Working better together to support student mental health

Insights on joined-up working between higher education and healthcare professionals to support student mental health, based on a ten-month action learning set project

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A report to the Office for Students

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1 Executive Summary

This report documents the main takeaways from a ten-month Office for Students (OfS) funded action learning set (ALS) project that brought together higher education and healthcare professionals to identify and solve problems around joined-up working to support student mental health. This report builds on interim findings, shared at the half-way stage of the project.[1]

Over the ten-month project, the ALS groups identified five key challenges and developed proposed approaches. The proposed approaches were documented by Nous facilitators based on the themes discussed within each set's meetings. These ideas were shared, tested and endorsed within the sets but are not necessarily the views of all participants. These are summarised below:

Table 1 | Key challenges and proposed approaches developed by the ALS groups

Challenge	Proposed approaches
1. Clarifying roles and responsibilities	**A government-led declaration of responsibilities for student mental health** would support higher education providers (HEPs), healthcare colleagues and service users to distinguish and understand the provision of support students can expect from a higher education provider support service, and when their needs require NHS support. This will also guardrail HEP colleagues from the requirement to 'provide everything' for their students, which many higher education participants said they felt responsible for.
2. Improving NHS-higher education communications and information sharing	**Guidance on data sharing protocols between NHS and HEPs** is something participants repeatedly said was needed. For students presenting at A&E in mental health crisis or being discharged from hospitalisation, there should be a protocol whereby students are asked to firstly declare their student status, and then asked if they would like to opt-in to sharing with their institution the incident. This is not always a given, with some higher education providers finding out through student's peers about an incident. Doing so would help the HEP to understand any additional support an individual needs. If a student does not want to engage with student support services, then this may look like monitoring through check-ins.
3. Addressing the diverse needs of today's students	**Improved and timely guidance for students to prepare them for life in higher education** would support them with a smoother transition. Higher education participants spoke of how it would be useful for students to receive guidance on what to expect across life in higher education, what support services are

[1] See OfS Action learning sets on student mental health - Interim Report (nousgroup.com)

Challenge	Proposed approaches
	available and recommended pathways to follow, should students need help. This way, students are clearly signposted with the actions they should take and when, how the HEP can support them and support available outside of the HEP (for example, NHS and charities).
4. Resources and support	**Participants in the sets ultimately want to see increased funding so that there are more qualified staff available to meet the increasing demand**. As an adjunct, the HE sector must take steps to review and streamline processes to remove duplication across NHS and HE and maximise resources available (possibly leaning on student mentors and mental health first aiders to provide low level support). There is increasing interest in the Manchester Model – whereby universities and health trusts in the region all co-fund a shared service. While this would help overcome resource barriers, some higher education participants from institutions – notably those which were small and/or in London – disputed the viability of the model for their institution.
5. Lack of strategic-level approach to collaboration between higher education and NHS	**Development of a joint higher education and NHS strategy for student mental health** is probably the most critical of the next steps, since it has the potential to tackle the four challenges noted above and allow the broad area of joined-up working to be tackled through a co-ordinated and strategic approach. Participants across both sectors noted the need for a strategic plan to follow whereby a joint-sector directive is given to HEPs and the NHS workforce on how to approach joined-up working. Critical to success of this is the engagement of senior health representatives. This is an area that Professor Edward Peck CBE in his role as Higher Education Student Support Champion will be working on.

The proposed approaches will rely on senior buy-in from both health and higher education. This will enable a strategic, co-ordinated approach that makes the best use of time, money and effort. The challenges and opportunities are described at greater length in Section 3.

The task ahead

The challenge of addressing joined-up working across the two sectors of health and higher education will remain active for many years. This report is intended to stimulate the conversation, share good ideas that have emerged and enable better collaboration around future progress. None of the ideas reflected here are fully resolved but are shared in the spirit of collaborative endeavour to support continued progress.

These findings reflect a point-in-time view of the continually changing higher education and healthcare landscape and a snapshot of the journey towards improved cross-sector joint working. Participants and facilitators are united in their hope that this work contributes towards a positive future trajectory.

Authorship

The report is written by Nous Group (who facilitated the sets) and published by OfS (who funded the project). All ideas described were developed within the ALSs, many of which are works in progress. They are shared to help advance the country-wide work on joined-up support for student mental health. Some ideas are prototypes for future approaches, others early stage thinking. These ideas and any associated products remain the intellectual property of those who developed them.

2 This project sought to address challenges faced in joining up health and higher education efforts to support student mental health

Effective partnership working between higher education providers (HEPs), NHS organisations and local authorities is essential for delivery of mental health services for students, and invaluable for improving design and delivery of those services. This need provided the impetus for this work to happen.

Context

The Office for Students (OfS) has made it a strategic priority to encourage effective joint working to ensure that students receive timely and effective mental health support. This has included distributing £15 million in 2022-23 to fund student mental health support, enabling HEPs to develop effective joint working between their student support services and local NHS mental health services.[2] This also complements the £33 million funding from NHS England in 2022-23 allocated towards developing accessible mental health services for young adults and the wider NHS Long Term Plan.[3]

On 20th June 2022, the Department for Education and the Department for Health and Social Care held a ministerial summit on joint working between the higher education and health sectors to support student mental health. The summit explored new and innovative models of joined-up care to support students. Attendees included representatives from the OfS, NHS England and from OfS-funded Mental Health Challenge Competition projects.[4]

Arising from the summit, OfS committed to funding an action learning project to encourage joint working between HEPs and NHS partners on student mental health and commissioned Nous Group to facilitate this initiative.

This project

The ALSs were delivered over a ten-month period, with participants split across England's NHS regions. The ALS initiative engaged participants from both the health sector and the higher education sector. However, all sets saw a higher representation from higher education participants. Each group commenced the ALS with between eight to eleven participants. Higher education participants were mostly individuals who have oversight across student wellbeing services in their HEPs. Health participants were mostly patient-

[2] Office for Students (2023). Joint working between providers and the NHS to support student mental health. Retrieved from: https://www.officeforstudents.org.uk/advice-and-guidance/student-wellbeing-and-protection/joint-working-between-providers-and-the-nhs-to-support-student-mental-health/what-were-doing/

[3] NHS Longer Term Plan (2020). Retrieved from: https://www.longtermplan.nhs.uk/

[4] Mental health Challenge Competition (2023). Retrieved from: https://www.officeforstudents.org.uk/advice-and-guidance/student-wellbeing-and-protection/student-mental-health/mental-health-challenge-competition-improving-mental-health-outcomes/

facing health care professionals and clinicians, supporting young people's mental health on a day-to-day basis. This is explored in more detail in Appendix B.3.

The ALSs reflected on challenges and barriers and collaborated to identify approaches to address these issues. The ALSs aimed to develop lasting and collaborative relationships that will improve student mental health outcomes. The groups and their facilitator met monthly over two phases:

1. Explore phase (February – May) - four monthly meetings focused on the challenges that hinder joined up working
2. Develop (July – October) - four monthly meetings looking at potential approaches to mitigate these challenges.

The participants also came together for two cross-regional forums – one at the mid-point and a second at the end-point of the sets. The forums were attended by participants, sector body representatives, and Professor Edward Peck CBE, in his role as the government's Higher Education Student Support Champion.

3 Five common challenges emerged – participants together proposed approaches for better joined-up working

Over the ten months, participants discussed a broad range of challenges in regard to joined-up working. Of these, five key areas came up time and time again as the overarching barriers to success. Below, we detail both the challenges and proposed approaches developed by the groups (section 3.1), and examples of the sets' ideas (section 3.2) which participants worked on in the Develop phase of the ALSs.

3.1 Challenges and approaches to joined-up working observed across the regional sets

This section describes the challenges and proposed approaches developed by the ALSs over the course of the project.

3.1.1 Clarifying roles and responsibilities

Higher education participants frequently raised the question of whose responsibility it is to support a student at certain points in time. This is a particularly contentious topic, given the recent debate in parliament around a statutory duty of care for higher education. There are clear scenarios when a student should be in NHS care; for example, when they lack the capacity to care for themselves and/or require hospitalisation. There are also clear instances when a student is best supported by the HEP mental health services; for example, when struggling with academic-related stress and in need of additional, low-level support. However, higher education participants frequently reported grey areas which sit between these two extremes.

The lack of clarity around roles and responsibilities is particularly important during periods of transition (e.g., as an individual becomes a student for the first time).

- Higher education participants expressed difficulties in knowing how best to support students who are on an NHS waitlist, post-crisis, and/or post-hospitalisation.
- Higher education participants feel ill-equipped to support students who are at such a vulnerable position and bear the concern for the student's welfare. This speaks to people's understanding of the role higher education support services exist to perform (as expressed by higher education ALS members) of enabling students to keep their studies on track, versus operating a secondary care-like service. Higher education staff would therefore like to better define the boundaries to which they can and should offer students support and make this known to all relevant stakeholders.

Proposed approaches from action learning set participants

- **Clear guidance on responsibilities.** A government-led declaration of responsibilities for student mental health would support higher education providers (HEPs), healthcare colleagues and service users to distinguish and understand the provision of support

students can expect from a HEP support service, and when their needs require NHS support. This will also guardrail HEP colleagues from the requirement to 'provide everything' for their students, which many higher education participants said they felt responsible for.

- **Student consent.** Wherever possible, the NHS should seek a student's consent to inform their HEP of their current mental health status. Higher education participants would like to see a risk-based approach to NHS discharge communications. This would allow HE staff to better prepare for student care to plan how they will support students. This information is key to ensuring responsibilities are well managed via information sharing. Within this, if a student does not consent to informing their HEP of their mental health, there should be a consideration to share it if it is viewed in the best interest of the student.
- **Proactive discharge protocol.** An example where it has worked well was described by one participant who had experience at a HEP where there was a proactive discharge protocol in place from their hospital trust, based on a strong relationship between the HEP and local health partners. The NHS participant helped to put into place a Disabled Students' Allowance (DSA) for students where appropriate. Furthermore, it was protocol to speak to the student to explain what it was and how they could obtain it.
- **Fitness-to-study assessments.** Higher education participants would also like to see a more collaborative approach to fitness-to-study assessments. Higher education participants report instances where healthcare participants have declared a student as fit to continue studying, while the HEP's assessment of this student is that they are not well enough to continue studying.

3.1.2 Improving communication and information sharing

Directly linked to the previous challenge, participants all felt that that insufficient information sharing creates a significant barrier to joined-up working. Without access to sufficient and timely information, HEPs struggle to provide effective support to students, placing additional strain on limited resources and jeopardising student well-being. Addressing this issue is crucial for fostering a more joined-up approach in higher education.

ALS participants identified three main challenges related to information sharing:

- Absence of communications and effective protocol around post-hospitalisation discharge risks leaving students without support and ultimately risks the student's health since there is a lack of holistic oversight of their wellbeing. Higher education participants sometimes discover that a student has been hospitalised several days/weeks/months post-discharge. Furthermore, due to the lack of joined-up working, HEP wellbeing staff often find this information out through a student's peer or a trusted staff member (for example, an academic) rather than the student themselves.
- Student transition from mental health services in their hometown to their new HEP town (not applicable to students living at home / commuter students). Participants referred to the current process as 'clumsy' since it was unclear which individuals needed to be involved, leaving the student waiting for an extended period for a first appointment with

secondary services in their new location. This once again leaves vulnerable students in the hands of universities.

- When a key point of contact in the local NHS trust leaves their post, particularly without any communications to the HEP and/or handover to their replacement.

Higher education participants would like to see information sharing by default, in a way that overcomes the lack of shared systems, and ensures communications are consistent rather than on a case-by-case basis. Health and higher education participants also raised an interest to better understand each other's service provision, processes and ways of working. For example, many higher education participants would like to better understand NHS referral pathways, and NHS participants would like to better understand the service offering that universities provide.

Proposed approaches from action learning set participants

- **Multi-agency meetings.** Participants outlined the benefit of multi-agency meetings, which bring together key stakeholders to understand the needs of the local student population and any challenges that they need to overcome. Participants saw this as a good opportunity to understand who the key stakeholders are in the area, to learn about current projects across different organisations that impact students and to foster joined-up working.
- **Higher education provider directory.** To improve ease of information sharing, participants suggested that the NHS has an up-to-date directory of nominated contact points within universities. This is so that when a student consents to sharing information, and declares their student status, the NHS have direct contact details for the appropriate service area within the HEP to send details to. Higher education participants reported that they provided details through Student Space previously, but are unsure if it has been updated or to what extent it is used by the NHS.
- **Protocol for home to higher education transition.** Set participants suggested that a clear protocol be developed to smooth the transition from Child and Adolescent Mental Health Services (CAMHS) to mental health services in a student's HEP residence.
- Participants also reported that they would benefit from sharing training materials to support consistent approaches.

3.1.3 Addressing the diverse needs of today's students

Today's student population is increasingly diverse and a range of factors combine to add complexity. Some of the needs of this diverse population include:

- **Knowing what to expect**. Students can often feel left in the dark and uncertain of whether they will receive support and when. Support from HEPs will differ from that provided at school or college, and the transition (for many new students) from 'child' to 'adult' in healthcare contexts also leads to uncertainty.
- **The 'Covid generation'**. Higher education participants noted that, post-Covid, students appear to be struggling more with psychological difficulties and absenteeism, and they anecdotally reported seeing a higher incidence of risky behaviours including self-harm,

suicidal ideation and eating disorders. Higher education participants found that there are a greater number of self-diagnoses, which is having a direct impact on students' expectations and the demand for student services. These self-diagnoses are often based on information which students have come across on TikTok and Instagram, about which participants shared concern.

- **International students**. The growing international student population brings challenges of culture shock, isolation, lack of preparedness for independent living abroad and cultural differences with respect to attitudes towards mental health at increased scale. International students are not always registered at a GP and may not understand how to access NHS services.
- **Complex mental health needs**. Higher education participants feel that universities are expected to cater to the full range of needs students might present to wellbeing services. However, there is often not the capacity or capability to do so, and it is also often beyond what higher education wellbeing services consider to be their remit.

Proposed approaches from action learning set participants

- **Signposting and expectation-setting for students.** Many participants felt they would benefit from establishing how best to support students as they transition to higher education, particularly when they are transitioning from school or college. This would include understanding the skills young people need to develop to adjust to university life. Participants felt students would benefit from clearer definition of the services available to them should they need mental health support and the steps that will be taken to support them, including what is within or outside of the higher education provider's remit. Realistic expectations of what to expect and how long this will take would help both students and higher education staff. In conjunction, there should also be clear signposting available to empower students to support themselves to take the appropriate steps.
- **Providing additional support for students during their transition to higher education.** Many participants felt they would benefit from establishing how best to support young people as they transition from school or college to higher education, including understanding the skills young people need to develop (e.g., building resilience), and whose responsibility it is to bridge that gap to ensure they are fully prepared for life in higher education.
- **Specialised advice for international students.** Participants felt international students would benefit from receiving specialised advice on how to access higher education mental health services, register with a GP and use NHS services. This exists for some universities and students, but not for all. Universal access to this will help students to take ownership of their mental health, reducing the risk of severe cases building up and overwhelming services.
- **Engaging parents or legal guardians**. Higher education participants have suggested in severe or complex cases, where the HEPs and local NHS services have exhausted their support for the student, as a last port of call they feel they must contact the parents or guardians. The parent/guardian may be required to collect the student and provide care themselves and contact their local NHS for further support. Higher education

participants have raised that hesitance to contact parents can have dire consequences for the student and add pressure to HEP mental health services. However, set participants noted the legal complexities of obtaining consent for this kind of contact.

3.1.4 Resources and support

Both HEP and healthcare participants expressed strongly that they are finding that the student mental health challenge is getting more severe, but funding is not increasing in step. Higher education participants reported that universities simply do not have capacity to support the surge in demand for higher education mental health services that they have experienced, nor the capability to support the increasingly complex cases that participants are observing. Participants also expressed concerns around the increasing difficulty in recruiting appropriately qualified mental health advisors to work in HEPs. Many higher education participants felt that the demand on their services was very high – encompassing on-the-day presentations, assessments, referrals, and ongoing support and oversight for students. This is particularly so given the reported increase in students whose needs are viewed 'too complex' for HEP support services but are not viewed critical enough to receive urgent NHS care. These students are therefore being supported by the HEP until they can receive more appropriate support. From both higher education and healthcare perspectives this challenge is escalating, which further raises the need for effective joined up working.

Proposed approaches from action learning set participants

- **Student mentors for low-level needs.** One group proposed using student mentors and/or trained student mental health first aiders to help support those with low-level needs. This would allow HEP services to focus their limited resources on the more high-risk and/or complex students who need more support.
- **Higher education provider maturity assessments**. Some participants suggested that HEPs take a more proactive approach to assessing staff capability and attitudes to best support student mental health in their institution. This assessment can then be used both internally to assess gaps, and shared with NHS colleagues, so that they have understanding of their local institution's service provision.
- **Secondments and charity support.** Some participants shared that clinical NHS secondments into universities and leaning on local charities who can support students with specific needs can be successful. ALS participants would like these practices to be extended.
- **Funding.** Participants expressed that many of their problems would be solved by greater funding, which would allow their institutions to be better able to respond to deal with the increase in demand.

3.1.5 Lack of strategic-level approach to collaboration

Delivery staff expressed that they do not feel that they have the remit or mandate to take necessary actions and require senior-level decision makers to direct change.

Ultimately, participants would like to see improved collaboration at a senior level to support the challenges detailed above. This includes information-sharing agreements, key objectives

for what HEP-NHS partnerships should look like and an agreed, holistic approach to funding for student mental health.

Proposed approaches from action learning set participants

- **Joint HEP and NHS strategy for student mental health at a national level.** A joint strategy across health and higher education will help focus efforts and align the wide number of stakeholders involved in meeting student mental health needs. Getting services right has wide-ranging implications for society and can save student lives. The stakes are high, and appropriate direction from leadership, including appropriate funding and resource allocation, is important.
- **Engagement from senior health representatives.** This project elicited lower participation from senior figures in health than in higher education. This was seen at less senior levels too. Higher education provider staff are solely focused on students; for most NHS staff, students are just one of the population groups they support. To progress activity and outcomes for student mental health, senior engagement from both sectors will be essential. This will require either individual leaders choosing to focus on student mental health, or a policy mandate that encourages all regions or NHS trusts to engage in solving these challenges.

3.2 Example pieces of work undertaken by each regional set

In the Develop phase, the six regional groups focused their efforts on a particular challenge of interest. These challenges varied from exploring service boundaries, to better understanding the service needs of the local student population. The set-by-set case study summaries are included below, and some of the working outputs are included in Appendix A.

3.2.1 Northwest region ALS

Participants represented institutions with student numbers ranging between 20,000-35,000 each. One set member was previously a member of the NHS, but there were no current NHS employees. Participants included directors of student services and a clinical lead in mental health services.

The group discussed a lack of appropriate mental health support for students during complex crisis stages. It was noted that after being discharged from hospitals, students still face the risk of relapse without adequate support. HEPs feel that this responsibility lies with them, although they may lack the capability to manage this risk effectively. It was highlighted that while promising integrated pathways between HEPs and the NHS exist in the Greater Manchester area, these are not designed to handle crisis-level students.

Additionally, the absence of a clear, agreed-upon definition of 'crisis' between universities and the NHS contributes to a lack of appropriate support or exacerbation of the issue. Participants emphasised the need for the NHS to provide more crisis care support and assume responsibility for emergency care, establishing clear expectations of support

between the NHS and universities. Below is a snapshot of the group's work on principles for partnership working.

Principles of good practice within NHS and HEP collaboration

Description

The North West ALS set out to articulate principles that would support successful partnership models between HEPs and the NHS.

The principles were originally drafted by a set member within the group and have since been refined by other participants. In parallel, the principles are being tested with various NHS services.

The working principles include:

1. Build relationships between local NHS and HEP to understand roles and responsibilities and develop local-level commitment to working in collaboration and partnership.
2. Information sharing agreements to be in place between HEP and local NHS mental health service.
3. HEP services should have access to the NHS multidisciplinary team (MDT) to discuss students who are open to community mental health team (CMHT), students who require CMHT intervention and transfers of care for students moving areas to access higher education or for complex case discussions to take place.
4. HEPs should hold a 'risk register' of students who are accessing secondary care mental health services (CMHT/Crisis Teams).
5. NHS services should identify at-risk students e.g., those who access crisis services, and share the risk management plan with the student's HEP.

These principles are supported by tangible actions and strategies including for example:

- Bi-monthly meetings to allow NHS and HEP members to develop a local-level commitment and allow regular review meetings.
- In relation to a risk register, should a student access an HEP support service, the secondary care NHS team can be involved in this communication to prevent multiple assessments by different organisations and different interventions being implemented that may not always be appropriate.

Next steps

Wider testing of principles across a selection of HEPs in the North West and engagement with local NHS services. Set members have organised visits to HEPs within the region to learn from each other's practice and to understand how clinical services are being delivered.

A fuller excerpt of this group's work can be found in Appendix A.1.

3.2.2 North-East region ALS

The North-East group included both representatives from HEP support services and NHS clinical staff. For this group, the opportunity to 'Explore' the challenges in phase one was vital to build relationships with regional colleagues and gain perspectives on challenges they are facing in their organisation. As the group moved into the 'Develop' phase of work, they were particularly interested in defining service boundaries for HEP support services, since it is an area that participants felt was increasingly unclear.

Clarifying boundaries of responsibility between NHS and HEPs

Description

The North East group set out to create a common and accepted framework to define when the responsibility for supporting student mental health lies with a HEP, and when it is the responsibility of the NHS.

The need for this was prompted by an increasing level of responsibility felt by many HEPs, whereby HEP staff find themselves supporting students to a level beyond the remit of HEP support services. Clarification of this would also help both sectors to understand where overlap points – such as communication around an individual's care – can be improved.

Participants defined a list of services which currently fall under NHS, HEP, or where the responsibility is unclear. Areas where participants felt responsibility was unclear include:

- Full overview of an individual student's wellbeing and health
- Therapeutic interventions for mild to moderate mental health problems
- Specific therapies other than integrative counselling, e.g., Cognitive Behavioural Therapy (CBT)
- Monitoring of long-term conditions and relapse prevention
- Ongoing community support a young person is transitioning out of CAMHS
- Assessment of need
- Crisis and post-crisis care

Next steps

Participants hope to socialise this document and raise with groups such as the Higher Education Mental Health Implementation Taskforce to help distinguish boundaries of service provision for HEPs.

A fuller excerpt of this group's work can be found in Appendix A.2.

3.2.3 Midlands region ALS

Participants included representatives from HEP student support, young adults commissioning/programme leads at NHS Trusts and Integrated Care Boards within the region. This ALS had between two and eight participants each time they met. Meetings usually included both NHS and higher education representatives.

The group discussed a variety of topics over the ten months, including the differences and overlaps between NHS and HEP mental health services, successful regional examples of joined-up working and sharing resources, the role of safeguarding, a need for a joint HEP-NHS strategy for student mental health and more. In the final three meetings, they identified a specific gap around knowing what students want from their mental health and wellbeing services at a regional level. They codeveloped a survey for students to complete, with an accompanying toolkit for their fellow NHS and HEPs to use in developing their own regional surveys.

Developing a survey and toolkit for evaluating service requirements

Description

The group developed a survey, accompanying toolkit and resources for HEPs and mental health partners to use to better understand students' mental health service needs in a region.

The group identified an opportunity to involve the student voice in decisions about designs and improvements to HEP and NHS student mental health services. The group's participants brought together their collective experience and knowledge to develop this Midlands Student Mental Health Survey too, a joint HEP and NHS approach to consulting students about their mental health needs, along with a toolkit for other regional peers to use in developing their own survey.

The survey is set to be released in October/November 2023, with the outputs presented at the NHS England (NHSE) Midlands Young Adults Mental Health Forum in December 2023.

A fuller excerpt of this group's work can be found in Appendix A.3.

3.2.4 London region ALS

The London ALS was comprised of mostly HEP staff. The group spoke in depth about the unique challenges of joined-up working and supporting student mental health in the capital. Two of the major challenges in London include the high cost of living and the high concentration of international students (e.g. 55% and 51% of the student bodies at two of the HEPs represented). The latter brings about particular issues including cross-cultural challenges, isolation, loneliness and home-sickness, and visa compliance issues for those who are out of study long-term due to illness.

Below is a snapshot of this group's exploration of the unique barriers to joined-up working that HEPs in London face.

Defining the unique challenges of joined-up working for London

Description

The London group saw the complexity of both HEP and health landscapes

London is made up of:

- 5 Integrated Care Boards
- 10 NHS Mental Health Trusts
- 33 local authorities for public health and safeguarding

The region also has a high proportion of commuter students, and those studying at HEPs in London are often very geographically spread, rather than concentrated in and around one campus, as is more common in other regions.

This ALS would like to:

- Jointly articulate London's regional challenges

as a unique challenge.

- Work with London Higher (a membership organisation for London-based HEPs) and Association of Managers of Student Services in Higher Education (AMOSSHE) London and Southeast Region (LASER) group to highlight key challenges to inform strategic thinking.
- Explore scope for the Higher Education Student Support Champion to influence Department of Health to require Integrated Care Boards to include HEPs in their work and strategic planning.

3.2.5 South East/South West region ALS

The South East/South West set was large and differed in composition at each meeting. Diversity in institution type and size amongst the HEPs was a key feature, with perspectives ranging from large Russell Group institutions to small, vocational institutions and a primarily distance-learning institution. Each had different challenges and worked in different ways with their NHS partners. The set's top three challenges were how to define boundaries between HEP and NHS support, appropriate information and data sharing, and appropriate resources. They chose to address the first challenge, boundaries, in their case study output.

Using a case study example to define similarities and differences in approach in supporting student mental health

Description

The South East/South West group developed a case study of a student seeking mental health support. Each member then completed a table to capture how they would handle the case.

Blurred boundaries between where HEPs' mental health support ends and NHS support begins emerged as a common challenge across the set. Therefore, the group developed a resource to highlight, explore and address this issue.

The resource is an example case study of a student who presents with mental health challenges at an HEP's student support services, followed by a table capturing how each member would handle the case. Although it is a fictional case, it is based on common experiences of students and support services.

The table captures the official structures and procedures in place at each organisation, the approach that the HEP or NHS representative would take, any boundaries to consider, their expectations of the reciprocal organisation (NHS or HEP) and required means of collaboration.

The objectives are to:

- Highlight the varying approaches that different HEPs would take, based on their size, resources, networks and other enablers.
- Uncover any assumptions that NHS representatives have about how HEPs operate, and vice versa.
- Surface opportunities for more effective collaboration between HEPs and the NHS.

Next steps

The output will serve as a stimulus for future ALS discussion to enable higher education and NHS participants to clarify the boundaries and opportunities in how they work together.

A fuller excerpt of this group's work can be found in Appendix A.4A.1.

3.2.6 East of England region ALS

The East of England group had representation from both the NHS and HEPs. An area that was of interest to this group in particular was transitions between school and higher education, and the level of preparedness a student should have to successfully make the transition. A proposed solution from the group is outlined below.

Creating a 'journey map' to portray the transition of a student from school to higher education

The East of England group sought to produce a 'journey map' of the life of a student pre-higher education and throughout their first year of higher education. The journey map would include what preparation students need to understand the demands of studying at an HEP and living away from home, and how can they be supported once they start. From this concept and mapping process, colleagues would hope to then identify the challenges, gaps and barriers for students in supporting their emotional wellbeing and mental health.

4 ALSs were a useful approach to develop joined-up working across health and higher education

This section explores reflections about the effectiveness of ALSs in enabling joined-up working in student mental health. Throughout the project, participants provided reflections on the overall approach, which iteratively shaped subsequent engagement. Key insights included deepening cross-sector relationships; sharing knowledge and practice; engaging in non-judgmental, open discussion; constraint by competing priorities and demands. These are described below.

Several sets intend to continue meeting after the formal end of the ALS project, which indicates buy-in to the process and belief in the value of the approach. Some flagged concerns about keeping momentum without a designated facilitator. Nominating a facilitator from within the group in advance of each future session may help mitigate this concern.

4.1 Deepening cross-sector relationships

Participants noted they were able to foster connections with individuals that they otherwise would not have interacted with.

- Higher education participants found it helpful to connect directly with health participants and understand the 'nuts and bolts' of provision of care for students and the pressures facing the system. These participants observed that they have been able to address issues that are at the nexus of health and higher education in a way that they would not have been able to do on their own.
- Health participants observed they have a much better appreciation of the complexity of needs and diversity of student populations that engage in higher education. In the sets where health and higher education participants already have a working relationship, this

process has provided space for individuals to deepen connections and working relationships. Figure 1 provides a participant snapshot of these insights.

Figure 1 | Snapshot of participant observations about cross-sector relationships

> *"Good forum to bring together views and experiences and have a set of goals managed externally." – Higher education participant*
> *"Looking at bigger picture issues at interface with health/education." – Health participant*

4.2 Sharing knowledge and practice

The structure of the sets supported sharing best practice and mutual insights. Each meeting began with a challenge that participants would pose and then invite reflections from their peers on the issues. Participants built on the initial set-based connection for wider collaboration. They made plans to visit each other's institutions to understand how they have organised their services, co-developed resources, shared good practice guides and helped reframe current challenges.

Figure 2 | Snapshot of participant observations about the impact of sharing of practice/knowledge

> *"These sessions are really meaningful and I'm getting a lot out of them." – Higher education participant*
>
> *"These sessions are really helpful, come out of things feeling better… how do you take some of the calm you find in here back outside…." – Health participant*

4.3 Engaging in open and non-judgmental discussion

The ALS meetings were seen as a safe space, and an opportunity to speak frankly about what they and their institution are facing, with the support of other participants who can emphasise. One participant said, *"I've really wanted to have these kind of discussions for years!"*. These types of issues are often challenging to discuss with peers at work.

4.4 Constrained by competing priorities and demands

Participants noted that there is a limit to what can be realised through the ALS process in relation to joined-up working, in light of other constraints. The barriers included resource constraints, competing demands on time and the scope and influence of their roles. They felt there was a disconnect between what they could do as individuals through this process and the desired outcomes from joined-up working. This was particularly true of health participants, from whom there was far less engagement compared to those in higher education. While this may reflect their limited time, it may also reflect the lesser priority

students as a population group are within the NHS. This is in contrast to HEPs, who solely support students within their wellbeing services. Furthermore, while higher education participants can relatively easily shape the service offering and ways of working within their local area, this is a far more complex undertaking within the NHS.

Figure 3 | Snapshot of participant perspectives on competing priorities and demands

> *"I think participation should be extended further. A lot of the work that needs to be done can't be done with the people that are in the group." – Higher education participant*
>
> *"It was a really good opportunity again to hear of the diverse range of projects and initiatives from the various contributors. It would be nice to have more representation from health organisations but I understand it's difficult to achieve." – Higher education participant*

Appendix A Works in progress across the groups

Below are four examples of work completed by the North West, North East, South East/South West, and Midlands ALS groups. Given the iterative nature of the ALS process, these pieces of work are tentative in nature and require further testing and validation.

A.1 North-West: Principles of Partnership Working

The North West group set out to define principles of good practice of how NHS-HEP collaboration would be developed. These five principles are set out below.

Principle 1: Build relationships between local NHS and HEPs to understand roles and responsibilities and develop local-level commitment to working in collaboration and partnership.

NHS mental health services are difficult to navigate, with multiple services all with different criteria. HEPs have also developed in terms of the services they offer to students, however these are not a replication of NHS services. Through building a relationship, neighbouring NHS services and HEPs can share knowledge and service updates with each other with the view to resources being shared between organisations to meet the needs of the student.

These relationships will also an offer an opportunity to support NHS colleagues to understand the context of student life and implications of treatment options and other decisions made.

Arranging bi-monthly meetings will allow NHS and HEP participants to develop a local-level commitment and allow regular review meetings for this, and allow arrangements to be made to visit each other's relevant teams to share knowledge and service updates.

Principle 2: Information-sharing agreements to be in place between HEPs and local NHS mental health services

The requirement for information to be shared between the NHS and HEPs is real and deeply felt, but needs clear governance. Government policy places a strong emphasis on the need to share information across organisational and professional boundaries to ensure effective coordination and integration of services. The Caldicott Review 'To share or not to share' specified that "The duty to share information can be as important as the duty to protect patient confidentiality" (NHS England, 2019).

Implementation of an Information Sharing Agreement offers legal clarity for both HEPs and NHS providers when consent is not available/provided/appropriate. However, this is not applicable to information-sharing in relation to mental health as the 'processing is necessary for the purposes of protecting an individual from neglect or physical, mental or emotional harm, or, protecting the physical, mental or emotional well-being of an individual' (schedule 8, condition 4: Data Protection Act (DPA) 2018 (legislation.gov.uk)). NHS or HEP providers would need to ensure that it is necessary, proportionate and lawful to

share any information. Additionally, paragraph 18 of part 2, schedule 1 of the DPA 2018 (Safeguarding of children and of individuals at risk) is met if the following conditions are met:

- the processing is necessary for the purposes of:
    - protecting an individual from neglect or physical, mental or emotional harm
    - protecting the physical, mental or emotional well-being of an individual
- the individual is aged:
    - under 18
    - aged 18 or over and at risk

The sharing of information between NHS and HEP will offer the student a joined-up approach to their support and care at times of increased risk and ensure the student's support needs are led by the most appropriate service. By sharing information, the student can be supported by all parties to aid their recovery alongside supporting the student to achieve their academic potential, thus limiting the potentially debilitating impact of mental ill health.

Principle 3: HEP services should have access to the NHS multidisciplinary team (MDT) to discuss students who are open to community mental health team (CMHT), who require CMHT intervention, discuss transfers of care between NHS Services for students moving areas to access HEP's (for example HEP applicants) or for complex case discussions to take place.

MDT working provides a whole system approach to better support the increasing number of people with long-term health conditions (Health Education England, October 2021). The community mental health framework (2019) proposed by NHS England highlights that as part of this framework there is an integrated system where patients have fewer assessments, have access to the right care at the right time and will not fall through 'gaps' in service provision.

Accessing the NHS MDT approach, and sharing information, allows for improved collaboration so that students with mental health problems can access the right service at the right time to reduce the need for them to navigate complex health systems. An MDT approach will also support in the seamless management of risk, ensuring that when an increased risk is identified, HEP staff can readily access appropriate NHS intervention.

Principle 4: NHS to hold information of complex and high-risk students who are accessing secondary care mental health services (CMHT/Crisis Teams) and share information as required to HEP's for awareness and joined up working.

This would allow for a coordinated approach by NHS and HEP services to students open to secondary care. Should a student access a HEP support service, the secondary care NHS team can be involved in this communication to prevent multiple assessments by different organisations and different interventions being implemented that may not always be appropriate. When these students are identified by NHS providers, appropriate risk

management strategies can take place by all involved in the student's care to ensure consistency and that robust risk management plans are in place across the NHS and the HEP. Information for the development of reasonable adjustment plans and crisis plans can also be shared so that the student is fully supported within their academic studies, and the approach taken is seamless. A whole system approach should be implemented in the event of 'support to study' processes, or for students who are returning to study, and are open to secondary mental health services.

Principle 5: NHS services should identify HEP students within their assessments and consideration should be given on discharge from an NHS service to the student status, with NHS services notifying the HEP following any A&E liaison or Crisis Team contact.

Students who access crisis services or A&E liaison for their mental health are more likely to need HEP support and the presence of any risk/risk management plan should be shared between organisations as good practice.

The Department of Health's Best Practice in Managing Risk document (2009) identified that collaboration in risk is essential, involving all those involved in an individual's care. In Universities UK's Suicide-Safer Universities guide (2021), it is strongly recommended that HEPs build links with local and national partners from the healthcare sector and a multi-agency action plan be developed.

Student Minds found in their Charter Consultation focus groups that there appeared to be common misunderstandings between HEPs and their local NHS or Social Care agencies. For instance, there were multiple accounts, from support staff in focus groups, of students being discharged to 'university support services' without consultation with the HEP. Others reported instances of ill and distressed students being returned to halls of residence late at night, as a place of safety, when no staff are available.

Discharge of care from A&E Liaison or Crisis Services back to the care of HEPs is not an appropriate pathway, although students would benefit from a follow-up from HEP support teams in the event of a presentation to A&E for mental health reasons to offer any academic support and refer on as appropriate.

Written by: Jennifer Sumner, Clinical Lead for Mental Health, University of Central Lancashire.

A.2 North-East: Clarifying boundaries of responsibility between NHS and HEPs

HE participants within the North-East group felt that HEPs are increasingly providing support that goes beyond their remit as student support services. The group therefore felt it would be beneficial to map out where responsibility sits firmly within NHS, an HEP, or the student, and where it is unclear where responsibility lies. The unclear cases are examples where HEPs are providing support but feel it may be beyond the scope of their role as HEP support services. The hope is that formal clarity around this topic would result in improved direct pathways for students, informed decisions around where students choose to study, robust care planning, safer support with pathways for escalation being clear and more effective use of resources across the NHS and HE sector through reduced duplication.

Table 2 | Views from the North-East ALS on the different areas of responsibility across NHS, higher education, and the student, and where it is unclear

Statutory responsibility/NHS	Unclear where responsibility lies*	HEP responsibility *(Proportionate and reasonable as to what an HEP can competently provide in an educational setting)*	Student (and trusted contact) responsibility
Medication and prescribing	Ongoing community treatment and support when transitioning out of care	Welcoming, inclusive living and learning environments - the breadth of support available – SU, financial, extracurricular. When it works well – this is beneficial for mental wellbeing.	Register with a GP
Diagnostic assessment	Assessment of need	Provision of supportive community	Seeking and responding to health engagement (if capacity to do so)

Statutory responsibility/NHS	Unclear where responsibility lies*	HEP responsibility *(Proportionate and reasonable as to what an HEP can competently provide in an educational setting)*	Student (and trusted contact) responsibility
Hospital admission, inpatient treatment, detention under MH act	Specific and complex needs/diagnosis (needs to be defined)	Assessment of need – in relation to educative environment	Sharing responsibility for managing own safety
Diagnosis	Crisis, and post-crisis care	Interventions to address barriers to learning created by mental health problems	Declaring long-term MH needs to HEP
Medical monitoring	Full overview of an individual student's wellbeing/health – 'holding' the student while not under NHS support	Reasonable adjustment plans	Sharing information re medication/treatment
Management of significant and imminent risk	Therapeutic interventions for mild to moderate mental health problems	Risk assessment and safety planning – referral to statutory services	For international students – sharing medical history/needs/medication
Working to NICE guidance re. treatment protocols	Psychoeducation – not unclear but should be responsibility of both	Provision of training for staff to ensure baseline knowledge and awareness consistent with reasonable expectations of role. Training to cover mental health awareness, psychological first aid, signs of difficulty and appropriate actions	

Statutory responsibility/NHS	Unclear where responsibility lies*	HEP responsibility *(Proportionate and reasonable as to what an HEP can competently provide in an educational setting)*	Student (and trusted contact) responsibility
Mid- to long-term psychological therapies (students regularly expect this from HEPs)	Specific therapies other than integrative counselling, e.g. CBT	Psychological services for students to manage the conflicts, tensions and difficulties relating to their developmental life stage as a student (separation from family, emerging adult autonomy, managing transition to and pressures of HE study, capacity to take up and hold growing personal responsibility, navigating matters of identity – faith, career choice, sexuality; for mature students' life-course changes) – typically insight-based therapeutic work that facilitates problem solving, strengthens self-worth and increases capacity to tolerate and overcome setbacks. Supports positive mental health but not framed as a 'mental health treatment'	
	Monitoring of long-term conditions and relapse prevention (could easily put this in all four columns based on current models!)		

Illustrative examples of blurred responsibilities

1. A student increasingly discloses personal information pertaining to their mental health to an individual they trust e.g. a tutor. The student unconsciously expects support where it is not appropriately placed to offer, while declining in health. The HEP is then left to support this student when they have not formally declared poor mental health, they do not want to use the HEP wellbeing/support services, or the NHS is unable to offer any support at that time e.g. waiting list.

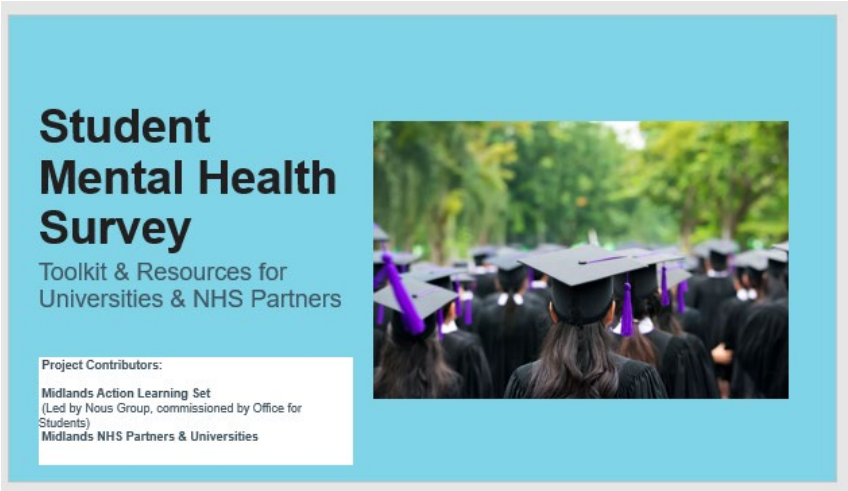
2. A student is accessing support from an HEP mental health practitioner to implement strategies for managing low mood. After receiving a few sessions the student mentions that they have been receiving weekly contact from 'someone' at their GP. They don't know the role of the person but it sounds like it is a primary care mental health worker. No communication between two services. Duplication in support or inconsistent support for student?

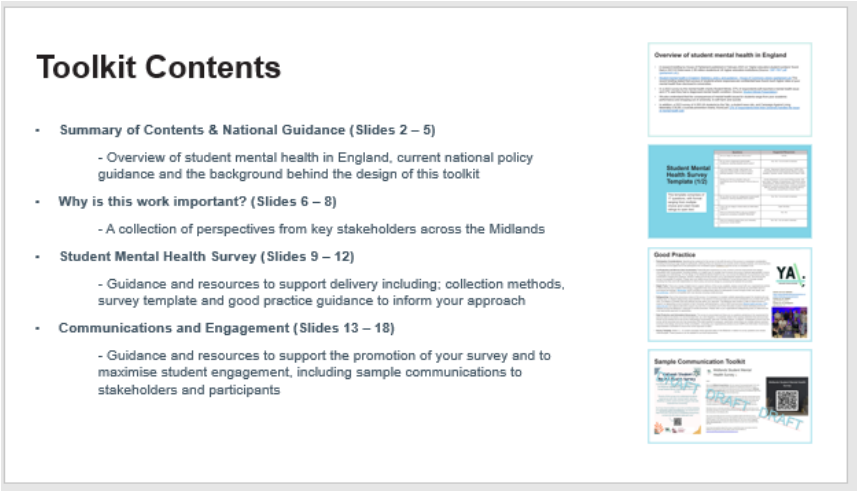
3. A student is displaying concerning behaviour and has family history of psychosis. The HEP supports student to access services such as Psychiatric Liaison and Crisis Team but student does not quite fit the criteria. HEP supports student, staff, school and family (all of whom become increasingly concerned and distressed) whilst student deteriorates over the course of a week until they are eventually detained in hospital. In cases like this the HEP has a fairly comprehensive picture of need as multiple reports and concerns funnel into them whilst NHS services only see the student for a relatively brief and isolated assessment. If relationships were stronger and communication was clearer, could student get help at an earlier stage and could ensuing levels and reach of distress be minimised?

A.3 Midlands: Designing a toolkit for survey development to evaluate students' service requirements

The Midlands ALS identified the need to involve students in decisions about the design of mental health services across both NHS and HEPs. They decided to codevelop a survey for students in the region that would specifically ask about their service needs and wants. Survey design was led by Laura Brown, Assurance & Transformation Manager – Central Midlands & Black Country. The group has submitted a survey toolkit as part of this report, as they wanted to develop a resource that could be used in other regions of England to assess the needs of their students. Below, we include several excerpts from the final toolkit.

Figure 4 | Excerpts from the Midlands Student Mental Health Survey Toolkit





Why is this work important?

A collection of perspectives from key stakeholders across the Midlands

Good Practice

- **Participation Considerations:** Specifying the audience for the survey in line with the aims of the survey is a necessary consideration, including introducing an age range for participants, defining if they are required to be currently and/or recently students, and ensuring there is a process via the digital tool to link participants into immediate support whether or not the survey is completed in full.
- **Co-Production and Service User Involvement:** Patient/Student experience is a key conduit in service improvement and design; consultation with young people, including students, is a helpful way to consider how to ensure the survey is tailored appropriately in terms of language and methodology. For the design of the Midlands Mental Health Survey, we involved the Midlands Young Advisors who have contributed to shaping the questions, decision making around the inclusion of our neurodiverse student community, and ensuring the survey is accessible to students. Please see more detail around the work of the Midlands Young Advisors team to provide context including how they work with stakeholders to inform policy and service design by accessing the website link provided.
- **Digital Tools:** There are a range of digital tools to support delivery of the survey available, please consult with your organisational policies to determine the most suitable methodology. Suggested tools may include; Microsoft Forms (which produces an automated report to summarise the findings), Mentimeter (which includes an audience-led option for participants to work through at their own pace), and SurveyMonkey (which is compatible with most devices including mobile phones).
- **Safeguarding:** Due to the anonymous nature of the survey, it is necessary to consider suitable signposting support for students who are seeking help, to mitigate safeguarding responsibilities in the absence of personal data and to ensure participants are provided with quality care. It is helpful to consider local and national sources within your approach. The Midlands have chosen to refer to three sources of support, by signposting current students to their University well-being teams, a link to NHS local services (Mental health services - NHS (www.nhs.uk)) and national alternative support sources from a University and Further Education student mental well-being tool kit we released across the Midlands in response to suicide prevention. Please refer to your organisational safeguarding policy to determine the most appropriate approach to signposting.
- **Data Protection and Information Governance:** The survey is anonymised and there are no questions pertaining to the requirement for personal data to be shared, it is recommended that, as a risk mitigation, it is explicitly stated in the opening statement that personal data should not be shared due to the survey methodology incorporating 'open text' narrative options. In addition, consideration around how the survey will be launched and who has ownership of the data received is necessary, particularly where there are multiple delivery partners involved in the design and launch of this consultation. Consulting your organisational policies around GDPR and Information Governance responsibilities is advisable to ensure the correct approach is taken.
- **Survey Template:** Slides 11 - 12 contain examples of the approach taken in the Midlands in relation to survey questions and chosen methodologies. These questions can be adapted to suit local requirements.

YA. MIDLANDS YOUNG ADVISORS

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Student Mental Health Survey Template (1/2)

This template comprises of 17 questions, with format ranging from multiple choice and Likert Scale ratings to open text.

	Questions	Suggested Responses
1	Are you happy to take part in this survey?	Yes/No
2	Do you have a diagnosed mental health condition(s), learning disability and/or autism?	Yes / No / I do not wish to disclose
3	If you are happy to share, what is/are your diagnosed mental health condition(s) and/or learning disability? (Tick as many as apply)	Anxiety Depression Stress Psychosis EUPD Other Personality Disorder Eating Disorder Bipolar Learning Disability Dyslexia Autism ADHD None of these Other
4	During your time as a student, have you experienced any of the following? (Tick as many as apply)	Anxiety Depression or low mood Feeling suicidal Self harm Anger Feelings of hopelessness Disordered eating Sleeplessness Stress Feeling demotivated Loss and/or bereavement Intense mood swings Loneliness Increased difficulty starting/completing tasks Increased difficulty looking after yourself None of these Other
5	Do you feel you have an undiagnosed mental health condition(s), learning disability and/or autism?	Yes / No / I do not wish to disclose
6	If yes, are you happy to share what you think these might be?	Open Text Box
7	Have you previously been or are you currently a student at a University in [INSERT REGION]?	Yes / No
8	Have you received support from your University around your mental health?	Yes / No / I do not wish to disclose

Sample Communication for Survey Participants

YA. associate development solutions

Hello from the Midlands Young Advisors team!

We are a group of young people aged 16-25, who have lived experience of mental health, experience of supporting a loved one, or just a general passion for mental health and improving services. We are launching the Midlands Student Mental Health Survey, which has been commissioned by the Midlands region NHS England Children & Young Peoples Mental Health Team.

The aim of this survey is to understand students' experiences with their mental health and/or learning disabilities & autism, and the support that was accessed while at University. We are also eager to learn how you were supported, how this support felt, what worked well, and ways in which this support could have been better. So, if you have studied or are currently studying at a University within the Midlands, we would love to hear from you!

We believe that it is extremely valuable to capture first hand experiences like these, as this information will help us to inform and drive forward the agenda to improve support services that Universities in the Midlands offer.

This survey should take around 5-minutes to complete. Please note that the survey is designed to be completely anonymous. We therefore kindly ask you to avoid providing any personal details in your responses that might identify you. **The survey closes [Date and Time] so please do respond before this date if you would like to have your say.** You can find the survey here: [LINK] or follow the QR Code on the attached communications by opening your phone on the camera function.

If you have any questions about this survey or would like to learn more about what the Midlands Young Advisors do, then please contact jasmine.wilson@associatesolutions.co.uk.

A.4 South East/South West: Defining boundaries between HEPs and NHS in student mental health support: a case study

Chris, a student, presents at the university support service complaining of suicidal thoughts, and with a history of previous attempts. Chris discloses no protective factors, including limited friendship and family support. They disclose a history of complex mental health difficulties, and a diagnosis of autism.

Chris says they have been waiting for the outcome of a referral their GP made a year ago regarding their mental health.

** Note that this is a fictional example, based on elements of real cases.*

The South East/South West ALS participants developed the example case (left).

The table below captures how the HEPs and NHS trusts represented in this set would handle Chris' case. This includes the official structures and procedures in place, the approach that the HEP or NHS representative would take, any boundaries to consider, their expectations of the reciprocal organisation (NHS or HEP) and required means of collaboration.

The objectives are to:

- Highlight the varying approaches that different HEPs would take, based on their size, resources, networks and other enablers.
- Uncover any assumptions that NHS representatives have about how HEPs operate, and vice versa.
- Surface opportunities for more effective collaboration between HEPs and NHS.

This output will serve as a stimulus for future ALS discussion to enable higher education and NHS participants to clarify the boundaries and opportunities in how they work together.

Table 3 | South East/South West ALS: exploring the variety of approaches an organisation may take to a given case study example

HEP/ NHS provider	Structures/procedures	Approach	Boundaries	Expectations of NHS/HEP (depending on which you are)	Ways to collaborate
HEP A	24/7 access to Student Hub including to 24/7 Wellbeing Support: Advisors available in person 24/7 365 days a year for Wellbeing walk-ins, phone calls and email Multidisciplinary team with specialist options: Harassment specialists Wellbeing specialist practitioner (solution focussed approach) Counselling Fitness to study These teams then loop into local services for access to local treatment (onsite GP, crisis team, specialist services (rape crisis); Or to mental health support funded through our partnership with Primary	Hierarchy of support: preventative via Student Engagement activities through to more specialist interventions Access via one-stop route – the Student Hub which has four locations, one email address and one phone number Students can walk in to the Student Hub and be triaged to Wellbeing Support or can directly attend Wellbeing walk-ins All support is triaged from the Student Hub	Data sharing via consent only Partnership with PCN North enables peer review of approach – e.g. decision making in relation to Student of Concern list which is managed on an 'in principle' basis where data sharing is not permitted	We have a funded partnership with PCN North which is in its second year: To provide specialist input and support for people with Mental Health needs, who are students at the HEP and are registered with HEP Health Service GP practice located within the campus who are part of the North Primary Care Network To supplement HEP support by offering psychological approaches and frameworks to try to address the mental health needs of	Quarterly steering group meetings to review funded partnership against a variety of criteria, including outcomes, feedback, value for money, etc

HEP/ NHS provider	Structures/procedures	Approach	Boundaries	Expectations of NHS/HEP (depending on which you are)	Ways to collaborate
	Care Network (PCN) North – direct access to group workshops and 1:1 clinics with a mental health nurse	Targeted risk management includes: Student of Concern process Fitness to Study process		students which can impact on their studies, personal activities and social activities To provide greater input for those students whose mental health difficulties require more recovery-focused support to help them to find new and effective ways to deal with distress • Offer was initially workshop focussed but we have extended this to include 1:1 clinics and peer review	
HEP B	Daily Drop-In support appointments Mental Health Duty Desk appointments	Immediate referral to either a drop-in appointment or a MH Duty	NHS support required for historic mental health	Positive engagement with HEP support staff on a peer-professional basis	Weekly PCN MDT. Shared case-conference/care

HEP/ NHS provider	Structures/procedures	Approach	Boundaries	Expectations of NHS/HEP (depending on which you are)	Ways to collaborate
	Individual Learning Plan process (for disability-related reasonable adjustments) Health, Wellbeing and Support for Study procedures (fitness for study) NHS liaison through PCN Multi-disciplinary Team meeting, or direct referral	Assessment appointment (same day, with a mental health nurse, (RMN)), depending on the nature of the presentation Holistic assessment of needs using Dialog+ framework. Provision of immediate response options (signposting, referral, self-help tools, emergency numbers, etc) depending on assessment. Review at end-of-day meeting and weekly Case Supervision. Likely	assessment/referral from GP NHS support required for current suicidality/ideation assessment, and co-case working to support the student	(and not treating referrals as from 'members of the public') Subject to review, intake assessment for mental health needs review in view of severity of current symptoms	planning for the individual

HEP/ NHS provider	Structures/procedures	Approach	Boundaries	Expectations of NHS/HEP (depending on which you are)	Ways to collaborate
		referral of case for discussion at MDT meeting with local PCN. Possible consideration of Health, Wellbeing and Support for Study procedures			
HEP C	Direct contact with the HEP via telephone, email or webchat. Triaged to appropriate support depending on student need Distressed and Suicidal Students procedure which aligns to UUK guidance Range of training for staff, in house and external, including: Zero Alliance training for staff, Mental Health First Aiders	As the HEP is a distance learning provider, the support is provided by email, telephone or webchat depending on need. All front-line advisers and tutors use the Distressed and Suicidal Students' procedure to respond Possible that the student would be	Across all four nations, referral into crisis teams - no contacts or information sharing protocols, but something we would like to explore. Due to size of student numbers and demographics, there are a number of considerations associated with working with large range of NHS trusts (Ireland, Scotland	To provide information, advice and guidance to the HEP on information sharing protocols. Relationship-building to ensure we have confidence in making appropriate referrals	England – develop relationships with trusts. Wales initiative – feasibility study into whether the HEP in Wales could be part of an all-Wales partnership between HE and the NHS in a National Mental Health University Liaison Service based on the current model being used by the four universities in

HEP/ NHS provider	Structures/procedures	Approach	Boundaries	Expectations of NHS/HEP (depending on which you are)	Ways to collaborate
	Student Support Teams, Associate Lecturers, Disability Support and Mental Health Casework and Advice Team and Students Association provide support for students depending on need Wellbeing Apps available to all students and staff: HEP Wellbeing, SHOUT and Talk Campus Counselling from Lifelink in Scotland Help Centre online for students Addressing strategy: Suicide Prevention, Intervention and Postvention Working Group	referred to the Mental Health Casework and Advice Team for ongoing support and any collaboration with the student's NHS service Signposting to external support where appropriate In Scotland students could access counselling	and Wales have different approaches)		Cardiff. Early days but potentially quite exciting. For it to work, each HEP has to use the same categorisation model which is where the severity index comes in, but we're still finding out more about that Northern Ireland also in early discussions about students potentially having access to a similar Dept. of Health funded scheme

HEP/ NHS provider	Structures/procedures	Approach	Boundaries	Expectations of NHS/HEP (depending on which you are)	Ways to collaborate
	Mental Health Charter: Student Mental Health Working Group Disability Support Team support for Disability Support Allowance (DSA) claims and reasonable adjustments Safeguarding Team working with any safeguarding issues Fitness to Study policy and procedure where appropriate				
HEP D, Student Health Service (SHS)	GP surgery serving the needs of the HEP population. Open core hours Mon-Fri plus extended access appointments out of core hours to 20:30 most evenings and Saturday morning, occasional	Supportive team of staff at SHS who are responsive and receptive to student need. We are experts in the health and wellbeing of younger people and strive to enable them to thrive	Confidentiality as per NHS guidance and General Medical Council (GMC) regulation. We share information where needed with consent from the patient. We breach confidentiality	Expect the NHS local Mental Health Team run by Avon and Wiltshire Partnership to respond to our referrals in a timely way, to treat us as trusted partners who hold and manage	Regular link consultant meetings are helpful. New Student Mental Health Liaison Service starting hopefully 2024. Would be useful to be able to view RiO –

HEP/ NHS provider	Structures/procedures	Approach	Boundaries	Expectations of NHS/HEP (depending on which you are)	Ways to collaborate
	Saturday afternoon. Offer Same Day Mental Health (SDMH) appointments with GP or mental health nurse (we have four employed) for 20 minutes. If we run out of SDMH appointments then the Duty Doctor team deal with mental health emergencies. We can signpost to support, prescribe, refer social prescriber, refer for assessments for Autism/ADHD, refer to mental health crisis services and we have a link Psychiatrist we can speak to for advice.	at the HEP, regardless of health or mental health need. We liaise with HEP support systems – but only with explicit patient consent – to ensure they are receiving the support they need.	without consent only if there is a risk to the patient or public.	complex risk, and to communicate with us regularly if and when patients are under their care or being recovery-navigated or care-coordinated.	used by the mental health team for their electronic records. This would improve communications and allow us to enhance patient safety. Single patient record held so we can all add to – and patient does not have to constantly repeat their history.

Appendix B Method

B.1 Delivery of the action learning sets

In this section, we detail the design and delivery method for the ALS initiative including the facilitation approach and strategies undertaken to maximise participant engagement. Here we also explore the overall engagement of participants from both the health and higher education sectors, and across key stages of the ALS initiative throughout the year.

An ALS comprises a series of confidential facilitated discussions that encourage reflection through exploring new and different perspectives, create space to share leading practice and help participants develop actions that will lead to improved student mental health outcomes. ALSs aim to create an inclusive and open culture, which nurtures relationships where they exist and helps build new ones.

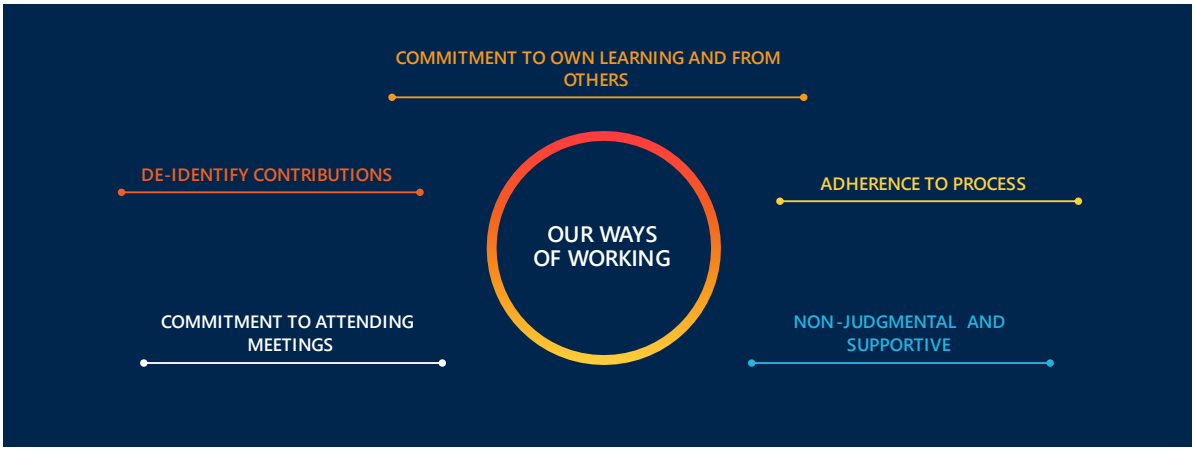
The sets were organised around two rounds with a distinct focus of each:

- **Phase One – Explore:** Between February and July, participants reflected on current barriers to joint working. Through questions and sharing of experiences, participants gained a better understanding of the factors which drive these challenges.
- **Phase Two – Develop:** From August to October, participants focused on one of the challenges highlighted in the Explore phase to investigate in-depth, with an emphasis on developing potential approaches. These approaches vary in focus, with some tailored towards addressing challenges specific to a region or that were more systemic in focus.

Each meeting followed a cyclical learning model of observe, diagnose, act. It required participants to be open to different perspectives and ask thoughtful questions. Participants then formed interpretations about what is causing these issues, and tested those interpretations through actions to be undertaken between the meetings. However, each meeting reflects the group's priorities and desired approach, and so the meetings were distinct in content and form.

At the outset of the ALS initiative, facilitators established rules of engagement to set out ways of working. These principles governed the way participants interacted with each other, both during and outside of meetings. The ways of working were designed to empower participants to have ownership of their set, while supporting individual and collective learning over the course of their involvement. The rules of engagement are summarised below in Figure 5.

Figure 5 | Rules of engagement



Participants met online for 1.5 hours per month after an introductory two-hour session. Each ALS comprised eight to eleven participants, and there was one set each for six of the seven NHS regions, and a seventh set which included participants from both South East and South West regions.

B.2 Cross-regional forums

At the end-point of phase one and phase two, participants from across sets came together to share insights and reflections about the ALS process at a mid-year and final cross regional forum. These forums were attended by ALS participants and by sector representatives, including the Higher Education Mental Health Implementation Taskforce[5] and key agencies.

Summary of mid-point forum

At the halfway mark of the ALS initiative, participants came together to share perspectives across sets and were joined by representatives from the OfS, NHS England, Department for Education (DfE) and Professor Edward Peck CBE, Vice-Chancellor of Nottingham Trent University in his capacity as the DfE-appointed Higher Education Student Support Champion. The forum commenced with a presentation from Edward Peck on his reflections about joined-up working and the priorities of the then newly formed Higher Education Mental Health Implementation Taskforce. Following this, set members presented and discussed key provocations arising from the Explore phase in breakout groups. Key themes included:

[5] This taskforce was established by the Department of Education mid-way through the ALS initiative. The purpose of the taskforce is to build on existing best practice to ensure that guidance and key initiatives in student mental health are implemented in full. A key area of work for the taskforce is to foster approaches in joined-up working, Retrieved from: https://www.gov.uk/government/groups/higher-education-mental-health-implementation-taskforce#terms-of-reference

- The need to tailor standardised approaches to local populations and contexts including student communications, crisis management protocols and transitions in care approaches.
- Building staff capability and capacity to service diverse student needs across NHS services and within HEPs.
- Developing a comprehensive picture of student needs and 'journeys' across NHS services and HEPs.
- Mapping services by geographical location and boundaries.

The forum concluded with a look ahead to the aims and objectives of the Develop phase and canvassed brief reflections from participants on how the approach of the ALS could be adapted moving forward to fulfil the aims of the Develop phase.

Summary of final forum

As the final milestone in the formal ALS initiative, participants shared their potential approaches across sets and with sector representatives, namely those listed above. Participants were able to critically appraise potential approaches and explore how they supported joined-up working.

Participants were able to directly engage with Professor Edward Peck once again in his capacity as Higher Education Student Support Champion and as the chair of the Higher Education Mental Health Implementation Taskforce. Together, participants were able to share their regional approaches to joined-up working, and discuss what is next in the space.

B.3 Participant engagement

The ALS initiative was designed with the intent to equally engage participants from the health sector and higher education sector and across the seven NHS regions. However, all sets saw a higher representation from higher education participants.

Below follows a summary of participant engagement at key stages of the initiative, including at the commencement of the Explore phase, the Develop phase and at the cross-regional forums.

The implications of overall participant engagement on joined up working are discussed in **Section 4.**

B.3.1 Explore phase

At the outset of the Explore phase, each group commenced the ALS with between eight to eleven participants, with attendance decreasing slightly as the initiative progressed. Sets were initially oversubscribed to account for some expected natural attrition. As demonstrated in Table 2 the sets were made up of majority higher education participants. This reflects both the success of recruiting participants from HEPs and challenges in engaging health partners for this collaborative problem-solving project.

Higher education participants were mostly individuals who have oversight across student wellbeing services in their HEPs. Health participants were mostly patient-facing health care professionals and clinicians, supporting young people's mental health on a day-to-day basis.

Table 2 | Participant recruitment split across seven sets, at the outset of the Explore phase

Region	Higher Education	Health
London	9	1
South East	4	3
South East/South West	9	3
North East	6	4
North West	7	1
Midlands	5	4
East of England	5	3
TOTAL	**45**	**19**

During the Explore phase, participants met online for 1.5 hours per month after an introductory two-hour session.

The objective of this delivery approach was to enable co-located stakeholders in health and higher education to build meaningful collaborative relationships whilst addressing the system-wide challenges of joined-up working between the NHS and education partners. The overall volume and mix of health and higher education participants dictated the set groupings (discussed further in Appendix C).

In advance of the introductory session, Nous facilitators provided all participants with a briefing pack that outlined the aims and purpose of the ALSs together with relevant contextual information. Given the diversity of participants within the sets, it was critical that they received common guidance and information about past development and recent initiatives. This was foundational to establishing collaborative norms and ways of working. Figure 3 provides an excerpt from this briefing pack.

Typically, two participants per meeting would share a challenge they were experiencing within their organisation and/or sector, and the cyclical model of observe, diagnose, act was applied. Other participants within the set were invited to ask open-ended questions which would support those presenting the challenge work towards actionable steps. A sample selection of open-ended questions that participants used to meaningfully probe each others' challenges is given in Figure 6 below.

As meetings progressed, participants were encouraged to trial actions that were generated in an earlier meeting and report back on the impact of these actions. Within this framework each set varied considerably in the topics, with facilitators adapting their approach to suit the needs and ambitions of each set. In between each meeting, Nous facilitators met to share common themes across sets and discuss participant dynamics, which informed changes to the facilitation approach for the subsequent meetings.

Figure 6 | Example open-ended questions

- What result do you want?
- What is your biggest difficulty or problem?
- How do you feel about this situation?
- What could you do differently?
- Why can't you do it?
- What are you trying to achieve?
- What can you do about it?
- What should make the situation better?
- How does the situation affect you?
- What's the worst thing that might happen?
- What's the most extreme measure you could take?
- What's the best possible outcome?
- When will you start?
- What options are open to you now?
- What could you start to do differently?
- What action are you going to take?
- Who could help you?
- How important is this to you?

In addition to the individual actions that participants trialled outside of sets, they were also encouraged to complete homework tasks to help them think about their challenges using

problem solving framework and creative approaches. The purpose of these homework tasks was to encourage reflection about challenges from diverse stakeholder perspectives and evidence sources, adding rigour to the process of exploring challenges in joined up working.

B.3.2 Develop phase

During the Develop phase, the overall number of participants continued to decline. While some of the attrition was expected due to summer holidays and predicted patterns of annual leave, other factors emerged as significant including increases in workload for participants, changes in role and other competing priorities. This was more acutely experienced by health participants, though also impacted the ability of higher education participants to sustain involvement in their ALS.

As demonstrated in Table 5, the seven original sets were consolidated into six to maximise participant engagement from health and higher education sectors as well as in response to feedback from participants themselves. The consolidation achieved a better balance of representation from health and higher education sectors. This change primarily impacted participants from the South West and South East regions.

Table 5 | Participant recruitment split across six sets, at the outset of the Develop phase

Region	Higher Education	Health
London	5	1
South East/South West	13	4
North East	7	2
North West	3	0
Midlands	3	3
East of England	2	1
TOTAL	**33**	**11**

During the Develop phase (which commenced after the mid-year cross-regional forum), participants met online for 1 – 1.5 hours per month.

At the first meeting of the Develop phase, participants prioritised the range of themes discussed during the Explore phase to focus on the one challenge for which they wished to develop potential approaches. The remainder of the meetings for this phase varied considerably between sets, both in terms of topics discussed and structure.

Across most sets, participants self-directed the discussion to explore potential approaches. Some participants met outside of their sets to progress potential approaches and test these

with stakeholders within their local region (e.g., local NHS services, students, senior leaders within HEPs) and/or exchanged perspectives with other sets about their emerging approaches. Resources from outside meetings were also shared, including material from the OfS Mental Health Challenge Competition.

In advance of the final cross-regional forum, participants met without a facilitator present to support the aims of developing lasting collaborative relationships outside of the formal ALS process.

B.3.3 Cross-regional forums

Cross-regional forums had strong representation across all regions, with up to 41 attendees at each event. For those participants that were unable to attend, the forum was recorded and circulated amongst ALS members (except for confidential breakout group discussions) following the event.

Nous facilitators produced an article summarising the cross-regional forums and shared early findings with participants in advance of the cross-regional forum. These approaches helped shape a rich and informed discussion at the cross-regional forum, and with sector representatives who were not involved within the individual sets.

Table 6 | Attendance at cross-regional forums

Forum	Higher Education	Health	Guests	Total
Mid-year forum	28	5	8	41
Final forum	21	2	13	36

Appendix C Participant recruitment

This section covers our approach to recruitment, and the corresponding strengths and challenges.

C.1 Recruitment method

Our aim was to create a diverse mix of professionals and perspectives across the seven regional groups and with equal participation from the higher education sector and NHS. We sought participants who:

- have day-to-day familiarity with student mental health (from frontline or management perspectives) and therefore have the knowledge and experience to positively contribute to the group meetings
- are willing to fully engage in the process in order to maximise the opportunity of relationship building, joined-up working and ultimately improved student mental health outcomes
- are part of an organisation that is committed to improving student mental health outcomes, and already testing improvement initiatives
- can commit to the time requirement of eight set meetings (of 1.5–2 hours each) across February to September 2023

We took a comprehensive approach to recruitment using multiple methods. Following an initial introductory email, we directed participants to a custom-built microsite, which provided information about the programme and the ability to register. The site explained the impetus for the programme and the value of being involved for the individual.

We undertook a significant recruitment campaign over November 2022 to January 2023, which included engaging and cascading communications through NHS England, sector forums such as the National Learning Collaborative and sector agencies such as London Higher, Russell Group and Universities UK among others. We engaged in direct outreach with over 200 participants.

We anticipated a degree of participant attrition through the pre-launch period, and also after the sets began, and so planned to build sets that were not just equally representative of health and higher education stakeholder groups, but had enough resilience within each cohort to remain viable if some participants were to drop out.

C.2 Strengths and challenges of the recruitment approach

The greatest strength from the recruitment approach was utilising the existing networks available to Nous and the OfS. Our email send-out to over 100 of our existing contacts – primarily higher education participants responsible at executive or operational level for

student wellbeing - and the OfS's LinkedIn recruitment post (reposted by Nous) was the source of most of our participant sign-ups. There were 218 expressions of interest from the initial sign-up form (via the microsite), which converted to 80 'interested in participation' sign-ups, and a final 64 participants whose availability aligned with the time slots offered.

Recruitment of health partners was more challenging than higher education participants. Notably, there was a lack of senior, strategic-level NHS participants. Since this is a higher education led project, the bias towards higher education interest has not been surprising. However, this also reflects the time constraints health participants are under, and possibly reflects that students are just one of the many population groups they oversee, leading to a lower sign-up rate.

Scheduling the sets created another barrier to participation. Finding a time that all participants could commit to on a regular basis meant that not all interested parties could participate in the sets. To maximise attendance, we chose times and dates for the different groups based on the most popular slot that participants confirmed they could attend. However, attendance continues to fluctuate in line with unavoidable personal and work commitments.

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