standing challenge and universities are very devolved and siloed places' (Pr_P92_6). Participants pointed to a range of factors that inhibit collaborative working across departments: a lack of established communication, competing priorities, restricted budgets and differing approaches to student support. These factors complicate not only the design and delivery of interventions but can also act as a barrier to students accessing support.

One stakeholder observed an 'incrementalism' of organisational structures leading to duplication of work:

> 'And often it's been additive rather than a substitute and sometimes local, and it's just been taken in particular academic schools, which don't necessarily connect with what's happening in the rest of the institution [...] But the downside of that is some of these systems as silos have become very tangled. And there's not a clear sense of priority, where the evidence lies, where repetition might occur, or indeed where gaps may be located.' (St_GB_40)

They observed that these 'tangled' systems led to a layering of services that have a similar purpose because departments design interventions in reaction to priorities within their immediate scope. The danger of services being 'additive' speaks to the concern shared by many participants that students are not able to navigate the sheer volume of information about the many services available within a HEP.

Siloed structures pose a particular difficulty for interventions that are designed to be embedded within the curriculum or require involvement from academic staff. Many

participants mentioned that having academic involvement is crucial because academics have more contact with students and are trusted if they signpost to a particular source of support. The most successfully embedded interventions were ones that could rely on signposting from academic staff, allowing the interventions not only to reach more students, but to mitigate the risks of an intervention being overly reliant on the work of one person. However, there were varying experiences of enthusiasm on the part of academic staff to be involved in mental health support interventions and some disagreement around how much academic involvement is appropriate or feasible given the often limited support or training in place.

Shared problems and shared solutions

In the cases of HEPs working with external partners such as the NHS, a similar issue of disconnected working relationships was identified. Due to the complexity and varied demands and practices of different Integrated Care Boards[5], there is a lack of clarity between HEPs and statutory healthcare services as to what their respective capacity and demands are. One participant noted that establishing a working relationship with statutory services required discussions about 'limits' and 'what came out was some assumptions about what universities had [and] how they were set up to run' (Pr_P92_17). In cases such as this where partnerships with the NHS and local general practitioners (GPs) are in their infancy, HEPs have to clearly manage expectations of how far their own funding stretches. The misunderstandings, according to participants, further complicates the access issues that originate from the restricted eligibility thresholds for care in statutory services (see *Underfunding of crisis support*).

In nurturing relationships between HEPs and statutory healthcare services such as local emergency services or GPs, HEPs often rely on an individual or on small teams to act as a 'gatekeeper' (Pr_P92_17), connecting the different organisations. As short-term funding structures can lead to high staff turnover, maintaining those relationships between organisations can be difficult if a key member of staff moves on. It is important to note here that high staff turnover can affect relationships with any external organisations, as well as internal relationships with different departments within a HEP. As one stakeholder noted, the over-reliance on individuals to hold significant working relationships means that 'the institutional memory is not there' (St_MHC_31). In their experience, this leads to work being repeated each new academic year.

However, in cases where relationships between statutory healthcare services and HEPs have been productive, specially dedicated staff, or 'gatekeeper[s]' (Pr_P92_17) help to bridge organisations. By sitting in both organisations, whether it is a charity and a HEP, or a local NHS service and a HEP, these members of staff are able to navigate the different data systems, organisational hierarchies and referral pathways. Many participants expressed enthusiasm for student specific NHS pathways of care imitating established targeted healthcare models such as Child and Adolescent Mental Health Services. Many cited the success of eight HEPs involved in projects establishing partnerships with local NHS services as part of the Office for Students funded Mental health Challenge Competition: Achieving a step change in mental health outcomes for all students (2020).

What participants drew from their experience of establishing partnerships with the NHS was that aligning agendas was crucial to their success. In one case, a participant managed to get a contact with a local Integrated Care Board 'because they're doing so much and young adult work that our agendas kind of align' (Pr_P92_17). Partnerships in which both the HEP

[5] Integrated care boards (ICBs) are statutory NHS organisations responsible for planning and delivering healthcare in a geographical area. ICBs replaced clinical commissioning groups (CCGs) in the NHS in England from 1 July 2022.

and the external partner or statutory organisation had similar problems found it easier to come to solutions that were mutually beneficial. Another participant remembered a similar case in which a HEP and a GP practice identified a shared agenda because they faced the same difficulties:

> ‘After two years of meetings, there was a light bulb moment when they all realised they are really struggling with ADHD. So both the GPs can't get an ADHD assessment, the university, they're all struggling with all these poor students who probably either do have ADHD or have a diagnosis and can't get medication who are compensating left, right and centre. And they were like: "Oh, you have that!", "oh god, we have the... oh!" And then suddenly, you know, you just need a shared ground where you feel like you're on the same side. And I think that's the problem is that most of the time they don't feel like they're on the same side, but they are.’ (St_HEB_1)

In effective partnerships, partner organisations are able to fill gaps in each other’s organisations such as offering space in exchange for staff training. Such partnerships worked around funding difficulties by supporting each other in kind. Many also valued the opportunity to share expertise: ‘we've got expertise that no one person or even probably institution might hold’ (Pr_RG_9).

Community building

There was a consensus that the most frequent way that concerns are raised for a student’s wellbeing is by academic staff. Most participants mentioned that academic staff have the most contact time with students and, therefore, are in a position to notice a change in a student’s behaviour or to be approached by a student in need of support. Apart from formal risk escalation processes, raising concerns about a student’s mental health at an earlier stage is often more informal and reliant on relationships between departments and the individuals working within them.

Many participants found that an enabling factor that helped them to overcome the aforementioned difficulties of disconnected working (see *Siloed Structures* and *Shared problems, shared solutions*) was community building: ‘it really has been friendship and it's been talking and understanding and sharing and building’ (Pr_P92_36). In this case in particular, the collaboration between a range of academic staff and mental health practitioners with shared experiences, goals and values was instrumental to the development of the mental health intervention. They reported that their intervention came about because academic staff began noticing unusually high levels of trauma in their students and decided to work together to implement a survey using a validated scale, the Adverse Childhood Experience Questionnaire (Felitti et al, 1998) to investigate further (Pr_P92_36).

Developing networks of care also relies on student involvement. Many practitioners used a student consultation process either via focus groups or questionnaires. What many found was that consultation processes that involve student voice serve a dual purpose; that of data gathering and of community building. Practitioners remarked that the consultation process itself also helped to increase engagement through word of mouth. In fact, many practitioners felt that recommendations via word of mouth and by student representatives was more effective in increasing student engagement than other strategies such as promoting via email or student union websites.

Building trust between staff in support services and students creates a sense of collaboration that raises student engagement both in the interventions themselves and the evaluation processes. Many participants developed a sense of community by establishing a physical presence of wellbeing practitioners either in office hours or introductory sessions. Ensuring that staff are visible is a way of developing personal connections and building trust between

students and staff. For example, in one case, a practitioner implemented a mandatory introductory lecture where staff could introduce themselves to establish trust:

> 'Establishing a physical presence of the Wellbeing Advisors in front of the students helps to build trust that sometimes you just don't want to phone or send an email not knowing who's behind it.' (Pr_P92_14)

In other cases, practitioners used already trusted networks to develop trust with students by collaborating with academic staff to signpost to wellbeing services using 'the power of the personal invitation' (Pr_P92_29).

Community building among staff and students was identified as an important way to develop student mental health interventions that feel relevant and increase student engagement. By doing so, they also ensured student engagement in the evaluation processes of interventions. Many participants were dismayed by the high attrition rates of surveys evaluating interventions. To tackle this, one participant sent out a survey asking students about what would motivate them to engage more in feedback and evaluation. They found that financial incentives were less important to students than the possibility of 'affect[ing] policy':

> 'They [the students] came back and said, 'No, we want to feel that we can actually make a difference by sharing our opinion'. So we very much couched it [the evaluation process] in that when we sent it [the evaluation surveys] out. That was the kind of language we used: "Help us help us help you".' (Pr_PRU_28)

It is important to note here that this example does not necessarily argue for a withdrawal of financial incentives for participation as these may open up opportunities for all students, regardless of their socioeconomic status. It does, however, provide insight into students wanting a collaborative relationship with their institutions.

Collecting, managing and sharing data on student mental health

There was a consensus that data collection, sharing and management was an important and often difficult aspect of implementing student mental health interventions. From early efforts to collect data on student needs to implementing evaluation plans, data collection is complicated by questions of cultural sensitivity and levels of student engagement. Equally, data management was considered to be entangled in questions of staff capacity, resourcing and the complex relationships between different departments within a HEP.

Cultural differences and data collection

Despite many practitioners articulating an impression that stigma around mental health was reduced following the proliferation of public discourse on mental health during COVID-19, many also pointed out that this might be limited to certain groups of students. One participant noted that they noticed that the stigma attached to discussing mental health was not nearly as great as being recorded for doing so for Black, male students. In a series of focus groups exploring how to develop support for Black students, they found that none of the male participants agreed to registering their participation, even when offered a financial incentive:

> 'I've had a room full of young men in focus groups and I'd say it's probably balanced in terms of the male female ratio, but when it comes down to what is registered in our data collection, we've had trouble. So I've seen them. I don't know what it is about putting their names on a piece of paper or maybe publicly affiliating themselves with this project, it's still a barrier that we have to get over.' (Pr_P92_14)

There was an acknowledgement that stigma around speaking about mental health differs widely. The factors most commented on as affecting stigma were age, ethnicity, gender and socio-economic background. Indeed, there may be wider social norms that affect mental health stigma and the concerns about confidentiality that are shared and it is difficult to disentangle this from more particular cultural differences. And, many practitioners mentioned that students valued complete anonymity when accessing mental health support for the first time. The example above, however, illustrates the way in which data collection is complicated by student concerns about confidentiality.

Some HEPs struggle with understanding the different levels and types of mental health needs of different student groups:

> 'But I do wonder how in depth we actually understand those cultural barriers. So, for example, the university [...] has got quite a large Chinese national population [...] And yet, that's the smallest percentage of students that access our support, so, you know, it would be quite easy to make some assumptions on why we think that is happening, but I suppose the real reason is we don't know.' (Pr_PG_8)

There was a shared recognition that there was a limited awareness of cultural differences because of a lack of useful demographic segmentation of students at some HEPs.
One stakeholder cautioned against an over-reliance on demographic data because some categories tend to be too large a grouping to be culturally relevant:

> 'And you know, the label South Asian is mega interesting because it's not in the census.[...] And again, you know, it's attempting to be inclusive of, you know, literally billions of people. And by doing that in a research context, you might be doing like big, you know, massive longitudinal review of the data sets from South Asian populations, and that's great, I think that makes more sense. But then when you're thinking about specific interventions delivered in a grassroots context and you're thinking about South Asian communities, it just doesn't work.' (St_MHC_31)

The danger with inaccurate demographic segmentation is homogenising potentially different linguistic expressions and cultural experiences of mental health.

To mitigate the difficulties of disclosure and reporting, many participants have used a mixed method approach to gathering information about student mental health needs. This ranged from conducting surveys, focus groups, listening rooms (recorded discussions on a topic, without a researcher present) and interviews as well as implementing student panels to consult on various stages of designing an intervention.

Apart from ascertaining the differences in student mental health needs, practitioners who consulted students in early stages of developing interventions, also found that they were able to ascertain what kind of mental health support feels accessible for different groups of students. For example, one project focused on developing a signposting webtool that would address how students choose from the many different types of support available to them. To tackle any potential cultural and generational differences, they delved into the student understanding of mental health through a series of focus groups:

> 'We want to hear students, not just their experience, but their worldviews. What is it in how they identify and understand mental health and wellbeing, disability and health issues? How do they frame them? And what does that mean for our service design and delivery? [...] What's your understanding of mental and emotional well-being? Is any of this linked to spirituality for you? You know, where do you like to get support from? How do you understand the National Health Service support in relation to university support?' (Pr_P92_17)

Consulting students allowed these practitioners to learn more about cultural differences in help seeking behaviours and understand the underlying assumptions that define mental health for different people 'because it's very hard to talk about such personal and nuanced situations and circumstances in another language' (Pr_P92_17). From this process, the practitioners developed a webtool with a series of relevant questions that guided students through identifying their need and what services could help them to address it.

Adapting evaluation practices

Practitioners found that the two main difficulties with rigorously evaluating their interventions were deciding on appropriate outcome measures and ensuring good completion rates. Many participants found that the logistical difficulties of data collection had a decisive effect on the reliability of pre- and post-intervention data. The causes for these logistical difficulties varied. In some cases, pre-intervention data could not be guaranteed if there were multiple referral pathways and practitioners did not want to deny a student access to support if they had not done a pre-intervention survey because of the way they were referred (Pr_RG_23). In other cases, student engagement fell, affecting the completion of post-intervention surveys.

Most practitioners measure student engagement when evaluating their intervention as engagement data is often the most readily available. However, many found data regarding attendance to be an unreliable proxy for the success of a student mental health intervention as student engagement can fluctuate for a number of reasons, not least when academic pressures and deadlines take priority. One team developing a peer support intervention considered measuring student engagement with the Wellbeing Service as a way of evaluating their intervention, but realised they were unsure about what the appropriate correlation would be:

> 'We don't know the outcome we want from this because do we want to be able to say that the number went down because we're helping people's mental health or do we want to be able to say that the number went up because we're destigmatising mental health and we're making the wellbeing services more known that we are encouraging people to that it's OK to go and seek help, if you see what I mean. So like, then we said, Well, do we want it to go down? We don't actually know, and in the end, it stayed the same.' (Pr_P92_24)

Evaluation processes were considered time consuming for both students and staff. However, some participants considered that evaluation practices themselves had a difficult reputation:

> 'So overall feedback in therapeutic services isn't the easiest of tasks. One thing that really helps is just to make it very matter of fact. Just: "This is the course of events. This is what we do. We do this and then we ask for feedback" and everybody accepts that. And that's part of our practice, both for the practices of the students. Normalising it in that way actually really helps. We need to have practices that we do regularly so both parts need to know that they're doing it for a purpose that it's useful to inform something. So I think that part of the challenge is actually establishing practices that nurture that rather than feeling like a burden on everyone.' (Pr_RG_23)

For some practitioners, implementing evaluation practices that do not feel like a 'burden on everyone' meant tailoring practices to the student context. For example, one practitioner increased their completion rates by adapting the way their questionnaires flowed on the online survey platform Qualtrics so that an answered question automatically led to the following question, speeding up the process (Pr_PRU_30). In another example, a practitioner brought in external evaluators to evaluate a series of mental health and wellbeing workshops who found that multiple intervals mitigated fluctuating student attendance:

> '[The evaluators] evaluate in the middle of the session as well, because sometimes students have to go up to a lecture or something part way through. There's so many contrary factors to

> really keeping track of all of this information. So they're sort of building in more little touch points along the way.' (Pr_P92_29)

There was a consensus that a great risk to the evaluation of interventions was student engagement and attrition levels. Many participants highlighted that email contact with students was not effective generally, least of all when asking students to participate in feedback. There was a shared perception that students are already 'saturated' (Pr_SS_2) with surveys and questionnaires and a reluctance to contribute to burdening students with more requests. To address this, many participants commented on improved attrition levels if evaluation was done as part of the intervention itself. They gave examples of asking students to complete questionnaires in the last few minutes of workshops as well as using qualitative methods such as focus groups as a way of continuously adapting the intervention or as a therapeutic reflective practice.

Managing and sharing data for effective evaluation

Siloed structures are also often built around complex data management systems. Many participants encountered difficulties in accessing data from different departments, contributing to significant delays in beginning new projects and delivering student support. The difficulties with accessing data often relate to confusion about who the data handlers are and access permissions. Participants noted that what they found hardest to access was confidential data related to students who had disclosed a mental health difficulty or had been flagged as a potential concern. In one case, a practitioner found it difficult to access data disclosed through the UCAS application process to be able to contact students and offer them support.

> 'But we still get third years with undisclosed conditions or we're still having those conversations. So it's, you know, we've certainly been having conversations with our data keepers, as such, to be able to say, "Actually, we need that information to just proactively contact those students to see whether they're willing to listen to disclose at this stage".' (Pr_SS_2)

As many HEPs are moving towards a whole university approach, these complex and overlapping data systems are being looked at. However, retroactively searching and analysing data from older systems is a difficult and slow process that can leave some students behind.

Efficient data collection and data sharing systems enable HEPs to ensure a continuity of care across different services and even with external organisations. However, several participants reported cases in which HEPs were unaware of students being discharged following admittal into accident and emergency departments due to a mental health crisis and therefore unable to support them appropriately. The cases in which more work was needed to develop good data sharing with external organisations were ones whose internal structures were particularly complex or where data is more dispersed or disconnected such as in the case of HEPs with collegiate structures, multiple campuses in different geographical areas or those with high proportions of commuter students.

There was a consensus that even though many HEPs collect large amounts of data on students, this often has little real impact on the development of mental health interventions. This was a particular difficulty faced by practitioners wanting to implement targeted interventions. For example:

> 'It makes it incredibly hard because sometimes you just don't have the evidence that if you want to do a targeted initiative, say we want you to do something with students with caring responsibilities. We have no records to identify students with caring responsibilities. You know, care leavers, again, there's lots of different groups that it's very hard to understand who

> you're working with and what they need, because despite the fact that vast amounts of data must be collected, they're not always being well utilised or efficiently utilised.' (Pr_RG_26)

According to one participant, navigating the existing data systems goes further than disputes over permissions to access data. It is a problem of staff capacity:

> 'But universities find it very difficult A) to use the data they've already got. That's partly because there is a lack of training within the staff body. That is partly because the systems are not user friendly, and it's partly because staff are completely overloaded. And so the ability to use the data that they've already got is weak.' (Pr_P92_36)

Being unable to access, analyse and interpret existing student data hampers not only student access to mental health support but also possibilities of identifying changes and trends in the student population. Without this, it becomes difficult to rigorously evaluate interventions or make institutional changes.

Discussion

The findings bring to the fore three key challenges as well as opportunities for the development of student mental health support. The landscape of student mental health is made up of a complex web of people, policies and processes. Practitioners in particular are having to make some difficult choices regarding who to support, how to support them and to what extent. These decisions might be between implementing whole population preventative interventions as opposed to targeted interventions or crisis support. Such decisions are caught between resourcing restrictions, siloed organisational structures, inadequate data and conceptual debates around mental health, all of which risks students not receiving the mental health support they need.

The changes in the parameters of need and capacity in delivering interventions in a HE setting are mirrored in statutory services. There are concerns that crisis support is hard to access and that there are students who cannot be supported appropriately in either setting. This finding is supported by a recent qualitative report commissioned by the Department for Education in which participants noted a need for clarity on NHS referral criteria and that practitioners focus on supporting students to navigate the complex referral processes (IFF Research, 2023: 58). The restrictions in resourcing and difficulties in communication faced both by the NHS and HEPs means that gathering data to ascertain the scale of the problem is difficult in itself. Indeed, similar conclusions that better data sharing is needed to improve partnership working was reached in the final report on the Office for Students Mental Health Challenge Competition (Wavehill, 2022b: 53).

We found that evaluation practices are caught up in the same issues as those of implementation; that of data management, siloed systems and resourcing. What helps practitioners navigate this thorny landscape is the development of communities with academic staff, support staff and students as well as finding common ground with external partners. It seems that the factors enabling better implementation and evaluation speak to a holistic approach to mental health support.

In proposing a more holistic approach to improving mental health support for students, this study contributes to recent proposals and guidance in developing a whole university approach to student mental health, as seen in University UK's *Stepchange: mentally healthy universities* framework (2021) and *The University Mental Health Charter* (Hughes and Spanner, 2019). There may be some systemic difficulties that will take longer to solve than others. However, the findings suggest that improving one factor, such as data management systems for example, could have a widespread positive impact on each aspect of an intervention, from design to delivery, and to evaluation.

Holistic approaches to designing mental health support also address a key issue of adapting mental health provision to their context. This study found a wide variety of interventions being delivered in a variety of contexts, using a variety of delivery and evaluation methods. This variety in itself speaks to the diversity of the student population and their needs. It also speaks to the creativity with which HEPs are adjusting to the diversity of student needs. Adjusting provision to the particular needs of the student body is important because it seems increasingly difficult to refer to students as a homogenous group. There is a need to pay attention to the ways in which different cultural and socio-economic backgrounds inform not only what mental health and distress mean to a student but how that meaning shapes their engagement with support. There are two ways of interpreting this for the future of student mental health support; one is that this is a call for HEPs to implement more targeted interventions, while the other is a call for HEPs to build in more rigorous evaluation and systems for reflection and adjustment into an intervention design. Though more resource intensive in the short term, the latter path might allow HEPs to work with their context and its limitations in the long term, rather than against it.

Conclusion

This study untangles the factors that inform how student mental health interventions are delivered and evaluated from the perspective of practitioners who work in student support and stakeholders from external organisations such as charities and HE bodies. What emerges is a landscape composed of structures which are not changing at the same pace. That is, while practitioners are noticing a rise in demand for mental health services and changes in student demographics, the supporting systems such as resourcing, inter-departmental communication and data management systems are causing frictions that hinder the development of better mental health support. There is no silver bullet to designing, implementing or evaluating an intervention because, as this study shows, there is a complex interplay of systemic factors that shape the development of student mental health support. Investment in staff, in relationships and in data management systems may, however, create the context within which reliable and accessible mental health support can not only flourish but become rooted in everyday practice and processes.

Next steps

As a rapidly growing field of inquiry, there is already a significant amount of valuable research but more work is needed to strengthen the evidence base, particularly in the context of UK HE.

Firstly, to tackle the difficulties regarding the changing needs of the student body, more research is needed to ascertain the levels and the nuances of student needs. Furthermore, building on the work of Dodd, Ward and Byrum (2022), it may also be of value to consider the constructs that inform the measurement of student mental health and wellbeing in future research. These considerations may provide insights into the questions regarding the implementation and evaluation of ‘stealth’ interventions (that is, those that avoid naming that they aim to provide mental health support). Indeed, more evaluations and case studies of interventions by ‘stealth’ would also help inform future practice.

As the whole university approach becomes increasingly popular, further research in this area is needed. Contributions by Dooris (2006) and Dooris, Powell and Farrier (2020) have already provided some important discussion regarding the evaluation and conceptualisation of whole university approaches. Further evaluation guidance, rigorous evaluation and case studies of whole university approaches could help HEPs find ways to better evaluate their own practices.

To address the complexities of partnership working with NHS services, there seems to be a need for more examples and case studies of interventions that provide examples of effective data sharing agreements and practices. Examples of practice that follow guidance provided by the Student Services Partnerships Evaluation and Quality Standards toolkit (Broglia et al., 2022) would be welcome contributions to the sector. More research would also be valuable in delivering support for students in crisis or those living with severe mental illnesses. Some work has already been done in this area, such as the South East Wales Mental Health Partnership pilot programme of their Mental Health University Liaison Service which provided a clear severity index to help practitioners assess a student's need prior to referral and ensure that students do not fall through the gaps in the referral process (2023: 27). It is in building on existing research in a variety of UK contexts that can help strengthen the evidence base and improve practices across the sector.

References

Baber, M., Haas, J., Ji, E., McLafferty, M., Murray, E., Robinson, O., and Vafeiadou, K. (2022) *The Student Mental Health Crisis, A fresh perspective.* Health Action Campaign.

Braun, V. & Clarke, V. (2006) *Using thematic analysis in psychology*. Qualitative Research in Psychology, 3:2, 77-101, DOI: 10.1191/1478088706qp063oa

Broglia, E., Nisbet, K., Chow, H., Bone, C., Simmonds-Buckley, M., Knowles, L., Hardy, G., Gibbon, L., & Barkham, M. (2022). Student Services Partnerships Evaluation and Quality Standards (SPEQS) toolkit.

Centre for Transforming Access and Student Outcomes in Higher Education, The (TASO). (2023) *The Student Mental Health Evidence Hub.* https://taso.org.uk/student-mental-health-hub/ [Accessed 1 November 2023]

Dodd, A., Ward, J. (ed.), & Byrom, N. (2022) *Measuring wellbeing in the student population*. SMaRteN, Kings College London.

Dooris, M. (2006) Healthy settings: challenges to generating evidence of effectiveness, Health Promotion International, Volume 21, Issue 1, March 2006, Pages 55–65, DOI: 10.1093/heapro/dai030

Dooris, M., Powell,S., and Farrier, A. (2020) Conceptualizing the 'whole university' approach: an international qualitative study, Health Promotion International, Volume 35, Issue 4, August 2020, Pages 730–740, DOI: 10.1093/heapro/daz072

Fancourt, D., Steptoe, A., and Bradbury, A. (2022). *Tracking the Psychological and Social Consequences of the COVID-19 Pandemic across the UK Population: Findings, Impact, and Recommendations from the COVID-19 Social Study (March 2020 – April 2022).* London: UCL

Felitti, V.J., Anda, R.F., Nordenberg, D, Williamson, D.F., Spitz A.M., Edwards, V.K., Koss, M.P., and Marks, J.S., (1998) *Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study*. American Journal of Preventive Medicine, vol 14 (4), 245-258.

Core System Trust. (2020) *CORE General Population Questionnaire.* https://www.coresystemtrust.org.uk/wp-content/uploads/2020/03/GP-CORE-English.pdf [Accessed 11 October 2023]

GOV UK (2023) *Higher education mental health implementation taskforce.* https://www.gov.uk/government/groups/higher-education-mental-health-implementation-taskforce [Accessed 1 November 2023]

HC Deb (5 June 2023) Vol. 733. Available at: https://hansard.parliament.uk/commons/2023-06-05/debates/9BA59E93-4342-4AD6-BA94-379DCA6A24E0/HigherEducationStudentsStatutoryDutyOfCare [Accessed 1 November 2023]

Hughes, G. & Spanner, L. (2019) *The University Mental Health Charter.* Leeds: Student Minds.

IFF Research (2023) *HE providers' policies and practices to support student mental health: Research report*. Commissioned by the Department for Education. https://assets.publishing.service.gov.uk/media/646e0c027dd6e70012a9b2f0/HE_providers__policies_and_practices_to_support_student_mental_health_-_May-2023.pdf [Accessed 1 November 2023]

Löwe, B., Kroenke, K., & Gräfe, K. (2005). Detecting and monitoring depression with a two-item questionnaire (PHQ-2). *Journal of psychosomatic research*, *58*(2), 163-171.

Office for Students (2020) *Mental health Challenge Competition: Achieving a step change in mental health outcomes for all students.* https://www.officeforstudents.org.uk/advice-and-guidance/student-wellbeing-and-

protection/student-mental-health/mental-health-challenge-competition-improving-mental-health-outcomes/ [Accessed 1 November 2023]

Office for Students (2021) *Mental health funding competition: Using innovation and intersectional approaches to target mental health support for students* https://www.officeforstudents.org.uk/advice-and-guidance/student-wellbeing-and-protection/student-mental-health/mental-health-funding-competition-using-innovation-and-intersectional-approaches/ [Accessed 1 November 2023]

Office for Students (2023) *Working better together to support student mental health* https://www.officeforstudents.org.uk/media/49499c81-ac0e-4ec5-80d0-842ce876ac74/insights-on-joined-up-working-to-support-student-mental-health_nous.pdf [Accessed 13 December 2023]

Plummer, F., Manea, L., Trepel, D., & McMillan, D. (2016). Screening for anxiety disorders with the GAD-7 and GAD-2: a systematic review and diagnostic metaanalysis. *General hospital psychiatry*, *39*, 24-31.

Sanders, M. (2023) *Student mental health in 2023, Who is struggling and how the situation is changing?* King's College London, the Policy Institute and The Centre for Transforming Access and Student Outcomes in Higher Education (TASO).

South East Wales Mental Health Partnership (SEWMHP) (2023) Project context and evaluation, Including the pilot Mental Health University Liaison Service. https://taso.org.uk/intervention-smh/intersystem-collaboration/#heading-where-can-i-find-more-information-and-guidance [Accessed 1 November 2023]

Robertson, A., Mulcahy, E. and Baars, S. (2022) *What works to tackle mental health inequalities in higher education?* The Centre for Transforming Access and Student Outcomes in Higher Education (TASO).

Universities UK (UUK). (2021) *Stepchange: mentally healthy universities.*

Universities UK (UUK). (2023) *Suicide-safer Universities.*

University of Warwick. (2006) *Warwick-Edinburgh Mental Well-Being Scale (WEMWBS)*. Available at: https://warwick.ac.uk/fac/sci/med/research/platform/wemwbs/ [Accessed 3 November 2023]

Wavehill. (2022a) *Evaluation of the Mental Health Challenge Competition.* Commissioned by the Office for Students.

Wavehill. (2022b) *What Works in Supporting Student Mental Health, Final Report to the Office for Students.* Commissioned by the Office for Students.

Annex A. The Student Mental Health Hub

This study identified that developing evaluation practices requires more rigorous evaluation and that many are facing resourcing challenges to do so. The Student Mental Health Project aimed to address this by providing support for practitioners in student support services, policy makers, evaluators and researchers in HE. As part of this project, Student Mental Health Evidence Hub (TASO, 2023) was developed as a free resource consisting of an evidence-based toolkit, evaluation guidance, examples of current practice and results of our student panel work.

The evidence-based toolkit addresses the need for a bank of evidence on the kinds of interventions that work to maintain and improve student mental health. This can help practitioners when making difficult choices when deciding on which interventions to implement, and how to allocate resources.

The evaluation guidance seeks to address some of the difficulties that practitioners interviewed in this study faced in deciding on reliable and appropriate outcome measures by providing a set of validated measures that research has shown to work in a student context. The evaluation guidance is mindful of practitioners working in a non-clinical context and also provides further resources and guidance on the process of choosing outcome measures.

The Student Mental Health Evidence Hub also houses a growing collection of examples of practice that demonstrate the implementation and evaluation processes currently in place across the UK. The examples of practice aim to encourage a community of practice which hopes to encourage a growing evidence base on student mental health interventions. There is also further guidance on adapting practice to your context which addresses the need to ensure that interventions fit their context and the student needs.

It is hoped that by providing resources that will enable HEPs to evaluate their mental health interventions, the Evidence Hub will eventually also hold more examples of practice of effective interventions that have been rigorously evaluated.

Annex B. Interview schedule

The following questions were used in the semi-structured interviews:

1. Could you tell me about X intervention?
    - What were the drivers behind the intervention or initiative?
    - Who delivered the intervention or initiative?
    - Who was involved? (number, demographic)
    - How were they selected?
    - How did students access the support?
    - When was / for how long is the intervention or initiative running?
    - Was/is this intervention or initiative part of a whole-institution approach?
    - What enabling factors affected any of the above? (Probed throughout above questions).

2. What challenges arose / have emerged during the set up or delivery of the intervention or initiative?
    - How were these overcome? / How will these be addressed?

3. What approach to evaluation has been adopted to assess this intervention or initiative?
    - What do you feel would be required to further support such evaluation?
    - What are the challenges of evaluating this intervention or initiative?
    - Is data used to inform analysis of longer-term outcomes, such as attainment, retention and MH outcomes for students?

4. Does partnership collaboration with other bodies feature in this intervention or initiative? How?
    - What do you feel are the challenges of incorporating partnership working?
    - What do you feel are the enablers helping partnership working?

5. Do you feel there are barriers to the HE sector's engagement with supporting student mental health? What are they?
    - Where do you feel there are gaps in what the sector is already doing?
    - What challenges are there?

Annex C: Further details on selection criteria

A sample of participants was initially formed based on desk research and existing contacts from our consortium partners on the Student Mental Health Project (What Works Wellbeing, SMaRteN, Student Minds and AMOSSHE, the Student Services Organisation). Additional participants that were considered approached TASO via the Call for Examples of Practice[6] as part of the Student Mental Health Project which sought to find examples of interventions currently ongoing across the UK to contribute to the resources available as part of the Student Mental Health Hub. All participants were assessed following the selection criteria before selection for interview.

The participant selection criteria was established in order to fill gaps in the evidence that were identified as part of the initial report preceding the Student Mental Health Project, *What works to tackle mental health inequalities in higher education* report (Robertson, Mulcahy and Baars, 2022) as well as the gaps in the evidence found as part of the extensive Evidence Review in the Student Mental Health Project[7]. For this reason, priority was given to interventions targeting specific groups such as students from Black, Asian and minority ethnic backgrounds.

The additional focus on innovative interventions in particular aimed to encompass interventions that may not neatly fit into the established intervention typology because they are too new to be part of an established practice. Innovative practice has also been a particular focus of the Office for Students who also funded the Student Mental Health Project. As innovative practices may not be embedded in their HEPs or have an established evaluation practice, it was hoped that this focus on innovative interventions could bring to light some current context of the factors affecting the development of evaluations of student mental health interventions.

The intervention typology used as part of the Student Mental Health Project was SMaReN/King's College London and What Works Wellbeing for the Student Mental Health Project. The typology is based on the categorisations most often used in research in student mental health. The categories were designed to be mutually exclusive and most participants worked on a project that fit neatly into one of the categories. If they did not, the participants were asked what the primary focus of their activities was. For full descriptions of each category, please see Annex D.

In the initial selection process, participants were also categorised by the intervention type they represented. Decisions regarding how to categorise interventions and the context within which they were implemented was based on desk-research and some preliminary email exchanges or short pre-interviews, depending on availability. Following this, a cross-section of interventions was considered in the selection process. These considerations were, however, secondary to the selection criteria outlined in the methodology of this report. While attempts were made to have each intervention type represented, it proved logistically difficult to find and engage with appropriate participants for some of the intervention types within the time-frame of the research.

[6] For more information on the results of this work, see https://taso.org.uk/student-mental-health-hub/examples-of-practice/

[7] For more information on the gaps in the evidence, please see https://cdn.taso.org.uk/wp-content/uploads/TASO_Student-Mental-Health-Project_Gaps-in-the-Evidence_October-2023.pdf .

For a breakdown of the practitioners and stakeholders by their intervention types, please see the table below:

Intervention Type	Practitioner	Stakeholder
Psychological	3	5
Recreation	1	0
Physical activity/exercise	0	0
Active psychoeducation	3	1
Passive psychoeducation	3	0
Pedagogy and professional training	4	0
Places and spaces	0	0
Settings-based	3	2
Peer mentoring/peer support	5	3
Intersystem collaboration	4	0
Not applicable	0	3

Annex D: Intervention descriptions

The following intervention typology was designed by SMaReN/King's College London and What Works Wellbeing for the Student Mental Health Project. The typology is based on the categorisations most often used in research in student mental health.

Psychological

Interventions under this category are typically therapies that provide a safe and confidential space for a person to explore their feelings, thoughts and behaviours with a trained professional. A psychological intervention can include talking therapies and counselling, of which there are many kinds such as Cognitive Behavioural Therapy (CBT), Acceptance and Commitment Therapy (ACT) or psychotherapy. A psychological intervention may also take the form of mindfulness (a practice characterised by control of attention, awareness of the present moment and non-judgemental thoughts), attention training or stress management.

A psychological intervention can be tailored to the needs of the client or targeted group. It can be appropriate for people living with a wide range of experiences and mental health difficulties. This sort of intervention can be universal or targeted towards specific demographics.

Psychological interventions tend to be delivered on a one-to-one basis but may also be delivered in small groups. It is usually led by trained professionals who help the client to develop a better understanding of themselves and the world around them in order to help them to bring about the changes that they want to make. Many services offer time-limited interventions, though some individual therapies can be ongoing, at the client and therapist's discretion.

Many services can be run online, either via online conference platforms or specialist apps and websites. Online therapeutic platforms may not involve direct contact with a trained professional though they are usually designed and moderated by trained professionals.

This intervention can be integrated within student support services or be outsourced to specialist organisations. Funding requirements and referral structures will depend on which departments or organisations are delivering the intervention as well as the level of training required.

Recreational

A recreational intervention uses creative methods such as writing, music or art to explore feelings, thoughts and behaviours. Animal therapies are also included in this category. This sort of intervention can be intended to relieve stress and can aid self-expression. Some offer a way of communicating and exploring feelings that are non-verbal and may be considered a good alternative intervention for those who might find it hard to express themselves in words. They can also be appropriate for a wide range of experiences and mental health difficulties and can be targeted (towards specific demographics) or non-targeted. This sort of intervention is often framed as preventative.

A large variety of facilitators may run recreational interventions, ranging from untrained volunteers with a keen interest in the activity to trained art or animal therapists. Most often, they are run in small groups and have an additional benefit of reducing social isolation. This sort of intervention often requires additional materials and space. For this reason, it is

sometimes difficult to run recreation interventions online unless materials are provided beforehand.

Physical activity/exercise

A physical activity intervention engages people in physical activity over a period of time in order to improve both their physical and mental health. This may include indoor activities such as yoga or gym sessions, or outdoor activities such as running, cycling or walking. They can be offered in groups or individually and, in some cases, without being guided by a professional. This intervention can also be delivered online via online conferencing or specialist apps that track progress and make recommendations for the individual to follow. Physical activities can be adapted to suit an individual's needs regardless of physical ability. This type of intervention can be a good accompaniment to other therapies and is often preventative.

Active psychoeducation

Active psychoeducation refers to workshops and training programmes where a trained professional informs students about mental health. In active psychoeducation, practitioners might guide students in learning about better mental health or they might focus on raising awareness about particular mental health difficulties. The intervention often includes teaching skills that enable students or staff to manage their mental health. These workshops or programmes can be broadly themed such as managing wellbeing, or more specifically themed, such as managing exam stress, breakups or alcohol problems. This intervention also includes programmes that equip attendees with the skills to help others such as the mental health first aid training course.

This intervention is often preventative. It can help to raise awareness, reduce stigma and signpost to other services. Psychoeducation workshops can be delivered in person and online and therefore have the benefit of reaching a large number of people. This intervention can be delivered in a one-off or drop-in format or as a longer running programme of sessions.

Passive psychoeducation

Passive psychoeducation refers to information, guidance and toolkits aimed at raising awareness, signposting and providing essential information for managing mental health difficulties. As students can access these resources independently, this intervention does not require a trained professional to actively guide students. These resources can vary widely in their theme and content, ranging from tips to help with general wellbeing to developing skills that help people to manage anxiety, sleep or other specific difficulties. Passive psychoeducation materials can be devised by a variety of practitioners, ranging from those working in a mental health context to those supporting a student's academic development.

They are often preventative resources that provide students with some initial or additional support. This intervention can be made accessible in multiple media forms, online, in print, or on video, for example. As they are a self-service resource, they hold the benefit of being accessed independently and privately, on a student's own terms, though some can be programmes which can be accessed for a certain number of hours, days or weeks.

Pedagogy and professional training

This intervention aims to improve mental health through the academic aspects of the student experience. It makes changes to the teaching practices, assessment or curriculum in ways that may help improve student mental health. Professional training can be aimed at any staff working with students and might cover topics such as listening skills or signposting. While this intervention is usually non-targeted in its approach, it may also provide targeted support

such as training to support specific student groups (those living with autism, for example). A pedagogical intervention may also include new systems that provide tailored support or reasonable adjustments for students living with specific mental health difficulties.

Places and spaces

An intervention that makes use of spaces in order to improve the mental health of people using them are referred to under the places and spaces category. Most often this is in reference to shared spaces where people meet to socialise, work or engage in leisure activities. This may include interventions that look at building use or infrastructural or landscape design to affect how people feel in the space. An example of this may be making aesthetic changes or engaging the community to use it in new or different ways. This intervention usually benefits the whole population though it may also be targeted if it is designed with the aim of supporting certain student groups in a particular space in the case of interventions that improve accessibility for disabled students, for example.

Settings-based

A settings-based interventions involve a holistic, 'whole-system' approach to implementing changes to improve mental health. It relies on working collaboratively across a HEP, implementing the same ethos to the ways of working of all aspects of the institution. This intervention holds at its core the principle that mental health is affected by a combination of environmental, organisational and personal factors. The intervention therefore aims to provide support at multiple different junctures of the student experience. For example, this may include financial support interventions to aid financial anxieties, or interventions that improve a sense of security and belonging on campus. The delivery of this type of intervention involves strategic planning and often the collaboration between multiple departments.

Peer mentoring/peer support

The central tenet of a peer support intervention is that the facilitators and recipients share a certain set of experiences. These experiences may be based on a particular mental health difficulty or the experience of living in a certain social context. Most often this means that peer support interventions are delivered by students themselves. This category includes peer learning, peer support groups or peer mentoring interventions. Facilitators may have some prior training and most often are provided with some additional supervision. This can be an intervention appropriate for a wide range of experiences and does not have to be targeted in order to establish a model of shared experience. It is often seen as an accessible solution that balances out hierarchical imbalances in support groups led by professionals. These interventions require a significant amount of support to be run safely, as well as a safe space in which the intervention can be delivered. Delivery can be individual or in small groups and can be done either in person or online via video conferencing. This sort of intervention can also be delivered on specially designed platforms where peers can communicate anonymously online. The frequency of peer support sessions can also be adjusted to suit the needs of the recipients. The structure of peer support means that it can be delivered in varying levels of formality in terms of referral and monitoring.

Intersystem collaboration

Intersystem collaboration refers to an intervention which is delivered by multiple organisations or departments working in partnership. This can be for preventative, ongoing or crisis support. Collaboration and communication between services can be internal or external, and is centred upon information sharing through appropriate channels. Internal intersystem collaboration may be between, for example, academic staff and student support services within a singular HEP. External collaboration may be between a HEP and a local

NHS Trust or a mental health charity. Depending on the organisations involved, this intervention can be targeted or for a universal student population.

Intersystem collaboration initiatives are distinct from setting-based interventions as they may include collaboration between one university department and another, or an external body, as opposed to providing a provider-wide approach.

Annex E. Codebook

Nodes and sub-nodes	Files	References	Sub-theme	Theme
Who are the students	12	14	Changing student body	Resourcing needs
Demographic segmentation	3	3	Cultural differences in data collection	Data collection and management
Medicalisation of Unhappiness	13	29	Conceptualising mental health	Medical and social models
Methods of understanding student need	7	19	Conceptualising mental health	Resourcing needs
Student disclosure and reporting	15	21	Stigma and stealth	Resourcing needs
Staff reported	2	2	Changing student body	Resourcing needs
Evidence based	11	21	Changing student body	Resourcing needs
Changes in student population	5	7	Changing student body	Resourcing needs
Disparity between crisis support and low level needs support	7	11	Changing student body	Resourcing needs
International students	3	3	Cultural differences in data collection	Data collection and management
Caring Responsibilities	1	2	Cultural differences in data collection	Data collection and management
Reach and engagement	21	40	Stigma and stealth	Medical and social models
Accessibility	7	12	Changing student body	Resourcing needs
Active service awareness raising	25	70	Stigma and stealth	Medical and social models
Rewarding Participation	12	19	Stigma and stealth	Medical and social models
Multi-stakeholder working	10	36	Shared problems and solutions	Networks of care
Data sharing practices and barriers	14	28	Managing and sharing data	Data collection and management
External Providers	13	32	Community building	Networks of care
Hierarchy of services	3	4	Community building	Networks of care
Ineffective Partnerships	17	35	Siloed structures	Networks of care

Mutual problems and solutions	14	22	Shared problems and solutions	Networks of care
Student Specific NHS Pathway	12	32	Shared problems and solutions	Networks of care
Working with other HEPs	10	16	Community building	Networks of care
Institutional ways of working	2	3	Siloed structures	Networks of care
Systems overly reliant on individuals	17	26	Short-term funding	Resourcing needs
Staff wellbeing concerns	8	16	Short-term funding	Resourcing needs
Pressurised academic environment	12	24	Short-term funding	Resourcing needs
Pressures from policy climate	14	40	Changing student body	Resourcing needs
Increased staff training	17	41	Changing student body	Resourcing needs
Difficulties of Institutional change	16	47	Siloed structures	Networks of care
Departmental cooperation	10	20	Siloed structures	Networks of care
MH services cooperation	3	4	Shared problems and solutions	Networks of care
Academic and wellbeing relationship	5	8	Siloed structures	Networks of care
Data management	13	31	Managing and sharing data	Data collection and management
Confidentiality	8	20	Managing and sharing data	Data collection and management
Funding	17	28	Short-term funding	Resourcing needs
Budget cuts	5	8	Short-term funding	Resourcing needs
Crisis support expensive	2	4	Underfunding of crisis support	Resourcing needs
Funding issues delay projects	7	7	Short-term funding	Resourcing needs
Project sustainability	9	11	Short-term funding	Resourcing needs
Findings and observations OR Unmeasured outcomes	8	12	Community building	Networks of care
Community building	8	12	Community building	Networks of care
Evaluation practices	15	48	Approaches to evaluation	Medical and social models
Data collection practices	26	47	Adapting evaluation practices	Data collection and management
Funding evaluation chicken vs egg	13	15	Short-term funding	Resourcing needs

Informal evaluation	16	19	Approaches to evaluation	Medical and social models
Lack of dedicated staff	11	19	Short-term funding	Resourcing needs
Medical v social model	6	6	Conceptualising mental health	Medical and social models
Need for longitudinal data	19	37	Short-term funding	Resourcing needs
Outcome measures	33	78	Short-term funding	Resourcing needs
Qualitative evaluation	18	25	Approaches to evaluation	Medical and social models
Surveys	24	42	Approaches to evaluation	Medical and social models
Attrition rates	9	11	Adapting evaluation practices	Data collection and management
Barriers to support	8	21	Short-term funding	Resourcing needs
Bureaucracy	8	11	Siloed structures	Networks of care
No capacity in services	16	36	Underfunding of crisis support	Resourcing needs
Stigma	11	18	Stigma and stealth	Medical and social models
Waiting times	2	5	Short-term funding	Resourcing needs
Design Methods	4	9	Conceptualising mental health	Medical and social models
Adoption of other practices, models and guidelines	19	32	Conceptualising mental health	Medical and social models
Design through evaluation and adaptation	21	42	Approaches to evaluation	Medical and social models
Design through student voice	28	85	Community building	Networks of care
Reactive design	20	39	Short-term funding	Resourcing needs
Participatory action research	4	6	Adapting evaluation practices	Data collection and management