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A 'whole university' approach to improving student mental health and wellbeing

mixed-methods evaluation of a new university wellbeing service

A 'whole university' approach to improving student mental health and wellbeing: Mixed-methods evaluation of a new university wellbeing service

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Abstract

Background

There has been increasing concern for the mental health and wellbeing of higher education students in the last decade with greater numbers seeking support during their studies. Robust evidence for both the scale of the issue and support services that work for a 'whole university' student population is very limited. This research examines the impact of a £1 million investment in new student wellbeing services at one large UK university in 2018, which saw a step-change in student support delivery and the addition of ~40 wellbeing advisers.

Methods

I used a mixed-methods convergent research design to examine population mental health and help-seeking trends using student wellbeing surveys (>8,000) before and after the new services were introduced. I collected service-use data at two time points in the first eighteen months of service operation (>600) and examined trends in other student wellbeing indicators such as student counselling volumes and course withdrawal rates across a five-year period from 2014-2019. I also investigated the 'lived-experience' of students and staff studying and working at the university in forty focus groups and interviews (n=120 participants).

Findings

The new services appeared to offer timely, low-intensity wellbeing and mental health support for an increased number of students, providing an accessible alternative to academic, clinical and online support. The services launch and ongoing communications were a vehicle for changing institutional mental health narrative from 'long wait times' and 'lack of care' to 'confidence in finding help' and there was evidence of an improvement in population wellbeing and anxiety levels. However, there were ongoing challenges for information sharing and added concern over the sustainability of the model. Importantly, particularly for the services in student accommodation, the demand for student support appeared to compromise the new teams' community-building and prevention effort, with potential consequences for downstream wellbeing issues.

Covid-19 Statement

The content of this thesis only briefly touches on the issue of the global pandemic despite its impact on UK education and support services between 2020 and 2021. My main research focus was to examine the impact and effectiveness of a new university wellbeing service introduction in 2018 and I wanted to avoid conflating Covid-19 associated wellbeing issues with the evaluation of the new services specifically. Nevertheless, the PhD has been shaped by those events and the following is an overview of the pandemic influence on my research design. I have outlined in more detail how I had to adapt the separate studies in the individual research design sections (Ch. 4-7).

UK lockdown began in March 2020 when I was partway through my fieldwork and data collection. I had aimed to run three service-user surveys across the 2019/20 academic year – and I carried out two (November 2019 and February 2020), but the third in April 2020 was cancelled. I had also aimed to track the broader impact of the new wellbeing services between 2018 and 2021 using the institution's cross-sectional Student Wellbeing Survey as well as in further student wellbeing indicators such as student counselling and course attrition rates over the longer time frame. However, I decided not to use any quantitative data collected after March 2020, because disruption to both teaching and support delivery from that point was simply too significant.

I had also aimed to carry out 40 focus groups and 1:1 interviews in the 2019/20 academic year, but along with much of the research community I had to pause data collection in March 2020 with more than half of my fieldwork still to carry out. As the trajectory of Covid-19 became more apparent, I carefully considered how to approach the research given the new context and applied for emergency ethics amendments to continue online. I only had a research window between April and July 2020 to collect student data before the cohort finished for the year. While the method of data collection certainly changed, I did everything I could to mitigate the nature of

what we collected, making every effort to keep data concerning previous support service experience and the (then) current Covid experience separate (see Ch. 7).

By moving the focus groups and interviews online and redesigning the cross-sectional survey analysis to simply capture the before and after impact of the services introduction (2018-2019), I still comprehensively addressed my research question. Undoubtedly this work would have been strengthened by being able to examine trends over the longer term as planned, but that was not possible. Nevertheless, I met the original aims of this research element; and as a team (my supervisors were key) we were agile and flexible in adapting our response. All of these decisions were made with Steering group, Annual reviewers, Ethics Committee and student PPI input.

However, that is the nature of Population Health research, and I was diligent and well supported by substantial expertise. I have systematically triangulated evidence from many different sources and remained reflexive, and despite the challenges of Covid-19, this thesis makes a valuable contribution to the field.

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And finally for Lindsay - the dear friend who I started this academic adventure with (and who made me promise to name her here), and for my Mum, who always believed - even in the depths of a pandemic…I'm so sad neither of you are here at the finish line. Losing you was the hardest part of this remarkable journey. I miss you.

Author's Declaration

I declare that the work in this dissertation was carried out in accordance with the requirements of the University's *Regulations and Code of Practice for Research Degree Programmes* and that it has not been submitted for any other academic award. Except where indicated by specific reference in the text, the work is the candidate's own work. Work done in collaboration with, or with the assistance of, others, is indicated as such. Any views expressed in the dissertation are those of the author.

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Publications and Reports

associated with this work

Bennett, J., Heron, J., Gunnell, D., Purdy, S., & Linton, M. J. (2022). The impact of the COVID-19 pandemic on student mental health and wellbeing in UK university students: a multiyear cross-sectional analysis. *Journal of Mental Health*, 1-8. https://doi.org/10.1080/09638237.2022.2091766

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Glossary, Acronyms and Abbreviations

AMOSSHEE	The Student Services Organisation (formerly known as the Association of Managers of Student Services in Higher Education)
Attrition	Numbers of students who withdraw/drop out of university
ASR	Adult Self Report Measure- a mental health screen
CBT	Cognitive Behavioural Therapy
CI	Confidence Interval
CMD	Common Mental Health Disorder(s)
CPD	Continuous Professional Development
DfE	Department for Education, UK Government
Faculty	University Academic Discipline e.g., Faculty of Arts or Science
FOI	Freedom of Information
GAD-7	Generalised Anxiety Disorder Questionnaire
GDPR	General Data Protection Regulation
GP	General Practitioner (Primary-care doctor)
Hall	(Hall of) Residence- university student accommodation
HE	Higher Education - tertiary education at (university/college) undergraduate degree and postgraduate level
HEPI	Higher Education Policy Institute
HESA	Higher Education Statistics Agency

LGB (TQ+)	Lesbian, Gay, Bisexual (Transgender, Queer) denoting sexual orientation
MD	Mean Difference
MH	Mental Health
MHFA	Mental Health First Aid
MRC	Medical Research Council
N	Number (of participants)
NHS	National Health Service, UK
NSS	National Students Survey
OCD	Obsessive Compulsive Disorder
OfS	The Office for Students, UK Government
ONS	The Office for National Statistics
OQ	Outcomes Questionnaire – mental health screen
OR	Odds Ratio
PGT/R	Postgraduate taught/research student
PHQ-4 or PHQ-9	Patient Health Questionnaire - 4 and 9 item depression screen
P value	Statistical test of probability
PNS	Prefer not to say
PPI	Patient and Public Involvement - stakeholder engagement
RCPsych	Royal College of Psychiatrists

RCT	Randomised controlled trial
Resi-Life (RL)	Residential Life service (local staff and student abbreviations)
Residential Life adviser	Professional non-clinical advisers based in central campus hubs offering low-intensity support and wellbeing signposting for students in university accommodation
School	Academic departments within a Faculty e.g., School of Physics
SCS	Student Counselling Service - onsite and university-funded
SD	Standard deviation
SES	Socioeconomic status - indicated by previous education (fee/non fee paying) or family level of education
SHS	Student Health Service – on-campus NHS General Practice (GP)
SMaRteN	The Student Mental Health Research Network
SSRI	Selective Serotonin Reuptake Inhibitor (anti-depressant)
SU	Students' Union
SWEMWBS	Short Warwick and Edinburgh Wellbeing scale - 7 item
TA	Thematic analysis
UG	Undergraduate student
UK	United Kingdom
UUK	Universities UK
University	Tertiary/Higher Education provider e.g., college, university

Wellbeing Access	One point of access to student support services via online form/contact number. Students triaged by wellbeing advisers and allocated support on basis of need introduced in 2019
Wellbeing adviser	Advisers with mental health training working in faculties and academic departments to offer low-intensity support and signposting for non-residential students
Wellbeing service	'Wellbeing service' (capitalised) to mean faculty advisers as opposed to Residential Life advisers
wellbeing services	Includes Wellbeing and Residential Life teams (not Health or Disability Services or Student Counselling). Together referred to here as 'wellbeing services' (not capitalised)
WEMWBS	Warwick and Edinburgh Mental Wellbeing Scale - 14 item
WHO	World Health Organisation
WMH-ICS	World Mental Health International College Student Initiative

Chapter 1 <u>An introduction to student mental health and wellbeing support in higher education - overview and context</u>

1.1 Chapter overview

This first chapter contains an outline of my thesis, sets out my specific research aims and characterises mental health and wellbeing in the student support setting. I also offer broader context for my research, providing a background summary of UK higher education (HE) and student mental health, focusing on changes in the last decade. That is followed by an overview of a corresponding shift seen in student support service models, highlighting examples of university wellbeing and accommodation support services. Lastly, I describe the university setting in which this evaluation of a new model of service delivery sits.

1.2 Thesis overview

There has been increasing focus in the last decade on a lack of evidence for effective mental health and wellbeing interventions in the higher education sector (Pollard et al., 2021; Thorley, 2017). Attention on university student mental health has mirrored concern for young people's mental health more widely (Brown, 2016; Gunnell et al., 2018; Bould et al., 2019). Transition into higher education coincides with significant neuro-developmental and social change for young adults (Blakemore, 2019). Almost three-quarters of common mental health disorders start before the age of 24 and more than half before the age of 18 (Kessler et al., 2007; Jones, 2013).

Growing numbers of students now seek additional mental health support to study successfully, in part due to increasing levels of mental health concerns in the general population and widening participation policies (Hubble et al., 2020). Furthermore, university is a critical environment in which universally applied population health measures can have a significant impact on young people's mental health and wellbeing (Duffy et al., 2019; Smith, 2021, p. 17). Internationally,

even before the global Covid-19 pandemic, a World Health Organisation survey (WMH-ICS, n.d.) across eight different countries estimated that up to 35% of first year college students had experienced a diagnoseable mental health condition at some point in their lives, 31% of them in the previous 12 months (Auerbach et al., 2018).

Very few studies have assessed the effectiveness of support service treatment and prevention approaches in HE populations, and evidence-based research for organisational-level wellbeing and mental health support models is even more limited (Thorley, 2017; Broglia et al., 2021b; Fernandez et al., 2016; Worsley et al., 2020). In the UK, a new University Mental Health Charter has recently been developed - designed to recognise and share good practice in HE (Hughes & Spanner, 2019). It lends weight to growing calls for 'real-world relevant' research, based on collaboration and systematic evaluation of student support services and interventions (Callard et al., 2022; Pollard et al., 2021; Sampson et al., 2022; Office for Students, 2019a).

My thesis addresses that critical gap with a pragmatic evaluation of the impact of the introduction of new student wellbeing support services at one large university in the United Kingdom (UK) in the academic year 2018/19. The new services represented a substantial financial investment for the institution (an added ~ £1 million annually), recruitment of more than 40 new wellbeing staff into non-clinical student support roles with the restructure of pastoral care in university-run student accommodation (Ames, 2021, p.210). The natural experiment afforded by this major change in support provision created the opportunity to investigate its impact (Craig et al., 2017). My novel research contribution comprises four studies: (1) a quantitative study examining changes in student mental health outcomes and help-seeking behaviour before and after the introduction of the new services; (2) an examination of other trends in related student mental health and wellbeing indicators before and after the introduction of the new service; (3) a quantitative study examining a sub-sample of students using the services to characterise the volume and nature of student engagement with the new support; and (4) a qualitative study exploring student and staff experiences of using or working with the new wellbeing services.

My thesis is presented in nine chapters. This chapter describes my research aims, defines mental health and outlines the UK higher education and student support service landscape as well as describing the changes to the university support provision at the centre of my study. Chapter 2 outlines the epidemiology and prevalence of student mental health concerns nationally and globally and what is currently known about help-seeking behaviour in university populations. It also summarises the existing research evidence for effective support services and interventions in HE settings. Chapter 3 is concerned with methodology and measurement of mental health and wellbeing in this setting, with the rationale and overview for my mixed methods convergent approach. Chapters 4 to 7 present the findings from each of the four studies outlined in the previous paragraph. A detailed synthesis (Ch. 8) brings together the four research elements, summarises the individual study results and triangulates the evidence to offer overarching findings. In a final chapter (Ch. 9), I discuss those overall findings further, locating them in wider existing research and theory and considering the strengths and limitations of this work. I draw general conclusions about the impact of the new services and make a number of policy and research relevant recommendations.

1.3   Research aims and objectives

1.3.1   Overall research aim

To evaluate the impact and effectiveness of a new 'whole university' organisational approach to providing student mental health and wellbeing support at a large UK university, using a mixed-methods research design.

1.3.2   Specific research objectives

My specific research objectives relate to the way I have assessed service 'impact' and 'effectiveness' for the wider student population, new service-users, staff, and the university community as a whole.

1. To investigate whether there was an improvement in mental health and wellbeing outcomes across the student population i.e., depression, anxiety and mental wellbeing,

following the introduction of new wellbeing support services in September 2018 (Chapter 4).

2. To examine whether any effects of the support services' introduction differed according to gender, age, year of study, faculty of study, course level, ethnicity, place of residence, international status, sexual orientation, socioeconomic status, previous mental health diagnosis or disability (Chapter 4).

3-4. To measure changes in student help-seeking behaviour and perceived barriers to seeking support after the introduction of the new services (Chapter 4).

5. To investigate whether the service introduction led to improvements in other indicators related to student mental health and wellbeing at this institution i.e., levels of antidepressant prescribing at the on-campus student health service; numbers of students seeking student counselling appointments; course withdrawals; and student course satisfaction (as measured in national and local surveys) compared to the former support model (Chapter 5).

6. To measure and characterise the number and nature of student interactions with the new Wellbeing and Residential life services, by evaluating student perception of service accessibility and usefulness, as well as assessing adviser caseload/mix and actions taken, and adviser confidence (Chapter 6).

7. To examine the views and 'lived-experiences' of staff and students' using and working in and alongside the new support services through narrative accounts (Chapter 7).

1.4   Defining mental health terms

Use of differing terminology and outcome measures is an ongoing issue for the student mental health field, with academics and policymakers calling for greater clarity and consensus to better

compare both prevalence and effective prevention and treatment strategies (Barkham et al., 2019; Pollard et al., 2021). Those challenges are highlighted in the literature summarised in Chapter 2; therefore, the following sections outline my use of mental health terms for the purpose of this research.

1.4.1   Mental Health

Definitions of mental health vary and are often framed in the negative, yet mental health like physical health, is a spectrum ranging from good mental health to poor mental health and mental disorder/illness, with no clear boundaries (Barden & Caleb, 2019, p. xv). All definitions agree that good mental health means more than absence of illness and is a dynamic state which allows people to make a positive contribution to society and enjoy life, while responding appropriately to negative situations and emotions (World Health Organisation, n.d.). The Royal College of Psychiatrists (RCPsych) suggests poor mental health or mental health problems should be considered on a spectrum of mild to severe and may follow major life events such as transition, loss, or periods of major stress (RCPsych, 2011; 2021). As such, mental health problems/difficulties can affect anyone at any time, influencing thinking, feelings and behaviour, and have a significant impact on someone's ability to manage their life. Further, the RCPysch suggests mental disorders/illnesses are chronic or acute conditions that may be due to a combination of organic, genetic, psychological, environmental or behavioural factors, which reduce functioning and may be eligible for a clinical diagnosis or disability statement (see 1.4.4). From this point, I will use problems/difficulties when describing mental health symptoms that may or may not be severe enough for a diagnosis and disorder/illness for symptoms that make up a diagnosable condition and may benefit from treatment.

1.4.2   Mental health disorders

Close to one billion people worldwide have a mental health disorder, including one in seven 10-19 year olds - with half of them experiencing symptoms before the age of 14, many going undiagnosed and untreated (World Health Organisation, 2021). Significant mental health disorders include depression, anxiety, obsessive compulsive disorder (OCD), phobias, eating disorders, bipolar disorder, and psychosis (NHS, n.d.). The two most common areas of mental

health difficulty and disorder, not only in the general population but also in young adults and students, are depression and anxiety symptoms (Auerbach et al., 2018). Depression is the leading cause of disability worldwide and is the largest contributor to the global burden of disease; symptoms are often described as low mood that can last for weeks or months and significantly affect daily life (WHO, 2021, NHS, n.da.). Anxiety is a feeling of worry or fear, usually a normal response to stressful events, but which can develop into a mild to severe condition that also makes day to day life difficult (NHS, n.db.). Anxiety disorder covers a number of conditions: generalised anxiety disorder, phobias, panic disorder, obsessive compulsive disorder (OCD), post-traumatic stress disorder (PTSD), or social anxiety disorder. Common mental health disorder (CMD) is an umbrella term for mood and anxiety disorders like clinically significant depression and generalised anxiety, with evidence to show they are also frequently comorbid (Pilling et al., 2011; Saha et al., 2021). Population health researchers often use CMD questionnaires such as the Patient Health Questionnaire (PHQ-9) or the Generalised Anxiety Disorder Scale (GAD-7) which are in effect screens for levels of depression and anxiety symptoms in the general population (Kroenke & Spitzer, 2001; Spitzer et al., 2006). While they are not clinically diagnostic, they reflect a scale of poor to good mental health.

1.4.3 Mental Wellbeing

Mental wellbeing[1] is a broader concept allied to mental health, and on a similar continuum, however it is possible to have good wellbeing alongside a diagnosed mental illness (Barden & Caleb, 2019, p. xiv). There is still considerable debate over a fully standardised definition of mental wellbeing, but descriptions tend to be positively framed and stress 'mental flourishing' and 'satisfaction', alongside positive emotional, spiritual, social and physical dimensions (Linton et al., 2016; Dodd et al., 2021; Barkham et al., 2019; Pollard et al., 2021). My definition is taken from the Warwick and Edinburgh Mental Wellbeing Scale (WEMWBS), a subjective measure

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[1] I use a non-hyphenated spelling of *wellbeing* rather than the north American *well-being,* simply because most key UK organisations or health and support providers do, including Warwick Medical School and the university in this research.

widely used by the UK's National Health Service (NHS) and also by applied researchers and policymakers across the globe (Warwick Medical School, 2020). WEMWBS researchers describe good mental wellbeing on their website as *"feeling good and functioning well"*, with an ability to respond to challenging *"external circumstances in a way that is resilient and enables rapid recovery"* (Warwick Medical School, 2020).

1.4.4   Disability

Under the Equality Act 2010, some mental health issues are considered disabilities (Equality Act, 2010). The Act defines a disability as a condition that has *"a long-term effect on normal day-to-day activity' and is considered 'long term' - if it lasts, or is likely to last, 12 months."* Having a registered disability qualifies for support and reasonable course adjustments from HE providers. Mental health difficulties regularly classified as non-physical disabilities include depression, bipolar disorder, OCD and psychosis, however not all will automatically qualify under the Act (Barden & Caleb, 2019, p. xv).

1.5   UK higher education landscape

To understand the impact of a university support service investment it is important to understand the broader education context. Almost half of young adults in the UK access higher education before they are 30 (UUK, 2018). In the academic year 2018/19 there were just under 2.5 million registered UK students, a 25% increase on the year 2000 (HESA, 2021). Higher education or 'tertiary level' student definitions vary globally, but in the UK that is defined as someone studying post-secondary-level education at a provider registered with the Higher Education Statistics Agency (HESA) for a recognised award (HESA, n.d.)[2]; for undergraduates - a bachelor's degree, and for postgraduates - a master's or higher degree (PhD). Of the 165 publicly and privately-funded universities in the UK, 24 form the Russell Group (RG) – highly-selective institutions with 'world-class, research intensive' reputations, where on average a third of the students are

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[2] UK Further Education colleges also deliver post-secondary-level education e.g., higher certificates and diplomas with a career focus. Their differing profile means FEs are not further considered here.

international (Russell Group, n.d.)[3]. In 2018/19, 68% of all UK students were under the age of 24, 57% were female, and 75% were studying at undergraduate level (HESA, 2021). Student tuition fees - first introduced in England in 1998 - rose to an annual high of £9,250 per year in 2017/18, with overseas students paying more than three times that (GOV.UK, n.d.). Although models vary across the nations, many students (particularly in England, Wales and Northern Ireland) fund their fees and basic living costs with government loans repaid through future earnings, with individual accrued debt often reaching £50,000 or more (GOV.UK, n.d.; Hubble & Bolton, 2020a). A related and additional concern for university students is accommodation (as discussed in section 1.8), and in 2018/19 more than 1.1 million UK students lived away from home with more than half of new undergraduates living in university or private-sector purpose-built student accommodation (halls of residence) where average rent totalled £5,400 a year (Hubble & Bolton, 2020b). Financial stress is just one of several issues linked to student wellbeing – see 2.4.2 (Benson-Egglenton, 2019; McCloud & Bann, 2019).

With increased tuition fees and the expansion of student cohorts over the last decade, there has been a parallel drive to widen university participation, with the UK government setting a target in 2015 to increase the number of students who may have previously faced barriers to HE i.e., those with disabilities, disclosed mental health challenges, disadvantaged backgrounds, lower household incomes and other under-represented groups (Connell-Smith & Hubble, 2018). As described in 2.4, the UK's widening participation strategy is likely to be linked to increased student wellbeing issues with those from disadvantaged or minority backgrounds more vulnerable to mental health challenges (Thorley, 2017).

1.6   Student mental health and wellbeing in the UK

With changes in the education sector, there has been a parallel shift in the way universities need to address student welfare and support. Nationally and globally, concern for the mental health

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[3] Note that this research focuses on a RG experience

of young people in HE has gained increasing attention, particularly in the last decade (Brown, 2016; Duffy et al., 2019; RCPsych, 2011; 2021). The number of UK students disclosing a diagnosable mental health (MH) condition to their HE provider has risen in the last decade, more than trebling between the academic years 2012/13 and 2017/18, from 1.4% to 3.5% (Student Minds, n.da.; OfS, 2019b). Mental health issues can have far-reaching consequences for students: and Office for Students (OfS) analyses of students declaring a MH condition suggest an association with poorer outcomes e.g., they are more likely to drop out in the first year and less likely to achieve higher grades, go on to study at postgraduate level or secure good employment (OfS, 2019a). At its extreme, a young person may take their own life, with numbers of student suicides increasing over the last decade - although notably this has been in line with rises in suicide rates amongst young people in the wider population (Caul, 2018; Bould et al., 2019; Gunnell et al., 2019). Indeed, incidence of self-harm and suicidal behaviour is still lower than that of same-age non-students in the general population (McManus & Gunnell, 2020).

Similarly, there have been growing numbers of students actively seeking help from university mental health services in the last ten years leading to growing attention on what has been labelled 'university mental health in crisis', placing increasing pressure on institutions to act in regard to student support provision (Brown, 2016; Evans et al., 2018; Thorley, 2017; Spitzer-Wong, 2018; The Guardian, 2012). In 2017, the Institute for Public Policy Research (IPPR) released an influential student mental health report examining key sector issues, followed by the launch of University UK's *Stepchange* framework introducing a 'whole university approach' to improving student wellbeing and welfare (Thorley, 2017; UUK, 2017). The 'whole university' model advocates systemic mental health and wellbeing consideration across pedagogy, support service provision, and community and residential life (Hughes & Spanner, 2019). A new University Mental Health Charter has recently been launched - with a quality assurance award that aims to *"recognise and reward universities that demonstrate good practice"* in improving mental health outcomes for whole university communities (Tressler, 2019, p.4).

Since the landmark publications of 2017, calls have grown for greater strategic mental health planning, research investment and evidence-based policymaking (Brown, 2018; UUK, 2018). Such

calls have been harnessed and coordinated by organisations such as: the sector regulator - the Office for Students (OfS, n.d.); Universities UK (UUK, n.d.); the Student Mental Health Research Network (SMaRteN) - funded by the UK Research and Innovation agency (UKRI) and led by Kings College London (SMaRteN, n.d.); the UK Healthy Universities Network (UK Healthy Universities Network, n.d.); the Worldwide Universities Network (WUN, n.d.); and the student mental health charity - Student Minds (Student Minds, n.d.). However, there is ongoing uncertainty about what constitutes an effective approach to student mental health support, despite the development of strategic guidance such as the UK Healthy Universities Network tool and the UUK *Stepchange*: Mentally Healthy Universities framework (Dooris et al., 2018; UUK, 2020). Further, a key UK government report was published in 2021 (conducted before the Covid-19 pandemic with a 63% response rate from 163 surveyed universities) which showed that only half of HE providers had a designated mental health strategy in place, despite the fact that 96% of them had seen an increase in demand for mental health support in the five years to 2020, and with many still struggling to meet student need (Pollard et al., 2021).

1.7   University support services in the UK

To set my evaluation in context, it is important to consider the spectrum of student support in the UK. Recent government and Charter consultation analyses underline the fact that university mental health and wellbeing provision varies considerably according to size and context of the HE provider, with no standard approach to supporting students (Hughes & Spanner, 2019; Pollard et al., 2021). Academic tutors and supervisors, along with residential wardens (or staff/senior students living in accommodation) often traditionally provided the main form of pastoral university support, supplemented by student counsellors, health, disability and chaplaincy services (Ames, 2021, p. 208). Historically, student counselling services have been the most referenced type of 'professionalised' support (Hughes & Spanner, 2019). Over the last decade, student welfare provision has grown substantially and now regularly includes: mental health teams, wellbeing teams, mental health nurses, 24/7 accommodation support, financial services, international services, inclusion teams, online and peer support, digital self-help resources, and interventions such as CBT and mindfulness group workshops, staff mental health first aid (MHFA)

training, and taught psychosocial education units. Appendix A shows a recent DfE summary of HE mental health support services (Pollard et al., 2021). The University Mental Health Charter authors acknowledge that the landscape has changed:

> *'…many universities are devoting considerable resource and effort into supporting student wellbeing'. (Hughes & Spanner, 2021, p. 32).*

In analysing Freedom of Information (FOI) data obtained by the BBC in 2018, I found that more than half of all Russell Group universities[4] had already increased their mental health budget by more than 50% between 2012/13 and 2016/17, with the largest increases at the universities of Warwick (80%) and Bristol (100%) (BBC, 2018). For one in four institutions, the number of students seeking support in the same time period had also doubled (see Appendix B). The budgetary consequences of expanding mental health provision have strengthened the argument for robust service evaluation (Broglia et al., 2021a; 2021b).

For more than a decade, the student support sector itself, led by the UK student services organisation - AMOSSHEE, has been similarly keen to assess service impact (AMOSSHEE, 2011). Currently, amid calls for cross-sector, 'whole university' strategic approaches, individual institutions have autonomy in their support service provision, and the moral and statutory issue of mental health support and the link with 'duty of care' is complex (Barden & Caleb, 2019, p. 27; Hughes, 2021). As in the general population all students also have access to NHS primary and secondary care services. Unlike schools - universities are not 'in loco-parentis' and almost all UK students are legal adults; and as a result, clear and comprehensive guidance on what 'duty of care' means in regard to university mental health support in practice, is limited or still in development, leaving it subject to legal debate (AMOSSHEE, 2015; Sladdin, 2018). A recent landmark civil case brought by parents of a student who died by suicide after suffering social anxiety, highlighted the complex ethical and legal issues for both HE providers and families in

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[4] 85 universities provided complete datasets including 18 Russell Groups

supporting student mental health issues (Courts and Tribunals Judiciary, 2022). In the context of services - on its mental health support webpage, the Office for Students states:

> *'Universities and colleges are independent and have their own policies and processes. We don't prescribe how they should support their students, as the specific needs of students in different contexts and at different institutions will vary hugely.'*
> (OfS,2020)

Despite ongoing debate about institutional responsibility, there is general recognition that individual institutions cannot address the growing issue of mental health support in isolation, and that cross-sector relationships with the NHS, Students' Unions, local councils and third-sector organisations such as Togetherall[5], Papyrus[6] and the Samaritans[7], are critical (Brady, 2018).

1.8   University accommodation

More than half of all new undergraduates opt to live in student accommodation or campus residences; and while the transition to university is exciting it can also be challenging (Hubble & Bolton, 2020b; Student Minds, n.da.). Shared university accommodation can present unique stressors such as new relationships, living with strangers, isolation or homesickness, dealing with drugs and alcohol, and new financial and domestic commitments (Worsley et al., 2021a). A single UK hall of residence typically houses between 300-700 students and is generally guaranteed to first years and international students in the first instance (Jones & Blakey, 2020). An important shift in the last decade toward private-sector rather than university-owned student residences has seen the typical 'warden' or 'academic-run' accommodation model slowly evolve into more professionalised 'residential life' services to support all aspects of student life on campus (Hubble & Bolton, 2020b; Ames, 2021, p. 208). One early adopter was the University of Sheffield, where its *Residence Life* service now oversees community events and runs education workshops but

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[5] https://togetherall.com/en-gb/
[6] https://www.papyrus-uk.org/
[7] https://www.samaritans.org/

also provides campus mentors to help signpost students into centralised wellbeing support when necessary (University of Sheffield, n.d.). However, today's accommodation support models still vary considerably, with some institutions retaining a collegiate warden-run system, led by academics and onsite doctors or counsellors e.g., University of Oxford (University of Oxford, n.d.); others operating separate accommodation services and wellbeing services; and some moving towards a residence-life framework e.g., University of Edinburgh (University of Edinburgh, n.d.). Student Minds and the Mental Health Charter have highlighted the important role that accommodation staff play in student wellbeing, not only in responding to student mental health crises or distress but also in creating communities that promote and enhance wellbeing (Hughes & Spanner, 2019; Piper, 2017).

1.9   A new student wellbeing support service - the context

In examining the specific impact of new support investment, it is critical to understand the local context. My research was carried out at a Russell Group university in an urban city in the west of England, after the introduction of new student wellbeing services in academic departments and university accommodation in September 2018. Between 2017 and 2019, the institution had almost 20,000 undergraduates, 7,000 postgraduates and 6,000 staff. More than 8,000 (mostly first year) students lived in halls of residence (both university and privately-run) across the city campus, with the remaining majority living in shared, privately rented accommodation (see 1.8). It is one of very few UK universities with a dedicated on-campus NHS GP practice - the Student Health Service - serving all students living in campus postcodes. In 2018/2019, a fifth of the institution's students were international, almost three-quarters were undergraduates, and just over two-thirds were under 21 (see Chapter 4, Table 4.3). The university was made up of 25 academic schools[8] organised into six broader disciplines known as faculties: Arts, Engineering, Health Sciences, Life Sciences, Science, Social Science and Law.

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[8] A school is an academic department within a broader faculty e.g., School of Physics within Faculty of Science. Minor school/faculty restructuring in 2018/19 and 2020/21 means there were 27 schools by 2020.

Between 2016 and 2018 the institution had experienced a highly-publicised point cluster of student deaths, i.e., more than three suicides in a specific location and time period (Hawton et al., 2020). In the five years to 2016/17, the number of students seeking help at this institution had also risen by 106% - see Appendix B, against a backdrop of overloaded NHS mental health services and increased wait-times for existing student services such as counselling (Thorley, 2017). In line with the Universities UK *StepChange* model and taking an integrated 'whole university' approach, the institution chose to commit an extra £1 million annually to its mental health budget, investing in a new wellbeing support framework which based on BBC figures was an approximate doubling of spend (UUK, 2017; UOB, 2017). The new Wellbeing service was introduced in the 2018/19 academic year; it offered a new Wellbeing advisory service in academic departments alongside a restructured, 'Residential Life' service in student accommodation (Ames, 2021, p.211).

The new support services ambition was to have embedded 'non-clinical' support staff in academic schools (wellbeing advisers), with '*a clear focus on proactively supporting the wellbeing of all students, as well as identifying and ensuring access to more specialist support for those with additional needs*' (Ames, 2021, p.211). It was based on a wellbeing advisory service model previously limited to advisers in the institution's Medical School. More than 40 new support posts were recruited to work alongside existing academic and established frontline services -see Figure 1.1 (Appendix C lists the institution's pastoral and support services).

Figure 1.1 Institution's Key Student Pastoral and Support Services in Academic Faculties and in Student Accommodation 2017/18 and 2018/19
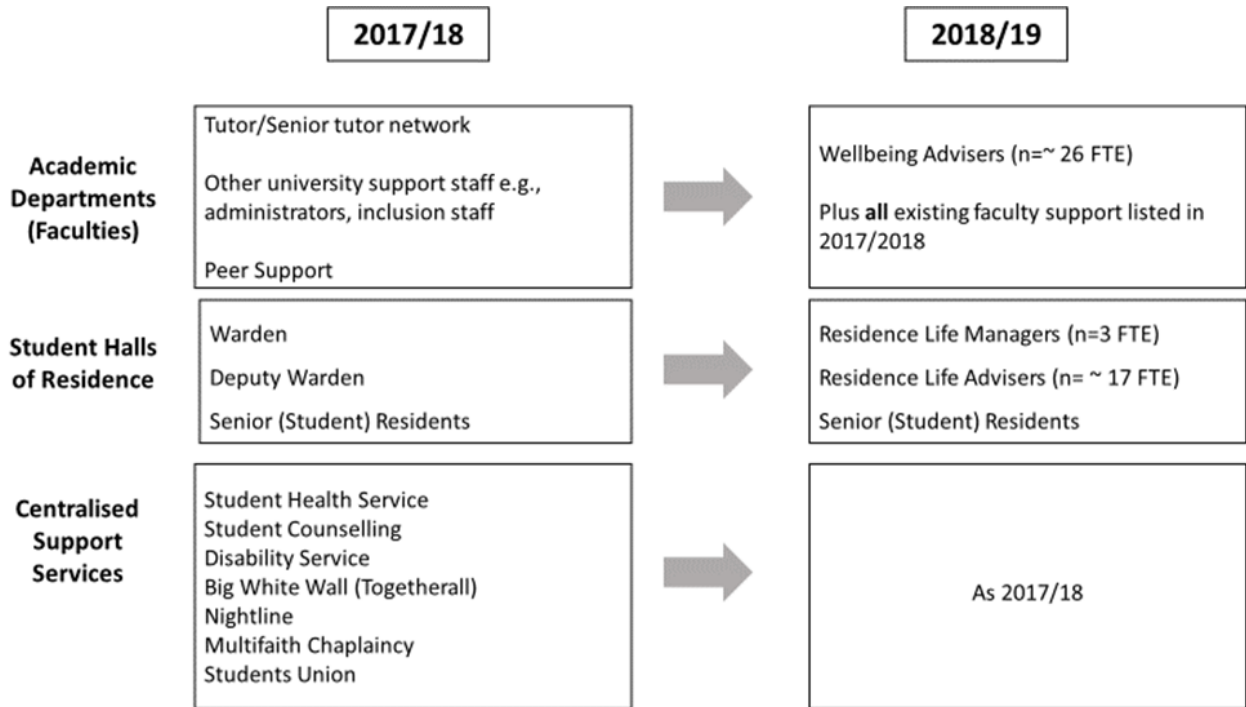
The job descriptions of the new support roles required *'strong interpersonal and problem solving skills and the ability to work effectively with students and colleagues on complex wellbeing related issues'* with more senior roles requiring *'relevant professional training and experience in one of the helping professions'* but with no explicit requirement for counselling or clinical mental health skills[9]. The new model differed from the traditional support framework that relied primarily on academic staff [10], university disability, health and counselling services, as well as referral into the

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[9] Taken from an internal draft wellbeing service proposal in 2017
[10] The institution had an academic personal tutor/supervisor network where staff provided a supportive contact for allocated groups of student tutees during their studies. Serious concerns were escalated to a department Senior Tutor.

NHS or IAPT (Adult Improving Access to Psychological Therapies, n.d.). This stepped[11] care model was designed to relieve pressure on academic staff and professional services, adding a less resource-intensive wellbeing advisory service for students with milder difficulties and improving pathways into counselling for those with more severe mental health concerns (Watkins, 2021). Early intervention was also intended to tackle downstream effects by addressing student concerns before they spiralled into mental health difficulties. Additionally, it had the dual 'whole university' ambition to deliver new proactive mental health and wellbeing initiatives (Ames, 2021, p.212).

In parallel, the residential pastoral model was restructured to ensure *"a similar level of proactive support for student wellbeing and early access to additional support"* for students living in university accommodation (Ames, 2021, p.212). Prior to the introduction of the new services, university accommodation was made up of more than 30 'residences' across the city. They were largely university-owned 'halls' or 'residences' in which students either lived on corridors and were catered for i.e., provided with breakfast/dinner in a cafeteria, or blocks divided into a number of self-catered flats each shared by ~8 students. They were run by academic wardens and senior students (known as *senior residents*) who lived on-site, providing oversight and pastoral care in return for subsidised accommodation and expenses, often alongside their teaching, research or studying commitments (see Figure 1.1). There were also a number of privately-run university residences operated by companies such as Unite, where senior residents also lived on-site. Each university residence had an elected group of students, or JCR (Junior Common Room Committee) whose role it was to organise student events with warden and senior resident co-operation. The introduction of the new model in September 2018, saw student accommodation 'professionalised' and re-organised into three residential 'villages', each covering a group of residences across a geographic section of the city (see Figure 1.2). The new Residential Life service replaced the wardens with three central village hubs manned by

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[11] Stepped care refers to a model in which the least resource intensive intervention is delivered first Bower, P., & Gilbody, S. (2005).

professional support service staff 24/7 (residential wellbeing advisers), with a number of chief and senior residents still living on each site. There was an ongoing commitment to work with students[12] and an ambition to improve transitions through proactive community building work. The new model had been met by considerable staff and student resistance, largely focused on concerns for community cohesion and having fewer staff on the ground (Worthington, 2017).

Figure 1.2 Illustrative Map Representing the Three New Residential Villages (Comprising more than 30 Halls of Residence) in Relation to Main University Campus and the City (Appx Scale 1cm to 0.3 miles)

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[12] A number of halls of residence had Junior Common Rooms (JCRs) - self-governing bodies of elected students who organise events

Notably, the wellbeing services iterated during my PhD; and my research offered interim evaluation in the form of several reports between 2018 and 2022 (see Reports and Publications). In 2018/19, the first year of service provision, the services i.e., Wellbeing and Residential Life, reportedly provided unique support to more than 5,000 individual students (Ames, 2021, p.218). Initially students seeking support had to self-select which support service to approach e.g., Student Counselling, Residential Life or Wellbeing, but in 2019/20, '*Wellbeing Access*' was introduced. It offered a streamlined 'one point of access' i.e., 24/7 email/telephone service staffed by Wellbeing and Residential Life advisers, providing an initial triage of student need via an online contact form before support was allocated. It became the only route into the Student Counselling Service but was an additional route into the Disability team and to Wellbeing and Residential Life advisers who could also be contacted on campus via drop-ins and hubs (Ames, 2021, p.218). Students could contact the university's NHS general practice (Student Health Service) separately. It should also be noted that the Student Counselling Service adopted a 'single session' counselling model in parallel in 2018/19; a move that saw students offered a single session of therapy followed by more if needed, as opposed to a typical up-front six session commitment (Dryden, 2019). Institution figures suggest that waiting-time targets reduced from six weeks to two weeks after full 'single session therapy' (SST) implementation (Ames, 2021, p.216). Lastly, the timing of my research meant I only examined impact of the new services up to the point of disruption caused by the Covid-19 global pandemic in March 2020.

1.10 Chapter summary

In evaluating the impact of a university support service investment, it is important to understand the broader education, student mental health, and current HE support context. UK universities have expanded significantly in the last decade, offering greater access to a wider group of students. Models of university welfare provision have adapted to reflect that evolution, but in parallel with a growing demand for mental health support and a sense of 'crisis' in the student mental health debate. Many institutions now offer a wealth of therapeutic tools and services to help students who struggle during their studies, but policymakers are still faced with an ongoing lack of clarity about what works and for whom. A lack of research evidence is particularly

apparent in wellbeing and accommodation advisory models as highlighted by the following chapter. This institution's introduction of new Wellbeing and Residential Life services in 2018 presented a unique opportunity to examine the impact of a major investment in new student wellbeing support, and allowed me to address that research gap.

Chapter 2 <u>Overview of evidence for student mental health difficulties, help-seeking behaviour and effective university wellbeing support</u>

2.1 Chapter overview

In this chapter I outline the literature related to prevalence of student and young people's mental health concerns more broadly, to better locate the specific issues for higher education. I then examine evidence of particular wellbeing challenges for students, describing characteristics that may increase a vulnerability for mental health difficulties and need for extra support. That is followed by an overview of the student help-seeking literature to highlight key knowledge gaps: what is known about how, where and why a student might seek welfare support from their university provider, and similarly what might prevent them from doing so. Lastly, I consider the complexity and limitations of the current literature for effective student support and accommodation models. I briefly touch on individual interventions but focus on the critical lack of evidence for 'whole university' support services that I intend to address in this thesis.

2.2 Literature search strategy

Since the start of my research in 2018, I have updated my endnote referencing library on a bi/weekly basis (until June 30th, 2022) using key search terms - see Appendix D. I have also received email search updates using the above terms from sources such as Elsevier, Safety Lit, BMJ, Google Scholar. Similarly, I have regularly monitored and collected grey literature/policy documents, signing up to alerts and regularly checking briefings, reports and articles from SMaRteN, Universities UK, the Students' Union, HEPI, HESA, OfS, DfE, Student Minds, AMOSSHEE, NHS, ONS and other key stakeholders.

2.3 Prevalence of student mental health and wellbeing difficulties

2.3.1 Young people's mental health

The latest Adult Psychiatric Morbidity Survey (APMS) data in 2014 suggested the UK prevalence of common mental health disorders[13] in 16-24 year olds was almost one in five (18.9%), and the incidence of depression, anxiety, self-harm and suicide appeared to be rising, particularly in young women (Bould et al., 2019; McManus et al., 2016; McManus & Gunnell, 2020). Likewise, a trends analysis between 2005 and 2015 using two large UK cohorts born ten years apart (n=16,945) found evidence for increased mental health problems in millennials (age 14), such as depression (11.8% to 14.8%) and self-harm (9.0% to 14.4%), suggesting the trend for older adolescents may only worsen (Patalay & Gage, 2019; Patton et al., 2016). While not every study shows an upward trend, it is likely that young people's mental health and wellbeing is not improving, with mental health problems now one of the leading causes of global disease burden in 10-24 year olds (Collishaw & Sellers, 2020; Pitchforth et al., 2019).

2.3.2 Student versus non-students

There is conflicting evidence on whether HE students have poorer mental health than their non HE age-matched peers in the UK. Using three waves of APMS data between 2000 and 2014, McManus and Gunnell (2020) found no evidence for a difference between students and non-students aged 16-24, in common mental health disorders (CMD), suicide attempts or non-suicidal self-harm. The exception was an increased risk for female students compared to male students and male and female non-students in the most recent wave. Conversely, a recent study using two large representative samples (the Longitudinal Studies of Young People in England) concluded HE students did show higher levels of CMD than those not in HE at age 18/19 and age 25 (Lewis et al., 2021). However, effect sizes were small, data collection periods differed, and outcome differences had disappeared at 25. Nevertheless, that is supported by earlier findings indicating

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[13] APMS survey asks about CMD in the last week apms-2014-ch-02-tabs.xls (live.com)

student distress (as measured by the GP-CORE)[14] is heightened but only during the years at university, suggestive of mental health stressors unique to HE (Bewick et al., 2010; Evans et al., 2005). Differing findings and research designs simply emphasise the challenges for prevalence estimation and comparison, and it is still unclear whether exposure to HE causes mental health difficulties, or whether those that choose to go on to HE have a different mental health profile (Pollard et al., 2021).

2.3.3 Student populations

In a government-cited national student survey (n=38,000) in 2018, 21.5% of respondents reported having at least one diagnosed common mental health disorder, which may be an underestimate as many students will not inform their education provider (Insight Network, 2019; Eisenberg et al., 2012; Hubble & Bolton, 2020). Despite its size, the Insight Network sample only represents 1.5% of UK students and is therefore unlikely to reflect the broader student population. Widely-cited WHO global student survey analyses suggest that CMD rates in universities and colleges across the world are high, with pre-pandemic data indicating 21.2% of first year students had experienced depression at some point in their lives (lifetime) and 18.6% had experienced anxiety, with similar 12-month prevalence; but more than a third (35%) had experienced at least one lifetime CMD (Auerbach et al., 2018; Bruffaerts et al., 2018). This ongoing research comes from the World Health Organisation World Mental Health International College Student Initiative (WMH-ICS, n.d.); and includes data from eight different countries (n=13,954), although not the UK. A key strength is its consistent study design across student populations, but response rates, timings, method of survey delivery and characteristics of respondents will all differ.

UK single study findings also face challenges in measurement differences and heterogenous samples. For example, a 2017 cross-sectional survey of health science students at a Russell Group

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[14] GP-CORE General Population Clinical Outcomes in Routine Evaluation

university (n=1,139) found that 27% reported symptoms of moderate to severe depression and/or anxiety using the PHQ-9[15] and GAD-7 (Knipe et al., 2018; Kroenke et al., 2001; Spitzer et al., 2006). By comparison, only 17.3% screened positive for CMD using the General Health Questionnaire (GHQ-28) in another sample of UK undergraduates (n=1,197) studying law, engineering, business and social science at a Post-92[16] university, (Goldberg & Hillier, 1979; Macaskill, 2013); and a smaller SMaRteN study examining postgraduate CMD in a convenience sample across 48 UK universities in 2018-19 found 25% of students (n=431) screened positive for probable depression [17] using the short Warwick and Edinburgh Mental Wellbeing Scale (SWEMWBS) scale (Byrom et al., 2020; Warwick Medical School, 2021). What is clear is that students are not a homogeneous group, and it further emphasises how study design, measures and timing make comparison or generalisation challenging (Broglia et al., 2021).

2.3.4 Changes in student mental health over time

There is also uncertainty about whether student mental health and wellbeing in HE settings has actually declined over time and by how much (Dodd et al., 2021). Until recently the larger UK cohort studies and education data agencies such as HESA, did not collect repeated mental health and education data in this age group, with policymakers relying on ad hoc self-report surveys or student MH disclosure figures to monitor change (Thorley, 2017). Furthermore, any worsening seen in student mental health wellbeing outcomes may in part be due to greater mental health awareness and reduced stigma, or changes in student survey participation, rather than true incidence (Wiens et al., 2020). Yet despite differences in international education and support systems, there have been several large longitudinal studies in the US which because of their similar HE populations have particular relevance for the UK. A 2019 review of almost 800,000 US students, using two national cohort studies, shows a broad worsening trend in mental health in the last decade - with 41.4% students screening positive for moderate/severe depression

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[15] Moderate /severe depression or anxiety as measured by scoring $\geq$10 on the PHQ-9 or GAD-7
[16] Post-92 universities were called polytechnics until 1992
[17] Probable depression indicated by scoring <18 on SWEMWBS

symptoms (using PHQ-9) and 34.4% screening positive for anxiety symptoms (using GAD-7) in 2017-2018 (Duffy et al., 2019a). Over the previous four years, where methodology and response rates had been largely consistent, that represented a 72% increase in depression and 92% increase in anxiety symptoms. Further research now shows an upward trend of increasing depression and anxiety extending into the global Covid-19 pandemic and the end of 2020 (Bennett et al., 2022; Abelson et al., 2022; Lipson et al., 2021; Moskow et al., 2022).

2.3.5 Mental wellbeing

Estimating mental wellbeing in HE settings is also problematic, with a recent scoping review underlining similar measurement and conceptual issues (Dodd et al., 2021). The authors examined wellbeing measures used in quantitative UK student population studies using Colquhoun guidelines, the largest of which was a health science student survey (n=1,139) using WEMWBS, which found 70% of participants had poorer wellbeing i.e., scoring less than the national average for 16-24 year olds (Colquhoun et al., 2014; Knipe et al., 2018).

A 2017 analysis of Health Survey for England data (n=27,519) suggested the average general population mental wellbeing score[18] for 16-24 year olds was 51.7 on the 14-item WEMWBS scale, and 23.4 on the 7-item SWEMWBS scale (Fat et al., 2017). A further student study which enrolled 600 participants[19] using a recruitment database of 4,758 students across 161 UK universities reported an average SWEMWBS score of 19.9 (95% CI 19.6-20.2) during the Covid-19 pandemic (Defeyter et al., 2021). Further examples also suggest student wellbeing is generally lower than age-matched peers (Galante et al., 2018; Gorczynski et al., 2017); but wellbeing measurement (like depression and anxiety) is also dependent on timing (e.g., exams are periods of heightened stress), local context and sample characteristics (Dodd et al., 2021; Thorley, 2017). The necessary

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[18] WEWMWBS is scored between 14 and 70 and SWEWMBS between 7 and 35 with higher scores indicating better wellbeing (Tennant et al., 2007).
[19] n=469/600 were usable responses

longitudinal evidence to make comparison across HE populations or to track changes in student mental wellbeing over time is as yet largely missing.

In sum, young people's mental health does appear to be worsening in the UK, but it is still unclear if student mental health is also declining to a similar or greater extent, and whether those in higher education have poorer mental health than those who are not. In general, student mental wellbeing is shown to be worse than non-HE peers, and as many as one in three may have already experienced a mental health disorder at some point in their lives (Auerbach et al., 2018). However, the issue of prevalence is complex and likely to be influenced by increased disclosure and reporting of mental health difficulties as well as competing environmental and individual factors as described below, and a number of which (n=12) I will consider in this research (Table 4.2).

2.4   Risks and predictors for poorer student mental health or wellbeing

The university transition coincides with unique stressors: leaving home and facing new academic, financial and domestic challenges alongside heightened social experiences such as forming relationships, expectations for use of recreational drugs or alcohol, and potential sleep disruption - and for some, study may also be combined with employment or caring roles (Duffy et al., 2019; Student Minds, n.da.). Today's university communities are increasingly diverse, made up of students with a wide range of needs, and as described in Chapter 1, recent policies aimed at widening participation, a growth in student numbers, and the introduction of fees have all likely contributed to changes in the characteristics of the student body and the proportion of those most vulnerable (Student Minds, n.da.; Barden & Caleb, 2019, p. 11; Broglia et al., 2021; Wiens et al., 2020). While there is good evidence for a number of modifiable mental health risk factors in the adolescent general population, including drug and alcohol use, poor sleep or physical health - a lack of detailed understanding of the specific help-seeking needs of university populations can hamper provision of effective mental health support and prevention strategies (Bourke et al., 2022; Cairns et al., 2014; Pollard et al., 2021; Worsley et al., 2020). There is now substantial evidence for a number of student characteristics and contextual factors related to CMD, as outlined in the following sections.

2.4.1 Diagnosis, disability, age, and gender

One reliable finding is that those with pre-existing mental health issues and physical or non-physical disabilities are more likely to be at higher risk of depression, anxiety and wellbeing issues during their studies (Auerbach et al., 2018; Bruffaerts et al., 2019; Hubble & Bolton, 2020). Age too is relevant: More than two thirds of UK students are under the age of 24, coinciding with late adolescence, ongoing neural, hormonal and social development and the critical period for onset of CMDs (Blakemore, 2019; Kessler et al., 2007). Gender is also linked - with female students and those identifying as minority gender (i.e., non-binary, transgender, another gender) at particular associated risk of CMDs compared to males (Bould et al., 2019; Lipson et al., 2019a; McManus & Gunnell, 2020). 2014 APMS findings suggested that at their peak in 16-24 year olds, the prevalence of CMDs were three times higher in females (26%) than males (9.1%) (McManus et al., 2016). In their US survey of more than 65,000 students across 71 campuses, Lipson et al. (2019) found that minority gender was associated with 4.3 higher odds (95%CI 3.61 to 5.12) of having at least one mental health problem while at college.

2.4.2 Sexual orientation, ethnicity, socio-economic and financial concerns

Similarly, there is evidence to suggest that other minority or marginalised student groups may be at greater risk of CMD. Research indicates that identifying as LGBTQ+[20] is linked to worsened mental health, and several studies have examined ethnicity as a risk factor, hypothesising that discrimination, bullying or greater social isolation may play a part (Arday, 2018; Campbell et al., 2022; Smithies & Byrom, 2018). Black, Asian and Minority Ethnic students report poorer mental wellbeing than their white peers, and minority ethnicity students in the UK who declare a CMD while studying are also ten percent less likely than white peers with a CMD to get a first-class degree (Arday, 2018; Lipson et al., 2022; Stoll et al., 2022; UUK, 2019). Further attention has been

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[20] The term LGB/LGBT+/LGBTQ+ is generally abbreviated (and conflated) in different contexts in regard to gender and sexual orientation e.g., the university in this research uses LGBT+ and Student Minds and Stonewall use LGBTQ+, while others use LGB (+). I have used LBGTQ+ in all general chapters but specify LGB in chapters 4 and 5 where my student characteristic variables are constrained a) sexual orientation including lesbian, gay, bisexual (LGB) and b) gender including transgender (T).

given to risk factors which include a disadvantaged background and students who may face added financial or academic stresses, with growing evidence pointing to an association between poorer levels of wellbeing and financial strain, housing and food security (Defeyter et al., 2021; Hardeman et al., 2015). However more specific research around student finances has been inconclusive to date: In their rapid review McCloud and Bann (2019) found only weak evidence for a relationship between financial stress and poor mental health, and none for a hypothesised association with student debt, despite the trebling of UK student tuition fees in 2012.

2.4.3 Loneliness

Campbell et al. (2022a) recently carried out a rapid review of student CMD and associated characteristics highlighting important behavioural and potentially modifiable risk factors for students, specifically those who do not engage academically or socially - citing loneliness as critically linked to mental health outcomes. Indeed, there is growing evidence for loneliness and social isolation as a predictor for CMD at university, with almost one in four (23%) students saying they feel *often or always* lonely compared to 7% of 16-24 year olds in the UK general population and 5% in the UK adult population (SCIS, n.d.; ONS, 2021). A survey of students (n=1,135) in a northern UK university, found feelings of loneliness were consistently the strongest predictor of poor mental health and that social connectedness was the most protective factor against anxiety and depression (McIntyre et al., 2018). The authors also showed some evidence that addressing social connection improved mental health outcomes although the bidirectional/causal relationship between loneliness and mental health remains a complex one (Miller et al., 2017).

2.4.4 Living space and social relationships

Loneliness has implications for the campus residential experience, and that relationship is mirrored in the few UK studies to date that have focused on student accommodation in relation to mental health. For example, Worsley and colleagues (2021b) conducted eight focus groups in two northern universities with first year students (n=38) living on campus; and using thematic analysis found that depression, anxiety and loneliness were often associated with new social experiences, feeling uncomfortable in student accommodation, poor relationships with fellow residents and not using the communal and social spaces. Another recent study used online

qualitative surveys (n=90) to examine the UK undergraduate accommodation experience for second and third years and found related themes. That included quality of social connection and housemate relationships as important supportive (or isolating) influences for mental wellbeing (Foulkes et al., 2021). Despite their size in relation to many quantitative population samples, qualitative studies like these are critical for understanding student wellbeing, particularly in relatively under-researched issues such as living spaces and relationships.

Further studies support the argument that accommodation concerns can have significant wellbeing impact, but the quality of evidence varies considerably. In a 2019 survey of more than 2,000 students, 63% of respondents said poor-fit accommodation and cost implications had adversely impacted their mental health (Save the Student, 2019). However, it was a student organisation survey; and while similar one-off cross-sectional surveys often gain media attention and have policy impact, they generally have low response rates (with no caveats or published methodology) and are unlikely to be representative of the whole study body. A recent systematic review did identify 36 studies in relation to student housing conditions and psychological distress, and not surprisingly showed students living on campus face a number of stressors such as drugs and alcohol, poor sleep, risky sexual behaviour or dissatisfaction with accommodation (Franzoi et al., 2022). The authors similarly underlined the weaknesses of heterogenous, small studies where mental health outcomes can be influenced by complex individual and environmental factors, and they determined that the existing evidence was too weak to offer generalisable conclusions.

2.4.5   Pedagogy and academic life

Beyond the living space, student perception of academic life is inevitably a key determinant of stress, which has been underlined by Upsher et al. (2022, p.2) in a recent review of curriculum-based wellbeing approaches - *"The university experience is built around learning and students' educational experience impacts their mental health".* Indeed, there is good evidence to suggest pedagogical concerns are related to mental health and wellbeing (Houghton & Anderson, 2017; Hughes & Spanner, 2019). They relate to areas such as assessment, workload, increased perfectionism, and also staff mental health (Brewster et al., 2021; Flett & Hewitt, 2014; Jones et

al., 2021; Riva et al., 2020). In one example, Boulton et al. (2019) examined student engagement with learning - demonstrating that relationships between academic outcomes and wellbeing are bi-directional, with poor academic performance affecting wellbeing and vice versa. The added complexity of differing individual student characteristics and the arguably necessary academic stretch of tertiary-level study, mean that the intersection of pedagogy and wellbeing are a key pillar of the whole university approach, with consequences for support service design (UUK, 2018).

There is considerable evidence to suggest that year of study may also be important in predicting student difficulties, however the literature is mixed. Bewick et al. (2010) found greater strain on students' mental health after starting university, with MH fluctuating throughout a three-year course - never returning to pre-university baseline, and with levels of depression at their highest in the final year - using GP-CORE (Evans et al., 2005). Conley et al. (2020) conducted a four-year longitudinal US study (n=5,536) showing students experienced increased depression, anxiety and stress in the first two years of college, with improvement in the last two. They suggest the first two years indicate an extended period of transition for students, followed by improvement in stress levels as students grow, develop their interests and look forward to graduation and entering the workforce. However, they saw considerable gender differences, and the authors acknowledged the overall findings may have masked relative stability for some groups and greater fluctuation for others. Moreover, US undergraduates' programmes are four years, but generally three years in the UK[21] re-emphasising the challenges for drawing firm conclusions (Study International, 2018).

Discipline or area of study may also be relevant to student wellbeing. Research spanning five UK universities found medical students reported the lowest academic distress (but highest eating concerns), social scientists reported the highest mental health symptoms, and engineering

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[21] Four year courses are the norm in Scotland

students met the lowest clinical criteria for all outcomes, particularly anxiety (Broglia et al., 2021). Importantly, the authors did not account for gender despite its notable differences in MH outcomes and case composition, but an earlier large US study (n=64,519) also reported similar findings - Lipson et al. (2016) found arts and humanities students were the most likely to experience mental health difficulties, even after adjusting for age, gender, ethnicity and parental education. Any causal inferences are also unclear i.e., whether academic stressors are different across disciplines or students' personal characteristics mean they are attracted to different subjects.

Similarly, there are also potential course level differences i.e., with undergraduates having both a different study experience to postgraduates as well as different mental health characteristics, but there is more limited comparative research in this area. Findings of two recent studies have shown that on average postgraduate researchers tend to have better mental health and wellbeing than their undergraduate peers, however postgraduates are less likely to be facing the same transition challenges as undergraduates, and age may be an important confounder (Bennett et al., 2022; Brett et al., 2022).

The complex interplay of individual mental health characteristics and behaviours alongside environmental and cultural factors is increasingly apparent. There is now almost universal acceptance that ongoing examination of their interaction is needed to better target resource, training and services (Broglia et al., 2021). Consequently, I have addressed this in my evaluation (Ch. 4-6) by examining the differential impact of the new support services in 12 of these individual and contextual factors see Table 4.2.

2.5   Student help-seeking behaviour and barriers to seeking support

Against this backdrop of complexity, one trend is clear - the number of tertiary students seeking mental health support has risen over the last decade both internationally and nationally, with 94% of UK universities saying they have seen higher demand for their counselling services (Duffy et al., 2019a; Hubble & Bolton, 2020; Lipson et al., 2019; Oswalt et al., 2020; Thorley, 2017). UK university support services also report working with more complex cases, and Broglia et al. (2018)

have suggested students may be delaying help-seeking until their mental health difficulties are severe (Broglia et al., 2017; Thorley, 2017). Long counselling waiting-lists, coupled with additional pressure on the NHS and external mental health agencies means university support services have been under increasing strain (Hubble & Bolton, 2020; Pollard et al., 2021). In their study examining student use of counselling services at each of four UK HEs in 2017/18 (where the populations ranged from 11,000 to 28,000), Broglia et al. (2018) reported that 8-10% of the student population were attending counselling.

2.5.1   Differences in help-seeking behaviour

Evidence suggests that students who do (or do not) seek university help are not entirely representative of the wider student population either with gender, socio-economic, cultural, and course differences (Broglia et al., 2021; Liu et al., 2019; Thorley, 2017). One study in Ireland across 13 HE providers (n=>6,508), found that students with a CMD who were younger, male, identified as heterosexual or studying for a PhD were the 'largest unmet need' for professional help (Cullinan et al., 2020). However, before controlling for mental health diagnosis, students from the lowest socioeconomic backgrounds and those with the greatest financial pressure had the greatest unmet support need - the disparities driven by their higher rates of mental ill-health.

With females twice as likely to disclose a mental health issue to their HE provider, there are now a number of studies examining why female students experience greater distress or mental health difficulties and/or male students may find it harder to seek help or admit they are struggling (UCAS,2021; Sagar-Ouriaghli et al., 2020). Yet, as Robertson et al., (2022) highlighted in a recent UK report, the issues of gendered mental health inequality in both prevalence and help-seeking are likely to be more complex than current research findings may suggest. Indeed, one US college study (n=778) examined student mental health symptoms, self-reported CMDs and help-seeking behaviour, and found females were significantly more likely to report a wider range of symptoms than males, but their symptom severity and treatment seeking did not differ (McIntyre et al., 2014). The authors suggested the way different genders perceive their symptoms, their openness to discussing them and a lack of gender sensitivity in self-reporting diagnostic tools (in this case the CHOIS mental health scale) may lead to over and under diagnosis and allocation of support

(Sarkin-Andrew & Sklar-Marisa, 2014). Similarly, gender is not a binary issue and while evidence suggests students identifying as minority gender or sexuality are at greater risk of CMDs, there are mixed findings in relation to help-seeking behaviour, with some studies suggesting a greater willingness to seek support but considerable variance in use of formal mental health services (Hughes et al., 2018).

There are also further individual differences: Black, Asian and minority ethnic students have been shown to be less likely to seek help when they need it, often citing a lack of access to culturally appropriate services (Lipson et al., 2022; UUK, 2019). Likewise, data from a large US population study (n=228,421) found that while international students appeared to be at lower risk of mental health issues, those who were experiencing a problem were less likely to seek support (Zhou et al., 2021). In their cross-discipline analysis, Lipson et al. (2016) found undergraduates with a CMD studying natural sciences, engineering or business were the least likely to seek help (compared to social science students); masters students studying social work were more likely to seek help than their peers; yet there were no significant cross-disciplinary differences for doctoral student help-seeking.

These examples highlight some of the variance in the way different student groups will declare mental health issues and seek university help (see also Table 4.2), with growing evidence of complex nuance in the relationship between an individual's perception of their mental health symptoms and cultural and contextual attitudes. The following section shows how that may be further complicated by structural and perceptual differences of university support provision.

2.5.2   Barriers to university help-seeking

Despite the rising demand for support services, it is thought that the majority of students experiencing mental health difficulties do not seek help (Bruffaerts et al., 2019; Eisenberg et al., 2012; Hartrey et al., 2017). The WMH-ICS surveys (n=13, 984) found that only 24.6% of first year students think they would definitely seek help for an emotional problem (Ebert et al., 2019). Reasons students gave were mostly attitudinal rather than structural, for example embarrassment and preferring to handle the problem alone or turn to friends. Indeed, recent

research supports the idea that students choose to approach family, friends or familiar academic staff (Hughes, 2021; Hughes et al., 2018); that is a pattern also seen in adolescents and young adults in the broader population (Rickwood et al., 2005; Rickwood & Braithwaite, 1994). In Ebert et al.'s (2019) multivariate analysis, for those students with diagnosed depression or anxiety - embarrassment was also a barrier to help-seeking. Likewise, a 2017 systematic review of students with mental health difficulties suggested they face greater barriers including stigma, symptomology and lack of mental health literacy (on both their and academics' parts) when seeking help compared to other students with other disabilities (Hartrey et al., 2017). While research often cites *stigma* as an issue for support-seeking, it is often an internalised phenomenon (Bathje & Pryor, 2011). For example, a recent survey of 376 UK students recruited through the SMaRteN network suggested that *self-stigma* was a particular barrier, followed by wider *public stigma*, alongside debilitating symptoms and fear of educational impact (Cage et al., 2020; Thorley, 2017). There is now good evidence that positive experience, social support and encouragement from others - both peers, staff and professionals - can help to address some of these help-seeking issues (Gulliver et al., 2010).

Perhaps most concerningly, research suggests some of the most at-risk students do not actively seek support, with one UK survey of student medics, vets and dentists (n=1,139) reporting that only one in five of those screening positive for severe depression (i.e., scoring >20 on the PHQ-9) had sought professional help, with the most cited barriers being a fear of documentation and intervention, or a lack of time – pointing to specific issues regarding professional health courses, academic timetabling or future employment concerns (Knipe et al., 2018).

As mentioned earlier, another barrier to seeking support may be mental health symptoms themselves. An analysis of more than 27,000 students at a UK university found those experiencing greater depression or anxiety were less likely to consent to close contacts being alerted in a mental health emergency by their HE provider (Linton et al., 2022). Likewise, a single city case study examining student deaths between 2010 and 2019 showed that almost 90% of students who had taken their own lives had not previously informed their university about a mental health issue (McLaughlin & Gunnell, 2020). It underlines a need for universities to juggle

increasing student distress and rising demand for support services with pro-active monitoring of those who may never seek help at all and increased service accessibility for complex, at-risk students (Hughes & Spanner, 2019).

Equally, evidence suggests that availability and accessibility of mental health support continues to be a key challenge for the university sector, particularly from the student perspective (Broglia et al., 2021; Hartrey et al., 2017; Priestley et al., 2022). Priestley et al. carried out six UK focus groups (n=73) in spring 2019 for the Mental Health Charter, capturing student views of UK university support services. Their narrative analysis describes three types of barriers: structural i.e., capacity and waiting times; physical i.e., location and service opening-hours; and perceptual i.e., student lack of awareness or understanding of services, lack of culturally appropriate support and mental health stigma. In a 2021 study across five UK universities (n=1,956), Broglia et al. (2021) drew similar conclusions that specific student help-seeking issues included difficulty in accessing services alongside stigma, fear of academic consequences and mental health literacy. Both studies mirror the wider literature in which wait times, stigma and fear of documentation can prevent students from seeking timely help (Knipe et al., 2018; Frampton & Smithies, 2021). Qualitative research or mixed methodology is critical in understanding detailed experience; however, student samples are often small and self-selecting making it difficult to generalise; and as Priestley et al. (2022) also found, participants can often be unaware of the differences between mental health and wellbeing, or what might constitute crisis or stress, therefore conflating interventions or services they are being asked to comment on.

These studies illustrate some of the variance in the way students seek support and the barriers they may face. Individual differences are often further complicated by attitudes, context, cultural norms and mental health literacy as well as the availability and accessibility of support services in different university settings. The methodological limitations of existing studies highlight the importance of being able to track changes in the same population over time as I have done in the following chapters (4-5), allowing me to take individual differences into account in the same context. It also underlines the importance of understanding how to create whole university approaches to mental health support, using strategies and interventions that encourage greater

help seeking particularly among those most at risk, but that also address issues at population level, improving mental health literacy, reducing stigma and helping students to better support themselves.

2.6 Current evidence for student mental health and wellbeing support in university settings

In the UK, there have been a number of studies examining the effectiveness of student counselling services, but my searches identified no research evidence for the effectiveness of university wellbeing teams or low-intensity mental health advisory services (Broglia et al., 2021a). Similarly, there has been some limited research examining factors influencing the university accommodation experience but little academic evaluation of UK accommodation welfare provision (Sampson et al., 2022; Thorley, 2017). The following sections summarise the evidence for broader student mental health interventions/approaches, followed by what is known about the effectiveness of university support services.

2.6.1 Student mental health interventions

In contrast to the gaps in the student literature regarding wellbeing and accommodation advisory services, the wider student mental health intervention literature is large but dispersed. To date, there have been at least 600 individual randomised control intervention trials in HE settings, with a growing number of reviews and meta-reviews for the efficacy of psychological, technological/digital, and educational student wellbeing interventions (Abelson et al., 2022; Cuijpers et al., 2021; Robertson et al., 2022; Worsley et al., 2020) – and I have provided an overview of individual example interventions in Appendix D. While CBT, mindfulness, recreation and technology-delivered interventions generally show efficacy compared to controls, notably and almost universally, review and meta-review level authors report limitations in drawing any firm conclusions due to publication bias, substantial heterogeneity and a lack of high-quality literature (Abelson et al., 2022; Cuijpers et al., 2021; Robertson et al., 2022; Worsley et al., 2020).

Population-level evidence for student wellbeing support service or mental health setting-based interventions (i.e., structural or organisational strategies) is far more limited. An exception is a

systematic review which synthesised evidence for broader student mental health and wellbeing interventions in global university and college settings (Fernandez et al., 2016). The researchers reviewed 'whole university' approaches to mental wellbeing e.g., academic strategies, social marketing strategies and structural/organisational policies, with 19 papers included in their narrative synthesis. The most promising findings were those that included changes to the ways that students are taught and assessed but inconclusive evidence related to policies or services promoting mental health. Once again, the authors determined that the existing body of evidence was too limited to draw any robust conclusions.

Another recent scoping review examining health studies (n=101) related to settings and whole university interventions - to include 'whole settings', 'complex systems', 'participatory'/ 'action' approaches and interventions to improve health, wellbeing and/or health-behaviours - simply concluded there was no evidence for their impact (Sweeting et al., 2021, p. 21). The authors reported that establishing an evidence base was slow, with "*enormous challenges for institutions to fully, rather than tokenistically implement healthy university interventions, and for researchers aiming to evaluate them within a funding and evidence context that is skewed towards trials, short-term outcomes and simple linear models of cause and effect*".

2.6.2   Student counselling services

The most established form of professional student support is counselling, with evidence suggesting it is effective for addressing short-term student mental health concerns i.e., depression and anxiety (Broglia et al., 2021; Connell et al., 2008; Murray et al., 2016). While improvements can occur across time without intervention, positive results (measured with Adult Self Report measure ASR and the Outcome Questionnaire OQ-45) have also been found using an RCT design in which students were randomly allocated to an experimental group (n=66) or wait-list control (n=44) for psychotherapy (Achenbach & Rescorla, 2003; Biasi et al., 2017; Lambert & Hill, 1994). Effects were sustained over a three-month period and students in receipt of counselling went on to be able to take some exams (compared to the control group). RCTs like this, while gold-standard, would certainly benefit from replication using different measures and larger samples to be able to generalise findings.

While therapeutic counselling appears to be effective for many students experiencing common mental health issues, it is also resource-intensive (whether delivered individually or in a group), often meaning limited access and long waiting lists (Broglia et al., 2018; Dufour, 2020). Broglia et al. (2018) found students in 2013/14 typically attended 3-4 sessions, and in large institutions waited up to 6 days for an initial consultation, with 17 to 18 days between subsequent sessions. In 2016/17, Freedom of Information data from 47 of the UK's 165 universities found the median wait for an initial appointment was 9.2 days (BBC, 2018). One solution to rising wait-times has been the introduction of a single session 'one at a time' (SST or OAAT) therapeutic counselling model which has been trialled in at least two UK universities, but with no academic evaluation to date (Dryden, 2019; 2020). As described in Chapter 1, the institution in my research introduced the SST model in 2018/19 at the same time as its new wellbeing services, with internal reporting suggesting its counselling wait-time dropped by 66% after the first year- see 1.9; however further examination was not within the scope of my research (Ames, 2021, p.216).

2.6.3   Mental health advisers

Universities have diversified their counselling and support provision to meet growing demand, recognising that not all students experiencing distress will have high clinical need - see Appendix A for an overview of services (Pollard et al., 2021). There can also be significant differences in therapeutic outcomes, with some experiencing a deterioration in symptoms after counselling, suggesting psychotherapy is not always appropriate (CORE, 2010; Curran et al., 2019). In their survey of UK Heads of Counselling Services in 2014/14, Broglia et al. (2018) aimed to characterise 'embedded counselling'[22] which sits in or alongside HE and FE counselling services, and to characterise service users, factors affecting services and any interest in uptake of technology. They suggested trained mental health advisers (MHA) had become the second largest form of (low intensity) support in many university counselling or disability services supporting "*students to cope a) in response to short-term stressors rather than long-term clinical need and b) out of*

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[22] Embedded counselling - counselling in an informal context by someone in a professional role e.g., nurse, doctor, teacher, social worker

hours". Similarly, in a report more than ten years ago, for the University Mental Health Advisers Network (https://www.umhan.com), the authors Blakely and Bragg (2010) estimated that 50% of HEs had committed to providing mental health adviser(s) in their support provision. One example of that is Specialist Mental Health Mentors who provide specialised support to students in 72 HEs across the UK through a not-for-profit University Mentoring Organisation (Matthews, 2020). The advisers work one to one with students with MH difficulties who are struggling with the demands of student life and at risk of dropping out. In a white paper analysis, 94% students self-report learning better strategies to manage both their course and their own mental health after mentoring (Matthews, 2020). While positive - evidence for interventions like this are rarely peer-reviewed meaning more robust comparison and synthesis with the wider academic literature is lacking.

More recently, the Royal College of Psychiatrists (2021, p.47) noted there are now MHAs at 127 UK HE institutions; but qualified MH advisers can differ from wellbeing advisers as they are required to have considerable mental health expertise or professional or postgraduate qualifications in fields such as nursing, or social work. The RCPsych report (2021, p.48) also acknowledges that "*some institutions have taken a different approach to mental health provision and have brought a range of health-related capabilities together to create 'health and wellbeing teams', others, despite not appointing an MHA, offer specialist advice through, for example, their disability or counselling services or their health centre*". While this model of 'stepped care' i.e., mental health advisers or wellbeing teams working alongside or within HE counselling teams or professional services has clearly been growing, there is considerable diversity in framework and range of provision (Barden & Caleb, 2019, p. 149; Ogrodniczuk et al., 2021; Pollard et al., 2021; RCPsych, 2021). Critically, to my knowledge there has been no academic evaluation in HE settings of either the MHA or a non-clinical wellbeing adviser role, which my research will now address.

2.6.4   Student accommodation support

There is also limited empirical literature for mental health and wellbeing support in student accommodation. New students will arguably spend more time in their residential accommodation than anywhere else - a space that impacts relationships, security, identity and

sense of belonging making it key in transition (Worsley et al., 2021a; Worsley et al., 2021b). It is also where some of the most severe experiences of mental illness and crisis can happen (Hughes & Spanner, 2019).

A recent Student Minds report outlining priorities for wellbeing in student residences did include an evaluation of a mental health training programme delivered to accommodation staff and student peer supporters in a northern UK university in 2016 (Piper, 2017). *The Student Living Project* involved a series of information workshops and training sessions covering MH awareness, signposting, suicide and self-harm. They ran between September and November, with survey and focus group data collected pre/post-delivery. The findings suggested that attendees felt their understanding, skills and confidence had significantly improved allowing them to better support students experiencing difficulties. However, almost all educational interventions report changes in knowledge/attitude outcomes, and it did not assess changes in student mental health outcomes. The study itself was carried out by professionals and supported by academics, but it was small, in a single institution, and again the findings were not published. Nevertheless, the *Student Living Project* was a practical student accommodation case study and the report itself was comprehensive and far-reaching in a policy and research landscape that lacks evaluation of the accommodation welfare role.

The wider report also highlighted the complexity for student accommodation wellbeing provision. As described in 1.8, university residential models differ substantially with wellbeing responsibility often shared between specific accommodation providers, wardens, central health and wellbeing support services, the Student's Union, and even Chaplaincy (Piper, 2017).

Although not specifically evaluating services, in one related piece of research, Worsley et al. (2021; 2021b) carried out both qualitative and quantitative research with students in halls of residence in a UK university in which focus group participants were asked about transition, accommodation, expectation and friendships. Worsley et al.'s thematic findings centred on accommodation, with the authors concluding: "*it is common for students to withdraw physically and psychologically when they do not form friendships within their flat, accommodation-based*

pastoral staff have an important role to fulfil." (Worsley et al., 2021b, p.12). Similarly, their qualitative survey findings (n=904) showed the strongest associations of depression (PHQ-9) and anxiety (GAD-7) with feelings of loneliness (UCLA-4 Loneliness scale) and poor relationships, but no association with quality of accommodation or the size of student group living together, something the authors had originally hypothesised (Russell, 1996; Worsley et al., 2021).

Foulkes et al. (2022) added weight to that evidence with the house-mate study underlining the importance of social relationships for student wellbeing. Furthermore, in a recent analysis of six student focus groups (n=65) at universities across the UK (again as part of the Mental Health Charter), Priestley et al. (2022a) report thematic evidence for the importance of 'facilitating regular, positive social interaction' and 'creating inclusive community cultures' for promoting wellbeing. These findings suggest the ongoing need for a strategic support and facilitative role in university accommodation i.e., the importance of professional accommodation advisers for fostering and facilitating social interaction and connection, as well as responding to crisis and immediate distress. Yet with the lack of research evidence to date, the empirical evidence for effectiveness of accommodation advisers, officers or wardens in university residences is still unclear. Again, I am able to directly address this by examining student (and staff) views of a new wellbeing service in university residences (Ch. 4, 6, 7).

2.7 Chapter summary

The breadth of student mental health literature mapping prevalence, risk factors and student help-seeking behaviour highlights the difficulties for evaluating the effectiveness of interventions designed to improve the higher education experience and student wellbeing outcomes. The most robust evaluation of interventions would be a cluster randomised controlled trial randomising whole universities, but there is rarely resource to conduct gold-standard RCTs in education settings. Similarly, as this literature shows there are myriad factors to account for in evaluations in complex organisations. Differing study designs, outcome measures, individual differences and specific university settings mean that the evidence for effective mental health and wellbeing support is at best mixed, often conflicting and difficult to generalise. It is precisely because of the complexities, issues of self-selection and cause and effect that it is important to carefully consider

what works and how. While there is now some evidence for the efficacy of student counselling services and peer-mentoring support in universities, there is a clear absence of literature for the impact of non-clinical services, settings-based or organisational-level strategies, arguably key to a 'whole university' approach. While UK universities have been expanding their support provision to include mental health advisers, wellbeing teams and accommodation welfare over the last decade, to date there has been little or no peer-reviewed evaluation. As such, I now examine the impact of a major investment in new university wellbeing services for one UK institution. I have taken a pragmatic approach, addressing the question from a number of different population health perspectives, which allows me to consider many of the key contextual factors discussed here. The following chapter describes my methodology in detail.

Chapter 3   <u>Methods</u>

3.1   Chapter overview

This chapter outlines the rationale for my overall study design, covering the background to natural experiments and intervention evaluation in complex systems, and my reasons for using mixed methods. I offer context for the cross-sectional student survey which makes up part of this research and describe the decisions I made in order to measure student mental health outcomes, in light of the methodological challenges described in the previous chapter. I include a research timeline and overviews of my individual study approaches, before discussing my philosophical and researcher position, as well as the steps I took to ensure that students and staff remained central to this work. Lastly, I describe my overarching ethical and data access/management considerations.

3.2   Measuring impact and effectiveness of support services in HE

As highlighted in Chapter 2, there is little, if any, research evidence for evaluating effectiveness or impact of non-clinical student wellbeing or accommodation welfare services in the UK. With important implications for university budgets and policymakers under pressure to act, it has therefore become increasingly critical to tackle the question I now address with this thesis (Sampson et al., 2022). The previously summarised literature establishes that methodology matters, yet without cluster randomised controlled trials or linked[23] longitudinal HE mental health data (of which there is a paucity in the UK), the ability to track intervention impact at this scale is rare. Even deciding what 'effectiveness or impact' looks like in student populations is complicated and unresolved (Brown, 2018).

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[23] Linked data includes an individual's personal, academic and (mental) health information and records

Consequently, I have taken a pragmatic approach, focused on a natural experiment and I have assessed the impact of the new support service from several different perspectives by combining research methods (Craig et al., 2017; Sampson et al., 2022). My definitions of impact and measures of mental health and wellbeing are drawn from population health research, epidemiology, psychological science and education performance statistics. Detailed methods, procedures and data analysis plans are contained in each individual study chapter (4-7), but the following sections provide an overview.

3.3   Natural experiments and complex intervention evaluation

Critically, my research was able to take advantage of a natural experiment i.e., the investment and introduction of new student wellbeing support services in a large university at a single point in time (September 2018). Academic evaluation of the new support model had not been built into the development or implementation phase, but the entire student population had been surveyed about university wellbeing issues in May 2018 prior to the introduction of the new services (and annually since), capturing baseline and ongoing student mental health outcomes for comparison. Natural experiments are a feature of an intervention rather than a methodology but can often be the only way to generate meaningful evidence for in-situ population health outcomes, and to assess impact and effectiveness (Craig et al., 2012; de Vocht et al., 2021; Ogilvie et al., 2020). Evaluation of complex interventions in education or healthcare is generally challenging, inevitably conducted in large working organisations made up of many moving parts, all influenced by their own socio-geo-political contexts and budgets (Campbell et al., 2000; Duncan et al., 2018).   While randomised control trials are the gold standard of evaluation methodologies, they are often unfeasible and expensive, and examples of high-quality trials in education settings reflect the need for considerable resource (Kidger et al., 2021; Kuyken et al., 2022). The latest Medical Research Council (MRC) intervention guidance supports adoption of deliberative but flexible evaluation methods and now includes observational methodology and natural experiments as valuable approaches (Craig et al., 2008; Craig et al., 2017; Skivington et al., 2021). Despite the opportunistic element of my research design, I have considered STROBE

epidemiological guidelines [24] in the reporting of my study methodology throughout – see Chapters 4-6 (Von Elm et al., 2007).

3.4   Mixed methodology

Mixed methodology has been key to my approach, and with strong support for doing so from across the complex evaluation field. O'Cathain et al. (2007) and others have long argued for the integration of quantitative and qualitative methods in population health intervention research (Johnson et al., 2007). More recently Fetters and Molina-Azorin (2020, p. 141) advised that mixed methodology should be used by default, without compelling reasons not to do so. They suggest that "*for the public good, society needs to have a better understanding if the resources invested in research provide information about not only 'whether' a novel intervention works, but also 'how and why', or 'why not'*". The hybrid approach is supported by the updated MRC guidelines, shifting evaluation focus from *"unbiased estimates of effectiveness"* to *"prioritising usefulness of information for decision making"* (Skivington et al., 2021, p. 8). As such, I have addressed my research aims with a convergent mixed-methods design to combine and triangulate findings - see Figure 3.1 (Creswell & Creswell, 2018, p. 237; Palinkas et al., 2019). Despite a combination of three quantitative studies with a single qualitative study, the latter is extensive and comprehensive, designed to give equal status to both approaches.

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[24] The 'Strengthening of Reporting of Observational Studies' statement is a checklist of 22 reporting items, used by methodologists globally to guide effective and transparent observational research

Figure 3.1 A Wellbeing Support Service Evaluation Using a Parallel Convergent Mixed Methods Approach
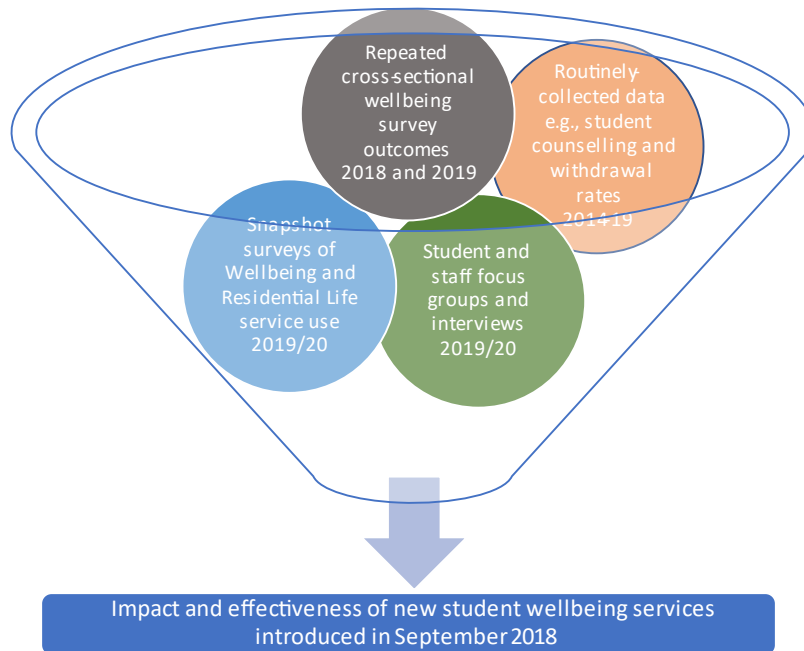
I used quantitative measures to describe and quantify prevalence and change in student mental health issues and help-seeking behaviour; to measure trends in secondary student wellbeing indicators; and to track service-use (Ch. 4-6). Statistical estimates, descriptive data and regression models are supported and extended by an extensive qualitative research component. I conducted more than 40 hours of focus groups and 1:1 interviews, using thematic analysis of student and staff 'lived-experience', to understand how the new wellbeing services might have benefitted users and the university system in which they were introduced (Ch. 7). Findings from of the main converging and diverging evidence in those separate but parallel studies are then integrated in a final interpretation stage (Ch. 8) - see Figure 3.2 (Plano-Clark, 2019; Moseholm & Fetters, 2017). The separate study findings are presented as a single results table, followed by a

merged synthesis in narrative discussion (Ch. 8). The overarching synthesised findings are then further discussed in the wider HE wellbeing context in a final chapter (Creswell & Creswell, 2018, p. 220; Fetters et al., 2013; Guetterman et al., 2015).

Figure 3.2 Integration of Findings at Interpretation Stage of a Mixed Methods Approach to a Natural Experiment
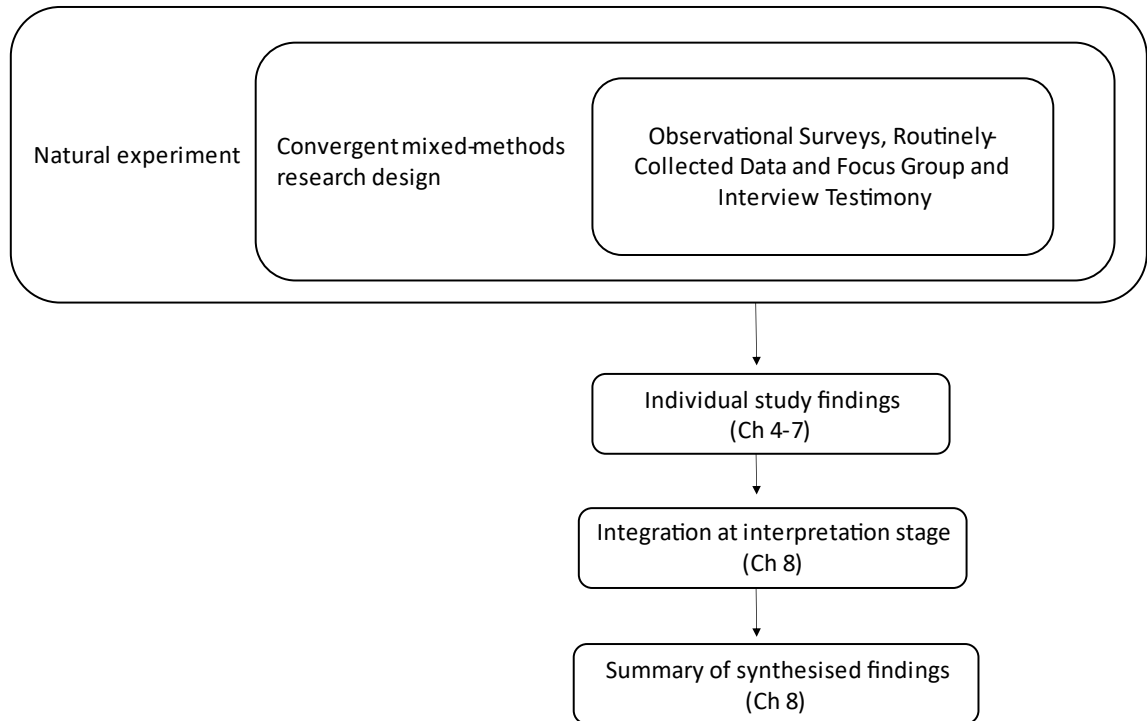
3.5   Individual study methodologies

I carried out four interlinked studies to examine the impact of the new wellbeing support service model. Design and development took place in the academic year 2018/19 with piloting and new primary data collection conducted in 2019/20; Figure 3.3 illustrates the research timeline.

Figure 3.3 Research Timeline and Key University Events
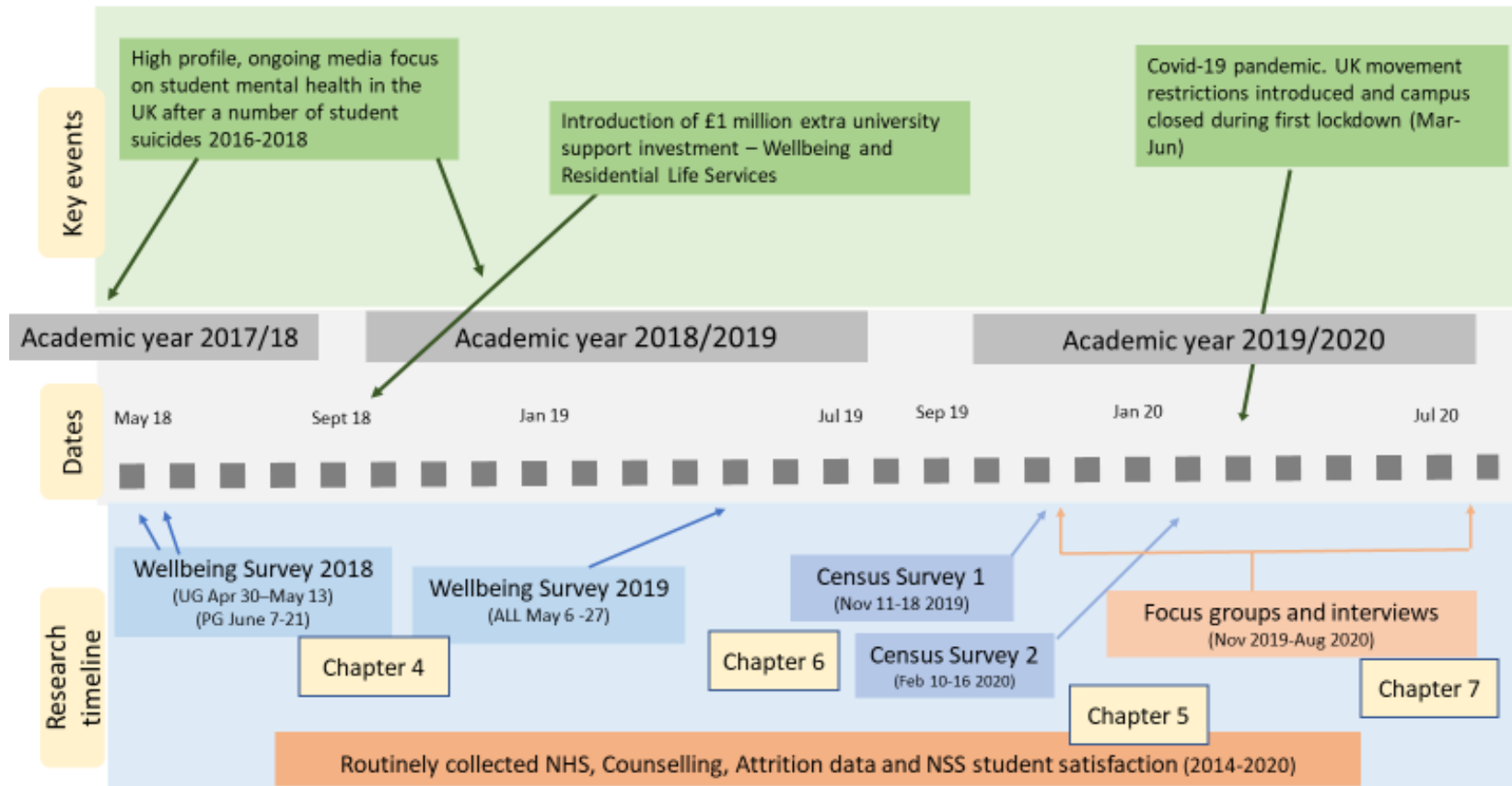
3.5.1 Cross-sectional student survey (Chapter 4)

I carried out statistical analyses of student mental health outcomes and help-seeking behaviour using cross-sectional student survey data collected in 2018 and 2019, i.e., pre/post introduction of the new services (see Ch. 4). The institution's *Student Wellbeing Survey*[25] is an anonymous online questionnaire open to all registered students annually (see Appendix E). It uses recommended and validated screening measures for depression, anxiety and wellbeing i.e., the Patient Health Questionnaire (PHQ-9), the Generalised Anxiety Scale (GAD-7), and the 14-item Warwick and Edinburgh Mental Wellbeing Scale (WEMWBS); and I used recommended clinical cut-offs to delineate poorer mental health or wellbeing (Kroenke et al., 2001; Spitzer et al., 2006; Stewart-Brown et al., 2011) – see Table 4.1. The PHQ-9, GAD-7 are widely used in UK primary care and IAPT as screens for possible clinical intervention as well as in other student longitudinal studies, making much broader comparison possible (Duffy et al., 2019a; Goodday et al., 2019). They are also the recommended Wellcome and NIMH mental health research measures (Wolpert, 2020). Similarly, the (S)WEMWBS[26] is used in the NHS and several large cohort studies, again improving its comparability (Linton et al., 2016; Shah et al., 2021; ALSPAC, n.d.).

Survey items also cover contextual student experience including adapted versions of the General and Actual Help-Seeking questionnaires - see Appendix E (Rickwood et al., 2005; Wilson et al., 2005). Many of the survey's mental health and help-seeking measures have been commonly used in other student populations (Duffy et al., 2019a; Goodday et al., 2019; Knipe et al., 2018); and recent studies have started to examine further student wellbeing issues using the survey data (Bennett et al., 2022; Linton et al., 2022).

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[25] The survey originated in a 2017 undergraduate research project investigating prevalence of mental health problems and support-seeking behaviour in health science students (Knipe et al., 2018). Adopted by the wider university in 2018, every registered student is now invited to take part in the *Student Wellbeing Survey* during the summer academic term each year.

[26] (S)WEMWBS denotes short 7-item SWEMWBS and long 14-item WEMBWS wellbeing questionnaires

3.5.2 Trends analyses of secondary student wellbeing indicators (Chapter 5)

My analysis of any change in levels of depression, anxiety, mental wellbeing and student support-seeking behaviour between 2018 and 2019 is supported by an analysis of five further indicators of student wellbeing recorded over a longer time period pre-service introduction. I investigated any effects of the new wellbeing services investment on other established frontline services and broader student experience, by analysing routinely-collected secondary data between 2014 and 2019 (Ch. 5).

The university has an onsite NHS Student Health Service which presented an opportunity to examine whether the introduction of the new wellbeing services reduced the need for some students to seek GP help, by offering an alternative source of support. I hypothesised that would reduce anti-depressant prescribing - the prevailing clinical treatment for symptoms of depression or anxiety (NHS, 2021).   Similarly, the organisational rationale for the development of the services had been to reduce the number of unnecessary or inappropriate referrals to the Student Counselling Service, and on that basis, I examined trends in numbers of unique counselling referrals between 2014/15 and 2018/19 hypothesising that there would be a decrease with the introduction of the new services, with reduced need for high-intensity support referrals.

I also hypothesised that the introduction of the new student wellbeing services would mitigate the need for some students to withdraw from their studies, particularly for mental health reasons, again by providing alternative or earlier support in the form of Wellbeing and Residential Life advisers. As such, I investigated trends in student course withdrawal rates (also known as *attrition* or *non-continuation*) over a five-year period. I also examined overall student course satisfaction ratings, a more general indicator of student experience but nevertheless a source of data rigorously collected at a local and national level every year by both the institution and the Office for Students, using surveys with higher response rates than the institution's *Student Wellbeing Survey*, e.g., *National Student Survey* (https://www.thestudentsurvey.com). I tested a hypothesis that course satisfaction ratings could offer insight into student perception of their broader university experience, with students feeling more positive about their course in general after greater investment in wellbeing support. Lastly, I examined a trend concerned with student perception of overall

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university wellbeing support during their studies, using routinely collected institution data combined with *Student Wellbeing Survey* data. My hypothesis was that student assessment of general wellbeing support would improve after the introduction of the new services.

3.5.3   Wellbeing Census Surveys (Chapter 6)

I carried out two week-long assessments of Wellbeing and Residential Life team activity in November 2019 and February 2020, after conducting a pilot in October 2019. The two observational surveys (herein called *Wellbeing Census Surveys)* assessed student use, staff delivery, and overall perception of the new services. To maximise student and staff survey completion and to ensure I could compare service-user characteristics, including mental health, with those of the wider population, I drew on items from the *Student Wellbeing Survey*. The *Student Census Survey* included shorter version wellbeing and depression/anxiety scales i.e., the 7-item SWEMWBS wellbeing scale and the PHQ-4, both of which show good reliability and consistency for comparison with the longer measures – see Table 6.1 (Fat et al., 2017; Kroenke et al., 2009; Lowe et al., 2010). The SWEMWBS focuses more on psychological functioning than subjective feeling states[27] and the PHQ-4 uses the first two items each from the PHQ-9 and the GAD-7 (Warwick Medical School, 2019; Kroenke et al., 2009).

The *Student Census Survey* also asked about presenting issues, with a very brief *Follow-up Student Census Survey* examining the helpfulness of the session (see 6.5). Advisers were asked (in a *Staff Census Survey*) about students' presenting issues, their confidence in dealing with them, and any actions taken. I hypothesised that presenting issues would be largely non-clinical in nature i.e., the low-intensity issues that the services had been set up to address.

I was unable to use routinely-collected data, as there was no centralised or standardised framework for recording student information across the new Wellbeing and Residential Life services in 2018/19. The questionnaires were designed in co-operation with the institution's

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[27] The 14-item WEMWBS scale focuses on 'feeling good and functioning well' to include hedonic and eudaimonic perspectives on wellbeing (Warwick Medical School, 2019).

senior support professionals, clinicians and academics who had insight and understanding of student presenting issues and possible referral pathways (see Chapter 6 and Appendix O).

3.5.4   Focus groups and 1:1 interviews (Chapter 7)

MRC guidelines recommend including evaluation of how a service interacts with its context, and I used reflexive qualitative research methods to gain a better understanding of that relationship (Skivington et al., 2021). Focus groups and interviews were conducted after the services had been in place for a full academic year, and included key stakeholder testimony e.g., students, staff, advisers and the Students' Union. The data collection focus was to gather detailed description of service delivery and the experience of having new wellbeing advisers in academic departments and halls of residence, offering insight into service impact on the university population and organisation as a whole (Chapter 7).

As briefly described in Chapter 2, growing numbers of student wellbeing studies have used qualitative methodology to examine single issues, for example student perception of university support services (Priestley et al., 2022); wellbeing in student accommodation (Worsley et al., 2021); student sleep quality and wellbeing (Foulkes et al., 2019); or racial inequalities and barriers to student support (Arday, 2018). Likewise, the use of qualitative data in mixed methods student mental health research is gaining increasing prominence (Remskar et al., 2022; Stoll et al., 2022).

Differences in methods are generally conceptually dependant on the nature of the research aim i.e., theory-generating or theory-driven, inductive or deductive, systematic and concerned with occurrences or rooted in subjective experience (Braun & Clarke, 2021a). My aim was to complement the quantitative research findings with a theoretically flexible, inductive analysis describing and conceptualising staff and students' perceptions of the value and impact of having new Wellbeing and Residential Life advisers in schools and halls. With awareness of my position as both researcher, student and research associate with a working relationship with the new services, I also wanted to reflect on that tension in development of my findings. As a result, I have used reflexive thematic analysis for its inductive, pragmatic approach to draw patterns of meaning from large and diverse data sets while critically acknowledging the researcher role (Braun & Clarke, 2021b). Use of thematic analysis (TA) as

a process is common to most qualitative research, but more recently Braun and Clarke have voiced strong concern that many health researchers have typically cited their influential 2006 TA methods paper, without understanding how reflexive thematic analysis differs from other approaches, often conflating methodologies (Braun & Clarke, 2006; 2014; 2021a, 2021c). Their particular objections are the use of empirical paradigms in reflexive TA such as double coding[28] to ensure 'consensus' alongside concepts of data saturation and frequencies. They have argued a positivist stance and acquired 'validity' is redundant in organic reflexive research, which explicitly acknowledges that the disciplined activity and critical engagement of the researcher (within defined parameters) is an influential part of the analytical process (Braun & Clarke, 2016). As a result, I did not 'double-code', but engaged in regular collaborative discussion of the analysis and development of findings with my supervisory team and others (see 3.8). I have explicitly addressed the academic debate about inconsistency and lack of transparency in the way TA has often been reported in the past, with a comprehensive methods and analysis section by way of audit trail- see 7.4 -7.5 (Braun & Clarke, 2021c; Byrne, 2021; Nowell et al., 2017; Trainor & Bundon, 2021; Yardley, 2000).

3.6 Ontology and epistemology[29]

In complex mixed methods health research, the challenge of using empirical and narrative data to triangulate knowledge-formation needs careful theoretical and philosophical consideration (Greenhalgh & Papoutsi, 2018; Skivington et al., 2021). A research paradigm is fundamentally influenced by the question of whether 'reality' can ever be accurately described, measured or captured independently or is it only ever constructed through the social lens of the observer/s. I would argue methodological pragmatism demands a level of philosophical pragmatism, and as such my research was designed and conducted from critical

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[28] Using a double-coding framework i.e., working with an independent researcher to separately code the same initial section of the data, to ensure consensus on codes and candidate themes

[29] Ontology is concerned with the philosophical position on the nature of reality i.e., is there a knowable reality or is it socially constructed; epistemology is concerned with knowledge acquisition, and what constitutes a source of knowledge e.g., observable data or subjective meaning.

realist (ontology) and contextualist (epistemology) perspectives (Bhaskar, 2010; Braun & Clarke, 2021d, p. 179).

For wider context, Margaret Archer and colleagues (2016) describe critical realism as positioned between scientific positivism i.e., concerned with numbers and regression-based variables, and a strong interpretivist school concerned only with hermeneutics, often judged to have a cost for practical explanation. Archer et al., (2016, para.2) call it a "*meta-theoretical position: a reflexive philosophical stance concerned with providing a philosophically informed account of science and social science which in turn informs our empirical investigations*". That pragmatic perspective is elegantly suited to this mixed methods and reflexive TA approach to my research. Maxwell and Mittapalli (2010) suggest that realism validates and supports key aspects of both qualitative and quantitative approaches while recognising the limitations of each, making it the most appropriate choice for mixed methods research and convergent design. Critical realism is a lens already usefully employed in complex health intervention, social science research and elsewhere in the higher education literature (Duncan et al., 2018; Sturgiss & Clarke, 2020; Martin, 2020).

My epistemology was particularly relevant to my qualitative study, where meaning and context (as opposed to simple recurrence of topics) were influential in the analysis of staff and student narratives, reflecting a contexualist position, sitting between positivism and constructionism (Henwood & Pidgeon, 1994; Madill et al., 2000; Pettigrew, 1985). Madill et al. (2000, p. 15) advocate that "*contextualism maintains that although an analysis is always partial and subjective, results can be justified to the extent that they are grounded in the data. This requires a careful, and tenuous balance between realist claims that results emerge from the data, with the constructionist position that analysis is necessarily interpretative*". As such, 7.5 outlines the thorough, recursive, analytical process I went through, to reflect on bias and ensure my findings were grounded in the data.

Inevitably, critical realist and contextualist lenses also shape my quantitative methodology, i.e., statistical development and analysis is similarly dependent on interpretation (Braun & Clarke, 2021d, p. 178). Despite its positivist pretensions and concern with validity and reliability, I would argue that empirical methodology is always affected by the

researcher/research team, therefore my (and the stakeholders') active development of research questions, choice of measures and interpretation of findings will have influenced the research. With that in mind, researcher position and transparency are particularly important (Braun & Clarke, 2021b; Elliott et al., 1999).

3.7 Researcher positionality

I am a UK doctoral researcher working in the institution's Medical School, both as a student and research associate. I was more recently a mature psychology undergraduate at the same university and studied at a London university in the 1990s. My early experience as a student was a challenging one, followed by an interesting career in journalism. Neither of my parents were university educated. I am white British, cisgender and the mother of two children, one of whom reviewed his decision to go to university during the Covid-19 pandemic and is now working, and another who is still at school and currently applying to several UK universities. Since 2018, I have produced an annual Student Mental Health Report for the university in which I work and study (Bennett et al., 2021).

I was comparatively new to the reflexive qualitative approach but had previously used Interpretative Phenomenological Analysis as well as Thematic Analysis as part of my BSc and as a Research Associate e.g., exploring student transitions into university, menopause in the workplace, and Teaching Assistant perspectives in an Early Years reading trial. Awareness of the positionality of my role(s), particularly any tension in being both student and researcher in the organisation in which this research took place, has been critical in remaining truly reflexive in the production and development of all my study findings. I also carefully considered conflict of interest. My PhD was funded by the university involved - who were interested in the service investment and where best to invest future resources. However, I was also directly working with support teams and students who were personally involved with the services; one Steering group member was involved in both of design of service and contributed to the design of the research but only in the first year - 2018. My supervisory team regularly ensured I retained a degree of impartiality and independence.

3.8   Co-production, PPI (Patient and Public Involvement) and Steering

My research development decisions were informed throughout by a supervisory team of senior Population Health academics, a student advisory-i.e., Patient and Public Involvement (PPI) group, a PhD Steering Group, Wellbeing and Residential Life managers and advisers, and the Faculty Research Ethics Committee. Rationale for broad stakeholder involvement in population health research is to democratise it and improve its quality (NIHR, 2019). Similarly, there has been growing consensus across HE that students (and staff) play a pivotal role in new approaches to university mental health and wellbeing, and that co-production should be a feature of all student support service design and evaluation (Hughes & Spanner, 2019; Priestley et al., 2022; Sampson et al., 2022; UUK, 2018; Worsley et al., 2021b).

I recruited a student advisory (PPI) group in 2018 via university and students' union social media. They were eight undergraduates/postgraduates, from different faculties, years of study, places of residence and backgrounds. We met four times during the research period (2018-2021) face to face and online to discuss research design, research questions and interpretation of findings. They received £20 Amazon vouchers and refreshments in acknowledgment of their input. Specific examples of their contribution are described in individual methods sections (Ch. 4-7). The PhD Steering group met every four months during research design and data collection periods (2018-2020) with two further meetings in 2021. The group included key university roles[30]: Pro Vice Chancellor Student Experience, senior university support service directors, Students' Union officials, and my academic supervisory team. The group facilitated access to university systems and helped engage staff in supporting data collection. Their breadth of professional expertise also provided institutional perspective and context for research design, ethical considerations and early findings.

3.9   Ethical considerations and data management

I developed a full study protocol in 2018 which was reviewed by an independent senior population health expert before ethical approval was sought and granted on May 22nd, 2019

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[30] Some individuals changed during the research period, but their successors took up the PhD advisory role

by the institution's Health Sciences Faculty Research Ethics Committee - *Ref: 85483*. Application amendments were made during data collection to reflect ongoing changes to the services such as 'Wellbeing Access' in November 2019 and Covid-19 disruption i.e., the transition to online fieldwork in April 2020 (*Ref: 85483- Ethical Amendment 4*). In addition, ongoing ethical approval was sought and granted for the *Student Wellbeing Survey* throughout the research period - *Ref:49861 (Amendment 3; 4; 5).* Changes to the *Student Wellbeing Survey* were also ratified annually by the institution's Student Survey panel*.*

My ethical considerations included issues of confidentiality, data protection and the sensitive nature of mental health research in an education setting. All reasonable steps were taken to ensure participant confidentiality, with clear procedures in place to maintain anonymity from recruitment to write-up and across every element of the research- see individual Data and Ethical sections. Only data managers and the research team had access to survey and participant data or recordings and transcripts, and all data storage complied with the institution's data protection policies and the updated General Data Protection Regulations (GDPR, 2018). The institution's *Student Wellbeing Survey* was, and still is, anonymous on the basis that students are more likely to take part if they feel reassured that personal mental health data cannot be linked to their academic profile (see 2.5). Despite a compromise for data-quality, I adopted the same approach in the *Wellbeing Census Surveys*, using anonymised staff and student questionnaires. Given the sensitive nature of the research, a full risk assessment was carried out with robust debrief, signposting, and distress protocols in place across every study element.

3.10 Chapter summary

Intervention evaluation in complex systems is challenging, and especially so in HE settings where there is still no consensus on appropriate ways to measure student mental health and wellbeing, or to quantify the impact and effectiveness of any support. I have taken a pragmatic approach, using mixed methodology across four different research elements to investigate whether and how this institution's investment in new Wellbeing and Residential Life services has changed the student mental health and wellbeing support experience for the better. In a final synthesis of all my study findings (Ch. 8) I determine key conclusions

regarding service impact, but the following four chapters first describe each individual research element, showing in detail what I did and what I found.

Chapter 4 <u>Changes in student mental health and help-seeking behaviour after the introduction of a new university wellbeing support service</u>

4.1 Chapter overview

This is the first of two chapters investigating the quantifiable impact of a new student wellbeing investment at a large UK university from a population perspective. Here, I have used anonymous cross-sectional survey data from the 2018 and 2019 waves of the institution's *Student Wellbeing Survey* to describe and measure differences in prevalence of student mental health concerns and changes in help-seeking behaviour before and after the introduction of new services. I also investigate any variation in student perception of barriers to using university support.

4.2 Research aims

Here I consider the specific aim and objectives for this research element.

Overall research aim: To investigate the population level impact of the introduction of new university wellbeing support services on student mental health, wellbeing, and help-seeking behaviour by using student mental health survey data.

Objective 1: To examine changes in student mental health and wellbeing outcomes before and after the introduction of new university wellbeing support services (i.e., between 2018 and 2019) using validated measures of depression, anxiety and wellbeing.

Objective 2: To examine differences in depression, anxiety and wellbeing between 2018 and 2019 according to 12 demographic, education, social and health factors: gender, year of study, age, faculty of study, course level, sexual orientation, ethnicity, place of residence, international status, socioeconomic status, lifetime mental health diagnosis or disability.

Objective 3: To investigate changes in help-seeking behaviour and rating of support usefulness for students in their first year of study between 2018 and 2019.

Objective 4: To examine changes in perception of barriers to seeking support at university for all students, first year students only, and students with *severe major depression* between 2018 and 2019.

4.3   Research design

As described in Chapter 3 ([3.5.1](#)), the institution's annual wellbeing survey has measured student mental health, wellbeing, and help-seeking behaviour since 2018. The new wellbeing support services were introduced in September 2018 after baseline student mental health and support-seeking data had been collected in May of that year, meaning any influence of the new model could be examined by investigating changes in mental health outcomes and help-seeking behaviours in the whole student population over time (see Figure 4.1). That includes measurement of depression and anxiety symptoms and mental wellbeing, as well as consideration of where students seek support at university, how useful they find it and any barriers they may have faced.

In the original study design, I aimed to track survey trends across a four-year period (2018-2021), however only two time points of cross-sectional data (2018 and 2019) could usefully be included in the main analysis, after Covid-19 restrictions forced UK university campus closures in March 2020 and teaching and support service delivery changed dramatically. Nevertheless, the routine data assessed in Chapter 5 examines additional student wellbeing outcomes over a longer time period between 2014/15 to 2019/2020, helping to place the 2018 and 2019 student survey findings and any changes in outcomes, in a longer time series of student experience.

Figure 4.1 Timeline of Key Events, Student Survey Timings and Data Collection Periods
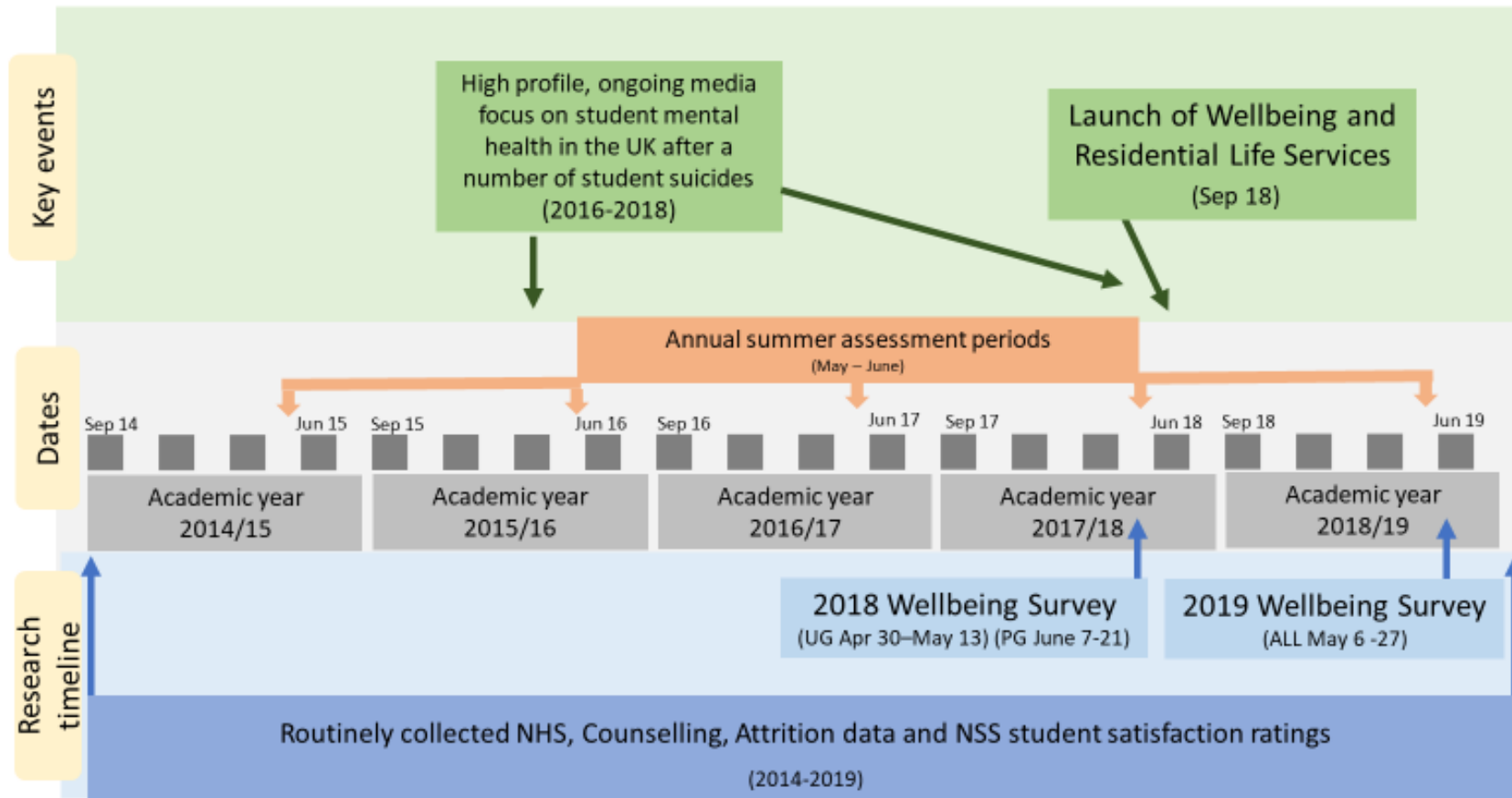
4.4 Methods

4.4.1 Sample and data collection

I used cross-sectional student mental health and wellbeing survey data collected by the institution in the academic years in 2018 and 2019, before and after the new university wellbeing services were launched, to meet research objectives 1-4. Survey participants were registered students studying at the UK university where the new support services were introduced. All current undergraduates and postgraduates were invited to take part in an anonymous online *Student Wellbeing Survey* in the summer terms of 2018 (n=24,915) and 2019 (n=26,053). The survey was estimated to take fifteen minutes to complete and contained 81 and 93 items respectively (Appendix E). The questionnaires included validated measures of depression symptoms - PHQ-9 (Kroenke et al., 2001); anxiety symptoms - GAD-7 (Spitzer et al., 2006); and mental wellbeing - the 14-item Warwick and Edinburgh Mental Wellbeing Scale or WEMWBS (Tennant et al., 2007). All three scales ask about aspects of mental health and wellbeing in the two weeks prior to questionnaire completion (Appendix E). Other questions included demographics, previous (lifetime) mental health diagnosis and support-seeking experience as well as further items such as emergency contacts, domestic violence, loneliness and drug and alcohol use (Appendix E). More details of the specific measures I used in this study are given in the next sections.

The surveys were designed with collaborative input from students, academics, the Students' Union, and a number of senior support service staff, as described in 3.8. Students received up to three email reminders containing the questionnaire link during the data collection periods and the surveys were promoted on University and Students' Union (SU) portals and social media sites. The 2018 survey was open to undergraduates from April 30th-May 13th and to postgraduate students from 7th-21st June to avoid a clash with assessment periods and larger national student surveys e.g., NSS -see Figure 4.1 (https://www.thestudentsurvey.com). The 2019 survey was open to all students from May 6th-27th, coinciding with the first week of undergraduate assessment period. Survey delivery was managed by the Students' Union (2018) and the University's student experience team (2019); no incentives were offered for taking part.

4.4.2   Outcome measures

The general rationale for the measures used for all three objectives was previously outlined in [3.5](3.5); item examples, detailed scoring and context for the mental health and wellbeing outcomes, and for the help-seeking behaviour measures are shown in Table 4.1.

4.4.2.1   Objective 1. Mental Health outcomes

I investigated change between 2018 and 2019 in three primary mental health outcomes using the *Student Wellbeing Survey* data - changes in depression (PHQ-9), anxiety (GAD-7) and mental wellbeing (WEMWBS). For measurement cut-offs see Table 4.1.

Table 4.1 Outcome Measures Used to Examine Change in Student Mental health, Wellbeing and Support Seeking Behaviour

Construct	Measure	Number of items	Sample item	Scoring	Score Meaning	Other users	Reference
Objective 1							
Depression - screens for symptoms	PHQ-9 Patient Health Questionnaire	9	In the last two weeks how often have you been bothered by any of the following: *Little interest or pleasure in doing things? Feeling down, depressed, or hopeless? Trouble falling or staying asleep, or sleeping too much? Feeling tired or having little energy? etc*	Not at all (0) Several Days (1) More than half the days (2) Nearly every day (3)	Depression symptoms: 1-4 None 5-9 Mild 10-14 Moderate 15-19 Moderately Severe 20-27 Severe Score ≥ 10 merits further clinical investigation in a primary care setting (see Appendix F)	UK NHS primary care, IAPT (n.d.), British cohort/longitudinal studies, ALSPAC (n.d.).	(Kroenke et al., 2001)
Anxiety - screens for symptoms	GAD-7 Generalised Anxiety Scale	7	In the last two weeks how often have you been bothered by any of the following: *Feeling nervous anxious or on edge? Not being able to stop or control worrying? Worrying too much about different things? Trouble relaxing? etc*	As above	As above Scores are between 1-21 and score ≥ 10 merits further clinical investigation	As above	(Spitzer et al., 2006)
Mental Wellbeing	WEMWBS Warwick and Edinburgh	14	Please tick the box that best describes your	None of the time (1) Rarely (2)	Scores between 14-70 with higher score indicating more	NHS Digital survey (2022), many other British longitudinal	(Tennant et al., 2007)

Mental Wellbeing Scale			experience in the last two weeks: *I've been feeling optimistic about the future I've been feeling useful I've been feeling relaxed I've been feeling interested in other people etc*	Some of the time (3) Often (4) All of the time (5)	positive wellbeing and recommended cut off $\leq$ 42 indicating low wellbeing-equivalent to the lowest 15% of scores in the general population. Average UK general population score is 51.0, SD 7. A meaningful difference considered between 3 and 8. (Shah et al., 2018; Warwick Medical School, 2021)	surveys e.g., ALSPAC (n.da.), Covid-19 Social Study (Fancourt, 2022).	

Objective 2 see [Confounders and Effect Modifiers](#)

Objective 3

Support networks used	Adapted from General Help-seeking Questionnaire (GHSQ) and the Actual Help Seeking Questionnaire (ASQ)	20	Which of the following have you **ever** sought help from since starting university? 11 university support options, including: *Staff in Residences, Wellbeing Adviser, Mental Health Professional, University Support Staff, GP, Peer Support, Students' Union adviser, Personal Tutor/Supervisor, Other Academic Staff, Togetherall (formerly Big White Wall), Nightline*	Yes, No, Not applicable	Description of available university services- Appendix C.	The Sense Study (2019)	(Rickwood & Braithwaite, 1994; Wilson et al., 2005)

Usefulness of support networks	As above	20	Alongside each support source, please indicate how **useful** this source was?	5 point Likert scale from '*not useful*' (1) to '*extremely useful*' (5)	Scored as a continuous variable and calculated as mean and standard deviation	As above	
Objective 4							
Perceived barriers to help-seeking		11	If you have had a mental health or wellbeing concern and have not used the university's support services, please indicate why: *Not had a problem Lack of time Fear of unwanted intervention Stigma of Mental Health care. Etc* (Question wording differed slightly in 2018 and 2019)[a]	(Tick all that apply)	Frequencies and percentages of all survey respondents encountering a barrier	Composite of factors identified in other studies as barriers to seeking support	(Knipe et al., 2018; Thorley, 2017)

a Question wording in 2018 "If you have had an emotional or mental health problem, and have not used the university's support services, please indicate what the main barriers were. Please tick all that apply".
Question wording in 2019 "If you have had a mental health or wellbeing concern and not used the university's support services, please indicate why (tick all that apply)"

4.4.2.2 Objective 2 - Confounders and effect modifiers

The *Student Wellbeing Surveys* record data on potential confounding factors highlighted in previous research such as gender, ethnicity, previous mental health diagnosis, or disability see 2.4 (Arday, 2018; Auerbach et al., 2018; McManus & Gunnell, 2020; Thorley, 2017). Given the differences in response rates across years, confounding was likely if responder characteristics markedly varied between 2018 and 2019, so I controlled for these factors in each analysis. I considered using parental education as an indicator of social-economic status, however because of a wording change in 2019, the data were non-comparable, therefore I used a similar indicator concerned with previous schooling i.e., feepaying or not. A full description of the 12 variables included in adjusted models is given in Table 4.2.

Table 4.2 Confounding Factors Included in Fully Adjusted Models

Construct	Measure	Inclusion rationale	Composite coding
Gender	Gender identity using the Office for National Statistics categorisations (ONS, 2019)	Females and minority gender at greater risk of MH issues (Lipson et al., 2019a; McManus et al., 2019)	Man (0)[a], Woman (1), Non-binary/Another gender [b] (2), Prefer not to say- PNS (3)
Age	Age in years	Students over 21 years are considered mature students with known age-related HE barriers and potential differential effects of intervention and service use (HESA, n.d.; OfS,2020a)	≥ 21 years (0) and < 21 (1)
Ethnicity	Ethnicity using Office for National Statistics categories (ONS, 2011)	Minority ethnicity has been associated with poorer outcomes (Arday, 2018);	White (0), Minority Ethnicity (1) and PNS (2)
Sexual Orientation	Sexual identity, attraction or behaviour using Office for National	Minority sexual orientation associated with	Heterosexual/Straight (0), Lesbian/Gay/Bisexual (LGB) (1), PNS (2)

	Statistics categories (ONS, 2021)	poorer MH outcomes (Liu et al., 2019)	
International or Home	Fee status	Cultural challenges for overseas students (Alharbi & Smith, 2019; Brunsting et al., 2018)	Home/ Channel Isles (0) and EU/International (1)
Level of study	Course level	PGR associated with better MH outcomes, PGT and UG poorer MH (Wyatt & Oswalt, 2013)	Undergraduate (UG) (0), Postgraduate Taught (PGT) (1), Postgraduate Researcher (PGR) (2)
Social Economic Indicator	Previous Education/Schooling	Disadvantaged background as a predictor for MH concerns (Stebleton et al., 2014)	State (non-feepaying), Grammar (non-fee paying), and Other (1), Private or grammar (fee-paying) (0)
Previous (Lifetime) MH diagnosis	Previous or current mental health concerns - sometimes called 'lifetime MH diagnosis'	Lifetime MH diagnosis associated with CMD 12 month prevalence (Auerbach et al., 2018)	No (0) Yes (1)
Disability	Physical and non-physical disability in line with institution's classifications	Associated with MH concerns (Thorley, 2017)	None (0) Physical (1), Non-physical (2), Both (3), PNS (4)
Year of study		First year transition and MH concerns (Bruffaerts et al., 2019)	Year 1 (0), Year 2 (1), Year 3 (2), Year 4 (3), Year 5/6 (4), Other (5)
Faculty of study	Overarching educational discipline or subject area comprising a number of separate schools (sub-divisions) e.g.,	Arts and Social Science studies association with poorer MH outcomes (Knipe et al., 2018; Lipson et al., 2019a)	Arts (1), Life Sciences (2), Engineering (3), Health Sciences (4), Science (5), Social Science and Law (6)

	Faculty of Arts contains School of English		
Place of residence		Hall of residence as a predictor for MH concerns (Brett et al., 2022)	University run hall (1), Private Hall (2), Private landlord (0), Other (3)

[a] Coding of each variable
[b] Includes respondents identifying as transgender

I was also interested in investigating whether any impact of the new wellbeing services (on indicators of student mental health and wellbeing) differed according to student demographic, course or health characteristics (**Objective 2**). It is possible that services may have been more or less accessible and appropriate for different student groups as described in 2.4, therefore I examined potential effect modification in relation to the factors listed in Table 4.2. I did so on the basis that some students may have had a different support service experience e.g., those who have a previous mental health diagnosis, international students, those identifying as minority gender, sexual orientation or ethnicity, or students from disadvantaged backgrounds (Arday, 2018; Auerbach et al., 2018; McManus & Gunnell, 2020; Stebleton et al., 2014). Due to collinearity between *age, year of study* and *residence*, I only tested effects of *year of study*, therefore ten of the twelve in Table 4.2 were included in this analysis.

4.4.2.3 Objective 3. Using and rating university support

The investigation of *first year students only* was to explore specific differences in experience of student support for new users between 2018 and 2019 and to avoid capturing the same student support-seeking experience twice in different survey years, or similarly students in 2019 who may have reflected on services throughout their time at university and prior to the introduction of the new services rather than simply the previous year[31]. I used responses to *Student Wellbeing Survey* items adapted from the General and Actual Help-Seeking

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[31] Question did not specify a timeframe

questionnaires (Rickwood & Braithwaite, 1994; Wilson et al., 2005). Students were asked *'Which of the following have you ever sought help from since starting university'* e.g., *Doctor, Mental Health Professional, Tutor, Nightline* and then asked to rate any support used on a 5 point Likert scale of *Not useful to Extremely useful* (Table 4.1)*. More detail of the institution's support roles and services is found in Appendix C.

4.4.2.4   Objective 4. Number and nature of support-seeking barriers

I examined changes in the barriers *all students* encountered in help-seeking between 2018 and 2019, followed by an investigation of *first year students only* with the same rationale as Objective 3 i.e., capturing new students and avoiding any student reflection on more than one year. I also examined barriers for those with symptoms of *severe major depression (SMD)* signified by a PHQ-9 score of more than 20, hypothesising that the new services would ease access to clinical services for those with more serious mental health concerns. The PHQ-9 ≥ 20 cut-off to indicate the poorest mental health has been used elsewhere (Knipe et al., 2018; Kroenke et al., 2001; Thorley, 2017). The question wording concerning potential 'barriers to seeking support' differed slightly from 2018 to 2019 (Table 4.1), however, both items effectively asked if respondents had had a mental health or wellbeing concern but had not used the university's support services, then **why not**. The response options were the same each year and included: *Lack of time, Lack of confidentiality, Concern 'no-one will understand my problem', Didn't know where to find help, Stigma of mental health care, Fear unwanted intervention, Fear of documentation, Difficulty with access, Lack of available services, Other*[32] (Table 4.1).

4.4.3   Data management and ethical consideration

As described in [3.9](#), I was granted ethical approval to use the survey data for research purposes in May 2019 (*Ref: 85483*) and had been issued a licence to use the Warwick and Edinburgh Scale from March 2018 to August 2023 under submission ID:553261204. The Patient Health Questionnaire and General Anxiety scales are in the public domain and have

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[32] Survey participants could select 'other' if they had encountered a barrier not listed. These responses were not analysed.

no copyright issues. All survey participants gave informed consent. Signposting was placed throughout the surveys, directing students to university and other appropriate support services. In addition, students with higher scores on the Patient Health Questionnaire item - *Thoughts you would be better off dead or hurting yourself in some way* - received further messaging to relevant support agencies (Appendix E). Survey responses were collected using university approved JISC survey software and stored on secure university servers.

4.5   Analysis - Objectives 1 & 2 - Depression, Anxiety and Wellbeing

4.5.1   Data preparation and missingness

The student survey responses were transferred from JISC as Microsoft Excel CSV files in June 2019, after which Stata release 16 and 17 (Windows) was used for all further analyses (Statacorp, 2019; 2021).

Although levels of missingness for variables included in the main analysis were low (0.0-3.4%) as shown in Table 4.3, an important exception was the question concerning a lifetime mental health diagnosis. There were higher levels of missing data for *previous MH diagnosis* in 2018 (16.7%) than 2019 (0.5%) due to the way the survey was set up, with students able to skip the item in 2018 but not in 2019. Further examination showed respondent characteristics of those with missing mental health diagnosis data were similar to the whole sample (i.e., all responses) in 2018 (see Appendix G). Likewise, the characteristics of those answering yes or no (or not responding at all) in 2018 were not suggestive of systematic missingness (Appendix G). An assessment of key confounders and mental health outcomes for survey respondents answering *yes* to having a previous diagnosis in both 2018 and 2019 was also broadly comparable (see Appendix G). I carried out a further sensitivity analysis to examine any impact of including or omitting *previous MH diagnosis* on adjusted (and unadjusted) mental health outcomes (see Appendix G). Results were not qualitatively different when MH diagnosis data were included or excluded from the adjusted models, and therefore MH diagnosis was included as a factor in all further analyses. A further examination of respondents with missing MH diagnosis and missing mental health outcomes in both years suggested missingness was likely a result of students gradually dropping out of each survey as they answered items. In all respondents with a lifetime diagnosis, 40.8% indicated they had been diagnosed before they came to university or before the age of 18.

4.5.2   Statistical analyses

Changes in mental health outcomes i.e., depression, anxiety and wellbeing scores between 2018 and 2019 were examined for *all* survey respondents to measure any impact of the new intervention on the *whole* student population (Objective 1). To describe the study sample and assess the representativeness of survey responders, descriptive statistics (frequencies and percentages) were used to summarise all the variables in both survey years and are presented with the available corresponding data for all students at the institution. Only fully completed mental health measures were included in the analysis i.e., if each response item was available for the PHQ-9, GAD-7 or WEMWBS (see Figure 4.2).

Figure 4.2 Flowchart Shows Student Population and Survey Respondents Numbers with Final Analytic Sample Sizes for Depression, Anxiety and Mental Wellbeing
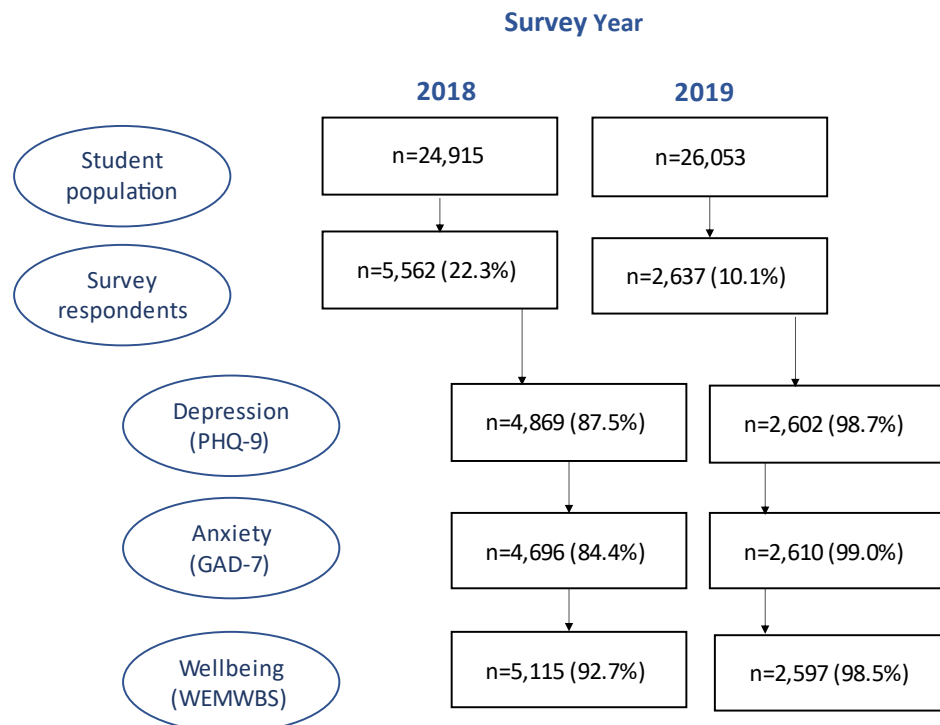
n= number respondents (% of available sample)

Three logistic regression models were used to estimate the association of survey year with each of the mental health outcomes. To control for any differences in the characteristics of responders in 2019 versus 2018, I included all the explanatory variables shown in Table 4.2 in the three adjusted multivariable models to investigate whether differences in responder characteristics across survey years may have influenced the findings. The results are reported as Odds Ratios (OR), Confidence Intervals (CI) and P Values (p). The ORs, for example, represent the odds of students at this institution having a moderate/high depression score in 2019 compared to 2018. An OR >1.00 indicates higher levels of depression than 2018 and <1.00 indicates lower levels. Confidence intervals in all my analyses were set at 95% (i.e., 95%CI).

In three final logistic regression models I explored interaction effects between 2018 and 2019 (Objective 2), i.e., whether any associations with survey year differed across levels of the

confounding factors listed in Table 4.2 for the three mental health outcomes. I included all the previously considered confounding variables in the interaction models, including *previous mental health diagnosis,* with the exception of *age* and *place of residence* due to collinearity with *year of study*. The findings are also reported as Odds Ratios (OR), Confidence Intervals (95%CI) and P Values (p).

4.6   Results - Objectives 1 & 2- Depression, Anxiety and Wellbeing

4.6.1   Sample characteristics

The final sample comprised 8,199 responses. 5,562 students responded to the survey in 2018 - a 22.3% response rate, compared to 2,637 students in 2019 - a 10.1% response rate. Table 4.3 shows student characteristics in each survey year, as well as the distribution of missing data, and comparison with the 2017/2018 and 2018/2019 institution registry data. Compared to the whole student population in both survey years, there was an over-representation of respondents who were white or female, minority gender or reporting a disability, as well as undergraduates and home students. The overrepresentation of UGs and home students was less marked in the 2019 than 2018.

Almost half of respondents each survey year were less than 21 years old - lower levels than seen across the institution; and just under one in five respondents identified as LGB (Lesbian, Gay, Bisexual) or minority sexual orientation. Almost a third of respondents had been privately educated, and similar levels indicated they were in their first year of study, which is smaller than seen at institution level. Finally, just under a third of students were in halls of residence in both survey years, with more than half living in private rental accommodation.

Table 4.3 Student Characteristics in 2018 and 2019 Wellbeing Survey Samples Compared to Institution Data

Year	2018	2019	Academic Registry 2017/18	Academic Registry 2018/19
Number of respondents/ Eligible students	5,562/24,915	2,637/26,053	24,915	26,053
Response rate (%)	22.3	10.1		
Gender - n (%)				

Female	3,614 (65.0)	1,829 (69.4)	13,755 (55.2)	14,520 (55.7)
Male	1,829 (32.9)	720 (27.3)	11,107 (44.6)	11,476 (44.0)
Nonbinary or another gender	62 (1.1)	28 (1.1)	52 (0.2)	53 (0.2)
Prefer not to say	33 (0.6)	35 (1.3)	0.0	0.0
Missing	24 (0.4)	25 (1.0)	n/a	n/a
Age - n (%)				
< 21	2,658 (47.8)	1,122 (42.6)	17,322 (69.5)	18,060 (69.3)
≥21	2,677 (48.1)	1,486 (56.4)	7,595 (30.5)	7,997 (30.7)
Missing	227 (1.8)	29 (1.0)	n/a	n/a
Ethnicity - n (%)				
Black, Asian or minority ethnic	952 (17.1)	528 (20.0)	6,339 (25.4)	7,087 (27.2)
White British	4,503 (80.1)	2,072 (78.6)	16,992 (68.2)	17,239 (66.2)
Prefer not to say/Non-disclosed	57 (1.0)	17 (0.6)	1,584 (6.4)	1,727 (6.6)
Missing	50 (0.9)	20 (0.8)	n/a	n/a
Sexual orientation - n (%)				
Heterosexual	4,364 (78.5)	1,968 (74.6)	n/a	n/a
Lesbian, Gay, Bisexual or prefer to self-describe	958 (17.2)	492 (18.7)		
Prefer not to say	210 (3.8)	155 (5.9)		
Missing	30 (0.5)	22 (0.8)		
Fee status - (%)				
Home[a]	4,847 (87.9)	2,129 (80.7)	20,254 (81.3)	20, 816 (79.9)
EU	273 (4.9)	196 (7.4)		
International students	393 (7.1)	307 (11.6)	4,654 (18.7)	5,233 (20.1)
Missing	49 (0.9)	5 (0.2)	7 (0.0)	4 (0.0)
Course type - n (%)				
Postgraduate research	366 (6.6)	279 (10.6)	2,122 (8.5)	2,124 (8.2)
Postgraduate taught	289 (5.2)	314 (11.9)	4,376 (17.6)	4,786 (18.4)
Undergraduate	4,867 (87.5)	2,041 (77.4)	18,423 (73.9)	19,151 (73.5)
Missing	40 (0.7)	3 (0.1)	n/a	n/a
Previous Education - n (%)				
State (non-fee paying)	2,610 (46.9)	1,401 (53.1)	n/a	n/a

Grammar (non-fee paying)	736 (13.2)	284 (10.7)		
Private	1,837 (33)	860 (32.6)		
Other	191 (3.4)	76 (2.9)		
Missing	188 (3.4)	16 (0.6)		
Lifetime MH diagnosis - n (%)				
No diagnosis in lifetime	3,074 (55.3)	1,739 (66.0)	n/a	n/a
Previously diagnosed	1,562 (28.1)	884 (33.5)		
Missing	926 (16.7)	14 (0.5)		
Disability - n (%)				
Physical Disability	106 (1.9)	57 (2.2)		
Non-physical disability	1,283 (23.1)	581 (22.0)	3,049 (12.2)	3,411 (13.1)
Physical and non-physical	68 (1.2)	62 (2.4)		
None	3,819 (68.7)	1,724 (65.4)	21,846 (87.7)	22,624 (86.8)
Prefer not to say	204 (3.7)	123 (4.7)	20 (0.1)	18 (0.1)
Missing	82 (1.5)	90 (3.4)	n/a	n/a
Year - n (%)				Registry data may differ[b]
0/Foundation	n/a	23 (0.9)	76 (0.3)	104 (0.4)
1	1,817 (32.7)	952 (36.2)	10,695 (42.9)	11,394 (43.7)
2	1,605 (28.9)	692 (26.3)	6,314 (25.3)	6,433 (24.6)
3	1,402(25.2)	583 (22.2)	5,594 (22.5)	5,833 (22.3)
4	496 (8.9)	268 (10.2)	1,801 (7.2)	1,858 (7.1)
5 and above	143 (2.6)	85 (3.2)	442 (1.8)	449 (1.7)
Other	47 (0.9)	25 (1.0)	n/a	n/a
Missing	52 (0.9)	9 (0.3)		
Faculty - n (%)				
Arts	1,238 (22.3)	544 (20.6)	4,851 (18.4)	4,952 (19.0)
Engineering	661 (11.9)	273 (10.4)	3,430 (13.8)	3,504 (13.4)
Health Sciences	760 (13.7)	442 (16.7)	3,275 (13.1)	3,368 (12.9)
Life Sciences[c]	448 (8.1)	364 (13.8)	2,800 (11.2)	2,994 (11.5)
Science	1,271 (22.9)	446 (16.9)	3,543 (12.0)	3,578 (13.7)
Social Science and Law	1,141 (20.5)	557 (22.1)	7,017 (23.9)	7,662 (29.4)
Missing	43 (0.8)	11 (0.4)	n/a	n/a
Residence - n (%)				

University Hall Residence	1,514 (27.2)	706 (26.8)	n/a	n/a
Private Hall Residence	214 (3.9)	155 (5.9)		
Private rental	3,496 (62.9)	1,511 (57.3)		
Owned property	156 (2.8)	94 (3.6)		
With parents	102 (1.8)	40 (1.5)		
Outside city postcode	n/a	105 (4.0)		
Other	43 (0.8)	22 (0.8)		
Missing	37 (0.7)	4 (0.2)		

a Inc Channel Islands & Isle of Man. Academic Registry figures are reported as Home/EU combined
b Registry year of study figures include PG and UG e.g., as first or second years etc- survey respondents may have answered this differently
c This was Biomedical Science in 2018

4.6.2 Main effects - Objective 1

Mental health and wellbeing outcomes in 2018 and 2019 are reported in Table 4.4. Results indicate a higher percentage of respondents reported moderate/severe depression symptoms in 2019 compared to 2018, whereas levels of anxiety symptoms and wellbeing both improved. The results were similar when I looked at both percentage-categorised or mean values for each of the depression, anxiety and wellbeing scales (see Table 4.4). Any differences between 2018 and 2019 were relatively small.

Table 4.4 Unadjusted Depression, Anxiety and Wellbeing as Dichotomous and Continuous Outcomes for All Survey Respondents in 2018 and 2019

Survey Year	2018	2019
(n= Number of eligible respondents)	(n= 5,570)	(n= 2,637)
Depression (n=analytic sample size) n (%)	(n=4,869)	(n=2,602)
PHQ-9 <10 (No/Mild symptoms)	2,679 (55.0)	1,383 (53.2)
PHQ-9 ≥10(Moderate/severe symptoms)	2,190 (45.0)	1,219 (46.9)
Anxiety (n=analytic sample size)	(n=4,696)	(n=2,610)

n (%)		
GAD-7 <10 (No/Mild symptoms)	2,885 (61.4)	1,663 (63.7)
GAD-7 ≥10 (Moderate/severe symptoms)	1,811 (38.6)	947 (36.3)
Mental wellbeing (n=analytic sample size) n (%)	(n=5,115)	(n=2,597)
WEMWBS >42 (Mod/High Mental Wellbeing)	2,509 (49.1)	1,337 (51.5)
WEMWBS ≤42 (Low Mental Wellbeing)	2,606 (51.0)	1,260 (48.5)
Average MH scores Mean (SD)		
Depression (PHQ-9)	9.59 (6.14)	9.88 (6.70)
Anxiety (GAD-7)	8.33 (5.54)	8.04 (5.85)
Mental Wellbeing (WEMWBS)	42.4 (9.95)	43.0 (10.37)

Unadjusted logistic regression models showed weak statistical evidence for a 9% drop in odds of students having poorer wellbeing (OR 0.91, 95%CI 0.83 to 1.00) in 2019 compared to 2018 as shown in Table 4.5. However, there was no evidence for any change in students reporting greater depression (OR 1.08, 95%CI 0.98 to 1.19) or anxiety (0.91, 95%CI 0.82 to 1.00). Subsequently, after adjusting for all the confounders shown in Table 4.2 there was stronger evidence for a 16% drop in odds of respondents experiencing poorer wellbeing in 2019 (OR 0.84, 95%CI 0.75 to 0.94), and a 14% drop in the odds of students experiencing greater anxiety symptoms (OR 0.86, 95%CI 0.77 to 0.96) compared to 2018. There was no evidence for a change in odds of greater depression symptoms between 2018 and 2019 (OR 1.05, 95%CI 0.93 to 1.17).

Table 4.5 Unadjusted and Adjusted Logistic Regression Models Examining Change in Levels of Depression, Anxiety and Mental Wellbeing Between 2018 and 2019

	Depression symptoms (PHQ9 ≥10)		Anxiety symptoms (GAD7 ≥ 10)		Mental Wellbeing (WEMWBS ≤42)	
	Unadjusted n=7,471	Adjusted [a] n=6,699	Unadjusted n=7,306	Adjusted [a] n=6,709	Unadjusted n=7,712	Adjusted [a] n=6,693
Survey Year	OR (95 % CI)	OR (95 % CI)	OR (95 % CI)	OR (95 % CI)	OR (95 % CI)	OR (95 % CI)
2018 (reference)	1.00	1.00	1.00	1.00	1.00	1.00
2019	1.08 (0.98-1.19)	1.05 (0.93-1.17)	0.91 (0.82-1.00)	0.86 (0.77-0.96)	0.91 (0.83-1.00)	0.84 (0.75-0.94)
p value	.122	.434	.054	.009**	.044*	.002**

a models adjusted for: gender, age, ethnicity, fee status, sexual orientation, previous education, faculty, year of study, previous MH diagnosis, disability, residence, course level
*p value or significance is * <.05 ** <.01 *** <.001

The odd ratios (OR) and confidence intervals (95% CI) for each potential confounding factor included in the fully adjusted model are reported in Appendix I. In keeping with the literature, there was evidence that higher levels of some or all adverse mental health outcomes were seen in females, minority gender and ethnicity groups, and also in students who identified as LGB, lower SES (as indexed by schooling), had a disability or a lifetime MH diagnosis. A further investigation examined which of the many confounders were responsible for the changes seen in the unadjusted and adjusted models. The factors resulting in the greatest decreased odds for anxiety when individually added to the unadjusted model (OR 0.91, 95%CI 0.82 to 1.00) included: disability (OR 0.87, 95%CI 0.78 to 0.97), sexual orientation (OR 0.88, 95%CI 0.79 to 0.97), and gender (OR 0.88 95%CI 0.80 to 0.97). The factors showing the greatest decrease for odds of poorer wellbeing in the unadjusted model (OR 0.91, 95%CI 0.83 to 1.00) were sexual orientation (OR 0.88, 95%CI 0.80 to 0.97), ethnicity (OR 0.89, 95%CI 0.81 to 0.98), disability (OR 0.89, 95%CI 0.80 to 0.98) and gender (OR 0.89, 95%CI 0.81 to 0.98).

4.6.3 Effect modification- Objective 2

A final analysis examined whether change in mental health and wellbeing outcomes differed between 2018 and 2019 according to different sociodemographic, health and university-related features listed in Table 4.2, i.e., all the confounding factors with the exception of age and residence for the reasons outlined in 4.4.2.2 The interaction test p values showed statistical evidence for a differential effect in depression symptoms associated with sexual orientation between 2018 and 2019, and a differential effect for mental wellbeing in relation to gender (see Table 4.6).

Table 4.6 Interaction Test P-values from Models Investigating Differential Effects of the New Wellbeing Services on Student Mental Health and Wellbeing

Risk factor [a]	Depression Symptoms (PHQ$\geq$10)	Anxiety Symptoms (GAD$\geq$10)	Mental Wellbeing (WEMWBS $\leq$42)
	Interaction p value	*Interaction p value*	*Interaction p value*
Previous mental health diagnosis	.498	.412	.557
State Educated	.868	.274	.958
International	.223	.208	.366
Gender	.465	.612	.011*
Ethnicity	.444	.662	.592
Sexual orientation	.013*	.866	.808
Year of study	.394	.781	.354
Course Level	.146	.404	.663
Faculty	.702	.548	.670
Disability	.193	.250	.142

a) all models adjusted for: gender, ethnicity, fee status, sexual orientation, previous education, faculty of study, year of study, previous MH diagnosis, disability, course level, residence and age
* p value or significance is * <.05 ** <.01 *** <.001

Odd ratios in a final stratified analysis for the two factors identified (in Table 4.6) indicated that the mental wellbeing of respondents identifying as non-binary or another gender (compared to the male reference group) improved between 2018 (OR 3.46, 95%CI 1.49 to

8.07) and 2019 (OR 0.64, 95%CI 0.27 to 1.51). A similar pattern was seen in students who preferred not to give their gender. However, for LGB students compared to students identifying as heterosexual (ref. 1.00), the odds of having greater symptoms of depression increased in 2019 (OR 2.08, 95%CI 1.63 to 2.63) from 2018 (OR 1.34, 95%CI 1.12 to 1.61). Note that interpretation of these particular results is limited by the context of the large number of models analysed (n=27) and the increased risk of Type One error. Similarly, sample sizes for some of these groups were small - resulting in wide CIs.

4.7 Analysis - Objective 3 - Student help-seeking behaviour

4.7.1 Data preparation and missingness

Analyses to assess changes in help-seeking behaviour and perceived usefulness of university support services used were restricted to first year students only, for the reasons previously outlined in 4.4.2.1 and due to wording used in the survey questionnaire which asked 'have you **ever** sought help from…' i.e., at any point since starting at university. Figure 4.3 shows the number of *first year* respondents included in the analysis.

Figure 4.3 Flowchart Shows Student Population, Survey Respondents and First Year Only Analytic Samples Examining University Support Use and Usefulness Ratings

n= number respondents (% of eligible sample)

99
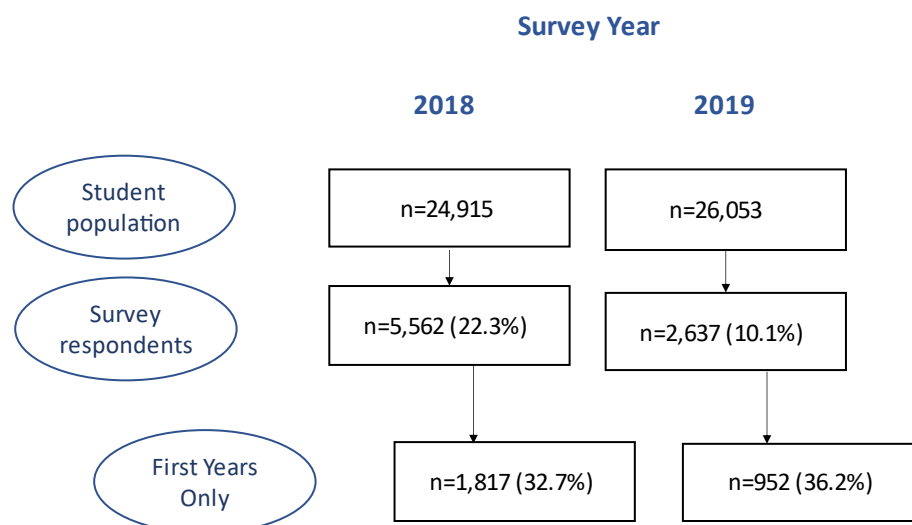
The analysis was also restricted to only those students who reported using a support source **and** giving a *usefulness* rating. The Residential Life service was only introduced in September 2018, so to enable comparison of *any* wellbeing support offered in university residences in either 2018 or 2019, the variable was simply coded as *Staff in residences*. Similarly, there was only a minimal Wellbeing service in 2018 (i.e., in one Faculty - Health Sciences), so between-year comparison of *Wellbeing Advisers* was limited. As such, the Wellbeing adviser analysis was restricted to a description of usefulness and use relative to other services in 2019. Finally, changes in perception of usefulness of other university support sources between 2018 and 2019 e.g., Mental Health Professional, GP, Peer Support, Nightline etc, were included on the basis that with the new services in place they would have benefited from shorter wait-times or better signposting i.e., an improved student experience as a result.

4.7.2   Statistical Analyses

Frequencies and percentages were used to describe student use of each source of university support e.g., *Staff in Residences, Wellbeing Advisers, GPs, Students' Union* (full list in Table 4.1 and details in Appendix C). Student perception of the usefulness of the support offered by the university were summarised as means and standard deviations for each individual service or source (scores ranged from 1= *not useful* to 5=*extremely useful)*. Linear regression was used to examine unadjusted and adjusted average support usefulness ratings between 2018 and 2019 accounting for all the previous confounders outlined in Table 4.2. Results are reported as mean differences, confidence intervals (95%CI) and p values (p).

4.8   Results - Objective 3 - Student help-seeking behaviour

4.8.1   Sample characteristics (Objective 3)

First year responses formed more than a third (34%) of the total survey sample (n= 2,769/8,199). Respondent characteristics in each year were largely well-matched with a few exceptions. Table 4.7 shows there were more first year females and Black, Asian and minority ethnic students in 2019 compared to 2018, and fewer students living in university halls. Levels of previous mental health diagnosis also differed between survey years for those in first year of study in 2019 (30%) and 2018 (26%) - explained by missing data in 2018 as described in 4.7.1.

Prevalence of depression, anxiety or poorer wellbeing in *first year* respondents was comparable to that of *all* respondents (see Table 4.7); similarly, a full description of respondent characteristics shown in Appendix J.1 suggests the first year sample was not qualitatively different to the full sample.

Table 4.7 Respondent Characteristics in 2018 and 2019 for First Years Compared to Whole Sample in Relation to Gender, Ethnicity, Residence, and Poorer Depression, Anxiety or Wellbeing

	First Years only		All respondents	
Year	2018	2019	2018	2019
Number of respondents/	n=1,817/5,562	n= 952/2,637	5,562/24,915	2,637/26,053
Eligible sample (%)	(32.7)	(36.1)	(22.3)	(10.1)
Gender - n (%)				
Female	1,198 (65.9)	686 (72.1)	3,614 (65.0)	1,829 (69.4)
Male	583 (32.1)	243 (25.5)	1,829 (32.9)	720 (27.3)
Nonbinary or another gender	27 (1.5)	8 (0.8)	62 (1.1)	28 (1.1)
Other[a]	9 (0.5)	15 (1.6)	57 (1.0)	60 (2.3)
Ethnicity - n (%)				
Black, Asian or minority ethnic	352 (19.4)	227 (23.9)	952 (17.1)	528 (20.0)
White British	1,442 (79.4)	718 (75.4)	4,503 (80.1)	2,072 (78.6)
Other	23 (1.3)	7 (0.7)	107 (1.9)	37 (0.8)
Residence - n (%)				
Hall of Residence	1,456 (80.1)	688 (72.3)	1,728 (31.1)	861 (32.7)
Other	361 (19.8)	264 (27.8)	3,791 (68.9)	1,754 (66.6)
Depression[b] - n (%)				
PHQ-9 ≥10	717 (45.1)	448 (47.7)	2,190 (45.0)	1,219 (46.9)
Anxiety - n (%)				
GAD-7 ≥10	570 (37.4)	319 (33.8)	1,811 (38.6)	947 (36.3)
Wellbeing - n (%)				
WEMWBS ≤42	856 (50.7)	449 (47.8)	2,606 (51.0)	1,260 (48.5)

a 'Other' includes Prefer not to say and Missing
b Prefer Not to Say and missing responses omitted from totals

4.8.2 Changes in help seeking behaviour (Objective 2)

The change in proportion of first year students who indicated using university support in 2018 and 2019 are shown in Figure 4.4 (and Appendix J.2). The most widely used sources of support were Mental health professionals, GPs and academic tutors. Reported levels of support-seeking rose in 2019, with the exception of the online resource - Togetherall (formerly known as Big White Wall) and the Students' Union.

Figure 4.4 Chart Shows Numbers of First Year Survey Respondents Using University Support Sources in 2018 and 2019
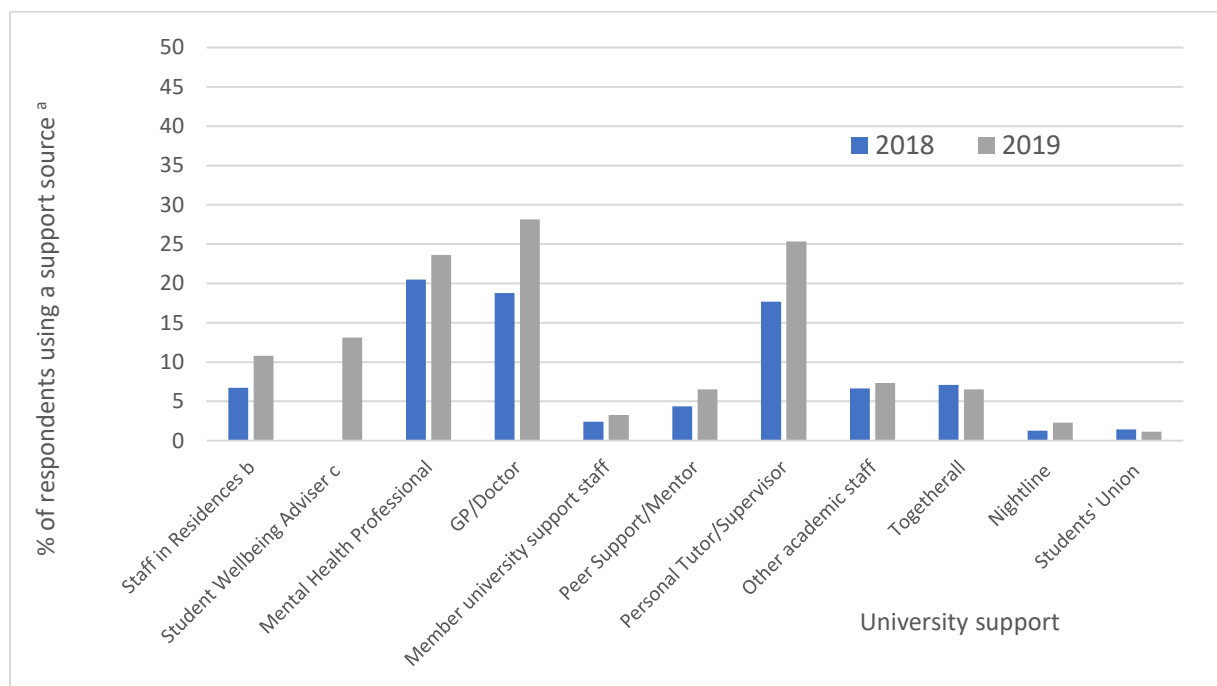
a Axis censored at 50% to accommodate smaller values
b All staff in residences collapsed into one category
c No wellbeing advisers in 2018 (only in Health Science)

When students were asked to rate how useful any university support was for a mental health or emotional issue, less than 6.6% students had reported using a service but did not give a rating. Staff in Residences were the most highly rated support source in 2018 (Figure 4.5 and Appendix K). However, that perception worsened in 2019, when Staff in Residences were rated one of least useful sources of help (Mean Diff -0.63, 95%CI -1.03 to -0.23) [33].

Figure 4.5 Changes in Perception of Usefulness of University Support Sources between 2018 and 2019 for Students Seeking Help from the University for a Mental Health or Emotional Problem (Reported as Means and SDs) [a]
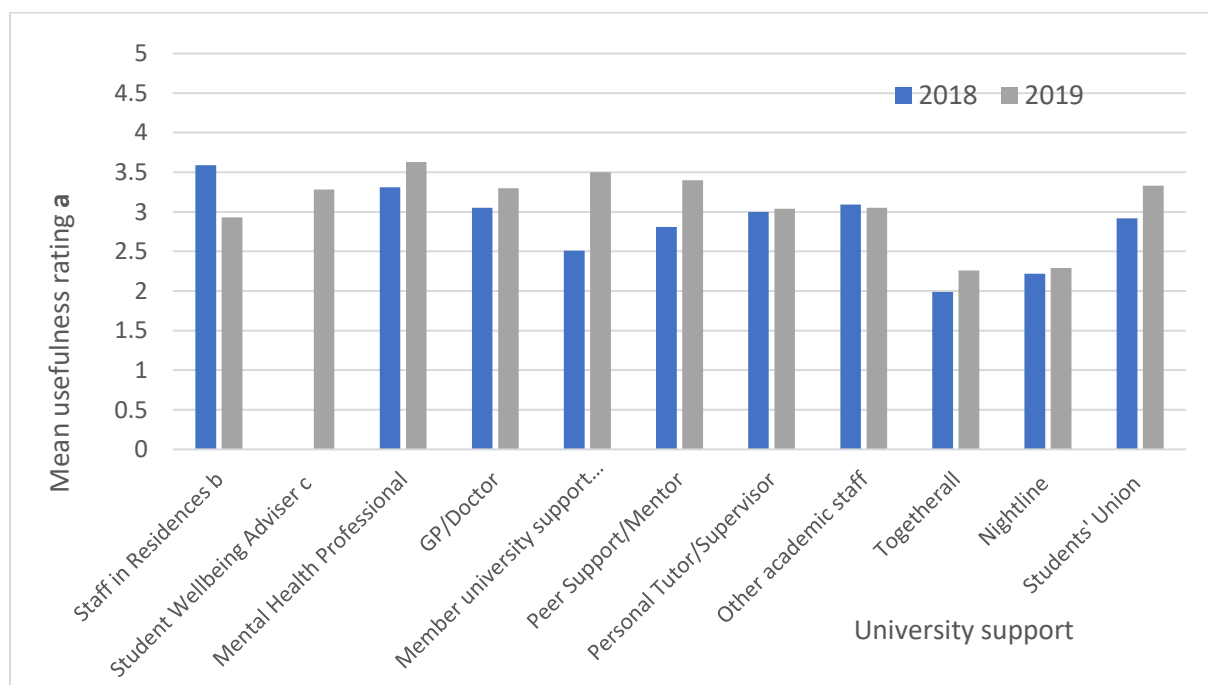
a Usefulness scored between 1 (Not useful) and 5 (Extremely useful)
b All staff in residences collapsed into one category
c No wellbeing advisers in 2018 (except in Health Sciences)

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[33] Model adjusted for previously listed confounders

In 2018, Mental health professionals were also one of the most highly rated sources of support, with evidence that student perception of their usefulness further improved in 2019 (MD 0.35, 95%CI 0.12 to 1.12). Similarly, perception of GPs improved between 2018 and 2019 (MD 0.31, 95%CI 0.10 to 0.51), as well as 'other university support staff' (MD 1.27, 95%CI 0.17 to 2.36). There was no evidence of change in perceived usefulness for any other university support such as academic staff, the Students' Union or (university funded) online/telephone support i.e., Nightline, Togetherall (see Appendix K). Any comparison of how students saw Wellbeing advisers in 2019 was constrained by it being a limited service in 2018. However, in 2019 Wellbeing advisers were more highly rated for usefulness than academic tutors, supervisors and online or phone services e.g., Togetherall, but not as highly as clinicians e.g., MH professionals.

4.9   Analysis - Objective 3 - Perceived barriers to seeking university support

4.9.1   Data preparation and missingness

An examination of change in student perception of barriers to seeking university support between 2018 and 2019 comprised three analyses including: *all* student responses, *first years only*, and lastly students with symptoms of *severe major depression*, for the reasons outlined in 4.7.1. Students were asked if *they had had a mental health concern but had not sought support from the university then **why not***. Respondents could tick all reasons that applied, and due to survey set up there were again a number of missing items. Therefore, respondents were only reported as experiencing a barrier if they positively indicated at least one reason for not using university support (see full list of reasons/barriers in Table 4.1 or Appendix E *Wellbeing Survey*). Figure 4.6 shows the number of respondents included in each of the following analyses.

Figure 4.6 Flowchart of Student Population, Survey Respondents and Final Analytic Samples Examining Perceived Barriers to Using University Support for All Respondents, First Years Only and Those with SMD -Severe Major Depression Symptoms (PHQ>20)

n= number respondents (% of eligible sample)
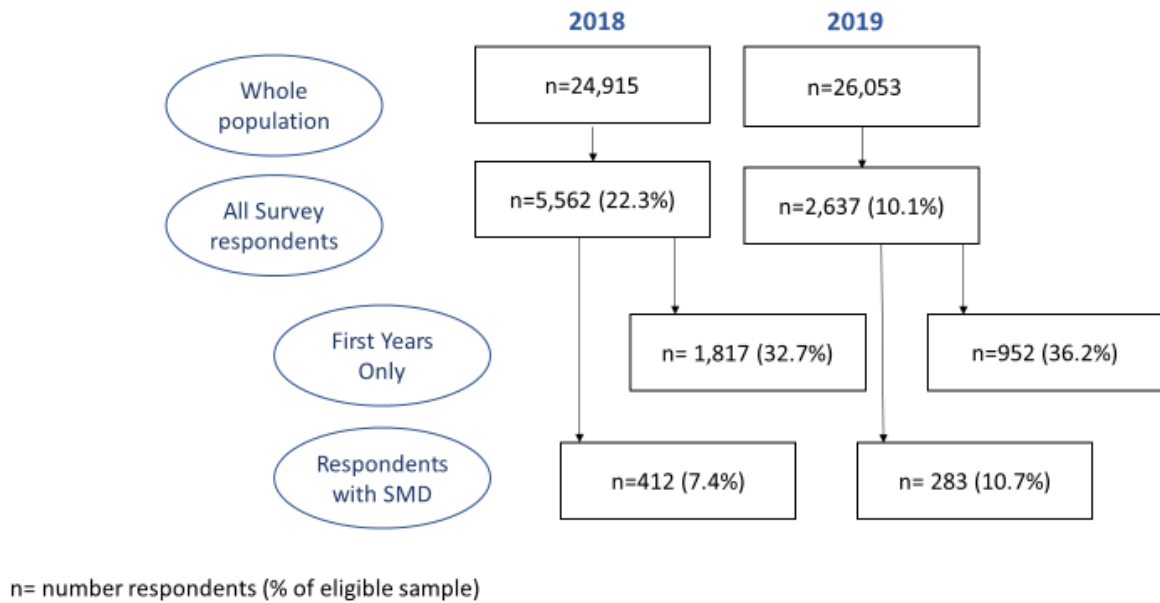
4.9.2   Statistical analysis

The number and nature of reasons students gave for not seeking university support in 2018 and 2019 are presented as frequencies and percentages. Unadjusted and adjusted logistic regression models were used to examine change between years, with results reported as odds ratios (OR), confidence intervals (95%CI) and p values (p).

4.10 Results - Objective 4 - Perceived barriers to seeking university support

4.10.1   Sample characteristics (Objective 4)

As previously outlined in Objective 3, respondents in their first year of study formed more than a third (34%) of the total survey sample, with student characteristics shown in brief in Table 4.7 and full in Appendix J.

There was a greater proportion of students with *severe major depression* in 2019 (10.7%) than 2018 (7.4%) as shown in Appendix L.1. Table 4.8 indicates respondents with *SMD* were over-

represented by females and students identifying as minority gender, ethnicity or sexual orientation compared to the wider sample. The majority of students reporting severe symptoms of depression, also reported greater anxiety and poorer wellbeing (see Table 4.8). Further characteristics of students with *severe major depression symptoms* are shown in Appendix L.2.

Table 4.8 Characteristics of Respondents Showing Severe Major Depression Symptoms (PHQ>20) in 2018 and 2019 Compared to Whole Sample in Relation to Gender, Ethnicity, Sexual Orientation, and Poorer Depression, Anxiety or Wellbeing

Year	2018	2019	2018	2019
	Respondents with SMD (PHQ$\geq$20)		All Respondents	
Number of respondents /	n=412/5,562	n=283/2,637	5,562/24,915	2,637/26,053
Eligible sample n (%)	(7.4%)	(10.7%)	(22.3%)	(10.1%)
Gender				
Female	284 (68.9)	204 (78.1)	3,614 (65.0)	1,829 (69.4)
Male	107 (26.0)	64 (22.6)	1,829 (32.9)	720 (27.3)
Nonbinary or another gender	19 (4.6)	4 (1.4)	62 (1.1)	28 (1.1)
Prefer not to say	2 (0.5)	8 (2.8)	33 (0.6)	35 (1.3)
Missing	-	3 (1.0)	24 (0.4)	25 (1.0)
Ethnicity				
Black, Asian or minority ethnic	97 (23.5)	227 (23.9)	952 (17.1)	528 (20.0)
White British	309 (75.0)	718 (75.4)	4,503 (80.1)	2,072 (78.6)
Prefer not to say/Not-disclosed	6 (1.5)	2 (0.2)	57 (1.0)	17 (0.6)
Missing	-	5 (0.5)	50 (0.9)	20 (0.8)
Sexual orientation				
Heterosexual	249 (60.4)	704 (74.0)	4,364 (78.5)	1,968 (74.6)
Lesbian, Gay, Bisexual or prefer to self-describe	146 (35.4)	198 (20.8)	958 (17.2)	492 (18.7)
Prefer not to say	17 (4.1)	48 (5.0)	210 (3.8)	155 (5.9)
Missing	-	2 (0.2)	30 (0.5)	22 (0.8)
Depression n (%)				

PHQ-9 ≥10	412 (100.0)	283 (100.0)	2,190 (45.0)	1,219 (46.9)
Anxiety n (%)				
GAD-7 ≥10	362 (87.9)	263 (93.3)	1,811 (38.6)	947 (36.3)
Wellbeing n (%)				
WEMWBS ≤42	405 (98.3)	272 (97.1)	2,606 (51.0)	1,260 (48.5)

4.10.2 Changes in perceived barriers to seeking university support (Objective 4)

Students were asked if they had experienced a mental health concern but had not used university support services, the reasons that had prevented them from doing so. As shown in Figure 4.7, the most frequently reported barriers for *all* respondents in 2018 were a 'lack of available services', a 'lack of time', and the 'fear of unwanted intervention'. In 2019, the greatest barriers were 'fear of unwanted intervention', 'lack of time' and 'concern that no one would understand the problem'- see full table in Appendix M. 14.1% (2018) and 11% (2019) of survey respondents selected '*Other*'. This option was not analysed further here. However, 'feeling like my problems aren't important enough' was commonly cited.
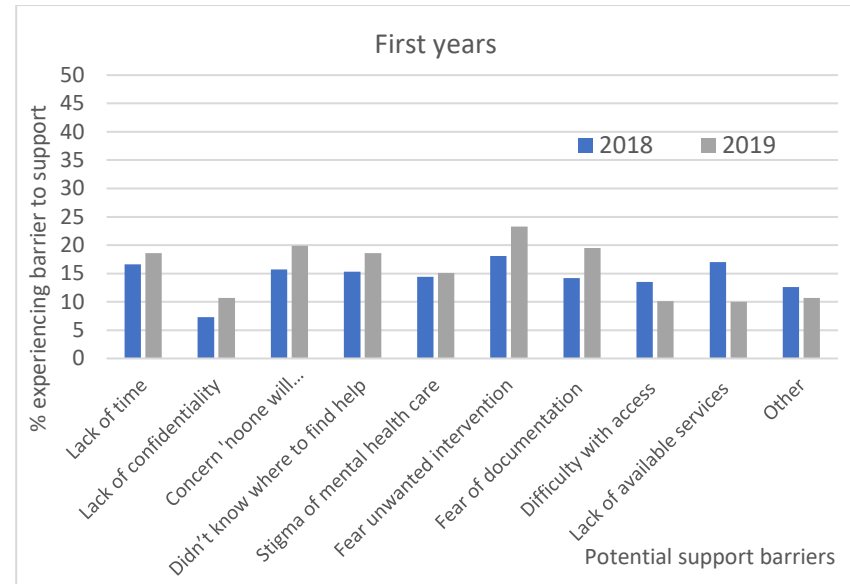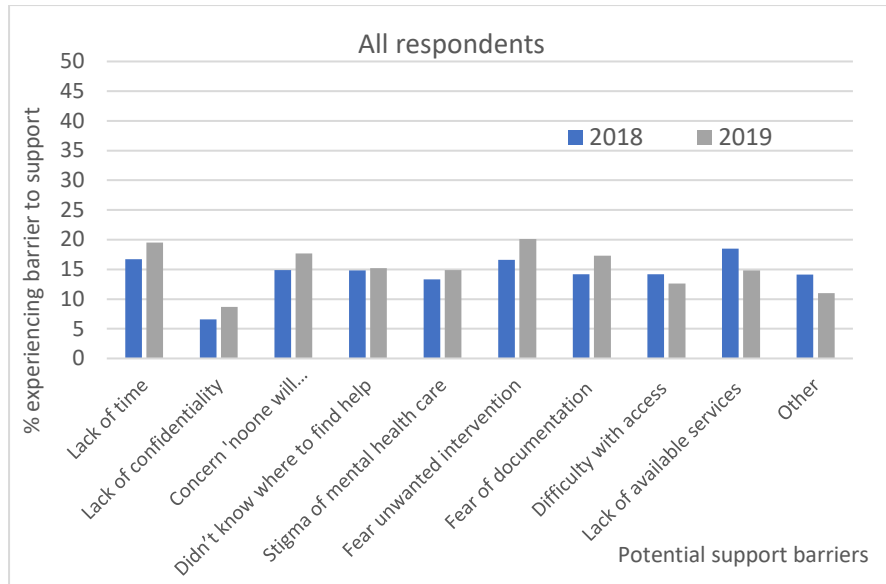
Figure 4.7 Graphs Show % All Respondents, First Years Only and Those with Severe Major Depression Experiencing Barriers to Seeking University Support [a]

a Y-axis censored at 50% to accommodate smaller values
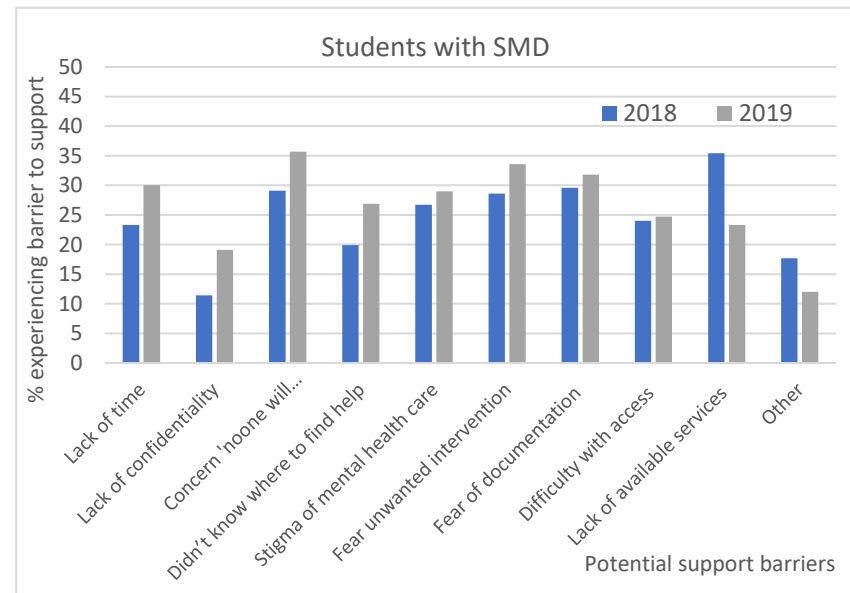
Any barriers experienced by *first year* respondents were very similar to those experienced by the whole sample (see Figure 4.7 and Appendix M), with 'fear of unwanted intervention' being their greatest concern in seeking support in both 2018 and 2019. For *students with SMD symptoms*, a 'lack of available services' was the biggest perceived barrier in 2018, however that improved in 2019 with 'concern that no-one would understand the problem' becoming the biggest reason for not seeking support in that year.

As Table 4.9 shows, fully adjusted regression models showed evidence of improvement in 2019 in *all* respondents' perception of barriers related to services i.e., lower odds of students citing a 'lack of available services' when seeking support (OR 0.59, 95%CI 0.51 to 0.67). Similarly, the odds of *all* respondents indicating any 'difficulty with accessing services' (OR 0.67, 95%CI 0.57 to 0.78) or 'not knowing where to find help' (OR 0.85, 95%CI 0.74 to 0.98) also fell between 2018 and 2019. A similar positive trend was seen in *first year* respondents' perception of availability and accessibility of services with evidence for an improvement in perception of service availability (OR 0.40, 95%CI 0.30 to 0.53) and accessibility (OR 0.59, 95%CI 0.44 to 0.77); but there was no corresponding change for *first years* 'knowing where to find help' (OR 1.07, 95%CI 0.85-1.34). For those respondents with *SMD*, while there was no evidence that they perceived a difference in 'accessibility of services', there was evidence of reduced odds in experiencing a 'lack of available services' (OR 0.47, 95%CI 0.32 to 0.70) in 2019. However, there was an increased risk in this group of 'not knowing where to find help' (OR 1.60, 95%CI 1.07 to 2.39) and concerns about confidentiality (OR 1.83, 95%CI 1.13 to 2.96) in 2018 compared to 2019 (see Table 4.9).

Table 4.9 Unadjusted and Adjusted Models of Change Between 2018 and 2019 in the Nature of Barriers Students Encounter When Seeking Help at University

	All students		First Years only		Students with SMD (PHQ9≥20)	
n= number students/eligible students (%)	8,199/50,968 (16.0)		2,769/8,199 (33.8)		695/8,199 (8.4)	
Barriers to seeking help	**Unadjusted** OR (95%CI) *p value*	**Adjusted** [a] OR (95%CI) *p value*	**Unadjusted** OR (95 %CI) *p value*	**Adjusted** OR (95%CI) *p value*	**Unadjusted** OR (95%CI) *p value*	**Adjusted** OR (95%CI) *p value*
Lack of time	1.21 (1.07 - 1.36) *.002***	0.92 (0.81-1.05) *.232*	1.15 (0.93-1.41) *.193*	0.87 (0.69-1.09) *.212*	1.41 (1.00-1.99) *.047**	1.46 (0.99-2.13) *.054*
Lack of confidentiality	1.34 (1.13-1.60) *.001***	0.99 (0.82-1.20) *.934*	1.52 (1.16-1.99) *.002***	1.22 (0.90-1.67) *.289*	1.83 (1.20-2.80) *.005***	1.83 (1.13-2.96) *.014**
Concern 'no-one will understand my problem'	1.23 (1.09-1.40) *.001***	0.98 (0.85-1.12) *.732*	1.33 (1.09-1.63) *.006***	1.11 (0.89-1.39) *.364*	1.35 (0.98-1.87) *.068*	1.31 (0.91-1.89) *.143*
Didn't know where to find help	1.03 (0.91-1.18) *<.001****	0.85 (0.74-0.98) *.023**	1.26 (1.03-1.56) *.027**	1.07 (0.85-1.34) *.564*	1.48 (1.03-2.11) *.032**	1.60 (1.07-2.39) *.022**
	1.14	0.95	1.06	1.01	1.12	0.97

Stigma of mental health care	(1.00-1.30)	(0.82-1.09)	(0.85-1.32)	(0.79-1.28)	(0.80-1.57)	(0.66-1.43)
	.050 *	*.439*	*.618*	*.964*	*.510*	*.918*
Fear unwanted intervention	1.26	1.03	1.37	1.18	1.26	1.20
	(1.12-1.42)	(0.91-1.18)	(1.14-1.67)	(0.96-1.46)	(0.91-1.74)	(0.83-1.74)
	*<.001*** *	*.584*	*.001** *	*.156*	*.167*	*.329*
Fear of documentation	1.27	0.98	1.47	1.25	1.11	1.06
	(1.12-1.44)	(0.86-1.13)	(1.19-1.81)	(0.99-1.57)	(0.80-1.54)	(0.73-1.55)
	*<.001*** *	*.817*	*<.001*** *	*.060*	*.538*	*.756*
Difficulty with access	0.87	0.67	0.72	0.59	1.04	1.03
	(0.76-1.00)	(0.58-0.78)	(0.56-0.92)	(0.44-0.77)	(0.73-1.48)	(0.69-1.54)
	.053	*<.001*** *	*.010* *	*<.001*** *	*.831*	*.880*
Lack of available services	0.76	0.59	0.54	0.40	0.55	0.49
	(0.67-0.87)	(0.51-0.67)	(0.43-0.69)	(0.30-0.53)	(0.39-0.78)	(0.33-0.73)
	*<.001*** *	*<.001*** *	*<.001*** *	*<.001*** *	*.001** *	*<.001*** *
Other	0.77	0.60	0.83	0.69	0.63	0.58
	(0.65-0.86)	(0.52-0.70)	(0.65-1.07)	(0.53-0.91)	(0.41-0.98)	(0.36-0.94)
	*<.001*** *	*<.001*** *	*.146*	*.009* *	*.042* *	*.027* *

[a] Models adjusted for: gender, age, ethnicity, fee status, sexual orientation, previous education, faculty of study, year of study, previous MH diagnosis, disability, residence, course level

* p value or significance is * <.05 ** <.01 *** <.001

4.11 Chapter summary

I found evidence that students' levels of anxiety and wellbeing improved between 2018 and 2019 in the period after the new wellbeing services were introduced. Adjusted models suggest there was a 16% drop in the odds of students experiencing poorer wellbeing and a 14% drop in odds of students experiencing higher levels of anxiety. There was no meaningful change in levels of depression (Objective 1). There was also some evidence of an improvement in mental wellbeing for students identifying as a minority gender between 2018 and 2019, but a worsening in levels of depression for LGB students. However, the evidence was less convincing due to the number of analyses carried out. (Objective 2).

The proportion of students seeking university support for a wellbeing or mental health issue increased between 2018 and 2019. My findings suggest that student perception of the usefulness of staff in residences worsened between 2018 and 2019, after the introduction of Residential Life and the new wellbeing support model. Student perception of the new student faculty and school wellbeing team suggests that the advisers were seen as more useful on average than academic tutors or online/phone services for emotional or mental health support in 2019 but less useful than clinical professionals. Student perception of the usefulness of Mental Health Professionals, Doctors/GPs, and other university support staff all improved in 2019 (Objective 3).

I also found evidence that student perception of the availability and accessibility of university support services improved between 2018 and 2019. For every sub-group examined, student perception of the 'availability' of university services had increased in 2019 after the new wellbeing support was introduced. Compared to *all* students or *first years*, students with symptoms of *severe major depression (SMD)* experienced more 'difficulty in accessing' university support services in 2018 and 2019 and that did not change or improve. For the other groups (*all* and *first year* respondents) the accessibility of university support in 2019 was perceived more positively than in 2018. Lastly, while *all* respondents saw positive

change in 'not knowing where to seek help' after the introduction of the new services, that was not the case for students with *SMD* or *first years* (Objective 4).

Chapter 5 <u>Secular trends in contextual student mental health and wellbeing indicators before and after the introduction of a new university wellbeing support service</u>

5.1   Chapter overview

In this chapter, I investigate the wider impact of the new support services investment in the Autumn of 2018, using routinely collected data on a number of additional mental health and wellbeing indicators over a longer time period. Here I examine trends in five markers of student mental health and HE experience between the academic years 2014/15 and 2018/2019. The chapter is comprised of overall research aims, design and ethical consideration followed by reporting of methods, analysis and results for each study sequentially.

5.2   Research aims

Overall research aim: To investigate whether the introduction of new university wellbeing support services at one large UK university led to improvements in five contextual indicators of student mental health and wellbeing **(Objective 5)**.

> **Study 1:** To examine whether there was a reduction in anti-depressant prescribing at the on-campus NHS general practice between 2018 and 2019.

> **Study 2:** To investigate if there was a reduction in numbers of students seeking Student Counselling Service appointments at this institution in between 2018 and 2019.

> **Study 3:** To examine whether there was a reduction in annual student course withdrawals at this institution between 2018 and 2019.

Study 4: To examine whether students at this institution reported greater overall satisfaction with their course between 2018 and 2019.

Study 5: To investigate whether students reported greater satisfaction with overall provision of mental health support at this institution - as indexed by National Student Survey (NSS) and local surveys between 2018 and 2019.

5.3   Research design

The scope of this research element was initially wider: I had intended to examine these additional student wellbeing-related indicators between the academic years 2014/15 and 2020/21 (i.e., three years after the new investment). However, the Covid-19 pandemic disrupted almost every part of the UK student experience after March 2020, meaning any contextual data collected after that period would also have been compromised. As such, the following study periods span the academic years 2014/15 to 2018/19 i.e., to the end of the academic year that the new student wellbeing services were introduced. An exception was SSRI prescribing trends where data was captured monthly rather than annually, so the research window could be usefully extended into the 2019/20 academic year.

The university in this evaluation is one of few in the UK to have its own onsite NHS Student Health Service, with 19,970 students registered at the practice in the 2018/19 academic year. It offered the opportunity to examine whether the introduction of the new services in September 2018 had any effect on anti-depressant prescribing trends at the practice. Selective Serotonin Reuptake Inhibitors (SSRI) are the most widely prescribed class of antidepressant and often the first line of treatment for symptoms of depression or anxiety (NHS, 2021).

I hypothesised that the introduction of the new wellbeing services may have reduced the need for some students to seek GP help because they represented an alternative source of MH support. Similarly, the organisational rationale for the development of the services had been to reduce the number of unnecessary or

inappropriate referrals to the Student Counselling Service, and on that basis I examined trends in numbers of unique counselling referrals between 2014/15 and 2018/19. I also hypothesised that the introduction of the new student wellbeing services would mitigate the need for some students to withdraw from their studies, particularly for mental health reasons, again by providing alternative or earlier support in the form of Wellbeing and Residential Life advisers. As such, I investigated trends in student course withdrawal rates over a five-year period. I also examined overall student course satisfaction ratings, a more general indicator of student experience but nevertheless a source of data rigorously collected at a local and national level every year by both the institution and the Office for Students, using surveys with higher response rates than the institution's wellbeing survey, e.g., NSS (OfS, n.da.). Course satisfaction ratings were included on the basis they could offer insight into student perception of their broader experience during this time. Lastly, I examined a trend concerned with student perception of overall university '*well-being*' support during their studies, using institution data combined with Wellbeing Survey data.

Note that I investigated time trends in each of the five indicators graphically. Due to the limited number of data points, it was not possible to undertake formal time-series analysis.

5.4   Data management consideration

The Student Health Service SSRI data were requested and received from the relevant regional NHS Clinical Commissioning Group in January 2019 and updated in October 2021. Numbers of practice registered students were provided by the Student Health Service in February 2022. Counselling referral data were recorded and collated by the Student Counselling Service and provided in November 2021. Aggregated institution student course withdrawal rates (attrition) were recorded by the University Education Data Insight Team and provided in December 2021 with permission for publication. NSS course satisfaction data is publicly available from the Office for Students, universities must reach a 50% response rate threshold in order for their data to be published (OfS, n.da.). Permission to use

and publish the local survey data was granted by the institution's Student Experience team in Spring 2022. Student population figures were taken from both HESA and the institution [34] (HESA, 2021; UOB, n.d.). All data were securely transferred using encrypted approved software, then processed and stored in university secure research files.

5.5   Study 1 - SSRI prescribing

5.5.1   Data sources and measures

I investigated change in the annual total number of SSRI items prescribed at the Student Health Service (SHS) between September 2014 and February 2020. The SSRIs included: Citalopram, Escitalopram, Fluoxetine, Paroxetine, and Sertraline. SSRI prescription item data was provided by the local Clinical Commissioning Group as monthly totals, which enabled examination of a further six-month period in the 2019/20 academic year before the Covid-19 pandemic closed UK campuses in March 2020.

5.5.2   Data preparation and statistical analyses

The number of SSRI items prescribed at the Student Health Service were plotted per 1,000 students registered at the practice. The numbers of SSRI items issued were reported monthly and the number of students registered at the SHS were provided as yearly capitations (i.e., allocated annual government funding for each registered patient) for each academic year -September to August. Capitation totals were used as denominators to calculate (per 1,000) registered student patient numbers. The data are presented in six-monthly periods from September to February, March to August each year between September 2014 and February 2020.

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[34] Due to their nature as live datasets the HESA and UoB population totals vary slightly (>1.2%) according to time of reporting

5.5.3   Results

Raw six-monthly totals of SSRI anti-depressant items issued by the Student Health Service rose by 116.9% between 2014/15 and 2019/20 while numbers of students registered at the practice increased by 30.5% in the same time period. There was a 66.2% increase between September 2014 and February 2020 in (six-month) total SSRI items prescribed per 1,000 students registered at the practice from n= 15,902 in 2014/15 to n=20,746 in 2019/20.

Figure 5.1 shows a year on year increase in the number of SSRI items prescribed (per 1,000 students) with evidence of levelling off in that rise in 2018/19 when the new university wellbeing services were introduced. The average annual increase between 2014/15 and 2018/19 was 11.4%, however as shown in Table 5.1, it fell to 4.5% between 2017/18 and 2018/19.

Figure 5.1 Six-Monthly Totals of SSRI Items Prescribed at the Onsite Student Health Service Between September 2014 and February 2020 per 1,000 practice registered students
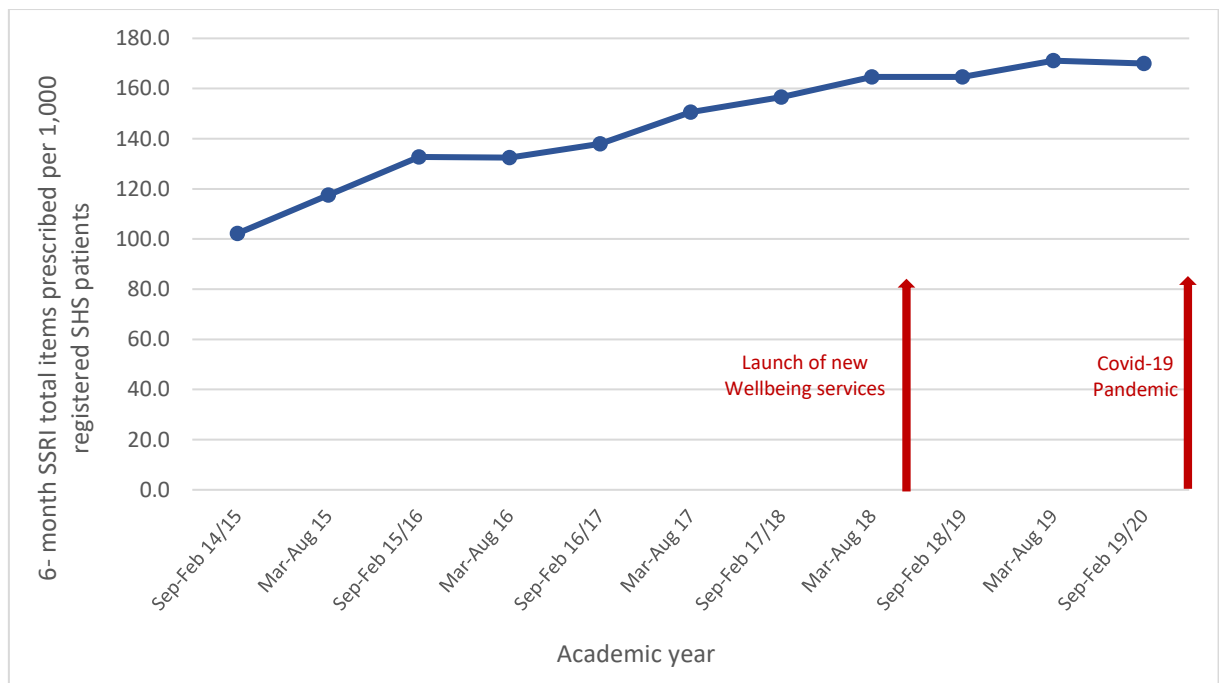
Table 5.1 Percentage Annual Change in SSRI Items Prescribed per 1,000 Registered Students

% Annual change per 1,000 students	Academic years
20.7%	2014/15 to 2015/16
8.8%	2015/16 to 2016/17
11.3%	2016/17 to 2017/18
4.5%	2017/18 to 2018/19

5.6   Study 2 - Counselling service use

5.6.1   Data sources and measures

I examined change in the annual number of individual student registrations/referrals to the institution's Student Counselling Service (SCS) between 2014/15 and 2018/2019. As previously outlined, the rationale was the new services would reduce the critical need for counselling by offering an alternative, more accessible source of support for students. Referral data are collated annually by the SCS as unique referrals/registration numbers in any given academic year (recorded between October and September).

5.6.2   Data preparation and analyses

Counselling referral numbers were supplied as academic year totals and then calculated as totals of the entire student population (per 100) for each academic year between 2014/15 and 2018/19. The totals are plotted graphically in relation to the introduction of the new wellbeing services. I used an incidence rate comparison to investigate statistical change in numbers of counselling referrals between 2017/18 and 2018/19.

5.6.3   Results

Table 5.2 shows that the proportion (%) of students referred to the institution's counselling service increased year on year from 2014/15 (10.2%) to 2017/18 (12.9%), before falling in 2018/19 (12.0%).

Table 5.2 Number of Students Referred to the University Counselling Service Each Academic Year Compared to Numbers of Registered Students Between 2014/15 and 2018/19

Academic Year	Counselling Referrals n= total (% population)	Student Population n=total
2014/15	2192 (10.2)	21,500
2015/16	2350 (10.7)	21,945
2016/17	2889 (12.2)	23,764
2017/18	3225 (12.9)	24,915
2018/19	3134 (12.0)	26,053

Figure 5.2 shows a levelling off in referral numbers after the introduction of the new wellbeing support services in September 2018. An incidence rate (IR) analysis showed statistical evidence (IRR 0.93, 95%CI 0.88 to 0.97, *p =.004*) that the number of student referrals to student counselling fell between 2017/18 and 2018/19.

Figure 5.2 Number of Referrals/Registrations at the Student Counselling Service Between Academic Years 2014/15 and 2018/2019 per 100 Students Registered at the University
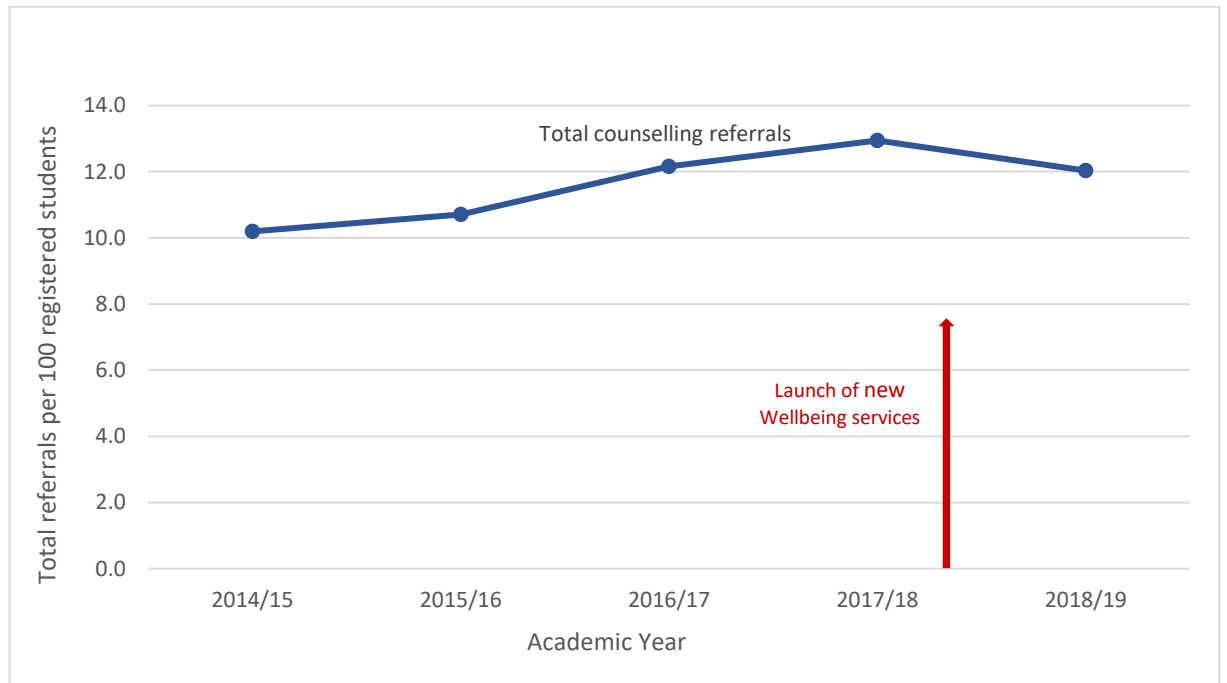
Note: Counselling data are collated at the end of the academic year and the new wellbeing services were introduced at the end of data reporting for 2017/18

5.7   Study 3 - Student withdrawal rates

5.7.1   Data sources and measures

I examined the number of students withdrawing from the institution's courses between 2014/15 and 2018/2019, on the basis that the new wellbeing support provision would prevent more students from leaving university or dropping out, particularly for *mental health reasons*. The university dataset included all active in-year student withdrawals but not cases such as suspension of studies. Reasons for leaving included: *Advised to leave, Course thought unsuitable, Death, Financial Reasons, Mental health reasons, Physical/general health reasons, Required to leave, Transfer to another University (Institution), Other, Unknown.*

5.7.2   Data preparation and analyses

The student withdrawal data were aggregated by reason for leaving and year of study. I examined changes in the annual number of students actively withdrawing from the institution's courses between 2014/15 and 2019/20 citing both *mental health* reasons and *all reasons* (including *mental health*). Similarly, I stratified the analysis by year and per 1,000 students, investigating reasons for leaving for those in their *first year of study only* and *all students* (including *first years*). Lastly, I examined change of incidence in withdrawal rates for all groups between 2017/18 and 2018/19.

5.7.3   Results

4.0% of students withdrew from their courses in 2014/15, with the proportion falling to 2.9% by 2018/19. Overall student withdrawal rates appear to decline dramatically between 2014/15 and 2015/16; reasons for this fall are unclear but may reflect differences in data collection methodologies. However, student in-year withdrawal rates have since remained largely stable when accounting for *all* reasons that a student might leave, but with rates in 2018/19 being the lowest recorded in the data series (Figure 5.3). However, there was no statistical evidence of a difference in incidence rate between 2017/18 and 2018/19 in *all students* (IRR 0.93, 95%CI (0.84 to 1.03), *p =.16*) *or first year* student withdrawals (IRR 0.98, 95%CI (0.86 to 1.11), *p =.74*).

Figure 5.3 Student Withdrawal Rates Citing Any Reasons Between 2014/15 and 2018/2019 (per 1,000 Registered Students)
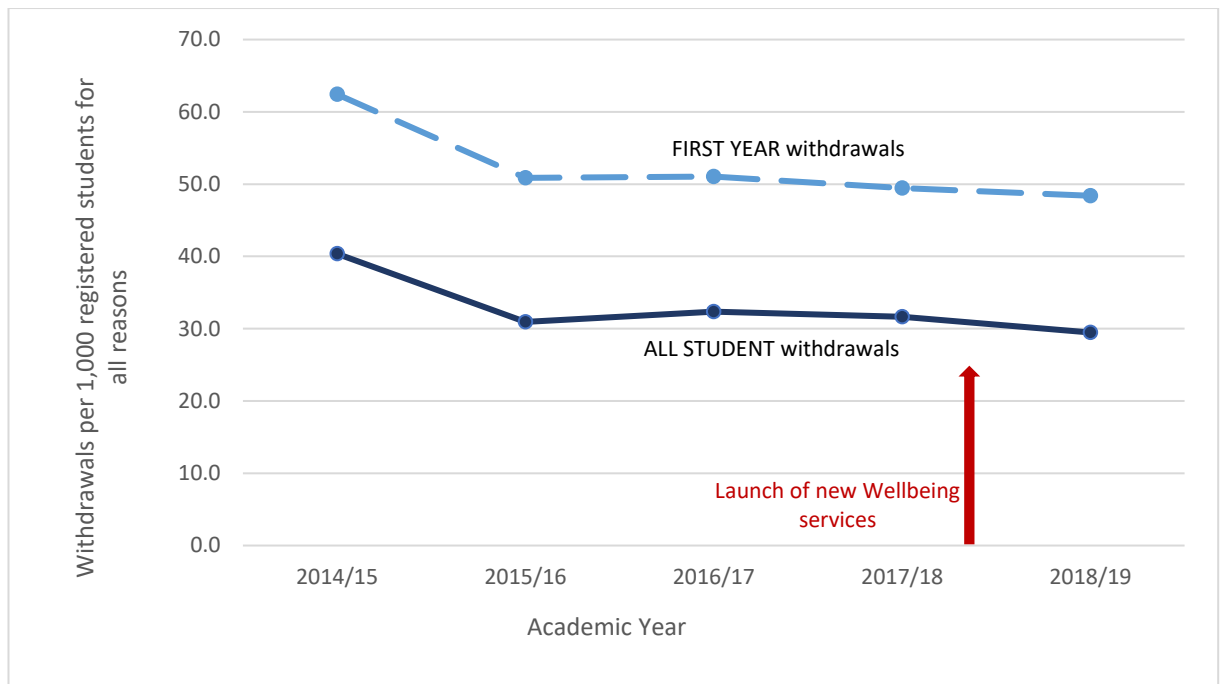
a Reasons for withdrawal include: *Course thought unsuitable, Death, Financial Reasons, Mental health reasons, Physical/general health reasons, Required to leave, Transfer to another University (Institution), Other, Unknown*

Withdrawal rates for students who left for *mental health reasons* (Figure 5.4) rose from 4.1% in 2014/15 as a proportion of all withdrawals to 12.2% in 2018/19. While there was a steady increase in students dropping out for mental health reasons between 2015/16 and 2017/18, there is again a levelling off in MH withdrawals for *all students* after the introduction of the new services in 2018/19. However, an incidence rate ratio analysis showed no statistical evidence of a difference between 2017/18 and 2018/19 in *all students* (IRR 0.97, 95%CI 0.72 to 1.30, *p= .82*) *or first year* (IRR 1.06, 95%CI 0.75 to 1.51, *p=.72*) student mental health withdrawals.

Figure 5.4 Student Withdrawal Rates Citing Mental Health Reasons Between 2014/15 and 2018/2019 (per 1,000 Registered Students)
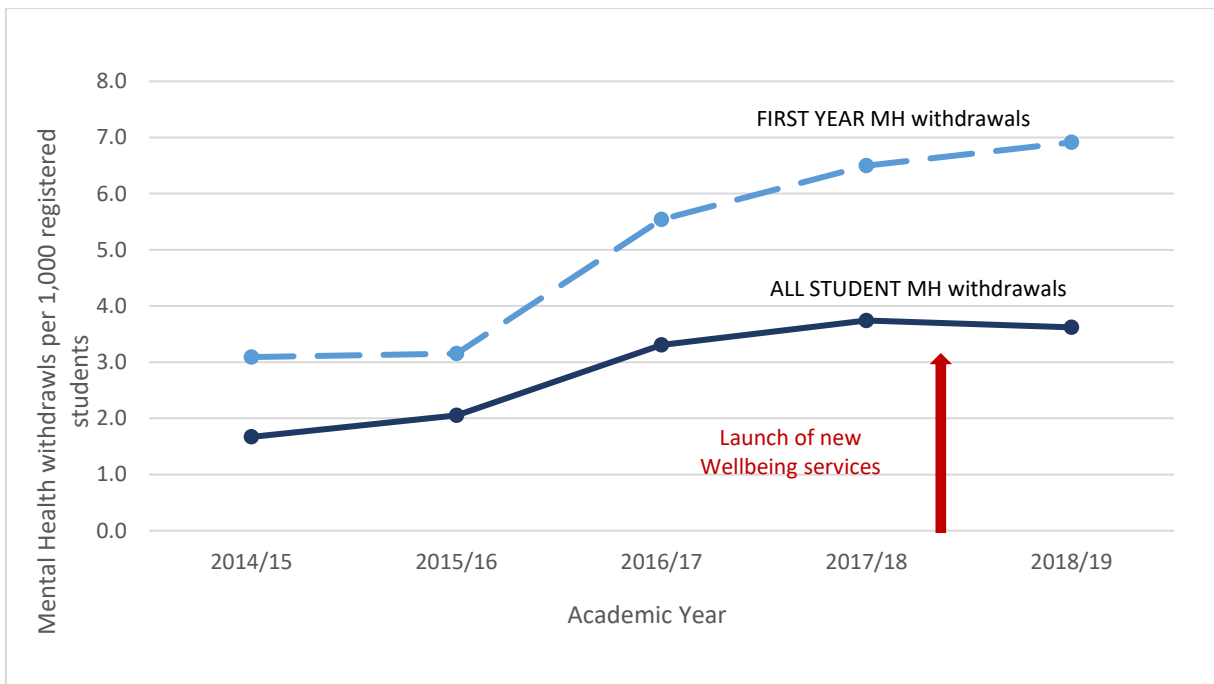
5.8 Study 4 - Student course satisfaction

5.8.1 Data sources and measures

Here I examined change in levels of student *overall course satisfaction* between 2014/15 and 2018/19 as reported in the National Student Survey and by the institution (OfS, 2020b). I hypothesised that *overall course satisfaction* might offer a proxy for assessing broader student experience after the introduction of new support services. The NSS survey is an annual national student survey, running since 2005, with current and historic data publicly available from the Office for Students website (OfS, n.d.). It contains 27 questions and is completed by final year undergraduates from every UK university between January and April each year. The NSS survey uses a 5-point Likert scale of agreement from *definitely agree* to *definitely disagree* with the statement: *Overall, I am satisfied with the quality of the course*. The same question was asked in an internal institution survey of those students not taking part in the NSS, i.e., non-final year undergraduates and

postgraduate-taught students at the institution, however the survey has lower response rates than the NSS (see Appendix N).

5.8.2 Data preparation and analyses

NSS and internal university data are historically reported and benchmarked as % agreement where percentage totals of *definitely* and *mostly agree* are combined. Therefore, I have also reported *definitely/mostly agree* outcomes (%) for student satisfaction with the quality of their courses between 2014/15 and 2018/19. The analyses of course satisfaction included: final year undergraduates nationally compared to final year undergraduates at the institution (using NSS data), alongside percentage agreement from all non-final year undergraduates and postgraduate-taught respondents (from the institution survey of those not taking part in the NSS). Statistical analysis could not be undertaken as individual item totals were not available.

5.8.3 Results

Figure 5.5 shows NSS trends in final year student overall course satisfaction have remained largely stable over the five-year period nationally, with 86.0% of UK students *definitely* or *mostly* agreeing they were satisfied with the quality of their course in 2015 compared to 84.0% in 2019. Institution NSS trends indicate the university's final year students saw a slight rise overall in course satisfaction between 2015 (84.0%) and 2019 (85.1%). There is more variation in the university's student perception of their course than in national trends; satisfaction ratings had dropped between 2017 (86.7%) and 2018 (81.6%) before the introduction of the new wellbeing services but rose again the following year at this particular institution (85.1%). That overall trend is also reflected in the institution's survey of non-final year students where course satisfaction rises from 2015 (81.0%) to 2019 (83.4%). Note there was considerable variation in 2016, which may reflect a student campaign that year to boycott institution surveys.

Figure 5.5 NSS Overall Course Satisfaction Ratings (Institution and National, Final Years Only) and the Institution's Survey Ratings (All Other Students with Final Years Excluded) Between 2015 and 2019ᵃ
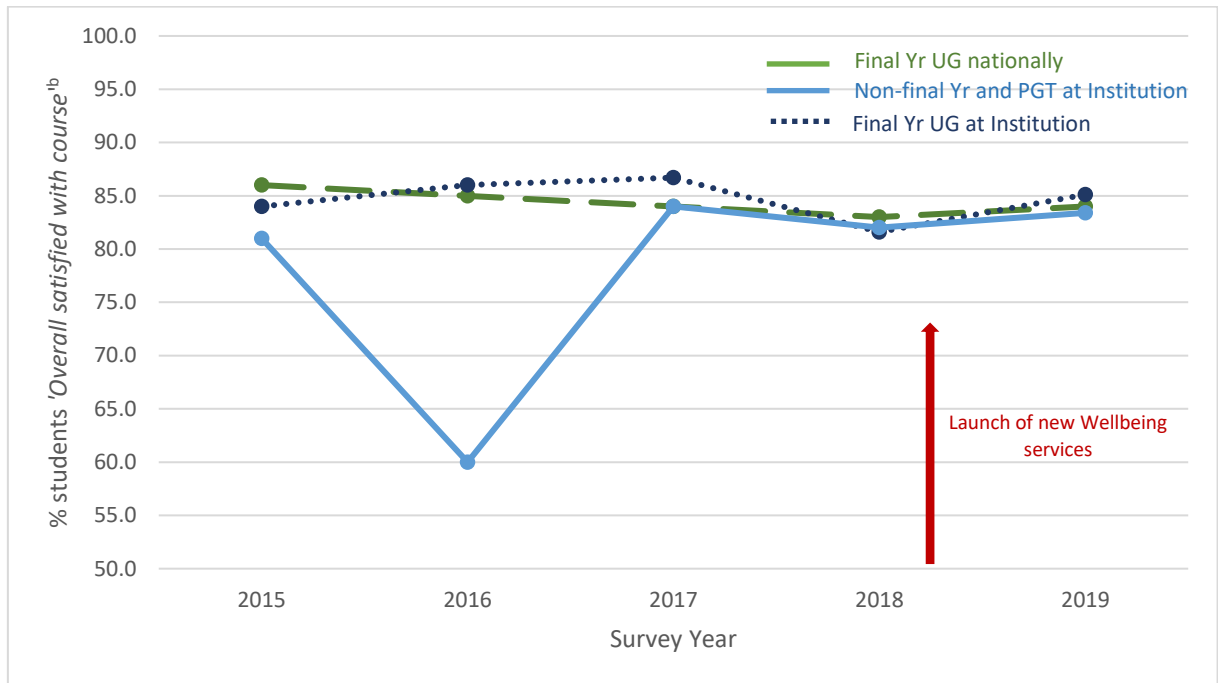
a Institution NSS rates range from 47-75% and national NSS rates are generally >70%; Local survey response rates range from 11-30% (See Appendix N)
b Y axis censored at 50%

5.9   Study 5 - Student support satisfaction

5.9.1   Data sources and measures

A final analysis examined student perception of university wellbeing support overall. The institution survey had asked students between 2016 and 2018 to rate agreement on whether *'Good support has been available for my well-being',* again with responses on a 5-point Likert scale from *definitely disagree* to *definitely agree.* A similar item was asked in the Wellbeing Survey in 2019[35], therefore providing a continuous data-series spanning academic years 2015/16 to 2018/19,

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[35] Question worded slightly differently in 2019 - *Good support is available for my mental health and well-being*

albeit from surveys with different response rates e.g., 30.0% in 2016 and 10.1% in 2019 (see Appendix N; Table 4.3).

5.9.2   Data preparation and analyses

Once again percentage agreement totals of *definitely* and *mostly agree* were combined and plotted between 2016 to 2019. To match the fact that third year students were not included in the institution survey, I excluded third year students from my summary of the *Student Wellbeing Survey* responses to this question. Distribution analyses were not undertaken.

5.9.3   Results

Figure 5.6 shows a sharp fall in the number of students agreeing '*good support is available for mental health and wellbeing*' between 2018 (68%) and 2019 (35%). Notably, this data came from two different surveys with different response rates and potentially engaged students with different mental health profiles.

Figure 5.6 % Students Mostly or Definitely Agreeing with the Statement 'Good Support has Been Available for my (Mental Health and) Well-being' between 2016 and 2019
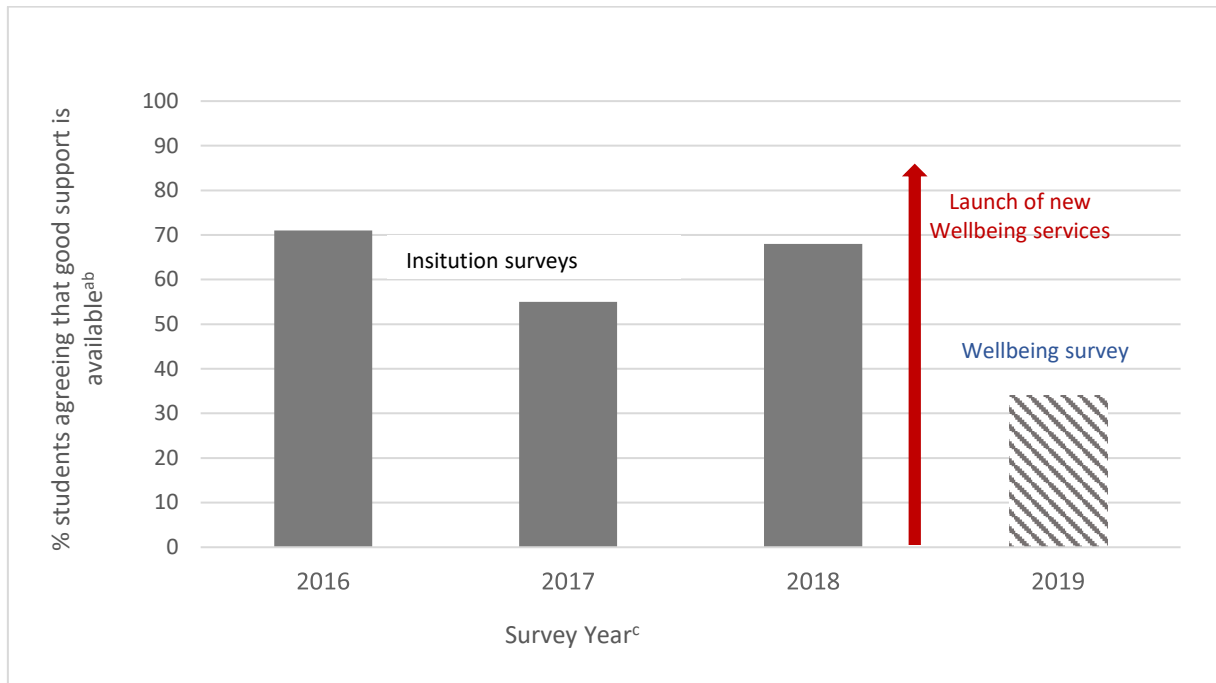
a Includes PGTs and all non-final year UGs from 2016-2018 and All students except third years in 2019
b Institution survey response rate ranges from 27-30% (See Appendix N); Wellbeing Survey response rate was 10.1% in 2019 (See Appendix N)
c Survey year reflects on student experience of previous academic year e.g., 2016 reflects 2015/16

5.10 Chapter Summary

The series of individual contextual studies in this chapter show a number of promising findings. I found evidence for a levelling off in anti-depressant prescribing at the onsite Student Health Service after 2017/18. With a year on year rise in the number of SSRI items prescribed between 2014/15 and 2017/18, there was a marked fall in the rate of increase after the introduction of the new wellbeing services in 2018/19 (Study 1). I also found evidence for a decrease in the proportion of students being referred to the Student Counselling Service between 2017/18 and 2018/19, after the introduction of the new services (Study 2).

While in-year course withdrawal rates were relatively stable from 2015/16 when examining *all the different reasons* students give for leaving the university, my findings suggest that the proportion of students citing *mental health reasons* for withdrawing, levelled off in 2018/19 after the introduction of the services. However, that trend was not statistically meaningful and was not apparent in a sub-sample of first year students (Study 3).

NSS overall course satisfaction ratings nationally for final year students were largely stable from 2015 to 2019. However, I found evidence to suggest that for this institution, final year students' perception of their course had deteriorated in 2018, reflecting the period before the new support services were introduced, and with an improvement in course satisfaction again the following year (Study 4). The results of my final analysis suggest that student perception of university wellbeing support deteriorated considerably between 2017/18 and 2018/19, the year after the introduction of the new university wellbeing services. It is important to note that these particular findings may have been constrained by the comparability of the datasets (Study 5).

Taken together, these five broader indicators of student wellbeing offer some indication that the introduction of the new wellbeing services in faculties and halls of residence had had a positive impact on the wider student support experience in 2019. However, they need to be viewed with caution as they all use indirect markers of mental health and wellbeing.

Chapter 6   Measuring and characterising student engagement with new university wellbeing support services

6.1   Chapter overview

This chapter outlines key findings from two one-week census surveys designed to characterise use of the institution's new Wellbeing and Residential Life services. The surveys were carried out in the academic year 2019/20, after the services had been operational for 12 months, tracking both service use and student perception of accessibility and usefulness of the new support, as well as staff caseload and self-reported adviser confidence in dealing with students' presenting issues. The chapter details study development, methods, procedure and findings concerned with how the new support services were being experienced by the students using them, and the advisers working in them.

6.2   Research aims

Overall research aim: To characterise the volume and nature of student interactions with the new Wellbeing and Residential Life services, and examine student perception of service accessibility and usefulness, as well as assessing adviser caseload/mix, confidence and the referral process **(Objective 6)**.

Objective 6a: To describe the students using the services, comparing characteristics and levels of mental health with those taking part in the institution's cross-sectional *Student Wellbeing Survey* and the wider student body, and to establish why students were seeking support.

Objective 6b: To examine student perception of accessibility and usefulness of the new services.

Objective 6c: To investigate support-setting i.e., how and where service interactions took place, and any actions taken e.g., referral or signposting.

Objective 6d: To assess the appropriateness of caseload/mix and adviser confidence in dealing with students' presenting issues.

6.3   Background

As described in earlier chapters, ~ 40 new staff had been recruited into wellbeing advisory roles across the new support services when they launched in September 2018. The restructure in student accommodation saw academic Hall Wardens replaced with professional Residential Life advisers meaning students living in university residences were able to drop-in or pre-book wellbeing support appointments in one of three central hubs across campus. New faculty Wellbeing advisers (n=~25) were initially situated in each academic school or department and offered wellbeing support to non-residential students, at either pre-booked appointments or scheduled drop-in clinics[36].

Data collection had been originally scheduled for key points across the 2019/20 academic year i.e., early in year (November 2019), mid-year (February 2020), and during the revision period (April), but after the Covid-19 pandemic lockdown in March 2020 and associated service disruption, the April survey was cancelled. When the *Wellbeing Census Surveys* were carried out, the 'Wellbeing Access' system had not been fully implemented, so students were still self-referring to individual services, rather than using the new single online form later introduced to allocate support centrally on the basis of need (see 1.9). That operational shift happened across the 2019/20 academic year.

6.4   Research design

This study was designed to examine the characteristics of students using the new Wellbeing and Residential Life support and to assess both student and wellbeing adviser views of the new services. To inform and refine data collection, I

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[36] Wellbeing advisers were originally attached to a specific school or department, but the role became increasingly centralised and with the introduction of Wellbeing Access.

conducted a pilot survey week and ran staff feedback sessions in October 2019. Two week-long *Wellbeing Census Surveys* were then carried out in the autumn and spring of the academic year 2019/20.

All students and staff working in or using the services were asked to complete questionnaires to assess service use and caseload/mix during each census week. Items included basic demographics and a brief student mental health screen which students completed before the service interaction. All students seen in the census period were also emailed a brief follow-up questionnaire asking about the helpfulness of the session. The surveys were developed in collaboration with the student PPI group, Wellbeing and Residential Life services, and external mental health clinicians – see Appendix O.

My findings are presented graphically using descriptive statistics, means and proportions, mean differences, confidence intervals and p values.

6.5   Methods

6.5.1   Sample and data collection

The week-long census periods took place between 11-18th November 2019 and 10-16th February 2020. All students and staff (advisers) who used the new wellbeing services or were working in them during those periods were asked to fill in surveys/forms for each interaction. No incentives were offered for taking part.

6.5.1.1   Student Census Survey

All students who used the new support services (Wellbeing and Residential Life) in the census weeks either for booked appointments, email advice, drop-ins or visits were asked to complete a pre-appointment questionnaire - *Student Census Survey* (Appendix O.1). Students were sent the online survey link via email by the Wellbeing and Residential Life teams at the point of referral; where this was not feasible students were offered paper versions in sealable envelopes e.g., at drop-in appointments.

6.5.1.2 Follow-up Student Census Survey

Every student seen during the census weeks also received a brief online post-appointment survey - *Follow-up Student Census Survey* (Appendix O.2). All students were emailed the questionnaire link by Wellbeing and Residential Life administrators after the census period, and within two weeks of contact. Those students who completed paper copies of the pre-appointment survey were also offered a paper copy of the *Follow-up Census Survey* immediately after the service interaction.

6.5.1.3 Staff Census Survey

Wellbeing and Residential Life advisers were asked to complete an online form (i.e., *Staff Census Survey*) for each advisory encounter they had with students during the census weeks (Appendix O.3). The teams were emailed a staff survey/form online link at the start of each census period by their managers, who then sent regular email reminders throughout the week.

6.5.2 Outcome measures

In order to describe and compare the students using the services with the wider student population, I used shortened versions of items from the cross-sectional *Student Wellbeing Survey* (see Table 6.1). I also used brief demographic and education-related questions from the wider survey to include gender, year of study, course level, fee status, ethnicity, age, residence, and faculty of study (Appendix O.1). Additional census questions were informed by a senior university clinical psychologist and the wellbeing service teams- Table 6.1.

Table 6.1 Outcome Measures Used to Characterise Students Seeking Support from the New Wellbeing and Residential Life Services and to Assess

Service Experience

Construct	Measure	Number of items	Sample item	Scoring	Score Meaning	Other users	Reference
Objective 6a - MH outcomes (Student completion)							
Depression and anxiety - screens for symptoms	PHQ-4 taken from Patient Health Questionnaire and Generalised Anxiety Scale	4	In the last two weeks how often have you been bothered by any of the following: *Little interest or pleasure in doing things? Feeling down, depressed, or hopeless? Feeling nervous anxious or on edge? Not being able to stop or control worrying?*	Not at all (0) Several Days (1) More than half the days (2) Nearly every day (3)	Depression/Anxiety symptoms: 0-2 Normal 3-5 Mild 6-8 Moderate 9-12 Severe Total between 0 and 12, score ≥ 6 indicates caseness and recommended clinical cut-off (Wicke et al., 2022).	(Khubchandani et al., 2016; Löwe et al., 2010)	(Kroenke et al., 2009)
Mental Wellbeing	SWEMWBS Short Warwick and Edinburgh Mental Wellbeing Scale taken from	7	Please tick the box that best describes your experience in the last two weeks:	None of the time (1) Rarely (2) Some of the time (3) Often (4)	Scores between 7-35 and recommended cut off < 19.5 indicating low wellbeing-equivalent to the lowest 15% of	NHS Digital survey (2022), many other British longitudinal surveys e.g., ALSPAC (n.da.),	(Fat et al., 2017)

	longer 14-item WEMWBS		*I've been feeling optimistic about the future* *I've been feeling useful* *I've been feeling relaxed* *I've been dealing with problems well* *I've been thinking clearly* *I've been feeling close to other people* *I've been able to make up my own mind about things*	All of the time (5)	scores in the general population. Average UK general population score for 16-24 year olds is 23.4 (SD 3.7). A meaningful difference considered between 1 and 3 (Shah et al., 2018; Warwick Medical School, 2021)	Covid-19 Social Study (Fancourt, 2022).	
Presenting Issues	Factors contributing to support-seeking as identified by clinician, adviser and student PPI groups	27	*Study difficulties* *Exam difficulties* *Terminating studies* *Issues arising from repeat year* *Other course issues* *Friendship/Peer problems* *Relationship problems* *Parent/Family problems* *Supporting friends with problems* *Bullying/Harassment* *Accommodation issues* *Homesickness* *Issues relating to overseas study*	Tick all that apply	n/a	n/a	n/a

			Bereavement				
			Physical health				
			Gender/Sexual identity				
			Disability				
			Sexual assault				
			Violence				
			Theft				
			Finances/Debt				
			Low mood /Depression				
			Stress/Anxiety				
			Self-harming				
			Drug/Alcohol problem				
			Disordered eating				
			Other – please specify				

Objective 6b - Accessibility and helpfulness (Student completion)

Ease of access	Adapted from *Student Wellbeing Survey*	1	*How easy was it to get an appointment to talk to an adviser?*	5 point Likert scale - *Very easy to Very difficult*	n/a	*Student Wellbeing Survey*	n/a
Helpfulness of support service	Adapted from *Student Wellbeing Survey*	1	*How helpful was this service for you?*	5 point Likert scale - *Very helpful to Very unhelpful*	n/a	*Student Wellbeing Survey*	n/a

Objective 6c - Support Process (Adviser completion)

Support setting	Location of support interaction	1	*Face to face, email, phone, text, skype, other*		n/a	n/a	n/a

Adviser action	Action taken by adviser after support interaction	1	*Signpost, Liaise with faculty, Refer, Close case, Book another appmt, Escalate, Other*	Select all that apply	n/a	n/a	n/a
Objective 6d - Appropriateness and confidence (Adviser completion)							
Appropriate service	Caseload/mix appropriateness	1	*Did you feel this service was appropriate for the student?*	Yes, No-please explain	n/a	n/a	n/a
Adviser confidence	Staff confidence in actions taken	1	*Do you feel confident in the action you took?*	Yes completely, most aspects, some aspects, not at all, please explain	n/a	n/a	n/a

6.5.2.1 Objective 6a - Mental Health Outcomes

I calculated average SWEMWBS and PHQ-4 scores, with proportions of students scoring above and below the clinical cut-offs from the *Student Census Survey*, as well as the cross-sectional *Student Wellbeing Survey* in 2019.

Staff and students were asked to indicate the nature of the mental health and wellbeing issues being experienced to assess whether the services were dealing with the difficulties they were set up to address. The two wellbeing services did not use the same codes for registering student concerns, so a novel list of possible reasons for support-seeking was developed with the advice of service professionals and students– see Table 6.1.

6.5.2.2 Objective 6b - Ease of access and helpfulness of services

A further rationale for investing in new services was to improve access to university mental health support, and students were asked how easy it was to get an appointment, which was scored on a five-point Likert scale from *Very easy* to *Very difficult*. Similarly, the *Student Follow-up Survey* asked how helpful students had found the service they used on a scale of *Very unhelpful* to *Very helpful*. A further item asking about service location i.e., '*Faculty*' or '*Village*', was added to the February follow-up survey to examine within-service differences.

6.5.2.3 Objective 6c & d - Staff experience

Along with items detailing the student's demographics and presenting issues, advisers were asked about where and how the support took place and any further support actions taken such as referral or signposting, as shown in Table 6.1. Similarly, they were asked about the appropriateness of the service and their confidence in dealing with student issues. Wellbeing and Residential Life managers also provided routinely-collected service volume data so overall staff and student response rates could be calculated.

6.5.3 Data management and ethical considerations

The census questionnaires were anonymous and similarly, pre/post student surveys could not be linked to the same individual. As described in [3.9](#) this addressed pragmatic and ethical concerns about identification but meant a compromise for linking staff and student data. To clearly differentiate the research from the institution and to encourage participation, I used a study logo 'The Your Wellbeing Study' for all survey communications (see Appendix O).

Each questionnaire included study information, wellbeing signposting and made clear that completion was taken as informed consent. Students were not asked to fill out a pre-appointment survey where it was considered inappropriate e.g., an in-person presentation where a student was in considerable distress or at immediate risk of harm. Nevertheless, interactions of that nature would have been captured by staff questionnaires and those students would still have received an email invitation for the *Follow-up Student Census Survey*. Online responses were collected using Redcap survey software. Sealed envelopes with paper surveys were collected from the advisory teams at the end of the census periods and stored securely (see [3.9](#)).

6.6 Analysis

6.6.1 Data preparation and missingness

Online responses were transferred from Redcap servers as Microsoft Excel CSV files in March 2020, and paper student survey responses were entered manually in the same Excel files. 20-25% of pre-appointment surveys were paper, but only one post-appointment survey was submitted this way; all came from the Residential Life team, reflecting the limited amount of post-appointment data collected at drop-ins. Stata 16 was used for all further analyses.

In total, there were 323 completed staff responses, 217 student pre-appointment responses, and 95 follow-up survey responses across the two survey weeks (see Table 6.2). Although sub-analyses suggested data missingness was low and non-systematic (see Missingness in Appendix P) I carried out complete-case analysis,

which was 89-92% of all responses. A further sensitivity analysis showed no statistical differences in student characteristics between November and February in staff or student surveys, therefore the two census datasets were combined. Data collection issues relating to service use for Residential Life in the November census week meant their overall response rates could not be calculated.

6.6.2   Statistical analysis

W*ellbeing Census Survey* demographic and outcome data are summarised as frequencies, percentages, means and standard deviations. Numbers and characteristics of students using each service and the presenting issues are represented graphically. Demographic indicators allowed me to compare students using the new support services in the census weeks with those filling in the larger *Student Wellbeing Survey* in May 2019 and the wider university cohort. T-tests and chi-square tests were used to estimate differences in mental health outcomes. I undertook further sensitivity analyses to examine whether census timing or service was related to depression/anxiety scores to assess any differences in student characteristics. Summary data are used to show how accessible and useful the students found the services, what actions advisers took, and to what extent they felt equipped to meet student need. I also carried out a sensitivity analysis to examine whether student perception of service usefulness differed by faculty or residential village.

6.7   Results

The final complete-case analysis included 289 staff responses, 200 student pre-appointment responses, and 95 follow-up survey responses. Response rates in general were higher for staff (80%) than student pre/post surveys (44%; 24%) as shown in Table 6.2. Individual team response rates also differed which is reflected in sample sizes. Service data broadly suggested each team was seeing just over 100 students during each census period, i.e., over 200 students each week, with just under half of those students completing a pre-appointment questionnaire.

Table 6.2 Service Data, Staff and Student Survey Responses and Completion Rates During Each Census Week

n=number surveys	November 2019				February 2020				Total Overall
	Wellbeing	Residential Life	Don't know/both /Missing	Total	Wellbeing	Residential Life	Don't know/both /Missing	Total	
Number (n) of advisory interactions e.g., meeting/call, according to service data	112	-	-	-	104	109	-	213	-
Staff census surveys (n)									
Completed staff surveys/forms	97	55	1	153	102	65	3	170	**323**
Staff survey response rate %	**87%**	-	-	-	**98%**	**59%**	-	**80%**	-
Student census surveys (n)									
Pre-appointment surveys sent [a]	186	-	-	-	150	115	-	265	n/a
Pre-appointment surveys completed [bc]	57	28	15	100[c]	70	27	20	117[c]	**217**
Response rate student pre-appmt	**31%**	n/a	-	n/a	**47%**	**37%**	-	**44%**	n/a
Student post-appmt surveys sent	112	n/a	-	n/a	104	109	-	213	n/a
Completed post-appmt surveys [b]	26	18	0	44	29	22	0	51	**95**
Response rate student post-appmt %	**23%**	n/a	-	n/a	**28%**	**20%**	-	**24%**	n/a

a Surveys included online and paper copies

b February census week rates only due to missing information in November

c ~14% students in each census did not know which service they used or had used both. Further analysis indicated those students were likely using RL suggesting the RL response rate would have been higher.

6.7.1 Sample characteristics

Approximately two thirds of students were seeking help from the Wellbeing service and a third from Residential Life according to the staff surveys (see Table 6.3). Almost 14% of students responding to surveys did not know which service they had used or indicated both. The characteristics of students seen in both the staff and student (pre-appointment) survey samples differ, with student respondents more likely to be white, younger, undergraduates, home students, and in halls of residence. The staff surveys had higher response rates so are likely to be a better indication of actual service use (see Table 6.2).

More than two thirds of students represented in the staff surveys were female, which was an overrepresentation compared to the wider university population in 2019/20; they were also, on average, older than the overall student population. White, undergraduate and foundation year students were also overrepresented among the wellbeing service users in the staff surveys. Male students, postgraduate taught, international, third years, and Black Asian and minority ethnic students were underrepresented when compared to the *institution's academic registry data*. There were also indications in staff surveys that those using services were underrepresented by Engineering and Social Sciences students and overrepresented by Arts and Life Science students compared to registry data*.

I did not collect sexual orientation data, but 7% students (in *Student Census Surveys*) had concerns related to gender/sexual identity; while staff surveys reported seeing less than 1% of these issues.

Table 6.3 Student Characteristics as Recorded in Students and Staff Census Surveys Compared to Student Wellbeing Survey 2019 and Academic Registry Data

	Student Census Surveys n (%) [a]	Staff Census Surveys n (%)	Student Wellbeing Survey 2019 (%)	Academic Registry Dec 2019/20 (%)
Number of respondents	200	289	2,637	27,675
Service				
Wellbeing adviser	116 (58.0)	186 (64.3)	-	-
Residential Life adviser	55 (27.5)	103 (35.7)	-	-

Don't know[b]	28 (14.0)	-	-	-
Both	1 (0.5)	-	-	-
Gender				
Female	145 (66.8)	225 (69.7)	1,829 (69.4)	15,503 (54.7)
Male	61 (28.1)	97 (30.0)	720 (27.3)	12,320 (45.1)
Another gender/prefer not to say	9 (4.2)	n/a	63 (2.4)	50 (0.2)
Missing	2 (0.9)	1(0.3)	25 (1.0)	n/a
Age [c]				
Under 21	139 (64.1)	169 (52.3)	1,122 (42.6)	19,150 (69.2)
21 and over	75 (34.6)	150 (46.4)	1,486 (56.4)	8,528 (30.8)
Missing	3 (1.4)	4 (1.2)	29 (1.0)	n/a
Fee Status %				
Home [d]	181 (83.0)	255 (79.0)	2,129 (80.7)	21,747 (78.6)
EU	11(5.1)	8 (2.5)	196 (7.4)	
International	25 (11.5)	50 (15.5)	307 (11.6)	5,921 (21.4)
Missing	-	10 (3.1)	5 (0.2)	7 (<0.0)
Ethnicity %				
White	164 (75.6)	221 (68.4)	2,072 (78.6)	17,888 (64.6)
Black Asian or minority ethnic	50 (23.5)	81 (25.1)	528 (20.0)	7,858 (28.4)
Non-disclosed	1 (0.5)	14 (4.3)	17 (0.6)	1,929 (7.0)
Missing	1 (0.5)	7 (2.2)	20 (0.8)	-
Level of Study				
Undergraduate	186 (85.7)	258 (79.9)	2,041 (77.4)	20,328 (73.4)
Postgraduate taught	18 (8.3)	28 (8.7)	314 (11.9)	5,080 (18.4)
Postgraduate research	11 (5.6)	16 (5.0)	279 (10.6)	2,275 (8.2)
Other	<1 (0.5)	12 (3.7)	-	-
Missing	-	9 (2.8)	3 (0.1)	-
Year of Study				
Foundation	5 (2.3)	7 (2.2)	23 (0.9)	113 (0.0)
First	124 (57.1)	193 (43.0)	952 (36.2)	12,285 (44.4)
Second	34 (15.7)	71 (22.0)	692 (26.3)	6,736 (24.3)
Third	25 (11.5)	55 (17.0)	583 (22.2)	5,999 (21.7)

Fourth or more	23 (10.6)	30 (9.3)	353 (13.4)	2,551 (9.2)
Erasmus UK/Abroad	2 (0.9)	4 (0.3)	-	n/a
Other	4 (1.8)	4 (1.2)	25 (1.0)	-
Missing	-	12 (3.7)	9 (0.3)	-
Residence %				
University/Private Hall	126 (58.1)	123 (38.1)	861 (32.7)	n/a
Rented private landlord	80 (36.9)	169 (52.3)	1,511 (57.3)	
Live outside UK	<1 (0.5)	<1 (0.3)	-	
Other	2 (0.5)	28 (8.7)	261 (9.9)	
Missing	-	2 (0.6)	4 (0.2)	
Faculty				
Arts	56 (25.8)	83 (25.7)	544 (20.6)	5,231 (18.9)
Engineering	19 (8.8)	25 (7.7)	273 (10.4)	3,822 (13.8)
Health Sciences	21 (9.7)	40 (12.4)	442 (16.7)	3,733 (13.5)
Life Sciences [e]	29 (13.4)	51 (15.8)	364 (13.8)	3,108 (11.2)
Science	37 (17.1)	38 (11.8)	446 (16.9)	3,698 (13.4)
Social Science and Law	51 (23.5)	75 (23.2)	557 (22.1)	8,086 (29.2)
Missing	4 (1.8)	11 (3.4)	11 (0.4)	-

a May not add up to 100% due to rounding
b 85% of students answering 'don't know' were living in halls of residence so likely to be seeing Residential Life advisers
c Age at survey and age at registration will differ slightly ~ 3 months
d Includes Channel Isles
e This was Biomedical Science in 2018

6.7.2 Mental health outcomes (Objective 6a)

6.7.2.1 Student mental wellbeing

The average mental wellbeing score (SWEMWBS) of students seen by the new support services (Mean 18.28, SD 3.04) was lower than students taking the *Student Wellbeing Survey* (Mean 20.07, SD 3.92) in 2019 (MD -1.78 95%CI -2.35 to -1.24, p <.001). Those using Residential Life had slightly higher average levels of wellbeing than those seeing the Wellbeing service as shown in Table 6.4, however there was no statistical evidence of a difference between services (MD -0.73, 95%CI -1.71 to -0.26, p= .148). The proportion of students with the poorest wellbeing (70.5%) as indicated by SWEMWBS $\leq$19.5, was higher

than those with the poorest wellbeing (49.5%) in the *Student Wellbeing Survey*, X^2 (1, N=2,810) =33.0, p <.001.

Table 6.4 Unadjusted Prevalence (%) and Mean Scores for Student Depression/Anxiety and Wellbeing Across the Different Wellbeing Services

	Number of students using new support services n (%)	Moderate/severe depression and anxiety symptoms (PHQ4 $\geq$6) [a] n (%)	Low mental wellbeing (SWEMWBS <19.5) n (%)
Service			
Wellbeing	116 (58.0)	79 (68.1)	87 (75.0)
Residential Life	55 (27.5)	33 (60.0)	36 (65.5)
Don't know/both	29 (14.5)	18 (62.1)	18 (62.1)
All	200	130 (65.0)	141 (70.5)
		PHQ-4 **Mean (SD)**	**SWEMWBS** **Mean (SD)**
Service			
Wellbeing	As above	7.11 (2.83)	17.89 (3.06)
Residential Life		6.18 (2.80)	18.62 (3.04)
Don't know/both		6.28 (2.64)	19.15 (2.76)
All		6.74 (2.81)	18.28 (3.04)

a) Scores not sex-weighted

6.7.2.2 Student depression and anxiety symptoms

Mental health, as indexed by the PHQ-4, was on average poorer in students using the new services (Mean 6.74, SD 2.81) than for respondents to the *Student Wellbeing Survey* (Mean 4.96, SD 3.43) in 2019 (MD 1.77, 95%CI 1.28 to 2.26, p <.001). Similarly, a higher proportion of students using the new services showed poorer mental health (65.0%) as indexed by PHQ$\geq$6 compared to those taking the *Student Wellbeing Survey* (39.9%) in 2019 (X^2 (1, N=2,820) = 48.4, p <.001).

As shown in Table 6.4 there were indications that students using the Wellbeing service reported poorer mental health than those using Residential Life. Students seen by both services in November (67.4%) showed slightly more symptoms of depression and anxiety than those seen in February (62.9%) however a sensitivity analysis showed no statistical differences, even after adjusting for case-mix (OR 1.36, 95%CI 0.73 to 2.54).

6.7.3   Presenting issues (Objective 1)

As shown in Figure 6.1 advisers reported the main concerns of students using the new services as stress and anxiety (65.7%), low mood and depression (48.1%), and study difficulties (35.3%). Students commonly presented with more than one problem. While student perception of the issues they were experiencing broadly reflects the profile of cases recorded by staff, students flagged greater numbers of difficulties than advisers reported. Students may have highlighted every issue they were experiencing rather than every issue they discussed with an adviser.

Figure 6.1 Nature and Percentage (%) of Presenting Issues Reported by Staff and Students During Census Weeks
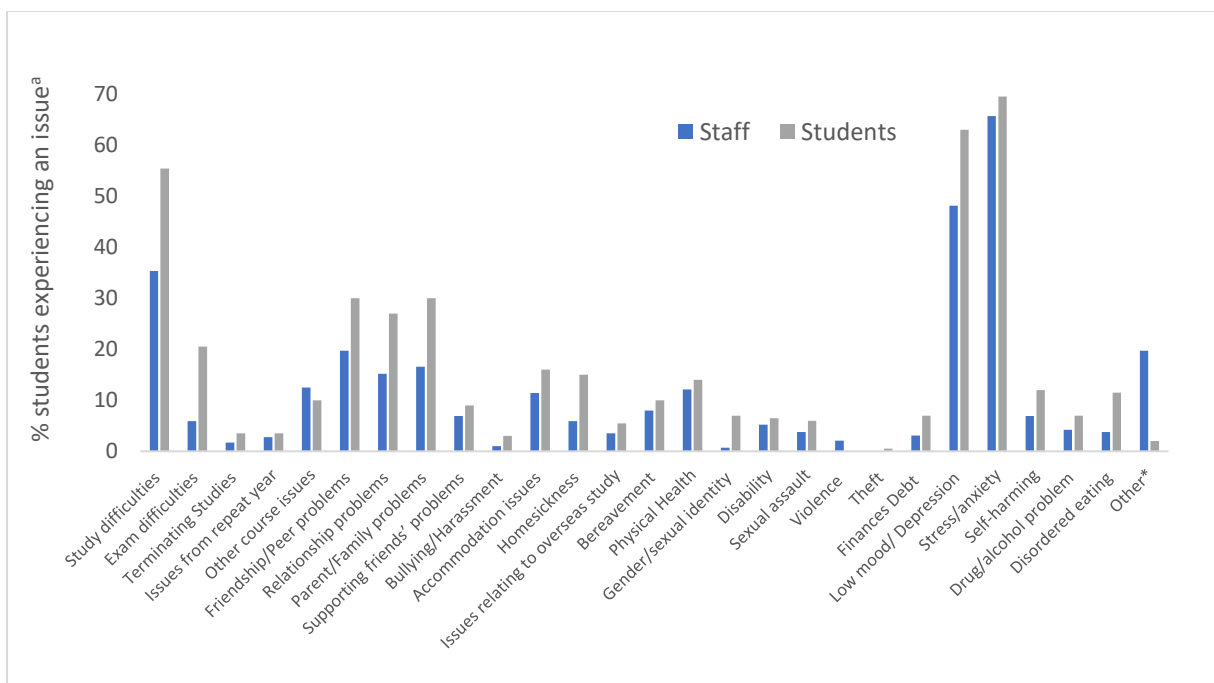
a) Axis censored at 70% to accommodate smaller values

The most common student concerns were study and exam difficulties, accommodation issues and friend, family and relationship problems, alongside low mood, stress and anxiety. However, students were also seeking wellbeing support for other difficulties such as homesickness, physical health, bereavement, supporting friends, disability, and self-harming and in greater numbers than for concerns like alcohol/drugs, disordered eating, financial worries or harassment/assault (Figure 6.1).

The mental health and wellbeing concerns seen by the two teams were broadly similar. Residential Life saw slightly more accommodation and homesickness issues and Wellbeing advisers saw more study and course difficulties (Figure 6.2). Wellbeing advisers appeared to see more stress, anxiety and low mood than Residential Life advisers.

Figure 6.2 Nature of Presenting Issues Seen by Wellbeing and Residential Life Services as Reported by Advisers
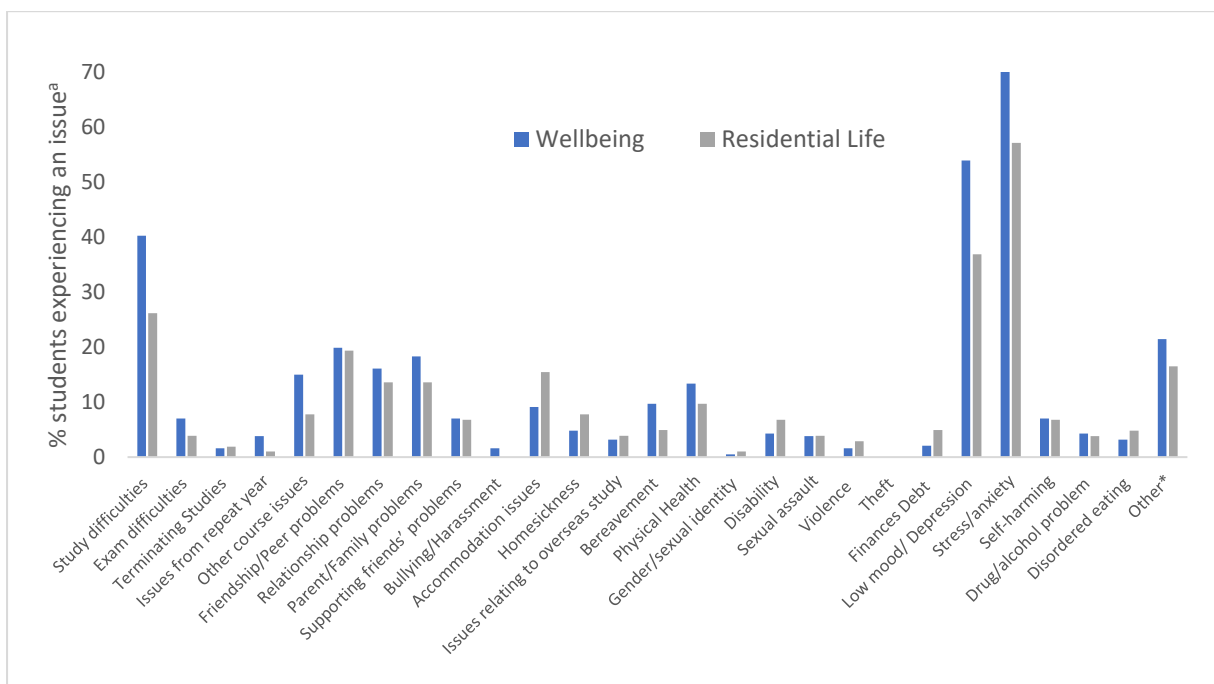
a)   Axis censored at 70% to accommodate smaller values

Altogether 20% of presenting issues were logged by advisers in the 'other'* category which allowed for free-text responses not covered by tick box category. These responses included more serious mental health disorders such as bipolar, paranoia, post-traumatic stress

disorder (PTSD) and obsessive compulsive disorder (OCD), as well as sleeping problems, isolation and loneliness, and concerns about unrest in a home country. More than a quarter of all 'other' issues (n=15) include reference to suicidal thoughts or a suicide attempt.

6.7.4   Service accessibility and student satisfaction (Objective 6b)

Students were asked how easy it was to get an appointment (see Figure 6.3), with more than three quarters (77.5%) finding it *fairly or very easy* to book a meeting with an adviser, and only 4.5% finding it *fairly or very* difficult. A greater proportion of students using Residential Life (65.5%) found it *very easy* to make an appointment compared to students using the Wellbeing Service (35.4%).

Figure 6.3 Student Perception of Accessibility of New Wellbeing Services
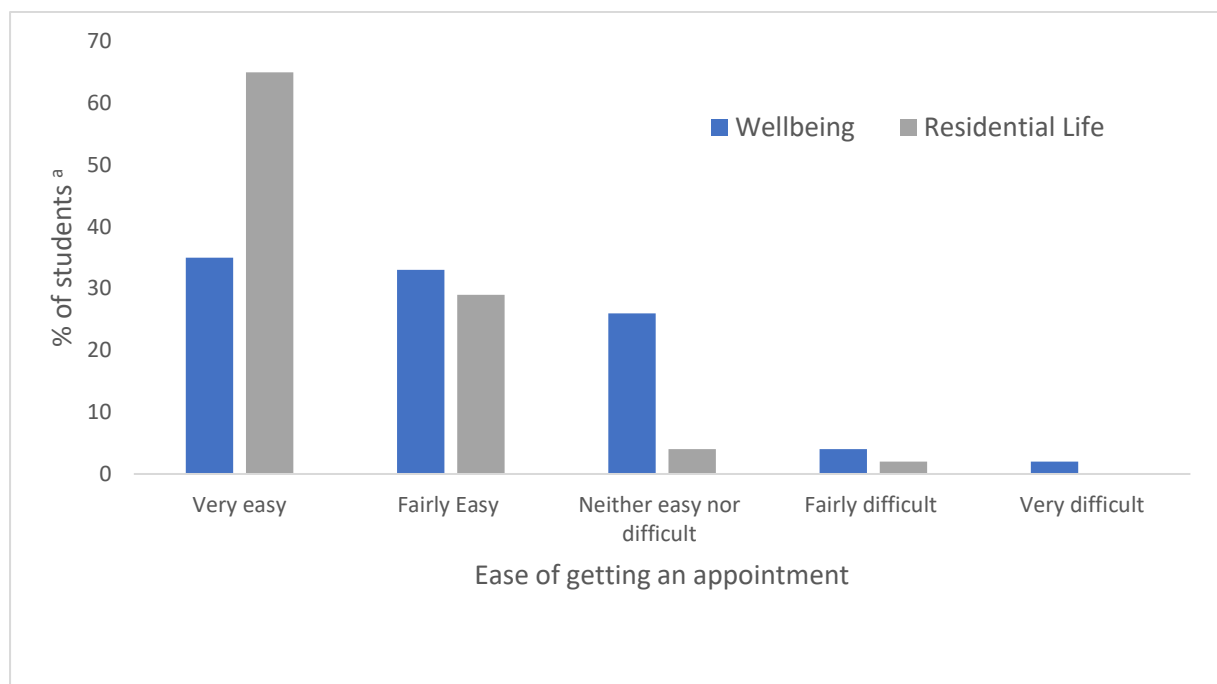
a)   Axis censored at 70% to accommodate smaller values

The *Follow-up Student Survey* asked '*how helpful*' the session had been, with more than three quarters of students seeing Wellbeing (76.4%) or Residential Life (75.0%) finding the new services *very* or *fairly helpful* (see Figure 6.4). Less than 10% found them *very* or *fairly unhelpful*. The greatest levels of perceived helpfulness i.e., *very helpful*, were higher for the Wellbeing service than for Residential Life (OR 1.68, 95%CI 0.70 to 3.97) but not statistically

meaningful. There were no significant differences in students' experience of support helpfulness between academic faculties (X^2 (10, N=29) = 14.87, p =.137) or residential villages (X^2 (4, N=22) = 3.28, p =.511) after the question was added in February 2020.

Figure 6.4 Student Perception of the Helpfulness of the New Support Services
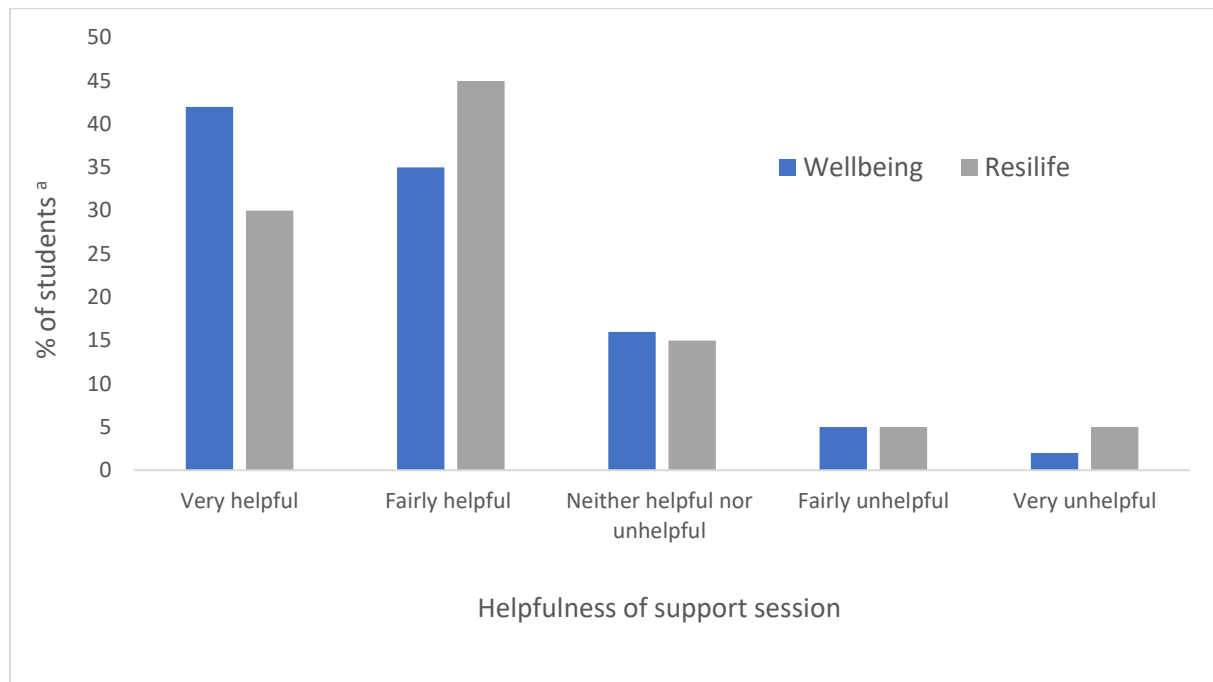
a) Axis censored at 50% to accommodate smaller values

Almost a third of respondents chose to leave additional information about their experience, with the majority of it positive, such as '*very welcoming*', '*really supportive*'. However, negative comments included speed of response, inflexible office hours or perceived lack of concern, for example '*they don't care*'.

6.7.5 Support setting, and advisory action (Objective 6c)

6.7.5.1 Support setting

The majority of students (86.9%) were seen face to face by wellbeing advisers (see Figure 6.5). Phone and email were the most used remote methods of contact, with no online (skype) meetings recorded in the two census weeks, something likely to have significantly changed post-Covid-19. Meetings were mostly pre-booked (and face to face) either on campus (64.4%) or in halls (10.7%) and a much smaller number were drop-in sessions (11.8%). Wellbeing

advisers used email for some advisory contact in the census weeks whereas Residential Life advisers did not use this method at all; however, contacting students by phone was similar across services. There is a possibility that phone-calls and emails were under-recorded.

Figure 6.5 Percentage of Students Seen in Different Support Settings Across Each Service
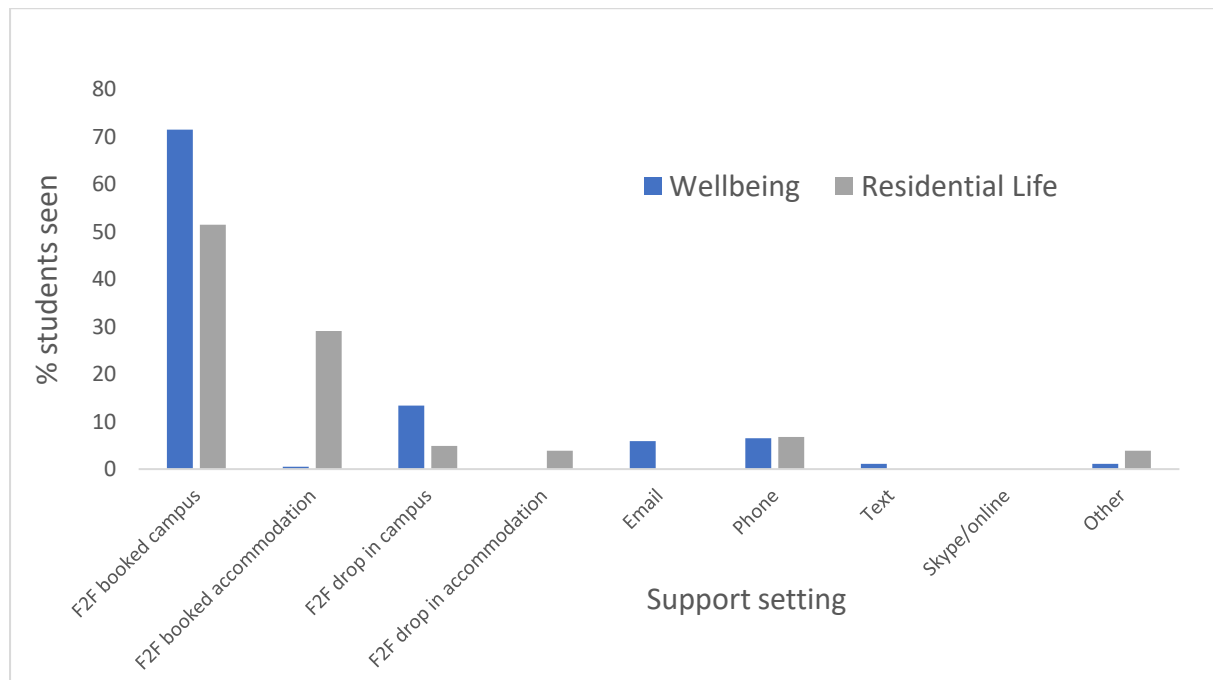
a)   Axis censored at 80% to accommodate smaller values

6.7.5.2   Advisory action

More than two thirds (68.2%) of all interactions involved signposting with the student taking some responsibility for next steps, and in a third of cases (32.9%) advisers made referrals as shown in Figure 6.6. Other actions specified by the teams that were not signposting or booking another appointment, involved offering self-help information or further resources. The main service differences included: Residential Life liaising less with academic departments and closing fewer cases. More than ten percent of adviser actions were recorded as 'other'. The majority of the free text responses included providing advice, workbooks or offering another meeting. Other actions included helping the student to fill in forms e.g.,

extenuating circumstances[37] study forms, or moving them to a priority transfer list into other support services.

Figure 6.6 Advisory Action After Student Support Interaction
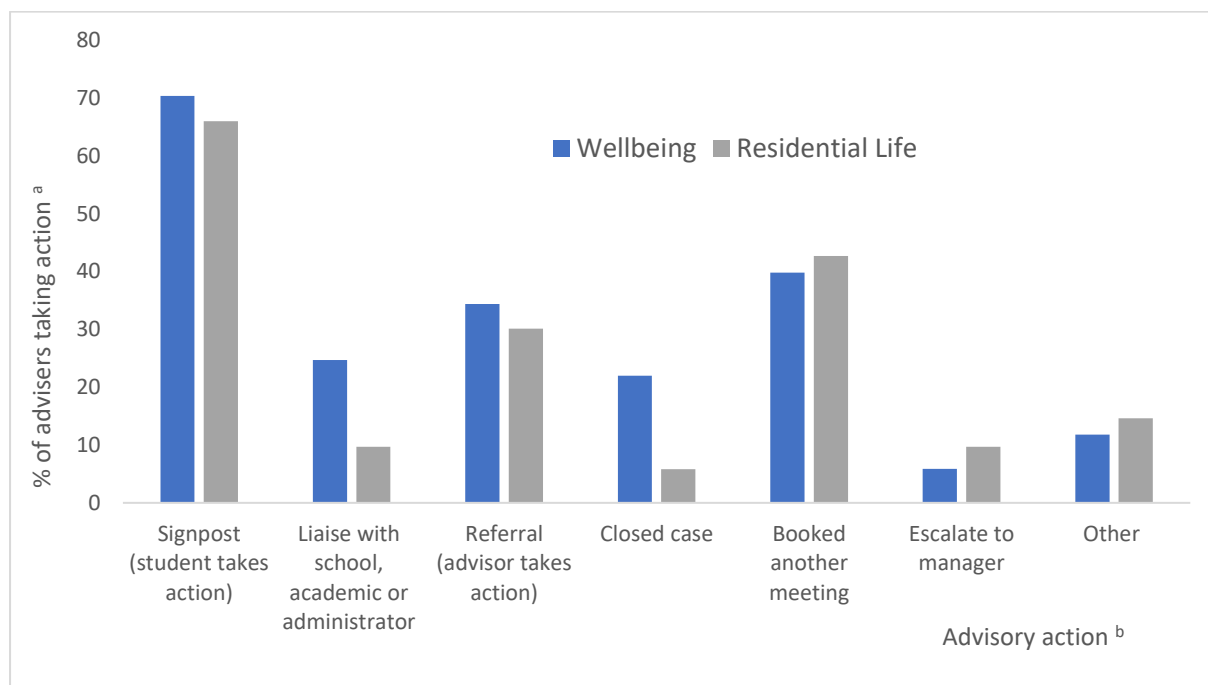
a) Axis censored at 80% to accommodate smaller values
b) Totals not 100% as more than one action could be selected

6.7.6   Appropriateness of support and staff confidence (Objective 6d)

6.7.6.1   Appropriateness of adviser caseload/mix

Despite the more clinical nature of some issues recorded by staff and students, Wellbeing and Residential Life advisers agreed that most students (95.8%) seen in the census periods were coming to the right service. In very few support encounters did Wellbeing (3.2%) and Residential Life (5.8%) advisers think the student should have been directed elsewhere, e.g.,

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[37] Extenuating Circumstance forms allow students to ask for mitigation if their studies have been significantly disrupted by personal or health problems, disability or specific educational difficulties

Student Counselling. Reasons for considering the service inappropriate for a student included: students needing more complex care than wellbeing advisers could provide, students specifically wanting counselling, or student offered counselling but preferring to work with wellbeing[38].

6.7.6.2 Adviser confidence

Staff were asked how confident they were in the actions they took to support a student and Figure 6.7 shows that most advisers (97.6%) were *completely or mostly confident*. In general, Wellbeing advisers were slightly more confident than Residential Life advisers but not significantly so - X^2 (1, N=289) = 3.27, p =.07). If an adviser had indicated anything other than *completely confident,* they were asked to give more detail and comments included: complex issues and serious situations which require further input; students not being able to access counselling or more suitable support; a need for training in bereavement/panic attacks and more practical tools; language barrier and cultural concerns; or a need for further input from faculties or academics.

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[38] Many of these issues will have been addressed by the triaging process of 'Wellbeing Access' – see 1.9

Figure 6.7 Adviser Rated Confidence in Action They Took to Support Students
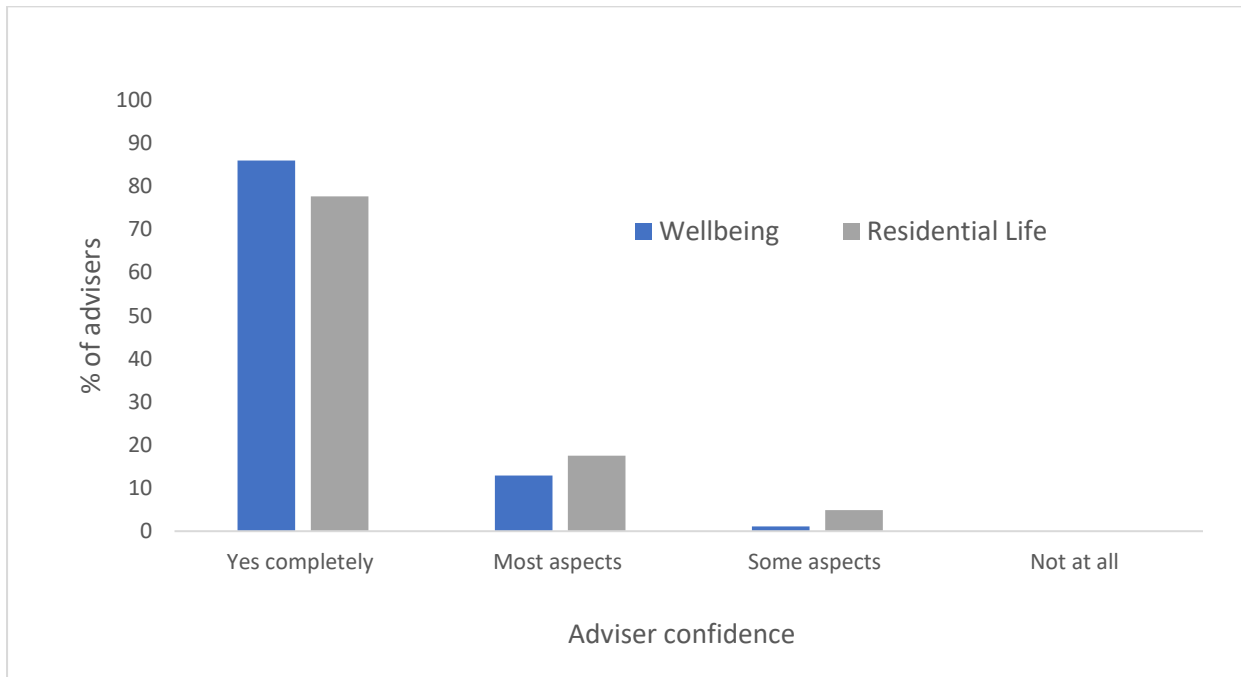
6.8   Chapter summary

This study aimed to characterise students using the Wellbeing and Residential Life services and explore staff and student views of the new support. The service data and survey findings indicate each service was typically seeing just over 100 students a week[39], and those seen typically had poorer mental health and lower levels of wellbeing than the wider student population, suggesting the case-mix was appropriate. There were some indicators that the service may be underused by several student groups identified in the wider cross-sectional *Student Wellbeing Surveys* as vulnerable to poor mental health such as international, minority ethnicity and postgraduate taught students. Wellbeing services might arguably expect to support greater numbers of these students not fewer. Minority gender and LGBTQ+ information was not recorded because of a need to keep the survey focus as brief as possible. Nevertheless, it is highlighted elsewhere in the literature as a risk factor and while I cannot

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[39] Note Wellbeing service response rates were higher than Residential Life

comment on whether the services were reaching these groups, a number of students did record issues related to gender/sexual identity, but with far fewer staff reporting the same concerns which may indicate an embarrassment or reticence to share those issues with advisers.

In general, the Wellbeing and Residential Life advisers were seeing a broad range of student problems, with the main presenting issues being stress, anxiety and low mood, alongside study concerns and relationship problems. However, both services were also seeing more serious mental health concerns. Advisers largely agreed they were seeing the right students and the wellbeing services were being appropriately used, with staff confident they could help students by signposting, making referrals, and offering ongoing advice. Students in general were happy with how easy it was to get an appointment with advisers, with Residential Life seen as easier to access than Wellbeing advisers, and more than three quarters of students found the wellbeing support they received either *very* or *fairly* helpful.

Chapter 7 The student and staff wellbeing support service experience - focus groups and interviews

7.1 Chapter overview

In this chapter I use qualitative methods to examine in detail how the university community experienced the new wellbeing support services. I captured a broad range of staff and student views in almost 2,500 minutes of focus groups and semi-structured 1:1 interviews carried out between November 2019 and August 2020. The qualitative component provides a better understanding of the new services' impact on student wellbeing and perception of support, investigating how they might have influenced people's experiences of the university system in which they operate. This chapter includes: a description of study design and theoretical approach, qualitative methods and procedure, and a full account of the analysis and findings.

7.2 Research aim

To examine staff and student views of the introduction of new wellbeing services at a large UK university: A qualitative account of the lived experiences of those using and working alongside non-clinical 'whole university' student support services (**Objective 7).**

7.3 Research Design

As advocated by the MRC complex intervention evaluation framework described in Ch.3, I have used a pragmatic qualitative approach to investigate how and why new wellbeing services may benefit student wellbeing from the perspectives of key stakeholders (Skivington et al., 2021). I conducted forty focus groups and 1:1 interviews, fourteen months after the services introduction in September 2018. Staff and student perspectives provided detailed insight into the operation, perception and experience of having the new wellbeing advisers in schools and halls, describing service impact on the whole university population and wider organisation. At every stage in the design of this qualitative study, decisions were supported and informed by stakeholders, in line with the co-production principles outlined in 3.9 and the Mental Health Charter (Hughes & Spanner, 2019). The original research had been due to finish before the end of the academic year in June 2020, but more than half of the focus

groups and interviews were delayed by ~8 weeks after the Covid-19 pandemic closed institutions across the UK in March 2020. I conducted the remaining focus groups and interviews online, achieving what I originally intended for data collection.

As outlined in 3.5.4, I used Braun and Clarke's updated reflexive Thematic Analysis (TA) approach in both design and analysis (Braun & Clarke, 2006; 2021d); with added awareness of my realist perspective (Bhaskar, 2010; Braun & Clarke, 2021d, p. 179). I examined the narrative data i.e., focus group and interview transcripts, to inductively identify shared patterns of conceptual meaning or 'themes', making no explicit or explanatory theoretical assumptions (Braun & Clarke, 2021b; 2021d, p. 157). Braun & Clarke advocate that themes do not simply 'emerge' from the data as if they already exist, like 'diamonds in the sand' waiting to be discovered (@drviclarke, 2021, March 28). Rather, they argue that themes are 'developed' by a reflexive researcher (or research team), a process more analogous to 'sculpture' than 'archaeology' (Braun & Clarke, 2013, p.225). That process corresponds with contextualist and critical realist perspectives of meaning and experience i.e., that each participant and researcher has brought their own 'worldview' to data captured by qualitative methods (Pilgrim, 2014). Therefore, as described in 3.5.4, to avoid imposing a positivist paradigm of a 'right' answer in the data, I did not use a rigid double-coding framework i.e., working with an independent researcher to ensure consensus on codes and candidate themes (Braun & Clarke, 2016). Nevertheless, I undertook regular, collaborative discussion of the coding, analysis and findings with my supervisory team.

7.4   Methods

7.4.1   Sampling, information power and recruitment

I recruited staff and students from across the university, using purposive and then snowball sampling methods (Ritchie et al., 2013). An a-priori list of sampling criteria was agreed to include a broad range of experience and backgrounds (see Table 7.1) and where appropriate, interested parties were asked to share the study information with their networks. The projected sample size was pragmatic - informed by Malterud et al. (2016)'s concept of information power i.e., the sample is determined by information richness across a dataset. It differs from the traditional concept of 'saturation' i.e., a point in which collecting new data no longer adds new insights to the analysis (Morse, 1995). Braun and Clarke (2021) have

recently argued that 'saturation' is difficult to justify methodologically and philosophically with little practical consensus on what 'enough' data looks like, and they caution against its use in reflexive TA.

I combined focus groups and interviews to enhance data collection and triangulation, and because the 1:1 interviews would be covering personal experience of a sensitive nature which may have been difficult to share in a group situation (Lambert & Loiselle, 2008; Ritchie et al., 2013, p. 213). For the practicalities of focus group size, Braun and Clarke (2013, p. 115) suggest six to eight participants, however the supervisory team had experience of study recruitment dropout in student research settings which is often seen elsewhere (Carlsen & Glenton, 2011). Therefore, a pragmatic solution was to oversample, aiming for approximately ten participants in each focus group, with an understanding that larger groups are successfully employed elsewhere in healthcare research, but there might be a trade-off in depth and breadth of data to aid study management and administration (Kitzinger, 1995). My recruitment and fieldwork were carried out concurrently in the academic year after the introduction of the new wellbeing services.

7.4.1.1   Staff focus groups and interviews

Students come into contact with a broad range of university employees, but the scope of my research meant a need to focus on those whose work was directly impacted by the service changes. Therefore, the staff focus groups included the new wellbeing adviser teams and other key university stakeholders involved in supporting students e.g., tutors/supervisors, clinicians, administrators, other support services, and SU representatives (see Table 7.1). All staff needed to be currently employed in the institution in which the research took place, with academic and professional staff contracted from at least the start of academic year 2017/2018, allowing them to make informed comparisons between the old and new support service models. Wellbeing and Residential Life advisers needed to have been employed since the launch of the new services i.e., September 2018.

A recruitment invitation was sent out in two staff newsletters (~6,000 employees) in November 2019 and April 2020 asking staff to email me for more details. Senior staff from the Steering Group and my staff contacts also distributed an email invitation and Participant

information Sheet (PIS) to their networks. Respondents were added to a database of potential participants, and in consultation with the supervisory research team, a sub-sample were later allocated to a focus group based on their role and availability. Broad representation of all groups was achieved in this way without needing to recruit any individuals by approaching them directly. Once allocated to a focus group, staff were re-sent the PIS and a consent form to complete and return, either on or before the scheduled focus group (see Appendix Q.1-2). All employees taking part were offered refreshments to compensate them for their time.

7.4.1.2   *Student focus groups and interviews*

I purposively recruited student participants into three focus groups; one for postgraduates, one for undergraduates and one for students living in halls of residence – focus group participants were not selected on the basis of actually having used a service (see Table 7.1). In contrast, students recruited for interviews had specific personal experience of wellbeing service use. All students were recruited to focus groups (and some interviews) via adverts in the student newsletter (~28,000 students) and on the SU Facebook page (~20,000 students) in November 2019. In June 2020, the Wellbeing Service emailed all students who had used the service in the previous 12 months, and Residential Life contacted every student then living in hall, with further invitations to take part in a 1:1 interview. Students were offered a £20 Amazon voucher and refreshments as both incentive and acknowledgment of their time. I added all interested students to a database of potential participants and selected final participants against my a-priori criteria in consultation with the senior academic team (Table 7.1). Students were also sent the PIS and consent form to complete and return, on or before the focus group (see Appendix Q.1-2).

Table 7.1 Sampling Characteristics Used to Recruit Staff and Student Focus Groups and 1:1 Interviews

Staff focus group	Student Focus group	Student 1:1 Interviews
Tutor/Senior Tutors/Supervisors	Undergraduates	Male/Female
School/Faculty office administrative staff	Postgraduates	White/Black/Asian/Minority Ethnicity
Uni Professional Services	Students in hall	Disability

Clinicians (GP, Counsellor)	Home/International
Students' Union reps	Undergraduate/Postgraduate
Wellbeing advisers	Age - to include mature (over 21 years)
Residential Life advisers	Residential village (x 3)
	Faculties (x 6)

7.4.2 Topic guides

I created four separate topic guides for i) student focus groups, ii) staff focus groups, iii) wellbeing adviser focus groups, and iv) student interviews (see Appendix Q.3). I developed them in collaboration with senior mental health researchers, senior Support Service professionals, Wellbeing and Residential Life teams and the students in the study PPI group. Each contained 10-12 open questions with a number of detailed prompts. Questions comprised: overall perception of the new services; understanding of what they do; contact and experience of using or working with services; and more general feedback about what worked well and what could be changed. I updated the topic guides during the research period (April 2020) to include a question about the impact of the 'one point of access' system (Wellbeing Access) and to reflect any changes after UK pandemic restrictions were introduced in March 2020 (note that I have not reported here on any narrative data which reflects material service changes in response to the Covid-19 disruption).

7.4.3 PPI involvement

The research PPI group commented on the draft participant information sheets and topic guides for the student interviews and focus groups (March 2019). I revised the topic guides after their input e.g., they highlighted the importance of student views on factors that might impact someone getting support or not. The PPI team also informed the recruitment process, with suggestions for maximising engagement e.g., advertising through sports groups and kitchen posters, and using (non-gendered) shopping vouchers to incentivise a broader uptake. Three students from the PPI group also contributed to discussion and reflection of theme development and interpretation of findings.

7.4.4 Data collection

7.4.4.1 Sample size

More than 400 staff and students (n=97; n=387) initially applied to be part of the study. As a consequence of the level of interest and the oversampling strategy, the first research focus groups were larger than I anticipated, e.g., 11 or 12 participants, which required closer attention to ensuring everyone had an opportunity to contribute but arguably enhanced the breadth of data collection. After campus closure (UK pandemic lockdown) in March 2020, the fieldwork had to be paused temporarily. When the focus groups and interviews moved online in May 2020, it became apparent that remote groups would be improved with fewer participants - with the online environment proving more challenging for natural discussion. Therefore, the later focus groups were either sub-divided or reduced in size (from n=11 to 12 to n=5 to 7) in order to give all participants the time and opportunity to contribute. Due to the changes in timings, some participants were no longer able to take part (or preferred not to do so remotely).

Similarly, due to the large number of students applying to take part in the interviews, all applicants were then sent a short form asking them to detail: course, year of study, fee status, school of study, and residence, which supported the selection process against the a-priori student characteristic criteria. Once again, due to Covid-19 disruption and changes in timings, some recruited participants were no longer able to take part. I discussed the reasons given with the advisory team, but they were not considered to be systematic. For example, one participant felt uncomfortable with so much time in online meetings/seminars, another participant had moved department, and a third had childcare constraints.

7.4.4.2 Staff and Student focus groups

Staff and student focus groups which took place before UK Covid-19 restrictions were conducted in central university meeting rooms or private offices. I led the focus groups, with larger groups (i.e., more than 7 people) with a second researcher present i.e., a postgraduate or senior researcher. I conducted the focus groups which took place after UK Covid restrictions online i.e., March 2020 to Sep 2020, using university approved video-conferencing software e.g., Blue Jeans (Verizon) and Microsoft Skype for Business. All staff and students were sent two meeting reminders and where possible offered an opportunity to join another

group if they were unable to attend the date offered. Each group was scheduled for an hour and recorded using encrypted smartphone technology, with notetaking by a second researcher. I used the semi-structured questions as a guide but did not follow them prescriptively, allowing the group some flexibility in discussing the issues that were salient for them, but with my oversight and direction to ensure all topics were covered and all participants given an opportunity to contribute.

7.4.4.3   Student interviews

I conducted the student 1:1 interviews in university meeting rooms or public/private spaces, which afforded enough privacy for the interview to be confidential, but for the participants to be comfortable. After UK Covid restrictions were introduced, I interviewed participants remotely using the video conferencing software with confirmation that students had a safe and private space in which to speak[40]. All interviewees received an email information sheet and consent form when the interview was confirmed, and then again just before the meeting. All interviews were scheduled for an hour and recorded using smartphone technology. I took a similar conversational approach, allowing the participant flexibility to discuss detailed context where it was relevant to their individual experience with the wellbeing services.

7.4.5   Data management and ethical consideration

As described in 3.9 a full research protocol was observed, and ethical approval was granted. Written informed consent (and e-signature after April 2020) was obtained from every participant in the study. All contributors and interviewees were offered the opportunity to withdraw their data both before, and immediately after, the focus groups and interviews. A distress protocol was in place for potential issues arising from the sensitive nature of the subject matter. Any serious concerns for a participant (or another's) welfare could be escalated to the research supervisory team, university wellbeing services, or emergency

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[40] Only one participant did not have a private space to speak (they were looking after a young relative) but preferred to go ahead with the interview.

services if appropriate or necessary. All participants were debriefed at the end of the groups/interviews and given a list of support contacts.

All interviews and focus groups were audio-recorded in line with the institution's mobile data policy. Focus group and interview recordings were uploaded to a password secure server within a reasonable time frame (<12hrs). Five recordings were transcribed by the researcher; n=35 recordings were transferred as encrypted files to a university approved transcription service, where they were transcribed to written copy, and all identifying features removed. A confidentiality agreement was signed prior to this work commencing. All participants were made aware that the anonymised transcript data might be published and held in an open access repository for future research purposes (Appendix Q).

The audio files were kept in a password protected file that only the study team had access to. Storage of all data complied with the university's data protection policies – see 3.9.

7.5   Analysis

As outlined previously, I used reflexive thematic analysis, employing the latest iteration of Braun and Clarke's thematic framework, which was being updated during my analysis process and published on social media ahead of new guidance released in the Autumn 2021 (@drviclarke, 2021, March 28; Braun & Clarke, 2021a; 2021d, p.35). All six steps of their revised framework (Table 7.2) are covered in detail in the following section.

Table 7.2 Braun & Clarke's (2021d) Six-Phase Framework for Reflexive Thematic Analysis

Step 1: Familiarisation	Step 4: Developing and reviewing themes
Step 2: Data coding	Step 5: Refining, defining and naming themes
Step 3: Generating initial themes	Step 6: Writing up

7.5.1   Step 1: Data familiarisation and writing familiarisation notes

Data familiarisation was an ongoing process. I double-checked and anonymised every focus group and interview after transcription. This took place in parallel with the fieldwork, meaning early data familiarisation informed subsequent data collection. Before I began coding, I re-reviewed the transcripts and recordings, making general notes with the Microsoft Word comments tool. My final examination of all transcripts was carried out over a two-week period before they were moved onto a research software platform.

7.5.2   Step 2: Systematic data coding

The anonymised and annotated transcripts were uploaded to NVivo-12, an established qualitative software tool (QSR International Pty Ltd, 2020). I generated short statements (codes) systematically, capturing either descriptive or latent concepts in the narrative accounts e.g., *'professional and boundaried services'*, *'the adviser remit is too broad'*, *'Resi-Life as reactive not proactive'*, *'a confusing system to navigate'* or *'too hard to reach out'*. Using 'complete coding' across the whole dataset, the codes were developed inductively for everything considered of relevance to the research question. I initially coded the student interviews, followed by student focus groups, then staff focus groups using the three lists of codes to determine whether I could treat them as one dataset for theme generation. Not unexpectedly, the breadth of the research question generated many initial codes (n=431) with considerable overlap, informing my decision to proceed on that basis (see Figure 7.1). As described in 1.9, the new wellbeing services were evolving during the research period (and later significantly disrupted by the pandemic), therefore I also concentrated on developing broad themes which were not dependent on any ongoing material changes in service delivery, transcending what might be temporary features.

Figure 7.1 Themes Developed from Three Categories of Data Analysed as One Dataset
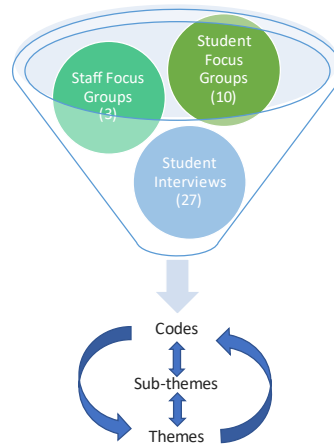
During this process, codes were regularly reviewed and collapsed into hierarchies and categories using the software, an efficient way of managing and organising the large number of concepts. The team met weekly to discuss and review the analysis and ensure the coding process supported and reflected the research aim and chosen methodology.

7.5.3 Step 3: Generating initial themes from coded and collated data

As described earlier, coding and generating themes was not a linear process; I captured very early thoughts and patterns in a reflexive journal, a process designed to challenge my preconceptions and offer an opportunity for others to engage in my early interpretation (Braun & Clarke, 2021d, p. 19; Gerstl-Pepin & Patrizio, 2009). As such, it contained comments, links and simple mind-maps of the data, starting as a written journal and a Microsoft Excel spreadsheet (during Step 1), and later becoming (Steps 2-5) a combination of thematic maps, handwritten notes and NVivo memos (Figure 7.2). A key priority was to avoid simply categorising topics as they appeared in the data (arguably creating a deductive reflection of the topic guide) but to capture broader patterns e.g., ideas and concepts that recurred regardless of specific group/interviewee or discussion. The thematic maps offered a template for identifying and developing provisional candidate themes, i.e., organising concepts, and sub-themes i.e., a single aspect of an organising concept, and the relationships between them.

Figure 7.2 Examples of Reflexive Handwritten Journal notes/Mindmaps/NVivo 12 Memos and Excel Spreadsheet Notes Informing Development of Codes to Candidate Themes
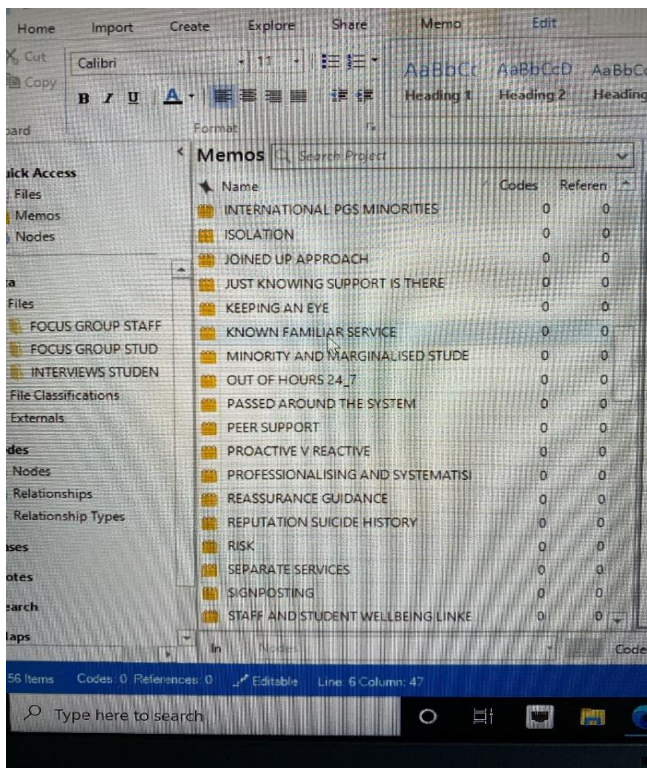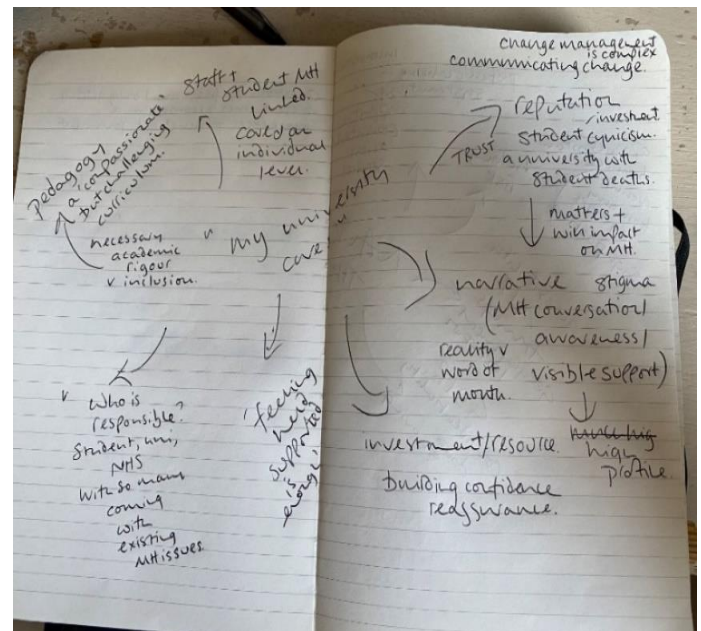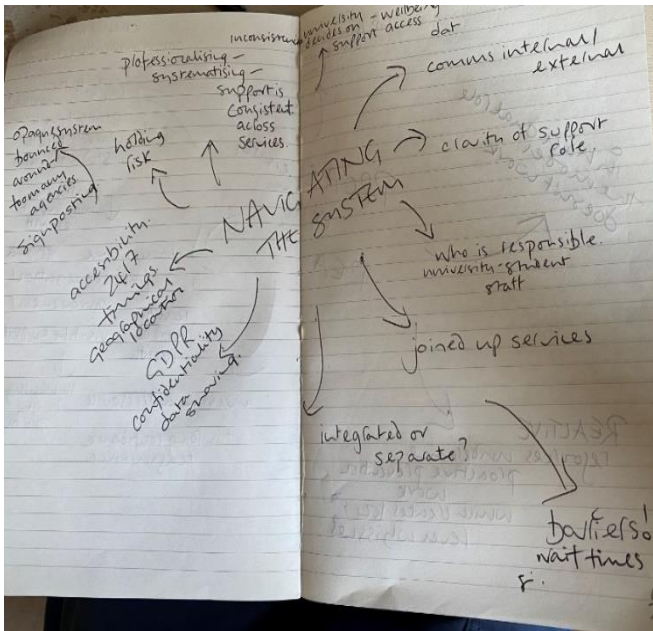
Candidate theme	Candidate sub theme	Codes	Meaning	Reference/Quote
Trusted Friend	Trusted Friend Gateway to support	Familiar face Gateway to support Signposting What services do Personal relationship First point of contact Timely/accessible support	Trusted friend/Filling a gap: timely response(you reach out and don't have to wait but has issues for more serious for whom it's just another hurdle to jump) signposting, gateway to other services, low level support, familiar face, timings and response, emergency service, barriers, feeling heard/reassured-this has worked to fill a gap for Wellbeing but not the RL model and the consistency of provision between first years and rest is questionable .	
My University Cares	Narrative Responsibility Whole University cultural change Visible Services	Responsibility (whose)- resource and investment Cultural shift *Getting to the hard to reach* Comms and narrative Highly visible support services Risk (parents and staff reassurance) Confidence Reassurance Whole university - staff students - pedagogy Numbers of students-anonymity of system as it grows *I belong (minority/variation in support)*	
Joined up approach	Clarity of roles Comms Consistency	Comms between services Clarity of roles GDPR and confidentiality Wellbeing support is improving Responsibility (whos) Training and CPD Feedback, evaluation and research	
Reactive v proactive	Whole university Reactive v proactive for services Reactive v proactive for individual	Prevention Opening the floodgates/resource/caseload Resi Life dual role Hard to reach and systematic checking Complex MH needs growing Research and feedback to build on what works and iterate systems	This two fold:Idea that the services were as much about creating cohesive communities (RL) and helping students to support themselves (WB) with psychoeducation workshops etc. But 'opening the floodgates' means that service could only largely be reactive and this continues into covid, it wasn't just a launch thing. Critically this is where the RL system definitely not working - basically all the issues with dual role and many hats - Sheffield unpicking their system. Secondly the idea of systematic check in, staying on top of those hard to reach students. Should the system be tracking/picking them up or waiting for the student to come to them? Is the university a passive player in this regard.	
BELONGING		Minority representation, PG/Ugs Belonging and community RL shifts and WB more part of team I belong (minority/variation in support)		

With the supervisory team meeting regularly to discuss data interpretation and theme development, the recursive nature of the reflexive TA process i.e., 'rigorous coding' followed by a 'tussle' with the data to answer the research question was well-suited to those collaborative meetings. Early thematic ideas were also explored in conversation with other academics with qualitative expertise in the field and three members of the student PPI group. Braun and Clarke contend *"if more than one researcher is involved in the analytic process, the coding approach is collaborative and reflexive, designed to develop a richer more nuanced reading of the data, rather than seeking a consensus on meaning"* (Braun & Clarke, 2019, p. 594).

7.5.4   Step 4: Developing and reviewing themes

The initial thematic maps were expanded into Microsoft Word table (Figure 7.2), at which point all the codes were reconsidered. At this stage several codes were deleted because they were peripheral to the research question, some again collapsed into one code, and others I saved as miscellaneous. After extensive re-examination and revision (leaving n=323 codes), I developed four final candidate themes, with potential for a fifth. At this point the team met bi-weekly to discuss the reordering of the coding foundations. A new Microsoft Excel document and early thematic model mapped the process back to early candidate themes and sub-themes generated in Step 2 (Figure 7.2).

7.5.5   Step 5: Refining, defining and naming themes

Braun and Clarke (2013 p. 337; 2014) define themes as *"useful, accurate and fair reflection of patterns of shared meaning in the data, united by a central organising concept"*. They refer to themes as *"stories"* developed in the data, as opposed to summaries of topic responses generated from interview and focus group questions without the underlying shared conceptual significance. While the sub-themes reflect single aspects of an organising theme, they also help to further delineate and navigate conceptual boundaries, serving "*the purpose of telling the strongest story about the data*" (Braun & Clarke, 2021d, p. 88). Each candidate theme had 2-4 sub-themes, developed with an awareness of the tension between structural complexity and analytical depth (Braun & Clarke, 2021d, p. 87; Trainor & Bundon, 2021). A decision was made to start writing the chapter and make final refinements to the thematic framework alongside the writing process. Therefore, the process of defining and refining

themes was again recursive and overlapped with the final stage, Step 6. This intuitive reflexive and recursive process was later validated by the first published worked example of a Braun and Clarke analysis using the same process (Byrne, 2021)

7.5.6   Step 6: Writing the report

I developed the final five themes and their sub-themes into a report format from the draft thematic tables and map, and my writing iteratively informed revision of the final summary table and thematic model (see Table 7.5 and Figure 7.3). As mentioned in 7.5.4, my initial reporting of the first four themes supported the decision to include the fifth, as the evidence for it became clearer. Codes are presented in *'single quotation marks and italicised',* themes and sub-themes are in 'single quotation marks', and direct quotes from staff and students are in *"double quotation marks and italicised"*. Detailed student descriptors are included e.g., **International UG First Year Humanities Male**, offering added context without identifying individuals; however where necessary, some elements of descriptors have not been included e.g., **International UG Third Year [course omitted] Female**, in order to preserve anonymity in the specific context in which they appear. Finally, rather than reporting my qualitative findings and discussion in one 'report' (or thesis chapter) as more recently advocated by Braun and Clarke for reflexive TA, I present results here, followed by final separate synthesis and discussion (Ch. 8) in order to integrate the mixed methods findings across all four research studies (Byrne, 2021; Braun & Clarke, 2021d, p. 131).

7.6   Results

7.6.1   Sample characteristics

I carried out 13 focus groups and 27 interviews between December 2019 and September 2020 capturing the views and experiences of 120 staff and students (see Table 7.3 and Table 7.4). Four focus groups took place on campus (face to face) and nine took place online; 12 interviews were carried out face to face and 15 conducted online. Sessions lasted between 30-80 minutes depending on group size and participant availability. Table 7.3 shows characteristics of staff and students who took part in the focus groups, while Table 7.4 shows characteristics of those taking part in the interviews. More than half of interviewees were female, with only one participant explicitly identifying as non-binary. Almost a third of interviewees were Black, Asian or minority ethnicity, and three students referred in their

interview to having a documented disability. Overall, while there appeared to be a gender balance in the staff and student focus groups[41] - an exception was the postgraduate group which was predominantly female.

Table 7.3 Characteristics of Staff and Students in Focus Groups

Focus groups (n=participants) n= number of groups (participants)	Location	Date
Staff[42]		
School/Faculty Office Administrative staff (11)	On campus	Jan 2020
University Professional Services (11)	On campus	Feb 2020
Students' Union staff and reps (11)	Remote	May 2020
Wellbeing advisers x 2 (7)	Remote	May 2020
Clinicians x 2 (7)	Remote	June 2020
Academics (5)	Remote	Sept 2020
Residential Life advisers x 2 (7)	Remote	June 2020
Students		
Postgraduates (12)	On campus	Feb 2020
Undergraduates (11)	On campus	Feb 2020
Students in hall (PG/UG) (11)	Remote	May 2020

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[41] Data concerning detailed staff characteristics (other than role or faculty) was not collected.
[42] For detail of staff roles see Appendix C

Table 7.4 Characteristics of Students in 1:1 Interviews

Characteristics (n= n/27 participants)		
Fee status	Home (19)	EU/International (8)
Course level	Undergraduate/Foundation/Exchange (19)	Postgraduate (8)
Residence	Halls (19)	Private accommodation (8)
Year	First Year (15)	Other (12)

Faculties: Arts, Engineering, Health Sciences, Health Sciences, Life Sciences, Science, Social Sciences and Law

7.6.2 Overview of thematic findings

The focus groups and interviews generated 2,500 minutes of rich narrative data examining the views and experiences of students and of staff working in the university between 2017 and 2020. Five themes were identified – 'Trusted Friend', 'A Joined Up Approach', 'Proactive versus Reactive', 'Belonging' and 'My University Cares'. The themes represent key concepts and shared patterns of significance drawn from the data (see Figure 7.3 and detailed overview in Table 7.5). Figure 7.3 illustrates where sub-themes are linked conceptually in the findings, for example – 'Timely and Accessible' (Trusted Friend) support is linked to 'Narrative' (My University Cares) for its potential to create a more positive perception of university support. While sub-themes within each candidate theme are necessarily linked to each other by the overarching concept, I have not illustrated that in the thematic model except where explicitly discussed in the findings. The following sections describe the themes and any relationship between them in detail, with student and staff views presented together as each facet of a theme or sub-theme is explored. Each theme has been summarised and will be further examined in relation to the quantitative studies (Ch.4-6) in a final mixed methods synthesis in Chapter 8.

Figure 7.3 Thematic Conceptual Model shows Themes and Sub-themes and Associated Relationships

Themes with corresponding sub -themes
Sub-theme relationships
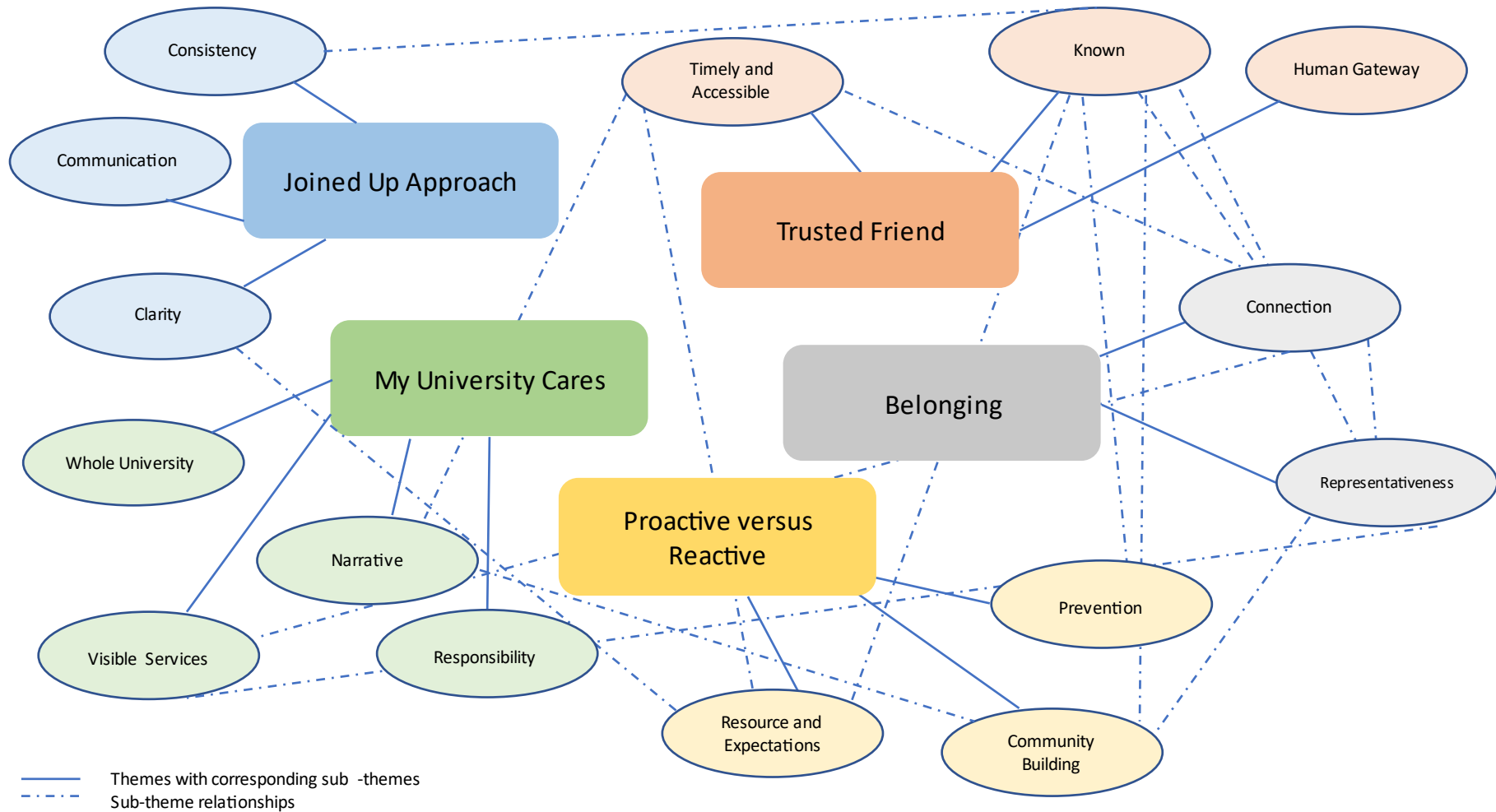
Table 7.5 A Summary of Themes, Sub-themes, Conceptual Meaning and Example Codes

Theme	Sub-themes	Meaning	Example codes
Trusted Friend	**Timely and Accessible**	Timely and accessible non-clinical wellbeing support. Reduced wait-times and clear alternative/addition to previous academic or clinical support pathways. Services offered advice and signposting to students with less complex needs e.g., stress, study, social, financial concerns. Quick access to appointments, but potential logistical issues particularly with geographical location of support in residences. The 24/7 nature of the service well-received by students and staff but with significant resourcing implications for residences-based team.	What services do e.g., practical advice Accessible help Low tier Timely, fast response I can't wait for help Accessibility of online forms First point of contact 24/7 and 9/5 Geographical location of support Challenges for Residential Life
	Human Gateway	Non-clinical, friendly, personal contact seen as offering short term advice and support, as well as a signpost and gateway to formal services. New services generally perceived as meeting their remit in response to students initially seeking support, but for those with more serious MH issues it could be another 'hurdle to jump'. Some students felt that advisers were 'powerless to help' and could only refer them on. Apparent that they added an extra level of welfare support (particularly in schools) but potentially still not reaching students who do not actively seek help.	Feeling heard Someone to talk to Signposting Gateway to other services Triage Unnecessary bureaucracy New services as powerless to help Too many people to talk to/repeating my story
	Known	Advisers in schools (in particular) welcomed by staff as additional support for themselves as well as students, but recognition that academics/administrators are still critical	Familiar face Personal relationship Academics as important

		for frontline wellbeing support despite the new wellbeing teams. Adviser familiarity and knowledge of students in schools and residences was seen as important. Mixed views on whether services were known and familiar to students, particularly in hall with nature of shift rotation and central hubs. Concerns that the disciplinary element to the Residential adviser role could also impact relationships on the ground. Similarly, without a visible presence in all halls, fear that some students who find it hard to ask for help may be missed.	Services as known and unknown Seeking a familiar face in hall Centralised support is less personal Hard to reach out feeling bad Neutral advice
A Joined Up Approach	**Clarity**	Confusion about what the new services are, who does what, where the services fit into the whole organisation and general clarity of Wellbeing and Residential adviser roles. Risk of students being bounced around the system, circular signposting or even students being missed. The new 'Wellbeing access' introduced in September 2019 may have mitigated this confusion for staff and students.	Clarity of roles Who is responsible Bridge between academics and counselling Navigating a confusing system Bounced around the system One point of access
	Communication	Change management process of support services was often seen as too fast and lacking thorough consultation by staff and Students' Union representatives. A common effect of intervention/system change or a specific institutional issue of poor communication that needs addressing? There was a perception that ongoing communication between all university support services, in particular the new services and academics, could be improved, as well as relationships which contribute to streamlined pathways. GDPR and confidentiality an issue for clear internal communications and for risk management. Evidence for need to find a balance in data	Communicating change An evolving service Comms between services Holding Risk Silo-ed information Information sharing Privacy and risk GDPR and confidentiality Fear of getting it wrong

		sharing as well as to address concerns about lack of integrated information-sharing platform.	
	Consistency	Consistency and quality of support, training, professionalising and supporting staff. Can one wellbeing advisory model serve a diverse community of different schools and halls? Service introduction and ongoing changes and development- are they evidence-based and evaluated? Without consistency, staff and students can find the model confusing.	Professionalising/systematising Adviser support quality/consistency varies Different needs in halls and schools Training and Continuous Professional Development (CPD) Feedback, evaluation and research Benchmarking
Proactive versus Reactive	**Resource and Expectations**	Juxtaposition of resource allocated versus expectation of the new intervention to offer responsive support as well as outreach and community building effort. Advisers found themselves 'overwhelmed' by the volume of students seeking support, with crisis/distress management prioritised at an apparent cost to prevention work. Set against wider discussion about rising student numbers, more students seeking support and institutional resource, strategy and responsibility. Residential Life described as particularly stretched and under-resourced. Perceived by services themselves and other staff as a model 'that's not working', although students in hall were less aware of internal staff strain.	Dual role Proactive versus reactive Opening the floodgates Pre-existing MH issues Increasing student numbers Complex MH Too many students to support Crisis management Resource and investment 24/7 and shift rotation RL role too wide a remit RL a tough role
	Prevention	Once a student was in the system, both adviser teams were described as good at proactively checking in and following up to prevent further individual problems. However, the model still relied on student actively engaging with services, raising further concerns that 'at risk' students (who have not disclosed a MH issue at any stage) can still be missed. Wellbeing service in schools	Follow up/tracking Keeping an eye Systematic check in Hard to reach Prevention of mental health issues Prevention/outreach work Tackling the causes of stress

		seen as starting to deliver on prevention/community building workshops, but Residential Life were less able to engage in effective outreach. Concerns that the lack of psycho-education work to help student to better support themselves may result in more students experiencing difficulties.	Feeling safe Psycho-education
	Community building	Clear evidence that Residential Life (with responsibility for out of hours and with the shift nature of employment) were unable to deliver community building resource in the form of social events. Findings reinforce the understanding that 'building communities' in hall is often key for successful transition, and that the new service role to help to create safe, cohesive communities is important and potentially currently not working.	Community building Less community in hall Where I live Resi-Life as helpful Differing needs in schools/halls Proactive wellbeing activities Proactive RL community building
Belonging	**Connection**	'Feeling connected' (for students and staff) has implications for service use but particularly for Residential Life. Recognition that for students a lack of early 'connection' can set them up for preventable issues e.g., loneliness, 'overwhelm', which then impacts support service operation. Further evidence for an absence of opportunities for students to make social connections in residences or faculties (see Community building) as well as the downstream influence of social issues or unsatisfactory accommodation allocation on services. Perceived culture of narrow social groupings, drug taking, excessive drinking, could be a cause of stress and distress with consequences for service provision. Apparent that some wellbeing support staff (especially in residences) do	Transition overwhelm Feeling connected Loneliness and isolation Feeling like an outsider Living arrangements matter Drugs and alcohol Positive experience Halls as homes RL advisers and belonging Staff belonging and student staff MH

		not feel connected either. Wider evidence that many staff, feel disconnected from the 'university' as a whole.	
	Representativeness	Feeling 'represented' has clear implications for perception and use of the new support services, which was linked to feeling valued, included and 'part of' the university. Suggestion that support can appear targeted toward white British younger undergraduates. Evidence that international students, postgraduates, mature students and those of minority ethnicity, gender, sexuality or from disadvantaged backgrounds may still find it harder to seek appropriate wellbeing support. Reasons included either a lack of reassurance that services will understand and reflect individual need; or an inability to approach services in the first place due to different cultural and social perceptions of help-seeking and stigma.	Culturally sensitive support I belong Services for home students not international Cultural differences Undergraduates get more support PGs get forgotten Gendered support Minority students need support International student wellbeing needs Barriers Services that reflect me LGBTQ+ support
My University Cares	Narrative	Reflects the influence of new service launch on institutional and cultural narrative. A vehicle for changing the mental health conversation to 'we care' - with highly visible support and wellbeing communications, raising mental health awareness, reducing stigma. Evidence that negative reputation can and does prevent students from seeking help when they need it. The lived reality of support experience however was largely positive which exceeded low expectations set by institution's reputational legacy.	Reputation Negative narrative Expectations and reality Word of mouth Wellbeing support is improving Raising mental health awareness We care Lip service and mental health priorities Cultural change
	Visible Services	Visible investment and resource as well as regular service nudges (i.e., reminders in the form of emails and social media) and clearer pathways to support (i.e., signposting) have increased confidence and reassurance in both 'finding' support and 'feeling' supported. Evidence for	Highly visible support services Confidence in finding support Feeling supported is enough Trust and confidence Reassurance

	increased positive student perception of university support even by students who have not used wellbeing services, largely due to support visibility and messaging. Similarly, students that found it too hard to reach out were aware services were there and available to them but were unable to engage.	Nudges Feeling safe Better support than other universities 'Harder to reach' students
Whole University	Idea that services cannot work to address student wellbeing in isolation. Reflects staff and student perception of a need for a 'whole university' approach e.g., cultural change, pedagogy, the links between staff and student wellbeing, social or accommodation issues, as opposed to simple resourcing of responsive support services. There was some ongoing cynicism about 'university' motivation for offering support.	Whole University Increasing student numbers Wider adolescent distress Pedagogy Mental health and studies linked Staff and student mental health linked Where I live matters University culture impacts wellbeing
Responsibility	Wider issues linked to service provision in individual, NHS and institutional responsibility for student mental health. Questions about model sustainability and cost effectiveness, and whether clinical services need added investment if there is an ongoing increase in volume of students seeking support with complex MH issues. Clear staff and student concern that offering more support can also pathologise distress and may not help students in the longer term.	Investing and resourcing Universities as businesses University responsibility Student responsibility Students as part of the solution Duty of care In loco parentis Student as consumer

7.6.3 Theme One: Trusted Friend

"I said, 'talk to the people at the university, they're far more human to talk to,' because they are. Again, my experience of medical professionals has generally- speaking, been very clinical. The university is far more human." **Home UG First Year English Male**

The 'Trusted Friend' theme reflects both the positioning and overall impression of the new services, with the stepped care model having offered an approachable alternative to existing university support. 'Trusted Friend' spans three sub-themes: 'Timely and Accessible', 'Human Gateway', and 'Known', each developed from detailed coding (see Table 7.5 and Figure 7.4).

Figure 7.4 Conceptual Thematic Model of Theme One: Trusted Friend
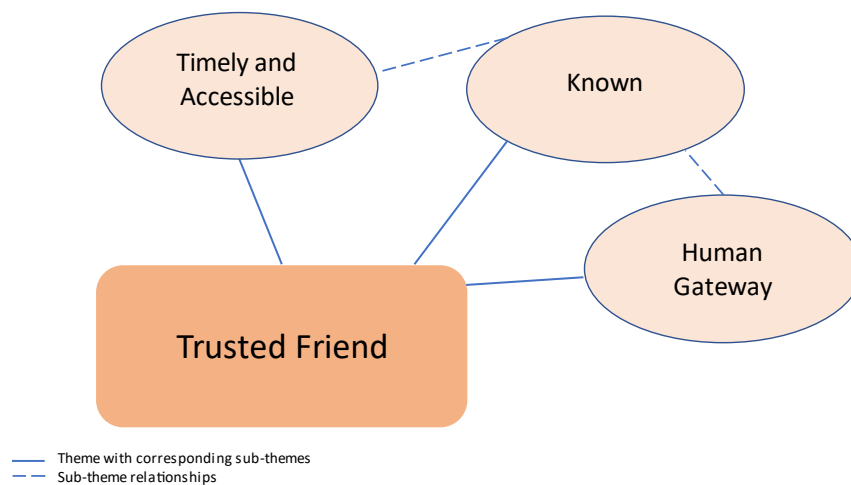
7.6.3.1 Trusted Friend: Timely and Accessible

'Timely and Accessible' captures staff and student recognition that both new wellbeing services delivered initial, fast, approachable wellbeing support. They were generally described as providing a *'low-level'*, *'professional but informal'*, *'first point of contact'* for *'practical advice'*. For many students who had used the services, both in hall and schools, the new model met their needs well:

"I just had one session with that person [Residential Life] and it was really helpful. It was a very friendly and kind of informal atmosphere and it really made me feel very comfortable to talk to her. And I was mainly discussing my family problems that are happening right now, and how I was feeling, and why I was feeling this way. And again, she was really helpful after the session as well. She sent me all the techniques and videos and instructions how to do meditation and different techniques to kind of calm myself down which we discussed previously in the session." **Home UG First Year Humanities Female**

Students gave many reasons for contacting wellbeing services, mirroring the presenting issues found in the *Student Census Surveys* ([6.7.3](#)). They included: the stress of transition, academic pressure, accommodation issues, managing relationships, finances, harassment, bereavement, or a deterioration in pre-existing mental health difficulties. For international students, concerns around the transition to the UK and education differences were coupled with language and cultural complexities.

> *"We talked about uni and how my course was going and how I felt about being away from home and I told them that I was stressed about my studies and my course, because I had problems understanding maths in the class. I think it was mainly because of language barriers and yeah, they just talked to me about these stuff."* **International UG Foundation Psychology Female**

Both students and staff generally agreed that the adviser role offered more accessible university support and guidance.

> *"Once I got in contact, the first response…I found that you literally went on to Student Wellbeing and there was that nice box, that was 'Request Support' and then you fill out a form, how you're feeling. I thought it would be a 'request a counsellor', but it was, tell us how you're feeling, what's going on and we'll suggest what you need."* **Home UG First Year Science Female**

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Academic staff had often historically been the 'first point of contact' for students, but several reflected that this part of their role had become increasingly difficult over the last few years. That included heightened concern following the student suicides and the increasing number of students to support, many of them with more complex issues and needing specialist help. Both staff and students generally agreed that the academic welfare pathway could be *"patchy"* and *"unreliable"* with some academics more engaged or skilled in the pastoral role than others. This undergraduate summed up what several others described in tutor or supervisor relationships:

> *"I suppose the way that I see the changes at University over the past few years, I see it as trying to make the university's way of dealing with student mental health much more structured and less based on the luck of whoever your particular personal tutor is, whether they are particularly empathetic or whether they actually couldn't care less and saying well, we don't want it to be based on individual quirks and whether you get a good personal tutor or not, we actually want to have a structure in place where there are people whose role it is, ostensibly, to support students' wellbeing." **Home UG Third Year [course omitted] Female***

In the previous model, academics were generally only able to signpost students to a GP or the Student Counselling Service, with a key criticism being the *"long wait"* for clinical help. Reassuringly, every student interviewed was initially contacted within a matter of days, and most within a matter of hours (particularly by Residential Life). Almost all students who had used the new advisers, described a *"quick"* response, with several underlining the importance of immediate contact.

> *'I think the speed with which we're able to talk helps really well.' **Home UG First Year Chemistry Female***

> *"I prefer to go somewhere that's quicker because sometimes you just need someone to talk to, like as quickly as possible. For the moment… just someone". **Home UG First Year Humanities Female***

Similarly, 'availability' was very important to staff and students. Early in the new service implementation, and in the earlier focus groups, administration and academic staff talked about the historic difficulties of managing distressed students out of hours. That was especially apparent on Friday evenings and weekends, when there was no support on site for those students who were not in university residences.

> *"I definitely have a case... I have a 17 year old who has been in private accommodation. She was in distress at five o'clock and I think it was a Friday, but it was at five and I phoned Resi-Life, 'oh she's not in halls so we can't do anything'. There was nobody on Wellbeing. So, I had to take her, with another member of staff to an emergency GP appointment and then let her walk home on... let her get home on her own at night, because there was nobody."* **Central Administration Manager**

In response to issues of that nature, a 24/7 wellbeing support number had become available to all students from September 2019, a service manned overnight by the Residential Life team. However, one academic was concerned that even with an out-of-hours service, the on-call advisers still had no-one else within the university to refer to.

> *"If they've got somebody suicidal at 11 o'clock on Sunday morning because they've had the most unbelievably foul weekend and everything has gone wrong, the person on the desk may have 900 students to be responsible for and there's nothing they can do except ring 999. There is nobody at the university. There is no real professional, a medical doctor or counsellor or psychologist or psychiatrist. There is nobody to whom the student can be sent."* **Senior Academic**

For the Residential Life team, running an overnight service also had operational consequences for prevention work (see also 'Proactive versus Reactive-Expectation and Resources').

"I think Wellbeing Access [24/7] is a very good idea but staffing it with just Residential Life just takes us away from what we were doing before." **Residential Life Adviser**

Nevertheless, for students, the introduction of 24/7 access to support, was particularly welcome:

"The thing that I love the most is that it's a 24/7 service…when you have something like a panic attack or an anxiety attack, they don't happen at specific times. Sometimes it can be at night, sometimes it can be at three in the morning, and you just wake up and start getting anxious…" **International PGR Third Year Engineering Female**

While there was consensus among staff that access to support had improved, a number of students questioned the timing and location of appointments. Several pointed out that daytime support slots would be harder for students on professional (full-time) courses like medicine or law. Similarly, geographical location of support was an issue, and particularly relevant in residences. Where previously a warden would have been present in each hall, the advisers were now situated in the three hubs (villages) serving residences across the city (see Figure 1.2). So, for some students that was seen as a *"trek uphill"* across campus:

"It seemed to be that we were put in a village that was a 40-minute walk away so if you went, 'Oh, could I have a Residential Life meeting?', they're like, 'Yeah, sure. If you could just have a 40-minute walk over to [hub name] that'd be great'. Again, very hilly so if you've got even relatively common disorders like anxiety and depression or even if you're just showing symptoms of them, if you don't really want to leave your room - you're not going to go 'well, I think I'm going to go on a 40-minute little jolly over to [hub name]'." **Home UG Second Year Psychology Male**

"As a student who might be hiding in their room because they feel so unwell…they're not going to go to a hub, they're not going to know

*there's a hub there, they're not going to call it a hub." **Student Support***
Staff

*"It's a hill to climb literally and metaphorically!" **Home UG Third Year***
Economics Female

In reality the institution's halls of residence were no more than a thirty minute walk from their central hub, with university buses on campus (Figure 1.2) but student perception of the distance and location of advisers appeared to have a negative psychological impact. Students who lived in (or near) central hubs, were more likely to describe *'feeling supported'* because they knew staff were nearby (see 'My University Cares- Narrative' and 'Belonging-Connection'). This student lived in a hall of residence which was a central hub with advisers on site:

"It's kind of reassuring to the students that, 'oh we have a person in our
halls, they know what they're doing, they'll help us. We have a first
*contact to kind of talk to – first point of contact.'" **Home UG First Year***
Veterinary Science Female

7.6.3.2   Trusted Friend: Human Gateway

As described in 1.9, the new service was revising its model, with the new 'Wellbeing Access' system fully introduced in September 2019. After that point students were triaged (by a central support team) to Wellbeing or Residential Life advisers, Student Counselling or other support e.g., Disability services, rather than them having to decide which service to contact. In early interviews, prior to Wellbeing Access introduction, students more often suggested that signposting was a limitation of the adviser role i.e., they were 'powerless to help', often just directing students elsewhere. Some questioned whether it was useful to resource an *'expensive signposting service':*

"I think a lot of the advice is so general because…there's so many
bureaucratic rules they have to go by…It's almost as if everyone's job in
Wellbeing and Resi-Life is just to refer and you're… [general focus group

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agreement] *…constantly getting referred and signposted."* ***International UG Third Year Law Male***

"…the wellbeing advisers don't seem to have a huge amount more knowledge than what is potentially already up on the University's website and then it ends up being a case of signposting, which is useful and definitely has a place, but I think there is some students questioning how useful it is having this amount of money spent on Wellbeing advisers when they don't seem to be providing a particularly novel role…?" ***Home UG Third Year [course omitted] Female***

However, that view was less apparent in interviews after the triage system was set-up, suggesting a potential shift in that perception. Yet, advisers themselves still largely described their role as signposting i.e., providing an accessible, friendly 'human gateway' to other support on offer.

"The students find it really overwhelming like to try and know what support is available and where do they go for what…a huge part of our role is like a link, so we're like linking in with all the support and like a first port of call, or possibly loads of students were filtered through to counselling who maybe didn't need it and they just needed something else, but without knowing what else there was. So, I think that's been quite useful for students." ***Wellbeing Adviser***

However, it was clear that advisers were more than a signpost service. Many students agreed it was useful to have '*someone to talk to*' promptly who could help with practical advice or suggest options but who also offered a sympathetic ear:

"I very much saw them as a signposting service with the added bonus that they were actually human beings with sympathy, and they were orientated towards being sympathetic towards students who might be feeling anxious or a bit distressed." ***Home UG Third Year Economics Female***

For students needing specialist support, the new services had both advantages and disadvantages. The benefits included a better link to clinical support, the possibility of interim help while waiting for professional services, and for some students it meant additional care-coordination.

> *"I've got the support that I'd needed all that time through the NHS now. But yeah, it was good for the time. And my Wellbeing adviser really helped me during that time. Really. She without her I really don't know what position I would be in to be honest."* **Home UG Third Year Biology Female**

> *"I've got one at the moment who is about to fall off her course, she's run out of money, and she's got a long wait for any psychological intervention on the NHS, and I thought wellbeing might give her some brief intervention from the counselling service. They can liaise with the tutors, sort out academics, so she knows where she's going, and they can help her sort out in the interim some money issues."* **GP Student Health Service**

Where a trusted intermediary was useful for some students, for others the 'non-clinical' nature of the services was either another *"hurdle to jump"* to get the support they actually wanted or again seen as 'not adding any value'.

> *"…it was quite hard having to sort of re-explain certain things, and within such a short time to try and map out the last sort of 20 years of my life, it was quite difficult. Then there were a lot of things they couldn't potentially help with; it was more just like casual advice."* **Home UG Second Year Science Female**

For students struggling with more common concerns around academic stressors or their living arrangements, there was also a frustration that wellbeing advice was not a panacea and advisers were often powerless to deal with the perceived root cause of their problems. This student was unhappy with his accommodation:

"That person's whole mindset was concentrating on proving my psychology of my mind, he wanted to counsel me...not proceed ahead with the consequences of stress, but he was not able to actually...address the cause of the stress." **International Masters First Year Psychology Male**

"...I didn't feel like they were necessarily able to provide much more information than I'd already found out myself. And in some ways I think that is completely understandable because the people who make decisions about giving a suspension or not, are not the wellbeing advisers." **Home UG Third Year [course omitted] Female**

7.6.3.3 Trusted Friend: Known

This sub-theme relates to the concept of '*familiarity*' and *'neutrality'* in the new wellbeing support for both students and members of staff. Academics and administrators clearly play key roles in student pastoral care but there was a general recognition that for some students seeking help, they cannot (and do not want to) approach their faculties for fear of academic consequences (particularly on professional courses). Almost all staff agreed that the wellbeing advisers filled a gap in university welfare support that had been missing in the previous model, and for many students, the advisers offered impartial, confidential support or guidance not found elsewhere.

"I think that feeling lonely and feeling socially anxious isn't uncommon amongst students and I think that it can feel difficult for students to reach out to personal tutors if they think that it's going to affect their references for example. And it can be actually quite difficult talking to friends if they have a similar social anxiety to what I do, which is not feeling able to trust friendships very easily so actually having someone at a distance like a Wellbeing adviser, is - I think - one of the great roles which they are playing, and - I think again - this is underplayed, it is just the fact that they are an impartial listening ear." **Home UG Third Year Economics Female**

For those students, advisers did appear to serve a *'trusted friend'* role, as someone who was more *'familiar'* or *'approachable'* than a clinical service, but a clear alternative to other support networks such as tutors or supervisors.

> *"I think from my perspective it's pretty certain that it is helping, even if it's just because some students wouldn't have had a personal tutor who would have had the skills to support them, they are now getting a really effective form of support through the Wellbeing Service."* **Students' Union Adviser**

Many of those common difficulties in seeking support, such as issues with approaching academic staff were clearly reflected in the focus groups and interviews, as well as concerns about mental health stigma, believing problems are too insignificant, or not wanting to burden family and friends. The new services appeared to offer a *'friendly'*, *'face to face'* but *'neutral'* source of support, i.e., someone who is "*known*" but not in any other context.

> *"I think I was feeling confused, maybe, I had a few big decisions going on, I was quite lonely. Then I talked to my friends, I'm quite a good talker, so I was talking to a lot of my friends, and then just decided I wanted someone else to speak to maybe who wasn't a friend. It was all a bit claustrophobic, maybe, in halls with so many friends around. Then decided to reach out."* **Home UG First Year Dentistry Female**

> *"Actually, I haven't talked this information to my family because I don't want them to show much concern to me if they know that I'm not in a good situation in UK."* **International Masters First Year Accounting Female**

Prior to the new model, school administrators, like academics were often a *'first point of contact'* for a distressed student, as the '*familiar faces*' who students knew and had contact with concerning course issues. The Wellbeing advisers in schools in particular, were seen as a welcome new addition and '*known'* resource for staff

too, working alongside school administration teams who had often felt overwhelmed and isolated by the welfare responsibility:

> *"It's a huge change. You can't even compare it. It was - everything was knocking on our door; we were completely out of our depths at times. We were dealing with - you know, high suicide risk and everything and there was nowhere to go, except for referring them to a student counselling service that had something like an eight-week waiting list just to be seen at one point. And the responsibility there was huge. Even just that shared responsibility is a huge weight off our shoulders. And even when it is on your door, somebody that you can phone up and run it past and just talk to, that's also very reassuring. I think it's got some little issues that need sorting out, but I think overall it's unrecognisable."*
> **Student Administrative Manager**

Nevertheless, with study and wellbeing inextricably interlinked, many of the administrators and academics stressed that despite the new service role, they remain the only guaranteed point of contact with students and therefore the ongoing *'familiar face'* that many students would continue to approach first:

> *"My challenge is really the stress of having so many personal tutees and feeling that we are absolutely crucial. And I do think we are, not more so than Wellbeing but we're the frontline, aren't we? In those moments - where you suddenly have to deal with these things, we tend to be the ones students come to because they know us more don't they…?"*
> **Academic Tutor**

There was also a strong suggestion that all frontline university staff still need to have the skills, resource and training to support students, and that more should be done to facilitate and support that (see 'Joined Up Approach-Consistency'). Study participants often acknowledged or stressed that everyone plays a part in the good relationships that contribute to student wellbeing.

"I honestly don't know how I managed to get past my undergraduate year and get a 2:1 and all that. I think it's more the support that's outside of the support services that support you. For example, the tutor - my personal tutor was amazing." **Home Masters Fourth Year [course omitted] Male**

"I think recognising that all of the services feed into the wellbeing of the student, not just Wellbeing services. We all have an impact on making their life good here." **International Student Team Staff**

While in general students seemed to be more satisfied with the accessibility of support, it was usually in response to contact initiated by the student. As an everyday *'familiar face'* in schools and (particularly) halls and hubs, both staff and students seem to experience advisers as more of an *'unknown'* until they needed them. That contributed to a perception that the new Residential Life model in particular had lost its ability to create *'personal relationships'* (see 'Proactive versus Reactive- Community building'):

"Many of the students that I've seen from the first year don't even know that there are workers that are available for their halls- there is no visibility. I think it's been really damaging to the halls of residence not to have an adult available on each of the sites." **Support Service staff**

"When I've heard students talking about the Wellbeing service in faculties, I hear them talk about, 'My Wellbeing adviser', and it feels like there's quite a personal relationship and connection that they have with their adviser that I feel like I don't sense from Resi-Life." **Students' Union Staff**

Equally there was a much wider concern that without a *'visible pastoral presence'* in every hall and proactive community-building work (see 'Proactive versus Reactive'), those students who do not seek help (and are potentially most at risk) are missed:

"There needs to be at least one person that goes to that hall every day and works there, that's clearly visible you know that's front of house and clearly visible… students might say things to their catering staff and the catering staff will say 'by the way did you know so and so's dad has died you know they were really tearful three nights this week'… Now these staff [Residential Life], in order to provide cover for other halls they are just kind of a centralised unit…we really have lost all touch of what is going on with the students in the halls. And the students who ask for help are rarely students that need the most help… it's the ones that don't ask… you have to pick it up in other ways." **Student Support staff**

"I don't know exactly how much their [advisers in residences] roles have changed but I know that when I was there in my first year, I think I saw them a lot more, I think there was more knowledge of them, you know. When we had events, it would be to all the senior residents, you knew their names and you knew about them, would see them often, would be comfortable going up to them…I think now it just became a lot more detached and just a lot more cold environment, where people don't really get that chance to just know who people are in terms of their role and different things." **Home UG Third Year Social Science Female**

Even Residential Life advisers themselves found it challenging to be *'known'* as individuals on the ground, with the 24/7 nature of the shifts and out-of-hours operational demands having left them *"struggling with resources".*

"Instead of having a centralised hub out of hours, when all Residential Life advisers can work together and are able to support each other with the knowledge that they have, we are forcing this kind of three village [hub] system, where all RLAs are split up over different villages….Whereas, Wellbeing, for instance, they case-hold, so they don't need to read the student's notes from start to finish every time they call them, which we do, because you can't go into a conversation with them without knowing that – you know their mum committed suicide – all sorts of stuff. I know we're not set up to case-hold but at least if we did keep things within village, there would be more chance

that the student would see the same adviser twice and you'd work with the same student more often…that's affected our ability to support students as well as we could really." Residential Life Adviser

Similarly, there was recognition that the disciplinary demands of the Residential Life role also had an impact on how they might be perceived (see 'Proactive versus Reactive-Resource and Expectations').

'I just think they've got a really tough job because they're not just there for the wellbeing side of it, they're also…expected to do some of the disciplinary bits and also a big sense of trying to create that sense of community and they're really hard to do all three of them together' Wellbeing Adviser

7.6.3.4 Summary: Trusted Friend

The new Wellbeing Services appeared to provide a timely, accessible route for students seeking wellbeing support that had filled a gap in the previous model. The professionalised wellbeing adviser role addressed many of the barriers that students faced e.g., worries about academic records, not wanting to cause concern for others, or long wait times for appointments. The advisers appeared to offer a friendly, neutral and fast route to initial help and information, and further support if needed. For more complex cases, they were seen as helpful additional support but sometimes as an additional barrier to getting more professional expertise or as simply duplicating the function of the university online wellbeing site, providing an expensive signposting service. Overall, the Wellbeing and Residential Life teams were seen as a welcome addition in *"creating positive relationships on the ground with students"* **(SHS GP)** and valuable resource for university staff supporting students.

However, there was also a perception that a '*centralised service means a less personal service*', particularly in halls of residence. Supportive interactions were often perceived as more *'anonymous'* for students in residences (although often by those that had not used them) than in the previous model. There may have

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been several contributing factors: geography and location of residential support, or a lack of adviser resource for becoming known in their smaller communities (see 'Proactive versus Reactive'), alongside the nature of shift rotation and the disciplinary element of the role. Despite the new wellbeing teams in faculties and halls, and a greater accessibility and availability of support, there was concern that lack of *'familiar faces'* on the ground could lead to greater isolation and anonymity for students in residences, i.e., first years facing the challenges of a new environment. That may be particularly salient for students at risk of mental health issues, those who do not seek help and those who may not be identified in other ways. It highlights a repeating concern, that the new wellbeing support services cannot work in isolation, and that everyone has a part to play in identifying and supporting students in need.

7.6.4 Theme Two: Joined Up Approach

*"It doesn't seem to be very joined up." **Lecturer***

'Joined Up Approach'- a second theme, is anchored in codes influenced by the positioning and operation of the new intervention. Concepts consistently seen in the data referred to the operational structure of the new services: how they sat within the wider university alongside existing student support and academic models, the fine tuning needed in service delivery, and any internal and external communication. The codes reflect the complexity of integrating a new support tier into a large established system and the importance of reliable and appropriate information sharing (see Table 7.5). Three sub-themes here are 'Clarity', 'Communication' and 'Consistency' (Figure 7.5).

Figure 7.5 Conceptual Thematic Model of Theme Two: Joined Up Approach
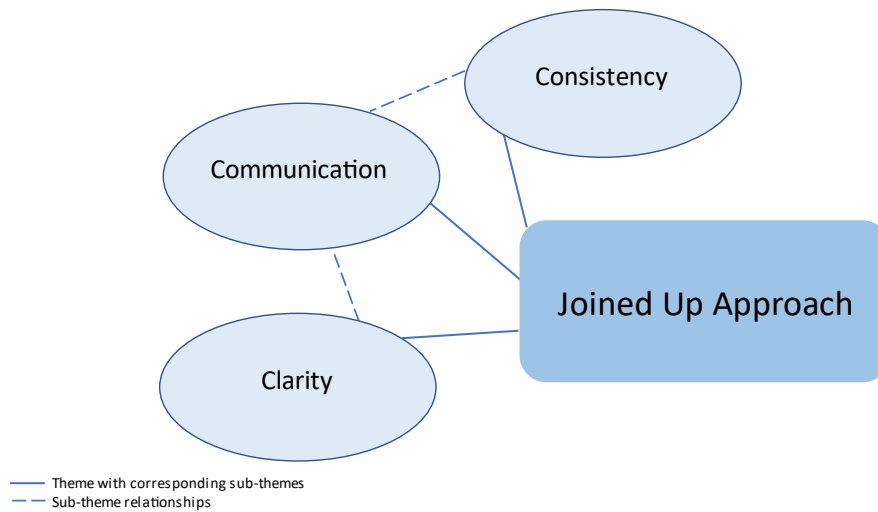
7.6.4.1   Joined Up Approach: Clarity

"Again, I can't remember if it was the Student Counselling, but there's two groups aren't there? There's the [hub name] wellbeing and there's the whole Uni Student Wellbeing? Am I right?" **International UG First Year Engineering Female (unaware they had seen the Residential Life service)**

Clarity broadly covers two concepts in the data: understanding of what services do; and how they fit into the whole organisation. The narrative accounts clearly indicated that a key issue for staff and students early on was *'who does what?'*. The services were only 12-18 months old during this fieldwork, and there was still considerable misunderstanding about what each service did, especially for staff. Similarly, there was confusion about where the boundaries of academic, other support service, and professional staff roles lay. As such, 'Wellbeing Access' was introduced to streamline pathways for students. Similarly, a new staff information portal was also created (informed by this research in June 2020) to help academics and professional services better support and guide students to services. However,

the early staff and student focus groups before these changes still clearly evidenced the confusion:

> *'I think there isn't a formal document or somewhere where you can say 'Okay, these are the Wellbeing Advisers responsible for this'. We only know because I'm best friends with one of the Wellbeing Advisers so like someone said about word of mouth, that is pretty much maybe how staff find out about these things'* **Professional Support staff**

> *"I think they should either centralise all the different branches of it or task each different branch with its own responsibilities. So, the personal tutor can deal with the academic stuff, Residential Life deal with all the Residential stuff and then you've got the overarching Wellbeing service which you can go to for all mental health issues. Currently it's a bit chaotic and I think that should be made more clear."* **Home UG First Year Anatomy Female**

The distinct lack of clarity about the new Residential Life model was even evident to its own advisers.

> *"Some universities, are developing their role in Residential Life model, and so are we that? Or are we student support? We are called Residential Life but if we are Residential Life then we perhaps need to be more clear about that because it's a bit vague for the students. I think it is vague, I got someone asking me the other day, I thought you were my Wellbeing adviser."* **Residential Life Adviser**

> *"It's a bit confusing for students and the staff and I think when the whole service started it wasn't communicated really well to staff what it was for. Our understanding was that students could access Wellbeing whether they were in residences or not and that then Resi-Life might also take on some support of students. So originally when it was set up there was quite a bit of confusion because it looked like it worked more closely together than what it appears to me that it actually does."* **Peer Support Administrator**

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Coupled with the signposting role that the new services played, the lack of clarity about specific service roles, meant that students often found themselves *"bounced around the system"*.

> *"That's been a bit of a battle for me to make sure that these students aren't dropping off the radar because Wellbeing are telling them to go to Resi-Life, Resi-Life are then kicking them back to Wellbeing."* **Career Service Staff**

> *"I'd come from India so initially when I came it seemed really impressive because you see this massive array of services there, various services from the Whiteboard, Wellbeing Services to the GP eventually and Resi-Life. It seems pretty impressive from the outside, but I feel like sometimes for more serious issues you can get caught up in a bureaucratic struggle to reach somewhere helpful."* **International UG Third Year Science Female**

For students experiencing mental health concerns or potentially reliving trauma, *'navigating a confusing system'* was especially salient.

> *"Maybe if they were that centralised point of contact because it's honestly it's quite confusing speaking to all these different people and trying to keep up with the different things. And part of potentially like what I've got… is that it's really easy to just go you know what…like, I think probably like four/five times I just can't be bothered … I can't be bothered doing all of this. It doesn't feel like anyone's helping, you know."* **EU Masters First Year Business Male**

Many staff agreed it was *"early days"* for the services, and in later focus groups, and interviews in particular, there was evidence that service improvements, especially Wellbeing Access were already starting to simplify and clarify pathways:

> *"[Wellbeing Access] is the best solution in terms of students knowing exactly where to go and exactly what to do. So, one telephone number,*

*one online form, one email address and that's the gateway to all Wellbeing Services, is I think, a positive thing." **Residential Life Adviser***

Wellbeing Access removed the onus for students to know which service to contact in the first instance, which appeared to mitigate some confusion for students and university staff trying to support them. However, Residential Life advisers were particularly aware that they still had challenges to face in regard to their clarity of role, and largely linked to their broader remit (see 'Proactive versus Reactive-Resource and Expectations').

7.6.4.2   Joined Up Approach: Communication

Communication in a complex system is critical and it influenced staff and student experience of the new services at several levels: in the introduction of the wellbeing services; the ongoing refinement and development of services; communication between wellbeing services and the rest of the university; and the critical issue of confidentiality and information sharing. Despite improved visibility of services and an increased level of communication with students, for staff in particular, there was a sense that the launch had been *"rushed"* and the detail not clearly communicated:

> *"I think there's definitely that feeling of they just pump £1 million into Wellbeing but actually the way that it's communicated is almost like this is a new thing that we're doing as an institution when actually… there's been Disability Service, there's been Student Support. All those things exist and the way we communicate it should be better. And I think that because of the way they launched the service as this new thing, that meant that they were in a bubble, and they weren't connecting with anyone else." **Student Inclusion Team***

> *"It's the communication of how the new system was going to work was not amazing." **Home UG Third Year Economics Female***

There was recognition that change management is a dynamic process and *"teething problems"* (as one administrator described it) were inevitable. However, there was also a sense that as the services bedded in, any ongoing communication about change was also absent:

> *"So, they've made some adjustments and we don't know why or where they've come from and they've just suddenly sort of said, next week this is what's happening and stuff like that. It's been kind of frustrating because you sort of feel like, oh this is all integrated now and we're part of a team and all of these things and then suddenly they're like, this is what's happening."* **Undergraduate Administrator**

> *"Obviously their service is an iterative process, and we understand that- but they've never communicated to us what the iterations are. So, we're trying to advise students on how to use their service and then students will come back to us and say 'oh they say they don't do that' and we're just kind of like 'well when I went and checked with them before I referred you- whether that was a reasonable referral? They said it was.' So I think they're confused even themselves what it is they're offering. And then even if they did meet with us, how can they clearly explain how we were going to work together, when they don't really know."* **Student Support Staff**

Additionally, for many university staff, a lack of internal communication between services and other departments was an ongoing issue for working effectively together.

> *"This separation between Resi-Life and academic life. Resi-Life know that students have got big mental health problems. There is all manner of stuff going on over there and then it manifests itself in the department in whatever way and we have no warning. This is not a surprise because it's been going on elsewhere. But flow of information between academic and non-academic faces in the university is not very good."* **Academic Tutor**

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"The systems and the mechanisms for communicating between the different sections of the university are either not in place or they're not used. I have never ever had a communication from Residential Life about a student of mine. I have been left to find out that they have problems that Resi-Life is trying to sort out, for myself… My guess is that it's a structural [issue] and that the confidentiality issues are so terrifying for staff that they will not alert anybody else unless they absolutely have to. We don't have a whole university system. There is no operational system to make sure that everybody concerned with an individual student is kept up to date and it's crucial that that's put in place." **Senior Academic**

The biggest challenges for communication were confidentiality, privacy and GDPR. Staff repeatedly talked about referring students to wellbeing and then being left *"in limbo",* with no information about whether the student was being supported or not and leaving them uncertain about whether they were still holding risk.

"I've absolutely experienced this where you have a student that you're very concerned about, you either refer them with their permission or you say to the student, 'refer yourself'. You get an automated email saying we've received this, but then it's silence. These are people who you're worried about their welfare, like physically, and from that point on you don't know if either they've managed to get the student to engage or if the student has done so themselves. Do we persist with supporting them ourselves because we don't know? Or do we rely on the fact that they will have done everything they can to support them, because it's very, very unclear." **Senior Student Administrator**

Many more staff described that level of anxiety about *'not knowing'* if a student is being supported somewhere in the system either because privacy law precludes it or because there is no streamlined information sharing across all stakeholders involved in a student journey.

"Confidentiality is an issue and you'd need to have a system that allowed people access without seeing everything, so it might be that a personal tutor refers to wellbeing, the student says 'I'm happy for my tutor to know that you are seeing me, but I don't want them to know what I'm going to tell you', so the tutor just sees 'yeah they're engaged with wellbeing, that's fine, that's all I need to know'… It's really hard for us to be able to communicate with them effectively under our current rather fuzzy confidentiality process." **Wellbeing Adviser**

For others, like this new academic, there was concern about procedure and risk, and how to make sure they are "*getting it right*".

"I think just clearer rules or indications around confidentiality would be really helpful because I think that's something that causes a lot of anxiety for me. If a student comes to me in distress, I always ensure that I say to them 'Are you happy with me sharing this with X and Y?' before I do so. That's why I am often quite keen for them to be the person contacting the relevant service if necessary, just because I do worry about it a lot. I worry about getting it wrong and I think there's a fine line to be drawn isn't there?...I think that's the difficulty and that leads to some of those breakdowns in communication." **Academic Tutor**

Students themselves were divided. Some were keen for information to be shared, often removing the need for them to have to repeat their story and making it easier to seek mitigation or study support.

"I used the Resi-Life in first year and briefly the Wellbeing Service in my second year and one thing that I found quite frustrating was I'd go in every time, and they wouldn't really know anything about me, I'd have had a session with somebody, normally talked out quite a lot of stuff and then I'd go. And then especially when I left halls and had to go to the Wellbeing Service in my second year, I had to explain everything all over again. My stuff wasn't particularly deep but it's quite exhausting to have

to tell a really long story and all the context and all the implications over and over again, yeah." **Home UG Second Year Psychology Male**

Other students were clear that they wanted their personal issues kept completely separate from their course or 'the university' as they described it. As outlined earlier, this can be particularly salient for students on professional courses, where the declaration of a mental health condition can have implications for their study. This student counsellor reflected on the importance of student choice:

"I think for me it would be down to the student, I think to have a consent led process of an informed choice. So, for some students I think I meet would perhaps be quite open and they would really like that, other students will not want any of us talking to each other and therefore that would be their right to have that. So whatever system you have, I think you would need to be able to flex with those very two different types of presentations to preserve that person's confidentiality, you know, right to just come and study on a course but not have the uni know anything, in a sense, about what's going on for them or be involved if they want to." **Student Counsellor**

7.6.4.3   Joined Up Approach: Consistency

Many students and staff described the support changes as *"necessary"* to improve the student experience and standardise student welfare provision. This sub-theme of 'consistency' relates to staff and student understanding that mental health and wellbeing support in a large population with diverse needs, can be challenging. Several staff and students described the previous model, with its reliance on academic support, as being dependant on *"goodwill"* or *"luck":*

"The way that I see it, is that when I came in 2013 as I've already said there were definitely individuals who were incredibly sympathetic, incredibly supportive and understanding towards my own mental health struggles and went above and beyond to help me, but that was more to do with particular idiosyncrasies of those individuals rather than the fact

that that was inbuilt in their roles to do so." **Home UG Third Year [course omitted] Male**

Many staff were clear that appropriate and evidence-based models of professionalised welfare and care were essential, to offer *'consistency and quality of support'* in schools and halls of residence*.*

> *"I know it was quite a controversial change, but my understanding was that there was an inconsistency about the welfare provision, depending upon which Hall of Residence you were in, because they were run locally and also the 24 hour seven days a week aspect of the service was new and I think that has been particularly significant and a positive thing, compared to what was available in the past."* **Residential Life adviser**

> *"I think since the shift of the Warden model to the Residential Life service model- it was very paternal and obviously had all of the negative press with the move of the model- but for me, from the outside, it seems so much more professional, so much more healthier and boundaried… it was so patchy, so patchy and now it is consistent, I think."* **Student Counsellor**

However, some academic and professional staff felt that despite the new services, there was still no consistency in provision, while others acknowledged that in an organisation of thirty five thousand people across twenty five academic disciplines, all with different needs, that may be impossible.

> *"It feels less cohesive than it did under the old model."* **Professional Services**

> *"It's so strange; I thought with a new system that they would just be the same across the university. I thought that was the whole point of introducing a new service, you're doing the same thing in every faculty and every school. But it's totally different isn't it."* **Student Administration Manager**

"Certain courses do assess in different ways or cause stress in different ways. I know we had a problem with [department]…There is differences between departments, how departments handle different situations. I think that's getting better now but schools being so different means extenuating circumstances and extensions and length of assessments or type of assessments is all completely different, so it does have a different impact on students, on them as individuals." **Students' Union Adviser**

Similarly in halls of residence - factors such as the presence of communal facilities or whether they are located in the city centre as opposed to on campus, also appeared to influence one consistent approach.

"Yeah essentially, it's more impactful in some halls than it is in others, and…hasn't necessarily done what it set out to do and make it more consistent." **Students' Union Adviser**

Views about consistency relate back to whole-system change, and while it was acknowledged that support services needed to be flexible, there was a broader sense that *"everyone"* would benefit from a more joined-up, cohesive, and professional mental health approach. That included training for all staff not only in how to work with one another, but a coherent, well-communicated strategy for dealing with student distress, alongside robust evidence-based evaluation of what actually works.

"If the university is going to take this issue seriously it needs to be compulsory training on a process not an option, for everyone. For everyone on all of our services." **Professional Service Staff Focus Group**

"We need to do some kind of benchmarking with other universities that do Residential Life and they have had it for longer. And [work out] does that actually impact retention, attainment, what's the outcome for them? Because the UK have not done that much research…. But you really do have to think about it, it is strategic…" **Residential Life Adviser**

7.6.4.4   Theme Two Summary: Joined Up Approach

The 'Joined Up Approach' theme spans clarity of service role, communication, and procedural standardising and evaluation of the new support model in a complex organisation. For the student, access to pastoral help appeared to have improved but introducing another support tier had also made the system harder to navigate for staff working alongside it and those students with more complex needs. While there was general recognition that the services were needed and valued, particularly by students and frontline staff, there was also confusion about the boundaries of the service roles and how they fitted into the wider institution. That was largely experienced as communication issues between staff teams, where information could easily be siloed or absent. But for students it can also mean '*having to repeat their stories*' or being '*passed around the system*'. Communication and integration between Residential Life and the wider university was of particular concern to many staff who felt the service was disconnected from the rest of the institution (see 'Trusted Friend- Known' and 'Belonging- Connection'). Students however, experienced that less.

One of the biggest issues for academic staff and administrators was uncertainty, and by association risk, in whether a student was being supported in the system. A lack of joined-up intelligence was exacerbated by concern that teams did not always communicate effectively or feel they received the ongoing information about service updates, training or CPD they needed. Lack of confidence and fear about GDPR, privacy and information sharing, and any potential legal consequences were evidenced in every staff group who contributed to this research. A more comprehensive approach to communication and data sharing would arguably help to mitigate those concerns. While it was acknowledged that wellbeing services need to be flexible in their support approach across a diverse institution- service-consistency, professionalism and ongoing evaluation were also seen as critical to the successful integration, operation and ongoing development of the new services.

7.6.5   Theme Three: Proactive versus Reactive

"Personally, I just think it needs to go from being a reactive service to more of a proactive service and I think if that happens it will be really positive." **Student Support Staff**

The 'Proactive versus Reactive' theme describes evidence of a tension for the new wellbeing services in their dual ambition to provide non-clinical responsive wellbeing support for students, and to proactively engage in outreach and prevention work e.g., psychosocial workshops and community building events. For the Residential Life service that also included a more general 'student accommodation management' role and 'out of hours' (24/7) support. It is developed from codes which describe the particular nature of the new service roles as both 'prevention and cure' (see Table 7.5). 'Proactive versus Reactive' spans three sub-themes: 'Resource and Expectations', 'Prevention', and 'Community building' (Figure 7.6).

Figure 7.6 Conceptual Thematic Model of Theme Three: Proactive Versus Reactive
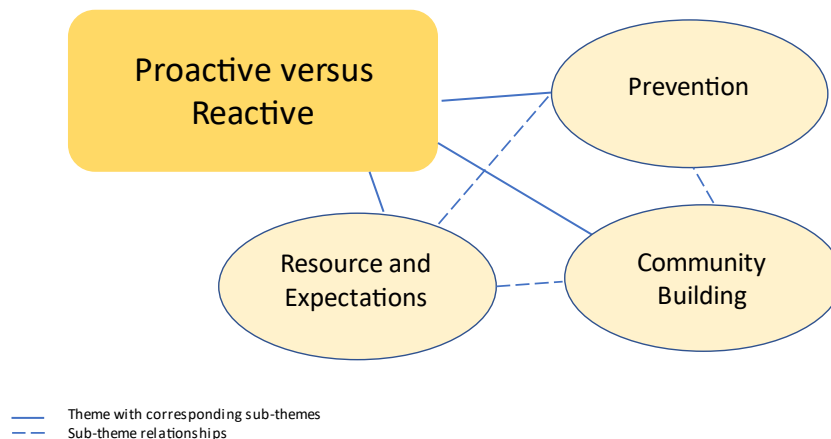
7.6.5.1   Proactive versus Reactive: Resource and Expectations

The 'Resource and Expectations' sub-theme reflects codes rooted in dual tension for the services to meet the original ambition for the model i.e., to be responsive to immediate student distress and manage ongoing caseloads (reactively), as well

as identify students who may not seek help and to provide psychosocial education and community building effort (proactively). That was all in a changing mental health landscape, where many of the students interviewed had arrived at university with previous mental health concerns.

> *"I think the first real contact with the service I had was when I started self-harming… in the beginning of the second term of first year. And that was because of issues that I'd had prior to university, not something that I picked up within university."* **Home UG Third Year Life Sciences Male**

Without wider systemic change, further investment, or a different model, many of the clinicians taking part in the focus groups felt they would only ever be able to "*firefight*", especially with growing numbers of young people arriving at university seeking support.

> *"I think a lot of the time we are still reacting and we're still seeing things happen, and then reacting. So, the preventative work, it's really challenging to do that when students come to university, there's more work that's got to be done prior. And what's our role in that, if there is a role? But that's preventative. I think we do much more reactive. I also think we are maybe picking up some slack because of what's not happening in certain statutory institutions within the NHS, and other services reducing. Every service I've ever worked in [this field], if you increase the capacity, you increase the service users. It's not the solution to increase the capacity again and again and again, it would just be the same thing happening. It's about the model, it's about actually reducing…having a better model that gets people out of those services as quickly as possible, the ones you're able to."* **Student Counsellor**

Other support service staff working across the institution, both clinical and non-clinical, also believed that offering more accessible wellbeing services had in the short-term, simply *'opened the floodgates'*:

"I don't know if it was the fact that it was like just a form to fill in, so that fits better with like the student generation of how to access a service rather than having to write an email or make a phone call, but it was an absolute kind of tidal wave. Very quickly of a lot of students coming in to the service…which when it happened so quickly, I think kind of just blew everyone's mind a bit as to how to get through such a huge number of students at the same time as actually kind of manning that service" **Student Wellbeing Adviser**

The institution could have invested in the existing support service structure in September 2018 but chose to resource the new non-clinical pathway. Several staff believed that investing in university wellbeing services without resourcing extra clinical services was *"ambitious"* but *"short-sighted"*:

"I think the complexity is so significant in some really unwell people who arrive at university, really so unwell…This [wellbeing service] could be a little bit of a support structure but there's so much work that needs to be done." **GP Student Health Service**

"… the university is committing itself to providing a service that it can't really sustain. Unless it actually funds that health service, and the counselling goes with it, then it shouldn't pretend it can do it." **Senior Academic**

Several students and staff acknowledged necessary limits for university wellbeing spending (see 'My University Cares-Responsibility'), but others referred to what they saw as ongoing under-investment in accommodation and mental health services:

"…because the number of students is increasing every year and this year it was really bad because we didn't even have enough beds for first years…and it was dreadful for them so yeah, it needs funding. The wellbeing, the counselling service, the Resi- life as well." **Home UG First Year Social Sciences Female**

*"The work they do is great, but they do appear to be comically underfunded." **Lecturer and tutor in Faculty of Science***

While the narrative findings suggested both teams were responsive and timely, and successfully filling a welfare gap, they clearly reflected services that were operating *'reactively'* at a cost to preventative work. The breadth of remit and expectation for Residential Life was particularly problematic. The team had not only out-of-hours operational demands but *"so many different hats to wear"* e.g., welfare and community building concerns as well as accommodation, disciplinary and student behaviour issues.

*"Resi-Life has to do the discipline in a way that I don't think Wellbeing does…That's just one of the examples of the stuff that Resi-Life's probably having to do that Wellbeing isn't and that increases the workload, increases the pressure, reduces the focus on the consistency of the support offer and…it does make it more difficult to interact with the service as a stakeholder, and it sounds like that might be happening for students as well." **GP Student Health Service (SHS)***

"I think Wellbeing is more focussed on just wellbeing- when we are doing everything and trying to juggle. Sometimes to fit in just the wellbeing part into Residential Life because there is so much more. I think the students do expect way more from us – expect the same standard as the Wellbeing service, but also to answer all other queries and solve all the other issues. For example, housing or anything else that comes out."
Residential Life Adviser

One Residential Life adviser described the service as *"trying to square a circle"*, while another believed simply having an opportunity to reflect on their roles would have helped, something which had been impossible in reacting to day-to-day demands:

*"It was a bit of a sort of step into the unknown when this service opened, so I think we were probably taken aback a little bit by the number of students coming forward with quite complex issues to deal with. So when you are faced with that situation, you do have to make a choice don't you? You can't turn someone away and say I am sorry I can't see you because I am doing a pizza night in ten minutes or something… Ideally if we had a little bit of time just to take stock and think about the experience of the last two years and think about how is the structure? Is it working? Where is it not working? What tweaks, what changes do we need to make to make it work better? That would be really great, but it's just finding the time to do that." **Residential Life Adviser***

For some, the Residential Life model was clearly not viable in its current form, and there were several calls for the service to separate its welfare and community-building responsibilities.

*"I think that clear separation between reactive provision and community building needs to be made with maybe two separate teams I think would make things a lot easier and a lot less confused. I think that'd be a really good step forward." **Students' Union Administrator***

One adviser described failed efforts to operate a similar hybrid design at another UK university:

*"That's the thing about it, it's adding it to existing full jobs, it's not gonna work. Just to say that when I was in [a Russell Group university], when I first went to work there…that's what they did, like here. They couldn't sustain it because the staff couldn't deliver both to a high enough standard, so the model did change, and it was split, and it worked so much better..." **Residential Life Adviser***

7.6.5.2 Proactive versus Reactive: Prevention

This sub-theme reflects the importance of *'prevention as well as cure'* in the service role. 'Prevention' here includes actively identifying students who might

need support but do not contact services, alongside population-level primary prevention i.e., stopping problems developing, through outreach and psycho-education work.

Reassuringly at an individual level, ongoing management of existing cases appeared to be a key strength of both services. It was very evident that once a student was in touch with either service (but particularly Residential Life), there were regular follow-ups and check-ins e.g., '*following up*' and '*keeping an eye*'.

> *"It's really useful because they'll email me as well, because they know that I've got, my mood can be quite volatile. If they don't hear from me for a few weeks, they'll email and say just checking in on you and that you're okay and all that kind of thing, which is really nice."* **Home UG First Year History Female**

> *"I don't know if they provide this for everyone but I have used it so I am constantly being forwarded at least one mail from them once in a fortnight, so that's kind of a thing that I really love that you know they keep sending mail, 'we are free from this time to this time, on this day, or we can adjust according to your schedule'- so that's a good thing."* **International PG Third Year Health Science Female**

However, that support relied on the student contacting services, and as described elsewhere ('Trusted Friend-Known'), there were fears that a responsive/case management-focused support model inevitably meant students were being missed. Several staff suggested that *'cultural differences'* (see 'Belonging-Representativeness'), *'a lack of personal tutor'* (to signpost to services)*,* or simply being *'too unwell to reach out'* meant that services which focused on crisis response and case management then risked vulnerable students *'falling through the gaps',* leading to course withdrawal or even more serious consequences.

> *"If like you're in the thick of it, it is so hard to just open your laptop and tell. It's so difficult. I think I've been stressed this year, but the one time I was the most stressed was when I did not have money. So, I think it's*

definitely very difficult to - kind of- reach out to someone, which I guess is why senior residents are there, to check up on you and to make sure you're okay. But when there was no one going around knocking on doors, it was at some points, very difficult to even just tell someone you're struggling because you couldn't even find the words." **International UG First Year Engineering Female**

Despite issues around data protection, the boundaries of a university 'in loco parentis' role, and resource (see 'My University Cares-Responsibility'), several participants wanted to see a systematic method for proactively checking and tracking the wellbeing of every student:

"They should talk to those people, not through e-mails, face to face. They should call them and talk to them 'So, how's it going? Are you enjoying it you know?' and that process should be legalised, legalised in the sense that it should be officialised." **International Masters First Year Psychology Male**

Although several staff and students suggested systematic wellbeing check-ins could only be done via the tutor/supervisor network and not through wellbeing services (see 'Trusted friend – Known'), others thought wider joined up policy was needed to catch students who did not engage:

"Eventually I guess it will tie in with the attendance policy they're bringing in, so they'll be other avenues into this…you know, where we refer a student, if they don't engage with the wellbeing service, if they're still not engaging with us, then eventually they're picked up by the attendance policy and wellbeing will be brought back in, with a slightly different hat at that point. So, I think eventually it will mesh together, but there's just a lot of new things coming in recently with this university." **Centre Administration Manager**

Without automated monitoring of student attendance, any ability to proactively identify students who might need support is still arguably linked to both the

academic pastoral network and broader outreach prevention and community work with a visible wellbeing presence on campus ('Trusted Friend-Known' and 'Belonging-connection').

Similarly, ongoing psychoeducation in the form of homesickness, drugs/alcohol, sexual consent workshops were and are, designed to ease transition and prevent wellbeing issues from developing, with the capacity to engage more vulnerable students early on.

> *"…we were under the impression that they would be doing the kind of transition to university work because actually we get quite a lot of first years come in being just like 'I'm struggling to make friends', all the normal questions… we were really excited when they said they would be doing that work but my sense is there's nothing more there now than was ever there in the halls before."* **Student support service**

It was more generally noted that Wellbeing advisers were making some headway with prevention work.

> *"I think Wellbeing has a better opportunity to meet those intended goals more quickly than Resi-Life because they feel more settled. They seem to have a bit of a better understanding of what they're doing and because they're very clearly boundaried by their nine to five working."* **Wellbeing Support Staff**

> *"They [Wellbeing] did a really good workshop for our students, just specifically for the under 18s on culture shock and homesickness… It was great. So, we're hoping that they can do that centre wide, for the entire cohort. They're still experiencing those issues now."* **Centre Administration Manger**

Even so, some of the prevention effort was seen as too basic or limited; and sometimes lacking in real intervention when needed:

"Even the stuff in university is a little bit like, 'Don't do drugs kids', and…if you do have an issue with this where do you go anyway? Because especially with drugs and with alcohol and everything I feel that there's always a danger that you'll go, but what if I get judged for this? One of my flatmates last year had a huge problem with alcohol and you know they did the little postcards where they were like, 'If you're worried about your flatmate write it on a postcard and put it in the little box'? The Residential Life advisers, they were really nice, and they really made an effort to get to know us, but they went up and knocked on his door and were like, 'Hey, are you doing okay?', and he was like, 'Yeah'. They were like, 'Okay', and that was it." **Home UG Second Year Psychology Female**

7.6.5.3 Proactive versus Reactive: Community-building

The population-level wellbeing service agenda also included helping to 'create communities' in which students could thrive, particularly with the restructure of student accommodation. This student summed up the tension particularly with the two different arms of the advisers' role in halls, firstly as a student trying to organise events, and secondly when asking for help after a serious self-harming incident:

"As a JCR (Junior Common Room) [43] they were terrible… and we couldn't really put on any events for our halls at all. But as a student using them [for mental health], they were great. I called them up and they came over straight away and they sorted me out and then they arranged regular meetings after that to make sure I was alright, but I think it just depends on your experience." **Home UG Second Year (course and gender omitted)**

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[43] Junior Common Rooms are traditional student committees set up to organise events and 'formals' i.e., formal dinners, in halls of residence. They are largely absent in the city centre and privately-operated student halls of residence.

While the consensus seemed to be that many students had a good experience seeking responsive or ongoing support, a number of participants were aware of something missing socially:

> *"…if there was a bit more integration to do more social things; perhaps like all within the department, or within Halls I think that would have been nice."* **Home UG First Year Science Female**

> *"I don't have much time meeting people living in the same accommodation and they haven't organised too many opportunities for the communication or networking, but people just sign up for the events and then they can show up wherever they want so I felt there's something they need to improve."* **International [course level omitted] Accounting Female**

Wider negative cultural narrative (and early resistance to the change) may have played a part in the way students and staff saw the new model in halls (see 'My University Cares-Narrative'), but as described earlier in 'Resource and Expectations' even Residential advisers suggested the model needed careful re-consideration:

> *"In terms of community building, we absolutely need to think about how we are gonna provide that… At the moment…it's kind of just an add-on and whenever a welfare case kicks in, it takes a back seat, that's how I see it, so all that lovely preventative work that we could be doing to reduce some of the high-risk levels - in terms of activity events and getting students involved and engaged in reducing isolation, but there are barriers…"* **Residential Life Adviser**

Residential advisers felt strongly that catching students early was key:

> *"If you do not have big events that first week, then you lose students, because they develop patterns. They develop patterns quickly, the first three weeks at university is like a lifetime, if you think about it, to a*

student., coming from home, an 18-year-old. Their world changes hugely in that time and if you do not get them at the first weekend, then you will not retain them…This is to do with the kind of structural management of the service." **Residential Life adviser**

That was reflected in student testimony, particularly those that had experience of the old and new models in residences:

"I think one of the things that is really beneficial for students, particularly in their first year when they're really going through that very intense transition coming into young adulthood, is that there isn't that very integrated, more close-knit community that you can use as that replacement for the support network that you've just gone away that you've potentially built up for 17, 18 years. I think that with the student body increasing with the shift rota thing of the Residential Life advisers, that sense of community…that that has just been lost a lot, that there is just this increasing anonymity." **Home UG Third Year Economics Female**

However, first year students were far less likely to raise direct concerns about community than staff were, and many of the new undergraduates described a positive community experience, especially those who did not have the old system to compare to:

"They put on a host of things. All the events that ran through fresher's week, and stuff the student union does is really good. They did a tie-dye class, all these sort of small things throughout the year, which sort of makes you – I don't know, they're just really fun to do and I think those are really nice. If you want something to distract you or you want entertainment to just get it out of your head, there is always stuff running and that's what I really like… Yeah, they do a lot." **Home UG Life Sciences First Year Female**

Building communities is a 'whole university' challenge, and staff and students were aware that this particular institution was more than one homogenous entity

and made up of many diverse academic and living spaces across a large urban city with differing student needs. Location, drug use, alcohol and social groups were all highly influential in the way students discussed their campus support experience (see 'Belonging-Connection') and staff acknowledged that the ability to build communities and engage with students varied across different parts of campus:

> *"[Residential] Village is much more set up for building community, because we are all in a very small location and we have the communal facilities you just don't get in a lot of the other halls. You don't get table tennis rooms and pool rooms and JCR common rooms and stuff like that. Also, the catering aspect of a lot of halls in here brings all the students together every day and then they have the formals on top of that and there's a big facility to accommodate lots of people- there's a bigger tradition of it here."*

Perhaps most critically, what was generally raised by staff and students (and advisers themselves) that without community-building work, they faced a self-fulfilling cycle of students presenting to services with issues that may have been avoided.

> *"…like the whole idea was proactive community building will reduce reactive welfare provision but that hasn't happened on the ground. In order to make it a success that's something I think that needs to change."* **Students' Union Staff**

7.6.5.4   Theme Three Summary: Proactive versus Reactive

Overall, while this theme provides evidence that the intervention is making a positive difference in the short term, it suggests an important component was missing. It was apparent that both services had been 'overwhelmed' in responding to students needing support, and that prevention and outreach effort had been compromised, particularly in halls of residence. That may in part be explained by the rise in student numbers overall, the increased visibility of the services, or more

students simply accessing the new services. Residential Life advisers replaced the traditional warden model in halls, inheriting not only the accommodation management and community building effort, but also a professionalised welfare responsibility (24/7), arguably a far broader remit than the Wellbeing advisers who were a new addition in faculties. Overarchingly, there was good evidence in both staff and student testimony, that the model in residences was under strain, with potential consequences not only for advisers themselves, but individual students who may fall through the gaps. Similarly, the community building effort had not materialised in the way it was conceived, often leaving schools and residences feeling more anonymous for students than had been envisioned. Critically the wider impact of less outreach and preventative work as well as community building effort in student accommodation was seen as having the potential to have a more detrimental long term effect, leading to poorer outcomes and more potential welfare cases in the future.

7.6.6   Theme Four: Belonging

"It was about how insecure I felt in the university, how insecure I felt walking around, how … I didn't belong. It was about that… that was affecting my mental health and then my mental health was affecting my productivity, and that's what the main issue was so that was the knock-on effect." **Home [course omitted] Male**

It was apparent in this fourth strand of evidence that lack of community building can lead to a lack of sense of belonging with consequences for wellbeing and further, an added need for wellbeing support. 'Belonging' is built from two sub-themes: 'Connection' and 'Representativeness' rooted in coding and analysis capturing the conceptual significance of 'belonging' for students in their experience of the new services (see Table 7.5 and Figure 7.7).

Figure 7.7 Conceptual Thematic Model of Theme Four: Belonging
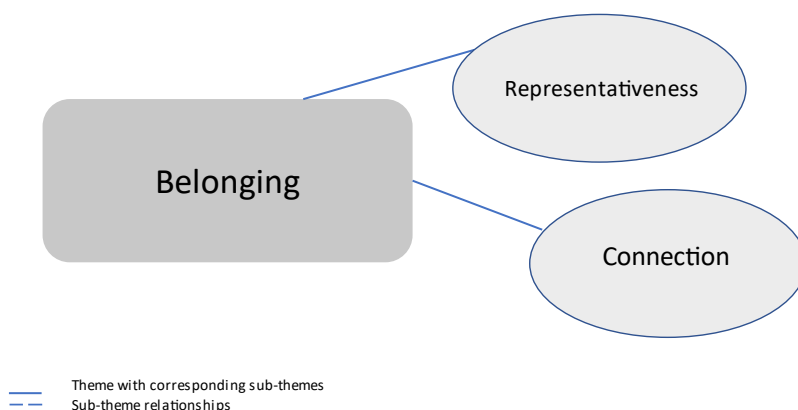
7.6.6.1   Belonging: Connection

Strong underlying patterns in the staff and student narrative indicated how important *"connection"* is to the university welfare experience, and the critical role the new wellbeing services play. It was very apparent from service user testimony that 'isolation and loneliness' or a 'lack of belonging or connection' were related to the need to seek wellbeing support. Again, this was particularly salient in halls of residence.

Several students seeking help from wellbeing advisers had struggled to feel part of their academic departments, which had repercussions for stress concerning their studies. This student was based in two different schools:

> *"I'm just not really feeling welcome by the department at all. Whereas at the [name of school] they've kept up with what they said – they were, like, we actually do care about you. And we feel like they do, at least. And I'm sure they do. So our personal tutors would actually make an effort to, kind of, contact us before Christmas, during Christmas, after Christmas as well. Whereas in [name of other school], I literally don't know where the Wellbeing Adviser is, I've got no clue where the building is 'cause you just scout around [department area], and I feel, like – I*

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definitely don't feel like they care about us at all." **International Postgraduate Second Year [faculty omitted] Female**

For others that lack of connection was broader:

> *"I think it was just general sort of loneliness, but I'd be struggling to sort of make friends or sort of form social groups because my flat was very sort of kept to themselves and had friends elsewhere. And I was sort of moving between classes, so I wasn't seeing the same groups of people on my course which made it quite difficult to sort of become part of sort of like the various social groups that seemed to be forming. And it was worse in second year because I only had one class that was even with other people. And I was finding the societies difficult to get to because the building was quite far away, and they were very big and if found that a bit overwhelming."* **UG Home Second Year Humanities Female**

Any causal relationships were difficult to untangle i.e., whether the university environment created feelings of disconnection, or some students were more predisposed to feeling isolated. However, many of the students interviewed had contacted wellbeing services because their feelings of isolation had escalated to the point where it was impacting their studies and they needed help. It was also apparent that in the previous support model, it would have been harder to seek support for issues like loneliness.

> *"It was really good to talk to someone because at the time I hadn't made many friends so I couldn't really… I didn't feel comfortable with people to talk about how I felt. Because no-one did talk about it. No-one was like, 'Oh my God I'm so homesick' or like, 'I'm so stressed.' They were just having fun, and no-one seemed to talk about these things. So, I didn't feel comfortable with the people that I knew to just talk about how I felt. So, when I found Resi-life advisers it was really good to just talk about how I felt."* **International UG First Year Psychology Female**

In almost all the student and staff focus groups and interviews it was possible to map concepts concerned with isolation and loneliness to concepts of good (or poor) mental health and wellbeing and support seeking. The student focus groups in particular reflected on how hard it can be to *"fit in"* and find *"your people"* and that without structured university wellbeing support through community building, or the benefit of an established social network, there is also a culture of 'heavy drinking and partying' that can also be hard to navigate:

> *"I think there was an expectation of the university [Residential Life] to do a lot more, but then again I think coming here and there's so much stuff, so much new things that you're interacting with. And it's just a lot of people are doing a lot of drugs and a lot of drinking. I think it's a time where there's always going to be a lot of mental health problems and it's just got to shock some people. As opposed to school where you have got these close relationships with everyone, and you just don't have that anymore…"* **Home UG Fourth Year Geography Female**

Similarly, in the 1:1 interviews where students arguably felt more able to be candid, one of the biggest support concerns involved issues with 'where' a student lived, or 'who' they lived with. A poor fit in accommodation was very often the reason a student was seeking help, not only with an impact on responsive wellbeing service resource but causing considerable stress and disruption.

> *"I just didn't love my accommodation, especially where I was in. I found it very – I didn't find people to be the friendliest, mostly because everyone had kind of figured out what clubs they want to join or societies they wanted to join and stuff, and people were just coming in and out, and I didn't even know what bus to use. It was definitely very, very isolating."* **UG International First Year Engineering (gender omitted)**

Arguably those accommodation issues which appeared to have significant wellbeing consequences might have been prevented. Several students questioned accommodation allocation as a starting point, suggesting many transition

challenges could be mitigated by better strategic planning. Many of the students interviewed had experienced problems in their living environment. While some concerns were more serious matters concerning drug use, sexual harassment or homophobia on campus, many more experienced lower-level social problems with flat-shares, disruption or privacy issues, all of which caused enough stress to force them to seek help.

> *"I feel like the group in halls was very female dominated, like there were a lot of girls in the hall. And it wasn't a very well distributed hall, so it became very bitchy very quickly, and it was quite difficult for some of us. So, first year was quite difficult. But I think it was just a poor mixture of people because the other groups above and below us did fine."* **UG Home First Year Humanities Female**

> *"I'm not really sure why, I was put with international students, so I literally just lived with four international students, and they weren't maybe as sociable as me, or maybe they didn't have the same expectations, so they sort of stuck to themselves, and at the same time I could see lots of other people who had flatmates, and they were doing everything together, sit down at meals together, and have rotas and things. And then in my accommodation, I just used to go back, and I used to have well I didn't really have anyone."* **UG Home First Year Medicine Male**

7.6.6.2   Belonging: Representativeness

The sub-theme of 'Representativeness' is concerned with the extent to which a diverse community of students (and staff) felt wellbeing support services were accessible to them, reflected or understood their needs, and how that in turn connected to their feeling valued and part of the university community. Critically that also influenced how likely some students were to seek support. As previously discussed in Chapters 2 and 3, the wider literature and findings from the cross-sectional surveys highlight several groups who are potentially more vulnerable to

mental health or wellbeing concerns e.g., students with a lifetime mental health issue or a disability, students of minority gender, sexuality or ethnicity, international students and students who are first in their family to go to university. There was considerable evidence that staff and students felt some ground had been made in changing both the demographic and focus of student wellbeing services to reflect the population they serve.

> *"I had a student say they went and spoke to a Wellbeing Adviser, and they weren't culturally competent but then they were actually able to recognise that and were able to signpost them to someone else at the school."* **Student Administrator**

> *"So, I met that senior resident twice, but then after that they sent – I don't know why – but the senior resident that came was a black woman after that. So, I was like, okay, this is really cool. It's interesting."* **International UG First Year [course omitted] Female**

> *"…so I think [the university] are trying very hard to support LGBT groups and different kind of awareness months and appreciating different cultures which I definitely have not seen as much at other universities."* **Home UG First Year Science Female**

However, perceived barriers for different groups of students were still apparent.

> *"It is insane because it's one in two postgrads suffer from mental health issues. Whereas it's one in three in the whole population. But there's nothing specific to look after postgrads."* **Home Final Year PGR Health Science**

> *"I feel, like, a lot of the times whenever we hear about postgrad, it's always targeted at PGRs, whereas I am on a taught programme. I literally feel no support."* **International Masters Law**

> *"It's very much UK, home, coming straight from school who have been supported by a family. I work with mature students, care leavers and*

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estranged students and sometimes some of the advice they are given is totally inappropriate like 'Have you tried to go out of the house?' Some of them have got really severe mental health issues but some of the approaches we use are not looking at what the student needs." **Student Support Manager**

Issues of representation and barriers to using the services were especially common for students who had added social, cultural or language challenges:

"I did have expectations. I was an international student and being Caribbean I didn't know what kind of representation I would have, but I still don't feel comfortable speaking...I don't know who I would speak to about those specific things. I feel like international students have quite unique needs and I don't know if any of the wellbeing team deal with any of those concerns specifically- like representing ethnic minorities – I don't know who to speak to about that." **UG First Year Social Sciences Female**

"I think personally, I am willing to talk to someone in both English and Chinese, but I think for some students maybe they are just not so confident in their speaking ability. And that's when you are really feeling stressed and basically dealing with written English every day, and sometimes you just want to talk to someone in Chinese. I think that's why those students don't usually turn to the professional services." **International Exchange Social Sciences Female**

One in five students studying at this institution were from overseas in the academic year 2018/19. Those different cultural issues faced by international students were a key concern for many academic and administrative staff who did not believe the new wellbeing service intervention was right for this group, with cultural barriers meaning many students would not even approach services in the first instance.

"That particular student just doesn't speak- so giving her a phone number to a Samaritans helpline or the Mind nightline is pointless. She will not... she won't speak, she finds it incredibly difficult to talk about what's going on because she's had years of not having her wellbeing understood culturally. It is not acceptable to have mental health issues where she's from. So, she's come here with all of this support…and she didn't know what to do. That's consistently seen across particularly Chinese students …there is a cultural barrier for them to access the service. They don't understand. They don't think they've got disabilities, or any problems and their parents are telling them, 'oh just get on with it, it's just... that's what being a teenager's like. Oh no you don't need to speak to people; you just get on with it.' It's really heart-breaking to see that." **Centre Administration Manager**

"20% of our students are international and then we have about another 2,000 students who aren't full time students. They'll be Study Abroad or Erasmus or Pre-sessional or International Foundation. Those non-standard students are forgotten about I think at every step of the journey but also the focus seems to be on undergraduate home students. So postgraduate and particularly postgraduate international for undergraduate international students are forgotten about again. And relying on them to disclose when there's a problem especially if they are short term… isn't working as well as it could be." **International Student Team**

Those cultural barriers clearly linked back to focusing adviser resource on creating inclusive communities ('Proactive versus Reactive-Community building'), reducing the likelihood of students 'not fitting in' and preventing downstream wellbeing issues. This home student had experienced refugee status, was first in their family to go to university and identified as black british, all of which they believed contributed to the challenge of studying at university. They suggested that a lack of representation and 'feeling like an outsider' inevitably led them to wellbeing services:

"It wasn't about how hard the load was, it was about how insecure I felt in the university, how insecure I felt walking around, how insecure I felt just – I didn't belong. It was about that. I think that was the main problem. It was about how I really feel. Yeah, it was more about that than – it was that that was affecting my mental health and then my mental health was affecting my productivity, and that's what the main issue was". **Home [course, year, gender omitted]**

"The Chinese community is really big. They like to interact with themselves, but then it's really hard to enter that circle when they don't want to interact…we have international events. The university has been trying to organise more, like on the Asian culture, because they then give them the confidence, by feeling at home you avoid that home sickness..." **International PGR [course omitted] and Senior Resident Female**

7.6.6.3 Theme Four Summary: Belonging

Concepts related to the ability to forge early social connections in a community in which people feel 'safe', 'part of', and 'valued', were particularly important for student wellbeing, and with direct implications and consequences for services. Isolation and loneliness appeared to be intrinsically tied to later wellbeing service use. Representation and representativeness were also key issues for students not only in seeking support but in 'feeling' part of their communities. Not surprisingly this was particularly apparent for minority or marginalised students. Social and cultural barriers in seeking help or even engaging in the university community were still apparent, however there was acknowledgment that things were starting to change and improve.

7.6.7 Theme Five: My University Cares

"…plenty of students, mainly the ones who have been here before the change, still have the concept of the previous system…" **International PGR Third Year Engineering Female**

A final theme - 'My University Cares' represents conceptual evidence of a need for 'the university' to be perceived and experienced as a safe and supportive community by students and staff, both in regard to the effectiveness of wellbeing services and more broadly. Its foundations lie in detailed codes which focus on wider institutional narrative, visible support, a holistic approach, and responsibility as all linked to the new wellbeing service changes (see Table 7.5 and Figure 7.8). The concepts were often contextual, but nonetheless critical, in participant accounts of their expectations and perception of the new services.

Figure 7.8 Conceptual Thematic Model of Theme Five: My University Cares
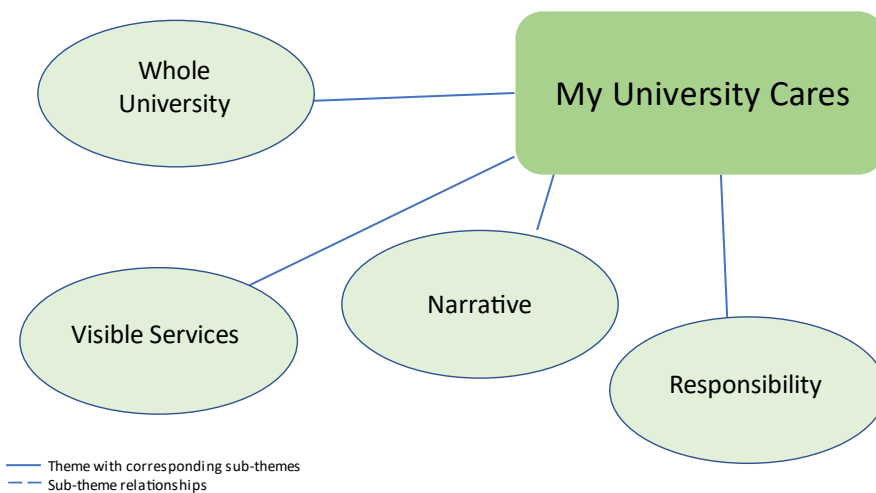
7.6.7.1   My University Cares: Narrative

The service introduction in September 2018 represented a substantial new financial investment in university support for this institution against a background of long-standing national concerns about lack of services. Although generally welcomed in faculties and schools, the changes to the existing residential support model in halls (from academic wardens to professionalised wellbeing advisers) had been met with some student and staff resistance. The longer-running negative narrative concerning student mental health more generally and the specific changes in the university's warden model was still very noticeable in student and

staff accounts of the new services. All the focus groups and most interviewees referred to the wider university mental health reputation when discussing wellbeing services, despite it never being directly asked about.

> *"I had heard before coming to university certain things about mental health at [institution]...so, that was actually, now that I'm remembering, that was actually one concern my parents had for me."* **Home UG First Year Law Female**

It was evident, particularly for new students that the broader public image of university mental health support influenced their expectations of what their experience might be like. Those expectations almost always differed from the reality:

> *"I think the reputation that mental health here is so poor and this and that…and I didn't feel that necessarily. I felt like I was supported when I came. I didn't feel like I was ignored. I felt I was supported. That's a good way of putting it. They [wellbeing services] do well!"* **Home UG First Year Humanities Female**

> *"I actually championed them a bit [wellbeing services] with people because people were quite like…don't know why…but they were very down on them. I think there's a perception of them not being good, but no one seemed to say why. So, the fact that the first day they were telling you where the wellbeing service is, to have someone then come and be like they don't put any effort in, they don't care about our mental health and stuff, I'm like, 'that doesn't add up', you know what I mean?"* **Home UG First Year Humanities Male**

In residences too, the reputation of the warden model meant that expectations and lived experience of Residential Life differed significantly:

> *"…just in terms of the reputation of mental health versus the actual experience for me…I just heard rumours and things, but I would say that*

if it was like a sort of five-star chart I would say my experience was quite high up…It's good that they have it so it's accessible, especially because up in [residence] it's all so close together and you're not far from support which is quite good." **Home UG First Year Dentistry Female**

There was also recognition of a considerable difference in institutional tone on mental health. The launch of the new services appeared to serve as a vehicle for changing the conversation: signalling investment as well as commitment and offering an opportunity to shift the narrative from negative *'lack of support'* and *'stigma'* to positive *'care'* and *'mental health awareness'*.

"It feels there's a different culture around mental health at the university. I can't explain it … I don't actually know what the policies or the provisions are per se, but I can clearly see the difference in culture amongst – I feel like it's taken seriously. I don't know how, what happened, but I feel like it's a different culture which makes you feel more heard." **Home Masters Fourth Year [course omitted] Male**

"'Because of the wellbeing concern and the fact that now you can actually say, 'There are hubs around the university that there is always going to be someone around'. That gives a bit of relief to the parents. I can now say that it's a really good impact compared to other universities on that point, because parents say, 'I know my kid, if they stay in university accommodation there is always going to be someone'." **International PGR [year and course omitted] Female as well as Senior Resident in Hall**

However, concerningly, for many students a reputational legacy and *'negative word of mouth'* was still a real barrier to even approaching the new services:

"In second year I was having a bit of a struggle, but I just really didn't fancy going to the uni. I don't know why, but I just thought that after hearing stories that it was just going to be a goose chase, going here, there and everywhere. I just thought no, I won't do it, and I just started

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to pick up something else and try new hobbies and things. That didn't really work, but I don't know, it seems a bit scary sometimes [to go to support services]." **Home UG Third Year Politics Male**

Similarly, despite a perceived change in cultural narrative, there was also some cynicism that the investment and change may not have been made for the *"right reasons"* (or in the *"right way"* - see 'Joined Up Approach').

> *"I think students as well… I think they're convinced that the university have introduced that wellbeing service after a couple of years just to show to the public, 'oh see we're doing something,' but they're not actually investing. They're not actually funding these services; they're not actually doing anything else."* **Home UG First Year Anthropology Female**

7.6.7.2 My University Cares: Visible support

Increased visibility of support services was very apparent in the data. The introduction of the new model meant that across the board students had been exposed to university communication about where to seek support, and almost all students described frequent '*nudges*' in the form of posters, emails, face-to-face talks and flyers.

> *"I knew what support there would be once I got into Halls. Because they're quite clear, they do lots of little sheets and posters around. They make it quite clear where the support is and where you can get help, which was really comforting actually."* **International UG First Year Engineering Female**

> *"It's really clear, to me, that much more effort is being made to not only try and develop services, but actually to inform people of what they are."* **Home UG Second Year Maths Male**

> *"I get notified from EVERYWHERE."* **International Masters Health Sciences Female**

For some students just *knowing* support was available was enough to feel *'confident'* and *'safe'*.

> *"I felt like it just puts people at ease that the support is (a) available and (b) it's absolutely okay and to see you're probably definitely not the only one struggling because there are posters about it…if you're like sitting on the toilet. You can just do it in confidence."* **Home UG First Year Science Female**

> *"I think it was useful in a sense of making me feel sort of grounded and like welcomed and accepted because I know a lot of other, from my friends who went to other unis, that kind of support was not available for them and hence they sort of felt very sort of trapped."* **Home UG Second Year Chemistry Female**

Reassuringly, several international students, who often described cultural barriers to seeking support and were referred to by staff as *'harder to reach',* (See 'Belonging-Representation')*,* had also been influenced by the level of mental health awareness that the new services facilitated.

> *"I think I was actually quite influenced by this whole 'how mental health is important' thing and I realised how important it is after I come to the UK. I didn't much be aware of that before, but I think I personally started to pay more attention to it after I came to the UK. And I think that's why I would like to reach out, I would like to talk to someone to seeking some help…"* **International Exchange Sociology Female**

> *"I think the fact they keep reminding you of what kind of help you can receive and that there are people that you can talk to. There is Wellbeing. There's Resi-Life advisers and I think it's good to remind people that yeah, you can reach out for help. So, yep. In [my country] they don't really do it. It's not a thing…"* **International UG Foundation Psychology Female**

One PGT student who had been at the university both before and after the new investment reflected that his journey might have been easier if the wellbeing services (and the mental health awareness they amplified) had existed when he started:

> *"I think if I started my undergraduate right now, I think it would have been different because they would have caught me, as in they would have caught me earlier....I think at some point I would have bumped into some sort of wellbeing because now it's like it's everywhere. I can't miss it so it's like I would have bumped into it."* **Home PGT [course omitted] Male**

However, even with significant promotion of wellbeing support, once again many staff were concerned that services may still not catch or encourage the hardest to reach students.

> *"I do think that's a big problem at the university … that hard to reach hidden group, still not engaged, still problematic, we don't have much impact on that group of students and that's a problem..."* **Clinician focus group**

And for some students while the services may be more visible, there was still a barrier to using them:

> *"The hard part is reaching out, because I know there are lots of nice people out there who can give you that advice and just talk to you, like they understand the struggles you're going through. It's just about the student connecting with the services."* **Home UG First Year Medicine Male**

7.6.7.3 My University Cares: Whole University

This sub-theme captures evidence that both staff and students saw wellbeing support as unavoidably and inextricably part of a more complex issue. For many, a background of growing adolescent distress, student numbers, university culture,

pedagogy and staff wellbeing all contribute to the mental health support issues that universities face and the provision they offer. Without systemic change across the education sector, there was repeated group concern that new wellbeing services may only ever be a *"sticking plaster"*.

> *"We mentioned the health crisis amongst young people. It's bigger than student wellbeing…"*

> *"It just seems a bit pointless investing…the university investing money in a wellbeing service when they keep taking more students on. Every cohort gets bigger and bigger. What's the point in creating a wellbeing service when there's too many students for us to properly be able to look after them."*

> *"I'm not saying it's doomed…it's not doomed as a service, but I think it's bigger than this university."* **Student Administration Focus Group**

Several focus groups also flagged the link between staff and student mental health, questioning how a new student support service can make a difference in isolation.

> *"I definitely see academics' mental health and wellbeing as a necessary for universities to focus on alongside student mental health. It's not sufficient to say, 'right we're plugging all of this effort and money into student mental health' if they're not also prioritising academics mental health and experiences."* **Home UG Third Year [course omitted] Female**

> *"It's the grand irony of the wellbeing service that has got no wellbeing for its staff."* **Residential Life Adviser**

There was also considerable reflection that *"studies and wellbeing are inextricably linked"* (**Academic Tutor**), and therefore support services are necessarily tied to pedagogy and course structure.

"…what things can we provide on an individual scale for students to support their mental health, what are the structural things which are actually creating an environment which isn't conducive to positive wellbeing in the first place? And that might be having a more linked up transition from sixth forms and colleges to university. That might be looking at the way assessments are structured over the year. Is it actually the best thing to have January exams as well as June exams?" **Home UG Third Year Economics Female**

This student questioned the balance which was echoed by others, between the necessary challenge of academic study and the wider university social experience:

"They're getting depressed from first year which is…it just shouldn't be. It should be more relaxed, and kind of enjoying and finding balance between a social life and academic life. But people are just very confused and very depressed because of their course…and it's sad really." **Home UG First Year Social Science Female**

Alongside academic issues, those problems with accommodation and '*living arrangements*' described earlier, also appeared to be critical in their perceived impact on services (see 'Belonging- Connection'). Many first year students described initially sharing university flats in groups where they were unable to form relationships, causing them considerable stress and upheaval at a time when they were hoping to settle in, and others described issues with noise or privacy affecting their wellbeing. Many of those perceived problems inevitably led them to wellbeing services.

"I explained the problem, the room is very small. I feel stressed out you know. I don't want to live there… he listened to me very patiently, a very kind listener but, again, the only output was we have to learn to manage things in life… So, in the nutshell, the entire focus was on me to cope with the result of my stress…" **International Masters First Year [course omitted] Male**

Accommodation, social or pedagogical issues in the university environment all raised complex questions about whether the focus of any wellbeing support model should be on helping individuals to cope with the challenges they face or on addressing the perceived environmental stressors.

7.6.7.4 *My University Cares: Responsibility*

A final sub-theme is 'Responsibility'. This concept came up repeatedly in the focus groups and interviews when discussing the effectiveness of wellbeing support services. Several staff from across disciplines questioned the university role in student support, and whether the new model is justified or sustainable.

> *"How much support do we give? Is it supposed to be a self-help... you know, if they encourage them to self-help and they've put them on the road and everything, but actually my worry is that, sometimes this service is over supporting students throughout their studies and then where does that fit in with the university ethos of providing... you know, of producing strong, independent, young people that can go into work and everything?"* **Student Administration Manager**

Students too questioned the broader understanding of what a university support model could or should provide:

> *"I think there needs to be that clear distinction between University and what they're able to provide to students and more specialist services that are provided by the NHS or privately and that's a really, really hard reality and in an ideal world everyone, not just students but everyone in any walk of life, any age, whether they're at University or not should have access to long term mental health support if they need it, but unfortunately that's not the case and I think it is important for students not to start seeing the University as a crux for them, not least because when they eventually leave University, that's going to be an even more difficult transition."* **Home UG Third Year Economics**

While this new service model was designed to intervene on student wellbeing issues early - before they become more complex, several staff were also concerned that offering low-level welfare support could also simply exacerbate caseload by medicalising distress. Raising mental health awareness and promoting new university services appeared to have had inevitable downstream consequences with growing numbers of students seeking help (see 'Proactive versus Reactive'). This member of staff questioned whether the university can indefinitely resource the new wellbeing model.

> *"We're spending a lot of money putting these services in and all it does is confirm for the parents of the students, the students and the other staff in the university this is dangerous, this is unmanageable, this needs professional help, when actually we just need to be telling all of our staff, "Be a human. It's okay if someone comes and cries in your office, you just go, 'That sounds really hard. Hopefully just having this chat has helped a bit, I'm glad you got that out, you know things will be alright. Do come back and see me if they continue to get difficult.''' But that's not the direction that we've gone in, and I wonder where we go from now. I feel like we're going to end up employing yet more support staff because particularly Resi-Life are under so much pressure to manage the ones they've got, that they only thing I think they can do is employ more people".* **Support Service Staff**

Staff and students talked about the university transition being a 'perfect storm' for challenges - first time away from home coupled with social, developmental, and academic pressures, however this student counsellor was concerned that university support services are dealing with the consequences of much earlier socio-educational influences, not least the *"battle"* to get into competitive universities.

> *"I think the thing that always strikes me…it's such a competitive university, I think, to get a place, I think it's like an average ratio of seven people apply for one place. Loads of them have just really hammered*

*themselves before they get here and the pressure that's been on before just really does have a toll, I think." **Student Counsellor***

Similarly, while there was recognition that university is often not the starting point for many students' mental health challenges, it can be a critical point for positive intervention in a young adult's development. One GP stressed that the mental health changes they witness on the ground, cannot be addressed with a low level intervention in isolation.

> *"What I am struck by is the increasing complexity and severity of the mental health that we're seeing, and that's going up rather than going down, but this probably wasn't put in to sort that out, it's perhaps the people that we weren't going to see in the first place. I don't know... It's maybe the unknown that I still don't know about..." **GP SHS***

The tension between the presentation of more complex mental health problems and a perceived pathologising of distress presents real challenges for the services. That was echoed in wider staff and student concern about the blur in duty of care, the 'in loco parentis' role and the boundaries of responsibility.

> *"I know how strained they are as it is [wellbeing services], but that kind of reassurance that however bad it is, I can call them...it's not the university's responsibility for my mental health problems because I came to uni with them and they're quite complex" **Home UG Third Year Biology Female***

> *"At the start of the Residential Life I used to worry about them [advisers] in terms of them almost being in a loco-parentis role, when we had people who perhaps come back from hospital having overdosed, and you'd hear that Resi-Life had been quite amazing, going to check in on them and then there was this real kind of blur of margins of gosh, what are they being asked to do?" **Clinician SHS***

Many academic staff described ongoing anxiety about their role in supporting students despite the new wellbeing services:

> *"As a personal tutor I don't feel that my own risk exposure is in any way diminished by Resi-Life or Wellbeing services. I still have my responsibilities and if I get something wrong or if something goes wrong on my watch then it's my fault. I don't feel that the whole set of services diminishes that in any way."* **Senior Academic**

The concept of *'responsibility'* for student mental health was also framed by an understanding that 'the university' can often be seen as an anonymous, authoritarian/establishment figure, rather than a community that students are part of, contribute to, and can have an influence on.

> *"Students are active in preventing it [poor mental health], not just seeing students as the potential victims. But as actual people that are part of that and can be a positive influence, or could be a negative influence, and need to understand that. 'Cause I don't like that all of the thrust has been put on the university's responsibility. I know that these kids are 18, 19, but if they have such a high influence then I think effort should be made to make them have a positive contribution to the issue, because they're involved in it… I think it's easy for people who are angry and upset to perceive it as like this evil organisation."* **Home UG Second Year Maths Male**

Others also questioned where the burden of responsibility lies in an education environment where a student pays fees. Is the student *'a passive consumer'* or an *'active participant'?*

> *"The university's an easy target…that's seen as proof that it's incompetent in that area and that it doesn't care, which I think is like it's not proof of that, because I actually think that students have a much greater influence on each other's mental health then the university ever can, so to put the blame on the university is, I think…defeatist. Then*

*there's the whole, well, we spend nine grand a year, so there's the feeling of, therefore, everything should be perfect." **Home UG First Year English Male***

7.6.7.5 *Theme Five Summary: My University Cares*

The wider cultural narrative around student support services and mental health appeared to have an important influence on both student (and staff) perception of wellbeing support. Negative social narrative presented a barrier for students and appeared to erode trust in seeking and even offering help. Similarly, positive narrative appeared to give these students (and staff/parents) confidence and reassurance that they were well supported. The findings suggest that the launch of the new wellbeing service model, in and of itself, facilitated a positive shift in the wider institutional mental health culture, reputation, and awareness. In the short term, that was experienced by students as wellbeing support which largely exceeded their expectations. However, the narrative data also suggest that both staff and students had an implicit understanding that support services alone cannot address mental health problems, and any investment and change needs to be mirrored in pedagogical concerns, staff wellbeing, and changes in both university culture and earlier education settings. While there was an understanding that wellbeing support is not a limitless resource, any nuance around what appropriate university support looks like was complicated by different perceptions of the 'in loco parentis' role of the university and the wider debate about the student as a consumer.

7.7   Chapter summary

Using reflexive thematic analysis to examine staff and student testimony, I identified five key themes in relation to the new wellbeing services: Trusted Friend; a Joined Up Approach; Proactive versus Reactive; Belonging; and My University Cares. It was apparent from the narrative data that the new non-clinical services filled a gap (Trusted Friend) - providing more accessible, timely support for students seeking help, alongside academic and clinical welfare pathways. 'A Joined Up Approach' spanned evidence for procedural and operational challenges

including a lack of clarity in service roles and responsibilities, and issues concerning communication, information sharing and risk management. A third conceptual strand (Proactive versus Reactive) suggests that the intervention launch and consequent increase in the volume of students seeking support, compromised the ability of the service teams to operate (as originally intended) both responsively and proactively. This was particularly relevant in residential halls e.g., in providing outreach, workshops, community building. Additionally, there were concerns that some students remained 'harder to reach', with the new model still relying on students to actively seek support rather than identifying those at particular risk.

A fourth theme 'Belonging' outlined evidence for the importance of a sense of connection or isolation in determining student mental health and wellbeing and its impact for use of the wellbeing services. Some ongoing barriers to service use were still notable in student experience of the new provision such as cultural sensitivity and representativeness, however positive change was also apparent. A final theme reflects the importance of the service introduction in shifting a wider negative cultural narrative about university support, as well as reducing stigma and increasing mental health awareness. However, there was considerable concern about individual versus institutional responsibility in resourcing student support. In sum, these findings offer important and detailed insights into the impact of the services introduction.

The following chapter presents a further synthesis of this qualitative evidence to support and extend my statistical analyses, and to generate overarching conclusions about service impact and effectiveness.

Chapter 8 <u>Impact and effectiveness - synthesis of evidence for a new university wellbeing service</u>

8.1 Chapter overview

This synthesis chapter presents the integration and interpretation stage in my mixed methods approach. A summary of individual results from all four studies covered in Chapters 4-7 is followed by a detailed synthesis of the key convergent and divergent quantitative and qualitative evidence to generate overarching main conclusions from this body of work. Those synthesised findings are then discussed further in relation to existing literature and theory in a final chapter (Ch.9).

8.2 Summary of individual study findings

My primary research aim was to examine the impact and effectiveness of the introduction of new wellbeing services providing student mental health and wellbeing support in a large UK university. In a pragmatic approach, taking advantage of a natural experiment which saw a step change in university wellbeing investment, I used a parallel convergent mixed-methods research design to evaluate service impact from a number of different population health perspectives. I developed and conducted four studies: measuring change in student population mental health outcomes and help-seeking behaviour before and after introduction of the new wellbeing services; investigating secular trends in other student wellbeing indicators such as counselling presentations and course withdrawal rates; direct examination of student use of the new services in faculties and halls of residence; and qualitative analysis of staff and student views of the wellbeing services in focus groups and interviews. The individual findings of those studies are now summarised in Table 8.1 below.

Table 8.1 Summary of Thesis Research Findings

Student mental health and support seeking (Chapter 4)
Change in cross-sectional student survey responses between May 2018 and 2019, pre/post new services introduction in September 2018

Mental Health Outcomes (all students)

A 14% drop in odds of students[44] with higher levels of anxiety (GAD-7$\geq$10) in 2019.

A 16% drop in odds of students experiencing poorer mental wellbeing (WEMWBS$\leq$42) in 2019.

No change in odds of students experiencing higher depression symptoms (PHQ-9$\geq$10) in 2019.

Weak evidence for an improvement in mental wellbeing for students identifying as a minority gender in 2019, but a worsening in levels of depression for LGB(TQ)[45] compared to heterosexual students.

Help-seeking and usefulness of university support (first years only)

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[44] Students responding to the Student Wellbeing Surveys in 2018 and 2019
[45] As outlined in footnote 20 I use the term LGBTQ - but my gender (and transgender) and LGB analyses were separate

The proportion of *first year* students seeking support for a mental health or emotional issue increased between 2018 and 2019 from all sources of university support except for the Students' Union and Togetherall (online peer support)

First year student perception of the usefulness of Staff in Residences[46] deteriorated between 2018 and 2019, falling from them being rated the *most useful* source of university support by those using them to one of the *least useful*.

First year student perception of mental health professionals, GPs and university support staff all improved in 2019, with no evidence of change for any other support e.g., academic staff, SU or telephone/online support.

Wellbeing advisers were rated[47] as more useful than academics and online/phone services in 2019 but were less highly rated than clinicians e.g., mental health professionals, GPs.

Barriers to seeking support (all students, first years, and students with symptoms of severe major depression)

The most frequent barriers to seeking university support for *all* students who had experienced a MH concern but did not seek support in 2018 were 'lack of available services', a 'lack of time', and the 'fear of unwanted intervention'. In 2019 that became 'fear of unwanted intervention', 'lack of time' and 'concern that no one would understand the problem'.

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[46] *Staff in Residences* comprises all staff in accommodation for 2018 and Residential Life for 2019
[47] No year on year comparison as faculty wellbeing advisers were only a limited service in 2018

For *first year* students 'fear of unwanted intervention' was the most frequently reported barrier to support seeking in 2018 and 2019.

The most frequently reported barrier for students with symptoms of *Severe Major Depression (SMD)* was a 'lack of available' services in 2018 which improved in 2019 to be replaced with 'concern no-one would understand the problem'.

Fully adjusted models showed lower odds of *all* students citing 'lack of available services' (41%) and 'difficulty accessing services' (33%) or 'not knowing where find help' (15%) in 2019. There was a corresponding trend for *first years*, but no change in 'not knowing where to find help'. Students with *SMD* symptoms reported lower odds for 'lack of available services' (53%) but not for 'accessibility of services', and increased odds of 'not knowing where to find help' (60%).

Secular trends in further student wellbeing indicators (Chapter 5)

Trends in other routinely collected student wellbeing data between 2014/15 and 2018/19

Anti-depressant (SSRI) prescribing at the on-campus Student Health Service levelled off after 2018 following the introduction of new wellbeing services, and after a yearly rise since 2014/15.

Incidence of students being referred to the Student Counselling Service fell by 7% between 2017/18 and 2018/19, after a yearly increase since 2014/15.

Course withdrawal rates for *all the reasons* students give when prematurely leaving the university remained relatively stable from 2015/16 to 2018/19. The proportion of students citing *mental health reasons only* for withdrawing, levelled off in 2018/19 after the introduction of the services, but the trend was not statistically meaningful and not apparent in *first year*s.

Nationally - overall student course satisfaction ratings (NSS) for *final year* students were largely stable from 2015 to 2019, but at this institution *final year* student perception of their course deteriorated in 2018 and improved again in 2019.

Student perception of the university's wellbeing support overall (assessed using two separate institution surveys[48]) deteriorated considerably between 2017/18 and 2018/19, the year after the introduction of the new university wellbeing service.

Wellbeing and Residential Life service use (Chapter 6)

Characterising use of the new wellbeing services with one-week student and staff census surveys in Nov 2019 and Feb 2020

Mental health prevalence and presenting issues

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[48] Students indicated level of agreement with the statement *'Good support has been available for my well-being'*- these findings may have been constrained by the comparability of the datasets

Wellbeing and Residential Life services were each typically seeing over 100 students a week, with those students seen showing poorer mental health as indexed by average PHQ4 score (MD 1.77, 95%CI 1.28 to 2.26, p <.001) than the wider student population i.e., respondents to the *Student Wellbeing Survey*.

There were indications that students seeing Wellbeing advisers reported poorer mental health than those seeing Residential Life advisers, however the difference was not statistically meaningful.

Female, white, undergraduate and foundation year students were overrepresented among wellbeing service users in the staff surveys compared to the wider university population in 2019/20. The new services also appeared underused by several student groups identified in the wider cross-sectional *Student Wellbeing Surveys* as vulnerable to poor mental health such as postgraduate taught, international, and Black Asian and minority ethnic students.

Students using new services typically reported more than one issue; and the greatest concerns were stress and anxiety (65.7%), low mood and depression (48.1%), and study difficulties (35.3%).

Accessibility and helpfulness of new services

78% students found it *very or fairly easy* to book an appointment with Wellbeing and Residential Life advisers, less than 5% found it *very or fairly difficult.* A greater proportion of students using Residential Life (65%) found it *very easy* to make an appointment compared to students using the Wellbeing service (35%).

Three quarters of students found Wellbeing (76%) and Residential Life (75%) *very or fairly helpful.* Perceived helpfulness was slightly higher for Wellbeing than Residential Life, but with no differences between adviser *helpfulness* in academic departments or residential villages.

Adviser caseload/mix, referral process and confidence

98% of advisers were mostly or completely confident in the actions they took to support a student, with Wellbeing advisers slightly more confident than Residential Life advisers. Areas of less confidence included: complex issues and serious situations which require further input; students not being able to access counselling or more suitable support; training in bereavement/panic attacks and more practical tools; language barrier and cultural concerns; a need for further input from faculties or academics

Staff and student views and experience of the new wellbeing support (Chapter 7)

Five key conceptual themes (with sub-themes) developed in thematic evidence from focus groups and interviews with >120 staff and students including illustrative quotes

Trusted Friend (Timely and Accessible, Human Gateway, Known) – the new services offered more accessible, timely and approachable support for students seeking mental health and wellbeing support in 2019 compared to the previous model, and presented an alternative to academic, online, and clinical support pathways.

"I very much saw them as a signposting service with the added bonus that they were actually human beings with sympathy, and they were orientated towards being sympathetic towards students who might be feeling anxious or a bit distressed."

Joined Up Approach (Clarity, Communication, Consistency) – highlights operational and procedural challenges for clarity and consistency of roles, risk-management, communication and data sharing. Thematic evidence underlined the critical and ongoing issue of information sharing to prevent students falling through the gaps.

"The systems and the mechanisms for communicating between the different sections of the university are either not in place or they're

not used. We don't have a whole university system. There is no operational system to make sure that everybody concerned with an

individual student is kept up to date and it's crucial that that's put in place."

Proactive versus Reactive (Resource and Expectations, Prevention, Community Building) – reflects operational tension in the responsive versus preventative nature and responsibilities of the services, particularly for Residential Life in its 24/7, accommodation, discipline, welfare and community role. It further highlights the importance of support in the early weeks at university, and of resourcing or clearly delineating community-building effort to prevent downstream student wellbeing issues.

"…like the whole idea was proactive community building will reduce reactive welfare provision but that hasn't happened on the ground.

In order to make it a success that's something I think that needs to change."

Belonging (Connection, Representativeness) - ability of services to facilitate connection between students and the wider university community reducing or mitigating isolation or loneliness. There were similar issues of a disconnection between staff and the 'university' as a whole. Implications for services to be representative of the student body, inclusive, and culturally competent.

"It is not acceptable to have mental health issues where she's from. So, she's come here with all of this support…and she didn't know what to do. That's consistently seen across particularly Chinese students …there is a cultural barrier for them to access the service."

My University Cares (Narrative, Visible Services, Whole University, Responsibility) – the significance of the wellbeing services introduction for a positive shift in wider cultural mental health and support narrative and therefore student and staff confidence. It also underscores the importance of a whole university approach.

"It feels there's a different culture around mental health at the university. I can't explain it … I don't actually know what the policies or the provisions are per se, but I can clearly see the difference in culture amongst – I feel like it's taken seriously. I don't know how, what happened, but I feel like it's a different culture which makes you feel more heard."

8.3   Synthesis methods

The following section is a detailed triangulation of key evidence from all four studies (see [3.4](#)). The research was designed to give equal prominence to quantitative and qualitative findings with multi-directional synthesis at the interpretation stage i.e., the outcomes from the focus groups and interviews, student survey, service use and secular trend analysis now inform one another (Creswell & Creswell, 2018, p. 240; Fetters et al., 2013). With more than 30 individual outcomes, I do not discuss them individually; I draw out key converging evidence and any discrepancies between the different data sources (Table 8.1). I have used a 'weaving' narrative discussion approach for comparison and interpretation of the collective findings, merging the qualitative and quantitative findings together on a *"theme-by-theme or concept-by-concept basis"* (Classen et al., 2007; Fetters et al., 2013). The resulting main findings are captured in six key areas: Accessibility of support; Effectiveness of support; Transforming narrative; Complex systems and a whole university approach; At risk students; and the Residential model.

8.4   Accessibility of support

Overall, my findings suggest the service investment addressed some of the structural barriers students face when they are seeking university help. There was evidence that there are still some student groups who may be under-represented in service-use, despite a recognised improvement in service accessibility and cultural awareness.

8.4.1   Accessibility and availability

Before the new support introduction, 'a lack of available services' was the major reason that a student might not seek help from the university, but by May 2019 that was no longer the case. *Student Wellbeing Survey* evidence also showed significant improvement for all students in 'difficulty accessing services' and 'not

knowing where to find help' in 2019[49]. This finding is extended by strong thematic evidence which largely described 'highly visible' new services, with advisers in faculties and halls providing friendly, fast, impartial support where academic or clinical mental health support was not readily available or even appropriate ('Trusted Friend'- theme in qualitative study). Indeed, the service-use data collected 14 months after the services launch (*Student Census Surveys*) showed that more than three-quarters of students found the new support 'easy to access' and 'helpful'[50].

Those individual *Student Census Survey* findings also showed within-service differences - with Residential Life advisers generally regarded as easier to access than faculty Wellbeing advisers. That was despite strong staff and student reservations in the narrative data concerned with the new residential model having fewer staff 'on the ground' ('Trusted Friend') and the *Student Wellbeing Surveys* showing no improvement for *first year* students 'not knowing where to seek help' in 2019. This disparity may reflect the Wellbeing team's 9-5 casework patterns versus the Residential Life team's 24/7 drop-in, out-of-hours shift pattern, i.e., that students actually seeking support in halls found the services very accessible, whereas those seeing advisers in faculties were more constrained by their working hours. Further, the qualitative findings support the idea that Residential Life advisers were particularly responsive to students in distress, further evidenced by their timely and ongoing follow-up of students in halls once they had contacted services, yet they were often seen as disconnected and 'unknown' by other staff and students ('Joined Up Approach', 'Trusted Friend', 'Proactive versus Reactive'). The qualitative and census survey findings suggest Residential Life were far better received by those actually using them than they

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[49] This was not the case for sub-samples i.e., students with severe major depression and for first years -this is dealt with in subsequent sections.
[50] Census Surveys asked about 'helpfulness' and Wellbeing Surveys asked about 'usefulness'

were perceived by the wider population - and I discuss this further in Transforming narrative - <u>8.6</u>.

8.4.2   Barriers to support seeking in 2019

With improved general perception of the availability and accessibility of university support after 2018, 'fear of unwanted intervention' became the most frequently cited obstacle for student help-seeking in 2019. Critically, that distinction suggests that barriers to university support had become less structural and more perceptual, further recognition that the new services had filled a genuine gap in the previous welfare framework. That is also consistent with focus group and interview testimony suggesting even with the new services in place - self-stigma, symptomology or an unwillingness to seek help were now more likely to be an issue for students than a lack of available services- "*I know there are lots of nice people out there…It's just about the student connecting with the services.*" For *first years* 'fear of unwanted intervention' had been the biggest reported barrier to help-seeking in both 2018 and 2019 suggesting perceptual barriers precede structural ones.

Census Survey data suggested students seen by the new services were not representative of the wider student population. Female, white, undergraduate, and foundation year service users were overrepresented, with males, third years, international, and Black Asian and minority ethnic students underrepresented. Across faculties, service users also were underrepresented by Engineering and Social Sciences students and overrepresented by Arts and Life Science students. A similar pattern was seen in the mental health and help-seeking characteristics of students taking part in the *Student Wellbeing Surveys* which implies differences rooted in broader student help-seeking behaviour rather than structural barriers to the new services, specifically. In the qualitative evidence, staff and students acknowledged that improvement had been made in making the services more culturally sensitive, inclusive and representative, but with recognition of an ongoing tension between a 'tailored' versus 'consistent', "*one size fits all*" approach to wellbeing support when there are diverse communities across

different faculties and halls. However separately, the qualitative findings suggest focused 'tailored' resource was still needed to target students where there is an identified specific academic, cultural or social need ('Belonging'- qualitative theme). In my cross-sectional analysis that would include, marginalised or minority groups, postgraduate taught students or even students in particular disciplines such as Arts and Life Sciences.

8.5 Effectiveness of support

The proportion of *Student Wellbeing Survey* respondents seeking any form of university support increased between 2018 and 2019; with the new wellbeing services seeing approximately 200 students a week during the census periods. That is consistent with the 5,000 unique referrals recorded in the new services' first year of operation and an annual rise in presentations to all the institution's support services (Ames, p 207). The following section offers supporting evidence for the new wellbeing services as effective, appropriate and valued by the majority of students using them. However as mentioned earlier, broader staff and student perception of staff support in residences had largely deteriorated since 2018.

8.5.1 Perception of services

Any assessment of student perception of the new Wellbeing service in faculties pre/post introduction was inevitably limited by its innovation in 2018, unlike support in residences where the model simply changed. However, Wellbeing advisers were seen by (*first year*) *Student Wellbeing Survey* respondents in 2019 as more useful on average than academics or online/phone support but less useful than clinicians, which is consistent with the intended low-intensity but stepped-care nature of the new support. That was largely echoed in the focus groups and interviews where students found advisers useful as an alternative to academics but not when they needed more intensive support, seeing Wellbeing advisers as 'another hurdle to jump' to get clinical help (see At risk – 8.8). The *Wellbeing Follow Up Census Surveys* also showed that more than three quarters of students who used the services found them *helpful*, with Residential Life rated slightly better than Wellbeing.

Yet that was not the view of the wider student population. S*tudent Wellbeing Survey* findings suggested first year respondents had a significantly worsened perception of the usefulness of *staff in residences* between 2018 and 2019, with a corresponding lack of impact on first year course withdrawal rates (for mental health reasons). Importantly that was not reflected in the qualitative findings or the census surveys, where students seeing Residential Life advisers for a mental health issue almost always had a good experience and valued them ('Trusted friend')- *"I just had one session with that person [Residential Life] and it was really helpful."* That deterioration in how *staff in residences* were seen may have been an ongoing artefact of wider resistance to change in the original warden model (even in new first years) for which there was also strong thematic evidence ('Narrative' - qualitative theme) but could equally reflect the operational difficulties of a 'stretched' Residential Life service ('Proactive versus Reactive') which adversely affected the general student accommodation experience but not the specific welfare experience (see Transforming Narrative and Residential model).

I found further qualitative and quantitative evidence across the studies that in general Wellbeing advisers were highly valued by both students and other university staff. Although some academics suggested the new faculty support model did little to minimise their levels of day to day welfare responsibility, there was also acknowledgement, particularly from frontline administrators, that the service introduction reduced a perceived sense of risk and responsibility they felt they were holding; and similarly, by clinicians who valued the extra level of welfare in the system to support students more broadly. Focus group data suggested university staff were far less confident about the positive impact of advisers in halls, possibly again as a result of historic negativity about the change in model (see Transforming Narrative) but in the main, because academics and administrators appeared to have very little direct contact or communication with the residential team.

Meanwhile, the majority of advisers saw their support provision as appropriate and effective; more than 95% believed they were seeing the right students and felt confident supporting them (*Staff Census Surveys*). That was supported by the views of clinicians in the focus groups, who largely agreed that the 'stepped care'/intermediary role' was a valuable addition to university services. Any lack of wellbeing adviser confidence focused on complex mental health issues and a need for additional training e.g., bereavement (*Staff Census Surveys*). The qualitative data highlighted a lack of supervision and CPD for advisers in halls, which alongside their emergency/out of hours portfolio may also have contributed to them feeling slightly less confident than Wellbeing advisers.

8.5.2   Impact on other services

Further analysis of wider student wellbeing indicators also pointed to the new service introduction having the hypothesised positive impact for other university services and student outcomes. The proportion of students being prescribed anti-depressants at the onsite health service, being referred to student counselling, or withdrawing from their courses for mental health reasons (with the exception of *first years*) had all levelled off or reduced to some degree in the period after the new service introduction. It suggests that providing an alternative source of support or earlier intervention in the form of accessible, low-intensity wellbeing advisory services may have had the broader downstream consequences intended i.e., fewer students seeking unnecessary or inappropriate intervention from GPs or counsellors or needing to withdraw from their studies when wellbeing difficulties escalate. That is further scaffolded by *Student Wellbeing Survey* findings showing first year students' perception of mental health professionals, GPs and other university support staff (with the exception of academic or online/phone support) all improved between 2018 and 2019, potentially reflecting less need or reduced pressure on frontline services and administrators, easing student access to pre-existing support.

8.6 Transforming narrative

There was strong thematic evidence for a positive cultural shift in student and staff perception of university mental health support overall ('My University Cares') after the new service introduction in 2018. Despite reservations related to the resourcing and specific remit of the advisory teams (see Complex systems and Residential model – 8.9), the launch of the new wellbeing services appeared to have been a catalyst for changing a toxic university narrative which had been eroding staff and student confidence in student mental health support. The qualitative findings suggest the new service introduction signalled visible institutional concern and engagement with student mental health and wellbeing as well as increased investment, thereby generating a wider sense of students 'feeling supported' ('My University Cares').

The impact of that cultural shift is arguably strengthened by the quantitative findings. The *Student Wellbeing Survey* findings show that levels of anxiety and wellbeing improved across the student population between 2018 and 2019, after the introduction of the new services; yet there was no meaningful change in levels of student depression. Similarly, there was little convincing evidence for differential effects for any particular group of students. Nevertheless, timings and response rates may have been a factor (see 9.3.2). However, taken together that is suggestive of positive change through broader public health messaging across the whole university population i.e., improved anxiety and mental wellbeing overall as a result of greater overall confidence and reassurance in the institution's wellbeing support. Increased visibility of services and mental health awareness were very apparent in the qualitative evidence ('My University Cares'). Similarly, the improvement is mirrored in increased student perception of accessibility and availability of support services across all the subgroups examined, and in the national student survey data which suggested final year students' perception of their course experience deteriorated in the year before the new services were introduced, only to recover in 2019.

This conclusion is potentially weakened by a clear deterioration between 2018 and 2019 in *overall student perception of university wellbeing support*. Yet this particular analysis was constrained by its methodology, which I discuss further in 9.3.2. Additionally, the specific worsening in student perception of staff support in residences between 2018 and 2019 (*Student Wellbeing Surveys*) also weakens this conclusion. Despite the cross-sectional findings only being restricted to *first years*[51], it was apparent from the thematic evidence that even new students in 2019 had negative preconceptions of the service, especially those who had not used Residential Life - "*I think there's a perception of them not being good, but no one seemed to say why*" (**First Year Student**). Equally, the faculty-based Wellbeing team had the advantage of being an 'add on' to existing service provision after 2018, so may have been more positively received than Residential Life who were part of a controversial restructure. The qualitative evidence was more consistent with the introduction of Residential Life having had a positive impact on student support-seeking confidence generated by its messaging and perception of accessibility ('Trusted Friend'; 'My University Cares'), even for students who had never used services.

8.7 Complex systems and a whole university approach

With a largely positive change in broader perception of the institution's mental health provision, there was also strong thematic evidence of initial confusion for university staff about the specific nature of the new wellbeing support, both in its launch communications, how it related operationally to the existing university support framework and in ongoing service developments ('Joined Up Approach'). Staff anxiety about personal responsibility for student welfare was very apparent, particularly in relation to communication and information sharing. The qualitative findings underline the perceived absence of a comprehensive data-sharing

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[51] A limitation of the survey was that it did not provide students with a timeframe over which to consider university services, so the views of a 3rd year student responding in 2019 may well have been influenced by their overall perception of services throughout their 3 years at the university.

platform or systematic method of communicating mental health and academic concerns across university teams. That was countered by a tension for students wanting privacy from 'the university' versus a frustration at having to "*retell their story*" when information was not centrally held. Staff regularly underlined the need for ongoing wellbeing training for all student-facing employees, asking for more transparency and clarity in where personal and institutional responsibility for student mental health lies. Although in the qualitative focus groups several university staff acknowledged the psychological benefits of shared 'risk' with the new 24/7 support teams, there was no indication that the services had alleviated their day to day workload. Indeed, a lack of improvement in student perception of academics or online/peer support tools between 2018 and 2019 (*Student Wellbeing Surveys*) suggests there may be more work to do to help academics and peer mentors to support students, as well as the need to support staff mental health and wellbeing. There was related evidence to suggest that wellbeing advisers (especially in residences) as well as staff more broadly, can often feel disconnected from the 'university'.

The qualitative findings also highlight that with increasing numbers of students seeking support (evidenced by *Student Wellbeing Surveys*) the introduction of new services could not be considered a panacea. In line with a whole university approach, narrative evidence clearly pointed to student mental health and wellbeing support needing ongoing strategic consideration across pedagogy, acceptable behaviour policies, accommodation allocation, and broader public health areas such as physical, financial and social domains ('Whole University'). Similarly, poor ratings of *student perception of university wellbeing support overall* (Ch. 5) juxtaposed with high rates of satisfaction for those actually using wellbeing services (*Follow Up Census*) suggests a need to further clarify what support a university should reasonably offer ('Responsibility').

8.8   At risk students[52]

While there was good evidence that the institution's mental health support had become more accessible for the majority (Table 8.1), both the qualitative and quantitative findings suggest that for those with more serious mental health issues there were still several challenges ('Proactive versus Reactive; Joined Up Approach'). In my analysis of support-seeking barriers, students with symptoms of *severe major depression* clearly saw university support as more 'available' after the introduction of the new services, but not more 'accessible'. In fact, the odds of students with *SMD* 'not knowing where to find help' had increased, suggesting the new tier of support may have created a further barrier, evidenced by the initial frustration of students with serious mental health concerns "*being signposted around the system*". Nonetheless, qualitative evidence does suggest the introduction of Wellbeing Access had started to address that issue.

Staff and student qualitative testimony also highlighted ongoing concern that the new services did little to engage students who find it hard to seek help, and that the downstream consequences of reduced community building effort, a lack of preventative work or visible presence on campus ('Proactive versus Reactive'), particularly for advisers in halls of residence, could lead to more students needing mental health support in the longer term. While Wellbeing Access may have removed some of the structural obstacles to help-seeking for this group such as 'long waits' or circuitous routes into clinical services, the launch of the new low-intensity model did not appear to address key staff and student concerns that the 'most at risk' students may never seek support. That was further underlined by the apparent absence of systematic communication between university stakeholders i.e., academics, administrators and services of how or whether a

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[52] I use the term 'at risk' to include students who may need mental health support but do not seek it and those with complex mental health difficulties who need greater clinical support to study

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student of concern was being supported in the system ('Joined Up Approach'- theme in qualitative study).

8.9   Residential Model

Some of the clearest evidence across the qualitative and quantitative findings reflects the difficulties faced by the new model of residential wellbeing support. Between 2018 and 2019, staff in residences went from being one of the most valued university support services to the least valued. As described earlier (see Effectiveness), service users in both the *Census Surveys* and qualitative interviews generally experienced the Residential Life advisers as helpful and responsive, yet staff and the wider student population often rated them poorly. As described earlier, thematic evidence points to inherent difficulties for Residential Life, not only as part of a controversial restructure of an existing model but also in the breadth and 24/7 nature of their role ('Proactive versus Reactive'; 'My University Cares' - themes). Furthermore, there were clear indications that the team were under strain and potentially more disconnected from the wider university ('Joined Up Approach'- theme). Both wellbeing teams' ability to resource effective outreach appeared to be compromised by the initial volume of students needing mental health and wellbeing support, but community-building resource in student accommodation appeared to be the most negatively impacted ('Proactive versus Reactive'- theme).

There were calls to separate or more clearly delineate the teams' responsive and preventative roles and to invest greater resource in community building, particularly if service-user volumes continue to increase. As mentioned earlier, while wider university perception of the new accommodation model was likely to have been influenced by cultural narrative - almost all staff, including the advisers, expressed concern about the complexity and demands of the role. It was apparent that without resource or reorganisation, it had potential to negatively impact the broader student accommodation experience, setting up wellbeing issues for the future ('Proactive versus Reactive'- theme). The hall of residence experience is, by necessity, largely focused on transition and first year students, but the lack of

improvement for this group in course withdrawals *for mental health reasons* suggests it may not have been helping to improve first year outcomes. Similarly, a favourable perception of the Residential Life team's usefulness and accessibility by service users (*Census Follow-up Surveys)* is undermined by the finding that first years in general saw no improvement in 'not knowing where to find help' (*Student Wellbeing Surveys*). It re-emphasises the implication that the responsive welfare experience in halls was well-received but at the expense of the wider accommodation experience i.e., the intended Residential Life remit for community building/preventative activities was compromised by adviser caseload.

8.10 Summary of main (synthesised) findings

My main overarching findings suggest the new services offered timely, low-intensity welfare and advice for a greater number of students, providing an accessible alternative to academic, clinical and online support. Student perception of barriers to help-seeking such as availability and accessibility of mental health support reduced, and population levels of anxiety and wellbeing had improved after the first 12 months of service operation. The majority of students using the new services found them easy to access and helpful, with advisers filling a gap between academic and clinical support, and offering a fast, professional welfare response to students in distress. Advisers were generally confident in the support they offered and nature of issues they were dealing with, and many university staff felt reassured by the extra level of welfare in the system.

Wider impact was also seen in anti-depressant prescribing and student counselling presentation trends which levelled off after yearly increases since 2014. Student perception of GPs and student counsellors had also improved, suggesting the new services may have eased access to other university health services. It was further apparent that the service introduction had also been a catalyst for change in a toxic mental health narrative which was adversely affecting student and staff confidence, to one that offered reassurance and greater mental health awareness.

However, there had been challenges. Some vulnerable students were still underrepresented in service use, and students who are unable to ask for help may still have been being missed. Although the new services were set up to address low-intensity issues and reduce pressure on academics and clinical services, the sheer volume of student need appeared to have compromised the ability of advisers to do the prevention and community building work necessary to prevent downstream issues or identify students at risk. Similarly for academics it did not appear to ease pressure on their welfare role. For staff in residences, the model was under particular stress, with clear calls to separate or more effectively delineate responsive and community activity resource.

I now look at what those findings mean from a theoretical perspective and in the broader higher education and student wellbeing support context in a final chapter.

Chapter 9   Discussion

9.1   Chapter overview

This final chapter situates my findings from the overarching synthesis in the wider student mental health, support service and HE context. I also examine the key strengths and limitations of this work and suggest ways to extend knowledge in the field. Lastly, I consider the university policy and student support implications of my research.

9.2   Discussion of main findings in the HE wellbeing context

To my knowledge this is one of the first studies of its kind to directly address the evaluation gap in 'whole university' student support services in the UK (Broglia et al., 2021b; Sampson et al., 2022; UUK, 2018). Taken together, my findings suggest the investment in new non-clinical/non-academic student support services in 2018 had a positive impact on the UK university in which they were introduced. By 2019, students largely saw university mental health support as more available, accessible and approachable. A damaging mental health narrative for the institution had also improved, with encouraging downstream effects for student wellbeing and anxiety overall. However, there was also evidence of structural and procedural issues which hampered effective communication between stakeholders. Similarly, the resource needed to manage the new welfare response appeared to limit the preventative and community building effort of the new service model, with consequences for its intended 'whole university' approach, particularly in the residential wellbeing team. The following sections examine how my mixed methods results (Ch. 8) relate to the existing HE/student wellbeing support literature and relevant theory.

9.2.1   Accessibility of support

Overall, my findings offer evidence for an improvement in student perception of the availability and accessibility of university wellbeing support at this university in 2019. That directly addresses two well-documented help-seeking barriers highlighted in wider HE research and policy frameworks i.e., a lack of available

services and the *'long wait'* or length of time it can take to get university support (Batchelor et al., 2019; Broglia et al., 2021; Hughes & Spanner, 2019; Remskar et al., 2022; Thorley, 2017; UUK, 2020). Similarly, the improvements address more recent critical recommendations for *"creating more support access points, investing in additional service practitioners 'within the university' to improve speed of access, more effective support service publicity, and better sign-posting"* which have been outlined in research underpinning the Student Mental Health Charter (Priestley et al., 2022, p. 4).

The Charter also stresses that accessible services need to be culturally competent and reflect service users (Hughes & Spanner, 2019). My results suggest no one sub-group of students was differentially dis/advantaged by this new wellbeing service introduction, however I did find an overrepresentation of female, white, home, undergraduate students using both the new services and wider university support. That is in line with student help-seeking patterns seen in the wider literature suggesting those trends reflect general behavioural support-seeking differences (see Ch.2) rather than structural issues in accessing the new services (Eisenberg et al., 2012; Thorley, 2017). Nevertheless, there was also an indication that some vulnerable groups (as identified in the *Student Wellbeing Surveys)* may have been underrepresented in the new service use, such as minority ethnicity and postgraduate students[53], with recognition of more work to do to make wellbeing support accessible to all, and to continue to address the limitations of *"one size fits all"* approach (Arday, 2018; Liu et al., 2019; Nunez-Mulder, 2018).

In contrast, I also found qualitative evidence of a positive shift for some of those students who have been more widely identified as less likely to seek help or facing cultural barriers to accessing HE support, including Black, Asian and minority

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[53] Other groups were identified as under-represented in the new services, such as males, third years, Engineering students but they did not appear to be at more risk of poorer mental health than their peers in the cross sectional survey.

ethnic and international students (Alharbi & Smith, 2019; Lipson et al., 2022; Stoll et al., 2022a; Zhou et al., 2021). This change appears to have been a result of improved student mental health literacy and awareness, as well as greater service availability and cultural competency of the teams (Serebel, 2022). Priestley et al. (2022) have recently re-emphasised ongoing broader student uncertainty about what constitutes 'stress' or a 'mental health crisis' and when to seek support from a university provider. The service launch appeared to reduce some of the perceived stigma associated with help-seeking (see also Narrative) by providing a more culturally acceptable, visible, and inclusive entry point to university wellbeing support (Cage et al., 2020; Remskar et al., 2022).

Similarly, a highly visible, non-clinical route into services, after which students were systematically triaged or signposted to appropriate support, also appeared to reduce another identified risk i.e., that students might not seek help until their difficulties are severe (Broglia et al., 2017). Reductions in counselling numbers and course withdrawals for mental health reasons suggest the services were delivering on their ambition to catch some students earlier, by providing a more accessible opportunity to seek professionalised advice and support for what may be short-term difficulties such as exam stress or homesickness - not only to prevent further downstream difficulties, but to give students strategies to better support themselves (Ames, 2021, p 219). However notably, this did not appear to be the case for those with the poorest mental health (see At risk – 9.2.5).

Despite not being able to systematically evaluate the impact of the one point of access/triaging system (Wellbeing Access), my qualitative evidence did capture how the iteration appeared to both improve the new service delivery and the student support experience in 2019, further reducing unnecessary referrals. It ensured that the entry point to university support was *"simple and unambiguous"* by removing the need for students to decide what support they needed and offers preliminary evidence in a university setting for the value of this approach (Ames, 2021, p. 217; Hughes & Spanner, 2019).

9.2.2   Effectiveness of support

Policymakers and researchers have long identified that academic support, high-intensity clinical services and online tools alone may not be enough to address the growing diversity and level of student wellbeing need, yet there has been little evaluation of support service alternatives (Broglia et al., 2021b; Hughes et al., 2018; Pollard et al., 2021). The characteristics of these new wellbeing service users and their mental health concerns, such as anxiety, study stress and relationship problems, are consistent with Broglia et al. (2018)'s HE support service findings that there are two types of students seeking university help - those "*adjusting to the transition and tasks, and those in need of ongoing therapeutic intervention*". Prior to 2018, students at this institution experiencing more common wellbeing challenges or mild short-term mental health difficulties had fewer options when they needed support. The new advisory teams appeared to be largely supporting those "*adjusting to the transition and tasks",* filling a gap for students who needed advice, guidance or a 'listening ear' but who may have been unable to talk to friends, family or peers or academics on their courses (Cage et al., 2018; Knipe et al., 2018).

Service-users generally found the wellbeing advisers in halls and faculties approachable and *helpful*, and staff were confident in the support they delivered. While previous research shows efficacy for student counselling services, peer support, specialist mental health mentors, and curriculum-embedded interventions, my findings now offer evidence that low intensity wellbeing teams are also useful in responding to student wellbeing issues both in halls of residence and academic departments (Broglia et al., 2021a; Byrom, 2018; Upsher et al., 2022; Worsley et al., 2020; Matthews, 2020).

Yet notably and importantly, there had been a dual ambition for this particular model to combine responsive and case-management work with preventative and community-building effort, which was particularly salient for the teams in halls (Ames, 2021, p. 217). The subsequent impact on effectiveness for this element of the new provision was particularly apparent - see Residential Model - 9.2.6. As

described in several student service reports - wellbeing support models in universities differ considerably according to local context (Hughes & Spanner, 2019; Pollard et al., 2021); and my findings indicate the remit for this model may have been too broad, under-resourced, or it had underestimated growing demand. My findings point to a combination of all three, but the consequences of that were directly seen in the new teams' limited ability to be proactive. This is particularly important given the well-documented importance of prevention work to equip students with skills to manage their own wellbeing and to help foster a sense of connection and belonging in the student wellbeing experience -see Ch.2 and 9.2.6 (Brett et al., 2022; Pedler et al., 2021; Priestley et al., 2022a; Worsley et al., 2021; 2021a; 2021b).

From a wider staff perspective - the service investment was also intended to ease welfare pressure on other university employees and clinical services (Ames, 2021, p. 216). However, there was no evidence of improvement in the level of welfare responsibility experienced by academic staff – which has been a growing concern across the sector (Hughes et al., 2018; Hughes & Byrom, 2019). Likewise, despite the introduction of new support services, the lack of improvement in student perception of their academic wellbeing support in 2019 hints at the inextricable nature of welfare and the student-tutor relationship (Brewster et al., 2021; Hughes & Bowers-Brown, 2021) - see Complex systems – 9.2.4. It re-emphasises the value of a whole university approach (Hughes & Spanner, 2019).

Nevertheless, the service investment did appear to mitigate the 'level of risk' that other university staff (and to some extent tutors/supervisors), felt they were holding. That included administrators and clinicians - particularly university GPs who had been concerned that their previous "*toolbox*" had only allowed them to prescribe anti-depressants (as a first line treatment) or refer distressed students into high-intensity counselling services. More broadly over the last decade, SSRI use in students and young adults has continued to increase year on year (despite a change to SSRI prescribing guidance in general practice in the last decade) as have presentations to student counselling services (Dai Cao et al., 2021; Morris et

al., 2021; Thorley, 2017; GOV.UK, 2014). The levelling off in SSRI prescribing and reduction in counselling volumes seen at this institution in 2019 is therefore promising; it indicates the new stepped-care model may have been effective as an accessible, alternative form of mental health support.

9.2.3 Transforming narrative

The importance of wider university culture for healthy campuses is now well-documented (Dooris et al., 2018; Dooris et al., 2021; UUK, 2020). My qualitative evidence points to the far-reaching consequences that sensationalist reporting, institutional reputation and engagement, mental health narrative and 'word of mouth' may have on a university community. Prior to the new service investment in 2018, this HE provider had been at the centre of ongoing high-profile national reporting of student mental health in 'crisis' after a cluster of student deaths (Chaffin, 2018). There had been similar tragedies at other institutions which went unreported nationally, which suggests the particular media focus may have also contributed to a self-fulfilling negative cycle of socially transmitted information across this institution i.e., 'my university doesn't care' and 'we are not okay'. It led to increased student (and staff/parental) stress and even prevented students from seeking help when they needed it. Similar social influence has been seen more broadly in cases of public health misinformation or disproportionate focus such as vaccine safety or media reporting of suicide, often having lasting detrimental effects on communities (Morley et al., 2020; Niederkrotenthaler et al., 2020). Evidence for these effects is found in models of social transmission that describe evolved negativity bias in the way information is shared or repeated, a scenario made more likely by the unique university campus setting and the use of social media (Bebbington et al., 2017; Rozin & Royzman, 2001; Snoeijers et al., 2014).

The discernible change in university mental health narrative in 2019 appeared to be facilitated by the 'highly-visible' investment alongside frequent communication and promotion for the new wellbeing services, as vehicle for 'nudging' or influencing student, staff and public views (Fadlallah et al., 2019; Hinyard & Kreuter, 2007; Vlaev et al., 2016). Improvement seen in population levels of

student anxiety and wellbeing may be an outcome of that increased confidence in university support i.e., greater cognitive availability of reassurance - a conclusion supported by substantial evidence in my focus groups (Tversky & Kahneman, 1973). It underlines the importance of both positive communication (internal and external) at every level across institutions, and the influence of leadership and visible strategic policy (Priestley et al., 2022). While policy frameworks have long called for demonstrable investment and authentic institutional engagement with the wider issue of student wellbeing across the sector, this research offers evidence for the broad reach and impact that can have in a university setting (Hughes & Spanner, 2019; UUK, 2017).

Nevertheless, there is a notable exception to this theory of positive social influence; with the deterioration in perception of the new wellbeing support in student accommodation in 2019. While it is possible that was a direct consequence of a worsened student experience in halls of residence - potentially due to substantial operational challenges in the first year (see 9.2.2 and 9.2.6), there had also been considerable staff disagreement with the restructure and widely publicised student opposition (Worthington, 2017). First year students in 2019, with no direct experience of the former warden model, described their negative preconceptions of staff in residences driven by 'word of mouth', a cognitive dissonance apparent in their 'poor' expectations versus 'good' service-user experiences (Festinger, 1957; Nickerson, 1998). Organisational and system theories demonstrate clear stages for complex organisational change with periods of resistance and adjustment; it is feasible that 12 months may have been too early in the change management process to capture a stable perspective, free of narrative bias - see 9.3.2 (Schein, 1996; Shen et al., 2015; Skivington et al., 2021).

9.2.4   Complex systems and a whole university approach

As 1.2.3 demonstrates, change management in a complex and dynamic organisation is rarely straightforward and the introduction of new student support services in an HE community of 35,000 people was no exception (Eoyang, 2009 p. 465; Eoyang, 2011, pp. 371-322). My early findings of confusion for staff and

students in the launch of the new services are consistent with organisational theory suggesting a new support service would need to go through a process of adaptation as the existing system reorganises itself around it (Hawe et al., 2009).

Communication at several levels was a critical influence in the service launch and its ongoing delivery, in line with recurrent themes in the broader literature - i.e., issues for clarity of responsibility and procedure across the university and who needs to know what in relation to a student's wellbeing (Barden & Caleb, 2019, p. 36; Hughes & Spanner, 2019, p. 68). Nevertheless, there was evidence that some specific staff and student concerns surrounding clarity of roles and clear signposting may have been addressed with the addition of Wellbeing Access and as the new services established themselves, underlining again the stages of necessary adjustment involved in organisational change (Schein, 1996; Ames, 2020 p. 217). More general issues for procedural clarity and internal communications still mirror those frequently raised across the student sector and literature in relation to operational change, and my evidence supports the need for institutions to continue to address this - particularly in relation to the academic tutor and support service relationship (Hughes & Bowers-Brown, 2021; Piper, 2017; Priestley et al., 2022).

With new mental health and wellbeing support in the wider system, a specific theme was information sharing. It is not a new issue for HE - universities have been tackling issues of GDPR, rights to privacy and data sharing for many years (Barden & Caleb, 2019, p. 36; Linton et al., 2022; Dept of Health, 2021). Yet my qualitative findings indicate that the complexities of how and what information is shared remain a key problem, and that a lack of a central data-sharing platform or clear information-sharing procedures can elevate perceived risk for all involved. Stakeholders such as support, disability and counselling services often address this

with standardised case-management meetings[54], yet my findings reemphasise the difficulties for academics and other professional staff who sit on the periphery of these arrangements but are often at the frontline of wellbeing support (Hughes, 2021; Hughes & Bowers-Brown, 2021). The importance of 'cohesiveness' of support across the HE provider is also a key theme of the Student MH Charter (Hughes & Spanner, 2019, p. 68). It is linked to the 'whole university' case that academic staff need ongoing consideration of their welfare role combined with greater attention to staff wellbeing, as well as ongoing mental health training for all student-facing employees (Cage et al., 2021; Payne, 2022).

One of the most salient challenges reinforced by my findings is the interconnectedness of student mental health issues at every level. Complexity in evaluation research is also layered - as "*a property of the intervention, and a property of the system in which the intervention is implemented*" (Shiell et al., 2008 p.1281; Skivington et al., 2021). Both are re-emphasised here by the myriad factors implicated in organisational and student wellbeing challenges from individual student characteristics to the particular socioeconomic circumstances of university and healthcare systems as well as the broader geo-political climate. Not only do my results demonstrate the value of a 'whole university' approach, but they also further demonstrate that student wellbeing services cannot operate in isolation of upstream or downstream influences such as pedagogy, student accommodation provision, community, NHS services, staff wellbeing, early education, young people's mental health more generally, and societal attitude to a) the pathologising/stigmatising of distress/mental health disorders and b) who might be responsible for addressing the challenges faced (UUK, 2020). While duty of care and universities' legal and moral responsibilities for student welfare are an ongoing topic of debate across the sector, I found qualitative evidence to support

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[54] Case-management meetings involving all relevant support services are now standard at this institution as of 2022.

Professor Simon Wessley's widely-cited concerns[55] that overreporting of mental health issues and a perceived under-resourcing of mental health support simply leads to overstretched and demoralised organisations (AMOSSHEE, 2015; Arie, 2017).

9.2.5 At risk students

The new stepped care model was not targeted at students with complex mental health difficulties; however, its implementation was meant to help better identify at risk students, free up resource for students needing high-intensity support and establish clearer pathways into clinical services (Ames, 2021, p. 218). The single point of access to services does appear to have helped streamline pathways into university support, but it still relies on students connecting with services. That was especially the case for students with more serious mental health concerns, who appear less willing or able to engage with services, echoing trends seen in the wider literature (Eisenberg et al., 2007; Linton et al., 2022; McLaughlin & Gunnell, 2020).

Despite the improved levels of service availability, mental health awareness and positive institutional narrative generated by this service launch, many entrenched help-seeking barriers were still apparent such as 'concern no one would understand the problem', 'fear of disclosure' or 'fear of unwanted intervention' which are also well-documented elsewhere (Cage et al., 2020; Hartrey et al., 2017; Knipe et al., 2018). As discussed in 8.4.2 that supports the case that perceptual rather than structural barriers prevent many students from seeking help, and echoes staff concerns that the new model does nothing to reach those students who do not seek support. Several institutions have adopted data-analytic platforms which alert them when a student does not engage with their studies, an early indication that they may be struggling (Pollard et al., 2021, p. 56); but

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[55] Prof Simon Wessley - the first psychiatrist President of the Royal Society of Medicine cited in Arie (2017) as saying "*Every time we have a mental health awareness week my spirits sink*".

extensive research also suggests that at risk students are also identified through increased mental health awareness and education, early triage and intervention where students intersect with staff, alongside tailored support for vulnerable groups such as LGBTQ+ students (Pollard et al., 2021, p. 56). That association between preventative work and early opportunities to intervene is important, as the following section also highlights – 9.2.6. Evidence suggesting the new wellbeing services were operating reactively at a cost to proactive prevention or community building work, may mean advisers were missing opportunities to catch students at an earlier stage.

9.2.6   Residential model

In successfully ensuring wellbeing support became more accessible and approachable in halls of residence (and faculties), the volume of students in hall then seeking support appeared to limit adviser resource for preventative work. The key issue appeared to be the dual ambition to provide both wellbeing support and community building effort in the same adviser role, particularly preventing the residential teams from being as operationally effective as envisioned (Ames, 2021, p. 216). A need to prioritise reactive service delivery over prevention work is not an uncommon phenomenon in mental health care (Fazel, 2016); however, it is clear from both my findings and broader research that student transition work and community building effort is imperative, particularly in halls of residence to smooth first year transition from home to university life (Cage et al., 2021; Piper, 2017).

The Mental Health Charter describes the importance of student accommodation as not "*just a space to eat, sleep and study*" but also a space in which they can "*relax, have fun, feel connected and safe.*" (Hughes & Spanner, 2019, p. 54). Comparing my results with the existing literature similarly reinforces the critical nature of factors such as belonging, connection and community for the student residential (and overall university) mental health and wellbeing support experience (Adams et al., 2021; Cage et al., 2021; McIntyre et al., 2018; Priestley et al., 2022a; Worsley et al., 2021). Likewise, many of the student wellbeing issues

seen by Residential Life advisers resonated with further research linking (bi-directional) mental health difficulties with social isolation, social relationships and accommodation problems (Foulkes et al., 2021; Franzoi et al., 2022; Worsley et al., 2021a; 2021b). Universities have been working to address these challenges for students for many years - but as described in 2.5.4, accommodation support models still vary widely in the UK with wellbeing, disciplinary, community building, and accommodation responsibilities structured differently across institutions (Piper, 2017). This institution's new Residential Life team were managing much of that portfolio, as well as responsibility for the university's 24/7 wellbeing response; but with no academic evaluation of impact or effectiveness for other UK accommodation welfare models it is impossible to quantify or compare the challenges here. Nevertheless, my overarching evidence suggests the dual nature of the role was not working, highlighting a complex relationship between 'professionalised welfare services' in halls of residence versus creating a place of belonging for students in what is their 'home' – albeit a temporary one (Holton, 2017; Piper, 2017). As described in Ch.2, Worsley et al. (2021b, p.12) suggest "*accommodation-based pastoral staff have an important role to fulfil*", and my evidence demonstrates that clear consideration needs to be given to the remit and resourcing of the wellbeing adviser role both in halls and academics departments.

9.3   Strengths and Limitations

In the following sections I reflect on the main research strengths and weaknesses in my overall approach and individual studies. A significant strength of this work lies in its pragmatic convergent design i.e., triangulating evidence from a number of population health perspectives. However, despite (and because of) the breadth of my analyses, there are several limitations to consider - not least bias, measurement and validity, and generalisability.

9.3.1   Research strengths

Key contributions of this work are its scope and novelty – it offers some of the first evidence for the impact and effectiveness of low-intensity university wellbeing services in situ (Hughes & Spanner, 2019; Sampson et al., 2022). It was a

comprehensive evaluation using a repeated cross-sectional mixed methods design to include contextual time series measures spanning five years and more than 40 hours of narrative data. While mixed-methods evaluations often combine quantitative data with qualitative, I was able to go further and triangulate evidence of service impact from more than twenty different perspectives, examining outcomes for students, staff and the institution as a whole (Craig et al., 2017; Duncan et al., 2018; Skivington et al., 2021). The breadth and validity of my findings are based on statistical results and narrative detail from larger samples than generally seen elsewhere in the literature e.g., >8,000 students in the *Student Wellbeing Surveys*, >600 staff and students in *Census Surveys* of service use and >120 staff/students in the focus groups and interviews. Despite being a single-site evaluation, the scale of this work is comparable (and in places even exceeds) the volume of data underpinning the Student Mental Health Charter (Hughes & Spanner, 2019).

As described in Chapter 2, with ongoing debate around consistency in mental health measures used in student populations, I have used validated, Wellcome/NIMH recommended population health measures such as the PHQ-9, which offer greater capacity for comparison more broadly (Barkham et al., 2019; Kroenke et al., 2001; Wolpert, 2020). These measures offer the potential to examine differences for students with/without CMD and with young adults in the general population, which in turn can better inform specific wellbeing stressors for HE. While I have not discussed mental health prevalence findings here (Table 4.4), it is encouraging to see prevalence rates in my study largely match those seen in bigger cohort studies using the same mental health screens - PHQ-9/GAD-7 or (S)WEMWBS – see 4.6.2 (Duffy et al., 2019a; Duffy et al., 2020). Similarly, as outlined earlier, many of the student mental health and help-seeking differences in this sample match those seen in other observational research, e.g., differences across faculties, gender, ethnicity which increases my confidence that these findings have relevance for other HE institutions (Broglia et al., 2021a; McLafferty et al., 2017).

Final comments on the strengths of this work are my philosophical approach and the level of collaboration with stakeholders. My critical realist and contextual perspective is well-suited to complex evaluation in the social and political landscape of student experience and HE wellbeing support (Duncan et al., 2018). The plurality of my scientific methods, subjecting each to "organised scepticism" is a transparent recognition of the constraints for knowledge formation and ground-truth (Duncan et al., 2018; Pawson, 2013, p. 86). My interpretations are based on extensive triangulated evidence rather than relying solely on effect sizes and confidence intervals in a heterogenous sample. An additional and important strength was that I regularly engaged staff and students in this work in line with University Mental Health Charter co-production values (Hughes & Spanner, 2019). In setting up a student PPI group, a PhD Steering group and adhering to NIHR Applied Research Collaboration (ARC) West principles, I have genuinely sought to place the people most affected by this research at its centre - see also Limitations (NIHR, 2022).

9.3.2 Research limitations

9.3.2.1 Cross-sectional surveys

Although my sample sizes in the *Student Wellbeing Surveys* (Ch. 4) were larger than often seen elsewhere in the literature, response rates were low and differed considerably between 2018 and 2019, there was also a difference in survey timings. As I outlined in Chapter 2 - single institution, cross-sectional surveys with low response rates have myriad flaws, not least for selection bias, with students experiencing difficulties more likely to respond (Barkham et al., 2019). It can mean overestimation of poor mental health and engagement of respondents with atypical levels of mental health literacy and support seeking characteristics (Mortier et al., 2018). Similarly, without control universities it is not possible to determine whether changes between 2018 and 2019 reflect changing population trends rather than intervention effects. With anonymous survey data my primary concerns were missing data and confounding, hence the comprehensive sensitivity analyses I carried out to address those issues, particularly in relation to year on year differences in respondents' *lifetime mental health diagnoses.*

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Similarly in further tackling confounding, my adjusted statistical models in the cross-sectional analysis were large i.e., a competing interaction of twelve explanatory variables, which may have introduced collider bias (Cole et al., 2010). An additive sub-analysis of individual confounder variables and my a-priori hypotheses offer some reassurance that any improvements seen in mental health outcomes were not simply artefacts of data-mining, cherry-picking or 'data torture' (Murphy & Aguinis, 2019).

There were additional limitations for the questionnaire help-seeking items. Students were asked about university support seeking *ever* rather than the *last twelve months,* which meant I had to focus on first year experience to avoid conflation of students reflecting on more than one year of support ([4.7](#)). There were also construct issues in the particular wording of this question i.e., '*usefulness*' – see below 9.3.2.2.

9.3.2.2   *Census (service-use) surveys*

The *Student Census Surveys* presented similar challenges to the cross-sectional surveys i.e., differing response rates and self-selection bias. *Staff Census Survey* response rates however were very high, with wellbeing presenting issues recorded by advisers largely matching student self-reported issues. It offers reassurance that student respondents were representative of those actually being seen by advisers in those periods. Conversely, response rates for the *Student Follow-Up Surveys* were low, and without the possibility of linkage it is feasible that students who were more dissatisfied with their experience had just not responded. Data reporting was much more challenging for the Residential Life team throughout the census periods, with lower *Staff Census Survey* response rates overall. The numbers of recorded 'drop-in' appointments were also low, which may indicate students in hall who presented in immediate or serious distress were potentially underreported. Despite running a pilot *Census Survey* to assess the level of research burden for advisers, it is likely this team needed more allocated resource to help them participate fully.

A further issue was the way student support satisfaction was worded in the *Student Wellbeing* and *Census* surveys i.e., *helpfulness* or *usefulness,* with the terms qualitatively different and an added ambiguity for what they capture conceptually. When asked to comment on this, my Student PPI group reflected on the subjectivity of the terms and the possible distortion if students did not get immediate relief from their distress by seeing an adviser, but they concluded the differences were not a substantive threat to validity. A related concern was use of the variable *staff in residences* for the cross-sectional survey analysis which did not specifically capture the new Residential Life experience. It meant I was not directly comparing warden and adviser experience between 2018 and 2019, so I cannot account for those students who may have been considering other important staff in halls in their responses such as cleaners or porters. It is difficult to know how to address concerns like this without adding more questionnaire items, increasing survey burden and further jeopardising response rates.

9.3.2.3 Secular trends

In the absence of control data from other universities on most measures, I designed studies examining further wellbeing indicators, but there are a number of improvements I would make retrospectively. As I mentioned in 9.2.2, there has been conflicting advice to GPs over the last decade in relation to reducing SSRI prescribing in young adults, however I was unable to compare trends in students at the onsite GP (5.5) with the same age group in the CCG's general population which would have strengthened this research element (GOV.UK, 2014). Nevertheless, evidence to suggest SSRI prescribing has continued to increase more generally in young adults over the last decade does go some way to giving further context (Dai Cao et al., 2021).

An additional major limitation lies with my analysis of *student overall perception of wellbeing support* in 5.9. In retrospect, using data taken from two different survey samples in two different years to answer the same question may not have been reasonable. Far from triangulation, it is likely to have been an unrealistic attempt to combine non-comparable data. I have included it in my thesis on the

basis that it would be ethically unsound not to do so, particularly given its contradictory findings. Nevertheless, it is potentially the weakest part of my secular trends analysis.

9.3.2.4 *Researcher bias*

A further source of bias to consider is my critical realist and contextualist philosophical position, particularly in my reflexive qualitative analysis and convergent synthesis. However, in adopting that approach, I have openly framed my expertise, experience and social lens, allowing me to robustly consider researcher bias throughout the analysis and interpretation of both empirical and thematic findings (Maxwell & Mittapalli, 2010). I chose Braun & Clarke's (2021d) reflexive thematic analysis for my qualitative study for those reasons: its transparent, inductive and recursive approach, but I recognise that there were a number of alternatives I could have engaged, including using a form of coding-consensus (see 7.3). Nevertheless, a colleague and I did 'double-code' three of the early staff focus groups for an internal report in 2019, with extensive commonality, which offers some early validation of my coding process from a consensus perspective (7.5.2). Likewise, the mixed-methods synthesis of empirical and narrative methods is a nuanced science (Plano-Clark, 2019); and while I make no attempt to offer definitive conclusions, my interpretation of findings has been informed and sense checked by colleagues, experts and students throughout.

A similar note of concern is conflict of interest which I briefly addressed in 3.7. I made every effort to remain reflexive and independent from the university and support services which I was evaluating throughout this work. Yet although I have never personally used the wellbeing services, I am still a student and a colleague; therefore, it is conceivable that I have not remained fully objective. Similarly, despite clear HE and research sector recommendation to do so, I may have created an unintentional echo-chamber by fully incorporating stakeholder co-production throughout my studies (Mockford et al., 2012; Sampson et al., 2022). Nevertheless, I believe the breadth of expertise and student insight that I gathered

from across the university, education and research fields will have mitigated that likelihood.

9.3.2.5 Real world evaluation

A further key challenge was the material service changes that took place during my research period such as the introduction of Wellbeing Access and the 'One at a Time' model in the Student Counselling Service (Dryden, 2020); it is possible they also influenced staff and student perception of the speed and availability of support in ways I have not addressed. This is often the case in real-world/pragmatic evaluation in a complex organisation, where even randomised controlled trials are not immune from changing context - and HE settings are a key example (Kidger et al., 2021). By adding questions concerning Wellbeing Access to both the *Census Surveys* and the qualitative topic guides during my fieldwork in 2019, I was able to collect service-user detail on the influence of the service iteration in real time. It was an important insight that pre/post data collection or an RCT design could never deliver, and further supports my use of pragmatic evaluation methods (O'Cathain et al., 2019).

Changing context is not the only limitation in real world evaluation, timing is also critical. This was a major university investment and step change in support delivery after a particularly turbulent period (Brady, 2018). As Hawe et al. (2009) outline in their treatise on the complexity of events in systems, any change in reported outcomes in intervention evaluation are similarly dependant on evaluation period and context. Without further research over a longer time frame, it is difficult to know whether the improvements I report here are ongoing or transitory features of system change. Revisiting the study in future would address that concern and also generate useful post-pandemic service comparisons (see Covid-19).

9.3.2.6 Economic and theoretical evaluation

Due to the existing breadth of this evaluation, there was no scope for examination of cost-effectiveness or the detailed theoretical aspect of this complex system change (Skivington et al., 2021). While I have offered some theoretical

interpretation for my findings, my focus was efficacy and impact rather than theory building or financial modelling. However, it will be important to understand whether the added £1 million annual mental health investment by this HE provider could have been better spent elsewhere, such as clinical services or further online resources. A well-resourced economic investigation would strengthen and extend this work (Skivington et al., 2021).

9.3.2.7   Covid-19

My research took place in the early stages of service introduction, meaning the new wellbeing services were still 'bedding in' (Hawe et al., 2009). The Covid-19 pandemic and UK lockdown dramatically disrupted teaching and student support only 18 months after service launch. My cross-sectional survey findings would have undoubtedly benefited from tracking student mental health outcomes and help-seeking behaviour over the longer term to 2021 i.e., three years into service operation, as I originally intended. Re-examining student outcomes at a future date would address this – see Future Directions. Similarly, while I took every step to consider and adjust my research to the constraints of lockdown (see Covid-19 Statement), some of my interviews and focus groups and almost all of my analysis was conducted in the shadow of a global pandemic which may have influenced the findings in ways I have not considered.

9.3.2.8   Generalisability

Like others before me, I am aware of the constraints in generalising these findings to other HEs. This was a single university study, in a large urban Russell Group which may not bear comparison with institutions elsewhere in the UK. As outlined earlier, existing student support frameworks already vary widely (Broglia et al., 2018; Pollard et al., 2021). Likewise, students at other institutions may differ in both the factors I have considered such as social background and MH difficulties, and some I have not - such as levels of perfectionism or study and exam stress (Campbell et al., 2022; Lewis & Cardwell, 2020). Equally, the differing socio-geo-political contexts of university campuses all have potential for bi-directional influence on student wellbeing (Thompson et al., 2022). Nevertheless, there is

important learning for the sector in this study - not least that it reinforces the importance of a whole university approach in relation to wellbeing support provision.

9.4 Implications

As I have outlined - the myriad wellbeing support models in UK higher education including onsite GPs, mental health advisers, and differing accommodation models make it difficult to generalise the specific impact of these new wellbeing services, thus local context will always be relevant (Broglia et al., 2018; Pollard et al., 2021). However, there is clear learning in this evaluation for the wider sector – which I summarise below in Figure 9.1. Overall, my study indicates that accessible university wellbeing services, situated between academic welfare and clinical mental health pathways are valuable, relevant and arguably necessary, in light of the growing numbers of students needing extra wellbeing support to study. My findings show low-intensity wellbeing teams can offer approachable, neutral support and advice with considerable success, helping simplify pathways to other university support staff or frontline services such as counselling or GPs, and even reducing the need for clinical intervention. What they do not appear to do is reduce workload or pastoral responsibility for academic staff, simply reinforcing the need for universities to prioritise staff mental wellbeing and workload in any 'whole university' strategy (Brewster et al., 2021).

I have also shown that wellbeing services can also serve as a catalyst for raising mental health awareness at population level with implications for reassuring students and staff. Insights from this work show the far-reaching impact of institutional narrative, not only in its importance for the university business model but for the trust, confidence and wellbeing of its community (Pritchard, 2022). My findings also suggest that HE providers need to carefully consider the operational remit of any wellbeing team, particularly in halls of residence. It may not be appropriate or feasible without considerable resource to task wellbeing teams with responsive, preventative, disciplinary, accommodation and community building effort. Where clarity of roles is important in organisational change, so is

effective communication. This research reinforces the importance of joined-up data intelligence and clear communication for every university stakeholder - from student to tutor to administrator, with evidence for how effective communication systems prevent students slipping through the net, reduce staff anxiety and frustration, and streamline procedure. This work also underscores the importance of a whole university approach, and that student support services cannot work in isolation of wider academic, organisational and societal influences (Hughes, 2021; UUK, 2020).

Figure 9.1 Policy implications

- o Highly visible non-clinical university wellbeing services offer accessible, approachable university support for a greater diversity of students, addressing a number of help-seeking barriers and improving mental health awareness.
- o Non-clinical wellbeing services can ease welfare demand for other university professional and clinical staff, with evidence for reductions in counselling services volumes and student anti-depressant prescribing.
- o Non-clinical wellbeing services can help to reduce perceived levels of risk held by some university staff and offer clearer signposting pathways to support.
- o Mental health training for all university staff remains critical, alongside specific attention to levels of tutor/supervisor welfare responsibility, as well as ongoing consideration of all staff wellbeing.
- o Authentic institutional engagement and investment in student mental health and wellbeing can directly influence population mental health outcomes and staff and student confidence.
- o Ongoing institutional narrative and visible wellbeing promotion has the potential to directly influence student mental health, wellbeing and help-seeking behaviour.

- Ongoing consideration of data/information-sharing platforms is needed to improve the welfare experience for all relevant university stakeholders i.e., students, academics, clinical and professional support services.
- Clearly delineated adviser roles are recommended; particularly in an accommodation welfare model, with separately allocated wellbeing and prevention/community-building resource and responsibility.
- Students with poor mental health who do not approach university services cannot be identified with responsive low-intensity wellbeing services; further consideration is needed for this at risk group.
- A single point of access to university wellbeing services improves and streamlines the support-seeking experience, addressing the risk of students getting 'lost in the system'.
- Student wellbeing support delivery in a complex university system is inextricably linked to a broader whole university approach.

9.5 Future directions

Careful evaluation needs to be built into the future design and development of all new or restructured wellbeing support in HE, with findings more widely shared and disseminated across the sector. Literature examining the effectiveness of university mental health and accommodation welfare teams is some of the scantest in the academic field and needs ongoing attention in work such as this (Sampson et al., 2022). It is likely that many HE providers already carry out internal audits and process evaluations without sharing good practice beyond their leadership teams or institutions. With the sector demanding evidence-based practice and collaboration - the academic community i.e., students and researchers are well placed to investigate those issues, with a wealth of expertise and lived experience across geographical borders, and an ability to publish findings more widely - with SMaRteN an example of good practice (Pollard et al., 2021; UUK, 2020; SMaRteN, n.d.). I suggest systematic mental health data collection is

critical - ideally longitudinal, linked datasets, with some degree of standardisation across mental health measures (Barkham et al., 2019). Despite significant investment in student mental health research by organisations such as the OfS and UKRI to date, there is still no current commitment to national longitudinal data collection (OfS, n.d.; UKRI, n.d.). Population health evaluation across broad contexts is critical if universities are serious about creating healthy environments for students and staff, as opposed to stemming the tide. That includes working with schools, the NHS and private student accommodation providers. With student (and staff) wellbeing a critical factor in attracting students to specific institutions as well as driving academic performance, universities may want to consider funding this endeavour themselves through a central network such as Universities UK (UUK, n.d.). There are clear reputational challenges for institutions to engage in evaluation of this nature. However, with a new Mental Health Charter award scheme underway, leaders will need to be bold and transparent if they want to address the issues facing young adults in higher education today. This particular research would benefit from re-examination in 2-5 years, to assess the investment's reach across the longer term, ideally to include a nested cost-effectiveness evaluation. It would also be particularly valuable to re-run the *Census Surveys* to further assess the impact of Wellbeing Access on adviser caseload/mix and to establish if the Covid-19 pandemic has had a lasting influence on the nature of the wellbeing teams service delivery and operation.

9.6 Conclusions

My population health study offers evidence that non-clinical student wellbeing services can have a positive impact on a whole university system. My overall findings point to the wellbeing teams as a welcome addition to this university's suite of student support, filling a gap in existing welfare provision and offering an approachable and accessible alternative to academic, online, and clinical university support. The services introduction was also an important vehicle for improving the institutions' mental health narrative, reflected by improvements in wider student population levels of anxiety and wellbeing. That appears to have had valuable downstream consequences for students and staff, with the

qualitative data suggesting the service launch was more successful than the numbers alone can suggest. Overall, the services appear to have been largely effective and well-received by those using them in halls and faculties: wellbeing advisers were confident in the support they offered, and students using them found them useful. Likewise, the services were generally seeing the type of student issues they were set up to address. However, a number of operational issues were also apparent, hampering the teams' ability to be as effective as originally envisioned, particularly in student accommodation, with implications for preventative and community work. There were ongoing added concerns about communication, data-sharing and identification of students who may never seek help, as well as broader expectations and sustainability of the model given increasing numbers of students seeking support.

This is some of the first research to address the gap in the higher education literature regarding the impact of university mental health and wellbeing teams. While it is a single university study, there is clear learning for the wider sector, not least in demonstrating how a low intensity, stepped care model of student support can be effective and also offering evidence for how wellbeing support service models may need to be resourced and configured. In addition, this work illustrates that institutional communication and demonstrable strategic engagement with mental health issues can have direct consequences for student and organisational wellbeing. Finally, while I have focused on service evaluation, there are broader issues to consider such as the wider education system, young people's mental health more broadly, and the way we talk about challenge, adversity and mental health. While this work reemphasises the importance of a whole university approach, we should not lose sight of the value of a whole societal approach too.

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@drvicclarke '…implying the themes are "in" the data as "themes", as real things that exist and the researcher's analytic role is to find and extract these. This was in fact a conceptualisation of themes - as "diamonds in the sand' - that we wanted to challenge in our writing around TA. Instead…". Twitter, 28 March.2021,3.58pm,twitter.com/drvicclarke/status/1376186870137245701?s=20

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Appendices

Appendix A.   HE mental health and wellbeing services

Table A.1 Department for Education Summary of Mental Health and Wellbeing Services and Programmes Offered by HE Providers

In their recent survey of mental health support provision in the UK[56], Pollard et al. (2021) reported the many different mental health and wellbeing services and activities cited by HE providers, with each category summarised in order of frequency of mention. Services included are for students with or without a formal diagnosis or mental health need.

Wellbeing	Early intervention	Specific MH services
Group sessions/work-shops Self-help (digital resources) Peer-to-peer support Online CBT Digital mindfulness apps Campaigns/awareness raising Alternative therapies Physical health/fitness	Staff training (MH first-aid) Attendance monitoring Student training Awareness raising Targeting 'at risk' groups Activities at key pressure points Suicide prevention Encouraging disclosure	Face to face counselling Therapies e.g. CBT Online support (Big White Wall/Togetherall, Silver-cloud, Kooth) DSA funded support Reasonable adjustments alongside inclusive approaches Specialist trauma support* Emergency support* Out-of-hours support*

* working with external organisations
Source: IES/CRAC/AdvanceHE survey, 2020

Note: From Pollard et al., Department for Education, 2021. This information is licensed under the terms of the Open Government Licence v3.0 https://www.nationalarchives.gov.uk/doc/open-government-licence/version/3/. (https://dera.ioe.ac.uk/38141/1/Survey_of_HE_Providers_Student_Mental_Health.pdf, accessed 08/06/22).

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[56] HE mental health report commissioned in 2019 by the DfE, surveys and focus groups across the sector with a response rate of 63% from all HE providers

Appendix B.   BBC Freedom of Information data

Table B.1 Russell Group Universities Mental Health Spend Between 2012 and 2017

University	Academic Year	Overall MH Budget	% Change over time
University of Bristol	2012-13	£426,371	100%
	2016-17	£852,548	
University of Warwick	2012-13	£921,000	83%
	2016-17	£1,683,000	
University of Edinburgh	2012-13	£616,699	69%
	2016-17	£1,043,835	
University of Exeter	2012-13	£426,908	62%
	2016-17	£690,600	
University of Southampton	2012-13	£140,549	55%
	2016-17	£217,786	
Queen's University Belfast	2012-13	£283,718	54%
	2016-17	£436,357	
University of Oxford	2012-13	£746,100	53%
	2016-17	£1,139,000	
University of York	2012-13	£292,000	51%
	2016-17	£441,000	
University College London	2012-13	£916,474	50%
	2016-17	£1,370,177	
University of Glasgow	2012-13	£345,323	49%
	2016-17	£512,914	
Queen Mary London	2012-13	£282,206	40%
	2016-17	£396,000	
University of Birmingham	2012-13	£513,375	34%
	2016-17	£688,488	
Durham University	2012-13	£380,900	28%
	2016-17	£488,600	
University of Manchester	2012-13	£618,227	28%
	2016-17	£792,606	
London School of Economics	2012-13	£257,095	26%

	2016-17	£323,635	
University of Nottingham	2012-13	£698,000	22%
	2016-17	£851,000	
University of Sheffield	2012-13	£582,570	21%
	2016-17	£706,033	
University of Cambridge	2012-13	£698,000	5%
	2016-17	£730,000	
University of Leeds	2012-13	£532,233	3%
	2016-17	£548,461	

*Table B.2 Numbers of Students Seeking Help from Counselling Services and %
Change at Russell Group Universities Between 2012 and 2017*

Academic Year	2012/13	2013/14	2014/15	2015/16	2016/17	% Change
University	n=number of students					
University of Southampton	142	189	188	237	360	154%
University of Warwick	1397	1608	1851	2206	3514	152%
University of Exeter	1003	1371	1487	1751	2457	145%
University of Bristol	1375	1724	1485	1895	2827	106%
University of Edinburgh	1493	1778	2053	2863	3002	101%
University of Sheffield	1214	1742	1898	2171	2345	93%
University of Glasgow	1333	1653	1866	2276	2330	75%
Imperial College London	506	540	608	716	874	73%
University of Birmingham	838	1010	1291	1199	1260	50%
University of Manchester	2233	2718	2910	3085	3290	47%
University of Oxford	1497	1680	1949	2079	2143	43%

University of Nottingham	1931	2120	2461	2614	2650	37%
University College London	2805	2544	2620	3022	3023	8%
University of Cambridge	1562	1592	1570	1573	1575	1%
Queen's University Belfast	922	887	971	934	914	-1%
Queen Mary London	685	701	823	875	664	-3%
University of Leeds	1790	1948	2070	2025	1486	-17%

Appendix C.   Institution's student welfare support

Table C.1 The Institution's Mental Health, Wellbeing and Pastoral Support Services Available to Students in 2018 and 2019

GP/Doctor	Student Health Service (onsite practice for students in campus postcode) or other GP	**Nightline**	Confidential non-advisory telephone listening service (https://nightline.ac.uk/)
Mental Health Professional (psychiatrist, psychologist, counsellor, social worker)	Student Counselling Service, other university specialists and NHS/other clinical professionals	**Other member of academic staff**	E.g., lecturer, senior tutor
Personal Tutor/ Academic Mentor	Academic tutor/mentor/ supervisor	**Other member of university support staff**	E.g., faculty administrator, international team, mature student adviser, student liaison team
Student Wellbeing Adviser [57]	Professional (non-clinical/non-academic) trained support staff in faculties	**Other staff in residences**	E.g., Senior residents (i.e., student peer supporters/staff in halls), porters, catering staff
Residential Life Adviser[58]	Trained support staff in university accommodation	**Students' Union Adviser**	Just Ask Students' Union advisory service
Peer Support or Peer Mentor	Mentoring support for and by current students	**Nilaari**	Black, Asian and Minority Ethnic counselling service (https://www.nilaari.co.uk)
Togetherall (formerly known as Big White Wall)	Online support community (https://togetherall.com/en-gb/)	**Disability Services**	Advice and guidance for students with a range of disabilities, learning difficulties, and other health and mental health conditions
Multi-faith Chaplaincy	Drop-in service for service for secular pastoral support		

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[57] Introduced in academic year 2018/19
[58] Also introduced in academic year 2018/19

Appendix D. Literature search and example intervention reviews

My literature search terms included: 'Wellbeing' 'well-being' 'universit*' 'student*' 'college*' 'mental health' 'mental' 'intervention*' 'support' 'support service*' 'support-seeking' 'barriers' 'help-seeking' 'whole university' 'whole university approach' 'undergraduate*' 'postgraduate*' 'higher education'. My database searches were dated the year 2000 to June 30th 2022, and included: PUBMED, PSYCHINFO, MEDLINE, EMBASE, SCOPUS. The following tables D1 and 2 outline recent key meta/umbrella reviews and exemplars of individual student mental health and wellbeing interventions. While not specific to my research aim, they offer wider context for the review-level student wellbeing intervention literature.

Table D.1 Key Recent Student Mental Health and Wellbeing Intervention Meta-Reviews and Reports

Author and location	Population	Review type and number of included studies	Outcomes n=number of studies with specific outcomes	Findings
(Cuijpers et al., 2021) Global reviews	College students and non-college students	'Umbrella review' of 31 meta-analyses effect sizes (from 608	Depression, Anxiety, stress (n=31); substance use	14 meta-analyses examining depression, anxiety and stress outcomes reported largely significant effect sizes (ES) for universal prevention interventions (mostly small ES) and for indicated prevention and treatment interventions (moderate to large ES). There was considerable variance in meta-analysis effect sizes and heterogeneity in primary studies. Effect sizes

	(but only if effect sizes were reported separately)	primary studies) to include RCTs and controlled intervention/no intervention	(n=12); others (n=5)[59]	for alcohol interventions were small and potentially not clinically meaningful; but effectiveness was shown for 'other' interventions e.g., smoking cessation, test anxiety, internet addiction. The authors concluded that almost all meta- analyses and primary study data were 'sub-optimal' and any findings should be treated with caution.
(Worsley et al., 2020) Global reviews, predominantly US, UK, Australia	Post-secondary, FE, HE students	'Review of reviews' – a narrative synthesis of 24 eligible review papers to include review level-qualitative, quantitative and mixed methods	All mental health and wellbeing outcomes	The authors identified 11 types of university support interventions for all students[60] from 2,333 unique studies to include: cognitive behavioural therapy (CBT), and psychological therapies, mindfulness and meditation, online interventions, suicide and universal mental health prevention interventions, psychoeducation, recreation, relaxation and peer support. They report that CBT, mindfulness, recreation and technology-delivered interventions all appeared to be effective compared to controls, with CBT results sustained over time. However, at review-level, psychoeducation was not as effective as other interventions, with no sustained long-term effects. Worsley et al. (2020), acknowledged that intervention data is limited, sample sizes were generally small, and included reviews did not stratify by sub-group i.e., socio-economic status, gender, disability, age and sexual

[59] Others included meta-analyses examining sexual assault, internet addiction, procrastination, test anxiety
[60] Worsley et al. excluded interventions addressing specific pre-existing MH or neurodevelopmental concerns e.g., attention deficit hyperactivity disorder (ADHD) or autism

		studies. All RCT, control and comparator, plus no control and no comparator		orientation, recognising that some interventions may have been more effective for discrete groups of students. Similarly, while there was some evidence for effectiveness of specific prevention and treatment interventions, any research evidence for whole-population interventions addressing wider determinants like living environments or approaches aimed at promoting positive mental health was largely missing.
(Robertson et al., 2022) Global reviews with UK focus	As above	Rapid review of the academic and grey literature examining 57 eligible intervention studies for a narrative synthesis. Part of a UK report in 2021 commissioned by the Centre for Transforming Outcomes in	Researchers looked at what mental health interventions are available in universities with outcomes guided by Worsley et al. (2020) findings. Also examined lifecycle, support uptake,	Of the 57 intervention studies reviewed, 38 showed medium evidence for effectiveness, 14 strong and 5 emerging. The authors conclude psychological and mindfulness-based interventions appeared to have the strongest evidence base, but that more robust longitudinal studies will be needed to look at effects over time. Similarly, they suggest more causal studies are needed to look at the efficacy of interventions in high-risk groups such as students identifying as LGBTQ+ and minority gender or ethnicity, as well as research focused on those who do not seek help such as males. They also suggest that the strength of any evidence is undermined by the poor quality of studies and small sample sizes. Authors also surveyed and interviewed 92 sector experts, conducting a thematic analysis of views and experiences. They acknowledged the ongoing critical tension that exists between targeted and universal interventions but suggest that while the current evidence is for greater effectiveness of those interventions aimed at students who currently present with clinical symptoms - then at-risk students should be a priority but concede that

		Higher Education.	impact and efficacy, and gaps in the literature.	many practitioners felt there was value in offering universal preventative support.
(Abelson et al., 2022) Global reviews predominantly US	Post-secondary college and university students	A commentary review, with "*careful but not systematic*" appraisal of the review-level and primary evidence, not including clinical services.	All student mental health concerns	Multidisciplinary narrative overview of intervention evidence, adopting a public health approach, looking across all levels of a sociological model to include policies, programmes, and practices from strategic to individual level. Meta-review is descriptive rather than evaluative, focusing on the model and access points for intervention, suggesting there is good evidence for effective interventions at every level. Authors conclude "*supervised skill training (focused on mindfulness and social skills), peer support, belonging, screening, mental health curriculum, means restriction, and inclusive policy interventions stand out for quality evidence demonstrating their effectiveness with college students*". Areas for urgent intervention design and evaluation include: "*coaching, family interventions, school-wide interventions to address community norms, climate, stigma, help-seeking and referral; school policies; and public safety and policing practices*".

Table D.2 Examples of Review-Level Evidence for Differing Types of University Mental Health Interventions

Intervention	Author and location	Population	Type and number of studies *n= specific intervention type/ all included eligible studies*	Outcomes	Findings
Settings-based/ whole-university approach	(Fernandez et al., 2016) Global, mainly US, Australia	All students in HE settings	Systematic review of RCTs, case control, pre/post and time series studies. Narrative synthesis n=19	Any improvement in mental health or wellbeing	Researchers reviewed 'whole-university' approaches to mental wellbeing e.g., academic strategies, social marketing strategies and structural/organisational policies. The most promising findings included changes to the ways that students are taught and assessed but reported inconclusive evidence related to policies or services promoting mental health. Authors determined that the existing body of evidence was too limited to draw any robust conclusions.
	(Sweeting et al., 2021) Mostly UK, US	Students and staff	Scoping review of all health studies related to settings and whole-university	'Whole settings', 'complex systems', 'participatory'/ 'action' approaches and interventions to improve health,	There is no evidence - authors report that establishing an evidence base is slow with "*enormous challenges for institutions to fully, rather than tokenistically implement healthy university interventions, and for researchers aiming to evaluate them within a funding and evidence context that is skewed towards trials,*

		interventions - to include wellbeing		wellbeing and/or health-behaviours n=101	*short-term outcomes and simple linear models of cause and effect"*. Authors also suggest investing in *"detailed programme theory and assessment rather than large scale trials or natural experiments at this point in time, to further develop this field"*.
Peer Support	(John et al., 2018) International	Students with no or mild MH difficulties	Systematic review	Quantitative measures of reported mental health, perception of social support, positive and negative affect	Only three eligible studies from 489 identified papers: Two cross-sectional surveys and one non-randomised intervention study with no evidence that peer support increased student mental wellbeing. One study showed females felt more supported but report poorer mental wellbeing. Two studies found no significant improvement of peer support on wellbeing outcomes and was even detrimental to positive affect (Loane, 2015). One study found that a peer support programme was useful for connecting mentees in crisis to student services but did not report on its effectiveness.
Technological-based	(Harrer et al., 2019) [61]	All students	Systematic review and meta-analysis	Depression, anxiety, stress,	Authors reported small effects of internet interventions for depression (g= 0.18, 95% CI 0.08,

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[61] Research part of the WMH-ICS initiative

			RCTs n =48	sleep[62], eating disorders	0.27), anxiety (g = 0.27, 95% CI 0.13-0.40), and stress (g = 0.20, 95% CI 0.02-0.38). Moderate effects on eating disorder symptoms (g = 0.52, 95% CI 0.22–0.83) and non-significant effects for wellbeing (g = 0.15, 95% CI −0.20-0.50). Heterogeneity moderate to substantial throughout, and effects for anxiety became non-significant after adjustment for publication bias.
Psycho-education	(Upsher et al., 2022) International, English speaking	Undergraduate and postgraduate taught students	Systematic review of curriculum embedded pre/post studies n=46	Any quantitative MH or wellbeing outcome	No strong evidence to support impact of curriculum-embedded interventions for improving student MH or wellbeing, Overall, most studies did not affect stress or anxiety. Studies were heterogenous, poor quality and under-powered.
	(Barnett et al., 2021) Global, English speaking	Students at risk of or with CMDs	Systematic review and meta-analysis of RCTs n=5/84	Anxiety, depression eating disorders, self-harm	Authors found medium causal evidence for effectiveness of psycho-educational interventions on anxiety, depression and eating disorders (g = 0.18, 95% CI -0.00-0.37) in interventions for students with symptoms and those at-risk (see also Psychological therapies)

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[62] Only two sleep intervention studies reported, and as such not included in meta-analysis

		Healthy students with/without CMDs but without disabilities or neuro-developmental disorders	Review and meta-analysis RCT's n=20/41	Depression, anxiety, stress	Authors found evidence that MBIs significantly reduced depression reduced symptoms of depression (Standardised Mean Difference [SMD] -0.49, 95% CI -0.68 to -0.30), anxiety (SMD -0.53, 95% CI -0.78 to -0.29), and perceived stress (SMD -0.39, 95% CI -0.50 to -0.27) when compared to a passive control group (receiving no intervention/on waiting list)[63]. Halladay et al. acknowledge that included studies were of poor quality due to risk of bias and inconsistency.
Mindfulness-based intervention (MBI)	(Halladay et al., 2019) Global				
	(Bamber & Schneider, 2020) Global	All students	Thematic synthesis of findings from qualitative and mixed methods studies n=19	Interviews and focus groups post-MBI	Four key themes identified: awareness, barriers to meditation, improved focus, and facilitator's role. Students found MBIs beneficial overall for dealing with stress, anxiety, and emotions, improving learning, relationships, and career skills. Authors indicate that mindfulness-based interventions should be developed to meet specific HE student group need.
Psychological e.g., Cognitive	(Barnett et al., 2021)	Students at risk of or with CMDs	Systematic review and meta-analysis of RCTs n=57/84	CMDs and self-harm	Promising effects were found for some psychological interventions e.g., CBT, psychotherapy for anxiety, depression and eating disorders. Evidence for PTSD

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[63] Taken from Worsley et al., 2020

behavioural therapy	Global, English speaking				and self-harm data was limited, with no significant effects. Relatively few trials adapted the intervention for students, and those that did showed no specific advantage over non-adapted. Authors concluded some interventions show benefit but there is uncertainty over content and delivery for HE populations.
	(Huang et al., 2018) Global but mainly US	Students with CMDs	Systematic review and meta-analysis RCTs n= 51	Depression, anxiety	Authors reported moderate overall effect sizes for treating depression (Hedges' g = -0.60) and anxiety (Hedges' g = -0.48). In sub-group analysis, interventions based on CBT (face to face not online) and mindfulness were found to be effective (n=28), but the largest effects were seen in 'other interventions' (n=9) i.e., art therapy, exercise, and peer support (Hedges' g = -0.76 for depression; Hedges' g = -0.84 for GAD)

Appendix E.   Student Wellbeing Survey [64]

Your mental health and wellbeing are important to us.

We aim to support the mental health and wellbeing of all our students and staff, so you can make the most of your studies and student experience.

To help us understand how best the University and Students' Union can support you please complete the questions in this survey about your mental health, wellbeing and help-seeking. You do not need to have experienced mental health issues to take part in this survey. We will use this data to identify patterns and trends over time to help inform the University's approach and service provision, we may also include quotes and findings in research reports. We will not identify individual responses, and everything you submit will be anonymous, as such we will be unable to withdraw responses at a later date. You will also be unable to return to your responses if you leave the survey part way through, therefore will need to complete the survey in one session.

The questionnaire will take about 15 minutes to complete.

If you answer the questions and would like more information, advice and/or support, please visit Student Wellbeing for ideas about managing your wellbeing and sources of help. Relevant services are signposted throughout the survey.

Data protection information
All data collected in this survey will be processed in a lawful, fair and transparent manner; held anonymously and securely by the University. Individual responses to the survey are provided in confidence and will not be shared, your individual responses will not be identified. The data you give us about yourself in the survey will allow the survey results to be analysed by student characteristics and enable the University to fulfil its commitment to equality monitoring and provide a more targeted response to improving the student experience. Any such analysis will be presented at summary level and it will not be possible to identify the responses of individuals. Anonymised data may be shared with the University's Students' Union to inform and improve its services and with academic colleagues for research purposes. All responses remain confidential. By continuing to complete this survey you are agreeing to this data protection statement.

Thank you very much for your participation.

This survey is anonymous, so to help us best use your responses, please tell us a bit about yourself.

1   What is your level of study?

        1.   UG

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[64] This is 2019 survey questions only. I have highlighted relevant question differences between 2018 and 2019 in Chapter 4

	2.	*PGT*
	3.	*PGR*
2	If you are a doctoral student, is your training programme provided through a Training Centre (e.g. Doctoral Training Centre, a Doctoral Training, Partnership or a Centre for Doctoral Training)?"	

1. *Yes*
2. *No*
3. *Don't know*

3   What year of study are you in?

1. *0 / Foundation*
2. *1*
3. *2*
4. *3*
5. *4*
6. *5*
7. *6*
8. *Other (please specify) (open text box)*

4   Are you studying for a joint programme which is 'owned' by two different departments?

1. *Yes*
2. *No*
3. *Don't know*
4.

5   Which school are you in? (If you're on a joint programme, which school I the primary programme 'owner'?

List of Schools

6-11   Which department are you in?

12   What is your mode of study?

1. *Full time*
2. *Part time*

13   What is your university fee status?

1. *Home*
2. *EU*
3. *International*
4. *Channel Islands and the Isle of Man*

14   Have you had to repeat a year of your studies?

1. *Yes*
2. *No*

15   Where do you live during University term-time?

1. *University Hall of Residence*
2. *Private Hall of Residence*
3. *With parents within the Bristol postcode*
4. *Property rented from a private landlord within the Bristol postcode*

  5. *In a property you own within the Bristol postcode*
  6. *Outside of the Bristol postcode*
  7. *Other (please specify) (open text box)*

16 Which University residence do you live in?

  All listed

17 What is your ethnicity?

* Arab * Asian - Bangladeshi * Asian - Chinese * Asian - Indian * Asian - Other * Asian - Pakistani * Black - African * Black - Caribbean * Black - Other * Gypsy or Traveller * Not given * Not given (Dom=Home) * Not given (Dom=Osea) * Other * Other Mixed * Unknown * White * White and Asian * White/Black African * White/Black Caribbn

18 How do you define your gender?

* Woman * Man * Non-binary * Another gender *Prefer not to Say

18a Do you define yourself as transgender?

  1. *Yes*
  2. *No*
  3. *Prefer not to say*

19 What is your sexual orientation?

Bisexual * Heterosexual/straight * Gay man * Gay woman or lesbian * Prefer not to say * *Prefer to self-describe

20 How old are you?

21 Do you have caring responsibilities for a child or adult dependent?

Yes, No or prefer not to say

22 Do you consider yourself to have any of the following? (Tick all that apply)

* A physical disability - this includes any physical condition that has an effect on your day-to-day activities * A non-physical disability - - this includes any learning difficulty, mental health condition or condition such as autism that has an effect on your day-to-day activities * None of the above * Prefer not to say

23 What sort of school did you attend at secondary/high school level?

* State (non-fee paying) * Grammar (non-fee paying) * Private or grammar (fee paying) * Other (please specify) (open text box)

24 Are you the first person in your family to attend University?

Yes No

25   Was Bristol your first choice University?

        Yes   No

26   Which University was your first choice? Open Text

27   WEMWBS Please tick the box that best describes experience in last 2 weeks

        *None of the time *Rarely *Some of the Time *Often *All of the time*

- I've been feeling optimistic about the future
- I've been feeling useful
- I've been feeling relaxed
- I've been feeling interested in other people
- I've had energy to spare
- I've been dealing with problems well
- I've been thinking clearly
- I've been feeling good about myself
- I've been feeling close to other people
- I've been feeling confident
- I've been able to make up my own mind about things
- I've been feeling loved
- I've been interested in new things
- I've been feeling cheerful

28   How often do you feel lonely?

        *Often/always * Some of the time * Occasionally * Hardly ever * Never*

29   Please show the extent of your agreement with each of the statements below

        *Definitely agree *Mostly agree *Neither agree nor disagree *Mostly disagree *Definitely disagree *Not applicable*

- I am satisfied with my work-life balance
- My course does not apply unnecessary pressure on me as a student
- I have enough time to prepare for my assessments
- I have enough academic support to feel confident when undertaking assessments
- Good support is available for my mental health and wellbeing
- I am content with my overall physical health
- Whilst at University I have felt able to access sport and physical activity opportunities

30   Have you engaged with a wellbeing activity (either online or in person) provided by the University? Some examples are a mindfulness session, wellbeing workshop, mental health first aid session

        Yes   No

31   Please specify what the activity was and how useful you found it. *Open text*

32   Have you attended the Science of Happiness course?

        Yes   No

33   PHQ9 In the last two weeks how often have you been bothered by any of the following?

*Not all *Several Days *More than half the days *Nearly everyday*

- Little interest or pleasure in doing things?
- Feeling down, depressed, or hopeless?
- Trouble falling or staying asleep, or sleeping too much?
- Feeling tired or having little energy?
- Poor appetite or overeating?
- Feeling bad about yourself – or that you are a failure or have let yourself or your family down?
- Trouble concentrating on things, such as reading the newspaper of watching television?
- "Moving or speaking so slowly that other people could have noticed?
- Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual?"
- Thoughts that you would be better off dead, or of hurting yourself in some way?

If you find yourself experiencing difficulties, please contact your School Personal or Senior Tutor, your Student Wellbeing Adviser or your Residential Life team if you live in a University Residence. They may be able to support you directly and/or refer you to more specialist support. Details of the range of support for your health and wellbeing are available at: **www.bristol.ac.uk/students/wellbeing/**

Your previous response indicated that you may be experiencing suicidal thoughts.

Urgent help
If you are feeling distressed and need immediate help:

Call the Samaritans on 116 123 available 24 hours a day, 365 days a year. Calls are free from landlines and mobiles.
Contact your doctor's surgery and request an emergency appointment. If your surgery is not open, contact the NHS Out of Hours Service on 111 available 24 hours a day, 365 days a year. Calls are free from landlines and mobiles.
If you feel at immediate risk of harm to yourself, go straight to your nearest hospital Accident and Emergency department or call Emergency Services on 999.
If you are living in a University Hall of Residence, remember that your Residential Life team are available to support you 24 hours a day, 365 days a year

34   GAD7 In the last two weeks how often have you been bothered by any of the following?

 *Not all *Several Days *More than half the days *Nearly everyday*

- Feeling nervous, anxious or on edge?
- Not being able to stop or control worrying?
- Worrying too much about different things?
- Trouble relaxing?
- Being so restless that it is hard to sit still?

- Becoming easily annoyed or irritable?
- Feeling afraid as if something awful might happen?

35 Has a medical professional ever diagnosed you with a mental health condition?

Yes   No

36 Was this before you started University or whilst you were studying at University?

1. *Before University*
2. *Whilst at University*

37 In the last 12 months, have you had any therapy, medication or other treatment for a mental health condition?

Yes   No

38 Please indicate how you received this treatment

* University Service * NHS * Other (please specify) (open text box)

39 If you have experienced any mental health or wellbeing concerns during your University studies, have you ever informed any member of University staff about them?

* Yes * No * Not applicable - didn't have any concerns

40 Why didn't you let someone from the University know? Open Text

41 Have you ever submitted an Extenuating Circumstances Form to your School in relation to your mental health and/or wellbeing?

Yes   No

42 How many times have you done this? Open text

43 Which of the following have you ever sought help from for mental health or emotional problem since you started university? Please provide an answer for each row

Yes   No

* Partner / significant other (e.g. boyfriend/girlfriend)
* Friend (not related to you)
* Parent
* Other relative/ family member
* Peer supporter or peer mentor
* GP / Doctor
* Mental health professional (psychiatrist, psychologist, counsellor, social worker)
* Personal Tutor / Academic mentor
* Other member of academic staff within your school (e.g. a lecturer)
* Student Wellbeing Adviser
* Member of university support staff (please specify)

* Residential Life Adviser/ Residential Life team
* Other member of staff in University residences
* Big White Wall
* Nightline
* Samaritans
* Religious leader
* The internet
* Students' Union Adviser/Just ask
* None of the above
* Other (please specify)

44   Alongside each support source please indicate how useful this source was?

*Extremely Useful * Very useful * Moderately useful *Slightly useful * Not useful*

45   Overall how easy have you found it to seek help while you have been at university?

** Very easy * Fairly easy *Neither easy nor difficult *Fairly difficult *Very difficult*

46   If you have ever accessed any of the following sources of help for mental health and wellbeing, please indicate how easy it was to find them (if you have not accessed something please leave blank)

** Very easy * Fairly easy *Neither easy nor difficult *Fairly difficult *Very difficult*

47   If you have had a mental health or wellbeing concern and have not used the University's support services, please indicate why (tick all that apply)

* I have not had a problem
* Lack of time
* Lack of confidentiality
* Concern that "no one will understand my problems"
* I didn't know where to find help
* Stigma of mental health care
* Fear of unwanted intervention
* Fear of documentation on academic record
* Difficulty with access to care
* Lack of available services
* Other (please specify) (open text box)

48   Did you opt-in for the University to be able to contact your parents/or other nominated person in the case that we had any concerns about your wellbeing?

        Yes   *No*   Unsure

49   Is there a reason why you wouldn't want us to contact them? Open text

50   Regarding the University's mental health and wellbeing support for students, please let us know if you have any comments on what you think is good and works well and/or what more you feel the University could do to improve the support offered? Open text

51   Do you drink alcohol or take drugs?

* Yes, I drink alcohol * Yes, I take drugs * Yes, I drink alcohol and take drugs * No I don't do either

52   How often do you have a drink containing alcohol?

* Monthly or less * 2-4 times a month * 2-3 times a week * 4 or more times a week

53   How often during the last year have you found that you were not able to stop drinking once you had started?

* Never * Less than monthly * Monthly * Weekly * Daily or almost daily

54   Do you smoke cannabis?

Yes   No

55   How often do you smoke?

* Monthly or less * 2-4 times a month * 2-3 times a week * 4 or more times a week

56   Do you take other illegal drugs?

Yes   No

57   How often do you take other illegal drugs?

* Monthly or less * 2-4 times a month * 2-3 times a week * 4 or more times a week

58   If you drink alcohol and take drugs, do you ever mix these?

Yes   No

59   How often in the last year have you failed to do what was normally expected from you because of drinking or drug taking?

* Never * Less than monthly * Monthly * Weekly * Daily or almost daily

60   How often during the last year have you felt guilt or remorse because of your drug or alcohol use?

* Never * Less than monthly * Monthly * Weekly * Daily or almost daily

61   Have you or someone else been injured as a result of your drinking or drug use?

*No, never   *Yes but not in last year   *Yes during last year

62   On a scale of 0 - 10, 0 being 'not concerned' and 10 being 'very concerned' - How concerned are you about your own alcohol or drug use?

63   Has a relative, friend or health worker been concerned about your drinking or drug use and suggested you cut down?

        *No, never   *Yes but not in last year   *Yes during last year

64   Please let us know how you found out about this survey (tick all that apply)

- Student Newsletter
- Email
- Digital screen on campus
- My Bristol Portal
- Website
- Instagram
- Facebook
- Twitter
- Personal Tutor
- Lecturer
- Friend/Course mate
- Other

You have reached the end of the survey, thank you for sharing your responses with us.

If you are concerned about any of the issues raised in this survey, or if you are experiencing difficulties, please contact your School Personal or Senior Tutor, your Student Wellbeing Adviser or your Residential Life team if you live in a University Residence. They may be able to support you directly and/or refer you to more specialist support. Details of the range of support for your health and wellbeing are available at: **www.bristol.ac.uk/students/wellbeing/**

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Contact your doctor's surgery and request an emergency appointment. If your surgery is not open, contact the NHS Out of Hours Service on 111 available 24 hours a day, 365 days a year. Calls are free from landlines and mobiles.
If you feel at immediate risk of harm to yourself, go straight to your nearest hospital Accident and Emergency department or call Emergency Services on 999.
If you are living in a University Hall of Residence, remember that your Residential Life team are available to support you 24 hours a day, 365 days a year

Appendix F.   Patient Health Questionnaire Scoring [65]

Patient Health Questionnaire-PHQ-9 Scoring and Proposed Treatment Actions - Kroenke and Spitzer, 2002.

TABLE 1		
PHQ-9 Scores and Proposed Treatment Actions		
PHQ-9 Score	**Depression Severity**	**Proposed Treatment Actions**
1 to 4	None	None
5 to 9	Mild	Watchful waiting; repeat PHQ-9 at follow-up
10 to 14	Moderate	Treatment plan, considering counseling, follow-up and/or pharmacotherapy
15 to 19	Moderately Severe	Immediate initiation of pharmacotherapy and/or psychotherapy
20 to 27	Severe	Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy, expedited referral to a mental health specialist for psychotherapy and/or collaborative management

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[65] The GAD-7 anxiety scale is scored and assessed in the same way.

Appendix G.   Missing MH diagnosis sensitivity analyses

Table G.1 Characteristics of Respondents Stating Yes, No or Missing for "Has a medical professional ever diagnosed you with a mental health condition?" in 2018 Survey Compared to All Respondents

2018 Previous mental health diagnosis	Missing responses (n=926)	Yes responses (n=1,562)	No responses (n=3,074)	All responses (n=5,562)
Gender				
Female	580 (62.6)	1,156 (74.0)	1,878 (61.9)	3,614 (65.0)
Male	314 (33.9)	356 (22.8)	1,159 (37.7)	1,829 (32.9)
Non binary another	9 (1.0)	37 (2.4)	16 (0.5)	62 (1.1)
Prefer not to say	9 (1.0)	10 (0.6)	14 (0.5)	33 (0.6)
Missing	14 (1.5)	3 (0.3)	7 (0.2)	24 (0.4)
Ethnicity				
White British	712 (76.9)	1,319 (84.4)	2,472 (80.4)	4,503 (80.1)
Black, Asian and Minority Ethnic	174 (18.8)	226 (14.5)	552 (18.0)	952 (17.1)
Prefer not say	18 (1.9)	12 (0.8)	27 (0.9)	57 (1.0)
Missing	22 (2.4)	5 (0.3)	23 (0.8)	50 (0.9)
Sexual Orientation				
Heterosexual	708 (76.5)	1,085 (69.5)	2,571 (83.7)	4,364 (78.5)
LGB	146 (15.7)	408 (26.1)	404 (13.1)	958 (17.2)
Prefer not say	51 (5.6)	67 (4.3)	92 (3.0)	210 (3.8)
Missing	21 (2.3)	2 (0.1)	7 (0.2)	30 (0.5)
Depression				
PHQ-9 <10	115 (12.4)	555 (35.5)	2,009 (65.4)	2,679 (48.2)
PHQ-9 ≥10	118 (12.7)	1,007 (64.5)	1,065 (34.7)	2,190 (39.7)
Missing	693 (74.8)	-	-	693 (12.5)
Anxiety				
GAD-7 <10	37 (4.0)	660 (42.3)	2,188 (71.2)	2,885 (51.9)
GAD-7 ≥10	23 (2.5)	902 (57.8)	886 (28.8)	1,811 (32.6)
Missing	866 (93.5)	-	-	866 (15.6)

Wellbeing				
WEMWBS >42	214 (23.1)	510 (32.7)	1,785 (58.1)	2,509 (45.1)
WEMWBS <42	265 (28.6)	1,052 (67.3)	1,289 (41.9)	2,606 (46.8)
Missing	447 (48.3)	-	-	447 (8.4)

Table G.2 Characteristics of Respondents with a Previous Mental Health Diagnosis in 2018 and 2019 Wellbeing Surveys

Survey Year n=respondents indicating yes to previous MH diagnosis	2018 (n=1,562)	2019 (n= 884)	χ^2 (p value)
Gender			
Male	356 (22.8)	181 (20.5)	1.77 (.18)
Other[a]	1,206, (77.2)	703 (79.5)	
Ethnicity			
Black, Asian, Minority ethnic	226(14.5)	140 (15.8)	0.83 (.36)
Other	1,336 (85.5)	744 (84.2)	
Sexual Orientation			
LGB	408 (26.1)	248 (28.1)	1.08 (.30)
Other	1,154 (73.9)	636 (71.9)	
Education			
Private education	478 (30.6)	257 (29.1)	0.63 (.43)
Other	1,084 (69.4)	627(70.9)	
Depression			
PHQ-9 ≥10	1,007 (64.5)	597 (68.2)	2.35 (.13)
Other	555 (35.5)	287 (31.8)	
Anxiety			
GAD-7 ≥10	902 (57.7)	488 (55.2)	1.48 (.22)
Other	660 (42.3)	396 (44.8)	
Wellbeing			
WEMWBS <42	1,052 (67.3)	570 (64.5)	2.08 (.15)
Other	510 (32.7)	314 (35.5)	

a) includes missing

Table G.3 Sensitivity Analysis Comparing Unadjusted and Adjusted Models of Depression, Anxiety and Poorer Wellbeing Between 2018 and 2019 and Association with Previous Mental Health Diagnosis

Sample size n=6,648/8,199	OR (CI 95%)	*p value*
Depression symptoms (PHQ9 ≥10)		
2018 (ref)	1.00	*1.00*
2019 Unadjusted [1]	1.08 (0.98-1.19)	*.122*
2019 Adjusted Model [2]	1.03 (0.92-1.15)	*.617*
2019 Adjusted Model [3]	1.05 (0.93-1.17)	*.434*
Anxiety Symptoms (GAD7 ≥ 10)		
2018 (ref)	1.00	*1.00*
Unadjusted [1]	0.91 (0.82-1.00)	*.054*
2019 Adjusted Model [2]	0.85 (0.76-0.95)	*.006**
2019 Adjusted Model [3]	0.86 (0.77-0.96)	*.010**
Mental Wellbeing (WEMWBS ≤42)		
2018 (ref)	1.00	*1.00*
Unadjusted [1]	0.91 (0.83-1.00)	*.044**
2019 Adjusted Model [2]	0.83 (0.75- 0.93)	*.001**
2019 Adjusted Model [3]	0.84 (0.75-0.94)	*.002***

1 Model includes no confounders
2 Model adjusted for all confounders except MH diagnosis
3 Model adjusted for all confounders (including MH Diagnosis)
4 P value or significance is * <.05 ** <.01 *** <.001

Appendix H.   Student mental health outcomes

Table H.1 Adjusted Regression Models Showing Change in Student Mental Health Outcomes between 2018 and 2019 [a]

	Depression symptoms (PHQ9 ≥10)	Anxiety Symptoms (GAD7 ≥ 10)	Mental Wellbeing (WEMWBS ≤42)
	OR (95 %CI)	OR (95%CI)	OR (95%CI)
Survey Year			
2018 (ref)	1.00	1.00	1.00
2019	1.05	0.86	0.84
	(0.93-1.17)	(0.77-0.96)	(0.75-0.94)
p value	*.434*	*.009***	*.002***
Gender			
Male (ref)	1.00	1.00	1.00
Female	1.13	1.35	1.05
	(1.00-1.27)	(1.19-1.53)	(0.93-1.18)
Non-Binary/Another gender	2.34	1.84	1.73
	(1.27-4.30)	(1.10-3.07)	(0.97-3.07)
Prefer not to say	1.73	0.75	2.34
	(0.88-3.39)	(0.39-1.42)	(1.13-4.81)
p value	*.008***	*<.001****	*.033**
Age			
21 and over (ref)	1.00	1.00	1.00
Under 21	0.95	1.04	1.06
	(0.81-1.11)	(0.89-1.21)	(0.91-1.23)
	.489	.607	.455
Ethnicity			
White British (ref)	1.00	1.00	1.00
Black, Asian and Minority Ethnic	1.72	1.24	1.60
	(1.48-1.99)	(1.07-1.44)	(1.38-1.85)
Prefer not to say	1.24	1.89	1.26
	(0.64-2.38)	(0.99-3.59)	(0.65-2.46)

p value	*<.001****	*.004***	*<.001****
Fee status			
Home/Channel Isles (ref)	1.00	1.00	1.00
International/EU	1.13	1.37	1.11
	(0.95-1.35)	(1.15-1.63)	(0.93-1.31)
p value	*.153*	*<.001****	*.245*
Sexual Orientation			
Heterosexual/Straight (ref)	1.00	1.00	1.00
LGB	1.56	1.18	1.35
	(1.35-1.80)	(1.03-1.36)	(1.17-1.56)
Prefer not to say	1.54	1.48	1.42
	(1.17-2.03)	(1.13-1.94)	(1.08-1.87)
p value	*<.001****	*.020**	*<.001****
Previous Education			
Private (ref)	1.00	1.00	1.00
State/Grammar/Other	1.37	1.28	1.21
	(1.22-1.53)	(1.14-1.44)	(1.08-1.35)
p value	*<.001****	*<.001****	*.001***
Lifetime Mental Health Diagnosis			
No (ref)	1.00	1.00	1.00
Yes	2.10	2.15	1.84
	(1.85-2.39)	(1.89-2.45)	(1.62-2.10)
p value	*<.001****	*<.001****	*<.001****
Faculty			
Arts (ref)	1.00	1.00	1.00
Biomedical-Other/Life Sciences	1.31	1.08	1.38
	(1.07-1.59)	(0.88-1.32)	(1.13-1.68)
Engineering	1.30	1.25	1.47
	(1.07-1.59)	(1.02-1.53)	(1.21-1.79)
Health Science	0.73	0.81	0.87
	(0.60-0.88)	(0.67-0.97)	(0.73-1.05)
Science	0.99	0.93	1.16

	(0.84-1.17)	(0.79-1.10)	(0.99-1.36)
Social Science and Law	1.05 (0.89-1.25)	1.25 (1.06-1.49)	1.29 (1.10-1.53)
p value	*<.001****	*<.001****	*<.001****
Year of Study			
1 (ref)	1.00	1.00	1.00
2	1.23 (1.00-1.52)	1.01 (0.82-1.24)	1.13 (0.92-1.38)
3	1.04 (0.83-1.30)	1.13 (0.90-1.41)	1.16 (0.93-1.44)
4	0.97 (0.75-1.26)	1.15 (0.89-1.49)	1.01 (0.78-1.29)
5/6	0.77 (0.52-1.12)	0.80 (0.54-1.17)	1.09 (0.76-1.56)
Other	1.26 (0.74-2.14)	1.06 (0.62-1.81)	1.22 (0.73-2.08)
p value	*.049**	*.341*	*.623*
Course			
Undergraduate (ref)	1.00	1.00	1.00
Postgraduate Taught	0.88 (0.68-1.13)	0.96 (0.75-1.24)	1.08 (0.85-1.38)
Postgraduate Research	0.71 (0.55-0.91)	0.60 (0.44-0.80)	0.89 (0.70-1.13)
p value	*.028**	*.002***	*.408*
Disability			
None	1.00	1.00	1.00
Physical	1.66 (1.16- 2.39)	1.49 (1.03-2.15)	1.13 (0.80-1.62)
Non-physical	3.14 (2.71-3.64)	2.50 (2.17-2.88)	2.57 (2.22-3.00)
Both	6.76 (3.90-11.71)	3.46 (2.25-5.31)	3.30 (2.07-5.25)
Prefer Not to Say	2.29 (1.73-3.03)	2.34 (1.79-3.08)	3.16 (2.34-4.25)

p value	*< .001****	*<.001****	*<.001****
Residence			
Private rented	1.00	1.00	1.00
Uni hall	1.11	0.82	1.03
	(0.91-1.38)	(0.66-1.01)	(0.84-1.26)
Private hall	1.41	1.20	1.19
	(1.07-1.84)	(0.92-1.56)	(0.91 -1.55)
Other	0.91	1.13	1.20
	(0.72-1.15)	(0.89-1.43)	(0.96-1.51)
p value	*.050**	*.035**	*.274*

a) Models adjusted for all confounders - gender, age, ethnicity, fee status, sexual orientation, previous education, faculty, year of study, disability, residence, course level, previous MH diagnosis
b) P value or significance is * <.05 ** <.01 *** <.001

Appendix I. Risk factor analysis

Table I.1 Stratified Sensitivity Analysis of Two Highlighted Student Risk Factors (Gender and Sexual Orientation) with Depression, Anxiety and Wellbeing Outcomes in 2018 and 2019

Risk Factor [a]	Survey Year	Depression Symptoms (PHQ≥10)		Anxiety Symptoms (GAD≥10)		Mental Wellbeing (WEMWBS ≤42)	
		OR	95%CI	OR	95%CI	OR	95%CI
Gender							
Male (ref)		1.00		1.00		1.00	
Female	2018	1.12	0.96-1.30	1.35	1.16-1.58	1.15	1.00-1.33
Non-binary/ Another gender		3.09	1.40-6.84	2.31	1.20-4.49	3.46	1.49-8.07
Prefer not to say		2.74	0.86-8.74	0.98	0.36-2.65	3.00	0.87-10.33
Male (ref)		1.00		1.00		1.00	
Female	2019	1.13	0.91-1.39	1.33	1.07-1.65	0.86	0.71-1.06
Non-binary/ Another gender		1.41	0.53-3.78	1.25	0.52-2.86	0.64	0.27-1.51
Prefer not to say		1.31	0.55-3.11	0.59	0.25-1.44	1.88	0.75-4.70
	Interaction p value [b]	*.465*		*.612*		*.011**	
Sexual orientation							
Heterosexual (ref)		1.00		1.00		1.00	
LGB	2018	1.34	1.12-1.61	1.17	0.98-1.41	1.30	1.09-1.56

Prefer not to say		1.39	0.95-2.03	1.40	0.97-2.03	1.43	0.98-2.11
Heterosexual (ref)		1.00		1.00		1.00	
LGB	2019	2.08	1.63-2.63	1.22	0.97-1.54	1.43	1.14-1.80
Prefer not to say		1.81	1.20-2.72	1.61	1.08-2.39	1.43	0.96-2.13
	Interaction p value	*.013**		*.866*		*.808*	

a) all models adjusted for: gender, age, ethnicity, fee status, sexual orientation, previous education, faculty, year of study, previous MH diagnosis, disability, residence, course level

b) p value or significance is * <.05 ** <.01 *** <.001

Appendix J.   First year student characteristics

Table J.1 Student Characteristics of First Years Respondents Only Compared to All Respondents in 2018 and 2019

Year	2018	2019	Full sample 2018	Full sample 2019
Number of first years/ Eligible sample n (%)	1,817/5,562 (33)	952/2,637 (36)	5,562/24,915 (22.3)	2,637/26,053 (10.1)
Gender				
Female	1,198 (65.9)	686 (72.1)	3,614 (65.0)	1,829 (69.4)
Male	583 (32.1)	243 (25.5)	1,829 (32.9)	720 (27.3)
Nonbinary or another gender	27 (1.50)	8 (0.8)	62 (1.1)	28 (1.1)
Prefer not to say	7 (0.4)	9 (1.0)	33 (0.6)	35 (1.3)
Missing	2 (0.1)	6 (0.6)	24 (0.4)	25 (1.0)
Age				
< 21	1,330 (73.2)	581 (61.0)	2,658 (47.8)	1,122 (42.6)
$\geq$21	414 (22.8)	365 (38.4)	2,677 (48.1)	1,486 (56.4)
Missing	73 (4.0)	6 (0.6)	227 (1.8)	29 (1.0)
Ethnicity				
Black, Asian or minority ethnic	352 (19.4)	227 (23.9)	952 (17.1)	528 (20.0)
White British	1,442 (79.4)	718 (75.4)	4,503 (80.1)	2,072 (78.6)
Prefer not to say/Not-disclosed	14 (0.8)	2 (0.2)	57 (1.0)	17 (0.6)
Missing	9 (0.5)	5 (0.5)	50 (0.9)	20 (0.8)
Sexual orientation				
Heterosexual	1,404 (77.3)	704 (74.0)	4,364 (78.5)	1,968 (74.6)
Lesbian, Gay, Bisexual or another sexuality	346 (19.0)	198 (20.8)	958 (17.2)	492 (18.7)
Prefer not to say	65 (3.6)	48 (5.0)	210 (3.8)	155 (5.9)
Missing	2 (0.1)	2 (0.2)	30 (0.5)	22 (0.8)

Fee status				
Home[66]	1,539 (84.7)	736 (77.3)	4,847 (87.9)	2,129 (80.7)
EU/ International students	272 (15.0)	215 (22.6)	273 (4.9)	196 (7.4)
Missing	6 (0.3)	1 (0.1)	393 (7.1)	307 (11.6)
Course type				
Postgraduate research	119 (6.6)	88 (9.2)	366 (6.6)	279 (10.6)
Postgraduate taught	194 (10.7)	229 (24.1)	289 (5.2)	314 (11.9)
Undergraduate	1,502 (82.6)	635 (66.7)	4,867 (87.5)	2,041 (77.4)
Missing	2 (0.1)	3 (0.1)	40 (0.7)	3 (0.1)
Previous Education				
State/Grammar/Other (non-fee paying)	1,194 (65.7)	647 (68.0)	3,537 (63.6)	1,761 (66.8)
Private (fee-paying)	570 (31.4)	301 (31.6)	1,837 (33.0)	860 (32.6)
Missing	53 (2.9)	4 (0.4)	188 (3.4)	16 (0.6)
Lifetime MH diagnosis				
No diagnosis in lifetime	1,036 (57.0)	657 (69.0)	3,074 (55.3)	1,739 (66.0)
Previously diagnosed	470 (25.9)	292 (30.1)	1,562 (28.1)	884 (33.5)
Missing	311 (17.1)	3 (0.3)	926 (16.7)	14 (0.5)
Disability				
Physical Disability	38 (2.1)	23 (2.4)	106 (1.9)	57 (2.2)
Non -physical disability	451 (24.8)	213 (22.4)	1,283 (23.1)	581 (22.0)
Physical and non-physical	20 (1.1)	22 (2.3)	68 (1.2)	62 (2.4)
None	1,223 (67.3)	633 (66.5)	3,819 (68.7)	1,724 (65.4)
Prefer not to say	69 (3.8)	41 (4.3)	204 (3.7)	123 (4.7)

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[66] Inc Channel Islands & Isle of Man

Missing	16 (0.9)	20 (2.1)	82 (1.5)	90 (3.4)
Faculty				
Arts	406 (22.3)	195 (20.5)	1,238 (22.3)	544 (20.6)
Engineering	180 (9.9)	86 (9.0)	661 (11.9)	273 (10.4)
Health Sciences	208 (11.5)	125 (13.1)	760 (13.7)	442 (16.7)
Life Sciences[67]	145 (8.0)	146 (15.3)	448 (8.1)	364 (13.8)
Science	408 (22.5)	142 (14.9)	1,271 (22.9)	446 (16.9)
Social Science and Law	467 (25.7)	254 (26.7)	1,141 (20.5)	557 (22.1)
Missing	3 (0.2)	4 (0.4)	43 (0.8)	11 (0.4)
Residence				
University Hall Residence	1,374 (75.6)	628 (66.0)	1,514 (27.2)	706 (26.8)
Private Hall Residence	82 (4.5)	60 (6.3)	214 (3.9)	155 (5.9)
Private rental	255 (14.0)	177 (18.6)	3,496 (62.9)	1,511 (57.3)
Other	104 (5.7)	87 (9.2)	258 (4.6)	239 (9.1)
Missing	2 (0.1)	-	37 (0.7)	4 (0.2)
Depression n (%) [a]				
PHQ-9 <10	873 (54.9)	492 (52.3)	2,679 (55.0)	1,383 (53.2)
PHQ-9 ≥10	717 (45.1)	448 (47.7)	2,190 (45.0)	1,219 (46.9)
Anxiety n (%)				
GAD-7 <10	956 (62.7)	624 (66.2)	2,885 (61.4)	1,663 (63.7)
GAD-7 ≥10	570 (37.4)	319 (33.8)	1,811 (38.6)	947 (36.3)
Wellbeing n (%)				
WEMWBS >42	833 (49.3)	493 (52.3)	2,509 (49.1)	1,337 (51.5)
WEMWBS ≤42	856 (50.7)	450 (47.7)	2,606 (51.0)	1,260 (48.5)

a) Missing not included in mental health outcomes

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[67] This was Biomedical Science in 2018

Table J.2 First Year Survey Respondents Using University Support Sources in 2018 and 2019

Support Source	Students using support 2018 n (%)	Students using support 2019 n (%)
Number of first years/ Eligible sample (%)	n= 1,817/5,562 (33%)	n= 952/2,637 (36%)
Staff in Residences [a]	122 (6.7)	103 (10.8)
Student Wellbeing Adviser [b]	-	125 (13.1)
Mental Health Professional	372 (20.5)	225 (23.6)
GP/Doctor	341 (18.8)	268 (28.2)
Member university support staff	44 (2.4)	31 (3.3)
Peer Support/Mentor	79 (4.4)	62 (6.5)
Personal Tutor Academic Mentor	321 (17.7)	241 (25.3)
Other member of academic staff	121 (6.7)	70 (7.4)
Togetherall	129 (7.1)	62 (6.5)
Nightline	23 (1.3)	22 (2.3)
Students' Union	26 (1.4)	11 (1.2)

a) All Staff in Residences collapsed into one category

b) Wellbeing Advisers in Health Science only in 2018

Appendix K. Support usefulness ratings

Table K.1 Changes in Student Perception of the Usefulness of University Support Sources between 2018 and 2019 When Seeking Help for a Mental Health or Emotional Problem

Support Source	Mean score 2018 (SD)	Mean score 2019 (SD)	Unadjusted Mean Difference [b] (CI 95%) p value[d]	Adjusted Mean Difference [c] (CI 95%) p value
	n=numbers of respondents using and rating support source [a]			
Staff in Residences	3.59 (1.26) *116/122*	2.94 (1.29) *96/103*	-0.66 (-1.00 to 0.31) *<.001****	-0.63[e] (-1.03 to -0.23) *.002***
Student Wellbeing Adviser	-	3.28 (1.32) *114/125*	-	-
Mental Health Professional	3.31 (1.32) *353/372*	3.63 (1.13) *211/225*	0.32 (0.11 to 0.54) *.003***	0.35 (0.12 to 0.58) *.003***
GP/Doctor	3.05 (1.19) *329/341*	3.30 (1.17) *257/268*	0.25 (0.06 to 0.45) *.010**	0.31 (0.10 to 0.51) *.004***
Member university support staff	2.51 (1.30) *39/44*	3.50 (1.10) *22/31*	0.99 (0.33 to 1.64) *.004***	1.27 (0.17 to 2.36) [f] *.025**

Peer Support/Mentor	2.80 (1.33)	3.40 (1.11)	0.59 (0.14 to 1.04)	0.33 (-0.18 to 0.85)
	73/79	50/62	.011*	.202
Personal Tutor Academic Mentor	3.00 (1.20)	3.04 (1.22)	0.04 (-0.17 to 0.24)	0.03 (-0.20 to 0.25)
	302/321	227/241	.740	.814
Other member of academic staff	3.09 (1.26)	3.05 (1.37)	-0.04 (-0.45 to 0.37)	-0.21 (-0.66 to 0.23)
	113/121	60/70	.853	.344
Togetherall (Big White Wall)	1.99 (0.99)	2.26 (1.15)	0.27 (- 0.07 to 0.60)	0.21 (-0.16 to 0.58)
	122/129	54/62	.119	.270
Nightline	2.23 (1.27)	2.29 (1.23)	0.06 (-0.71 to 0.83)	0.21 (-1.52 to 1.94)
	22/23	21/22	.879	.797
Students' Union	2.92 (1.15)	3.33 (0.86)	0.41 (-0.45 to 1.27)	0.58 (-1.91 to 3.07)
	25/26	9/11	.336	.606

a) Students were asked to score *Not Useful to Extremely Useful* (1-5) if they had sought help from university.   Only those indicating they had used a support source were included.

b) Mean differences (co-efficients) taken from linear regression models

c) Models adjusted for: gender, age, ethnicity, fee status, sexual orientation, previous education, faculty, year of study, previous MH diagnosis, disability, residence, course level

d) p value or significance is * <.05 ** <.01 *** <.001

e) Residence not included as a confounder in this model

f) Stata removed disability confounder due to collinearity

Appendix L.   Levels of student depression symptoms

Table L.1 Levels of Depression Symptoms for All Survey Respondents in 2018 and 2019 as Indicated by Patient Health Questionnaire (PHQ-9) Scores

Survey Year	2018	2019
PHQ-9 scoring categories	n (%)	n (%)
None (1-4)	1,131 (20.3)	682 (25.9)
Mild (5-9)	1,548 (27.8)	701 (26.6)
Moderate (10-14)	1,162 (20.9)	583 (22.1)
Moderately Severe (15-19)	616 (11.1)	353 (13.4)
Severe PHQ-9$\geq$ 20	412 (7.4)	283 (10.7)
Missing	693 (12.5)	35 (1.3)

Table L.2 Characteristics of Survey Respondents Showing Severe Depression Symptoms (PHQ$\geq$20) in 2018 and 2019 Compared to Whole Sample

Year	2018	2019	Full sample 2018	Full sample 2019
Number of respondents with greater depression/ Eligible sample n (%)	412/5,562 (7.4%)	283/2,637 (10.7%)	5,562/24,915 (22.3%)	2,637/26,053 (10.1%)
Gender				
Female	284 (68.9)	204 (78.1)	3,614 (65.0)	1,829 (69.4)
Male	107 (26.0)	64 (22.6)	1,829 (32.9)	720 (27.3)
Nonbinary or another gender	19 (4.6)	4 (1.4)	62 (1.1)	28 (1.1)
Prefer not to say	2 (0.5)	8 (2.8)	33 (0.6)	35 (1.3)
Missing	-	3 (1.0)	24 (0.4)	25 (1.0)
Age				
< 21	186 (45.1)	581 (61.0)	2,658 (47.8)	1,122 (42.6)

≥21	211 (51.2)	365 (38.4)	2,677 (48.1)	1,486 (56.4)
Missing	15 (3.6)	6 (0.6)	227 (1.8)	29 (1.0)
Ethnicity				
Black, Asian or minority ethnic	97 (23.5)	227 (23.9)	952 (17.1)	528 (20.0)
White British	309 (75.0)	718 (75.4)	4,503 (80.1)	2,072 (78.6)
Prefer not to say/Not-disclosed	6 (1.5)	2 (0.2)	57 (1.0)	17 (0.6)
Missing	-	5 (0.5)	50 (0.9)	20 (0.8)
Sexual orientation				
Heterosexual	249 (60.4)	704 (74.0)	4,364 (78.5)	1,968 (74.6)
Lesbian, Gay, Bisexual or another sexuality	146 (35.4)	198 (20.8)	958 (17.2)	492 (18.7)
Prefer not to say	17 (4.1)	48 (5.0)	210 (3.8)	155 (5.9)
Missing	-	2 (0.2)	30 (0.5)	22 (0.8)
Fee status				
Home[68]	340 (82.5)	736 (77.3)	4,847 (87.9)	2,129 (80.7)
EU/ International students	69 (16.8)	215 (22.6)	666 (12.0)	503 (19.1)
Missing	3 (0.7)	1 (0.1)	49 (0.9)	5 (0.2)
Course type				
Postgraduate research	24 (5.8)	88 (9.2)	366 (6.6)	279 (10.6)
Postgraduate taught	35 (8.5)	229 (24.1)	289 (5.2)	314 (11.9)
Undergraduate	352 (85.4)	635 (66.7)	4,867 (87.5)	2,041 (77.4)
Missing	1 (0.24)	3 (0.1)	40 (0.7)	3 (0.1)
Previous Education				
State/Grammar/Other (non-fee paying)	408 (58.9)	647 (68.0)	3,537 (63.6)	1,761 (66.8)
Private (fee-paying)	234 (33.8)	301 (31.6)	1,837 (33.0)	860 (32.6)
Missing	51 (7.4)	4 (0.4)	188 (3.4)	16 (0.6)

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[68] Inc Channel Islands & Isle of Man

Lifetime MH diagnosis				
No diagnosis in lifetime	121 (29.4)	657 (69.0)	3,074 (55.3)	1,739 (66.0)
Previously diagnosed	270 (65.59)	292 (30.1)	1,562 (28.1)	884 (33.5)
Missing	21 (5.1)	3 (0.3)	926 (16.7)	14 (0.5)
Disability				
Physical Disability	8 (1.9)	23 (2.4)	106 (1.9)	57 (2.2)
Non -physical disability	225 (54.6)	213 (22.4)	1,283 (23.1)	581 (22.0)
Physical and non-physical	19 (4.6)	22 (2.3)	68 (1.2)	62 (2.4)
None	127 (30.8)	633 (66.5)	3,819 (68.7)	1,724 (65.4)
Prefer not to say	29 (7.0)	41 (4.3)	204 (3.7)	123 (4.7)
Missing	4 (1.0)	20 (2.1)	82 (1.5)	90 (3.4)
Faculty				
Arts	98 (23.8)	195 (20.5)	1,238 (22.3)	544 (20.6)
Engineering	46 (11.2)	86 (9.0)	661 (11.9)	273 (10.4)
Health Sciences	41 (10.0)	125 (13.1)	760 (13.7)	442 (16.7)
Life Sciences[69]	33 (8.0)	146 (15.3)	448 (8.1)	364 (13.8)
Science	102 (24.8)	142 (14.9)	1,271 (22.9)	446 (16.9)
Social Science and Law	91 (22.1)	254 (26.7)	1,141 (20.5)	557 (22.1)
Missing	1 (0.2)	4 (0.4)	43 (0.8)	11 (0.4)
Year of Study				
One	143 (34.7)	92 (32.5)	1,817 (32.7)	952 (36.2)
Two	125 (30.3)	83 (29.3)	1,605 (28.9)	692 (26.3)
Three	99 (24.0)	71 (25.1)	1,402(25.2)	583 (22.2)
Four or more/Other	43 (10.5)	36 (12.7)	686 (12.4)	378 (14.4)
Missing	2 (0.5)	1 (0.4)	52 (0.7)	9 (0.3)
Residence				
University Hall Residence	113 (27.4)	628 (66.0)	1,514 (27.2)	706 (26.8)
Private Hall Residence	33 (8.0)	60 (6.3)	214 (3.9)	155 (5.9)

[69] This was Biomedical Science in 2018

Private rental	237 (57.5)	177 (18.6)	3,496 (62.9)	1,511 (57.3)
Other	28 (6.8)	87 (9.2)	258 (4.6)	239 (9.1)
Missing	1 (0.2)	-	37 (0.7)	4 (0.2)
Depression n (%)				
PHQ-9 <10	-	492 (52.3)	2,679 (55.0)	1,383 (53.2)
PHQ-9 ≥10	412 (100.0)	283(100.0)	2,190 (45.0)	1,219 (46.9)
Anxiety n (%)				
GAD-7 <10	35 (8.5)	19 (6.7)	2,885 (61.4)	1,663 (63.7)
GAD-7 ≥10	362 (87.9)	263 (93.3)	1,811 (38.6)	947 (36.3)
Wellbeing n (%)				
WEMWBS >42	7 (1.7)	8 (2.8)	2,509 (49.1)	1,337 (51.5)
WEMWBS ≤42	405 (98.3)	272 (97.1)	2,606 (51.0)	1,260 (48.5)

Appendix M.   Perceived help-seeking barriers

Table M.1 Perceived Barriers to Seeking Help in 2018 and 2019- Before and After the Introduction of the New Wellbeing Services - for All Respondents, First Years Only and Those Showing Severe Major Depression Symptoms (PHQ9$\geq$20)

	All students		First Years Only		Students with SMD (PHQ9$\geq$20)	
Survey Year	**2018**	**2019**	**2018**	**2019**	**2018**	**2019**
N= number students/eligible students[70] (%)	n=5,562/ 25,024 (22.2)	n=2,637 /25,957 (10.2)	n=1,817 /5,562 (32.7)	n=952/ 2,637 (36.1)	n=412/ 5,562 (7.4)	283/ 2,637 (10.7)
Barriers to seeking help						
Lack of time	928 (16.7)	514 (19.5)	302 (16.6)	177 (18.6)	96 (23.3)	85 (30.0)
Lack of confidentiality	368 (6.6)	230 (8.7)	133 (7.3)	102 (10.7)	47 (11.4)	54 (19.1)
Concern 'no-one will understand my problem'	827 (14.9)	467 (17.7)	285 (15.7)	189 (19.9)	120 (29.1)	101 (35.7)
Didn't know where to find help	823 (14.8)	401 (15.2)	278 (15.3)	177 (18.6)	82 (19.9)	76 (26.9)
Stigma of mental health care	740 (13.3)	393 (14.9)	262 (14.4)	144 (15.1)	110 (26.7)	82 (29.0)
Fear unwanted intervention	923 (16.6)	530 (20.1)	329 (18.1)	222 (23.3)	118 (28.6)	95 (33.6)
Fear of documentation	790 (14.2)	457 (17.3)	258 (14.2)	186 (19.5)	122 (29.6)	90 (31.8)
Difficulty with access	790 (14.2)	333 (12.6)	245 (13.5)	96 (10.1)	99 (24.0)	70 (24.7)

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[70] Student cohort figures taken from Institution Academic Registry (2021)

Lack of available services	1,029	390	308	95	146	66
	(18.5)	(14.8)	(17.0)	(10.0)	(35.4)	(23.3)
Other	785	289	229	102	73	34
	(14.1)	(11.0)	(12.6)	(10.7)	(17.7)	(12.0)

Appendix N.   Student survey response rates

Table N.1 National Student Survey Institution Response Rates and Local Student
Survey Response Rates

Survey Year	Institution local survey response rate (%)[a]	Institution NSS response rate (%)[bc]
2015	28	75
2016	30	73
2017	28	47
2018	27	59
2019	20	65

a Survey includes non-final year undergraduates and all postgraduate taught students
b Survey includes non-final year undergraduates only
c National NSS survey response rates are generally >70%

Appendix O. Census survey materials

Table 0.1 Student Pre-appointment Census Survey

We are asking you to take part in key research looking at how students are supported in their mental health and wellbeing at university...it's a really brief survey...just five minutes...

Why? Because many of us will have experienced a personal problem at university or tried to support friends through a difficult time. Nationally there has been a steep rise in the numbers of students seeking support for their mental health and wellbeing in the last five years. Universities need evidence-based research to underpin mental health strategy and investment to ensure ALL students are well supported.

Who? This work has been commissioned and funded by the University, it's being run by a postgraduate researcher based in Population Health at the University of Bristol and supported by a team of academics with expertise in young people's mental health.

How? It's a short anonymous survey; it should take no more than five minutes. It will ask a bit about you, why you've approached the Wellbeing/Residential Life service, and how you're feeling now. And then shortly **after** your appointment, you'll be sent a second brief survey asking you how useful you found it.

What? The findings will support wider research exploring whether UoB's Wellbeing Advice and Residential Life Service makes a difference to student wellbeing and mental health overall. The results will be used to shape support for thousands of Bristol students both now and in years to come. It will also generate evidence-based research to help other UK universities find better ways to support their students.

Your privacy? Your taking part in this study is completely voluntary, and by filling out the survey you are consenting to taking part. Once your responses are submitted, they cannot be withdrawn because the survey is anonymous. For that reason, data cannot be linked to you. Your personal details will always remain confidential. All data will be held on a secure server or

repository, and any findings used in research publications or for education/policy purposes will NOT be identifiable.

When? This is the first survey. Please fill this in now, fold it over and put in a sealed envelope to ensure confidentiality. It will be collected by the Research team and securely stored.

Don't forget to fill in the second survey you get given today or sent in an email **after** your appointment.

If you have any questions, please contact Population Health researcher- Jacks Bennett
jacks.bennett@bristol.ac.uk

Your gender

- Woman

- Man

- Non-binary

- Other… please specify……………………………………….

- Prefer not to say

Your age (in years) ……………………………………….

What is your fee status?

- Home

- EU

- International

- Channel Islands and the Isle of Man

Where do you live in term-time?

- University Hall of Residence – please specify hall ……………………………………….

- Private Hall of Residence – please specify hall ……………………………………….

- With parents within the Bristol postcode

- Property rented from a private landlord within the Bristol postcode

- In a property you own within the Bristol postcode

- Rent or own elsewhere in UK

- Live outside UK

- Other (please specify) …………………………………………

What is your ethnicity?

- Arab
- Asian- Bangladeshi
- Asian- Chinese
- Asian-Indian
- Asian-Other
- Asian- Pakistani

- Black-African
- Black-Caribbean
- Black-Other
- Gypsy or Traveller
- Other
- Other Mixed

- White
- White and Asian
- White/Black African
- White/Black Caribbn
- Prefer not to say

What is your year of study?

- Foundation
- 1
- 2
- 3
- 4

- 5
- 6
- Erasmus (studying in UK)
- Erasmus (studying abroad)
- Other, please specify

What school are you in? *(Please specify primary provider if more than one)*

……………………………………

Course level

- Undergraduate

- Postgraduate Taught

- Postgraduate Research

- PhD

- Other, please specify

Are you repeating a year?

- Yes

- No

Which service are you using?

- Wellbeing Service

- Residential Life Service

- I don't know

Who/what encouraged you to come today? (tick all that apply)

- Academic team advised me e.g. tutor, senior tutor, supervisor

- Admin/office team/other advised me

- Peer recommended e.g. friend, another student

- Family recommended I come

- Saw Wellbeing or Residential Life service promoted e.g. Uni website or social media

- I decided to come

- Clinician referral e.g. doctor, counsellor

- Wellbeing adviser/Residential Life adviser contacted me

- Other please specify

  …………………………………….

How easy was it to get an appointment to talk to an adviser?

- Very easy

- Fairly easy

- Neither easy nor difficult

- Fairly difficult

- Very difficult

What factors may be contributing to any issues you have been experiencing?

(tick all that apply)

Study difficulties	Physical health
Exam difficulties	Gender/Sexual identity
Terminating studies	Disability
Issues arising from repeat year	Sexual assault
Other course issues	Violence
Friendship/Peer problems	Theft
Relationship problems	Finances/Debt
Parent/Family problems	Low mood /Depression
Supporting friends with problems	Stress/Anxiety
Bullying/Harassment	Self-harming
Accommodation issues	Drug/Alcohol problem
Homesickness	Disordered eating
Issues relating to overseas study	Other – please specify
Bereavement	

Please answer this quick questionnaire, it's similar to one you may have filled in at registration

Please clearly tick the box that best describes your experience of each over the **last two weeks**

I've been feeling optimistic about the future

- None of the time
- Rarely
- Some of the time
- Often
- All of the time

I've been feeling useful

- None of the time

- Rarely
- Some of the time
- Often
- All of the time

I've been feeling relaxed

- None of the time
- Rarely
- Some of the time
- Often
- All of the time

I've been dealing with problems well

- None of the time
- Rarely
- Some of the time
- Often
- All of the time

I've been thinking clearly

- None of the time
- Rarely
- Some of the time
- Often
- All of the time

I've been feeling close to other people

- None of the time
- Rarely
- Some of the time
- Often
- All of the time

I've been able to make up my own mind about things

- None of the time
- Rarely
- Some of the time

- Often
- All of the time

Over **the past 2 weeks**, how often have you been bothered by any of the following problems?

Feeling nervous, anxious or on edge

- Not at all
- Several days
- More than half the days
- Nearly every day

Not being able to stop or control worrying

- Not at all
- Several days
- More than half the days
- Nearly every day

Little interest or pleasure in doing things

- Not at all
- Several days
- More than half the days
- Nearly every day

Feeling down, depressed or hopeless

- Not at all
- Several days
- More than half the days
- Nearly every day

That's it for now. We would like to get your feedback after your appointment/call/meeting with **a couple of final questions about usefulness**. You'll get given it after this meeting or sent the link by email, PLEASE do take a minute to let us know how it went.

Thank you for your help

Your taking part in this survey really matters

Your anonymous data will be used in ongoing research to inform wider student wellbeing and mental health provision. If you find yourself experiencing difficulties, please contact your School

Personal or Senior Tutor, your Supervisor, your Student Wellbeing Adviser or your Residential Life team if you live in a University Residence. They may be able to support you directly and/or refer you to more specialist support. Details of the range of support for your health and wellbeing are available at: **bristol.ac.uk/students**

Table O.2 Student Post-appointment Follow Up Census Survey

You have just used the University of Bristol Wellbeing or Residential Life service - can you tell us how it went? It's just two brief questions but you can add comments …

Which service did you use?

- Wellbeing Service

- Residential Life Service

- I don't know

If you used the Wellbeing service, which faculty are you in?

- Arts
- Life Sciences

- Engineering
- Science

- Health Sciences
- Social Sciences and Law

If you used Residential Life Service, which Village are you in?

- North village
- East village
- West village

How helpful do you feel this service was for you?

- Very helpful

- Fairly helpful

- Neither helpful nor unhelpful

- Fairly unhelpful

- Very unhelpful

- **Any other comments you want to add?...** *continue overleaf if you wish*

Thank you for your help Your taking part in this survey really matters

Your anonymous data will be used in ongoing research to inform wider student wellbeing and mental health provision. If you find yourself experiencing difficulties again, please contact your School Personal or Senior Tutor, your Supervisor, your Student Wellbeing Adviser or your Residential Life team if you live in a University Residence. They may be able to support you directly and/or refer you to more specialist support. Details of the range of support for your health and wellbeing are available at: **bristol.ac.uk/students**

If you would be happy to be interviewed as part of this research please get in touch with Population Health researcher jacks.bennett@bristol.ac.uk. It's anonymous and we offer a £20 amazon voucher for your time.

Table 0.3 Staff Census Survey

We are asking you to take part in key research looking at how students are supported in their mental health and wellbeing at university...this form should take less than five minutes, please copy the information from the student's record.

Why? Nationally there has been a steep rise in the numbers of students seeking support for their mental health and wellbeing in the last five years. Universities need evidence-based research to underpin mental health strategy and investment to ensure ALL students are well supported.

How? We are asking you to fill in this anonymous survey for every student advice session you are involved in, across three separate week-long census periods in the academic year 2019/20. Each questionnaire should take no more than five minutes to fill in. It will ask some questions about the student you have seen, why they came to you, what actions you took, and how you felt.

Who? This work has been commissioned and funded by the University, it's being carried out by a Population Health doctoral researcher and supported by a team of University of Bristol academics with expertise in young people's mental health.

What? The findings will support wider research exploring whether UoB's Wellbeing and Residential Life Service makes a difference to student wellbeing and mental health overall. The results will be used to shape support for thousands of Bristol students both now and in years to come. It will also generate evidence-based research to help other UK universities find better ways to support their students.

Your privacy? Your taking part in this study is completely voluntary, and by filling out the survey you are consenting to taking part. Once your responses are submitted, they cannot be withdrawn because the survey is anonymous. For that reason, data cannot be linked to you. Your personal details will always remain confidential. All data will be held on a secure server or repository, and any findings used in research publications or for education/policy purposes will NOT be identifiable.

If you have any questions, please contact Population Health researcher Jacks Bennett-jacks.bennett@bristol.ac.uk

Student characteristics – please copy this information from the student's record

Gender - Please specify
Woman
Man
Non-binary
Not disclosed
Other (please specify)

Age
Select 17-71+

Residence during term-time Please specify

University Hall of Residence (please specify)	Clifton Hill House	115 Queen's Road
Private Hall of Residence (please specify)	Colston Street	Redland Road
With parents within the Bristol postcode	Culver House	Richmond Terrace
Property rented from a private landlord within the Bristol postcode	Deans Court	Riverside
	Durdham Hall	St Michael's Park
	Goldney Hall	St Micheal's Hill
In a property you own within the Bristol postcode Rent or own elsewhere in UK	Harbour Court	Student Village, Newport The Courtrooms
	Hiatt Baker Hall	The Hawthorns
	Hillside	Unite House
Live outside UK	Woodside	University Hall
Other (please specify)	Langford, North Somerset	Wills Hall
Badock Hall	Launchpad, Fishponds	Winkworth House
Brunel House	Manor Hall	Woodland Court
Chantry Court	Marlborough House	Woodland Road
Churchill Hall	New Bridewell	Other
	Northwell House	
	Orchard Heights	
	Print Hall	

Year of study

Foundation	6
1	Erasmus (studying in UK)
2	Erasmus (studying abroad)
3	Other
4	
5	

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School (select primary provider)

Bristol Dental School
Bristol Medical School
Bristol Veterinary School
Centre for English Language and Foundation Studies
Centre for Health Sciences Education
Centre for Innovation
School for Policy Studies
School of Arts
School of Biochemistry
School of Biological Sciences
School of Cellular and Molecular Medicine
School of Chemistry
School of Civil, Aerospace and Mechanical Engineering
School of Computer Science, Electrical and
Electronic Engineering, and Engineering Mathematics
School of Earth Sciences
School of Economics, Finance and Management
School of Education
School of Geographical Sciences
School of Humanities
School of Mathematics
School of Modern Languages
School of Physics
School of Psychological Science
School of Physiology, Pharmacology and Neuroscience
School of Sociology, Politics and International Studies
University of Bristol Law School

Course level

Undergraduate
Postgraduate Taught
Postgraduate Research
PhD
Other

Repeating a year

Yes No

Ethnicity

Arab
Asian - Bangladeshi
Asian - Chinese
Asian - Indian
Asian - Other
Asian - Pakistani
Black - African

Black - Caribbean
Black - Other
Gypsy or Traveller
Not given
Not given (Dom=Home)
Not given (Dom=Osea)

Other
Other Mixed
Unknown
White
White and Asian
White/Black African
White/Black Caribbn

Fee status

Home
EU
International
Channel Islands and the Isle of Man

Which service are you?

Wellbeing Service
Residential Life Service

What contributing issues did the student present with? (Please select all that apply)

Study difficulties
Exam difficulties
Terminating studies
Issues arising from repeat year
Other course issues
Friendship/Peer problems
Relationship problems
Parent/Family problems
Supporting friends with problems

Bullying/Harassment
Accommodation issues
Homesickness
Issues relating to overseas study
Bereavement
Physical health
Gender/Sexual identity
Disability
Sexual assault Violence

Theft   Self-harming
Finances/Debt   Drug/Alcohol problem
Low mood /Depression   Disordered eating
Stress/Anxiety   Other

Contact setting
Face to face booked meeting campus   Phone
Face to face booked meeting accommodation   Text
Face to face drop in campus   Skype
Face to face drop in accommodation   Other
Email

Type of appointment
First
One of several
Last

How many?
1-3
4-6
More than 6

How did student come to Service?
Student approached service
You approached student
Referred by third party
Wellbeing Access
Other (please specify)

Action taken (Select all that apply)
Signpost (student takes action)
Liaise with school, academic or administrator
Referral (adviser takes action)
Closed case
Booked another meeting
Escalate to manager
Other (please specify)

Did you feel this service was appropriate for the student?
Yes No
If no, please explain

Do you feel confident in the action you took?
Yes completely
Most aspects
Some aspects
Not at all
If not yes completely, please explain

Thank you for your help
Your taking part in this survey really matters. This anonymised data will be used in ongoing research to inform wider student wellbeing and mental health provision. Your personal details will be kept confidential

Appendix P. Missing census characteristics

Table P.1 Student pre-appointment survey

Survey item	n=missing responses/217 eligible responses (%)
Gender	2 (0.9)
Age	3 (1.4)
Fee status	0
Residence	0
Ethnicity	1 (0.5)
Year	0
School	4 (1.8)
Course	0
Service	1 (0.5)
Access	6 (2.8)
Presenting issue	1-2 (0.5-0.9)
SWEMWBS	0
PHQ4	0

Note: There were no missing student post-appointment survey responses, and Service and Faculty information was only collected in the February 2020 census week

Table P.2 Staff Missing Census Survey Responses

Survey item	n=missing responses/323 eligible responses (%)	n=largest reported missing in one census period (month)
Gender	1 (0.3)	1 (Nov)
Age	4 (1.2)	3 (Nov)
Fee status	10 (3)	8 (Nov)
Residence	2 (0.6)	2 (Nov)
Ethnicity	7 (2.2)	7 (Nov)
Year	12 (3.7)	11 (Nov)
School	11 (3.4)	10 (Nov)
Course	9 (2.8)	9 (Nov)
Service	4 (1.2)	3 (Feb)
Setting	0	
Access	2 (0.6)	Both
Presenting issue	0	
Action	0	
Appropriate	0	
Confidence	0	

Appendix Q.   Focus group and interview materials

Table Q.1 Example Information sheet

A 'whole university' approach: a research study looking at effective support for student mental health and wellbeing

Would you like to take part in key research looking at how students are supported in their mental health and wellbeing at university?

Why? Because many of us will have experienced a personal problem at university or tried to support friends through a difficult time. Nationally there has been a steep rise in the numbers of students seeking support for their mental health and wellbeing in the last five years. Universities need evidence-based research to underpin mental health strategy and investment to ensure *ALL* students are well supported.

Who? I'm a doctoral researcher, based in Population Health at the University of Bristol. My work has been commissioned and funded by the University and I'm working with a team of academics with a wealth of knowledge and expertise in young people's mental health.

How? We will carry out interviews and focus groups with students and staff at University of Bristol in 2019/20, exploring the greater detail of everyone's experience; we will also look at patterns and trends from the annual Mental Health and Wellbeing Survey. Those findings will help us establish if the University's Wellbeing service in schools and halls has helped to make a difference to student wellbeing and mental health.

What? You just need to commit an hour of your time to take part in a focus group. In a group of 6-8 students, we'll discuss your perception of university support systems both in hall and school. You don't need to share personal detail, just your views. The anonymised content of the meetings will be analysed to generate common themes. The findings will be used to shape support for thousands of Bristol students both now and in years to come. It will also generate evidence-based research to help other UK universities find better ways to support their students.

Your privacy? Your taking part in this study is completely voluntary, we also ask for your informed consent. You can leave the focus group or completely withdraw from the study up to the point of

analysis without giving a reason and without any negative consequences. Your personal details will always remain confidential, any breach of this would only be considered if there is concern of serious harm for you or others. The meeting will be audio-recorded, transcribed, and completely anonymised, after which point your data cannot be withdrawn. The data will be held on a secure server or repository, and any quotes used in research publications or for education/policy purposes will NOT be identifiable.

When and where? The video-focus groups will take place using Skype or Bluejeans and we'll say thanks with a £20 Amazon voucher.

How to get involved? If you are willing to take part, please get in touch with Population Health postgraduate researcher jacks.bennett@bristol.ac.uk

Table Q.2 Consent Form

A 'whole university' approach to student mental health and wellbeing

*Please read carefully and initial all the boxes to give consent

I have read and understood the information sheet and had the opportunity to ask the researcher any questions and/or to discuss any concerns.

I understand that my participation in this research study is voluntary, and I can withdraw without giving a reason, and without any implication for my legal rights.

I give permission for the interview/focus group to be audio-recorded by the researcher, for the recording to be securely transmitted and transcribed to a written copy by an approved transcription company

I understand that once data have been transcribed, anonymised, and included in the study, the data can no longer be withdrawn.

I understand that the information I give will be kept strictly confidential. My consent depends on the University of Bristol complying with its duties and obligations under General Data Protection Regulations 2018

I give permission for anonymised quotes from my interview to be used in publications stemming from this work, or for teaching and policy purposes, and understand that my name or other identifying information will NOT be included.

I understand that only members of the research team will have access to my personal data. Data that have been anonymised may be held in a secure repository and used in future by other researchers in ethically approved research projects, on the understanding that confidentiality will be maintained.

I understand that the researcher may have to breach confidentiality if there is concern of serious harm to myself or others.

I give full consent to my taking part in this study

Name (printed)   Signature   Date signed

Name of researcher   Signature   Date signed

Email: jacks.bennett@bristol.ac.uk

Ethical approval for this project was given by the University of Bristol Faculty of Health Sciences Research Ethics Committee - email: Liam.McKervey@bristol.ac.uk

Table Q.3 Topic Guides

All staff focus group

What's your understanding of how the Wellbeing Service works?

- *What's it for?*
- *Who is it for?*
- *How does it work?*
- *How do you know about it?*

(25 new advisers in schools, non- clinical professional service, face to face/phone/email

appointments Monday to Friday 9-5pm)

What's your understanding of how the Residential Life Service works?

- *What's it for?*
- *Who is it for?*
- *How does it work?*
- *How do you know about it?*

(Residents living in hall, professional Residential Life advisers working from village hubs with

face to face/email appointments, 24/7/365)

What are your general views on the Wellbeing Service?

- *Accessible – barriers/facilitators*
- *Effect on workload*
- *Gone well*
- *Gone badly*
- *A good idea/or not/why not*

What are your general views of the Residential Life Service?

- *Accessible – barriers/facilitators*
- *Effect on workload*
- *Gone well*
- *Gone badly*
- *A good idea/or not/why not*

Have you come into direct contact with the services?

- *School/staff general introduction*
- *Contacted by adviser for general advice*
- *Recommended or referred a student*
- *Student referred to you from service*
- *Ongoing liaison with service*
- *If not, why not? Not needed to? Not known about? Not been able to contact?*

Have you personally referred anyone to the service?

- *Frequency*
- *Experience*
- *Accessibility*

What sorts of presenting issues are you referring/liaising on?

Gender/sexual identity

(Studies/exam difficulties/academic problems/considering terminating/repeat year

Bullying/harassment/assault/violence

Drugs/Alcohol/Disordered eating

Physical health/ Disability

Finances/Debt

Accommodation

Theft/Crime)

Low mood/anxiety/stress/self-harm

Homesickness/Loneliness

Relationships

Supporting friends

Parents/family problems

Bereavement

What was your experience of the service?

- *Easier than traditional model to help students experiencing difficulty/or not*
- *Useful/not*
- *Accessible/not*

What has the feedback been?

- *Students*
- *Other staff*

Do you think support for students has improved with the new structure and a non-clinical advisory service?

- *How and why/why not?*
- *Issues*
- *Benefits*

Do you think the services have impacted your role in any way?

- *Workload*
- *Stress*
- *Responsibility*

Have you seen an impact of the new 'one point of entry' system this year?

- *Awareness*
- *Accessibility* [71]

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[71] Added in 2019

Any other changes you would like to see?

Anything to add?

* Added questions for Senior Tutors/Office/Professional staff

Do you think your schools/faculties face different issues? If so how and why?

- *Professional/vocational courses*
- *Grading systems*
- *International students*

What is your experience of the service from a School or Faculty perspective?

- *Overall pastoral care and admin is easier/harder*

Wellbeing/Residential Life Adviser Focus Group

Brief idea of who you are, your role and background?

What's your understanding of how the new services (Wellbeing and Residential Life) sit within the university framework?

(25 new Wellbeing advisers in schools, non- clinical professional service, face to face/phone/email appointments Monday to Friday 9-5pm) (Residents living in hall, professional Residential Life advisers working from village hubs with face to face/email appointments, 24/7/365)

What are your general views on the Wellbeing Service?

- *Accessible – barriers/facilitators*
- *Gone well*
- *Gone badly*
- *A good idea/or not/why not*

What are your general views of the Residential Life Service?

- *Accessible – barriers/facilitators*
- *Gone well*
- *Gone badly*
- *A good idea/or not/why not*

What's your sense of how and why students are coming to you?

- Chief resident/academic/ clinician/admin/friend recommend
- Self-referral
- General advice
- Email/Phone/Drop in/Face to face appointment

Has the 'one point of entry' system in 2019/20 changed the nature of your role?

- *Caseload*
- *Accessibility[72]*

Do the issues that students bring/are referred to you feel appropriate?

What are the barriers/facilitators to you dealing with issues that students bring?

- *Most difficult issues to deal with*
- *How dealt with*
- *Do anything differently*
- *Accessibility*
- *Training issues*
- *Workload*

Do you think different halls/schools/faculties face different issues? If so how and why?

---

[72] Added in 2019

- *Professional/vocational courses*
- *Grading systems*
- *International students*

What's your experience of liaising with frontline services (Gps and Counselling) and with academic/administrative staff?

- *Ease of communication*
- *Helpful/not*
- *Issues?*
- *How could issues be overcome?*

What has the feedback been?

- *Students*
- *Other staff*
- *Other wellbeing staff*
- *A sense of good outcome/resolution for student*

If you were involved in UoB support previously, do you think the new non-clinical support service has improved the student mental health and wellbeing experience?

- *How?*
- *Issues*
- *Benefits*

Are wellbeing/residential life staff supported?

- *How/by whom*
- *Is it enough?*
- *What else could be done?*

Has there been any impact of the opt-in consent?

- *Parental contact*
- *Student concern/awareness*

Any changes you would like to see?

What else could be done

Student Focus Groups

Introductions

What's your general understanding of the new Wellbeing service at University of Bristol?

- *What's it for?*
- *How does it work?*
- *Who's it for?*
- *How do you know about it?*

(25 new advisers in schools, non- clinical professional service, face to face/phone/email appointments Monday to Friday 9-5pm)

What's your general understanding of the new Residential Life service at University of Bristol?

- *What's it for?*
- *How does it work?*
- *How do you know about it?*

(Residents living in hall, professional Residential Life advisers working from village hubs with face to face/email appointments, 24/7/365)

Have you had any experience of the services?

- *Useful/not*
- *Barriers*
- *Accessibility*
- *What sorts of issues might you go with/or not*
- *Friends/recommend or not*

What do you know about other University of Bristol support services?

- *Which ones? e.g., counselling, peer mentoring, Big White Wall*

- *How do you know about them? Publicised/word of mouth*
- *Experience? Comparison?*

Are you aware of any other support services, outside the university?

- *Why might you use? e.g., Students' Union, NHS, Off the Record, private therapy*
- *How might students know about them?*
- *Comparison*

If you were here before the service began in 2018/19 do you think things have changed in terms of student support?

- *Changes – for better/worse*
- *One point of entry system[73]*

Do you think student support and student wellbeing needs vary across the university?

- *School culture*
- *Hall support*
- *Professional Courses*
- *International students/gender/minority groups*

What changes would you like to see, if any?

- *What Bristol could do better*
- *What Bristol does well*

Are you aware of the UoB annual student Mental Health and Wellbeing survey and have you taken it in the last two years?

- *If not/why not?*

---

[73] Added in 2019

What do you think of the survey?

- *Timing*
- *Questions*
- *Clarity*
- *Aims*
- *Plan to take in future/why not?*

Anything else you would like to add?

Student 1:1 interview

Can you tell me a little about yourself?

- *Course*
- *Year*
- *Hall or accommodation, current and past*
- *Gender*
- *Fee status*

What's your general understanding of the Wellbeing/Residential Life services at University of Bristol?

- *What are they for?*
- *How do they work?*
- *Did you know they'd changed/new?*

(25 new Wellbeing advisers in schools, non- clinical professional service, face to face/phone/email appointments Monday to Friday 9-5pm) (Residents living in hall, professional Residential Life advisers working from village hubs with face to face/email appointments, 24/7/365)

How did you know about the services?

- *Registration/in hall/school*
- *Website/Forum*
- *Word of mouth/friend/academic/other*

Why did you first choose to use a service?

- *Wellbeing or Residential Life/both?*
- *Recommended/knew about it/in hall*
- *Tried elsewhere*

What were your reasons for using the service?

- *Types of issues/problems*
- *Long term/short term issue*
- *Seen anyone else in relation to issue*
- *Pre-date university/started at university*

(Studies/exam difficulties/academic problems/considering terminating/repeat year

Physical health/ Disability

Accommodation

Low mood/anxiety/stress/self-harm

Homesickness/Loneliness

Relationships

Supporting friends

Parents/family problems

Bereavement

Gender/sexual identity

Bullying/harassment/assault/violence

Drugs/Alcohol/Disordered eating

Finances/Debt

Theft/Crime)

How easy was it to get into the system?

- *Accessibility*
- *Timeliness*

What was your experience of using the service?

- *Type of support you expected?*
- *Type and length of contact e.g. face to face, more than one session etc*
- *Did it meet your expectations?*
- *Useful? Why/Why not*
- *Referred elsewhere? Other outcomes e.g. seen again, self-help*
- *Barriers to using service*
- *Would recommend to a friend?*

Have you used any other UoB support services?

- *Which ones?*
- *Experience? Recommend/would/wouldn't use again and why?*

Have you used any other support services, outside the university?

- *Why/why not? NHS, private, apps, support groups etc*
- *What worked well/didn't work well?*
- *If both used- how do they compare?*

If you were here before the new service began in 2018/19 do you think things have changed in terms of support for students?

- *Changes – for better/worse*
- *Personal experience?*

Are you aware of the UoB annual student Mental Health and Wellbeing survey and have you taken it in the last two years?

- *If not/why not?*

What do you think of the survey?

- *Timing*
- *Questions*
- *Clarity*
- *Aims*
- Plan to take in future/ why not?

Any changes you would like to see?

- *What can Bristol do better?*
- *What does Bristol do well?*

Anything else you would like to add?

*added question for students in hall

What were your first few weeks in hall like?

- *What went well/any difficulties*