

Article

# Staff Confidence in Supporting Student Mental Health: Outcomes from a Survey

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**Abstract:** (1) Background: The number of university students experiencing mental health problems has been a growing concern over recent decades, and support for them is now considered an inevitable part of the role of an academic. Research into the role of the academic reveals ambiguous expectations and weak support regarding their pastoral responsibilities, leading to a lack of confidence when dealing with student mental health concerns. (2) Methods: Following previous research, the present preliminary study employed an online survey (N = 43) in three schools at a university in the East of England to identify academics' current confidence in supporting student mental health. This addressed four subscales: (i) identifying mental health concerns in students, (ii) approaching and discussing mental health concerns with students, (iii) academics' knowledge concerning the central support services available within the university, and (iv) academics' skills in providing ongoing support for student mental health and wellbeing. (3) Results: Female respondents scored higher than males on their knowledge concerning the central student mental health support services within the university, and 60+-year-old lecturers were least confident in identifying mental health concerns compared to 40–49- and 50–59-year-olds. (4) Conclusions: Recommendations for interventions include mental health awareness training, policy development, and a precise and nuanced description of an academic's pastoral role and responsibilities to ensure that students receive appropriate and sufficient psychological support.



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## 1. Introduction

Mental health has been a growing topic of interest in recent years. With three-quarters of mental health difficulties developing by the age of 24, it is evident that university students are a vulnerable group at high risk [1]. The number of students attending higher education institutions (HEIs) has reached record highs in recent years [2] (p. 5), and the proportion of UK undergraduates reporting mental health difficulties has almost tripled, meaning one in six now has poor mental health [3] (p. 27). The significant increase in university attendance among this high-risk group is mirrored in the surge of demand for counselling and disability services over the previous five years, reported by HEIs [4] (p. 10), thus emphasising the importance of tackling the challenge of mental health that the higher education sector is facing.

Mental health encompasses emotional, psychological, and social wellbeing. The WHO defines mental health as 'A state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community' [5]. It is a state of mind that can affect an individual's ability to learn, work, productively, socialise, and cope with the stresses of life [5,6]. Learning, working productively, and socialising are all integral to the life of a student; thus, if students do not receive adequate mental health support,

there is a greater risk that they will either withdraw from their studies or obtain lower academic and employment outcomes [7,8] (pp. 2–4). This, in turn, constitutes a loss of income for the student, HEI, and government [9] (pp. 6–37). In severe cases, failing to support students' mental health could lead to disastrous consequences, such as death by suicide; when compared to the general population, suicides in higher education students are estimated as being 2.7 times higher [10]. Causal and risk factors of poor mental health have been highlighted in previous research and consistently indicate that there are multiple risks within the student lifestyle, particularly in the first year of university. For example, moving away from the family home, having reduced access to previous support networks and establishing new ones, and creating new identities—all while acclimatising to their new living and learning environment and managing their own financial pressures, to name a few [11]. Students can also face considerable academic pressures from the current higher education trends, emphasising self-directed and blended learning more, further affecting their ability to cope [12] (p. 34). Intersectionality of students' backgrounds, such as those from disadvantaged or international communities, mature students, and neurodiverse individuals, significantly impacts their mental health and increases the risk of suicide due to the unique challenges and pressures they face [13] (p. 13). As a group that has been epidemiologically defined as being at high risk, the addition of these causal factors makes university students particularly vulnerable to developing mental health concerns. This emphatically demonstrates that support from HEIs is vital in overcoming mental health issues, as well as enabling students to reach their full potential.

Given these risk factors, responding to students' mental health concerns is now considered an integral part of an academic role [12,14] (p. 5). Yet, research into staff supporting student mental health is scarce. Most of the current literature concerning mental health issues in students focuses on, and targets, students rather than the academic staff supporting them. Of the limited research available, in 2015, the Institute for Employment Studies published a report consisting of both a literature review and a qualitative study interviewing 142 academics from 12 HEIs and concluded that there was an overall lack of awareness and confidence when responding to students' mental health concerns [11]. Similar findings were expressed in a 2018 qualitative study by Student Minds [12], where 52 academics from five English HEIs were interviewed. This report supported the view that increased demand exists for supporting students' mental health. Academics are often the first port of call for students experiencing emotional distress because, compared to support services, they are more immediately accessible and have an established relationship. It is also common practice for students to be advised to go to their academic or personal tutor (an assigned member of teaching staff to support students' academic and pastoral needs) as a point of contact within the university should they experience any difficulties. This has led to some staff, particularly those deemed more approachable, responding to students in distress outside their usual working hours, encroaching on their personal and professional lives. However, this report also revealed ambiguous expectations and weak institutional support provided to academics regarding their pastoral responsibilities. A key theme emerging from the study suggested that the necessary structures are not in place to support this additional role, and the academic staff struggle to limit student engagement to their working hours, with faculty facing the expectation of being available at any hour and leading to a significant increase in their workload and encroaching on their personal time [12].

In a recent study by Douwes et al. [15] exploring students' views on the educator's role supporting student wellbeing and the requirements thereof, students distinguishing between tutors and teachers perceived tutors as most crucial. Four roles were identified: confidant, linking pin, a monitoring role (all three for tutors only), and a signaller role for both tutors and teachers. Requirements for both tutors and teachers included a close and informal teacher–student relationship, availability of time/timing of contacts, ability to provide structure, empathic attitude, and a high level of dependability mentioned for tutors only. It was reported that students require emotional needs to be addressed as

well as intellectual needs (to a lesser degree), acknowledgement of diversity in needs and preferences, and the importance of managing student expectations.

Although supporting student mental health has been emphasised as an inevitable responsibility of academic staff, there has not been a robust attempt to investigate academics' confidence in helping students with their mental health concerns, nor any assessment of the impact of new interventions to inform future strategy. To further address this issue, the current study intended to use an online survey to identify current confidence levels and limitations for academics supporting student mental health. This would appear to be the first self-reported staff confidence survey to review the management of student mental health concerns from the perspective of academics rather than students.

## 2. Materials and Methods

A preliminary online survey was undertaken at a university in the east of England to assess academics' confidence in four subscales designed by the authors: (1) identifying mental health concerns in students; (2) approaching and discussing mental health concerns with students; (3) academics' knowledge concerning the central support services available within the university; and (4) academics' skills in providing ongoing support for student mental health and wellbeing. The survey measurement was the confidence scores on the four subscales, with a possible minimum score of 10 and a maximum score of 50, since ten items were in each subscale, each measured on a 1–5 Likert scale [16].

Subscale Examples:

1. Identifying mental health concerns in students: "I can recognise when a student is displaying signs of anxiety";
2. Approaching and discussing mental health concerns with students: "I feel comfortable initiating a conversation with a student about their mental health";
3. Knowledge concerning central support services: "I am aware of the mental health resources available to students within the university";
4. Providing ongoing support: "I know how to offer continued support to a student after the initial discussion."

The experimental hypothesis was twofold. Reviewing the demographic data of HEIs revealed that there are more male academics in the UK, particularly in full-time positions, which implies that male academics are more likely to engage with students on the front line, some of whom may have a mental health concern [17]. Reviewing the literature illustrated that sex (male and female) is a predictor of help-seeking behaviour and that there is a more positive attitude towards mental health in females when compared to their male counterparts [18,19]. Due to this, if females are more likely to seek help for their mental health, then, arguably, female academics may perceive higher confidence in supporting students compared to male academics. Therefore, it was hypothesised that female respondents would score higher in all aspects of the confidence survey. Additionally, it was anticipated that there would be differences in the confidence scores between the ages [19], with younger respondents having higher confidence levels in supporting students with mental health concerns when compared to older respondents.

This preliminary survey was distributed to faculty and staff across only three university schools due to constraints imposed by the university, including undergraduate and graduate programmes. Specifically, the Schools of Law, Life Sciences, and Medical Sciences were included due to their diverse student populations and the varying levels of interaction between faculty and students. Permission to contact staff members was approved for these three schools, and ethical approval was sought. Overall, 1146 members of staff were contacted. The inclusion criteria included anyone in regular contact with students. Following the initial email, follow-up emails were sent from the Wellbeing Champions at each school to encourage participation. All participants were sent detailed information sheets explaining what was required of them to participate and the purpose of this study, which was framed as an opportunity to contribute to further research into student mental health

that can inform the development of staff training. After four weeks, 60 people responded to the survey, out of which 43 surveys were completed in full and included in the dataset.

The respondents were divided into four age groups: 20–29, 30–39, 40–49, 50–59, and 60+. However, it is important to note that some of these subsamples were small, with as few as 5 or 8 individuals, which limits the statistical power and robustness of the findings. To address this limitation, we have adjusted our analytical approach and provided a cautious interpretation of the results.

Of the completed surveys, there were eight respondents from the humanities (18.6%), nine from law (20.9%), and 26 from LMS (60.5). The respondents occupied various roles and seniority: lecturers, principal lecturers, deans, administrators, technical officers, tutors, and academic managers. Of these respondents, 14 were male (32.6%) and 29 female (67.4%).

Table 1 specifies the respondents' ages, which were collected using a range to preserve anonymity. As academics are unlikely to be between the ages of 16 and 20, the categories were adjusted to exclude young adults.

**Table 1.** Summary of the survey participants' age range.

Age Range	N	Percentage (%)
20–29	1	2.3
30–39	8	18.6
40–49	12	27.9
50–59	17	39.5
60+	5	11.6

The survey was designed to take around 10 min to complete and utilised an online survey platform. At the outset, participants were asked to provide informed consent. There were 40 items in blocks of 10 statements, each corresponding to one of the four subscales. Their response to each statement was measured on a five-point Likert scale: 1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, and 5 = strongly agree. The survey adopted a simple item pool of statements, each item having the same agree/disagree response categories. Positive and negative statements were designed to produce an alternating order to avoid a response set or bias. Positive statements demonstrated a confident response to supporting student mental health, for example, "I know when it is appropriate to approach a student about their mental health". Negative statements show a lack of confidence when supporting student mental health; for example, "I do not know how to increase student help-seeking behaviour". The order of the questions within the subscales uses the funnel approach, asking broader questions first before progressively narrowing down to more specific questions; for example, "I am knowledgeable of the risk factors that may cause poor mental well-being" was asked before "I am not aware of the government legislation relevant to supporting a student with a mental health concern". Respondents were invited to complete the survey by indicating their level of agreement or disagreement with each statement and were assured there were no right or wrong answers. The survey was completed after answering the 40 statements, and no further action was required.

After the data input, negative items were reverse-scored, with 1 for strongly agree and 5 for strongly disagree, to ensure confident scores represented the positive and negative statements after analysis.

### 3. Results

To assess internal reliability, Cronbach's alpha compares the amount of shared variance; a value of 0.7 or greater was considered acceptable [20]. Analysis of the survey's question items and the five-point Likert scale indicated a Cronbach's alpha of 0.7 or above in three subscales. A total of two questions were removed from the dataset to ensure internal reliability in the statements, both concerning the same subscales: approaching mental health concerns. The two statements deemed as unreliable and therefore removed from

the final data set were “I do not feel comfortable speaking about mental health issues with students” and “I do not feel comfortable asking if a student has had suicidal thoughts”.

Overall, the internal reliability of the survey was considered satisfactory, as detailed in Table 2 below, demonstrating the survey accurately measured the four subscales. The survey demonstrated face validity as it comprised items directly pertaining to academics’ attitudes and their self-assessed efficacy when supporting student mental health, which is the construct the instrument aims to measure.

**Table 2.** A summary of the final scale property is used to assess the reliability of the questionnaire internally.

Subscale	Alpha	N Questions Retained	Mean	SD
Identifying MH concerns	0.79	10	32.6	6.0
Approaching MH concerns	0.74	8	25.0	5.1
Support services	0.80	10	29.8	6.1
Providing ongoing support	0.87	10	30.0	2.4

The above table provides the final confidence scores for all respondents. With two questions removed, the maximum confidence score that a respondent could achieve was 190, and a minimum of 38. Overall, respondents were most confident in identifying mental health concerns in students (mean = 32.6; SD = 5.1) and least confident in approaching mental health concerns (mean = 25.0; SD = 5.1). When comparing individual items, the two highest scoring items were “I know how stress can impact mental well-being” (mean = 4.2; SD = 0.85) and “I am certain of the written recording requirements of meetings with students with poor mental health” (mean = 4.0; SD = 0.91). The two lowest confidence scores were “I understand the limitations of my role as an academic supporting students with mental health concerns” (mean = 2.1; SD = 1.1) and “I am confident being a personal tutor” (mean = 2.3; SD = 1.0).

### 3.1. Comparing Male and Female Staff Confidence in Supporting Student Mental Health

The analysis considered differences in male and female responses to different subscales of the questionnaire, and the descriptive data are presented in Table 3 below.

**Table 3.** Mean and total (SD) confidence scores per subscale by sex.

	Sex	
	Male (n = 14)	Female (n = 29)
Identifying MH (n = 10)	30.4 (5.2)	33.6 (6.1)
Approaching MH (n = 8)	23.2 (4.5)	25.8 (5.2)
Support services (n = 10)	27.0 (4.0)	31.1 (6.6)
Providing ongoing support (n = 10)	30.1 (2.7)	29.8 (2.2)
Total (n = 38)	110.8 (16.4)	120.4 (16.3)

When comparing sexes, it is worth noting that male respondents had an overall lower confidence score (mean = 110.8; SD = 12.1) compared to females (Mean 120.4, SD = 16.3).

### 3.2. Comparing Male and Female Staff Confidence Supporting Student Mental Health

The analysis considered age group differences in responses to different subscales of the questionnaire, and the data are presented in Table 4 below.

**Table 4.** Mean and total (SD) confidence scores per subscale by age group.

	Age			
	30–39 (n = 8)	40–49 (n = 12)	50–59 (n = 17)	60+ (n = 5)
Identifying MH (n = 10)	30.3 (4.6)	34.6 (4.6)	34.8 (5.6)	26.2 (5.0)
Approaching MH (n = 8)	25.6 (6.7)	25.3 (4.3)	25.8 (4.8)	20.8 (4.4)
Support services (n = 10)	26.1 (6.2)	31.5 (4.8)	31.4 (6.5)	27.2 (5.5)
Providing ongoing support (n = 10)	30.5 (2.3)	29.7 (2.8)	29.8 (1.5)	29.8 (4.1)
Total (n = 38)	112.5 (16.4)	121.0 (13.8)	121.9 (15.4)	104.0 (10.4)

Due to having one respondent in the 20–29 age group, this data were excluded from the analysis due to insufficient respondents. Table 4 above represents the summary of the confidence scores between age groups. Respondents aged 50 to 59 (mean = 121.9; SD = 15.4) had the highest confidence score, closely followed by respondents aged 40 to 49 (mean = 121.0; SD = 13.8). Respondents aged 60+ had the lowest confidence score (mean = 104.0; SD = 10.4).

#### 4. Discussion

The survey assessed academics' confidence in four subscales to ascertain their current knowledge, skills, and awareness of the complexities surrounding their support for student mental health. This aimed to identify academics' current confidence in supporting student mental health and assess whether confidence levels differ between age groups and sexes.

The results of this study revealed a mid-range confidence score across all subscales in total for both sexes and all age groups, which highlights that there is still a need for improvement and that all academics need further development to enhance their confidence and ability to meet challenges related to student mental health concerns. Academics generally reported moderate confidence in identifying mental health concerns in students. This aligns with previous research indicating that while faculty are often the first to notice changes in student behaviour, they may lack specific training to accurately identify mental health issues [14]. Confidence levels varied significantly, with some academics feeling comfortable initiating conversations while others expressed discomfort and uncertainty. This finding echoes previous studies highlighting the discomfort faculty feel in addressing sensitive issues like mental health [12]. Academics reported higher confidence in their knowledge of available support services. This suggests that awareness campaigns within the university have been somewhat effective but still need support enhancing this knowledge as suggested in prior research [13]. The lowest confidence was observed in providing ongoing support, reflecting concerns about the sustainability of such support and potential encroachment on personal time [3].

Academics generally reported moderate confidence in identifying mental health concerns in students, with the highest confidence score observed in this subscale (Mean = 32.6, SD = 5.1). Female respondents scored slightly higher than their male counterparts (mean = 33.6 and 30.4). This finding aligns with previous research indicating that faculty often notice changes in student behaviour but may lack specific training to identify mental health issues accurately [12]. The moderate confidence suggests a need for enhanced training programs focusing on the identification of mental health concerns to improve early intervention efforts, in line with the previous literature [12–14].

The subscale concerning addressing and discussing mental health concerns revealed the lowest confidence levels among respondents (mean = 25.0; SD = 5.1), indicating significant discomfort and uncertainty in initiating conversations about mental health. The lack of confidence faculty staff appear to feel in addressing sensitive issues like mental health is consistent with previous studies [12,14,15]. This highlights the need for workshops and training exercises to effectively build communication skills to approach and discuss mental health concerns [13].

Academics reported higher confidence in their knowledge of available support services (mean = 29.8; SD = 6.1). Female respondents scored higher than males (mean = 31.1 and 27.0), suggesting better awareness among female academics. The effectiveness of awareness campaigns within the university is reflected in this result. However, it also indicates the need for continuous updates and clear communication about available resources to maintain and enhance this knowledge [9]. Given that male academics reported lower confidence, targeted interventions are necessary to improve their awareness and utilisation of support services.

Confidence in providing ongoing support was moderate (mean = 30.0; SD = 2.4) but revealed concerns about the sustainability of such support and its impact on personal time. This could reflect faculty concerns about workload and the potential encroachment on both work and personal time, as noted in previous research [12]. Institutions must define clear boundaries and provide additional support mechanisms, such as mental health liaisons, to help faculty manage these responsibilities effectively.

The hypothesis speculated that female respondents would score higher in all aspects of the confidence survey. Yet, statistical analysis revealed that females scored higher than males in one subscale regarding knowledge of central support services available within the university. This suggests male lecturers may need additional support understanding the services available and how to signpost students to support their mental health at the university. Given the existing research suggests that males are less inclined to seek mental health support [17], it is plausible that this extends to their awareness and utilisation of support services within a university setting. While future interventions need to provide all academics with the tools to improve their mental health support skills, because there are a greater number of male academics in full-time positions in the UK, addressing this gap in knowledge and awareness among male lecturers is important to foster a supportive and inclusive university environment.

While future interventions need to provide all academics with the tools to improve their mental health support skills because there are a greater number of male academics in full-time positions in the UK, it is important that confidence in supporting student mental health is not imbalanced across the sexes to ensure support for student mental health is the same, regardless of the sex (male or female) of their academic tutor or team. Traditional gender norms often discourage men from discussing emotional concerns or vulnerability [18,19]. Therefore, providing male-led interventions to improve mental health literacy and confidence may be practical to support male academics to feel more confident discussing student mental health.

The demographic data of academics in the UK also revealed more academic staff between the ages of 35 and 55. The previous literature has suggested that older people have a less positive attitude towards mental health, and younger people aged under 35 have the most positive attitude [21]. This discovery led to the hypothesis that confidence disparities between age groups would exist. It was expected that younger academics would achieve greater confidence scores and older academics the lowest. Consistent with the hypothesis, the most senior age category with respondents aged 60+ scored the lowest and, therefore, had the least confidence in their awareness, knowledge, and skills when supporting student mental health.

Interaction between subscales and age revealed: (a) academics aged 30–39 and 60+ scored the lowest in identifying mental health concerns; (b) all academics reported less confidence when approaching students with mental health concerns, mainly those aged 60+; (c) academics aged 30–39 and 60+ had the lowest confidence in student support services; and (d) there were no differences in confidence towards providing ongoing support. These results prove the hypothesis that the academics aged 60+ are the age group in greatest need of intervention. However, academics aged 30–39 were expected to score the highest, which disproves the prediction that younger academics have the most confidence. Furthermore, these two age groups need future interventions to provide them with the tools to be able to identify mental health concerns and improve their knowledge

of the support services available. According to the University Mental Health Charter, all academics, regardless of age, need training interventions to improve their skills, providing students with ongoing support [15] (pp. 47–49). A study by Payne interviewed staff and students, and a major recommendation was implementing bespoke staff training, providing staff with the knowledge and skills to support students with poor mental health [22]. This helpful information indicates that when devising future training, it should not be assumed that younger academics have more confidence. Instead, there needs to be more engagement with younger academics and older academics at HEIs to ensure all academics are confident in supporting student mental health, irrespective of their age.

The findings indicated, with some caution, some differences in confidence levels across age groups. However, due to the small sizes of certain age-based subsamples, these results should be interpreted with caution. Future research should aim to include larger and more balanced samples to verify these preliminary findings. The current study provides initial insights but highlights the need for more robust investigations.

Finally, the notably low confidence score associated with the statement “I am confident being a personal tutor” within our survey highlights a significant area for development. This aspect of the academic role is underscored by the University Mental Health Charter [14], which outlines personal tutors as pivotal in student support structure. These individuals are uniquely positioned to observe shifts in student wellbeing, situating them at the forefront for early detection of potential mental health issues. The results from our survey, indicating a deficit in confidence amongst possible personal tutors, could suggest a misalignment between the charter’s standards and current practices. This discrepancy necessitates a strategic review of ongoing training programs and support systems in place for personal tutors ensuring they are adequately prepared to undertake their roles to align with the charter’s guidelines.

#### *Limitations*

Overall, the methodology provided a good indication of the current confidence levels and the limitations for academics supporting student mental health. The design of the survey subscales had good face validity and internal reliability. One of the key benefits of this tool is that it can identify the training needs of new and existing academic staff. Although Likert scale surveys are subject to distortions such as central tendency bias, acquiescence bias, and social desirability bias, care was taken to mitigate the risk of distortions using positive and negative statements [23]. Respondents had a wide range of roles, which was beneficial in encompassing the confidence and experiences of academics across the hierarchy of occupations. The survey was designed to be distributed to as many academics as possible and to take a short time to complete, with the typical completion rate recorded as six minutes. One major limitation of this study is the small sample size, particularly within certain age groups, which reduces the statistical power and the generalisability of the findings. Future research should strive to build on this preliminary study with a larger, more representative samples to enable more reliable and valid conclusions. This low response rate may reflect a need for more confidence in the topic. The fact that a small percentage of faculty participated might suggest that many do not see mental health support as being within their purview. This aligns with the existing literature indicating that faculty often feel unprepared or unsupported in dealing with student mental health issues [12–15].

The present study is a preliminary phase of a broader research project and will be further developed in subsequent stages. Since the authors designed the survey and it has not been scientifically validated, it must be noted that complete confidence in the investigation results is weak. It would be necessary in any future research to investigate the psychometric properties of this data collection tool. Consequently, future research would need to conduct a reliability analysis of the survey.

To expand on this study, the demographic data could include an option for respondents to list their department to assess differences in confidence between departments/faculties



and have the remaining schools at the university in the inclusion criteria, since the results displayed here are not representative of the whole university. This would provide important information on any disparities in mental health confidence between the schools at HEIs and further inform appropriate and necessary training. Future research could also include focus groups to build on the outcomes of this survey and include more nuanced data.

## 5. Conclusions

Overall, the increasing demand for student mental health support needs to be addressed from the academics' perspective because they are most likely to encounter a student with a mental health concern. Therefore, the following recommendations are made, albeit cautiously:

1. Enhanced training programmes: HEIs need to ensure that all future training interventions engage enough staff to ensure adequate student support regardless of age or sex. However, this study has indicated that male academics and those aged 60+ and 30–39 may need more engagement.
2. Current practice to improve mental health awareness has been deemed as improving, but holding events tailored to raising more awareness should continue.
3. New academic staff should receive mental health awareness training at their induction.
4. All staff require training events and regular updates at their staff conference/meetings to improve their knowledge, awareness, and skills.
5. Personal tutors should have mental health training that aligns with the University Mental Health Charter [14].
6. A mental health policy needs to be put in place to clarify the boundaries for the duty of care academic staff have for their students and formal processes put in place to provide psychological support to all year groups.
7. A clear and nuanced description of an academics' pastoral role and responsibilities needs to provide for both academics and students to ensure that students receive the appropriate support.
8. Any staff training delivered needs to be rigorously evaluated to inform future designs and communicate outcomes to other UK HEIs.

While the risk and causal factors of poor mental health cannot be eradicated, with these recommendations, it is hoped that if a student experiences a mental health concern during their time at university, present and future students will be well supported to achieve their maximum potential.

### *Practical Implications*

This study cautiously highlights the need for targeted training programs, especially for male academics and specific age groups that need more engagement. This targeted approach ensures that all faculty members are adequately prepared to support student mental health. All staff should partake in ongoing professional development programs focused on student mental health to help maintain and enhance faculty skills, fostering a supportive student environment. Finally, the findings underscore the importance of institutional support and clear policies that define faculty roles in student mental health support. Institutions must provide faculty staff the necessary resources and support, ensuring they can effectively fulfil their responsibilities without compromising their wellbeing.

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