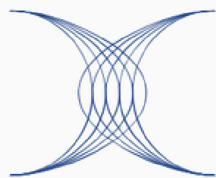

IARU

Whole-of-University Approach Guideline for Student Wellbeing

2026

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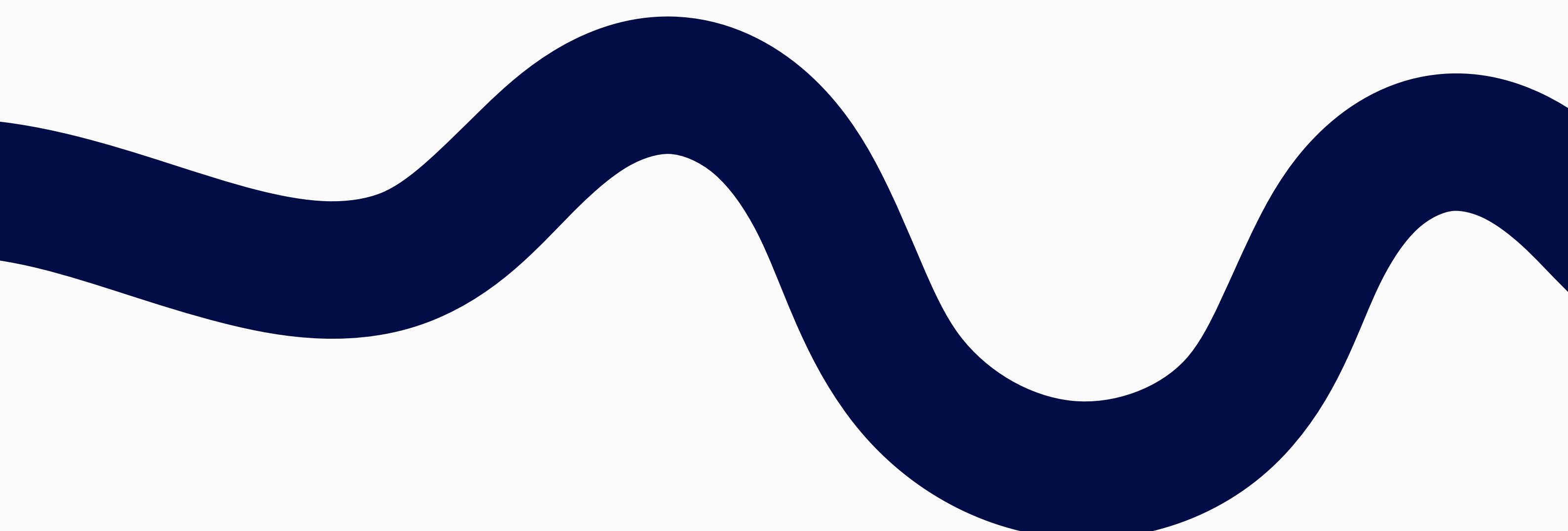
ABOUT US

The International Alliance of Research Universities (IARU), established in 2006, is a network of 11 international research-intensive universities from 9 countries across the globe. IARU members include the Australian National University, Yale University, ETH Zurich, the National University of Singapore, Peking University, the University of California, Berkeley, the University of Cambridge, the University of Cape Town, the University of Copenhagen, the University of Oxford, and the University of Tokyo.

The eleven members share similar values, a global vision and a commitment to educating future world leaders. Central to these values is the importance of academic diversity and international collaboration as reflected in IARU's principles. IARU projects are focused on three areas: addressing major challenges facing humanity, providing opportunities to students, and institutional joint working.

The guideline was created by the Student Wellbeing Working Group (SWWG), which convened in 2025. The SWWG provides strategic recommendations to IARU on emerging wellbeing challenges and solutions. The SWWG is guided by five core objectives: i) promote collaborative learning and knowledge sharing on wellbeing interventions, policies, and research; ii) develop joint initiatives leveraging global expertise to improve student wellbeing; iii) encourage evidence-based approaches to mental health, resilience, and holistic development; iv) strengthen institutional capacities through peer engagement; and v) provide strategic recommendations to IARU Senior Officers on emerging wellbeing challenges and solutions.



PREFACE

Across the world, universities are recognising that health and wellbeing are not peripheral to their mission, but foundational to enabling students to flourish academically, socially, and personally. As global challenges continue to reshape how students live and learn, institutions have an increasingly urgent responsibility to create environments where wellbeing is supported systematically, not left to chance or the goodwill of a few dedicated individuals.

The International Alliance of Research Universities (IARU) brings together some of the world's leading universities, each with a deep commitment to advancing knowledge and nurturing future leaders. In establishing the inaugural Student Wellbeing Working Group, we collectively recognised that while many frameworks and guidelines for campus wellbeing already exist, these are often highly conceptual. There remains a gap between theory and operational needs.

At our respective universities, we have grappled with this very challenge. Some of us have developed and implemented our respective frameworks to guide systematic implementation across the university, such as the WellNUS Framework by the National University of Singapore (NUS), and institutional policies, such as the University of Cape Town Student Mental Health Policy. Others have commissioned task forces to identify gaps in the support ecosystem. The main goal is to develop a systematic approach that translates principles into actionable, institution-wide strategies. By embedding wellbeing across policies, practices, people, and physical environments, this enables us to move beyond fragmented efforts to an integrated, evidence-informed model.

This document represents a shared endeavour among IARU members to bridge the theory–practice gap. In developing this framework, we were mindful of the diverse contexts in which universities operate. Student wellbeing is shaped not only by campus environments but also by broader social determinants such as inequality, financial strain, discrimination, disability, and the lingering effects of global crises. A whole-campus approach must therefore be grounded in equity, cultural responsiveness, and inclusion.

Recognising that institutions vary in their resources, histories, and levels of system maturity, we aimed to create a guide that is adaptable and scalable. The principles outlined here are designed to support universities at any stage of their wellbeing journey, whether strengthening existing structures or building new foundations. Our intention is to offer a practical, evidence-informed scaffold that translates policy aspirations into meaningful change across teaching, supervision, service delivery, campus design, and institutional culture.

It has been an honour to co-create this framework as an inaugural working group and to learn from colleagues across the IARU network. We are hopeful that this framework will inspire universities to move from fragmented initiatives toward integrated systems that uplift all students, particularly those who have historically been underserved or overlooked.

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On behalf of the IARU Student Wellbeing Working Group

INTRODUCTION

Around the world, students are navigating increasing levels of stress, uncertainty, and social disruption. Yet the burden of mental health challenges is not distributed evenly. Structural inequities, cultural stigma, financial barriers, and access gaps influence who receives support, how quickly, and with what outcomes. Addressing mental health equity is therefore essential to creating learning environments where all students can flourish. There has been a noticeable shift in universities going beyond approaches solely focused on the management or prevention of illness, but one that actively cultivates thriving, both personally and academically.

What is often overlooked is how deeply staff and student wellbeing are connected. Research suggests that educators' mental health directly affects the quality of their teaching and their capacity to support the students in their care (Rakow et al., 2024). When staff feel psychologically safe and supported, they are better equipped to model healthy behaviours, respond to student needs, and foster a positive campus climate (Edmondson, 1999). As a result, many universities have developed their own guidelines, frameworks and charters to best support both their staff and students' wellbeing.

> ***Their evidence-informed approaches consistently emphasise the need for a coordinated, whole-of-university approach that integrates wellbeing into every level of the institution, from its strategy and policies to the programmes implemented on the ground.***

Evidence shows that whole-of-university approaches are more effective than individual interventions (Pathare, 2021; Campbell, Blank & Cantrell, 2022; Dooris, Powell & Farrier, 2020). As student and staff needs have evolved, mental health and wellbeing have become a specific focus area for whole-of-university approaches.

A whole-of-university approach is a multi-pronged approach that recognises that all aspects of the university can support and promote an individual across the wellbeing spectrum. It goes beyond providing mental health services to consider the university culture, policies and infrastructure (Newton, Dooris & Wills, 2016). This means that while support and treatment strategies are critical, preventive strategies and systemic changes must also be implemented. An effective whole-of-university approach comprises three elements (Hughes & Spanner, 2024):

01

Provides adequately resourced, effective and accessible mental health resources and proactive interventions

02

Creates environments and cultures that both support good mental health and reduce poor mental health

03

Empowers staff and students to develop the knowledge and skills to manage and maintain their personal wellbeing

This was emphasised in the University Mental Health Charter, UK, a charter that is widely adopted by local institutions. This national framework, developed by Student Minds, provides guidance to universities to adopt a whole-of-university approach to mental health and wellbeing and create mentally healthy environments that promote both staff and students' wellbeing.

The Okanagan Charter, developed by the University of British Columbia (UBC) Okanagan Campus in partnership with the Pan-Canadian Health Promoting Universities and Colleges Network, is another example. This international charter calls for Universities and colleges to embed health into all aspects of campus culture (administration, operations and academic mandates). It additionally calls for them to lead health promotion action and collaboration locally and globally.

Similarly, in Asia, the ASEAN University Network Health Promotion Network (AUN-HPN) created the AUN Healthy University Framework to guide ASEAN universities to integrate health promotional activities as part of academic and administrative work. It also suggests monitoring and evaluating the success of these efforts.

Orygen, Australia's National Centre of Excellence in Youth Mental Health, developed the Australian University Mental Health Framework (AUMHF). This evidence-informed, student-centred framework provides practical and contextual steps for Australian higher education institutions to take to improve student mental health and wellbeing.

While huge strides have been made towards improving student wellbeing within higher education, there remain gaps in existing guidelines. Many of these frameworks are high-level and conceptual but lack detail on how universities can take actionable steps to effectively identify gaps and required interventions. Few provide guidance on how universities can begin to assess the effectiveness of their interventions in a meaningful way. There is also a need for greater alignment on key wellbeing initiatives across universities and a common set of student wellbeing indicators for benchmarking and measurement of efficacy. A further gap is that many existing frameworks are designed with well-resourced universities in mind. This creates barriers to implementation and adoption for those with limited resources.

Taken together with the growing complexity of student and staff mental health and wellbeing needs globally, more needs to be done in this area. Table 1 provides a summary of each whole-of-university approach and its key strengths and limitations.

In response to this, the Student Wellbeing Working Group (SWWG) developed a guideline to strengthen student wellbeing across member institutions of the International Alliance of Research Universities (IARU). The guideline consolidates international evidence, best practices and operational strategies that are adaptable and accessible across diverse university contexts. Its purpose is not to duplicate or replace existing guidelines or frameworks, but to supplement them and help address the highlighted gaps. Its recommendations are aimed at enabling universities to effectively identify gaps, implement, evaluate and scale wellbeing initiatives for the betterment of their staff and students' wellbeing.

Framework	Core Focus	Strengths	Limitations
Okanagan Charter (2015, Canada)	• Canadian-specific context • For campuses to embed health into all aspects of campus culture across the administration, operations and academic mandates. • For campuses to lead health promotion action and collaboration locally and globally.	• Focuses on holistic wellbeing, of which mental health and resilience are one aspect. Other aspects include nutrition, social inclusion, physical activity and environments. • Addresses both staff and student wellbeing	• Very high-level. No detailed implementation tools, gap analysis tools, budgets, or accountability measures

University Mental Health Charter (2024, UK)	• UK-specific context
	• Whole of university approach to mental health support that goes beyond the provision of specialised care and is integrated into 4 domains of the university:
	  ◦ Learn (Transitions into university, learning, progression)
	  ◦ Support (Support services, resources and risk)
	  ◦ Work (Staff wellbeing and development)
	  ◦ Live (environments and social integration
		• Addresses both staff and student wellbeing
		• Comprehensive domains with detailed guidance on the implementation framework
		• Uses charter award model as driver of accountability
			• Focused on mental health only
			• No detail on evaluation or accountability measures

Orygen University Mental Health Framework (2020, Australia)	• Australian specific context
	• Systems approach across six principles to support student wellbeing:
	  ◦ Student-centred approach Teaching and Learning environments
	  ◦ Whole of University Approach,
	  ◦ Student Services and Support,
	  ◦ Collaboration and Coordination
	  ◦ Evidence-informed Continuous
	  ◦ Innovation and Improvement
		• Recognises mental health as being on a continuum. Support services need to be present at all stages of the continuum
		• Provides practical tips on how each principle can be implemented
		• Case studies provided
			• Focused on mental health only
			• Less focused on support for staff wellbeing
			• Does not cover in detail how gaps can be systematically reviewed or how programmes can be evaluated

ASEAN University Network, Healthy University Framework (2023, ASEAN)	• ASEAN-specific context
	• To integrate health promotional activities as part of academic and administrative work among students and staff populations. It highlights 5 areas to be covered in the health-promoting model:
	  ◦ Curriculum
	  ◦ Environment
	  ◦ People
	  ◦ Research
	  ◦ Investing in staff,
	  ◦ Health Promotion Programmes
		• Focuses on health promotion, of which mental wellbeing is one aspect. Other aspects include nutrition, health literacy, work-life balance, social inclusion, physical activity and sexual health.
		• Addresses both staff and student wellbeing
		• Emphasises regional collaboration to embed health-promoting university principles across diverse ASEAN contexts
		• Provides practical implementation checklists, sample policies, and tools
			• While it takes a holistic approach to health promotion, it does not deep dive into mental health strategies or approach es
			• Does not cover in detail how gaps can be systematically reviewed or how programmes can be evaluated

Table 1. Summary of strengths and limitations of Health Promoting Frameworks

UNIVERSITY WELLBEING REVIEW AND STRATEGY DEVELOPMENT PROCESS

From a review of the existing literature and frameworks mentioned above, similar themes and recommended systematic processes to build a whole-of-university wellbeing strategy emerged. This has been extracted and summarised below:

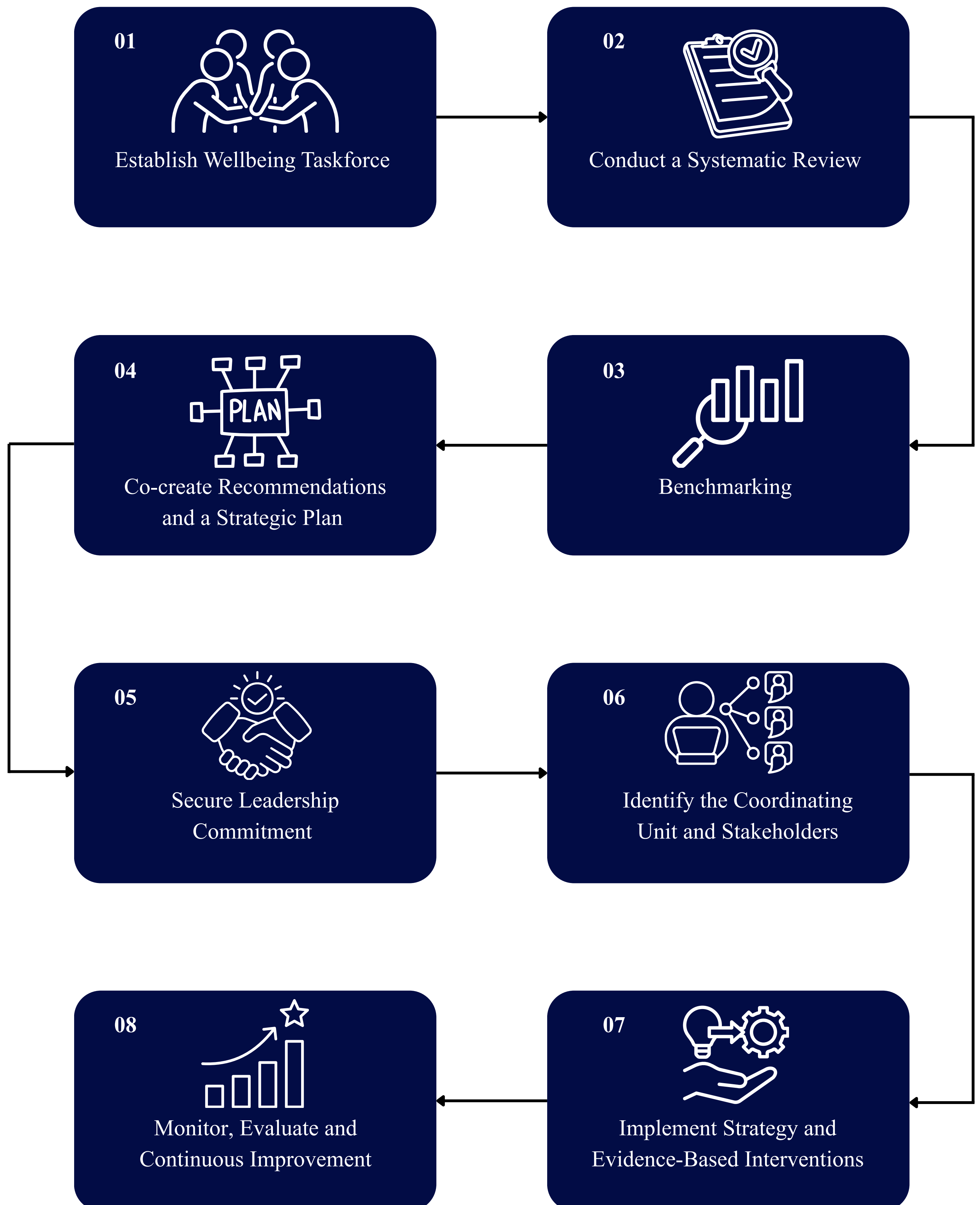


Figure 1: University Wellbeing Review and Strategy Development Process

1 ESTABLISH WELLBEING TASKFORCE

A wellbeing taskforce is a cross-functional team established to conduct a systematic review of the current wellbeing landscape. It collects and reviews wellbeing data sources and identifies priority areas for improvement (Ryan, Baik & Larcombe, 2022).

> ***Best practice recommends that there is representation from students (undergraduate and postgraduate), academic and administrative staff, leadership, individuals with lived experience and mental health experts in the taskforce (Orygen, 2020).***

Notable examples include Harvard University's Task Force on Managing Student Mental Health (2020), which conducted a year-long review and produced 8 key recommendations focusing on culture change, early intervention, and expanded service access (Harvard University, 2020). A similar Mental Wellbeing Task Force was created in the National University of Singapore (NUS) in 2020. The task force surveyed over 2,500 students to understand key mental health gaps. The task force came up with 5 recommendations, referenced from global best practices, to address their needs. Recommendations included individual care strategies, enabling access to services, training members of the communities and creating cultures of care within the university (National University of Singapore, 2020). The University of Melbourne established the Student Wellbeing Reference Group, led by academic and professional staff experts, to review current research and best practices, consult with staff and students on pressing challenges. This resulted in the development of the Student Wellbeing and Mental Health Framework (University of Melbourne, 2016).

It is important for task forces to establish a clear Terms of Reference (ToR). It sets out the group's purpose, scope, membership, roles and responsibilities, timelines and ways of working, including how decisions get made. This helps manage expectations, minimise overlaps in work, and ensure consistency even when membership changes. Defining deliverables and reporting mechanisms upfront keeps the group focused on and accountable for its objectives.

2 CONDUCT A SYSTEMATIC REVIEW

To establish a good baseline understanding of wellbeing levels, ground challenges and gaps within the university, a systematic assessment needs to be conducted. The Wellbeing Taskforce undertakes this review of the existing system of care and the policies and programmes in place. The scope and objectives of the review must be clearly defined so that adequate leadership sponsorship and resources can be allocated.

Systematic reviews are designed to be highly consultative with both robust qualitative and quantitative data sources. They generally take around 12-18 months to complete. Ideally, the review or needs assessment should draw on three overlapping but distinct sources of insight: (1) the existing research evidence base, (2) input from domain experts and practitioners (mental health professionals, student affairs staff, faculty, wellbeing specialists) to understand feasibility, and contextual constraints, and (3) "client" voices, i.e. students and staff themselves (across cohorts, demographic groups, levels of need) to surface lived experience, priorities, and unmet needs. The triangulation among research, expert judgment, and client experience strengthens validity, grounds assumptions, and helps ensure interventions are both evidence-informed and contextually relevant.

> ***"While comprehensive systematic reviews are recommended best practice, their scope should consider a university's available capacity to conduct this."***

In instances where resources are scarce, Koch-Kiennast (2026) recommends a tiered approach. For example:

Beginner

Broad review using existing administrative data (e.g. counselling utilisation data, existing staff and students' wellbeing survey data), 1-2 targeted focus groups and a service mapping exercise (e.g. using the WellNUS Framework).

Intermediate

A structured review of existing and new wellbeing data points, including the full suite of stakeholder consults and service mapping exercises.

Advanced

Full systematic review as described above, including longitudinal data, external benchmarking and equity analysis.

At all levels, the triangulation of data sources (research evidence, expert input, and student/staff voice) remains important, even if the depth of each differs (Ryan et al., 2022; Koch-Kiennast, 2026).

There are a variety of tools and approaches that can be used to build a more nuanced understanding of the wellbeing ecosystem. Task forces can reference the checklist in Table 2 to help start thinking about the review. It highlights areas of data collection to consider, potential stakeholders to consult with and common tools and approaches universities can use to begin their systematic review.

Category	Potential Areas to Consider
Potential Stakeholders to consult	☐ Student groups (Undergrad, Post grad) ☐ Staff groups (Admin, Research, Academics) ☐ Minority groups ☐ Persons with lived experience ☐ Leadership (Senior, Middle levels) ☐ Domain experts (Wellbeing specialists, Mental health experts) ☐ Health and Safety personnel ☐ Human Resources ☐ Mental health service providers ☐ Wellbeing ambassadors/volunteer groups
Data collection areas to consider	**Leadership and Culture** ☐ Reviewing governance structures ☐ Reviewing strategic documents to check if wellbeing is integrated (Health, safety and risk strategies, diversity and inclusion strategies, student success plans, communication strategies, data and impact measurement strategies) ☐ Review and catalogue culture-building initiatives (e.g. mental health campaigns, etc.) ☐ Review funding and resources allocated to wellbeing **Policies and Infrastructure** ☐ Catalogue and review all existing wellbeing policies (e.g. flexi policies, insurance policies, return to work policies) ☐ Catalogue and review all wellbeing infrastructure (wellness areas, counselling rooms, etc.) **Support services and programmes** ☐ Catalogue and review all existing wellbeing training programmes ☐ Catalogue and review all educational wellbeing resources ☐ Catalogue and review all existing wellbeing support services (e.g., counselling services, staff-to-student ratios, wait times, drop-out or no-show rates, programme feedback)
Tools & Approaches	☐ **Longitudinal wellbeing survey:** Annual surveys to monitor changes in wellbeing needs over time and track the impact of interventions for both staff and students. ☐ **Focus groups, interviews and consultation workshops** ☐ **Mapping exercises** ☐ **Life-cycle pain-point mapping:** Orientation, exams, transition to work. ☐ **Service pathway mapping:** A systems-mapping exercise to visualise how students and staff currently access support and identify bottlenecks or areas for improvement. ☐ **Service and operations mapping:** Creating a map of all programmes and services to identify any gaps in service provision (See WellNUS Framework in Fig 2 & 3) ☐ **Equity and inclusion mapping**: Collecting and analysing data by minority demographic (e.g., international students, first-generation students, LGBTQ+ students) to uncover any unmet needs. ☐ **External benchmarking and validation exercise** ☐ Engaging external experts to conduct a benchmarking exercise ☐ Participate in international or national awards (e.g. University Mental Health Charter Award), international (e.g. Global Healthy Workplace Awards) ☐ Review peer institutions to identify innovative practices and models

Table 2. Systematic Review Checklist

A useful operational tool to help map and catalogue the different wellbeing initiatives and policies is the WellNUS Framework (NUS Health and Wellbeing, 2021), developed by the National University of Singapore. The framework operates on the principle that mental health exists on a complex continuum (World Health Organisation, 2021). The WellNUS framework recognises that individuals enter at different stages of the wellbeing continuum and go up and down on this wellbeing spectrum over time. A report by Deloitte Insights investigating the return on investment (ROI) on mental health programmes found that organisations that achieved greater returns invested in activities that support employees along the entire mental health continuum (Chapman, Kangasniemi, Maxwell, et al., 2019).

> ***The WellNUS framework systematically maps out the different parts of a person's wellbeing journey and identifies the relevant initiatives and key stakeholders in charge.***

Depending on the severity of the mental health need and the intensity of support needed, initiatives are matched to support that. The wellbeing spectrum in the WellNUS framework is categorised into 4 stages:

Maintain

Individuals who are coping well or thriving. The initiatives implemented at this stage are aimed at helping the individual thrive and maintain at this stage in the continuum.

Manage

Individuals at-risk of burnout or exhibiting mild mental health distress. The initiatives implemented at this stage are aimed at preventing the escalation of symptoms.

Intervene

Individuals with mental health needs who require initiatives and services of moderate (e.g. psychotherapy, short-term disability claims, medical leave) to high intensity (e.g. inpatient-psychiatric access, longer-term disability claims).

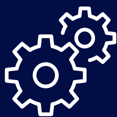
Recover

Individuals who are returning to work. Support services and organisational initiatives aimed at facilitating the individuals' return to work in a gradual and step-wise manner, often requiring case-management support and workload adjustment.

The whole-of-university approach dictates that universities need to go beyond individual-level support services, creating cultures and environments that both support poor mental health but promote mental wellbeing (Hughes & Spanner, 2024). Therefore, the WellNUS framework has been designed to ensure the institution is kept accountable at 3 levels:

Culture and leadership

To ensure that staff and student wellbeing is a strategic leadership priority and that adequate resources and budgets are allocated. This level also highlights the need for culture-building initiatives and outreach and marketing efforts that foster psychologically safe spaces, diversity and inclusion.



Systems and infrastructure

To ensure a psychologically safe and thriving university environment strengthened through safe and inclusive policies, where wellbeing risks are prevented or mitigated. This includes reviewing internal systems and policies, conducting psychosocial risk assessments to create safe and healthy ways of working.

Support services and resources

To ensure that wellbeing programmes, resources and services are put in place to support staff and students across the wellbeing journey. It also includes self-help resources that students and staff can use to take charge of their own wellbeing.

This helps give a high-level organisational overview of structures, policies and programmes in place. There are three main benefits to this. Firstly, it helps identify any gaps in support services or initiatives along the wellbeing spectrum. For example, a review of the flexible policies might show that there is a lack of mental health return-to-school or return-to-work policies for staff or students in the 'recover' category.

Secondly, it serves to highlight any duplication of wellbeing efforts across the university. For example, different faculties could be training student wellbeing ambassadors at different levels on a variety of skill sets using decentralised resources.

Thirdly, having a bird's eye view of programmes helps provide the university with a starting point to begin prioritising what needs to be done, what resources need to be reallocated and what programmes they need to streamline or remove.

Once services have been mapped out, the relevant stakeholders can be assigned to oversee that initiative. It is essential to synchronise efforts across the university and have multiple departments collaborating (wellness teams, HR, Safety teams, student affairs, comms team, etc.). This goes well beyond it being a student affairs, faculty or HR function and takes close collaboration between multiple stakeholders to support students and staff across the spectrum of wellbeing. This results in a more unified, holistic and structured approach that is sustainable.

The WellNUS framework can be used to keep stakeholders accountable and should be reviewed yearly. Constant monitoring of the effectiveness of the implemented programmes is essential in reviewing the impact of these programmes. This can be measured by the various outcome and process indicators (see Table 7) listed under the "Effectiveness" column on the right.

Figures 2 and 3 show the WellNUS Framework for students and staff, respectively, illustrating how some of the commonly implemented services can be mapped against an individual's capacity and identify the respective system owners. This framework allows for an intuitive appreciation of how the respective services come together to support wellbeing from a WOU approach, with the accompanying suggested impact measures.

The WellNUS framework is limited in that it does not cover the different theoretical elements of wellbeing (e.g. physical, emotional, social, financial, career, etc.) that often underpin many universities' wellbeing strategies (e.g. Six inter-related dimensions of wellness in the Resilience Framework by the Singapore Management University (n.d.)) as it is an operational tool, designed to translate the conceptual framework into tangible operations that are implementable by wellbeing practitioners. Programmes and interventions designed to support each element of wellbeing can, however, be embedded within the WellNUS framework.

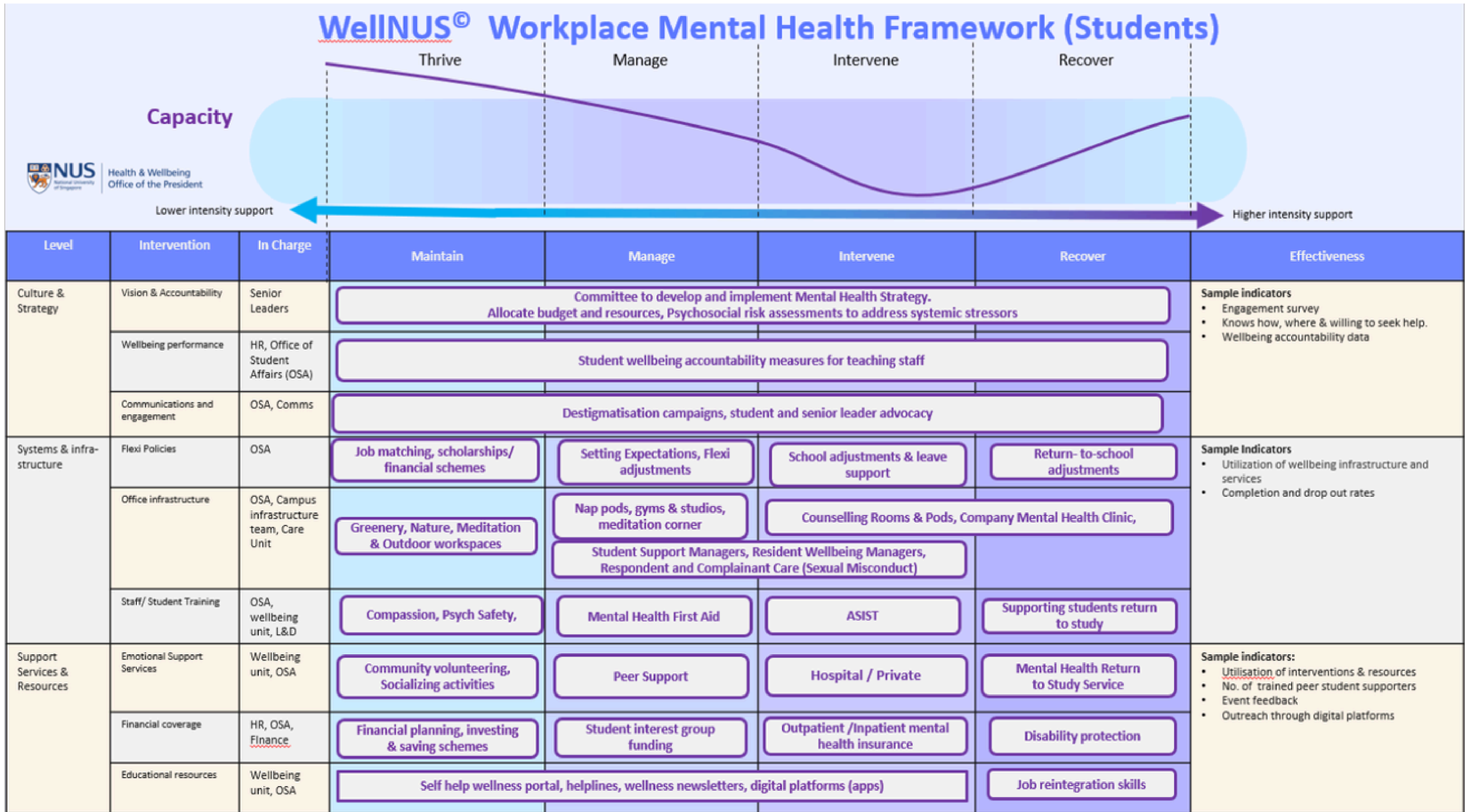
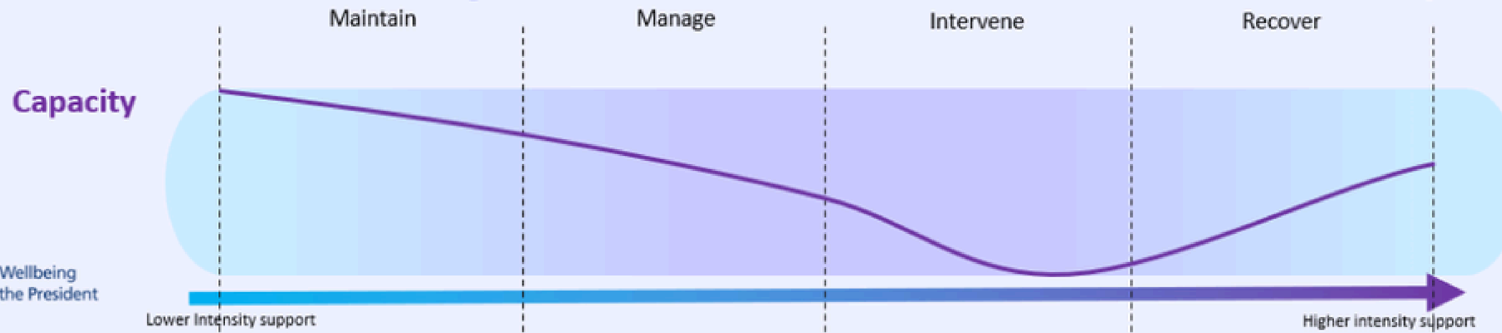


Figure 2. Examples of potential wellbeing initiatives under the WellNUS Framework (Students)

WellNUS© Workplace Mental Health Framework (Staff)



Level	Intervention	In Charge	Maintain	Manage	Intervene	Recover	Effectiveness
Culture & Strategy	Vision & Accountability	Senior Leaders	Committee to develop and implement Mental Health Strategy. Allocate budget and resources, Psychosocial risk assessments to address systemic stressors				Sample Indicators: • Engagement survey feedback • Knows how, where & willing to seek help. • Team wellbeing accountability data • Grievances & reasons for exit
	Wellbeing performance manager	HR	Wellbeing accountability measures for leaders				
	Communications and engagement	HR, Wellbeing unit, Comms	Destigmatisation campaigns, senior leader mental health advocates				
Systems & infra-structure	Flexi Policies	HR, HWB	Setting expectations	Flexi work policies and adjustments	Work adjustments, rotations, leave support	Return-to-work adjustments	Sample Indicators: • Absence monitoring • Retention data • Hours worked • Policy & process audit
	Office infrastructure	Campus infrastructure team	Quiet corner, Nap pods, Gyms		Company mental health clinic		
	Manager training	HR, Wellbeing unit, L&D	Wellbeing and self care workshop	Looking for signs of distress workshop	Supporting staff workshop	Supporting employees return to work workshop	
Support Services & Resources	Emotional Support Services	HR, Wellbeing unit	Coaching	Peer Support, Employee Assistance Programme	Hospital / Private	Mental Health Return to Work Service	Sample Indicators: • Utilisation of interventions & resources • No. of trained managers/ Peer supporters • Event feedback
	Financial coverage	HR, Wellbeing unit, Finance	Flexi benefits	Outpatient mental health insurance	Inpatient mental health insurance	Disability income protection	
	Educational resources	HR, Wellbeing unit, Comms	Self help wellness portal, helplines, wellness newsletters, wellbeing apps			Job reintegration skills	

Figure 3. Examples of potential wellbeing initiatives under the WellNUS Framework (Staff)

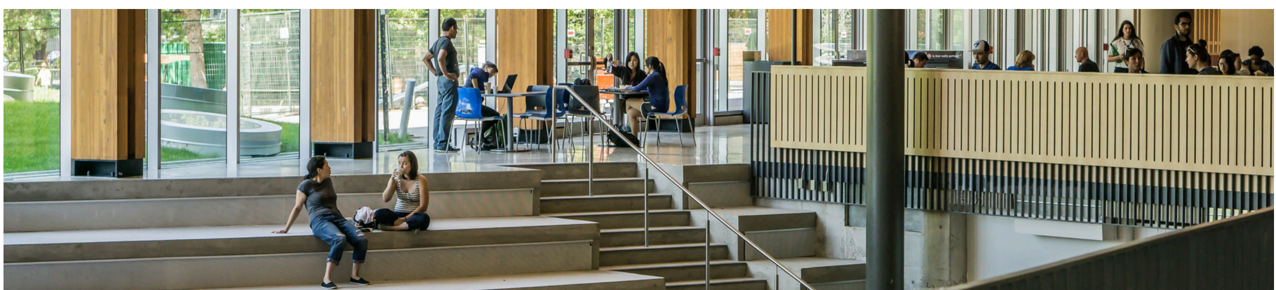
3 BENCHMARKING

> ***Benchmarking allows universities to evaluate their wellbeing efforts against nationally and internationally recognised best practices.***

The first step in the process is selecting the relevant frameworks or charters for comparison. Previously mentioned ones like the Okanagan Charter, UK University Mental Health Charter, Australian University Mental Health Framework and AUN Healthy University Framework are good points of comparison.

Apart from this, universities can identify peer or aspirational institutions that are similar in size, student demographics, or region, to compare with. Such peer benchmarking can be conducted by reviewing publicly available wellbeing strategies, annual wellbeing reports or dashboards. It typically includes a structured assessment where the university is rated against other institutions in the identified wellbeing domains. This can be conducted either by the task force or a third-party vendor, which often lends more credibility and objectivity.

Another way benchmarking can be conducted is through participation in external awards, both locally and internationally. For instance, in the UK, the University Mental Health Charter Award assesses a university's approach to fulfilling the Principles of Good Practice in the UMHC Framework and their progress towards embedding a whole university approach. The Global Healthy Workplace Awards is the first global awards program that recognises healthy workplaces and provides an opportunity for independent validation of institutional efforts from expert panels. Participating in such awards not only allows universities to showcase their work but also to learn best practices from other applying institutions.



Just as important is internal benchmarking to track progress within the university over time. This involves agreeing on baseline wellbeing metrics and measuring them at repeated intervals. This is helpful in assessing the impact of the implemented initiatives and strategies on wellbeing outcomes. It can be used to demonstrate impact to stakeholders, ensure accountability, and guide the refinement of strategies.

While these benchmarking exercises show the university where they stand in comparison to others, they should also highlight the areas in which the university did well, gaps and the domains that would require more investment. Recommendations could also highlight potential interventions, the resources required and suggested wellbeing targets, referenced from global best practices.

4 CO-CREATE RECOMMENDATIONS AND A STRATEGIC PLAN

With a clear understanding of the challenges, the task force can move into solution and strategy generation. It is important to co-create this together with the relevant stakeholders. The co-design process brings together students, staff, mental health professionals, and leadership to brainstorm strategies and possible interventions. It is also important that persons from across the wellbeing spectrum are consulted.

For example, those who experience mental illness or those in recovery who are returning to school or work should actively be involved in the co-creation of strategies and interventions. A whole-of-university approach must use their experiences to better understand needs and develop programmes and strategies that maximise positive impact and highlight areas to reduce risk of harm (Wavehill, 2022; De Pury & Dicks, 2020). Research has shown that interventions and strategies are likely to be less effective when created without fully understanding the experiences and views of such populations (Piper & Emmanuel, 2019).

> ***When solutions are co-created, they are more likely to be accepted, relevant and accessed (Orygen, 2020, Wavehill, 2022; De Pury & Dicks, 2020).***

Co-creation and participation from staff and students have been shown to be helpful in the development and review of several key areas listed below:

- Mental health strategy from conception
- Mental health policy
- Student or staff support services (e.g. telehealth support, redesigning referral pathways), ensuring they are responding to need and serving as an additional quality-assurance mechanism
- Wellbeing programmes or programmes in which the wellbeing curriculum is embedded into
- Communication and outreach interventions

It is important to emphasise that evidence-informed practices should also guide the development strategy and selection of interventions. Once mapped, initiatives can be prioritised (e.g. using an impact-feasibility matrix) to determine which should be implemented first.

> ***The aim is to balance a range of initiatives that can demonstrate short-term wins with ones that have longer-term systemic impact.***

Research from implementation science suggests that such quick, tangible wins early in a process can support sustained adoption and commitment over time (Proctor et al., 2011). Therefore, in the initial phase of the strategy, it is recommended that short-term wins are prioritised first. These are interventions that require minimal resources but can show observable benefits in short amounts of time. Demonstrating quick wins can help increase institutional buy-in and create momentum. For example, showing improved awareness of campus wellbeing resources after a campaign or showing that a certain percentage of staff or students have been trained in support skills.

> ***Strategic wellbeing plans should be envisioned over at least 3 years.***

Drawing on evidence from Deloitte's ROI analysis of workplace mental health initiatives, positive return on investment was reliably achieved only after three or more years of program maturity, compared to organisations with less implementation time often not yet seeing financial gains (Chapman, Kangasniemi, Maxwell et al., 2019). This longer timeframe allows sufficient opportunity for early investments in governance, policy, awareness and training to mature. It allows for culture change to take root, and for measurable outcomes (e.g. reductions in distress, improved retention or academic engagement) to become observable. Table 3 shows an example of how initiatives could be scaled across the years. It is important to note that at all levels, consultation with the relevant stakeholders is essential to improve the relevance and uptake of interventions (Piper & Emmanuel, 2019):

Year 1	Year 2-3	Year 4-5
Consult with stakeholders to identify 2-3 high-impact, low-resource interventions with measurable outcomes. Prioritise quick wins that can help build institutional confidence and buy-in (Proctor et al., 2011).	Starts to include wellbeing initiatives across the 3 levels in the WellNUS Framework (Culture, Systems and infrastructure, Support services and resources) that support individuals across the wellbeing spectrum. Include stakeholder co-design sessions and an impact measurement plan.	Focuses on holistic wellbeing, of which mental health and resilience are one aspect. Other aspects include nutrition, social inclusion, physical activity and environments. Addresses both staff and student wellbeing

Table 3. Scaling wellbeing activities across the years

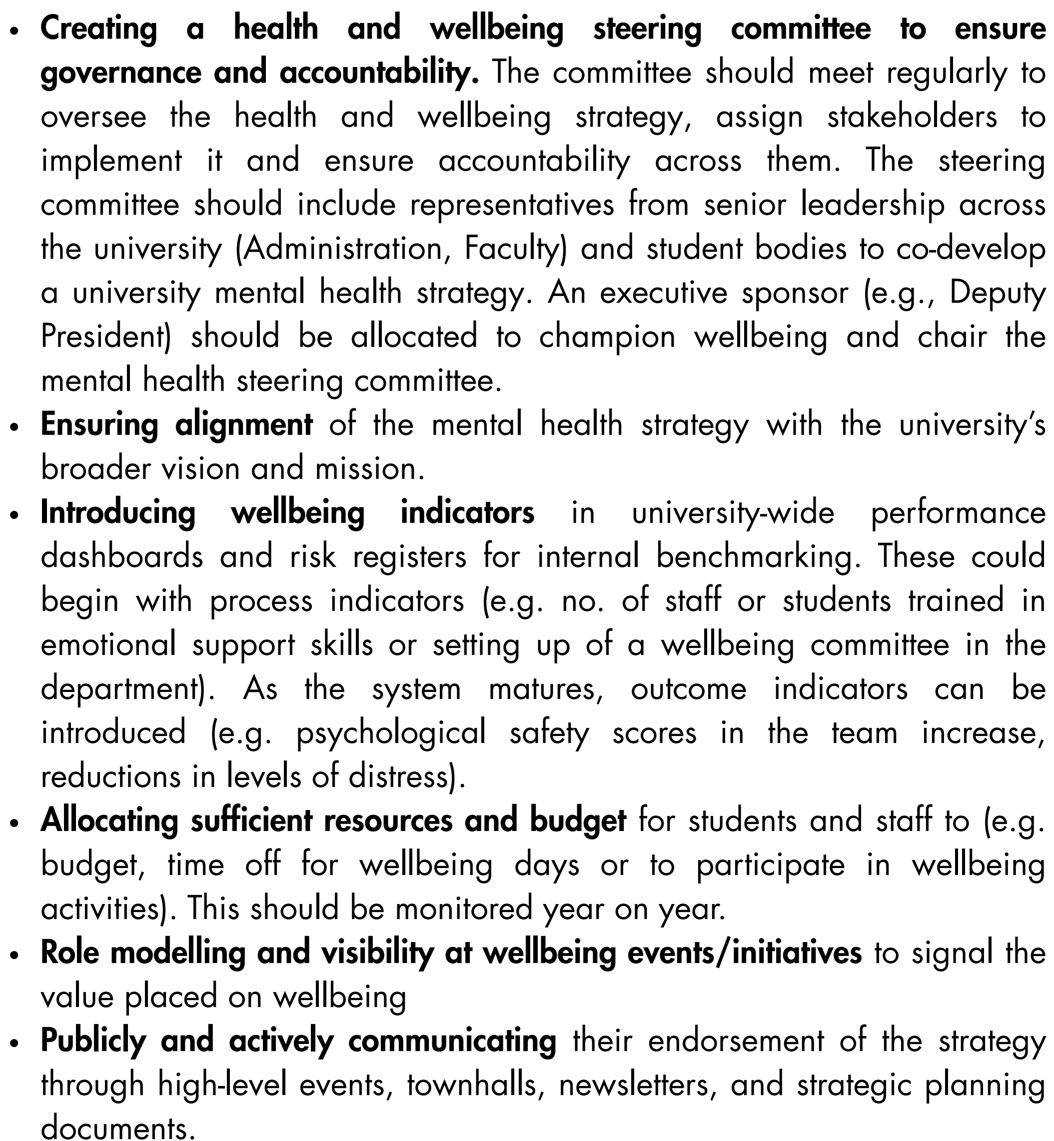
5 SECURE LEADERSHIP COMMITMENT

Leaders in the university have an essential role in establishing a shared university culture, environment and structure that supports the wellbeing of staff and students (De Pury & Dicks 2020; Plata, 2024).

> ***They have the power to ensure the institution takes a strategic, whole-of-university approach to wellbeing (Dooris, Powell, Parkin, Farrier, 2021).***

Leaders have just as much power to harm and create unsafe cultures that harm mental health and wellbeing and the university's performance and sustainability (Montano, Schleu & Hüffmeier, 2023). Therefore, leaders have a responsibility to ensure their behaviours, and the policies and practices of their institution, prevent harm and promote wellbeing (De Pury & Dicks 2020; Bodin, Theorell, 2024).

A successful strategy needs to have active commitment from the university's senior leadership team. This goes beyond simply signing off on the strategy. It involves establishing wellbeing as a strategic leadership and institutional priority. One that is integrated into every level of university life. Here are some ways leadership can demonstrate commitment:



- **Creating a health and wellbeing steering committee to ensure governance and accountability.** The committee should meet regularly to oversee the health and wellbeing strategy, assign stakeholders to implement it and ensure accountability across them. The steering committee should include representatives from senior leadership across the university (Administration, Faculty) and student bodies to co-develop a university mental health strategy. An executive sponsor (e.g., Deputy President) should be allocated to champion wellbeing and chair the mental health steering committee.
- **Ensuring alignment** of the mental health strategy with the university's broader vision and mission.
- **Introducing wellbeing indicators** in university-wide performance dashboards and risk registers for internal benchmarking. These could begin with process indicators (e.g. no. of staff or students trained in emotional support skills or setting up of a wellbeing committee in the department). As the system matures, outcome indicators can be introduced (e.g. psychological safety scores in the team increase, reductions in levels of distress).
- **Allocating sufficient resources and budget** for students and staff to (e.g. budget, time off for wellbeing days or to participate in wellbeing activities). This should be monitored year on year.
- **Role modelling and visibility at wellbeing events/initiatives** to signal the value placed on wellbeing
- **Publicly and actively communicating** their endorsement of the strategy through high-level events, townhalls, newsletters, and strategic planning documents.

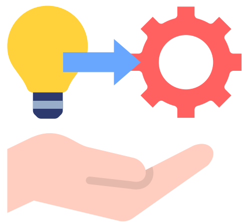
Leadership endorsement is an important foundation, but it is not enough on its own. Before implementing a university-wide strategy, it is worth assessing whether the institution is ready or has the capacity to support the proposed change. A readiness assessment helps establish whether the necessary conditions, such as shared vision, leadership alignment, staff or student motivation, resources, and infrastructure, are in place. The R = MC² framework (Scaccia et al., 2015) offers a useful lens for this process, conceptualising readiness as a function of Motivation, General Capacity, and Innovation-Specific Capacity. Assessing these dimensions allows universities to identify where strengths lie and where gaps may pose a risk to implementation. A common example is where leadership may be highly motivated, but gaps in staff capability or system infrastructure remain unaddressed. Without identifying these issues early, such gaps could hinder progress even when commitment at the top is genuine.

> ***Understanding readiness before implementation enables leaders to address barriers proactively, prioritise capacity-building where it is most needed, and sequence implementation activities more realistically and strategically.***

This significantly increases the likelihood of successful adoption and long-term sustainability of wellbeing initiatives. Importantly, the assessment should involve a broad range of stakeholders, including relevant departments, practitioners/trainers, and administrative and operational staff, rather than being confined to leadership alone. Without it, securing leadership buy-in risks remaining symbolic rather than translating into the operational change that sustains wellbeing initiatives over time. Domlyn et al. (2021) demonstrated how readiness can be systematically developed through structured capacity-building processes, which involve three stages: assessment, feedback and prioritisation, and strategising. Universities can consider using the Organisational Readiness for Implementing Change (ORIC; Shea et al., 2014) or Organisational Readiness to Change Assessment (ORCA; Helfrich et al., 2009), noting that items may need to be tailored to suit the specific context being assessed.

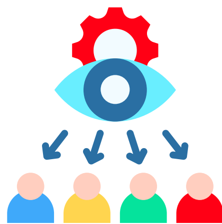
6 IDENTIFY THE COORDINATING UNIT AND STAKEHOLDERS

In line with the Okanagan Charter (2015) and the UK University Mental Health Charter (Student Minds, 2019), a coordinating unit or department should act as a central coordinating body to govern and drive the whole-of-university approach. The role commonly entails:



Overseeing the implementation and evaluation of the wellbeing strategy across the university

Integrating wellbeing into institutional strategies, policies, and curriculum, and ensuring alignment across departments and faculties



Having oversight of key university wellbeing interventions and the corresponding stakeholders in charge

Coordinating and managing stakeholders to ensure programmes are aligned to the overall strategy

Identifying areas for cross-collaboration to streamline efforts across stakeholders and ensure resources are efficiently deployed

Reporting progress to leadership & governance committees

Kuk and Banning (2009) discussed a variety of reporting structures of Student Affairs units (97.4% of them having counselling centres under their charge), ranging from direct reporting to the institutional president or chancellor (65.5%) and provost, to senior vice president or other vice president/dean within their institutions.

In the University of British Columbia (n.d.), Canada, the UBC Office of Wellbeing Strategy drives the university's strategic framework implementations. Similarly, in Singapore, the National University of Singapore (2025) and Nanyang Technological University (2024) set up distinct wellbeing offices that report directly to the university's president or provost. These central wellbeing offices were set up to proactively demonstrate leadership's commitment to improving the university's mental health. Being placed directly under the president or provost lends leadership's weight to help facilitate the integration and coordination efforts across the university.

Harvard University's Report of the Task Force on Managing Student Mental Health (2020) recommended the setting up of a dedicated and diverse team under the Provost's Office to coordinate the health and wellbeing efforts.

Whether the coordinating unit sits within the Student Affairs unit, Human Resources department, Health and Safety department, or as an independent wellbeing unit, the sheer complexity of taking a whole-of-university approach to address the spectrum of staff and student wellbeing needs requires extensive coordination.

> ***The absence of a dedicated coordination unit can increase the risk of siloed practices and reduce the efficacy of outcomes (Harvard University, 2020).***

To increase its effectiveness, this central coordinating unit should have a clear mandate from senior leadership, defined Terms of Reference, and regular reporting mechanisms to the university executive or governing committee. This ensures that mental health and wellbeing are recognised as core strategic priorities and embedded in university-wide decision-making processes (De Pury & Dicks, 2020). Table 4 provides a checklist of the key components required to set up this coordinating unit.

Category	Areas to Consider
Setting up a coordinating body	☐ Obtain formal endorsement from senior leadership: ◦ Stating that mental health and wellbeing is recognised as a strategic leadership priority ◦ Stating the core role and authority of the coordinating unit ◦ Stating allocated resources: manpower, training and budget, etc. ☐ Set up Terms of Reference ◦ Outline the coordinating unit's scope ◦ Outline objectives and deliverables ◦ Outline the roles and responsibilities of stakeholders involved ◦ Outline timeline ☐ Set up accountability measures: ◦ Outline reporting guidelines of deliverables (e.g. annual wellbeing report, quarterly reporting at wellbeing steering committee meetings)

Table 4. Checklist for setting up the coordinating unit

Recognising that universities operate under very different structural and resource conditions, a tiered implementation model can be utilised for universities that are resource-limited. This approach is not intended to set a lower standard for some institutions, but to ensure that all institutions, regardless of manpower, funding, or governance maturity, have a realistic entry point. One that is aligned to their current capacities and has a clear pathway for development over time. Many impactful interventions, including improving communication, fostering peer support, and strengthening psychological safety, do not require major financial investment. They rely instead on strategic prioritisation, leadership commitment, and the effective use of existing resources (Dooris et al., 2020; Grégoire et al., 2024). Table 5 describes three implementation levels — Beginner, Intermediate, and Advanced when implementing a coordinating unit. These should be understood as developmental rather than fixed. Institutions are encouraged to enter at the level that is realistic in their current context and to build progressively as resources, structures, and experience expand (Koch-Kiennast, 2026).

Implementation level	Institutional Profile	Example of Key Actions
Beginner	Institutions with minimal dedicated wellbeing resources, no formal coordinating unit, and early-stage commitment from leadership.	• Small informal cross-functional working group • Rapid low-cost needs assessment (short survey & existing data) • Improve visibility & accessibility of existing support services • Basic staff/student signposting and guidance materials • Initiate 1–2 small pilot activities • Light-touch tracking of 2–3 key indicators (e.g. service utilisation, perceived access)
Intermediate	Institutions with some dedicated resources and growing leadership commitment are buil ding on early foundations.	• Institutions with some dedicated resources and growing leadership commitment are building on early foundations. • Formalise coordination structures (e.g. named coordinating unit or role) • Expand data collection and evaluation practices • Integrate wellbeing into teaching curricula and institutional policies • Develop targeted interventions for specific groups (e.g. international students, postgraduates) • Scale successful pilots to broader populations • Track a balanced set of process and outcome indicators
Advanced	Institutions with sustained funding, dedicated leadership roles, and mature governance structures.	• Dedicated leadership roles (e.g. Chief Wellbeing Officer) • Formal governance and steering committees with executive sponsorship • Robust monitoring, evaluation, and benchmarking systems • Full strategic alignment with international frameworks (Okanagan Charter, UMHC) • Sustained multi-year funding and resource allocation • Comprehensive cross-departmental coordination and reporting

Table 5. Implementation levels when implementing a coordinating unit.

7 IMPLEMENT STRATEGY AND EVIDENCE-BASED INTERVENTIONS

Evidence-based interventions

It is key to ensure that implemented programmes and interventions are evidence-based. Universities need to be clear on the intent of the intervention and how it addresses the problem at hand. WHO mental health at work guidelines recommended a series of intervention approaches that mitigate, reduce or eliminate psychosocial risk (e.g., bullying, low job control) (WHO, 2022). The guidelines also promote individual interventions, like psychosocial interventions or physical activity, which positively impact mental health and work-related outcomes. For example, after their review of existing literature, they advocate for the implementation of manager mental health trainings that are designed to improve mental health knowledge, attitudes, skills, and help-seeking behaviours. Training should also equip managers with skills to identify and support others in distress and manage workplace stressors. Overall, such programmes were found to significantly reduce stigmatising attitudes and improve knowledge. However, no significant effect was found on mental health symptoms or help-seeking (Malik, Ayuso-Mateos, Baranyi, et al., 2023). Understanding what each programme can and cannot do helps the university better target its interventions to the existing ground needs.

As for return-to-work interventions, evidence-based mental health clinical care, paired with work-directed care (e.g., graded return to work) or alone, led to reductions in mental health symptoms and absence (Nieuwenhuijsen et al., 2020; Arends et al., 2012). Recovery-oriented strategies focusing on vocational and economic inclusion, such as (augmented) supported employment, were also found to be effective for persons with severe mental health conditions in obtaining and maintaining employment (Nieuwenhuijsen et al., 2020; Arends et al., 2012).

In addition to choosing evidence-based interventions, universities also need to evaluate the fit and feasibility of implementing programmes or practices in their own context. This involves assessing two complementary sets of indicators (Metz & Louison, 2018):

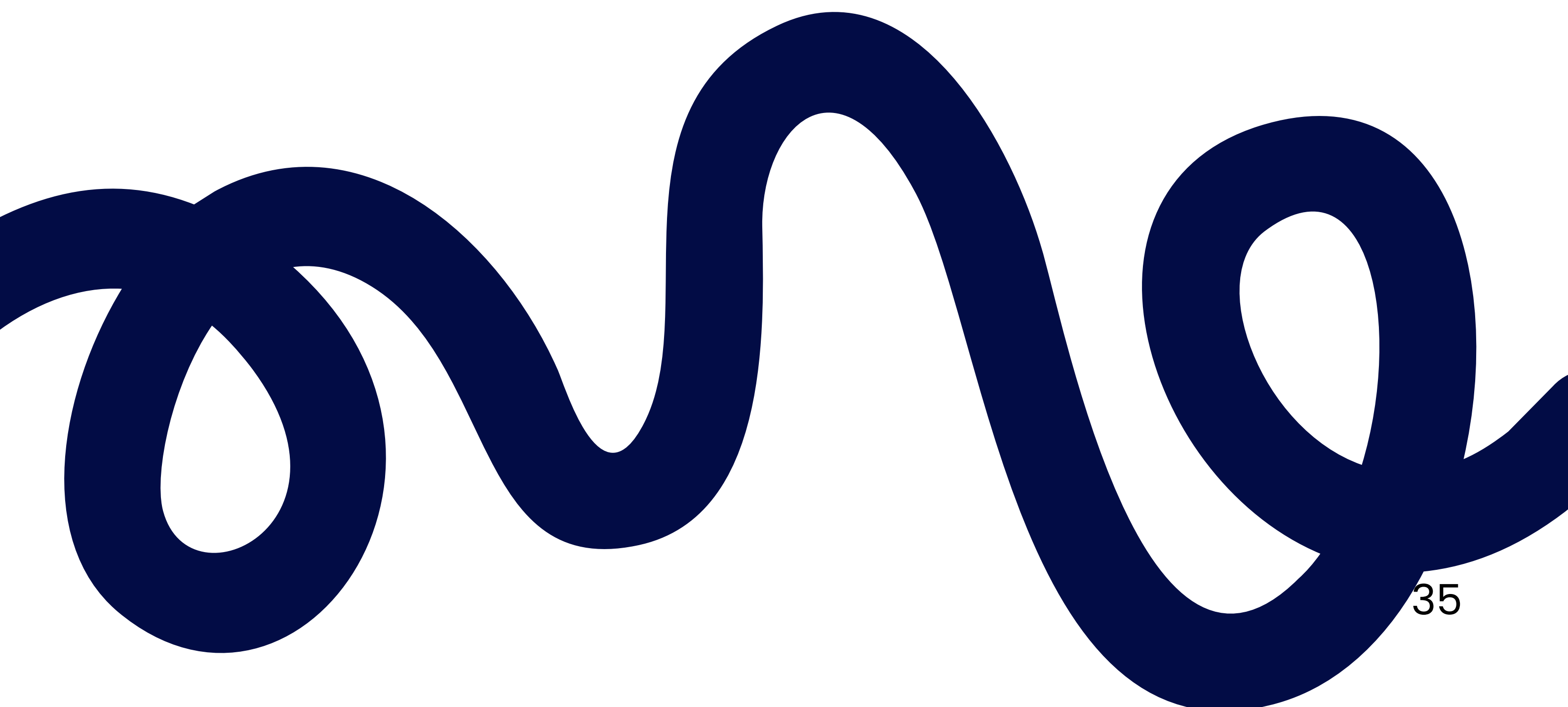
Programme indicators assess the extent to which new or existing programmes or practices demonstrate a solid evidence base, support implementation (training, manuals, tools), and usability across different settings. This ensures that the intervention has proven its effectiveness and has practical support built in.

Implementing site indicators assess how well the programme or practice matches the implementing site's characteristics, including student population needs, cultural context, and available capacity. This assessment specifies the conditions and requirements needed for a strong match to need, fit, and capacity for the identified programme or practice.

By examining both program and implementing site indicators, universities can choose interventions that are not only evidence-based but also contextually appropriate, sustainable, and more likely to achieve the intended outcomes.

If resources are limited, a common strategy is to integrate wellbeing into existing programmes, policies and structures (e.g. orientation programmes, leadership meetings, existing support policies). This helps prevent the duplication of efforts and demonstrates that wellbeing is something that is part of campus life rather than a standalone initiative (Dooris et al., 2020).

Table 6 summarises a list of other common evidence-based interventions that have been evaluated in higher-education or workplace settings and found to be useful. Universities can select and adapt these to their context.



Evidence-based Intervention	Description	Evidence-based outcomes
Mental health literacy training	Mental health first aid (MHFA) for staff and students	Systematic reviews show MHFA improves mental health knowledge, reduces stigma, and increases confidence to support peers (Hadlaczky et al., 2014; Malik, Ayuso-Mateos, Baranyi, et al., 2023).
Peer support	Peer support, learning and mentoring for staff and students	Associated with reduced stress, anxiety and depression, and increased psychological flexibility and well-being (Grégoire et al., 2024). Improves support service accessibility (Suresh et al. 2021)
Curriculum integration	Embedding wellbeing modules into the existing curriculum	Improves mental health knowledge and mental wellbeing (Hobbs, Jelbert, Santos et al. 2024)
Early Intervention Services	On-campus counselling, step care, digital triaging tools	Evidence shows stepped care reduces wait times and better matches students to care intensity (Bower & Gilbody, 2005).
Anti-stigma campaigns	Campus-wide destigmatisation campaign (e.g. NUS (kind)mind campaign, Australia's R U OK? Campaign, UK's Time to Change campaign	Demonstrated population-level reduction in stigma and improved attitudes toward help-seeking (Evans-Lacko, Henderson & Thornicroft, 2013; NUS Health and Wellbeing, 2021).
Sense of belonging initiatives	Inclusion programmes targeting minority groups. Cultural events.	Strong predictor of mental health and retention (Thomas, 2012).
Workload and policy review	Reviewing assessment load, flexible work adjustments	Linked to lower stress and better academic outcomes (Baik, Larcombe & Brooker, 2019).
Digital wellbeing tools	Evidence-based mental health apps, telehealth, chatbots	Linked to improved depression, anxiety, and psychological well-being (Lattie et al., 2019).
Physical and social environment	Green urban spaces	Environmental interventions improve mental and physical health and social cohesion (Jennings & Bamkole, 2019).

Table 6. Evidence-based interventions

8 MONITOR, EVALUATE AND CONTINUOUS IMPROVEMENT

Establishing a structured evaluation plan is critical for demonstrating the impact of a university's wellbeing strategy, identifying gaps for improvement and sustaining leadership commitment. Without structured evaluation, even well-designed interventions may be at risk of becoming a checkbox exercise with little accountability or measurable progress.

Types of Evaluation

The Kirkpatrick's Model of Evaluation is commonly used for evaluating training programmes and shows how initiatives can be measured at four levels (Kirkpatrick & Kirkpatrick, 2006). At the most basic level is a measurement of learners' immediate response to the programme (e.g. how they felt about it directly after). Level 2 assesses if knowledge, skills or attitudes were acquired as a result of the training. Level 3 measures behaviour change over time due to the intervention. The last level measures the long-term impact on the organisation (Kirkpatrick & Kirkpatrick, 2006). Using this model encourages universities to go beyond surface-level feedback and measure if the implemented initiatives are truly shifting behaviours and organisational outcomes. Key initiatives in the wellbeing strategy should be evaluated at all four levels and reported back to leadership. As mentioned above, impact data at level 4 often takes time to occur. Therefore, levels 1-3 can be reported in the interim. Figure 4 illustrates each stage of the model and examples of what measuring could look like.

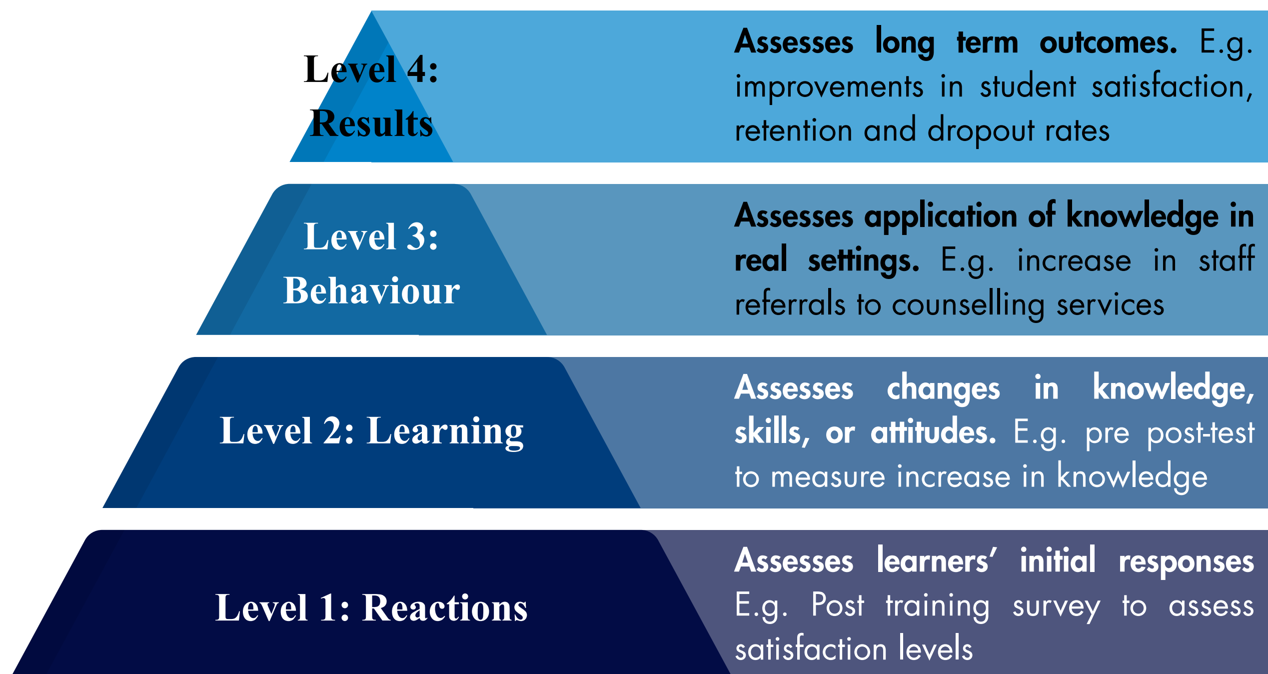


Figure 4. Kirkpatrick's model of evaluation.

Implementation Outcomes, Process Indicators and Outcome Indicators

Effective evaluation requires attention to three distinct yet interconnected types of metrics: Implementation outcomes, process indicators and outcome indicators.

Implementation outcomes assess how well an intervention is being delivered within its real-world context (Proctor et al., 2011). These indicate whether a programme is being delivered as intended and whether it has the conditions (e.g. support or infrastructure) needed to succeed. Table 8 summarises the eight core implementation outcomes central to evaluating the success of implementing evidence-based practices. Importantly, it serves to help interpret evaluation results, making it clear whether poor outcomes stem from the intervention itself or from issues in how it was implemented.

Process indicators, on the other hand, address a more operational dimension. It assesses whether planned programme activities are being carried out as designed (e.g. number of sessions delivered or people who attended, feedback data on how session quality and delivery are being carried out). These indicators help identify operational challenges early (e.g., low attendance, underutilised services) and allow for mid-course adjustments where needed.

Outcome indicators, in contrast, measure the impact of the intervention, focusing on changes in knowledge, attitudes, behaviours, and well-being outcomes. Together, implementation outcomes, process indicators and outcome indicators provide a comprehensive overview of programme performance, making it possible to understand not only "what works" but also "why and how it works."

Table 7 provides examples of process and outcome indicators that can be used to measure wellbeing in a university setting.

1. **Governance & Leadership**
    a. **Process Indicators**
        i. Existence of a dedicated mental health and wellbeing task force or steering committee
        ii. Presence of mental health and wellbeing on the institutional risk register or strategic plan
        iii. Inclusion of mental health & wellbeing as a standing item in executive leadership meetings
        iv. Inclusion of wellbeing Key Performance Indicators for leadership
        v. Number of senior leadership involvements in wellbeing programmes
        vi. Number of meetings held annually to review wellbeing priorities
    b. **Outcome Indicators**
        i. Increased budget allocation for mental health and wellbeing initiatives
        ii. Increase in allocated time for staff and students to engage in wellbeing activities
        iii. Achievement of wellbeing KPIs

2. **Access to Care & Support Services**
    a. **Process Indicators**
        i. Average wait time from first contact to counselling or coaching appointment
        ii. Ratio of mental health professionals to students/staff
        iii. Proportion of staff or students trained in Mental Health First Aid or equivalent programmes
        iv. Utilisation rates of services
        v. Insurance claim rates
    b. **Outcome Indicators**
        i. Increase staff and students reporting that they can access help promptly
        ii. Reduction in crisis presentations over time
        iii. Increased utilisation of early intervention and preventive services
        iv. Reduction in insurance claims over time

3. **Campus Culture**
    a. **Process Indicators**
        i. Number of anti-stigma or wellbeing campaigns and wellbeing workshops conducted annually
        ii. Number of staff and student leaders trained in wellbeing champion roles
        iii. Integration of wellbeing topics in orientation and transition programs
    b. **Outcome Indicators**
        i. Increase in % of staff and students reporting they feel comfortable talking about mental health
        ii. Increase in knowledge on how and where to seek help
        iii. Increase in % of help-seeking among staff and students
        iv. Reduction in perceived stigma scores on campus climate surveys
        v. Reduction in attrition
        vi. Reduction in sickness absence rates

Table 7. Examples of Process and Outcome Indicators

4. **University policies and infrastructure**
    a. **Process Indicators**
        i. Number of flexible workplace policies (extensions, special consideration, mental health return to work policy)
        ii. Number of wellbeing spaces on campus
        iii. Number of counselling rooms and centres available
        iv. Presence of annual psycho-social risk assessment for each department/faculty
        v. Utilisation rates of wellbeing infrastructure
    b. **Outcome Indicators**
        i. Improvement of key wellbeing indicators over time
        ii. Reduction in reports of workload stress on wellbeing surveys
        iii. Improved retention rates, particularly for at-risk groups

5. W**hole-of-university Approach & Partnerships**
    a. **Process Indicators**
        i. Number of cross-department collaborations on wellbeing initiatives
        ii. Partnerships formed with external mental health services or organisations
    b. **Outcome Indicators**
        i. Improved alignment of services and reduced duplication (measured through mapping exercises)
        ii. Improved satisfaction scores in annual student and staff wellbeing surveys

6. C**ontinuous Improvement & Data Use**
    a. **Process Indicators**
        i. Frequency of data collection and reporting cycles
        ii. Number of co-creation workshops or focus groups held with students and staff annually
        iii. Evaluation reports published and shared with stakeholders
        iv. Conduct of annual benchmarking exercises
    b. **Outcome Indicators**
        i. Improvement of key wellbeing indicators over time
        ii. Adoption of evidence-informed practices based on evaluation findings

Table 7. Examples of Process and Outcome Indicators

Outcomes	Definition	Examples	When It Is Useful
Acceptability (Satisfaction)	The perception among stakeholders that an intervention is agreeable, palatable, or satisfactory (i.e., their attitude and buy-in).	A survey conducted with stakeholders shows general acceptability of the proposed programme and implementation plan.	Early in implementation
Adoption (Utilisation, uptake, intention to try)	The intention, initial decision, or action to try or employ an innovation or evidence-based practice.	The HR department agrees to make peer support training a mandatory training course for all staff.	Early to mid-implementation
Appropriateness (Perceived fit, suitability, relevance)	The perceived fit, relevance, or compatibility of an innovation for a specific context, provider, or problem.	Counsellors believe that a programme aligns with client needs or organisational mission.	Early stage (assessed before or during the adoption)
Feasibility (Practicality)	The extent to which an intervention can be successfully used or carried out within a specific setting. Assesses readiness and practical capacity to implement.	Senior management, practitioners, and operations staff perceive the programme to be practical and implementable after considering manpower, cost, and space.	Early stage
Fidelity (Delivery as intended, adherence, quality of delivery)	The degree to which the intervention was implemented as intended by developers. This is crucial for maintaining intervention integrity and understanding variation in outcomes.	Facilitators deliver resilience sessions exactly as designed, using programme manuals and recommended exercises.	Early to mid-stages
Implementation Cost (Cost effectiveness, cost-benefit)	The cost impact or financial burden associated with implementation activities. Important for comparing the cost-effectiveness of strategies and informing sustainability decisions.	The university calculates costs for the proposed programme and compares them with alternative solutions.	Across all stages
Penetration (Level of institutionalisation, spread, service access)	The extent to which an intervention has been integrated into a service setting and its subsystems.	Resilience programme expands from pilot to 70% of the campus staff within 2 years, with high rates of attendance.	Mid to late stages
Sustainability (Maintenance, durability, continuation)	The extent to which an implemented innovation is maintained or institutionalised within ongoing operations.	The coaching programme continues to be implemented successfully after its initial launch and is funded by the annual budget.	Late stage

Table 8. Examples of implementation outcomes and when they are applicable based on Proctor et al. (2011)'s seminal paper.

Evaluation process

Evaluation should be built into the strategy from the outset, not retrospectively. This requires defining clear objectives and outcomes for each selected initiative before delivery begins. A theory of change provides the overarching framework for this process and explains why and how an intervention is expected to lead to the desired impact. It explains the underlying logic, key assumptions, and contextual factors that link specific actions to intended outcomes, offering a narrative or conceptual map of the change process. Building on this, logic models can be used to visually present these relationships in a structured and measurable way – mapping the resources invested in a program (inputs) to the activities delivered, the immediate outputs produced, and the short-, medium-, and long-term outcomes expected (Kellogg Foundation, 2004).

The logic model should also include a (i) rationale, which is the belief about how the change occurs and with your specific clients (or audience), based on research, experience, or best practices and (ii) the conditions/assumptions that are necessary for the programme to succeed. There are several benefits to having a logic model, including generating a clear and shared understanding of how the programme works, preventing mismatches between activities and expected outcomes, and supporting programme planning, improvement, and evaluation. Table 9 details an example of how this can be mapped out.

Sample Rationale and Conditions/Assumptions

Rationale: The peer support programme aims to strengthen student wellbeing by building a supportive campus environment where students improve their mental health literacy, feel more confident in seeking help and build meaningful peer connections. Research shows that peer-support initiatives can reduce psychological distress and increase both help-seeking behaviour and sense of belonging within university communities (Grégoire et al., 2024). The programme draws on peer influence and social connectedness to complement existing professional mental health services, with the goal of creating a more accessible and sustainable wellbeing ecosystem.

Conditions/assumptions (Not exhaustive):

- Visible leadership support and institutional endorsement
- Sufficient student engagement and willingness to participate as peer supporters and recipients
- A designated staff coordinator to oversee implementation, monitor outcomes, and ensure quality assurance
- Co-created content developed in collaboration with external providers, students and mental health experts to ensure relevance and appropriateness
- Ongoing support and supervision for trained peer supporters

Inputs	Activities	Outputs	Short-term outcome	Intermediate outcome (1-2 years)	Long-term impact (3-5 years)
$100k budget allocated to training, staff coordination, and engagement with the training service provider	Recruit and train student peer supporters; facilitate ongoing peer support circles	50 peer supporters trained, 300 students attending peer support sessions	50% improvement in mental health literacy scores and self-reported willingness to seek help.	20% increase in service utilisation and sense of belonging scores, 30% reduction in psychological distress scores,	20% increase in graduation rates, 50% decrease in student withdrawal attributable to mental health-related issues

Table 9. An example of how to use a logic model to map out the evaluation of an intervention.

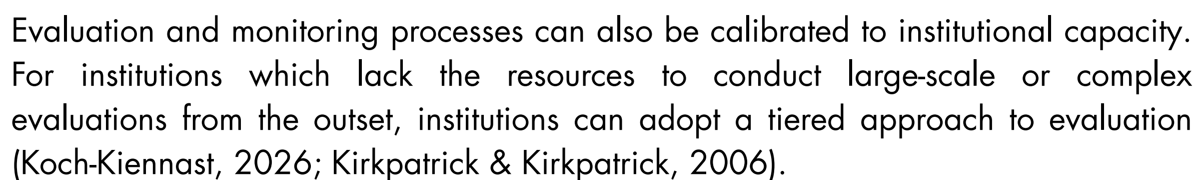
Common Survey Tools to Assess Wellbeing Climate

Annual Student Life Surveys and Employee Engagement Surveys are popular ways to help assess the overall university wellbeing climate. The most traditional surveys include scales that measure stress, anxiety and depression. However, with the shift toward a preventative approach towards wellbeing and creating thriving environments, measures on positive psychology like belonging or PERMA+4 are starting to be included. PERMA+4 is a framework for flourishing consisting of: Positive Emotions, Engagement, Relationships, Meaning, and Accomplishment. It includes 4 additional domains: Physical health, Mindset, Environment, and Economic security) (Donaldson, van Zyl & Donaldson, 2022). Depending on the priority areas highlighted by the task force, the appropriate scale should then be selected. A combination of scales should be used so that one can assess the impact of ground initiatives against identified wellbeing constructs. For example, measuring the hypothesis that faculties or departments that promote mental health resources (measured by the Workplace Mental Health Support Scale) are more likely to have staff or students with significantly higher PERMA+4 scores (i.e., a predictor of a flourishing community) compared to those which do not promote mental health resources.

Table 10. below summarises wellbeing survey instruments and their uses.

Instrument	Description
Patient Health Questionnaire (PHQ) (Kroenke, Spitzer & Williams, 2001 & 2003)	Assesses a person's risk of depression
General Anxiety Disorder (GAD) (Spitzer, Kroenke, Williams, et al., 2006)	Assesses a person's risk of anxiety disorders
Perceived Stress Scale (PSS) (Cohen et al., 1983)	Assesses the degree to which individuals appraise situations in their lives as stressful
Depression Anxiety Stress Scales (DASS) (Lovibond & Lovibond, 1995)	Assesses the key symptoms of depression, anxiety and stress
PERMA+4 (Donaldson, van Zyl & Donaldson, 2022)	Assesses nine dimensions of work-related wellbeing, spanning the five core PERMA pillars (Positive emotions, engagement, relationships, meaning, and accomplishment) and four additional domains (Physical health, mindset, environment, and economic security)
Experienced Compassion (Lilius, Worline, Maitlis et al., 2008)	Assesses the frequency with which individuals experience compassion from colleagues and supervisors at work and examines its relationship to positive emotion and affective commitment to the organisation.
Brief Resilience Scale (BRS) (Smith, Dalen, Wiggins et al., 2008)	Assesses an individual's resilience, the ability to bounce back or recover from stress
Stigma and Self-Stigma scales (Docksey, Gray, Davies et al., 2022)	Assesses multiple dimensions of mental health stigma, including cognitive attitudes towards others, emotional avoidance responses, anticipated stigma from others, self-stigma, avoidant coping strategies, and help-seeking intentions
Personal Stigma Scale (Tay, 2022)	Assesses the degree of personal stigma held towards individuals with depression, measuring stigmatising attitudes across a three-factor structure. Validated for use among university student populations in Singapore.
Social Distance Scale (SDS) (Link, Phelan, Bresnahan et al.1999)	Assesses the degree of comfort an individual has when engaging in everyday social interactions
Psychological Safety (Edmondson, 1999)	Assesses the shared belief among team members that it is safe to take interpersonal risks without fear of punishment, humiliation, or negative consequences.
Sense of Belonging Scale (Hoffman, Richmond, Morrow et al. 2003)	Assesses an individual's level of connection and acceptance by measuring perceived peer support, comfort in class discussions and lack of feelings of isolation.
Workplace Mental Health Support (WMHS) (Internal instrument with no published reference)	Assesses perceived departmental support & knowledge of mental health resources in an institution.

Table 10. Wellbeing Survey Instruments



Evaluation and monitoring processes can also be calibrated to institutional capacity. For institutions which lack the resources to conduct large-scale or complex evaluations from the outset, institutions can adopt a tiered approach to evaluation (Koch-Kiennast, 2026; Kirkpatrick & Kirkpatrick, 2006).

Beginner: Prioritise a small set of meaningful indicators (e.g. service utilisation rates, accessibility to support, general wellbeing measures) using existing data sources or brief surveys.

Intermediate: Implement a structured evaluation plan covering all four levels of Kirkpatrick's model for key programmes, with regular reporting cycles. Begin tracking a broader set of implementation outcome, process and outcome indicators.

Advanced: Robust monitoring and evaluation systems as described in the full guidance above, including longitudinal wellbeing surveys, external benchmarking, and systematic use of implementation outcome frameworks (Proctor et al., 2011).

Continuous Improvement

Finally, universities are encouraged to establish a wellbeing data review committee to regularly analyse findings and translate them into action. Using structured reporting intervals helps ensure that insights inform decisions about policy, resource allocation and strategic direction.

A practical and well evidenced way to operationalise this is through Plan–Do–Study–Act (PDSA) cycles (Deming, 1986; Langley et al., 2009). PDSA cycles test change on a small scale before broader rollout. In the "Plan" stage, the committee identifies a specific area for improvement and develops a small-scale test or pilot intervention. In the "Do" stage, the intervention is implemented in a contained setting (e.g., one faculty or student group). The "Study" stage involves analysing data to see what worked and what didn't, and in the "Act" stage, the university decides whether to adapt the approach, adopt it more widely, or abandon the intervention.

At all levels of evaluation, the PDSA cycle approach is strongly recommended. Starting small allows universities to identify barriers early, refine their approach, and build a credible evidence base before committing significant resources to full-scale rollout. When a pilot demonstrates positive impact and is feasible to sustain, it can then be scaled up across more faculties, campuses, or the entire student body with far greater confidence. This approach not only drives continuous improvement but also builds a culture of evidence-informed decision-making within the institution. .

Barriers identified along the way can be addressed using the COM-B Model and the Behaviour Change Wheel (Michie, van Stralen & West, 2011; Michie, Atkins & West, 2014). It offers a structured way to help identify whether the barrier to change is due to a lack of capability, opportunity, or motivation. From there, targeted solutions can be designed to address the specific nature of the barrier, making implementation more precise and likely to succeed.

Equally important is ensuring that there is a clear feedback process loop to the relevant stakeholders. This loop provides insights from monitoring, evaluation, and student or staff input, which are communicated promptly to decision-makers, programme leads, and frontline implementers. This allows universities to respond quickly to emerging issues, refine interventions in real time, and sustain stakeholder engagement. It allows universities to become more agile and better placed to sustain meaningful engagement over time.

Summary

Implementing a whole-of-university approach takes a collective effort to support the wellbeing needs of staff and students. This guideline provides a practical, evidence-informed roadmap universities can use to implement this. Beginning with establishing a task force to conduct a systematic review of the wellbeing ecosystem. As gaps are identified, solutions can be co-designed as part of a multi-year strategic plan backed by strong leadership commitment and a coordinating unit. It also highlights the importance of implementing evidence-based interventions and setting out a clear evaluation plan from the outset to demonstrate impact and continuous improvement. Institutions are encouraged to identify their current level of capacity honestly, begin with achievable and impactful actions, and build progressively over time. The process aims to support a coordinated, sustainable approach that strengthens wellbeing and fosters a culture of wellbeing across the institution.

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