BRINGING INNOVATION TO GRADUATE MENTAL HEALTH TOGETHER (BRIGHTER)

2019-2022 MENTAL HEALTH CHALLENGE COMPETITION PROJECT REPORT

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EXECUTIVE SUMMARY

Bringing Innovation to Graduate Mental Health Together is a project funded by the Office for Students which aimed to 1) deliver faster access to evidence-based psychological therapy for students, and 2) develop skills training workshops as early intervention to manage common issues in student life. The first aim was delivered through an 'in house' Cognitive Behavioural Therapy (CBT) service run and governed by Newcastle University. The second was delivered by co-creating cognitive-behavioural-therapy-based 'mind management' skills training with students.

The University's CBT service – the Psychological Therapies Training and Research Clinic – was established as a pilot service in 2018 and, following receipt of this funding, was expanded to a full-time service in 2020. It is staffed by qualified staff (Clinical Psychologists and Cognitive Behavioural Therapists) and trainee clinicians studying on our professional therapy training programmes. Between February 2020 and March 2022, there were almost 300 referrals, 73% of which achieved clinically reliable improvement and 45% recovered. Waiting times were significantly lower than for NHS treatment (average of 27 days for assessment and 58 days for treatment). The percentage of referrals that were offered a course of treatment and engagement with treatment was higher than NHS services for this age group.

Students seen in the clinic had very high levels of satisfaction with the service. Qualitative feedback given via questionnaires and individual interviews commented on the high level of therapist competencies and the strong therapist relationships created as a result; the strengths of the CBT approach; clients reported feeling stronger and more confident to face future challenges, as well as generally feeling happier and calmer; for some, attending the service had been 'life changing'.

Negative experiences of the service included lack of awareness of the service prior to referral and consequent apprehension due to previous negative experiences with other services; difficulty with online sessions during the pandemic; a desire for approaches other than CBT; and disappointment that sessions could not continue once student registration has ended.

Overall, the PTTRC dramatically reduced waiting times to access a full course of CBT treatment and simplified the process of referral, as students could be directly referred from the Student Health and Wellbeing Service. Anecdotally, onward referral to NHS services (for those where it was required) was simpler in some cases, as some referrals were accepted directly from our team, rather than via the GP or restart the process at the primary care entry point into NHS mental health services. Furthermore, there were no adverse events noted in the time period covered in this report, indicating that care was safe and effectively governed. Clinical outcomes were comparable or better than those observed for this age group in IAPT services, suggesting that students received a high quality of care.

The clinic has added sizeable additional capacity to existing provision. There was positive feedback from the students that the care was person-centred, effective and professional. There is interest from other Universities with existing expertise to replicate this model within their own institutions, although

replicating it in universities without clinical training programmes would require further support and resources.

Mind-management skills training was developed in consultation with 42 students in total across both postgraduates and undergraduates. The postgraduate sessions were delivered as a series of 4 linked workshops in small groups (up to 16 participants). The undergraduate workshops were run as stand-alone sessions. This element of the project was markedly impacted by the pandemic and the original aim to deliver workshops in very large groups (lecture-theatre-sized groups) was not well-received by the students and, instead, a small group format was used. As a result, the workshops were run on a smaller scale than originally envisaged. Nonetheless, they were valuable, well-received and associated with a short-term improvement in mental health symptoms (the lack of longer-term data precludes a statement about their lasting impact). However, they would require significant additional resource to provide them on the scale necessary to achieve a widespread preventative effect.

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The project partners who supported project delivery – Dr Alyson Dodd, Dr Stephen Barton, Professor Julian Edbrooke-Childs, Jennifer Hicken, Briana Gordon

INTRODUCTION

Aims

BRIGHTER had two keys aims:

1) Faster access to evidence-based psychological therapy for students. This is delivered through an 'in house' clinic run and governed by Newcastle University. The clinic is staffed by qualified staff (Clinical Psychologists and Cognitive Behavioural Therapists) and trainee clinicians studying on our therapy training programmes

2) Develop and evaluate early intervention for managing common issues in student life. This is through cognitive-behavioural-therapy-based 'mind management' skills training, with separate courses for undergraduates and postgraduates.

Rationale:

In 2018-19, approximately 3,500 students at Newcastle sought help from the counselling or Mental Health Advisor team, an increase of 24.5% on the previous year. A wider report found that students identified lack of provision of suitable services, long waiting times, and too few sessions as key barriers to accessing appropriate care when they need it (1). However, not all students experience a level of distress that requires clinical intervention. A comprehensive strategy that facilitates students to have a positive experience of higher education includes education and skill-building around emotional health and resilience, and proactive support for those identified to be most vulnerable. People thrive and flourish when they have the necessary skills in the right environment. Our approach was founded on the belief that combining rapid intervention with focused prevention forms the basis of a sound mental health strategy.

Project Activities:

ACHIEVING A STEP-CHANGE IN SUPPORT WITH RAPID ACCESS TO EVIDENCE-BASED TREATMENT

We established an in-house cognitive behavioural therapy (CBT) service, the Psychological Therapies Training and Research Clinic (PTTRC), where students could receive the full, NICE guideline-recommended dose of CBT for depression and/or anxiety (2). This is very similar to the care provided in primary care NHS services (the closest parallel is step 3 [high intensity 1:1 CBT] in Improving Access to Psychological Therapies services [IAPT]). Students are referred to the PTTRC from the Student Health and Wellbeing Service (SHWS) if they have been assessed as requiring CBT (the SHWS continues to offer up to 6 sessions of non-model specific counselling to students who do not need a full course of CBT). The clinic also hosts training placements for students on the Doctorate in Clinical Psychology programme and the Diploma in Cognitive Behavioural Therapy (approximately 8-10 students per academic year). The clinic employs both qualified CBT therapists/clinical psychologists (equivalent of 2.5 WTE), and qualified staff on our clinical training programmes offer some clinical time into the service (although this varies, it has been up to an additional 0.5WTE at times). There is also a 0.6 WTE clinic administrator. The clinic is available to all students (undergraduate and postgraduate) at the University and is based within

a dedicated, purpose-built suite of therapy rooms in the heart of the university campus (built by the university as their matched funding for the bid).

EARLY INTERVENTION THROUGH 'MIND MANAGEMENT' SKILLS TRAINING

Our initial intention was to develop large-scale curriculum-embedded mind-management workshops that focused on using evidence-based principles to tackle common issues in student life. However, student consultation made it clear that students preferred more specific provision of small-group workshops. Therefore, we developed two series of bespoke workshop programmes; one for undergraduates (UG) and one for postgraduates (PG)

Through a series of focus groups, we worked together with students to create the content and delivery plan for these workshops. This element of our programme was most affected by the pandemic. Whilst the postgraduate workshops were developed and implemented by April 2021, there were delays and difficulties in undertaking the UG focus groups. These went ahead in October/November 2021 and the finalised workshops were run as a pilot in March 2022, towards the end of the funded period.

Partnership:

The project was delivered in partnership with:

Dr Alyson Dodd, Northumbria University. Dr Dodd collaborated on the student engagement strategy, the focus groups and outcome measure selection for the workshops with her leading role in the Student Mental Health Research Network (SMaRteN).

Newcastle University Student's Union were pivotal in helping engage students and market various events (including the focus groups and the workshops themselves).

Dr Stephen Barton, based in Specialist Psychological Services in Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust, partnered with us to develop a research strategy to identify students at risk of adverse outcomes from CBT and to provide supervision and training to clinic staff.

Professor Julian Edbrooke-Childs of the Child Outcomes Research Consortium/Anna Freud Centre became a partner on the project in place of Professor Miranda Wolpert and helped inform the student engagement strategy.

The Chief Executive of Northumberland Tyne & Wear NHS Foundation Trust (NTW) and the Mental Health Programme Lead agreed to appoint a member of the Trust as Student Mental Health Lead and work with us to map and develop pathways into secondary or tertiary care for students whose needs cannot be adequately met by the University.

PSYCHOLOGICAL THERAPIES TRAINING AND RESEARCH CLINIC

Data Collection Activities

CLINICAL OUTCOMES

Routine outcomes reporting is very rarely undertaken for student mental health provision, and it is essential to measure and report on outcomes to understand the impact and effectiveness of these services (3). Existing standards and practices are in place for evaluating the effectiveness of CBT, and these are used in the PTTRC. We use the same definitions for outcome metrics as outlined in the IAPT[1] manual (4). We also use the same electronic record-keeping system that is used in many IAPT services (IAPTus).

At each appointment, clients are asked to complete outcome measures (the Patient Health Questionnaire 9-item measure of depression [PHQ9], the Generalised Anxiety Disorder 7-item measure of anxiety [GAD-7], the Work and Social Adjustment Scale [WSAS] – see Appendix A for these measures). At the start and end of treatment they may also complete an anxiety-disorder specific measure (ADSM) if relevant for the client's presenting difficulty[2].

Our primary outcome is the percentage of clients who achieve recovery and our secondary outcome is the percentage of clients that achieve clinically reliable change (see Appendix B for definitions). We also report on service metrics such as waiting time (in days from referral to assessment and from assessment to treatment), 'throughput' (the number of referrals transitioning into treatment, the engagement rate [percentage of clients that finish a course of treatment], drop out, and the percentage of students whose needs could not be met by this service) and the non-attendance rate.

We report demographic details of the students that were referred to the service (these are collected on a registration form that clients complete themselves prior to assessment) and contrast these with the demographic make-up of the student body in the 2020-21 academic year. Demographic details and clinical outcomes are reported for all referrals in the time period 03/02/2020 to 31/03/2022, which is when

[1] Improving Access to Psychological Therapy (IAPT) services provide psychological therapy (predominately Cognitive Behavioural Therapy) for the National Health Service. They are primary care services and are the services most students presenting with significant depression or anxiety would be referred to.

[2] The following disorders have their own disorder-specific measure that should be used alongside the PHQ9 & GAD7: Health Anxiety, Obsessive-Compulsive Disorder, Panic Disorder, Post-Traumatic Stress Disorder, Somatisation, and Social Phobia

the first member of staff appointed as part of the funding came into post to the final day of the funded period.

CLIENT EXPERIENCE OF SERVICE

In addition to these standard metrics, client experience of the service was captured in two ways – interviews and through the Patient Experience Questionnaire.

All clients discharged between September 2019 and March 2022 were offered the opportunity for an interview with an independent member of the team not involved in their care. Eight individuals consented to an interview and a further five opted to respond to the interview questions by e-mail.

All discharged clients are sent a Patient Evaluation Questionnaire that asks them about their experience of the service using 5 questions rated on a 5-point likert scale (see Appendix C) and a free text box for comments. The average scores on the likert scale questions are reported from the 39 clients who completed this between 03/02/2020 and 31/03/2022.

Interview transcripts and free text responses from the PEQ were analysed using a two-stage thematic analysis approach to obtain an understanding of the client experience at the clinic.

Outcomes

CLINIC REFERRALS – DEMOGRAPHIC CHARACTERISTICS

The demographic characteristics of clinic referrals are shown in table 1. Relative to the demographic composition of the student body at Newcastle, the following groups were underrepresented in referrals: males, students from Asian, Black, or Mixed ethnic backgrounds, home UK students, postgraduate students, students without a disability and students less that 21 years old. Due to the way in which referrals are made to the clinic, we do not have direct control over the reach of our service. The under-representation of students from specific ethnic groups is a focus of a second project funded by the Office for Student (see section 5.1).

CHANGES TO MENTAL HEALTH OUTCOMES

Figure 1 shows the flow of referrals through the service and table 2 presents a summary of the clinical outcomes. Between 03/02/2020 and 31/03/2022, there were 278 individuals referred (figure 1). Of these, 245 (88%) were assessed and 218 (78%) had at least one treatment session. The percentage of referrals transitioning in to treatment is higher than reported in IAPT services for an overlapping age-group (65% of referrals to IAPT for 18-35 year olds entered treatment in the time period reported by Baker (2018) (5).

Table 1: Demographic details of student referrals between 3/2/2020 and 31/3/2022 (percentages may not add up to 100 due to rounding)

	All referrals (n=278)	Composition of student body 2020-21
Gender identity		
Male	78 (28%)	47%
Female	188 (68%)	53%
Self-defined	4 (1%)	0%
Not known[1]	8 (3%)	-
Ethnic Group		
Asian	19 (7%)	5%
Black	6 (2%)	1%
Mixed	10 (4%)	3%
White	187 (67%)	64%
Other	12 (4%)	1%
Not known[1]	44 (16%)	25%
Disability		
Has disability	61 (22%)	10%
No perceived disability	163 (59%)	90%
Not known[1]	54 (19%)	-

	All referrals (n=278)	Composition of student body 2020-21
Home vs International Student		
Home UK	236 (85%)	76%
International	28 (10%)	24%
Not known[1]	14 (5%)	-
Student-type		
UG	223 (80%)	77%
PGT	20 (7%)	23%
PGR	21 (8%)	
Not known[1]	14 (5%)	-
Age (range 18-51)		
<21	132 (47%)	55%
21-29	124 (45%)	39%
30+	16 (6%)	6%
Not known[1]	6 (0%)	-

[1] Where data is shown as 'not known', this can indicate that the student did not answer the question, or that the question was not asked (demographic data on all of the above categories was systematically collected for all referrals from July 2020, so some elements may be missing for referrals prior to that date)
UG, undergraduate; PGT, post-graduate taught; PGR, post-graduate research

The average wait in days from referral to assessment was 27.1 days, and the average wait from assessment to treatment was 58 days (table 2). It is difficult to draw a direct comparison between this waiting time and the advertised waiting time for IAPT services. Although IAPT targets are to see 75% of referrals within 6 weeks of referral and 95% within 18 weeks, this is specifically from referral to first treatment session (6). A hidden wait can be obscured in these data by offering a single treatment session after assessment, but the client then waits 12 months or longer for their second treatment session and the remainder of their course of treatment. From anecdotal reports (from GPs, students who have been referred/referred themselves to IAPT but came to our service instead, and from therapists working in IAPT), the approximate effective wait for step 3 care in the Newcastle region is between 12-18 months. There are no hidden waits in our data; once a client begins treatment, their series of treatment sessions proceeds in one go without interruption (unless the student specifically requests to pause sessions; e.g. during holidays or international placements).

The overall engagement rate (the percentage of students referred who either completed treatment or were still receiving treatment by 31/03/2022) was 56%. Again, this is higher than the 37% of 18-35 year olds that finished a course of treatment in IAPT (5). Just over one quarter of our referrals were classed as

Table 2: Clinical activity and outcomes

	Number or percentage
Throughput	
Referrals received	278
Number assessed	245
Number Entered Treatment	218
Waiting times	
Referral to assessment (days)	27.1
Assessment to treatment start (days)	57.9
Clinical Outcomes	
Reliable improvement	72.6%
Recovery	45.3%
All sessions in the time period	
Number of Treatment sessions offered	3615
Average sessions per completed referral	15.4
Non-attendance rate	6%
Cancellation rate	9%

having 'dropped out' (26%). This could occur at any stage in the process from referral to completing treatment and ranged from students not responding to any communication from the service and therefore not being seen at all, to attending assessment and some treatment sessions before discontinuing. Students that did not respond to 3 communications from the team (e.g. to arrange or rearrange an assessment or treatment appointment) or who did not attend 3 consecutive sessions were discharged and designated as having 'dropped out'. Note that those classed as having 'dropped out' of treatment are still counted in recovery statistics provided they attended at least 2 treatment sessions.

Conversely, for 18% of referrals, this service was unable to meet their needs. This was measured from the discharge codes, where therapists were able to indicate that the client was not accepted for treatment or they were referred to another service (e.g. their course was due to end soon, they were not suitable for or did not want CBT, the presenting difficulty was not appropriate for a primary care service [e.g. high risk, psychiatry or multi-disciplinary team input required]). In the majority of instances, this was because the student's course was due to end before treatment could be completed (due to the limitations of the University's public liability and personal indemnity insurance policy, we can only see students for a maximum period of 3 weeks after the point they are no longer classed as a registered student). In other cases, it was because the student did not want to receive CBT and the therapeutic modality they preferred was not something we provide (e.g. Eye-Movement Desensitisation and Reprogramming). Or the student had complex needs or high levels of risk (or these emerged due to changes in circumstances during treatment) that could not be safely and responsibly managed by our service. We were able to develop links with other NHS services (e.g. Crisis Team, Secondary Care, the At Risk Mental States Service, Adult ADHD and Autism Assessment Service) and referred students on directly in some cases, or via the GP in others, to ensure they received the most appropriate care.

The majority of those entering treatment experienced reliable improvement (73%) with 45% of those entering treatment achieving recovery (table 2). The headline reliable improvement and recovery rates

for IAPT as a whole are typically in the region of 65-70% and 48-52% respectively (these statistics are reported monthly for IAPT as a whole and they fluctuate around these levels (6)), however, this has not been broken down for students specifically. Barker (2018) reported the IAPT reliable improvement rate for 18-35 year olds was 64% and the recovery rate was 46% (5). We have achieved a similar rate of recovery, but a higher rate of reliable improvement. We also noted that the recovery rate fluctuated markedly during the time period of the funding – in 2020, the recovery rate was 60.0% and the reliable improvement rate was 73%. However, in 2021 the recovery rate dropped to 45% with 71% of clients showing reliable improvement. It is interesting to speculate whether this drop could be related to the pandemic, which had a negative impact on mental health very broadly, but is widely acknowledged to have disproportionately affected young people relative to other age groups (7). This is something we continue to monitor.

In total, between 03/02/2020 and 31/03/2022, there were 3,615 sessions of CBT treatment offered with completed referrals receiving an average of 15.4 sessions. This is notably higher than the average 8-9 sessions per completed referral in IAPT services (6). Non-attendance rates were low at just 6%.

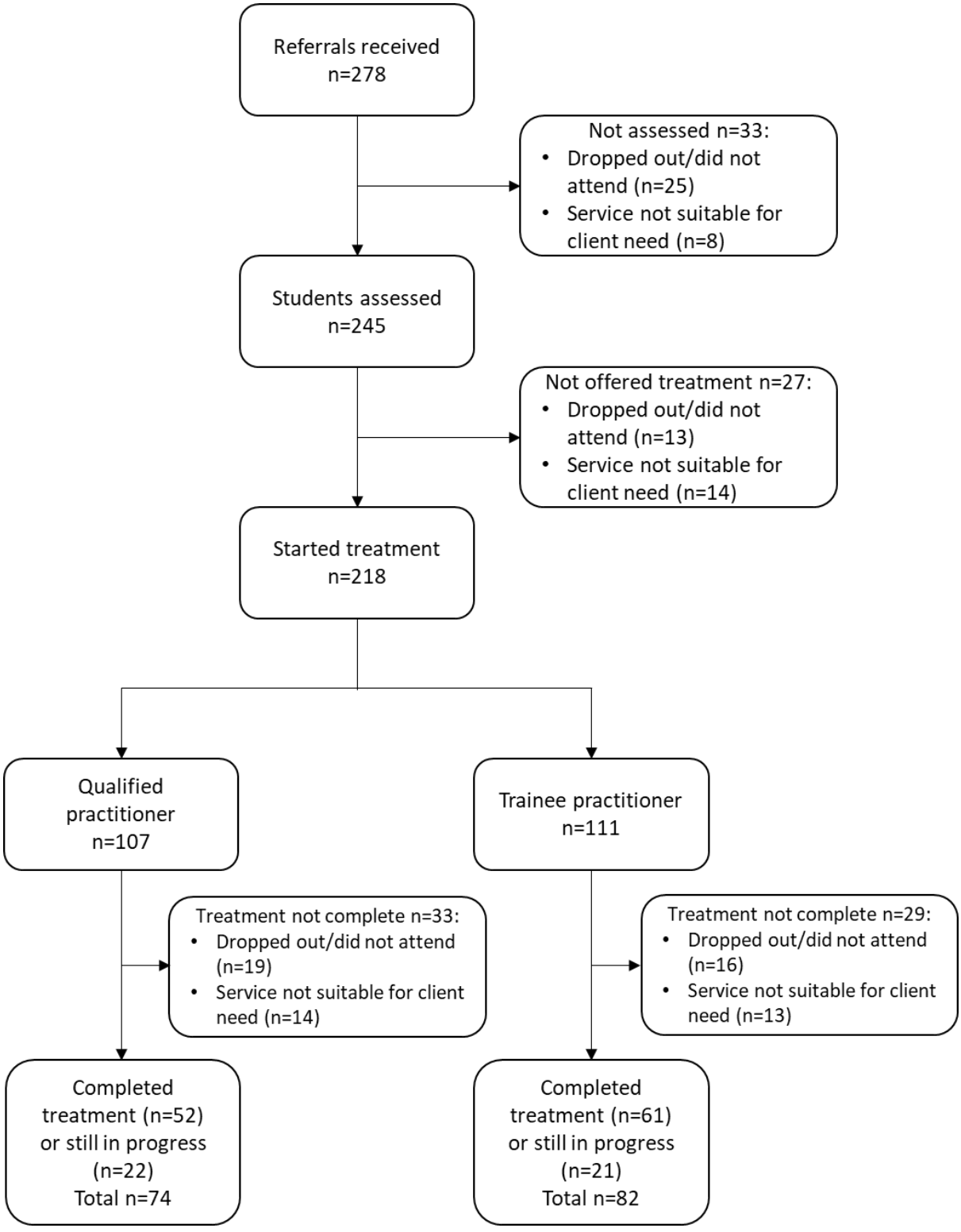

Figure 1: Flow diagram of referrals through the treatment pathway

PATIENT EXPERIENCE OF THE SERVICE

Patient Experience Questionnaires

Thirty-nine clients completed the Patient Experience Questionnaire (completion rate of 18%) and the average ratings indicate very high levels of satisfaction with the service (see table 3). All five questions had average ratings of 4.7 or greater (on a 1 to 5 scale where scores of 5 indicate high levels of satisfaction). Eight in 10 of the PEQ-completers experienced no issues with the service they received. Of those who did, factors varied from: treatment coming to an end because their course was finishing, not being able to receive anything other than CBT, having to switch therapists due to sick leave, or having to go through the details of their difficulties all over again with our team after initially being assessed by the Student Health and Wellbeing Service.

Although most discharged clients received the PEQ to complete, the spread of responses suggests that clients who were happy with the service they received were more likely to complete the questionnaire. This suggests the ratings and comments may be biased towards those with a positive experience of the service.

Table 3: Mean (standard deviation) of scores on the Patient Experience Questionnaire. The first five items are rated on a 1 to 5 scale, where 1 is 'never' and 5 is 'At all times'.

	Average score (1-5 scale) N=39
Did staff listen to you and treat your concerns seriously?	4.9 (0.4)
Do you feel that the service has helped you to better understand and address your difficulties?	4.7 (0.5)
Did you feel involved in making choices about your treatment and care?	4.8 (0.5)
On reflection, did you get the help that mattered to you?	4.7 (0.7)
Did you have confidence in your therapist and his/her skills and techniques?	4.7 (0.8) [1]
Did you experience any problems or difficulties which meant that the service you received did not run smoothly?	20% Yes 80% No

[1] n=38

Patient interviews and free text responses

As outlined above, discharged clients were offered the opportunity for an interview with an independent member of the team (a research assistant who had not been involved with their care) to understand their experience of the service. Clients were also able to provide feedback in free text questions on the PEQ. Analysis took place in two stages. First the interview transcripts and the e-mail responses from those who preferred to respond by email were analysed using inductive thematic analysis. Secondly, the free text responses on the PEQ were analysed using deductive thematic analysis based on the themes generated in the first stage of analysis. The thematic map is presented in table 4 below, followed by further description of the themes and subthemes with illustrative quotes.

Table 4: Thematic map derived from patient interviews and PEQ responses

Main theme	Sub-themes
A. Past experience and current needs	i. Need for clinic ii. Awareness of service iii. Previous experience
B. Experience of therapy	i. Therapist relationship and competencies ii. Therapy sessions iii. CBT approach iv. Logistics
C. Impact of therapy	i. Personal outcomes ii. Future challenges iii. Recommendations

Key:

- ***Clinic interviews***
- ***Open-text responses***

A. Past experience and current needs

For the first theme, many of the students discussed their experiences before accessing the clinic and how this impacted on their own expectations and hopes for their therapy sessions and outcomes. In particular, they discussed the need for the clinic, their awareness and understanding of the service, as well as their own previous experiences and their subsequent expectations as a result of these previous experiences.

i. Need for clinic

The majority of the feedback from the students focused on their need for the clinic and the services offered, as they were not able to access this help elsewhere within the same time frame or location. For some students, the need was focused on the unique stressors at university:

- *'Mature students, especially PGRs, I think they face a huge challenge going in to PhDs and research and this stuff. Especially the life after a PhD, it is stressful to go through research.'* (P1),
- *'You are isolated. I am telling you, yes, you are isolated.'* (P4)

For others, the need for the clinic was due to the difficulties accessing care in other services:

- *'If you go to the GP it's quite a fight sometimes depending on the doctor you get trying to get the help that you need and they might not necessarily know how to go ahead with it.'* (P7)
- *'I think having the Psychology Clinic is an asset to the university because I was able to get help quicker than I would have with the NHS and it is a well-structured and professional service.'*

ii. Awareness of service

Other students discussed their knowledge of the clinic prior to attending and the lack of awareness about the clinic's existence before being referred. Due to the positive experiences for many of the students, they believed the clinic should be better advertised and more accessible for all in the future.

- *'I think students should really learn there is a service at the university.'* (P1)
- *'I didn't really understand what is the difference between the clinic, they didn't provide enough grounding information on the difference between the clinic and student services. But I wasn't bothered because I just wanted to be seen.'* (P1)

iii. Previous experience

The final sub-theme within this section focuses on how previous experiences often impacted on the individual's expectations and aspirations for their therapy sessions. Often the students had previously had negative experiences at other services and were concerned it would be a similar experience at the university clinic.

- *'I kinda have experience of trying to get CBT with the NHS. I know that the University is generally a lot more responsive, although I am saying it is quite a while before my initial appointment, actually it's been 6-8 months to get it on the NHS and I think that would have been pretty problematic.'* (P2)
- *'I've been disappointed by services before'* (P5)

B. Experience of therapy

The second main theme looks at the therapy journey and the experiences and feedback from the students regarding the therapy they received. The sub-themes in this section focus on the therapist relationship and competencies, the experiences within the sessions, the CBT approach and the logistics of the sessions during this time.

i. Therapist relationship and competencies

The first sub-theme to emerge from the data focuses on the importance of the relationship between the student and the therapist. It was evident from the feedback to ensure a good therapist relationship relies on the therapists' competencies to create a relaxed, welcoming and engaged environment. Many of the students commented on how comfortable they felt in their sessions due to their therapist's welcoming and relaxed nature.

- *'I feel like they talk to you like a person rather than a patient. I know obviously you're meant to have that clinician patient relationships, but the boundaries were always set clearly.'* (P3)
- *'My therapist was really, really supportive and positive.'* (P4)
- *"It was really refreshing and nice to talk to someone so calm, positive and so likeminded as me. They were vital in helping me see things in a new light and have been great."*

In particular for some students, the relationship with their therapist was so strong that they felt comfortable to talk about particular issues and difficulties they had not spoken about to anyone else before.

- *"My therapist's empathy and lack of judgement allowed me to open up about things that I had spoken to no one about."*
- *"My counsellor in particular was extremely kind and courteous and she helped me open up about previous traumatic experiences which I never thought I would have discussed."*

ii. Therapy sessions (session experience)

The experience of the therapy sessions appeared to be very important for many of the students. In particular, involvement within the therapy sessions was a significant aspect of their experience.

- *'There was something about it feeling a bit more personalised or tailored to you'* (P1)
- *"When needed [therapist] did not hesitate to change the setting of the meetings (as I needed to go to parks rather than be in the therapy room towards the end of the therapy)."*
- *"I really appreciated the structure of the sessions and how I was given independence to work on the method on a weekly basis which was supported by [therapist] during the sessions."*

They described feeling included in the decision making and feeling as though the sessions were tailored to their needs allowed the trust in their therapist to grow and helped to ensure positive outcomes from the sessions.

- *"Also made me feel like I had a say because the therapist involved me in structuring my treatment and each session which also helped build my self-esteem. It also made me feel that I would get the help I needed, for as long as I needed it, such as co-deciding whether to add extra treatment sessions."*
- *"I also had a lot of control in each session which made me feel validated."*

iii. CBT approach

The third sub-theme focuses on the CBT approach adopted by the clinic. Many of the students commented on the effectiveness of this particular approach and the usefulness of the techniques developed through their sessions.

- *"My therapist helped trigger reflection and challenge my negative thoughts, helping me see myself in a new light and be more aware of behavioural patterns that had a negative influence on my life."*
- *"I never thought that using CBT to treat my specific problem would improve my outlook on every problem I come across in life. I got more than I could have hoped for in this way from therapy."*

Alternatively, some students felt this approach did not suit them and would have preferred an alternative option for their therapy.

- *"Was helpful but I personally was not ready. Despite engaging with the sessions, I feel I wasn't mentally prepared to be helped"*
- *"I think the service is great. I just think I was not really ready for CBT, and I would have preferred a different type of therapy … I think I would have found more useful the kind of therapy that focuses on resolving some specific issue that I have, I think it is the one where people talk about their childhoods or something like that."*

iv. Logistics

The final sub-theme focuses on the logistical and practical side of the clinic. Within the feedback some of the students commented on the location of the clinic, the positives and negatives of online sessions, and the number of sessions they received.

- *'The sessions fit me really well. The timing I mean, the place'* (P12)
- *"The experience was very good, however the online nature was often very difficult."*
- *"One of the most important reasons for my positive experience was the fact I didn't feel like I was rushed or just another number, I was never rushed and often asked to slow down myself sometimes."*
- *"I am not happy that my course has ended before I finish my treatment. I was waiting to get a therapist for around 8 weeks and as I was waiting my course were about to finish. Because I am a stage 3 student and I have graduated I can't continue the sessions, I hope you change this policy in the future..."*

C. Impact of therapy

The final theme is based on the impact of the therapy and the students' experience and feedback once they had finished therapy. The feedback looks at the personal outcomes, dealing with future challenges and recommending the clinic to others.

i. Personal outcomes

The first sub-theme for this section focuses on the impact the therapy sessions have on the individual and the personal outcomes for each individual. From the feedback received, it appears the therapy has a large positive impact on their lives. Many of the students commented they feel happier and calmer.

- *'The sessions were really beneficial. They changed a lot. Changed me to a better situation and a better person.'* (P2)
- *'The therapy changed not only my condition specifically but how I approach education and work..'* (P2)
- *"I never expected it to be solved long term and cannot thank you enough."*
- *"I worked with therapist for 12 months, I can quite honestly say she changed my life."*
- *"I am significantly calmer. My resting heart rate is lower. I am happier. They did a bang up job."*

ii. Future challenges

In addition to the overall impact the therapy session had, many of the students also described how they now had a newfound strength and confidence for dealing with any future challenges that may arise as a result of the tools and techniques developed within their CBT sessions.

- *'I can tell now that after finishing the sessions I can now keep up with my education. And even if I'm catching myself slip sometimes now I've had the sessions and stuff, I know how to try and basically reboot in a way.'* (P13)
- *"Through using your service I am now able to look ahead to my future instead of the past. I am more able to understand how my mind thinks and to combat anxiety when it comes on."*

iii. Recommendations

For the final sub-theme of this section, some students described how they would be recommending the clinic to their peers due to their positive and helpful experience during their time at clinic.

- *'I wouldn't be shy to tell my colleagues about attending the clinic if they needed the help.'* (P2)
- '*I have recommended universities CBT services to multiple people.'*

SUMMARY

Overall, the feedback from students suggests an overall positive experience throughout the therapy journey but with some areas in need of improvement. Before attending the clinic, it is apparent there was lack of awareness of the service and a lot of apprehension due to previous negative experiences with other services. Despite this, the feedback was mainly positive for the experience during therapy sessions. In particular, the students commented on the high level of therapist competencies and the strong therapist relationships created as a result. Additionally, although a few clients struggled with the CBT approach, overwhelmingly the students described the strengths of this approach. The logistics of organising the sessions also received mixed feedback with many accepting the online sessions but some finding this format difficult. Finally, there was a lot of positive feedback based on the experiences after attending the clinic. The clients described feeling stronger and more confident for any future challenges, generally feeling happier and calmer, and, for some, attending the service had been 'life changing'. Overall, there seemed to be strong positivity directed towards the service with many of the clients commenting they would happily recommend the service to others.

The CBT service dramatically reduced waiting times to access a full course of CBT treatment and simplified the process of referral, as students could be directly referred from the Student Health and Wellbeing Service. Anecdotally, onward referral to NHS services for those where it was required, was simpler in some cases, as some referrals were accepted directly from our team, rather than having to go via the GP or restart the process at the lowest rung of the ladder in NHS services. Furthermore, there were no adverse events noted in the time period covered in this report, indicating that care was safe and effectively governed.

Clinical outcomes were comparable or better than those observed for this age group in IAPT services, suggesting that students received a high quality of care. This is echoed in student feedback on the service, with high ratings on the Patient Evaluation Questionnaire and comments about the professionalism and broad benefits felt from receiving a course of treatment. Students commented that there should be greater awareness of this service within the university.

‘MIND-MANAGEMENT’ WORKSHOPS

Data-collection activities

Developing the content for the mind management workshops for undergraduates and post-graduates took place in several stages. We undertook focus groups for both different types of students separately, summarised the key themes and checked back with the students that these captured the discussions well. We then developed pilot content and sought feedback before offering the workshops to students.

Following input from the students, both sets of workshops evolved differently. The PG workshops were delivered as a linked series of 4 sessions offered once per week for 4 consecutive weeks. These began in April 2021 and were offered each month until September 2021 (when staff sickness absence meant workshop delivery had to pause). Initial workshops were offered online due to COVID-19 restrictions, but later workshops were run in person. The UG workshops were offered as 4 stand-alone sessions and were run as in-person sessions in March 2022.

The workshops were evaluated differently to one another because of this difference in delivery. Outcome measures for the PG workshops were given before the first session and at the end of the final session. The measures used were the PHQ9, GAD7 and WEMWBS-7, as well as additional unvalidated questions about the specific processes targeted by the workshops (how much participants had been bothered by uncertainty, negative self-critical thinking, and difficulties responding to setbacks in the recent past; see Appendix D).

Qualitative feedback from participants about what was helpful/unhelpful or what could be changed was also collected at the end of the final session. This data was used inductively to generate overarching themes.

The UG workshops were evaluated before and immediately after each individual workshop. Before the workshops, participants completed the PHQ2, the GAD2 and the WEMWBS-7, as well as 2 additional questions focused specifically on the content of the individual workshop. After the workshop (which was approximately 2 hours long), participants were asked 5 questions – how optimistic they feel, how relaxed they feel, how confident they feel about putting the workshop activities into practice, whether they found the workshop useful and whether it met their expectations. The rationale for these bespoke questions was that the time frame for measures like the PHQ2 is ‘over the past two weeks’ and therefore these measures are relatively insensitive to change over very short periods of time. Whereas more dynamic emotions can change over even short periods of time. Two of the items in the WEMWBS ask about motivation and relaxation, so these were selected to gauge the immediate pre-post impact.

There was also a free text response for comments (see Appendix D), and this data was considered in the light of the data from the PG workshops and deductive thematic analysis was used to combine the two sets of comments, as very similar themes emerged from both sets of responses.

Outcome measures were distributed one final time two-weeks following the final workshop/the workshop, but completion rates were low (n=3) and this data is not reported.

Focus groups

DETAILS OF PARTICIPANTS

Demographic details of the participants in the postgraduate and undergraduate focus groups are shown in table 5. In total, 42 students participated across 4 focus groups (two for postgraduates and two for undergraduates). In general, the mix of students represented a wide range of demographic characteristics, however, males were underrepresented in the undergraduate focus groups, and LGBTQIA+ students were under-represented in both focus groups. Alongside general emails, we used targeted recruitment focused on Newcastle University Students' Union societies that typically involve groups more vulnerable to mental health difficulties and/or minoritized groups.

Table 5: Demographic characteristics of focus group attendees

	Postgraduate	Undergraduate
Miscellaneous		
Full time / part time	22 / 2	20 / 0
Mature student	-	2 (10%)
Has perceived disability	-	4 (20%)
Year of programme		
1	3 (13%)	4 (20%)
2	8 (33%)	8 (40%)
3	9 (38%)	5 (25%)
4	4 (17%)	2 (10%)
Other	0	1 (5%)
Sexuality		
Asexual	0 (0%)	2 (10%)
Bisexual	3 (13%)	2 (10%)
Gay	1 (4%)	0 (0%)
Heterosexual	18 (75%)	12 (60%)
Pansexual	1 (4%)	0 (0%)
Other	0 (0%)	1 (5%)
No response	1 (4%)	3 (15%)
Socioeconomic status		
Upper class	3 (13%)	0 (0%)
Middle class	8 (33%)	11 (55%)
Working class	7 (29%)	7 (35)
Other	3 (13%)	0
No response	3 (13%)	2 (10%)

	Postgraduate	Undergraduate
Faculty		
Medical sciences	9 (38%)	11 (55%)
Agriculture & engineering	14 (58%)	3 (15%)
Humanities and social sciences	1 (4%)	6 (30%)
Gender		
Male	12 (50%)	2 (10%)
Female	12 (50%)	17 (85%)
Non-binary	0 (0%)	0 (0%)
Other	0 (0%)	0 (0%)
No response	0 (0%)	1 (5%)
Ethnicity		
White	13 (54%)	10 (50%)
Asian	3 (13%)	5 (25%)
Black	2 (8%)	2 (10%)
Other	3 (13%)	0 (0%)
Mixed	1 (4%)	1 (5%)
No response	2 (8%)	1 (5%)
Has parental responsibilities		
Yes	3 (13%)	0
No	21 (87%)	19 (95%)
Prefer not to say	0	1 (5%)

Postgraduate Workshops

CONTENT

The key issues raised in the postgraduate focus groups resulted in the development of the following 4 workshops:

1) Noticing when we are stuck – this covered the fundamental principles of CBT, identifying vicious cycles in thinking and key difficulties such as procrastination or overworking
2) Managing Self-Critical and Negative Thoughts – this covered perfectionism, procrastination, and comparison with others
3) Dealing with Setbacks – this covered negative reactions to unexpected events or setbacks in the PhD process and how to remain motivated and avoid a downward spiral
4) Getting Through Uncertainty – managing the uncertainty of a postgraduate research degree was a big theme and this workshop covered different mental responses to uncertainty (e.g. worry and hypothetical future thinking) that can create vicious cycles of their own and how to approach uncertainty differently

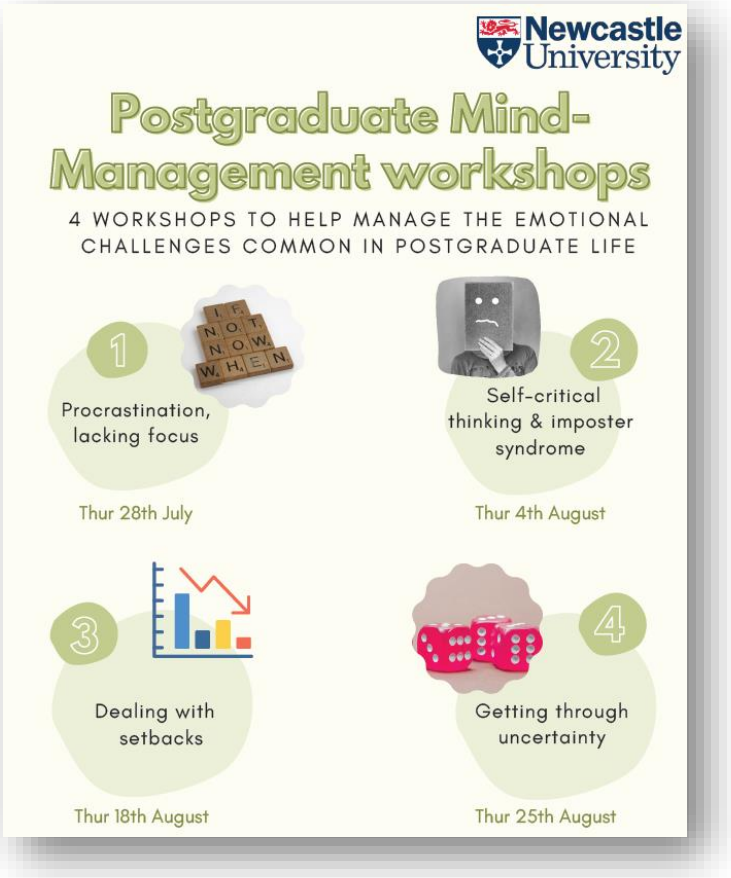

Figure 2: Advert for the PG mind management workshops

The best current evidence with regards to CBT in Higher Education (8) indicates that a key ingredient to effective CBT interventions in education is supervised practice[3]. Therefore the 4 workshops followed a similar structure to one another and re-iterated key skills with the chance to practice. Each workshop introduced the notion of the vicious cycle focused on the session topic and explored alternative perspectives and alternative behaviours. Participants had time to work through their own cycle and how the workshop content could apply to their own circumstances, with the opportunity for feedback and guidance from the workshop instructors (who were British Association of Behavioural and Cognitive Psychotherapies-accredited CBT therapists). Whilst the workshops were not group therapy, participants did get the chance to explore changes they wanted to make in their own lives and to practice applying the principles discussed and reviewing the impact the following week.

MENTAL HEALTH OUTCOMES

Tables 6 and 7 report the change in mental health outcomes associated with participating in the workshops. Note that there was a high degree of non-attendance at the workshops, with more than 50% of people who signed up not attending any of the sessions. As such, many more students completed the baseline measures (which were completed in advance of attending the first workshop) than completed the post-measures (completed at the end of the 4th session). The data in table 6 is therefore provided as all data available (n=35 baseline outcome measures and n=15 end-point measures), and as those datasets where it was possible to pair participants pre- and post-data (n=10). Data from one participant, who was an extreme outlier (they scored in the severely depressed and severely anxious range on the PHQ8 and GAD7 respectively and therefore was not the intended audience for these workshops), was excluded from the analysis due to the biasing effect on the mean.

Both depression and anxiety reduced from baseline to endpoint and wellbeing increased (table 6). The changes in depression and wellbeing were statistically significant (in the comparison using paired data) and were large effect sizes. On average, scores for depression fell from the top to the bottom of the mild range. The change in anxiety was not statistically significant and represented a medium effect size.

As the workshops were not designed as a treatment package for syndromal levels of depression and anxiety, we also measured changes in the key processes targeted by the workshops. The scores are summarised in table 7, but note that these are unvalidated measures and scores are from a single questionnaire item.

[3] Although the authors did not provide a specific definition, we reviewed the relevant papers this recommendation was based upon and interpreted it to mean the opportunity to practice the CBT skill in the presence of an instructor so that personalised feedback was available

Table 6: Average (standard deviation in brackets) scores for depression, anxiety and wellbeing at baseline and endpoint for all available data and paired-data only

	All		Paired-only (n=10)			
	Baseline (n=35)	End-Point (n=15)	Baseline	End-point	Mean difference	Effect size (d)
PHQ8	9.6 (4.6)	5.5 (6.1)	9.1 (4.0)	5.4 (4.4)	-3.7 (3.4)	1.09*
GAD7	8.4 (5.2)	5.3 (5.8)	7.6 (5.7)	5.3 (4.9)	-2.2 (4.2)	0.53
WEMWBS	19.7 (3.7)	23.2 (3.6)	19.6 (3.8)	23.4 (4.3)	+3.9 (3.7)	1.05*

*p<0.05, paired-samples t-test

Students identified they were less bothered by self-critical thoughts, uncertainty and difficulty dealing with setbacks in the two weeks leading up to the final workshop compared to the two weeks prior to the first workshop. These negative experiences were also rated as having had less of a negative impact on how they feel than prior to the workshops. However, the differences did not reach statistical significance in the paired data.

Workshop participants rated the workshops as very helpful, scoring them 4.2 out of a maximum possible 5 in terms helpfulness.

Table 7: Average scores (standard deviation in brackets) for the process-focused questions, as well as the mean ratings for the impact and helpfulness of the workshops

	All		Paired-only (n=10)			
	Baseline (n=35)	End-Point (n=15)	Baseline	End-point	Mean difference	Effect size (d)
Over the past two weeks, how much have you been bothered by: [a]						
Self-critical thoughts	2.8 (0.9)	2.3 (1.1)	3.0 (0.9)	2.1 (1.1)	-0.9 (1.2)	0.76
Uncertainty	2.6 (0.9)	2.3 (0.9)	2.6 (0.7)	2.2 (0.8)	-0.3 (0.9)	0.39
Coping with setbacks	2.5 (0.9)	2.2 (1.0)	2.5 (0.8)	2.1 (0.6)	-0.8 (1.1)	0.35
Taken together, how much have self-critical thoughts, uncertainty and problems coping with setbacks had a negative impact on how you feel over the past two weeks[b]*:*						
Impact	3.4 (1.0)	2.7 (1.1)	3.2 (0.7)	2.7 (1.0)	-0.4 (1.0)	0.55
How helpful did you find the skills workshops?[b]						
Helpful	-	4.2 (0.5)	-	4.2 (0.5)	-	-

[a] Scored from 1 (not at all) to 4 (nearly every day)

[b] Scored from 1 (not at all) to 5 (extremely)

PARTICIPANT FEEDBACK

The post-workshop evaluation questionnaire included free text boxes for further feedback on the workshops. Thematic analysis of the content generated two main themes with a number of sub-themes. The feedback largely focused on the content and learning within the workshops, and the logistical and organisational aspect. These themes are summarised and described below with illustrative quotes.

A. Content / Learning

The first main theme focuses on the content of the workshops and the learning involved for the students. In particular, the students commented on becoming able to be their own expert on their thoughts, gaining a new understanding of their difficulties and developing helpful behaviours for any future challenges.

i. Became own expert

Many of the students discussed how the workshops had allowed them to develop the tools and techniques to notice their own negative thoughts, issues and triggers. Thus, as a result they knew what to look out for moving forward and had become an expert in their own behaviour. They commented this increased their confidence and belief in themselves that they would be able to stop any negative cycles in the future.

- *"To notice the thoughts and triggers and how I respond and the unintended consequences"*
- *"Noticing unhelpful behaviour and thinking about that in context of the vicious cycle to improve actions/thoughts."*
- *"I found the 'noticing when you are stuck' exercises and identifying unhelpful thought patterns really useful…"*

ii. Gained an understanding

Some of the students also commented on how they had gained an understanding of their issues within a wider societal view, and this showed them how best to deal with their worries and helped to normalise how they were feeling. Many also commented that the workshop content and exercises, as well as discussions with other attendees at the workshop helped to reduce the feelings of loneliness they felt due to their difficulties.

- *" I learned what I am worried about may not become a reality. Actually completing some of the work relieves the anxiety of thinking about the work."*
- *"It was also reassuring to hear I am not alone and other students have experienced similar issues - not necessarily because it makes it go away, but it normalised feelings such as isolation and uncertainty, which in a way did make them less intimidating and more manageable. I also feel more empathetic towards my peers. I would definitely recommend the workshops to other PGRs.."*

iii. Developed helpful behaviours for future challenges

For the final sub-theme, the students commented on the techniques they had developed and tools they had learnt during the session would help with any future difficulties they may face.

- "*Also learnt that in any other difficult times I should do something towards reducing the negative possible scenario/outcome because even if the outcome is not good, there is something I can learn from it that will help me in the future. And this is better than just worrying inside my head and allowing it to overtake my life and reactions and waste my time and energy.*"
- "*The workshops have given me the chance to adapt and develop new behaviours*"

B. Logistics / Practicalities

For the second main theme, the students discussed the organisation and practical aspect of the workshops. In particular how the course was delivered and the need for extra materials for support in the future.

i. Course structure

The first sub-theme focuses on the delivery of the workshop and the exercises involved. Some students felt the breakout rooms were quite intense and would have preferred longer group discussion sessions. They feel this would have improved their experience further. Others commented on the content of the workshops and particular enjoyed learning about the theory and background of the topic.

- "*I would personally have found it easier to have fewer breakout rooms - depending on partners some people are quite clearly suffering quite a lot and it can be upsetting to try to counsel them. I was not majorly distressed and I am not worried enough about anyone to report anything said to me, but it was more just that I felt exhausted after.*"
- "*Maybe have more discussion time with the workshop presenters.*"
- "*I really liked hearing about the theory side of things.*"

ii. Extra materials

The final sub-theme focuses on the materials provided in the sessions. Some of the students commented that additional materials to take away from the sessions would be helpful to help learn more about the topic and as an additional form of support for any future challenges.

- "G*iven that the workshops are targeted at PhD students (who are mostly quite interested in reading!), I would appreciate some suggestions of further reading about CBT and self care, where appropriate*."
- "*Some more guidance and info about what can be helped using the skills learnt in the workshops*"

Undergraduate workshops

CONTENT

The key issues raised in the undergraduate focus groups resulted in the development of the following 4 workshops. The description of the workshops as advertised to students is included below:

1) Striking the balance

"I need to work, sleep and enjoy myself with my friends, but I only have enough time to do two of the three"
"There's always so much going on, it's relentless going from one assignment to the next"
This workshop covers mind management skills to help you lead a balanced life in the face of university demands
It covers:
• Mapping out the vicious cycles of thoughts, feelings and behaviours that happen in response to triggers that can make you feel 'out of balance'.
• The science behind motivation and what we can do about procrastination
• Different kinds of life activities and strategies you can use to improve your sense of balance

2) Prioritising what matters

"There's so many things competing for my time – friends, my course, societies, socials, my job… It's overwhelming what to do when. I feel like I'm always on the go, but always missing out on something"
This workshop focuses on mind management skills to help you identify your priorities and focus day to day on doing what matters
It covers:
• Mapping out the vicious cycles of thoughts, feelings and behaviours that happen in response to triggers that can make you feel 'down' or 'unfulfilled'.
• The relationship between meaningful activity and wellbeing
• How to assess and identify what is important to you
• How to align the things you do with your priorities

3) Adjusting to University Life

"Everything feels chaotic. We find things out at the last minute. I don't always know what I need to do or understand what's required. We can't get in touch with anyone to find out or people take ages to get back to you."
The system is definitely imperfect and that's stressful. Whilst this workshop can't change that, it can give you more skills to deal with those stressful thoughts and feelings and help you deal as best you can with the 'imperfect' university system
It covers:
• Mapping out the vicious cycles of thoughts, feelings and behaviours that happen in response to triggers that can make you feel stressed

• Understanding the psychological and physiological mechanisms of stress
• Helping you bring your coping abilities in line with your demands
• Problem- and emotion-focused strategies for dealing with stress

4) Social compare and despair

Everywhere I look there is someone smarter than me, someone who dresses better, someone who's more popular, someone who's got it together so much better than I have. Sometimes I feel like I don't really fit in anywhere and there's no one quite as much of an outsider as I am"

This workshop introduces mind management skills to support you to stop comparing yourself to others

It covers:

• Mapping out the vicious cycles of thoughts, feelings and behaviours that happen in response to triggers that can make you feel down or anxious due to comparing yourself to others
• Understanding why we compare ourselves to others and what happens when we listen to those inner negative thoughts in social situations
• Learning & applying attention training - a specific, evidence-based, strategy to deal with unhelpful comparisons
• Learning about unhelpful thought patterns that enable unhelpful comparisons to re-occur

PARTICIPATION AND MENTAL HEALTH OUTCOMES

There were 22 students who attended the pilot workshops, but after accounting for those who attended more than one workshop, this represented 16 unique individuals. The workshops were run on consecutive days within the same week, therefore only one post-workshop score is used for the students who attended more than one workshop (we have selected their highest rating, although this varied relatively little).

The workshops lasted 90 minutes, so outcome measures focused on feelings that could reasonably change over that time period. Two items of the WEMWBS ask about feelings of optimism and relaxation, so these were selected as the primary outcomes to measure at the end of the workshops (whilst the plan was to re-measure PHQ2, GAD7 and WEMWBS-7 two weeks post-workshops, completion rates were poor and this data is not reported). Despite the short time-scale involved, there were nonetheless increases in feelings of optimism and relaxation following the workshops (table 8). The changes were a medium effect size, with the change in how relaxed students felt reaching statistical significance.

Students rated their level of confidence in applying the learning from the workshops in the mid-range (an average score of 3.4 out of a maximum possible 5). This indicates further practice or follow-up workshops could be required.

Table 8: Average scores (standard deviation in brackets) for the pre- and post-measures from the undergraduate workshops

	Paired data n=16		
	Pre	Post	Effect size (d)
Optimistic[a]	3.1 (0.8)	3.7 (0.8)	0.50
Relaxed[a]	2.4 (0.8)	3.1 (0.9)	0.58*
How confident do you feel you can apply the learning from the workshops?[a]	-	3.4 (0.9)	-

[a] Scored 1 (not at all) to 5 (very much so)
*p<0.05, paired-samples t-test

PARTICIPANT FEEDBACK

The same key themes emerged from analysis of the free text responses from the participant feedback for the undergraduate workshops as for the postgraduate workshops. The theme definitions are not provided here again, but quotes specifically from the undergraduate workshops for each theme are added below (note that the subtheme 'extra materials' from the 'logistics / practicalities' theme did not emerge from this data, therefore no quotes are provided here).

A. Content / Learning

i. Became own expert

- "*Really helpful. Helps me to think about how I currently prioritise and values I have."*
- "*The workshop has helped serve as an initial start for me to start to think about my specific values and how they can affect what I'm doing."*

ii. Gained an understanding

- " *Really helpful to discover that it isn't just a me problem and actually a common cycle."*
- "*Made things a lot clearer, it debunked a lot of the negative thought patterns I am having that I thought were true."*
- "*Very helpful in trying to explain why I act certain way when I feel something. Interesting ideas on positive, negative reinforcement."*

iii. Developed helpful behaviours for future challenges

- "*Feeling more hopeful now."*
- "*I feel nervous but in the way of after reflecting on how much I need to improve."*
- "*I feel like I want to break down my tasks more, stop imagining the future product etc. I find my reflexivity is useful however I find myself questioning decisions I've made in the past. I feel this is unproductive and I need to keep my brain more in the present."*

B. Logistics / Practicalities

iii. Course structure

- *"I love these workshops and I think they should be done more regularly."*
- *"Only a thought, having so many 'Zoom' experiences created a weird atmosphere for me at the start, thinking, "wow, I'm actually here." It was very useful for me to actively be in the session and use the tasks."*
- *"Very easy to follow and encouraging to participate but not pushy."*
- *"A good session, with various useful exercises etc. I would be interested in further CBT/coping style sessions."*
- *"Really relatable & interactive."*

Summary

The workshops were also valuable, well-received and associated with a short-term improvement in mental health symptoms (the lack of longer-term data precludes a statement about their lasting impact). However, they were provided on a much smaller scale than originally intended (in response to student feedback) and would require significant additional resource to provide them on the scale necessary to achieve a widespread preventative effect. Even so, the method and scope of involvement of students in the design of these workshops is still relatively uncommon, even in the era where participant involvement is championed. This has resulted in a valuable additional resource for providing help to students with the mental and emotional demands of university education. The workshop materials are freely available to other universities via https://research.ncl.ac.uk/brighter/outputs/

IMPACT ON STAKEHOLDERS

There are a number of stakeholders impacted by the project including the SHWS, a range of NHS services (both those who would have received the referrals that we took instead and services we referred on to), the course directors and trainees on the DClinPsy and CBT Diploma and the project partners.

We have not undertaken formal evaluation of impact on stakeholders as of yet. We are keen to explore the impact of our service on the SHWS service at Newcastle, local primary care mental health services, the training courses to whom we offer placements and the trainees who undertake placements in the clinic.

Anecdotal reports from trainees who have undertaken placements in the clinic have been positive. They have especially valued the quality of the CBT training and the opportunity to see a range of clinical presentations. All students have passed their placements in our service and one has gone on to obtain a permanent role as staff in the service.

Broader impact

CLINICAL GOVERNANCE

In the process of developing and implementing this service, we developed our own clinical governance processes to ensure that care was safe and effective, and that both therapists and clients were appropriately protected in case of adverse events. Through discussions in the Mental Health Challenge Competition group, it was evident that clinical governance of wellbeing services more generally was an area that universities were seeking more guidance and support around. As such, we developed preliminary draft guidance, which was taken up by the University Mental Health Advisor's Network as the basis of a consultation exercise with their members and is in the process of being developed into a sector-wide guidance document.

ADOPTION OF SERVICE MODEL ELSEWHERE

One of the questions in our minds when we decided to try and establish a university-run CBT service, was whether this is a feasible way to provide mental health care to students. There are a number of benefits of university provision (e.g. delivery on campus, more control over the parameters of the service, focusing just on one age group with seasonal variation in presentation that limits the development of long waiting lists, provision of placements for therapy training programmes, enables clinically qualified staff to maintain professional accreditation/registration and clinical skills etc.), but there are also risks and disadvantages (e.g. requires clinical expertise, requires financial investment in staff, it can be difficult to clearly espouse the differences between different types and level of service to senior leaders at the university [and to the student and staff body], there is a degree of risk to tolerate and manage). Whilst we have been able to demonstrate it is feasible with a number of advantages above statutory provision, it is an open question whether the model can be successfully implemented elsewhere.

As part of our dissemination, we shared our experience with other clinical psychology training programmes via the Group of Trainers in Clinical Psychology annual conference and as part of a 'CBT in Higher Education' special interest group at the BABCP annual conference. Universities that run other training courses and whose staff have clinical expertise (often having senior roles in NHS services alongside their academic role) are in the strongest position to implement a similar model at other universities.

Following on from this, we have had communication from the universities of Bath, Lancaster, Oxford, Manchester and Exeter about establishing their own services. Furthermore, the publication of Health Education England's Psychological Professions Workforce Expansion plan (9) has led to a rapid and significant expansion in places on DClinPsy and CBT Diploma courses nationwide over the past 2 years. As such, there is marked pressure to expand clinical training placements and university clinics provide a means to achieve this. We have liaised directly with Manchester and Bath, who have both initiated services of their own.
We are very interested to watch developments in this area and to continue to support courses with our expertise in establishing university-led CBT services.

STRENGTHS AND LIMITATIONS OF THE APPROACH

The strength of our project lies in the robustness and comprehensiveness of the evaluation, especially for the clinic. Embedding routine outcomes monitoring from the outset and using a records-keeping system that enabled us not only to run regular reports on clinical outcomes but also to compare these directly to familiar metrics used in NHS services is a major strength. It has allowed direct comparability of outcomes with care that can be received in the NHS.

However, it is worth considering some of the limitations.

There were some aims we had initially that we have not achieved in the timescale (although intend to continue to work to find ways to achieve). One was to explore the impact of treatment in the clinic on educational outcomes and attainment. There are several challenges with this – records are kept in different ways in different parts of the university, and different processes are recorded on separate systems (e.g. the system for recording extension requests not only differs from one school to the next, but is a different system to that used to record degree stage outcome; likewise, degree stage transcripts (i.e. marks on exams and assignments) are stored in a different system to stage outcome (e.g. progressing to next academic year, repeating the year etc.). It is also not straightforward to determine what comprises a positive effect on educational outcomes. Whilst better retention and higher attainment seem positive outcomes in most cases, in others terminating studies and switching to a preferred life path can be a positive outcome.

We also intended to compare the cost-effectiveness of care in the University compared with IAPT. However, further exploration identified this was challenging, as IAPT costings processes are not clear and transparent, and it was also challenging to obtain comparable outcomes and retention data for students seen in our local IAPT service.

We are also aware that the demographic mix of students referred to us in the clinic is not representative of the student body, especially with regards to ethnicity. This is the focus of second funded project (see details in 'Conclusions and next steps' below).

The most frequent issue raised with the clinic was the fact we cannot continue to offer care to students once their student registration ends. This is due to the limitations of the public liability and professional indemnity cover. This is a significant issue for university-provided services. Continuity of care is important to young people and this represents a barrier to that. Whilst this prevents large waiting lists from building (as there is a limited timeframe in which individuals can be referred), it also creates limited access to the service for students in the second half of the final year of their degree or withdraws support from students who terminate their studies at a time that could be most challenging for them.

As mentioned above, the workshops were both markedly impacted by the pandemic and were changed in their ambition on the basis of student feedback. This led to smaller-scale, more focused provision than intended. There is also a multitude of communication channels at the university and sending regular messaging to students to advertise new cycles of workshops is time consuming and resource-intensive.

Finding ways to truly integrate mental health literacy in the university curriculum is still needed and we are exploring this further in another funded project (see details in 'Conclusions and next steps' below).

We also noted that the bandwidth of suitability for the workshops was reasonably narrow. Whilst the majority of participants appropriately identified that the workshops were appropriately pitched for them, some individuals had very high levels of anxiety and depression. All of the workshops re-iterate signposting information for other services and we re-designed some of the workshop marketing materials to target those with mild depression and anxiety. But having a direct referral pathway from the workshops to the PTTRC could be something valuable to explore in the future.

CONCLUSIONS & NEXT STEPS

The project successfully established a university-run CBT service that achieved commensurate clinical outcomes to NHS care with shorter waiting times and higher engagement rates. With almost 300 referrals in a 26 month period and over half of those referred completing or still in treatment in the time-frame of the Mental Health Challenge Competition (MHCC) funding, this has added sizeable additional capacity to existing provision. There was positive feedback from the students that the care was person-centred, effective and professional. There is interest from other Universities with existing expertise to replicate this model elsewhere, although replicating it in universities without clinical training programmes would require further support and resources.

Next Steps

The clinic will continue beyond the end of the MHCC, with staff salaries being picked up by the Faculty of Medical Sciences. Furthermore, staff involved in the clinic (Dr Lucy Robinson) have been successful in securing further funding from the Medical Research Council's Adolescent Mental Health and the Developing Mind funding call and from the Office for Students in the funding call to improve access to postgraduate education opportunities for Black, Asian and minority ethnic students.

The Nurture-U project, funded by the MRC, is in collaboration with 5 other UK universities and will pioneer digitally-supported CBT in our service, as well as establish a curriculum-embedded Mental Health Literacy programme (this will be offered as a credit bearing module from the start of the September 2022 academic year), and undertake a longitudinal survey of student mental health over 3 years.

The Office for Students-funded Postgraduate Research Opportunities: North East (PRO:NE) is in collaboration with the 5 North East universities, and the clinic's role in that project is to explore access barriers to mental health support for racially minoritized groups and develop a specialist care pathway and/or clinician training package to ensure equity of access to and outcome from tailored, effective mental health support to all students irrespective of their ethnicity.

There will also be further outputs from the data collected in our service exploring contributors to outcomes from CBT. Alongside routine outcomes data, clients are asked for consent to use their clinical data for research purposes and we collect a battery of measures at assessment that may predict subsequent engagement with and outcome from CBT. We have an interest in identifying students vulnerable to longer-term difficulties with their mental health and whether more intense support at such a key developmental timepoint can alter that trajectory.

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APPENDICES

APPENDIX A: ROUTINE OUTCOME MEASURES

PHQ-9

Over the **last 2 weeks**, how often have you been bothered by any of the following problems?		Not at all	Several days	More than half the days	Nearly every day
1	Little interest or pleasure in doing things	☐	☐	☐	☐
2	Feeling down, depressed, or hopeless	☐	☐	☐	☐
3	Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4	Feeling tired or having little energy	☐	☐	☐	☐
5	Poor appetite or overeating	☐	☐	☐	☐
6	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7	Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8	Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9	Thoughts that you would be better off dead or hurting yourself in some way	☐	☐	☐	☐
				Total score:	

Q6 CORE10	I made plans to end my life in the last 2 weeks	No ☐	Yes ☐

GAD-7

Over the **last 2 weeks**, how often have you been bothered by any of the following problems?		Not at all	Several days	More than half the days	Nearly every day
1	Feeling nervous, anxious or on edge	☐	☐	☐	☐
2	Not being able to stop or control worrying	☐	☐	☐	☐
3	Worrying too much about different things	☐	☐	☐	☐
4	Trouble relaxing	☐	☐	☐	☐
5	Being so restless that it is hard to sit still	☐	☐	☐	☐
6	Becoming easily annoyed or irritable	☐	☐	☐	☐
7	Feeling afraid, as if something awful might happen	☐	☐	☐	☐
				Total score:	

PHOBIA SCALES

Choose a number from the scale below to show how much you would avoid each of the situations or objects listed below. Then write the number in the box opposite the situation

0 1 2 3 4 5 6 7 8

Would not avoid it — Slightly avoid it — Definitely avoid it — Markedly avoid it — Always avoid it

1	Social situations due to a fear of being embarrassed or making a fool of myself	
2	Certain situations because of a fear of having a panic attack or other distressing symptoms (such as a loss of bladder control, vomiting or dizziness)	
3	Certain situation because of a fear of particular objects or activities (such a animal, heights, seeing blood, being in confined spaces, driving or flying)	

W&SAS

People's problems sometimes affect their ability to do certain day-to-day tasks in their lives. To rate your problem look at each section and determine on the scale provided how much your problem impairs your ability to carry out the activity. Write the number in the box after each item.

0 1 2 3 4 5 6 7 8

Not at all Slightly Definitely Markedly Very severely

1	**WORK (or STUDY** if you are in full time education) – if you are retired or choose not to have a job for reasons unrelated to your problem, write n/a (not applicable)	
2	**HOME MANAGEMENT** – Cleaning, tidying, shopping, cooking, looking after home/children, paying bills etc.	
3	**SOCIAL LEISURE ACTIVITIES** – With other people, e.g. parties, pubs, outings, entertaining etc.	
4	**PRIVATE LEISURE ACTIVITIES** – Done alone, e.g. reading, gardening, sewing, hobbies, walking etc.	
5	**FAMILY AND RELATIONSHIPS** – Form and maintain close relationships with others, including the people that I live with	

PHQ9 & GAD7 Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

APPENDIX B: Definitions of recovery and reliable change

Definitions:

Recovered – a client meets the definition for recovery if they

1) were above caseness[4] at the start of treatment
2) were below caseness at the end of treatment
3) received at least 2 sessions of treatment (exclusive of any assessment appointments)
4) have at least two outcome measures on record

The threshold for caseness on the PHQ9 is a score ≥10, and on the GAD7 it is a score ≥8. Each of the ADSMs has their own threshold for caseness (which can be found in Appendix D of the IAPT manual (4)).

Reliably improved – a client meets the definition for reliable improvement if they

1) received at least 2 sessions of treatment (exclusive of any assessment appointments)
2) have at least two outcome measures on record
3) have shown a reduction in scores that exceeds the threshold for reliable change[5] for the appropriate outcome measure. The appropriate outcome measure depends on the client's diagnosis.

The threshold for reliable change on the PHQ9 is a score change ≥6 points, and on the GAD7 is a score change ≥4 points. Each of the ADSMs has their own threshold for reliable change (which can be found in Appendix D of the IAPT manual (4)).

[4] Caseness is the point at which the client is deemed to be a 'clinical case'. Their score on the measure is sufficiently high to suggest they are likely to meet diagnostic criteria for the relevant disorder.

[5] a score change greater than would be expected in 95% of cases on the basis of re-administration alone. Reliable change therefore takes into account the test-retest reliability of the measure.

APPENDIX C: Patient Experience Questionnaire

The following questions are rated on a 5-point likert scale (At all times,

Most of the time, Sometimes, Rarely, Never):

1. Did staff listen to you and treat your concerns seriously?
2. Do you feel that the service has helped you to better understand and address your difficulties?
3. Did you feel involved in making choices about your treatment and care?
4. On reflection, did you get the help that mattered to you?
5. Did you have confidence in your therapist and his / her skills and techniques?

The following question is rated yes/no:

6. Did you experience any problems or difficulties which meant that the service you received did not run smoothly?

The following question has a free-text response box:

7. Please use the space below to tell us about your experience

APPENDIX D: Workshop outcome measures

POSTGRADUATE WORKSHOPS BASELINE MEASURE

Pre-workshops baseline

So we can measure the impact of these workshops, we ask everyone to answer 3 short questionnaires at three time points - before the workshops, after the workshops and 4 weeks later.

So that we are able to link your answers today to your other responses, please enter your student number:

_____

PHQ9 and GAD7 (see appendix 6.1)

WEMWBS-7: Below are some statements about feelings and thoughts. Please tick the box that best describes your experience of each over the last 2 weeks.

	None of the time (1)	Rarely (2)	Some of the time (3)	Often (4)	All of the time (5)
I've been feeling optimistic about the future					
I've been feeling useful					
I've been feeling relaxed					
I've been dealing with problems well					
I've been thinking clearly					
I've been feeling close to other people					
I've been able to make up my own mind about things					

What is the issue that you most want these workshops to help with?

_____

How much has this issue impacted you negatively over the past 2 weeks?

Not at all / A little / A moderate amount / A lot / Extremely

How often have you been bothered by self-critical thoughts over the past 2 weeks?

Not at all / Several days / More than half the days / Nearly every day

How often have you been bothered by uncertainty over the past 2 weeks?

Not at all / Several days / More than half the days / Nearly every day

How often have you experienced difficulties coping with a setback over the past 2 weeks?

Not at all / Several days / More than half the days / Nearly every day

Taken together, how much have self-critical thoughts, uncertainty and dealing with setbacks had a negative impact on how you feel over the past 2 weeks?

Not at all / A little / A moderate amount / A lot / Extremely

POSTGRADUATE WORKSHOPS ENDPOINT MEASURE
Post-workshops endpoint

So we can measure the impact of these workshops, we ask everyone to answer 3 short questionnaires at three time points - before the workshops, after the workshops and 4 weeks later.

So that we are able to link your answers today to your other responses, please enter your student number:

PHQ9, GAD7 (see appendix 6.1) and WEMWBS-7 (see appendix 6.3.1)

1. Did the workshops cover the issue that you most wanted help with?

   Yes / No

2. How much did the workshops help you deal with this issue differently?

   Not at all / A little / A moderate amount / A lot / A great deal

3. How much has the issue you most wanted help with negatively impacted how you feel you over the past 2 weeks?
   Not at all / A little / A moderate amount / A lot / Extremely
4. How often have you been bothered by self-critical thoughts over the past 2 weeks?

   Not at all / Several days / More than half the days / Nearly every day

5. How often have you been bothered by uncertainty over the past 2 weeks?

   Not at all / Several days / More than half the days / Nearly every day

6. How often have you experienced difficulties coping with a setback over the past 2 weeks?

   Not at all / Several days / More than half the days / Nearly every day

7. Taken together, how much have self-critical thoughts, uncertainty and dealing with setbacks had a negative impact on how you feel over the past 2 weeks?

   Not at all / A little / A moderate amount / A lot / Extremely

8. How helpful did you find the skills workshops?

   Not at all helpful / Slightly helpful / Moderately helpful / Very helpful / Extremely helpful

9. What have you learned from the workshops that you will put into practice?

_____

10. Do you have any suggestions how the workshops could be improved?

    _____

11. What would you like to see included in the workshops to tackle the issue you most wanted help with?

    _____

UNDERGRADUATE WORKSHOPS BASELINE MEASURE (EXEMPLAR)

NOTE: The highlighted questions were customised for each workshop

Questionnaire – Striking the balance Mind Management workshop

Last 6 digits of student number:

Q1) In the last two weeks, how often have you been bothered by the following symptoms: (please circle one answer)

'*Feeling down, depressed or hopeless':*

Not at all Several days More than half the days Nearly every day

'*Little Interest or pleasure in doing things':*

Not at all Several days More than half the days Nearly every day

Q2) In the last two weeks, how often have you been bothered by the following symptoms: (please circle one answer)

'*Feeling nervous, anxious, or on edge'*

Not at all Several days More than half the days Nearly every day

'*Not Being able to stop or control worrying'*

Not at all Several days More than half the days Nearly every day

Q3) Below are some statements about feelings and thoughts. Please tick the box that best describes your experience over the last 2 weeks

	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	○	○	○	○	○
I've been feeling useful	○	○	○	○	○
I've been feeling relaxed	○	○	○	○	○
I've been dealing with problems well	○	○	○	○	○
I've been thinking clearly	○	○	○	○	○
I've been feeling close to other people	○	○	○	○	○
I've been able to make up my own mind about things	○	○	○	○	○

Q4) How often have you been bothered by lack of motivation and procrastinating in the past two weeks? (Please circle one answer)

Not at all Several days More than half the days Nearly every day

Q5) How often have you struggled to maintain a 'balance' of behaviours in your day to day life over the past two weeks?

Not at all Several days More than half the days Nearly every day

UNDERGRADUATE WORKSHOPS ENDPOINT MEASURE (EXEMPLAR)

NOTE: The highlighted questions were customised for each workshop

Please fill these questions in at the end of the workshop

Q1) How optimistic do you now feel about the future (please circle one answer)

Not at all A little Unsure A lot Very much so

Q2) How relaxed do you feel (please circle one answer)

Not at all A little Unsure A lot Very much so

Q3) How confident do you feel you will be able to use activity scheduling with a balance of activities to manage motivation/procrastination (please circle one answer)

Not at all A little Unsure A lot Very much so

Q4) Have you found this workshop useful?

Yes No

Q5) Did the workshop meet your expectations?

Yes No

Q6) Please use the space below to expand on any of the above answers, or any other feedback you have following this workshop