Student Mental Health

RECOMMENDATIONS FOR POLICY IN HIGHER EDUCATION

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1. Summary

Across Europe, the mental health of students has become one of the most pressing structural challenges facing higher education institutions (HEIs). Rising levels of anxiety, depression and stress-related disorders, as well as crisis situations, affect student well-being, academic outcomes, engagement, retention rates, staff workload, and institutional stability.

HEIs are increasingly recognising that teaching staff require the skills to support students with mental health issues, communicate effectively and refer them to professional support services. Within the Erasmus+ project 'Support for University Student Mental Health – Training for Teaching Staff' (SUNMENTORS)[1], a specialist, evidence-based e-learning programme was developed to address this need.

However, cross-national experience demonstrates that training initiatives alone do not produce a sustainable systemic impact. Without institutional embedding, participation remains uneven, referral processes remain unclear, and responsibility becomes fragmented across organisational units.

This policy paper therefore provides a comprehensive HEI governance framework for embedding improved student mental health within institutional structures. It is primarily intended for the senior leadership team (e.g. education, diversity, inclusion and student affairs), as well as deans and other decision-makers in European HEIs.

It is argued here that student mental health must be recognised as an institutional governance issue that cuts across all areas of provision. Such integration would strengthen teaching quality, improve student academic outcomes, enhance inclusive participation, stabilise retention and reduce institutional risk exposure.

The embedding of mental health competence does not represent an expansion of institutional responsibility, but rather a strategic refinement of existing objectives related to educational quality, equity, and organisational resilience.

2. Student Mental Health as a Systemic Governance Challenge

Historically, student mental health was treated as an additional support service. Counselling services operated alongside academic structures, addressing individual cases on a reactive basis.
Current developments require a shift in perspective. Student mental health now has systemic implications:

- Increased requests for deadline extensions or alternative examination formats
- Faculty uncertainty regarding crisis situations
- Escalation risks in severe cases

1 For more information about the project, please visit: www.sunmentors.eu

These developments influence institutional performance indicators. Retention and progression rates are affected. Faculty experience increased emotional labour. Reputational risk exposure increases in the event of high-profile incidents.

Without institutional support for mental health, responses become inconsistent. Individual faculty members may adopt different approaches. Students experience variability in support. Administrative processes become reactive rather than predictable.

However, embedding mental health competence can transform a reactive model into a structured, preventive governance approach at HEIs.

3. The role of teaching staff within structured institutional frameworks

Teaching staff are often the first to observe, or be contacted by, students who are struggling with their mental health. They are well placed to spot behavioural changes, academic disengagement/decreased grades and emotional withdrawal.
However, without institutional clarity, faculty members may hesitate to act or take on more responsibility than they should.

Against this background, the SUNMENTORS E-learning programme offers:

- Mental health literacy
- Stigma-sensitive communication
- Early identification skills
- Referral competence
- Role and boundary awareness

Institutional embedding ensures that these competencies are applied consistently. It is important to note the training does not intend to deliver counsellor competences to teaching staff.

Clear referral maps, transparent recording methods, crisis escalation protocols and confidentiality standards reduce uncertainty. Transparent support structures increase faculty confidence.

4. Organisational Preconditions for Sustainable Embedding

Incorporating mental health knowledge, awareness, strategies and skills for teaching staff in HEIs requires more than strategic endorsement or the provision of training modules. It requires organisational feasibility. Without alignment between institutional expectations and operational realities, even well-designed initiatives risk being perceived as merely an ‘add-on’ or symbolic.

a) One of the most critical preconditions concerns **workload structures.** Teaching staff operate within an increasingly complex set of role expectations, including delivering high-quality teaching, engaging in research, fulfilling administrative duties, contributing to internationalisation, and participating in quality assurance processes. In this environment, emotional labour (including responding to students with mental health concerns) often remains invisible in formal workload models. If institutions expect staff to meaningfully engage with mental health awareness yet fail to acknowledge the relational and emotional dimensions of teaching, the result will be tension and resistance. Therefore, sustainable embedding requires institutional leadership to recognise emotional labour as an integral component of academic work. This does not imply lowering academic standards or expanding therapeutic responsibilities. Rather, it means acknowledging that supportive communication, the early identification of mental health concerns, and the responsible referral of students are all part of contemporary teaching practice. Workload frameworks and performance dialogues should reflect this reality. When faculty perceive alignment between institutional messaging and performance expectations, engagement increases.

b) **Communication norms** represent a second decisive factor. In many institutions, informal expectations of constant availability (such as rapid email responses, flexibility outside standard hours and immediate accommodation of student requests) create blurred boundaries between professional responsibility and personal capacity. In such environments, mental health initiatives may unintentionally intensify pressure, as staff feel compelled to assume additional availability in the name of student support. Clear communication policies that protect reasonable response times and define appropriate channels for urgent concerns are therefore essential. Institutional clarity reduces ambiguity and prevents well-intentioned staff from overextending themselves.

c) Visible **managerial support** is equally critical. Teaching staff must know that in situations involving serious distress or crisis, they are not isolated decision-makers. Leadership (at departmental, faculty and central levels) should communicate clearly that support structures exist and that escalation procedures are legitimate and encouraged.

d) A further organisational consideration concerns **consistency across units.** If faculties or departments interpret mental health policies differently, students encounter uneven responses and staff remain uncertain about shared standards. Institutional coordination (through central guidelines, shared referral maps and harmonised communication) enhances predictability. Deans and quality assurance units play a key role in ensuring that institutional principles are implemented coherently across faculties.

e) Finally, credibility depends on coherence between **policy and practice.** HEI increasingly emphasise well-being, inclusion and resilience within strategic documents. However, if operational structures (workload allocation, evaluation criteria, promotion processes) contradict these commitments, institutional messaging loses legitimacy. Embedding mental health competence therefore requires a realistic appraisal of organisational culture and incentive structures. Alignment does not require radical transformation, but it does require intentional adjustment.

In essence, sustainable embedding of mental health competence is not primarily a question of additional resources. It is a question of organisational alignment. When policy frameworks, workload models, communication norms and leadership practices support rather than undermine mental health initiatives, training becomes effective and institutional resilience strengthens.

5. Integration into Teaching and Learning Governance

For mental health awareness and competence to become stable components of institutional practice, it must be embedded within existing teaching and learning governance structures rather than positioned as an external or temporary initiative. Sustainable impact arises when training is integrated into the institutional architecture that already shapes academic development, quality enhancement and professional standards.

A primary entry point for such embedding is the **institutional Centre for Teaching and Learning or equivalent academic development unit.** These centres often function as hubs for pedagogical innovation, staff qualification and quality enhancement. By locating mental health training within this established environment, institutions signal that mental health competence is part of contemporary teaching professionalism. It becomes aligned with didactic excellence, inclusive pedagogy and student-centred learning, rather than framed as an additional welfare concern. Furthermore, integration within established development structures ensures continuity beyond project funding cycles and prevents fragmentation.

Teaching qualification frameworks provide a second strategic lever. Many European higher education systems require or encourage participation in structured teaching certificates, probationary training programmes or pedagogical qualification pathways for newly appointed academic staff. Embedding mental health awareness within these frameworks normalises competence as an expected dimension of teaching capability. When faculty encounter mental health literacy as part of their foundational pedagogical training, the topic gains legitimacy and becomes institutionally standardised.

Onboarding programmes represent another critical integration point. The first months of academic employment shape professional norms and institutional expectations. Including mental health awareness, referral clarity and boundary definitions within onboarding signals early that student well-being is interconnected with teaching responsibility. It also ensures that new staff are informed about support structures before encountering complex student situations.

Continuing professional development systems offer further opportunities for sustained embedding. Academic careers evolve, and expectations shift over time. Integrating mental health training within ongoing professional development pathways allows staff to revisit and deepen competence as institutional needs develop. Regular visibility within development catalogues and internal communication channels prevents the topic from fading into marginality.

Positioning the training within established academic development structures enhances sustainability in several ways. First, it avoids duplication of administrative systems. Second, it aligns mental health competence with existing quality assurance processes. Third, it embeds responsibility within recognised institutional units, ensuring accountability and long-term oversight.

Institutions can strengthen engagement through carefully designed incentives. Professional development credits, certificates acknowledged within promotion processes, or recognition within teaching excellence schemes enhance participation. When faculty perceive that engagement contributes to their professional profile and career progression, uptake increases organically.

Practice Example

To illustrate how such integration may unfold in practice: Example TU Dortmund.

The Centre for Teaching and Learning integrates the SUNMENTORS training into its annual professional development catalogue. Participants receive a certificate.

Participation is highlighted during new staff onboarding sessions, where referral pathways are presented alongside information on digital learning tools and assessment regulations.

Deans are asked to communicate the availability of the training within faculty meetings and to encourage participation.

6. Inclusion, Equity and the Social Dimension

Student mental health does not exist in isolation from broader structural inequalities. Mental health challenges are shaped not only by individual vulnerability but also by socio-economic, cultural and institutional conditions. Students from disadvantaged backgrounds often face cumulative stressors that increase their exposure to mental health challenges. Financial insecurity, precarious housing, family responsibilities, migration experiences, discrimination, language barriers and limited social capital can compound academic pressure. For first-generation students in particular, navigating HEI structures may involve additional uncertainty and isolation.

Within the European Higher Education Area[2] The Social Dimension emphasises equitable access, participation and completion for diverse student populations. Mental health is directly implicated in this agenda. When psychological distress remains unrecognised or inadequately addressed, existing inequalities are reinforced. Students who lack familiarity with institutional systems may be less likely to seek help. Those who fear stigma or academic consequences may conceal difficulties until they escalate. As a result, disadvantage accumulates over time, affecting academic progression and increasing dropout risk.

2 The European Higher Education Area (EHEA) is a multilateral framework that harmonizes higher education systems across Europe to ensure comparability, compatibility, and quality. It enables students and academics to move more easily between countries while having their degrees recognized. It emerged from the Bologna Process (1999), an intergovernmental reform initiative.

Institutional embedding is crucial in this regard. If mental health awareness depends solely on individual faculty interest, inclusive support becomes uneven across departments. Students encounter variability that may disproportionately affect those already navigating structural disadvantage. Governance-level integration ensures that mental health competence becomes a shared institutional norm rather than an optional personal attribute.

Practice Example:
In a UK HEI the E-training is mandatory for all new staff. They are required to have completed all modules within the first 12 months of tenure. Existing staff are required to complete the training within 24 months. In-person workshops complement the training in both cases.

Mental health integration thus contributes directly to widening participation and equitable completion objectives. By embedding awareness within teaching governance, universities strengthen not only student well-being but also their broader social mission within the European Higher Education Area.

7. Implementation Model: From Initiative to Institutionalisation

Transforming a mental health training initiative into a sustainable institutional practice requires more than formal approval. Institutionalisation is a process of structured integration, cultural alignment and procedural consolidation. It unfolds over time and benefits from a phased approach that balances strategic clarity with operational realism.

The *first phase* involves explicit **strategic endorsement at leadership level.** Institutionalisation begins when senior leadership (including rectorates and relevant vice-rectorates) formally recognise student mental health as a cross-cutting governance issue as well as a pressing economic issue due to the high prevalence of withdrawals for mental health concerns.. This endorsement should be communicated clearly and consistently, linking mental health competence to existing institutional priorities such as teaching quality, inclusion, retention and risk management.

Strategic positioning prevents the initiative from being perceived as peripheral or temporary. Importantly, endorsement must go beyond symbolic statements. It should clarify responsibility, designate coordinating units and outline intended integration pathways.

The *second phase* focuses on **structural integration within academic development systems.** Rather than creating parallel structures, institutions should embed the training within established professional development frameworks. Centres for Teaching and Learning, staff qualification pathways, onboarding programmes and continuing professional development catalogues provide stable entry points. Structural integration ensures visibility, continuity and accountability. It also normalises participation by positioning mental health competence alongside other pedagogical skills such as assessment design or digital teaching methods. This phase transforms the initiative from a project-based offering into part of institutional infrastructure.

The *third phase* **introduces incentivised participation mechanisms.** While maintaining voluntary engagement, institutions can strengthen uptake through professional recognition. Assigning continuing professional development credits, integrating certificates into staff reviews, promotion criteria or acknowledging participation within teaching excellence frameworks enhances motivation. Incentivisation should be proportionate and aligned with institutional culture. The objective is not to compel participation, but to communicate that mental health competence is professionally valued. Over time, such recognition contributes to cultural normalisation.

The *fourth phase* addresses **procedural clarity through referral mapping and communication.** Training effectiveness depends on clear institutional pathways. Staff must know whom to contact, how to escalate concerns and what confidentiality standards apply. Institutions should therefore develop and disseminate accessible **referral maps, crisis protocols and communication guidelines.** These tools should be reviewed regularly and embedded within internal communication platforms.

The *fifth phase* integrates **monitoring and quality review.** Institutionalisation is incomplete without feedback mechanisms. Participation rates, staff feedback and referral clarity can be incorporated into existing quality assurance cycles. Monitoring does not require extensive additional bureaucracy; rather, it involves embedding reflection within annual teaching reviews or strategic reporting processes. Continuous evaluation allows institutions to adjust implementation strategies, identify barriers and sustain leadership attention.

Crucially, implementation should be iterative rather than abrupt. Attempting comprehensive institutional change within a single cycle may generate resistance or overload. A phased approach allows gradual cultural adaptation. Early adopters can serve as internal ambassadors, demonstrating practical relevance. Feedback loops enable refinement before scaling across faculties.

Ultimately, successful implementation reflects coherence between policy, structure and culture. Institutions that adopt a phased and iterative approach increase the likelihood that mental health integration will endure beyond project cycles and become a stable element of governance practice.

8. Monitoring, Evaluation and Continuous Improvement

Sustainable embedding of mental health competence requires more than initial implementation. It depends on systematic monitoring and continuous institutional learning. Rather than creating parallel reporting structures, mental health integration should be incorporated into existing quality assurance and enhancement cycles. This ensures coherence, avoids administrative duplication and reinforces the perception that mental health is part of mainstream governance rather than an auxiliary initiative.

Monitoring begins with basic participation data. Tracking the number and proportion of staff who complete the training provides a first indication of reach and visibility. However, participation rates alone are insufficient.

Institutions should also assess and monitor qualitative indicators such as faculty confidence in recognising distress, clarity about referral pathways and perceived usefulness of the training in everyday teaching practice. Short internal surveys, focus groups or reflective components within teaching evaluations can provide valuable insight without generating excessive administrative burden.

Referral clarity represents a particularly important indicator. Institutions can periodically review whether staff know whom to contact in non-urgent and urgent cases, whether referral procedures are consistently understood across faculties and whether communication channels remain accessible and up to date. Where confusion persists, adjustments can be made proactively rather than reactively.

Integration within onboarding and academic development systems should also be reviewed. Monitoring whether new staff systematically encounter mental health competence during induction processes helps ensure that embedding is generationally sustainable. Over time, mental health awareness should become a standard component of professional formation rather than dependent on voluntary late adoption.

Importantly, monitoring should not be framed as compliance control. Its primary purpose is institutional learning. By incorporating mental health embedding into **annual quality reports**, teaching enhancement reviews or strategic planning cycles, leadership signals ongoing commitment. Continuous feedback allows refinement of training content, communication strategies and procedural clarity.

9. Risk mitigation and organisational stability

Embedding mental health competence proactively within institutional structures contributes directly to risk mitigation and organisational stability. HEI increasingly operate in complex and highly visible environments in which critical incidents, whether related to severe student distress, self-harm, or public crises, can have far-reaching academic, reputational and legal consequences. In such contexts, reliance on ad hoc responses or individual judgement is insufficient.

Proactive embedding reduces the likelihood of crisis escalation by strengthening early identification and structured referral. When teaching staff are equipped to recognise warning signs and are supported by clearly defined procedures, concerns can be addressed at an earlier stage. Early intervention does not eliminate all risk, but it significantly lowers the probability that situations deteriorate unnoticed or unmanaged. Structured pathways enable proportionate and timely responses, thereby preventing unnecessary escalation.

Clear institutional procedures also enhance consistency across faculties and departments. In the absence of shared standards, responses to student mental health concerns may vary widely, creating uncertainty for both staff and students. Inconsistent practice increases institutional vulnerability, particularly in situations where decisions are later scrutinised. Transparent recording and confidentiality guidelines and visible leadership support reduce ambiguity and protect staff from isolation in difficult decision-making processes.

Faculty confidence plays a crucial stabilising role in teaching environments. When staff feel uncertain about how to respond to students struggling from mental health concerns, teaching quality and classroom climate may suffer. Conversely, when faculty understand their role, boundaries and available support systems, they are better able to maintain academic continuity while responding responsibly. This balance between care and academic standards contributes to predictable and stable learning environments.

10. Strategic Recommendations

Sustainable embedding of student mental health within higher education institutions requires coordinated leadership, structural alignment and long-term commitment. The following strategic recommendations outline how HEI leadership, including rectorates, vice-rectorates, deans and senior governance actors, can translate principle into practice.

1. **HEI leadership should formally recognise student mental health as a structural determinant of teaching quality, inclusion and institutional performance.** This recognition should not remain implicit. It should be reflected explicitly within institutional strategy documents, teaching and learning frameworks, inclusion strategies and student success plans. Positioning mental health within these core policy documents signals that it is not an auxiliary welfare issue but a dimension of educational governance. When leadership frames mental health competence as contributing to academic excellence and equitable participation, institutional legitimacy increases and fragmentation decreases.
2. **Training programmes aimed at strengthening mental health awareness and competence** must be embedded within established academic development systems. Rather than operating as stand-alone initiatives or temporary projects, mental health training should be integrated into Centres for Teaching and Learning, teaching qualification frameworks, onboarding programmes and continuing professional development structures. Embedding within existing institutional architecture ensures continuity beyond project funding cycles and prevents duplication of administrative processes. It also reinforces the message that mental health competence forms part of contemporary academic professionalism.
3. **Clear referral pathways** must be institutionalised and communicated consistently across faculties. Teaching staff need clarity regarding whom to contact in situations of concern, how to escalate urgent cases and what confidentiality standards apply. Institutional guidelines should define boundaries of responsibility and ensure alignment with data protection regulations. Without procedural clarity, training remains theoretical. With clear and accessible recording and referral structures, competence translates into consistent practice. Institutionalisation of protocols protects students, supports faculty and reduces institutional vulnerability in crisis situations.
4. **Participation in mental health training should be incentivised in ways that respect academic autonomy while encouraging engagement.** Mandatory participation may be counterproductive in certain institutional cultures. Instead, leadership can assign continuing professional development credits, provide recognised certificates or incorporate participation within teaching excellence schemes. When teaching staff perceive that engagement contributes to their professional development and institutional recognition, uptake increases organically.

5. **Monitoring and evaluation** mechanisms must ensure long-term sustainability. Embedding mental health competence should be incorporated into existing quality assurance cycles rather than generating separate reporting systems. Institutions can review participation rates, faculty confidence levels, clarity of referral processes and integration within onboarding procedures. Feedback gathered through teaching evaluations or internal surveys can inform continuous refinement. Monitoring should not be framed as compliance control but as institutional learning. Regular review ensures responsiveness to evolving student needs and organisational contexts.

Beyond these core measures, leadership should ensure coherence across governance levels. Senior leadership teams provide strategic anchoring and risk management oversight. Team members integrate mental health within teaching, inclusion and student success frameworks. Deans translate policy into faculty-level practice. Coordinated action across these levels prevents fragmentation and strengthens institutional credibility.

Importantly, implementation should follow a phased and iterative approach. Sustainable institutionalisation requires time for cultural adaptation and procedural refinement. Early integration within academic development systems can be followed by gradual expansion, informed by feedback and evaluation.

Taken together, these strategic measures move mental health competence from initiative to infrastructure. They ensure that support for student mental health and well-being is not dependent on individual goodwill but anchored within institutional design. HEI that adopt such an approach strengthen not only student outcomes, and experience but also teaching quality, inclusion and organisational resilience.

Embedding mental health awareness and competence is therefore not an additional institutional obligation. It is a strategic investment in the stability, equity and long-term sustainability of European higher education.

11. Conclusion

Student mental health can no longer be treated as a peripheral concern within HEIs. It has become structurally intertwined with teaching quality, student progression, inclusion objectives and institutional risk management. As HEIs navigate increasingly complex academic environments characterised by diverse student populations, digital transformation and heightened public accountability, mental health competence emerges as a defining dimension of institutional governance.

Institutions that embed mental health structurally within their governance frameworks move beyond reactive crisis management. They create predictable procedures, strengthen faculty confidence and reduce inconsistencies across faculties. Early identification and clear referral pathways stabilise academic processes and mitigate escalation risks. At the same time, stigma-sensitive communication and inclusive teaching practices foster belonging and equitable participation. In this sense, mental health awareness and competence does not dilute academic standards; it supports the conditions under which standards can be upheld fairly and sustainably.

The SUNMENTORS e-training programme offers an open source and adaptable foundation for strengthening teaching staff competence across diverse European contexts. Its digital format enables flexible integration within existing professional development systems. However, the transformative potential of the training depends on institutional conditions. Leadership alignment across senior leadership teams and faculty governance structures is essential. Structural integration within academic development systems ensures continuity. Clear referral protocols and quality assurance mechanisms translate competence into consistent practice.

Higher education institutions that align policy, structure and culture around mental health awareness and competence strengthen their capacity to respond coherently to student needs, protect academic continuity and sustain inclusive participation.
In the long term, institutions that recognise mental health as a structural determinant of educational success position themselves more effectively within the European Higher Education Area. By embedding competence systematically rather than episodically, they reinforce their commitment to quality, equity and sustainability.

You can register for the e-learning via the following link:

https://sunmentors-hub.eu/login/signup.php

The Moodle course is free to access and available as an open-source resource.

Annex: Comparative National Contexts (SUNMENTORS-Project Partner Countries)

Although partner countries differ structurally, common governance challenges emerge across systems. The following contextual analyses highlight how embedding strategies may vary while underlying objectives remain consistent.

Germany

Germany's federal higher education system grants significant autonomy to individual institutions. While counselling services are widely established, integration of mental health competence within teaching governance varies considerably. Academic staff development structures are often decentralised, and no national standard mandates mental health training for faculty.

In Germany, strategic embedding within existing teaching qualification systems can generate sustainable impact without regulatory reform.

Governance Structure

Germany's higher education system is characterised by:

- Federal organisation (Länder responsibility)
- Strong institutional autonomy
- Increasing emphasis on quality assurance
- Decentralised implementation cultures

Mental health support services exist at most HEI, but their integration into teaching governance varies significantly between institutions.

Structural Characteristics Relevant to Study & Teaching

- Academic staff development is often decentralised.
- Teaching qualification frameworks are heterogeneous.
- Inclusion strategies are typically embedded within broader diversity policies.
- Formal referral structures exist but are not always systematically communicated to faculty.

Governance Challenge

Due to federal fragmentation:

- Implementation of mental health training is dependent on institutional leadership.
- There is no unified national standard for staff mental health competence in teaching.
- Uptake is often voluntary and driven by motivated departments rather than systemic embedding.

Recommendations

- Anchor mental health training within existing structures of employee training.
- Link training participation to teaching certificates.
- Align mental health competence with retention strategies and study success metrics.
- Integrate mental health considerations into system accreditation and internal quality reviews.

England

England's higher education system operates within a strongly performance-oriented regulatory environment. Student satisfaction metrics, retention rates and quality assessments exert significant influence on institutional reputation and funding. National discussions around student well-being and suicide prevention have increased public scrutiny.

In this context, mental health integration aligns closely with governance priorities. Embedding training within teaching excellence narratives and risk management strategies enhances institutional credibility. However, the challenge lies in preventing compliance-driven implementation. Sustainable integration requires linking mental health competence to pedagogical development rather than treating it solely as regulatory fulfilment.

Governance Structure

The English higher education system is characterised by:

- Strong central quality regulation (OfS framework)
- Performance-based funding logic
- High tuition fee environment
- Competitive institutional positioning

Student well-being has become increasingly visible due to:

- Regulatory expectations
- Public scrutiny
- National discussions around student suicide prevention

Structural Characteristics Relevant to Study & Teaching

- Well-established teaching and learning centres.
- Strong link between student satisfaction metrics and institutional reputation.
- Formalised quality assurance frameworks.
- Existing initiatives such as the University Mental Health Charter[2].

Governance Challenge

The main challenge is not awareness but:

- Fragmentation between welfare services and academic governance.
- Risk of compliance-driven rather than culture-driven implementation.
- Staff overload due to performance pressure.

[2]The charity organisation Student Minds (England) is committed to helping HE students experiencing mental health concerns through a number of initiatives and publications. Their vision: No student should be held back by their mental health.
Student Minds has launched the University Mental Health Charter (UMHC) initiative. The UMHC contains recommendations for a HEI-wide approach to mental health, covering the topics of learning, support, work, and living. The UMHC calls for HEI to proactively create environments that promote wellbeing of all members of the HEI community. Student Minds now also presents an award to HEIs that have implemented the programme well. https://hub.studentminds.org.uk/university-mental-health-charter/

Recommendations

Embedding mental health training within:
- Teaching Excellence Framework narratives.
- Student-centred learning commitments.
- Institutional risk management strategies.

Belgium (Flanders)

Flemish higher education benefits from structured governmental guidance and clear inclusion obligations. Support for special-status students and accessible counselling services are well developed.

The primary challenge is not infrastructural absence but pedagogical integration. Service utilisation remains socially stratified, and faculty engagement in mental health awareness varies. It is recommended to embed mental health competence within inclusive curriculum design and first-year transition programmes, thereby strengthening early intervention mechanisms.

Governance Structure

Belgium's higher education system (particularly in Flanders) is characterised by:
- Strong governmental guidance frameworks.
- Clear inclusion obligations.
- Structured student support infrastructures.

Structural Characteristics Relevant to Study & Teaching
- Mandatory attention to special-status students.
- Integrated counselling services.
- Government-supported funding for student guidance.
- Strong emphasis on inclusive educational environments.

Governance Challenge

Despite structured services:
- Service utilisation remains socially stratified.
- First-generation students are less likely to access support.
- Faculty engagement in mental health awareness is uneven.

Recommendations
- Bridge guidance infrastructure with teaching practice.
- Embed mental health awareness within inclusive curriculum design.
- Use existing governmental frameworks to formalise staff training integration.
- Strengthen early-stage intervention through first-year programmes.

Greece

Greek higher education operates under centralised oversight and significant resource constraints. Counselling capacity is often limited relative to demand, and teaching loads remain high. Under such conditions, scalable and cost-efficient solutions are essential.

For Greek institutions, embedding mental health competence within digital academic development systems represents a pragmatic and sustainable approach.

Governance Structure

The Greek higher education system is characterised by:
- Centralised state oversight.
- Resource constraints.
- High student-to-staff ratios.
- Increasing demand for digital solutions.

Mental health infrastructure has developed unevenly, often constrained by funding limitations.

Structural Characteristics Relevant to Study & Teaching
- Limited counselling capacity relative to demand.
- High teaching loads.
- Limited formalised academic development systems.
- Cultural stigma around mental health remains present.

Governance Challenge

In resource-constrained systems:
- Training risks being perceived as an additional burden.
- Referral pathways may be under-resourced.
- Faculty may lack confidence due to limited institutional scaffolding.

Recommendations
- Integrate the training within national reform initiatives.
- Position it as capacity-building rather than additional workload.
- Use digital infrastructure to compensate for limited in-person services.

Italy

Italy's higher education system combines national regulatory frameworks with institutional autonomy. Counselling services are present but vary in integration across regions. Quality evaluation through ANVUR[3] increasingly shapes institutional governance.

[3]Agenzia Nazionale di Valutazione del Sistema Universitario e della Ricerca (ANVUR) is Italy's National Agency for the Evaluation of Universities and Research.

The challenge lies in organisational alignment rather than infrastructural absence. Faculty often rely on informal support approaches without systematic referral clarity. Embedding mental health training within formal teaching qualification pathways and

linking it to national quality evaluation criteria can standardise practice and enhance institutional coherence.

Governance Structure

Italy's higher education system is characterised by:

- Formalised national regulations.
- Institutional autonomy within national frameworks.
- Growing focus on quality evaluation through ANVUR.
- Heterogeneous service quality across regions.

Counselling services are often present but unevenly integrated into teaching structures.

Structural Characteristics Relevant to Study & Teaching

- Strong emphasis on academic standards.
- High regional variation in resource allocation.
- Limited systematic integration of mental health into pedagogical training.
- Strong reliance on informal faculty-student relationships.

Governance Challenge

- Formal services exist, but pedagogical embedding is inconsistent.
- Faculty may rely on informal approaches.
- Systematic referral knowledge varies widely.

Recommendations

- Align mental health competence with national quality evaluation criteria.
- Integrate training within formal teaching qualification pathways.
- Standardise referral knowledge across faculties.
- Strengthen institutional coherence across regions.