

# Guidance for evaluating initiatives to improve student mental health and wellbeing within a non-clinical context

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This guidance stems from the Student Mental Health Project.

The Student Mental Health Project is an Office for Students (OfS) funded project that aims to help higher education providers develop their student mental health interventions. The project has developed a Student Mental Health Evidence Hub, a free resource consisting of an evidence-based toolkit, evaluation guidance, examples of practice and the results of our sector engagement and student panel work.

The project was led by The Centre for Transforming Access and Student Outcomes in Higher Education (TASO) as part of a consortium with What Works Wellbeing, SMaRteN, Student Minds and AMOSSHE, the Student Services Organisation.

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## Overview

This guidance has been put together to support the evaluation of non-clinical initiatives to improve student mental health and wellbeing. By non-clinical we mean interventions or initiatives that do not involve medical or clinical procedures, medications, or therapies. Instead, non-clinical approaches focus on other ways to improve a person's health or wellbeing, such as behavioural or lifestyle changes, social support, education, or self-care practices.

A range of advice and guidance exists on how to assess student mental health in counselling services and more widely in the student population, i.e., for research and practice:

- The [Student Services Partnerships Evaluation and Quality Standards \(SPEQS\) toolkit](#) provides guidance for service managers and practitioners, including recommendations for assessing student mental health within the clinical context, including university counselling services and their partnerships with NHS mental health services.
- SMarTeN developed [guidance for measuring wellbeing in the student population](#), integrating a scoping review of the literature and a Delphi-informed stakeholder consultation of priority outcomes.
- A SMarTeN consultation project has collated [guidance on measuring psychological wellbeing and mental health in university student cohorts](#).
- The Evidence Based Practice Unit has published a [Toolkit for schools and colleges](#) to support the measurement and monitoring of children and young people's mental wellbeing.

The rationale for this guidance document is to provide advice to support the evaluation of initiatives focused on mental health and wellbeing within the higher education sector. Here we focus on measures that are practical and suitable for use in the non-clinical space. Our guidance collates advice and recommendations from existing frameworks, with specific consideration of the population group (university students, primarily young adults) and context (public health, non-clinical).

## What outcomes should we measure?

In the context of mental health and wellbeing, "outcome" typically refers to the result or effects of a particular treatment or intervention on a person's mental health or functioning.

While an initiative might be designed to reduce mental health difficulties, simply measuring these difficulties is unlikely to provide a sensitive outcome measure. There are two reasons for this:

1. The intervention or initiative, delivered outside of the clinical setting, might target factors that contribute to the development of mental health difficulties, rather than targeting mental health difficulties directly. As such, it would be more effective to measure the direct targets of the intervention.
2. If the intervention or initiative is designed for all students, measuring mental health difficulties may only be relevant for a minority of participants. Including measures that look at wellbeing and sub-clinical<sup>2</sup> markers of mental health difficulties will increase the evaluation's sensitivity to identify change.

## Mental health and wellbeing

In this guidance we are looking at measures that can tell us about an individual's mental health and wellbeing. Evaluations may focus on improving mental health and / or wellbeing. This might contrast with evaluations of interventions that aim to reduce mental health symptoms. Such evaluations would be expected to focus on change in the severity of an individual's mental health difficulties.

The distinction between wellbeing and mental health has been extensively debated. Relating the two constructs, the World Health Organisation declared positive mental health to be the 'foundation for well-being' (Herrman, Saxena, and Moodie, 2005). Research with large general population samples suggests that wellbeing and mental health are related but independent constructs, adding weight to the argument that measures of wellbeing should be differentiated from measures of mental health (Patalay and Fitzsimons, 2016; Weich et al., 2007).

Mental health refers to a person's overall psychological and emotional state, including their ability to cope with stress, maintain healthy relationships, and function in their daily life. Mental health can be influenced by a variety of factors, including genetics, life experiences, and environmental factors. Mental health conditions, such as anxiety disorders, depression, and bipolar disorder, are conditions that can negatively affect a person's mental health.

Mental wellbeing, on the other hand, refers to a person's overall sense of happiness and life satisfaction. It encompasses a person's emotional, social, and psychological state, as well as their sense of purpose and meaning in life. Mental wellbeing is often influenced by factors such as social support, self-esteem, and a sense of belonging.

While mental health and mental wellbeing are related, it is possible for someone to have good mental wellbeing without necessarily having perfect mental health. For example, a person may experience symptoms of a mental health condition but still have a strong sense

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<sup>2</sup> A sub-clinical marker is a condition or symptom that does not meet the diagnostic criteria for a clinical disorder but may still cause distress or impairment in an individual's life.

of purpose and meaning in their life, which can contribute to their overall sense of wellbeing. Conversely, a person may not have a diagnosable mental health condition, but still struggle with feelings of unhappiness or dissatisfaction with their life, which can negatively impact their mental wellbeing.

## Measuring mental health and mental wellbeing

We consider measures of psychological functioning and mental wellbeing. Measures of psychological functioning provide us with an assessment of mental health while not focusing on specific mental health difficulties.

Through the SMARteN project on [Measuring Wellbeing in the Student Population](#), we consulted students on the outcomes that they wished to see prioritised for assessment of student wellbeing (Dodd and Byrum, 2022). Students prioritised the following outcomes:

1. Coping: the perceived ability to cope, having coping strategies and academic coping
2. Eudaemonic<sup>3</sup> wellbeing: functioning well, feeling motivated, able to engage in purposeful activity and find personal fulfilment.
3. Hedonic wellbeing: Quality of life and subjective wellbeing, including absence of negative affect and feeling satisfied with life
4. Social support: having a support network, the absence of loneliness and isolation.
5. Quality of sleep

Some of the widely used measures of mental wellbeing address many of the outcomes prioritised by students, however social support and quality of sleep are not included in these overarching measures of mental wellbeing.

## Sleep and mental health

Global measures of psychological functioning and mental wellbeing do not include assessment of sleep quality. The Mental Health Foundation (2020) notes that:

- Poor sleep over a sustained period leads to a number of problems which are immediately recognisable, including fatigue, sleepiness, poor concentration, lapses in memory, and irritability.
- Up to one third of the population may suffer from insomnia (lack of sleep or poor quality sleep). This can affect mood, energy and concentration levels, our relationships, and our ability to stay awake and function during the day.
- Sleep and health are strongly related, poor sleep can increase the risk of having poor health, and poor health can make it harder to sleep. Common mental health difficulties like anxiety and depression can often underpin sleep problems.

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<sup>3</sup> While hedonic and eudemonic wellbeing are related, they represent different ways of thinking about wellbeing. Hedonic wellbeing is focused on experiencing pleasure and avoiding pain. It is often associated with seeking out positive emotions and avoiding negative ones. Eudemonic wellbeing, on the other hand, is focused on living a life with purpose and meaning. It is often associated with engaging in activities that are in line with one's values and goals, and that contribute to a sense of personal growth and development. Research suggests that both forms of wellbeing can contribute to a person's overall sense of happiness and life satisfaction, and that they are not mutually exclusive.

## Social support and mental health

Students prioritised social support as an important wellbeing outcome. Some indication of social support is included in commonly used measures of psychological functioning and mental wellbeing. However, research is increasingly indicating that loneliness is a significant problem among university students and data indicates that young adults are one of the loneliness population groups (McIntyre et al., 2018; Richardson, Elliot and Roberts, 2017; Vasileiou et al., 2019; Office for National Statistics, 2018).

## Self-esteem

As noted below, brevity in survey design is absolutely key. The shorter the survey the more likely it is that students complete it. An assessment of self-esteem is not essential. Measures of psychological functioning and mental wellbeing tap into this. However, we include details about measuring self-esteem for consideration for a few reasons:

1. Self-esteem and mental health are strongly related.
2. Public health or non-clinical interventions might address self-esteem as a step towards improving mental health or mental wellbeing. As such, measuring a target proximal to the intervention is desirable.
3. Self-esteem was identified by clinicians, academics and researchers as a priority wellbeing outcome for students in the SMaRteN sector consultation (Dodd and Byrum, 2022).

## Clinical measures

This guidance focuses on non-clinical evaluations. However, we recommend considering three short scales to measure anxiety, depression, and alcohol use. These measures are not being recommended as outcome measures. That is, we do not expect public health initiatives designed around student mental health and wellbeing to be directly tackling anxiety, depression, and alcohol use.<sup>4</sup> Measures of anxiety, depression, and alcohol use will however provide greater insight into the mental health of students engaging with the initiative. Insight here might help inform understanding of what works for whom.

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<sup>4</sup> Interventions targeting anxiety, depression, and alcohol use, should be following clinically focused guidance. For instance, the [SPEQS guidelines](#) may be appropriate.

## Considerations for selecting measures

The [SPEQS toolkits](#) (Broglia et al., 2022) and the SMarTeN guidance for [measuring psychological wellbeing and mental health](#) (Heron et al., 2023), set out criteria by which to judge the suitability of candidate measures. These are outlined below.

### Core selection criteria

All recommended measures meet three core selection criteria:

#### 1. Psychometric properties

Here we consider the characteristics of the questionnaires recommended to assess specific psychological constructs or traits. The psychometric properties of a measure are important because they determine how well the measure works and how accurate the results are. There are several psychometric properties that are commonly assessed, including:

**Reliability:** Refers to the consistency and stability of a measure over time and across different situations or raters.

**Validity:** Refers to the accuracy and meaningfulness of a measure in assessing the construct it is intended to measure.

**Sensitivity:** Refers to the ability of a measure to detect meaningful changes or differences in the construct being measured.

**Specificity:** Refers to the ability of a measure to accurately distinguish the construct being measured from other related constructs.

It is important to be using measures that have published details on standard indicators of reliability and validity. Ideally these data should be population specific, i.e., the data on reliability and validity should be established in students. It is important to note that a looser criterion has been necessary in considering measures for inclusion in this guidance as very few measures have been validated within the student population.

#### 2. Sensitivity to change

For projects looking to evaluate whether an initiative has a meaningful impact on student mental health and wellbeing, measures need to be capable of detecting change when change occurs.

#### 3. Free to use

Some of the measures that are used to evaluate mental health and wellbeing require a licence for their use, which in turn requires some form of payment, such as a one-off cost or a cost per use.

This guidance only considers measures that are free to use. Some measures have been truncated for the purposes of brevity and publication rights but they are freely available.

## Additional selection criteria

### 4. Designed for, or validated in, the general student population.

This guidance prioritises measures that have been developed explicitly for use with the general student population. To evaluate initiatives designed for use within the general student population, measures need to be sensitive to variation in mental health and wellbeing of students who do not have mental health difficulties.

There is an important distinction between using measures of mental health in a clinical setting and a public health context. Measures designed for use in a clinical context are usually designed with the aim of detecting the severity of mental health symptoms. Used in a public health context, these measures may not have the appropriate sensitivity to identify variation in mental health or wellbeing for students who do not have difficulties.

### 5. Survey brevity

Effective evaluation of initiatives depends on students completing the survey. To maximise completion rates and minimise the number of students dropping out of the evaluation, it is essential to keep the measurement set short. Students suggest that anything taking longer than 15 minutes to complete would be too long. However, the feasible length of your measurement set depends on the context in which you are able to collect data. If you would like students to complete a survey at a face-to-face event, 5 minutes is likely to be the maximum time.

Where there is a choice between measures that meet the core selection criteria and are broadly equivalent across other criteria, this guidance recommends brief measures.

### 6. Comparability with NHS data and university counselling and wellbeing services datasets.

There are significant benefits in comparability of data. The NHS's Improving Access to Psychological Therapies uses a well-established routine set of measures. Similarly, most university counselling services have a routine set of measures. Where feasible, we have looked for measures that would allow comparability with these datasets.

However, it is important to note that this criterion does not always sit well alongside the first criteria, of being design for, or validated in, the general student population. The NHS and university counselling services need to be using clinical measures; they are working with a clinical population. These measures are not always appropriate for use in a public health context. Further, measures used by the NHS do not consider the specific needs of students.

This guidance document prioritises measures that have been designed for, or validated in, the general student population. Where possible, comparability with other datasets is considered.

### 7. Acceptable to students

Ideally, the measures we use should have been tested with students with the explicit objective of identifying if students found the measure acceptable. This criterion has rarely been reached.



## Outcome measures

### Wellbeing: GP-CORE

A range of measures exist to assess wellbeing. The GP-CORE (Clinical Outcomes in Routine Evaluation) might be described as a global multi-domain measure or a pan-diagnostic measure of psychological functioning. It has been widely used to assess mental wellbeing. The GP-CORE taps into the wellbeing outcomes identified as important for students, including, social support, eudaemonic wellbeing, hedonic wellbeing and coping.

The GP-CORE provides some comparison or alignment to measures used in a clinical context. The SPEQS guidance recommends use of the Clinical Outcomes in Routine Evaluation (CORE-OM or CORE-10) or Counselling Centre Assessment of Psychological Symptoms. The CORE Outcome Measure (CORE-OM), as suggested by the name, was developed as a routine outcome in clinical settings (Barkham et al., 1998; Evans et al., 2000). The CORE-OM is described as 'generic' in terms of theoretical framework, and measures wellbeing alongside anxiety, depression, trauma, functioning and risk. The CORE has been used in routine NHS and university counselling settings.

The GP-CORE, the General Population version of the CORE, provides a version of the CORE that has been designed for use in non-clinical populations, i.e., the general population. The GP-CORE provides a measure that is suitable for use across the general student population while also providing comparison to NHS and university counselling datasets.

The psychometric properties of the GP-CORE have been established, including assessment within the student population. It is sensitive to change and free to use. It has been designed for non-clinical populations. While the acceptability of the scale has not been assessed within the student population, it has been used extensively with students.

The Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) is also widely used to assess mental wellbeing. We are not recommending the WEMWBS here. Unlike WEMWBS, GP-CORE comprises both negative and positive items and capturing both positive and negative valence. With the WEMWBS, all questions are positively framed. This makes it more difficult to capture the full range of wellbeing and has the risk of assuming that wellbeing is always positive. This makes the WEMWBS less sensitive to picking up poor mental wellbeing and low levels of mental health difficulties.

#### Where to find it

<https://www.coresystemtrust.org.uk/wp-content/uploads/2020/03/GP-CORE-English.pdf>

#### Key publication

Sinclair, A., Barkham, M., Evans, C., Connell, J., & Audin, K. (2005) *Rationale and development of a general population wellbeing measure: Psychometric status of the GP-CORE in a student sample*. British Journal of Guidance & Counselling, 33(2), 153-174.

#### Examples of use in UK students

Bewick, B., Koutsopoulou, G., Miles, J., Slaa, E., & Barkham, M. (2010). Changes in undergraduate students' psychological wellbeing as they progress through university. *Studies in Higher Education*, 35(6), 633-645.

## The scale

The scale opens with a statement of:

This form has 14 statements about how you have been over the last week. Please read each statement and think how often you felt that way last week. Then circle the answer which is closest to this:

Examples of included items are as follows:

- I have felt tense, anxious or nervous
- I have felt O.K. about myself
- I have been able to do most things I needed to
- I have felt optimistic about my future

Participants respond on a scale of:

Score	Survey answer
0	Not at all
1	Only occasionally
2	Sometimes
3	Often
4	Most of the time

**Please note:** a number of items are reverse scored.

## Loneliness: the revised UCLA loneliness scale

Social connection is important for student mental health and wellbeing. Students identified social support as a priority wellbeing outcome. The Office for National Statistics (ONS) recommends using the three-item version of the Revised UCLA Loneliness scale. The psychometric properties of the Revised UCLA loneliness scale have been well established and the scale is sensitive to change. The scale is free to use and designed for non-clinical populations. It is brief and comparable to a wide range of research datasets.

The original UCLA loneliness scale was developed with students and extensively validated within student samples in the USA. The acceptability of the short three item version of the scale has been tested, through cognitive interviews, with young adults.<sup>5</sup>

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<sup>5</sup> See the ONS for further details:

<https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/compendium/nationalmeasurementofloneliness/2018>

The scale is used by the ONS and the English Longitudinal Study of Aging. This provides good comparability, allowing data from use in the student sample to be compared to a national sample.

Further guidance for measuring loneliness is available from:

- The ONS:  
[www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/methodologies/measuringlonelinessguidanceforuseofthenationalindicatorsonsurveys](http://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/methodologies/measuringlonelinessguidanceforuseofthenationalindicatorsonsurveys)
- What Works Wellbeing:  
<https://whatworkswellbeing.org/wp-content/uploads/2020/02/Brief-Guide-to-measuring-Loneliness-Feb2019.pdf>

Where to find it

<https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/compendium/nationalmeasurementofloneliness/2018/mappingthelonelinessmeasurementlandscape>

Key publications

Original development:

Russell, D., Peplau, L. A., & Ferguson, M. L. (1978). Developing a measure of loneliness. *Journal of personality assessment*, 42(3), 290-294.

Development of the 3 item form:

Hughes, M. E., Waite, L. J., Hawkey, L. C., & Cacioppo, J. T. (2004). A short scale for measuring loneliness in large surveys: Results from two population-based studies. *Research on ageing*, 26(6), 655-672.

Examples of use in UK students

Byrum, N., and Metcalfe, J. (2020) Impact of COVID 19 on Doctoral and Early Career Researchers. DOI: 10.6084/m9.figshare.12361493.v1

Richardson, T., Elliott, P., & Roberts, R. (2017). Relationship between loneliness and mental health in students. *Journal of Public Mental Health*, 16(2), 48-54.

Scale

Participants are asked to indicate the extent to which each of the following statements describes their experience of the last 2 weeks.

Items are as follows:

- How often do you feel that you lack companionship?
- How often do you feel left out?
- How often do you feel isolated from others?

Participants respond on a scale of:

Score	Survey answer
1	Hardly ever

2	Some of the time
3	Often

## Sleep quality: The Insomnia Severity Index (ISI)

The ISI is recommended as part of standard research assessments of sleep disorders. As a global insomnia symptom questionnaire, it captures subjective aspects of sleep experience and assesses several different dimensions of insomnia. The ISI can be used as a screening instrument or as a treatment-outcome measure.

The psychometric properties of this scale are well established, and it is sensitive to change. It is free to use. It has not been designed for, or validated in, the general student population. However, we have not identified any sleep measures that meet this criterion.

### Where to find it

[https://www.ons.org/sites/default/files/InsomniaSeverityIndex\\_ISI.pdf](https://www.ons.org/sites/default/files/InsomniaSeverityIndex_ISI.pdf)

### Key publications

Bastien, C. H., Vallières, A., & Morin, C. M. (2001). Validation of the Insomnia Severity Index as an outcome measure for insomnia research. *Sleep medicine*, 2(4), 297-307.

### Examples of use in university students

Ramón-Arбуés, E., Gea-Caballero, V., Granada-López, J.M., Juárez-Vela, R., Pellicer-García, B. and Antón-Solanas, I., (2020). The prevalence of depression, anxiety and stress and their associated factors in college students. *International journal of environmental research and public health*, 17(19), 7001.

Carpi, M., Cianfarani, C., & Vestri, A. (2022). Sleep quality and its associations with physical and mental health-related quality of life among university students: A cross-sectional study. *International journal of environmental research and public health*, 19(5), 2874.

### Scale

The Insomnia Severity Index has seven questions. The seven answers are added up to get a total score. When you have your total score, look at the 'Guidelines for Scoring/Interpretation' below to see where your sleep difficulty fits.

Participants are asked to circle the number that best describes the current (i.e. last 2 weeks) severity of their insomnia problem(s).

Examples of included items are as follows:

- Difficulty falling asleep
- Difficulty staying asleep
- How satisfied/dissatisfied are you with your current sleep pattern?
- To what extent do you consider your sleep problem to interfere with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) currently?

Participants respond on a scale of:

Score	Survey answer options (Please note: answers vary depending on items)
0	None/ Very satisfied/ Not at all noticeable/ Not at all worried/ Not at all interfering
1	Mild/ Satisfied /A little
2	Moderate/ Moderately satisfied/ Somewhat
3	Severe/ Dissatisfied/ Much
4	Very Severe/ Very dissatisfied/ Very noticeable/ Very worried/Very interfering

Guidelines for Scoring/Interpretation:

Add the scores for all seven items (questions 1 + 2 + 3 + 4 + 5 + 6 + 7) = \_\_\_\_\_ your total score

Total score categories:

0–7 = No clinically significant insomnia

8–14 = Subthreshold insomnia

15–21 = Clinical insomnia (moderate severity)

22–28 = Clinical insomnia (severe)

## Self-esteem

Research shows that global self-esteem is a better predictor of general well-being and mental health than specific self-esteem (Rosenberg et al., 1995). The Rosenberg Self-esteem scale is recommended in the What Works Wellbeing measures bank (n.d.).

The scale has been extensively validated and has good psychometric properties. The scale has been used frequently within the university population, with psychometric properties tested with students around the world.

Where there are some concerns that responses may not change significantly in response to interventions, a systematic review of self-esteem interventions in adults found 119 studies evaluating self-esteem interventions and the Rosenberg Self-esteem scale was one of the most frequently used outcome measures (Niveau, New and Beaudoin, 2021).

Where to find it:

[https://fetzer.org/sites/default/files/images/stories/pdf/selfmeasures/Self\\_Measures\\_for\\_Self-Esteem\\_ROSENBERG\\_SELF-ESTEEM.pdf](https://fetzer.org/sites/default/files/images/stories/pdf/selfmeasures/Self_Measures_for_Self-Esteem_ROSENBERG_SELF-ESTEEM.pdf)

## Key publications

Rosenberg, M. (1965). *Society and the adolescent self-image*. Princeton, NJ: Princeton University Press.

## Examples of use in university students

Duffy, A., Keown-Stoneman, C., Goodday, S., Horrocks, J., Lowe, M., King, N., and Saunders, K. (2020). Predictors of mental health and academic outcomes in first-year university students: Identifying prevention and early-intervention targets. *BJPsych Open*, 6(3), E46. DOI:10.1192/bjo.2020.24

## Scale

Participants are presented with a list of statements dealing with general feelings about themselves. There are four possible answers for each of the 10 questions, from "strongly agree" to "strongly disagree".

Examples of included items are as follows:

- On the whole, I am satisfied with myself
- I am able to do things as well as most other people
- I feel that I'm a person of worth, at least on an equal plane with others
- All in all, I am inclined to feel that I am a failure

Participants respond on a scale of:

Score	Survey answer
1	Strongly Agree
2	Agree
3	Disagree
4	Strongly Disagree

## Additional clinical measures

### Anxiety and Depression

While the GP-CORE has been developed to assess psychological symptoms in the general population, it is not as widely used as scales specifically designed to assess Anxiety and Depression. The Patient Health Questionnaire (PHQ-9), developed to assess depression, and the General Anxiety Disorder Assessment (GAD-7), developed to assess general anxiety, are widely used across the NHS. Further research funder guidance (e.g., guidance from UKRI) strongly recommends the inclusion of the PHQ-9 and GAD-7 in any studies considering mental health. The focus on these outcome measures is designed to improve comparability of evaluation data.

Inclusion of these measures will maximise comparability to other datasets and intervention evaluations. It may further help identify who benefits from the intervention.

The psychometric properties of both outcome measures have been well-established within the clinical context. There has however been some evaluation of validity within non-clinical contexts, including with university students. Both scales are sensitive to change and free to use. Inclusion of the scales provides comparability with NHS and university counselling and wellbeing services data.

Importantly, neither scale was designed for use in non-clinical populations. Use of the PHQ-9 within the non-clinical population comes with particular challenges as it explicitly asks about suicidality, requiring the administrator to have clear protocols in place to respond to students identifying suicidal ideation. Short two item forms of each scale have been developed and are being used increasingly to provide brief assessment of Anxiety and Depression in the non-clinical population. The GAD-2 has been validated within university students (though not UK students).

The short forms of these surveys, the PHQ-2 and GAD-2 are recommended for inclusion, providing a brief assessment of anxiety and depression symptoms and opportunity to compare with other datasets and evaluations.

#### Where to find it

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.

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.

#### Key articles

Kroenke, K., Spitzer, R.L., Williams, J.B., Monahan, P.O., and Löwe, B. (2007) Anxiety disorders in primary care: prevalence, impairment, comorbidity, and detection. *Ann Intern Med*.146:317-25.

Byrd-Bredbenner, C., Eck, K., & Quick, V. (2021). GAD-7, GAD-2, and GAD-mini: Psychometric properties and norms of university students in the United States. *General hospital psychiatry*, 69, 61-66.

#### Examples of use in UK students

Jenkins, P. E., Ducker, I., Gooding, R., James, M., & Rutter-Eley, E. (2021). Anxiety and depression in a sample of UK college students: a study of prevalence, comorbidity, and quality of life. *Journal of American college health*, 69(8), 813-819.

#### Scales

These scales are freely available. Below are the shortest versions.

#### PHQ-2

Over the last 2 weeks how often have you been bothered by the following problems?

	Not at all (1)	Several days (2)	More than half the days (3)	Nearly every day (4)
Little interest or pleasure in doing things (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Feeling down, depressed or hopeless (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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## GAD-2

Over the last 2 weeks, how often have you been bothered by the following problems?

	Not at all (1)	Several days (2)	More than half the days (3)	Nearly every day (4)
Feeling nervous, anxious or on edge (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Not being able to stop or control worrying (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## Alcohol use

Audit-C is a short, 3 item scale. This scale was developed for use in a primary care setting and is suitable for use in non-clinical settings. The psychometric properties are well established. The scale is sensitive to change. The AUDIT-C is used within the NHS and aligns to the full version of the AUDIT, which is routinely used in clinical settings. The scale is free to use.

In a validation study with university students, the AUDIT-C performed significantly better at detecting at-risk drinking than the full AUDIT scale (DeMartini and Carey, 2012).

### Where to find it

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/1113177/Alcohol-use-disorders-identification-test-for-consumption-AUDIT-C\\_for-print.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1113177/Alcohol-use-disorders-identification-test-for-consumption-AUDIT-C_for-print.pdf)

### Key papers

Saunders, J. B., Aasland, O. G., Babor, T. F., De la Fuente, J. R., & Grant, M. (1993). Development of the alcohol use disorders identification test (AUDIT): WHO collaborative project on early detection of persons with harmful alcohol consumption-II. *Addiction*, 88(6), 791-804.

Bush, K., Kivlahan, D. R., McDonell, M. B., Fihn, S. D., Bradley, K. A., & Ambulatory Care Quality Improvement Project (ACQUIP. (1998). The AUDIT alcohol consumption questions (AUDIT-C): an effective brief screening test for problem drinking. *Archives of internal medicine*, 158(16), 1789-1795.

### Example of use within students:

McCambridge, J., Bendtsen, M., Karlsson, N., White, I. R., Nilsen, P., & Bendtsen, P. (2013). Alcohol assessment and feedback by email for university students: main findings from a randomised controlled trial. *The British Journal of Psychiatry*, 203(5), 334-340.



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