Member Survey 2023

UMHAN
University Mental Health Advisers Network

Acknowledgements

Thank you to all our members who completed the Member Survey during September and October 2023.

About this report

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Executive Summary

This report presents the findings of the UMHAN (University Mental Health Advisers Network) Member Survey 2023. The online survey was open to all UMHAN members for completion during September and October 2023. Members were asked to consider their responses in relation to the previous academic year (2022-23). A total of 104 members completed the survey, a response rate of 16.9 per cent which is consistent with prior member survey response rates from 2022 and 2021. The respondents included Specialist Mental Health Mentors (47.1 per cent), Mental Health Advisers (36.5 per cent), Managers (9.6 per cent) and Associate Members (6.7 per cent). Sections relating to caseload and evaluation were differentiated in the survey by Mentors, Advisers and Managers.

Specialist Mental Health Mentors

Forty-nine (n=49) Specialist Mental Health Mentors (SMHMs) completed the survey. The largest proportions of SMHMs worked with between 11-20 students and 21-30 students. For the majority of SMHMs, their caseload had stayed about the same in the last 12 months.

In terms of the proportion of SMHM caseload defined as 'high risk', 75.5 per cent of SMHMs caseload was made up of up to 50 per cent of 'high risk' students. Over the last 12 months this proportion has stayed roughly the same for the majority of SMHMs. Mentors highlighted the increased numbers of students who are neurodivergent (primarily Attention Deficit Hyperactivity Disorder (ADHD) and/or Autism Spectrum Condition (ASC)) presenting with mental health conditions or awaiting formal diagnoses.

The majority of SMHMs evaluate their interventions/activities with students; the most popular types of evaluation are qualitative in nature, for example, interviews and focus groups whilst service user surveys were the most used quantitative tool. The greatest challenge to effective evaluation is that mentors do not have data collection, monitoring and/or evaluation in their job remit.

Mentors cited listening to students, building relationships and employing support strategies tailored to the individual whether that be in relation to their mental health or academic needs as their most effective interventions and activities.

Mental Health Advisers

Thirty-eight (n=38) Mental Health Advisers (MHAs) completed the survey. The largest proportions of MHAs worked with up to 25 students and between 26-50 students. Over the last 12 months, MHAs caseload had either stayed the same or increased.

For almost 70 per cent of MHAs, their caseload was made up of up to 50 per cent of 'high risk' students. Over the last 12 months this proportion had either increased or stayed about the same. In terms of proportion of caseload consisting of students with mental health conditions, for the majority of MHAs this was between 80 and 100 per cent of their caseload. MHAs reported dealing with more students who presented with complex or higher needs than in the past. Their caseload was complicated by the fact that it was harder to refer them to NHS or other services.

The majority of MHAs evaluate their interventions/activities with students. The most popular type of evaluation was a mixture of both quantitative and qualitative methods and the most popular quantitative tool was a service user survey. The greatest challenge was resource related - lack of time, or system related whereby there are multiple systems collecting student data across the organisation.

MHAs felt that listening to students and the one-to-one nature of support was important. The use of reasonable adjustments and liaison with university staff and departments was another popular approach.

Managers

Ten Managers (n=10) completed the survey. The number of students on Managers' service caseload this academic year requiring a one-off, short term or brief intervention ranged from five (n=5) to over six thousand (n=6030). For most Managers the service caseload had increased by some degree since the last academic year.

The numbers of students in receipt of crisis support (of the managers who had this data), ranged from three to 400 students. Over the last 12 months this proportion had stayed about the same or had slightly increased. The percentage of students in the total service allocation considered 'high risk' for the academic year ranged from 10 to 70 per cent amongst Managers. Over the last 12 months this proportion had stayed about the same or had increased slightly.

The majority of Managers evaluate their interventions/activities with students.
The most popular type of evaluation was a mixture of both quantitative and qualitative whilst the most popular quantitative tool is a service user survey. The greatest evaluation challenge was the multiple systems collecting student data across the organisation.

Managers felt that individualised support, delivered on a one-to-one basis, tailored to the needs of the student was the most effective intervention. Listening, displaying empathy, the use of goal-focused evidence-based therapeutic approaches and liaising on behalf of the student were also mentioned.

All Members

Working conditions

Respondents were divided in their opinions of team resourcing with some feeling their team was well staffed and others understaffed. Only five respondents felt that their team was well resourced.

A flexible working environment was favoured by the majority of survey respondents and almost half of members worked flexibly including working from home for a set number of hours.

Almost half of respondents do not plan on leaving their current role in the foreseeable future compared with approximately two fifths of members who are considering leaving in the next five years.

Pay was the most cited reason in terms of the factors influencing members who are considering leaving their current role whilst other influential factors include workload, work related stress, responsibilities of the role, lack of career progression and opportunities to undertake CPD as well as a lack of recognition of the work they do.

NHS waiting times

For most respondents, appointments for GPs were within 1-6 weeks or within 1 week whilst appointments for other primary care services were more likely to be between 6-12 weeks or between 1-6 weeks. The longest waiting times were for diagnostic assessments for ADHD and ASC with most respondents selecting 2 years + for both. Members noted that with increased waiting times, some students are not formally diagnosed until after they complete their studies and in spite of the Right to Choose (the NHS Constitution gives people living in England the right to choose where to have treatment) some private assessment centres are not currently accepting individuals for their waiting list. Similarly, wait times for Dialectical Behaviour Therapy (DBT) and specialist eating disorder services could be longer than two years.

The quickest wait times were referrals to crisis/acute mental health services with the majority of respondents citing between 24 hours and one week. Referrals by UMHAN members to NHS services was an ongoing source of concern. Some were unable to refer directly to NHS services whilst others described how their referrals were ignored or not accepted.

Current sector initiatives

Members were asked their views on the Higher Education Mental Health Implementation Taskforce (HEMHIT). The work of the taskforce was viewed positively in its demonstration of commitment to improving support for student mental health support but members had concerns about oversimplification, duplication, resources, responsibilities, implementation and buy-in.

In relation to the University Mental Health Charter (UMHC), the largest proportion of members who completed the survey did not know if their institution was participating in the Charter scheme. Only six respondents were involved in some way in their institution's engagement with the Programme, Charter or Award. Whilst members felt that it was a useful initiative, reservations were expressed in relation to the resource required for participation.

Membership of UMHAN

Overwhelmingly, members value the sense of community UMHAN creates through being part of a friendly group of similar professionals across institutions brought together at online meetings and in the forum where they can share information, experiences and resources in a safe space and grow with support from UMHAN. Members describe the online sessions as 'friendly', 'informative', 'useful', 'valuable', 'well-facilitated' and 'supportive':

The most well used resources are the website's CPD resources, publications, membership framework, the forum, Lunch and Learn sessions and members' meetings (including the recordings). Less frequently used and known resources include the UMHAN jobs board and the blog. The key reasons for non-attendance at online meetings is because members are unable to block out the time in their schedule to attend and because they do not have time for CPD. Preferences for online meetings were almost equally split between members who preferred them during term-time and those during vacations.

The largest number of members responding to the survey were in agreement that UMHAN's meetings, training and CPD are useful to them, however, almost 70 per cent of respondents struggled to fit in CPD although they did manage to do some. This aligns with data from member survey 2021 and 2022 which found that the majority of respondents struggled to fit CPD into their schedule.

Conclusion and Recommendations

The UMHAN Member Survey 2023 has revealed that the caseloads of many SMHMs, MHAs and Managers have stayed about the same this year or have actually increased. Mentors have observed an increase in the numbers of students awaiting diagnostic assessments for ADHD and/or ASC whilst Advisers have remarked on the complexity and higher levels of need amongst the students they support. Members feel that the work they do to support students with their mental health is frequently unacknowledged and unappreciated by university leaders and desperately under-resourced.

In terms of their working conditions, whilst low pay coupled with increasing caseloads and responsibilities means some members are considering leaving their current role in the near future, a more flexible working environment, post-pandemic, was the norm for most respondents and was generally viewed positively.

The majority of respondents are collecting, monitoring and evaluating data in relation to their support for student mental health with many members regularly using service user surveys as their main data collection tool. Lack of time and multiple data collection systems hampering efforts to successfully measure the impact of interventions and activities were the key evaluation challenges amongst members.

Based on our survey findings, we would like to make the following recommendations:
- **Practitioner expertise:** Senior HE leaders and managers need to liaise with their mental health support staff directly when undertaking strategic level work on student mental health.

- **Support for practitioner CPD:** It is imperative that MHAs and SMHMs are encouraged and supported to undertake relevant CPD and that time for their CPD is protected.

- **Evaluation and research:** Institutional researchers and evaluators should engage with their student mental health teams to incorporate their knowledge and support them to participate in evaluation activity where appropriate.

- **Equality Act 2010:** HEPs should focus on their legal duties. Reasonable adjustments are an important yet overlooked support mechanism whilst Disabled Students' Allowances are an underused component of support for students with mental health conditions and students should be encouraged to apply.

- **NHS resourcing:** Senior HE leaders need to put pressure on the Government to ensure NHS funding remains at the forefront of conversations around student mental health.

Introduction

About UMHAN

UMHAN (University Mental Health Advisers Network) was established as an information-sharing network for mental health specialists working in Higher Education (HE) and was a key part of a series of important firsts in HE, including the emphasis on practical and whole-institution approaches to mental health and illness, the development of mental health-specific services in HE, facilitating awareness-raising of mental health and illness, and increasing the appropriate uptake of Disabled Students' Allowances (DSAs) for students with mental health conditions. We are celebrating our twentieth year this year having been set up as a registered charity back in 2003 (registered charity number: 1155038).

UMHAN was founded by professionals in mental health work and has been instrumental in maintaining and improving the professional development and standards of mental health specialists and services in HE. Our core membership is made up of professionals working either in a Mental Health Adviser (MHA) role (or similar) or in Specialist Mental Health Mentoring (SMHM). Advisers and Mentors normally have a postgraduate or professional qualification in mental health and significant experience. The professions represented amongst our members include Occupational Therapy, Nursing, Social Work, Psychology, Counselling and Psychotherapy. UMHAN recently started welcoming a wider range of members, including those who directly manage MHAs and SMHMs as well as other education professionals with a mental health remit. We now have more than 600 members from over 150 organisations.

At UMHAN we use the social model of language and terminology to describe mental health. We feel that people are not disabled by their medical condition, but by the attitudes and structures of society. We use the following definitions adopted from the Office for Students, the independent regulator of HE in England (2019):

- *Mental health conditions are clinically diagnosable. They may be more or less severe and their treatment pathways vary depending on the condition.*

- *Mental ill health is a broader term describing mental distress that may or not be related to a diagnosable mental health condition.*

- *Wellbeing is broader still and relates to people's thoughts and feelings about their own quality of life.*

This report presents the findings of the UMHAN Member Survey 2023. For more information about UMHAN including our aims, priorities and how to join, please visit our website: https://www.umhan.com/

Survey Design and Analysis

The Member Survey 2023, an online survey designed using Google forms, was open to all UMHAN members for completion during September and October 2023. Members received an initial email to encourage participation whilst a subsequent post was made to the UMHAN Community Forum (this part of the UMHAN website is members-only). A final reminder post was made on the Forum a week before the survey closed. Members were asked to consider their responses in relation to the previous academic year (2022-23).

This year the survey was revised and extended to include a number of detailed questions relating to data collection, monitoring and evaluation as well as exploring members' perceptions of recent developments in the sector. The Member Survey included the following sections:

- Role

- Caseload

- Data collection, monitoring and evaluation

- Working conditions

- Current sector initiatives

- NHS waiting times

- UMHAN membership

- UMHAN resources, meetings and Continuing Professional Development (CPD).

Respondents could opt to enter a prize draw to receive one of five £20 e-vouchers which was utilised as a way to incentivise survey participation. All survey data is stored securely by UMHAN and email addresses are only collected and used for the purposes of awarding the e-vouchers. All respondent data is anonymised and no individual members are identified in this report. The quantitative data was analysed in Google sheets whilst the qualitative data was analysed manually by the author. Where this has been possible, the 2023 data has been compared to previous survey data from 2022 and 2021.

The findings of the annual Member Survey are presented to the UMHAN Board of Trustees and help inform development of the charity's work.

Findings

Survey respondents

A total of 104 members completed the Member Survey 2023. This represents a response rate of 16.9 per cent (based on our membership data at the close of September 2023) and is consistent with prior Member Survey response rates from 2022 (16.0 per cent) and 2021 (15.0 per cent).

Survey respondents included SMHMs (47.1 per cent), MHAs (36.5 per cent), Managers (9.6 per cent) and Associate Members (6.7 per cent). As proportions of UMHAN members this constituted 25.7 per cent of SMHMs; 12.3 per cent of MHAs; 23.8 per cent of Managers and 9.5 per cent of Associate Members (based on membership data from September 2023).
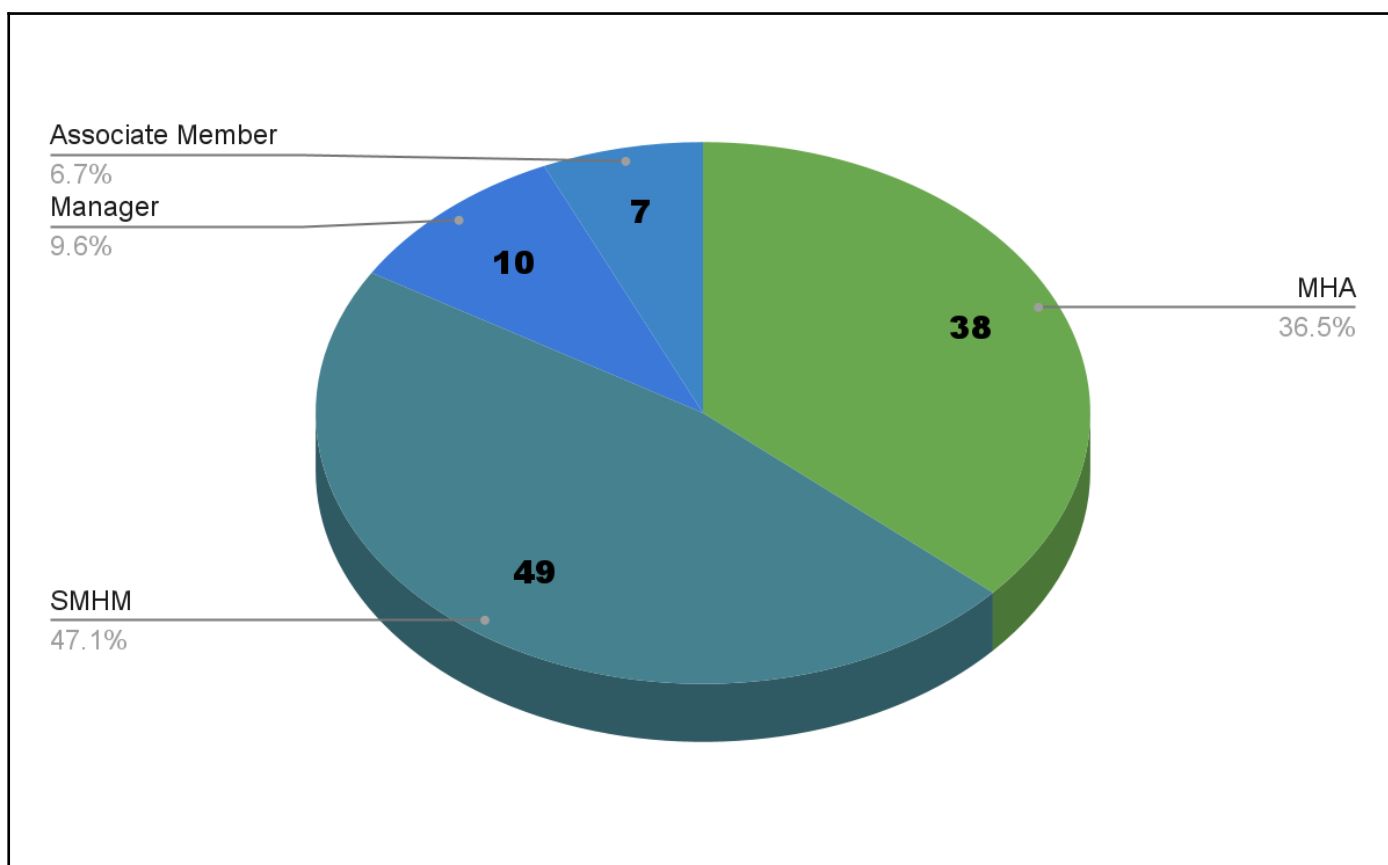
Fig.1 Member Survey 2023 respondents

Sections relating to caseload and evaluation were differentiated in the survey by Mentors, Advisers and Managers as per the 2021 and 2022 Member Surveys. Since the roles of MHAs and SMHMs are not always "well defined or understood" we believe that the provision of such data will "help improve awareness of the scope and importance" of these roles in supporting students (UMHAN, 2022, 3). Associate Members were not asked these questions as these members, whilst having direct contact with students, in either a school, college or university, and through this professional role have an interest in mental health, do not always undertake 1:1 work with students with mental health conditions.

Specialist Mental Health Mentors

Caseload

Forty-nine Specialist Mental Health Mentors (SMHMs) completed the Member Survey 2023. The Mentor role is normally funded by Disabled Students' Allowance (DSA), a non means-tested funding stream which helps pay for extra costs a student might have as a direct result of their disability including long term mental health conditions or a specific learning difficulty such as dyslexia. Many students with long term mental health conditions apply for Disabled Students' Allowances (DSAs) and then access 1:1 support from a Mentor (UMHAN, 2023). Some universities may fund specialist mentoring as an interim measure, while students are going through the DSA application process, or for students who are not eligible for this funding. While the majority of SMHMs work with DSA funded students only, some Mentors are directly employed by universities to work with other students, meaning that they may perform tasks outside of mentoring work such as training for staff and group work.

The largest proportions of SMHMs worked with between 11-20 students (34.7 per cent) and 21-30 students (20.4 per cent). For the majority of SMHMs, their caseload had stayed about the same in the last 12 months (n=29).

Comparison of this year's data with previous UMHAN Member Surveys reveals that SMHMs are working with similar numbers of students - the largest proportion were working with between 11-20 students in 2022 (27.0 per cent of SMHMs). Similarly, most SMHMs who responded in 2022, felt that their caseload had stayed about the same in the last 12 months (51.0 per cent).
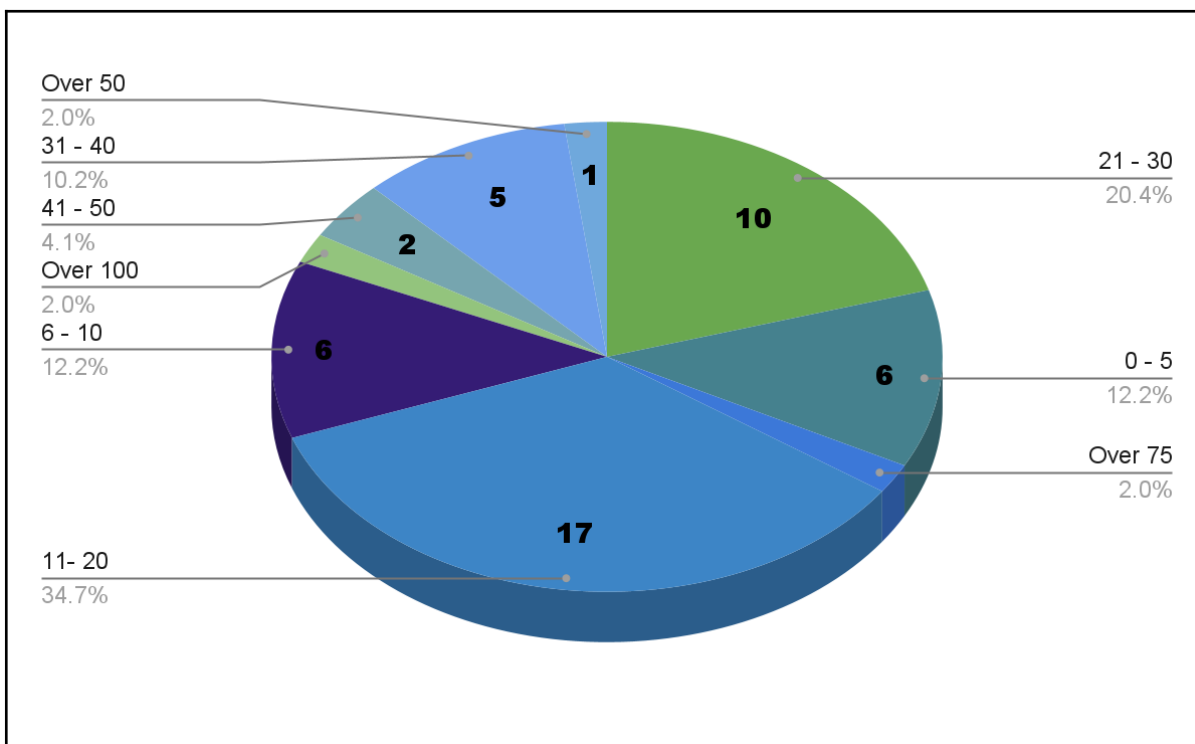
Fig. 2 Number of students on caseload: mentors

Supporting students with mental health conditions and 'high risk' students

We define 'high risk' in terms of deteriorating mental health, severity of mental health condition, suicide, serious harm to self or others, neglect, abuse, becoming socially isolated, at risk of radicalisation or experiencing significant disruption to their education.

In terms of the proportion of caseload defined as 'high risk', 75.5 per cent of Mentors' caseload was made up of up to 50 per cent of 'high risk' students (n=37). This is in line with data from 2022 which revealed that 80.0 per cent of Mentor caseload was made up of up to 50 per cent of 'high risk' students (n=28). However, caution should be exercised when making comparisons with small cohorts.
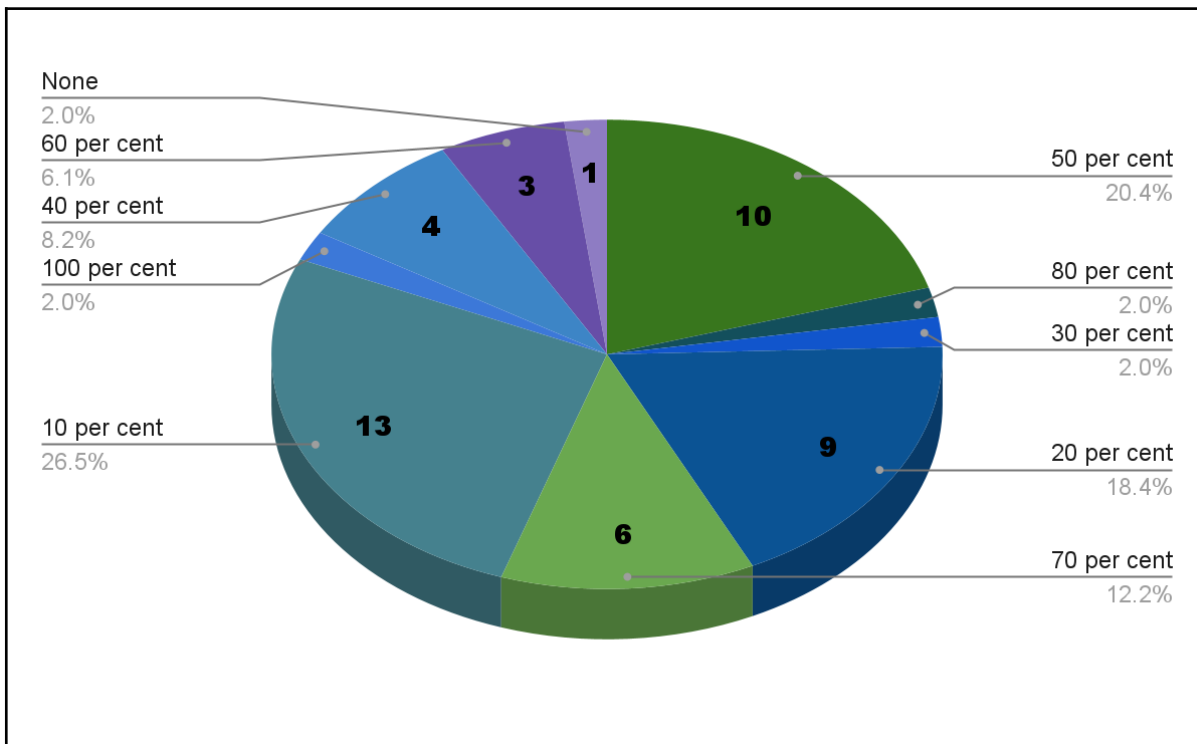
Fig. 3 Percentage of students considered 'high risk': mentors

Over the last 12 months the proportion of 'high risk' students within Mentors' caseload had stayed roughly the same for 63.3 per cent of SMHMs (n=31) but for 14 members this proportion had increased (28.6 per cent) compared with four members for whom it had decreased. These figures are broadly in line with data from 2022 where the proportion had stayed about the same for 51.0 per cent of mentors and increased for 26.0 per cent. However, both the findings of the Member Surveys of 2022 and 2023 are in contrast to data from 2021 where the majority of mentors indicated that the proportion of 'high risk' students had actually increased (71.0 per cent).

In terms of proportion of caseload consisting of students with mental health conditions, for the majority of SMHMs this was between 80 and 100 per cent of their caseload; for approximately two fifths of SMHMs this was 100 per cent of their caseload (n=20).
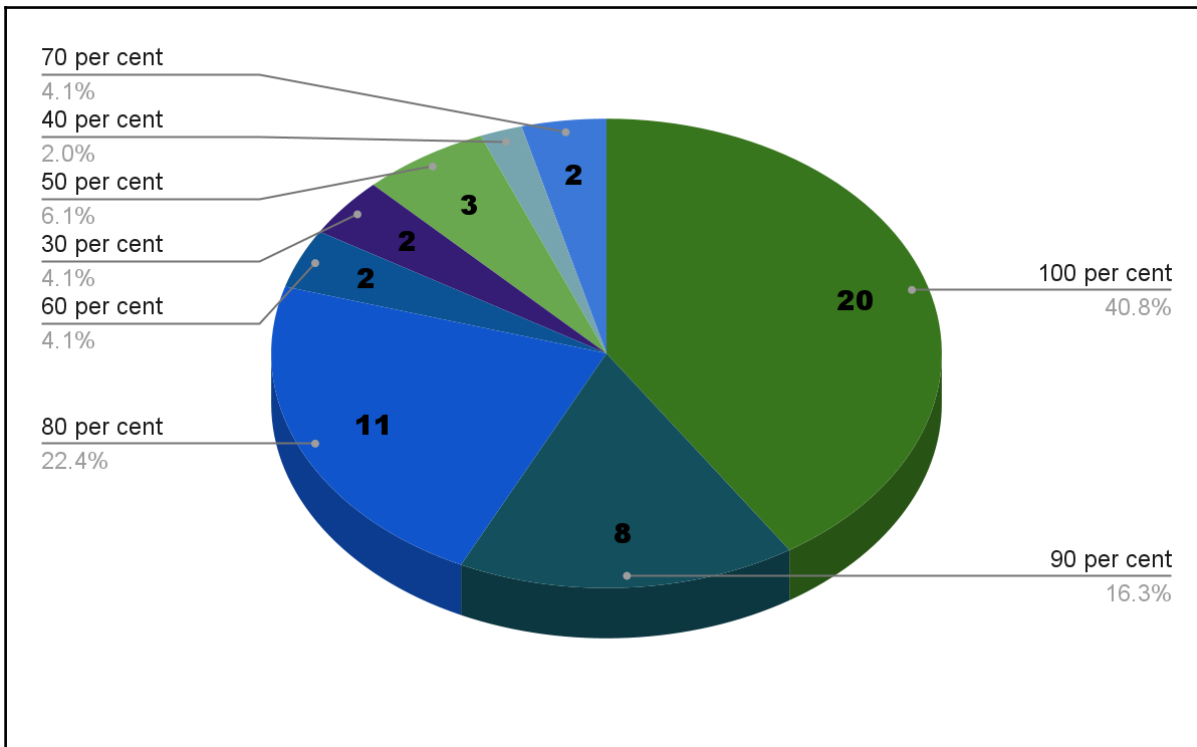
Fig. 4 Percentage of students with mental health conditions: mentors

Twenty seven Mentors commented on their caseload in response to an open question on the survey. Fourteen of these related to the increased numbers of students who are neurodivergent (a term used to describe a range of neurological differences including dyslexia, Attention Deficit Hyperactivity Disorder (ADHD) and Autistic Spectrum Condition (ASC)) presenting with mental health conditions or awaiting formal diagnoses:

> *Many of my students are ASD/C and so strictly speaking neurodiverse, not mental health but almost all of those have a comorbidity, thus I have said 100%.*

> *A growing number of students with ADHD/awaiting a diagnosis for ADHD.*

> *The majority of my caseload are students with mental health or neurodiversity conditions or both.*

> *I am receiving more referrals for students with a diagnosis of ADHD compared with a year ago.*

Six members judged their caseloads to be manageable, although this was often because of a reduction in hours following a period of absence from work or to maintain work-life-balance:

> *I have reduced my caseload significantly (approximately 50%) over the last year following concerns about being burnout after working intensively and in isolation over the previous two academic years during COVID-19.*

> *My caseload is normally around 10, due to being on a phased return, its maximum 5.*

> *I have a low caseload to fit around family life and commitments.*

Monitoring and evaluation of interventions and activities with students

The majority of SMHMs evaluate their interventions/activities with students (n=36). Please note that these questions were not compulsory and so total respondents may be fewer than 49.
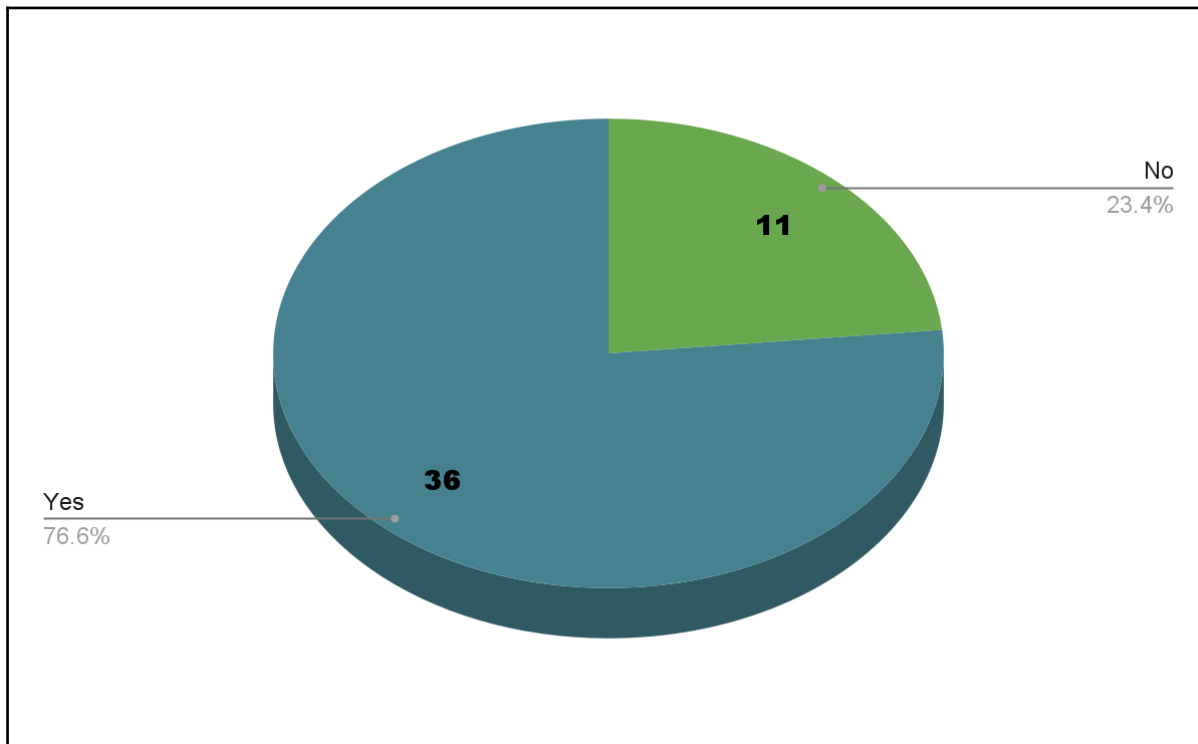
Fig.5 Evaluation of interventions/activities with students: mentors

The most popular types of evaluation are qualitative in nature, for example, interviews and focus groups (n=21) (see Fig. 6).
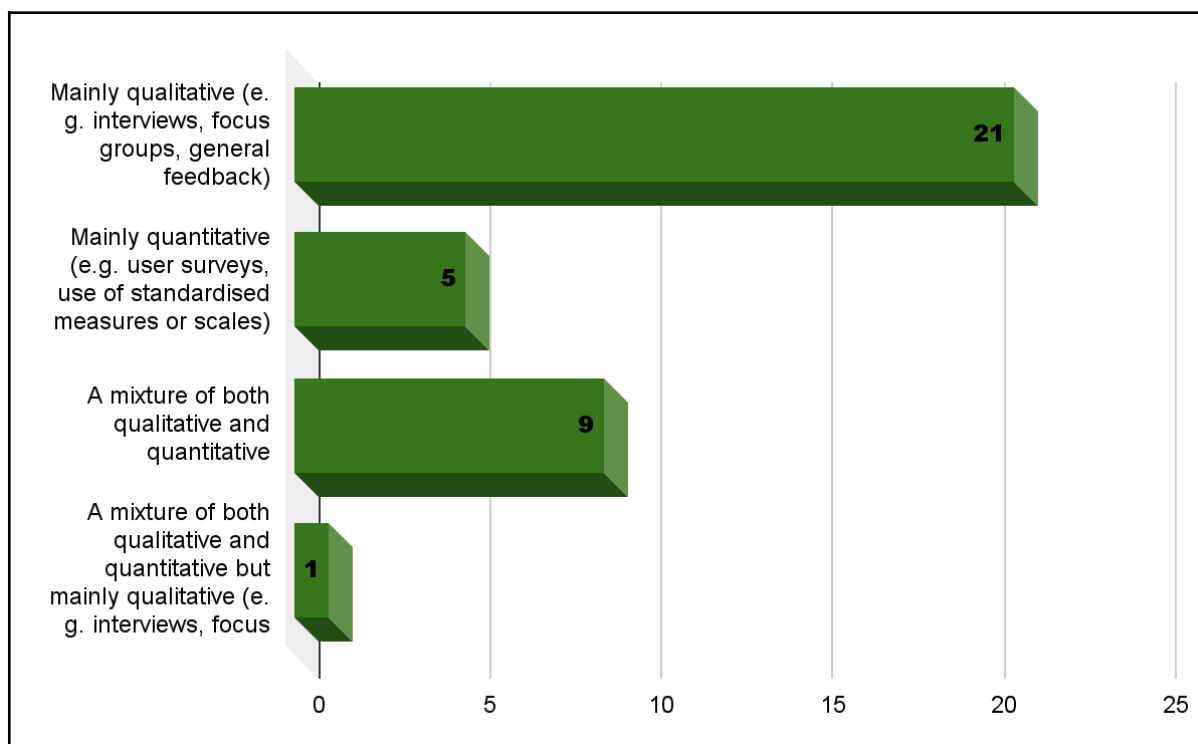
Fig.6 Types of evaluation: mentors

The quantitative tools used in monitoring and evaluation by SMHMs who completed the Member Survey 2023 are presented below (Table 1). Please note that because mentors could select more than one tool, the total (n=28) exceeds the number of mentors who use quantitative tools as shown above (n=15).

The most popular tools were service user surveys and institutional surveys both selected by nine participants.

Other tools included institutional evaluation (employer or university) (n=3) and external evaluation (n=2). The other approaches mentioned included:

- SWEMWBS - the short WEMWBS (Warwick-Edinburgh Mental Wellbeing Scale)

- Personal reflection.

Monitoring and evaluation tools (includes validated scales)	No. of participants using it	Percentage of all SMHMs using it
Service user survey	9	18.3
Institutional survey (employer or university)	9	18.3
CIAO (Counselling Impact on Academic Outcomes)	-	-
CORE-10 (Clinical Outcomes in Routine Evaluation - 10 item)	-	-
CORE-OM (Outcome Measure version of Clinical Outcomes in Routine Evaluation)	-	-
GP-CORE (General Population version of Clinical Outcomes in Routine Evaluation)	-	-
GAD2 (Generalised Anxiety Disorder - 2 item)	-	-
GAD7 (Generalised Anxiety Disorder - 7 item)	1	2.0
ONS-4 (Office for National Statistics Personal Wellbeing Questions)	-	-
PHQ-9 (Patient Health Questionnaire - 9 item)	1	2.0
WEMWBS (Warwick-Edinburgh Mental Wellbeing Scale)	-	-
Institutional evaluation (university team or project)	3	6.1
External evaluation (consultancy or other external team)	2	4.1
Other	2	4.1
Total	**28**	-

Table 1: Quantitative monitoring and evaluation tools used to evaluate interventions/activities with students: mentors

Respondents were asked to consider the challenges they faced in relation to data collection, monitoring and evaluation and were able to select multiple responses from a list of options. Please note that because mentors could select more than one tool, the total (n=76) exceeds the number of mentors who completed the survey (n=49).

The most cited challenge was that mentors do not have data collection, monitoring and/or evaluation in their job remit (n=22). Other challenges were resource related (lack of time) (n=12), organisational - in that other staff or teams were responsible for this activity (n=12) or it was system related whereby there are multiple systems collecting student data across the organisation (n=10). Other challenges (n=4) included a perceived fear of evaluation resulting in unwanted outcomes, inconsistent student data collection and mentors working for more than one agency.
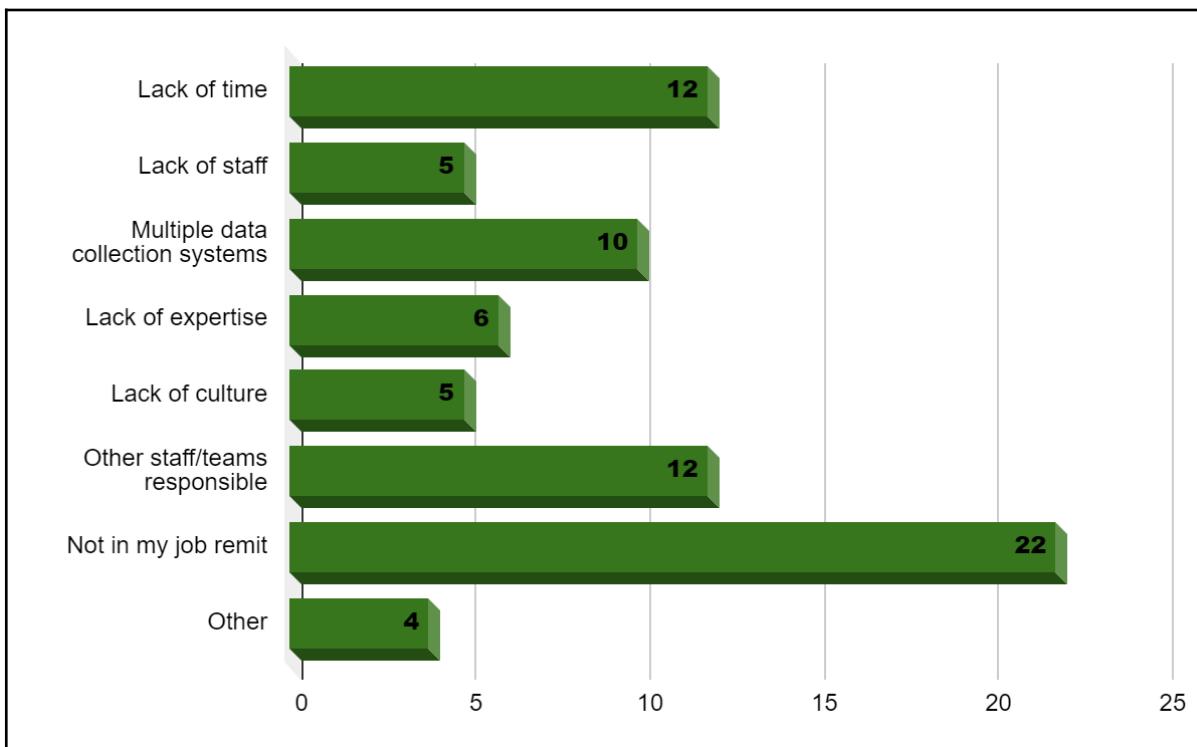
Fig. 7 Data collection, monitoring and evaluation challenges: mentors

Respondents were encouraged to add any comments about data collection, monitoring and evaluation. Seventeen of the Mentors responded to this question. Analysis of the comments revealed a number of common issues experienced in relation to collecting and evaluating data. These primarily related to the difficulties they encountered when collecting data from students including the best time to administer scales or tools:

> *With some students you are always fire fighting and it is difficult to shoehorn data collection in, especially when they don't see the relevance and just want help with whatever it is that they are struggling with that week.*

> *Lack of engagement with students completing feedback.*

> *I feel I need to collect the second data set sooner.*

Some Mentors highlighted that they had requested better or more data collection or monitoring tools and welcomed evaluation in order to help improve their practice:

I would welcome the opportunity of more regular monitoring from the providers that I work for.

Although concern was expressed that evaluation might be used as a way to cut services:

I would welcome more hard data and more hard evaluation, but fear that cost effective isn't the same as best for the individual and that depending on the monetary norms of education, it may back-fire.

Mentors employed by agencies were removed from data collection, monitoring and evaluation practices because of concerns around data protection and information sharing which, whilst understandable, was a source of frustration for Mentors who wanted to know which strategies were effective with mentees:

Much of the information is not shared with us and this depends so much on the university rather than having a set standard. So to be involved in a holistic level of strong support and monitoring for the students we work with is not possible. Often the most basic information is not accessible. I understand and totally respect confidentiality, privacy and consent but even with all this from the student we are not privy to valuable data collection.

It was also noted that reporting could be incredibly time consuming and resource intensive and was not remunerated, as this Mentor explained:

I am responsible for writing end-of-term reports which are sent to the student for their comments, so in terms of data-collection, my role ends there. However, even that part is incredibly time-consuming because the company I work for needs a considerable amount of data for each student and producing and sending this can take around 40 to 50 hours per time (which, of course, is unpaid). But it has to be done.

What works?

Respondents were asked to comment on what they felt was the most effective intervention or activity used in their work. Forty of the SMHMs responded to this question.

The key activities which emerged from analysis of the comments included listening to students, building relationships and employing support strategies tailored to the individual whether that be in relation to their mental health needs or academic needs:

Building trust - I offer person centred, non judgemental support. I use health, safety and well-being as a core focus and a variety of tools that work for each person. These range from weekly planning, listening to them, always and anything they want to share, keeping a journal, scaling questions and support, breathing and self regulation, prioritising tasks, self help and strengths based exercises and connection.

Popular academic support strategies included time management, organisation and planning whilst specific mental health interventions included support strategies for sensory processing and the use of therapeutic techniques, psycho-education and social prescribing:

My most effective intervention is something I called 'accompanied working'. In essence, I log on and the student logs on (all my sessions are now remote), we exchange greetings and cover how things have gone over the previous week; the student then uses the session to tackle a piece or work that has been giving them problems or that they have been avoiding. Sometimes we do this together; at other times they work for 15 minutes or so and then report back on how they're doing, and then work for another 15 minutes. We continue like this until the hour has finished. The most pressing and frequently expressed problem for my students is procrastination, especially with essay-writing, which is why I developed the idea of accompanied working. It provides the student with some accountability but also some company whilst they work, and a sounding-board for ideas. And I'm pleased to report that among those students who have tried it, it has never failed!

Time management and organisation strategies. These also tend to be the most popular.

Enabling students to set realistic goals on a weekly basis, discussing week on week how goals worked for students. Giving the student a voice whereby they feel at ease to discuss in detail how their week went, along with any challenge faced. I set up an Individual Learning Plan for each student, which enables both the student and I to address the weekly goals, focusing on preparation for forthcoming assignments.

Signposting, referral to and liaison with other staff, services and agencies were also employed:

Overall, it's probably providing support with their academic progress, in the context of their individual mental health and neurological needs, rather than specific mental health interventions. This includes encouraging the use of therapeutic techniques they have used previously, ongoing support with planning, motivation, stress reduction; alongside referrals to numerous specialised services/secondary care, and liaison/advocacy with the academic schools.

The key message from Mentors was that their interventions and work with students was student-centred, empowering and empathetic:

There is no one size fits all. It really depends on the student but the theme of openness, psycho-education and trialling strategies all foster a good mentor/mentee relationship. Overall relationship building can be one of the most effective techniques as support built on trust can be very effective.

Listening, remaining student centred & empowering approach recognising the student as an individual and an expert of their experience with the resources to move forward. Being open and transparent.

Making them aware that they are not alone.

Mental Health Advisers

Caseload

Thirty-eight Mental Health Advisers (MHAs) completed the Member Survey 2023. MHAs and those in similar roles have varied role responsibilities. Some have strictly managed and protected caseloads, enabling them to do very specific pieces of work with students whereas others are expected to have contact with any student referred into the service (which can then mean contact and support for students is limited). Some are the sole person responsible for students with mental health conditions at their institution, whereas others are part of large multidisciplinary teams.

The largest proportions of MHAs worked with up to 25 students (42.1 per cent) and between 26-50 students (26.3 per cent). Over the last 12 months, 47.4 per cent of MHAs reported that their caseload had stayed about the same in (n=18) or had increased (n=18). It had decreased for just two respondents (5.3 per cent). Comparison with data from UMHAN's Member Survey 2022 reveals that the largest proportions of MHAs were working with similar size cohorts of students - up to 25 (36.7 per cent) and between 26-50 (20.0 per cent). This had represented an increase for 36.0 per cent of MHAs but had stayed about the same for 69.0 per cent. Data from 2021 reveals that, for the majority of MHAs, the numbers of students in their caseload had increased (65.0 per cent).
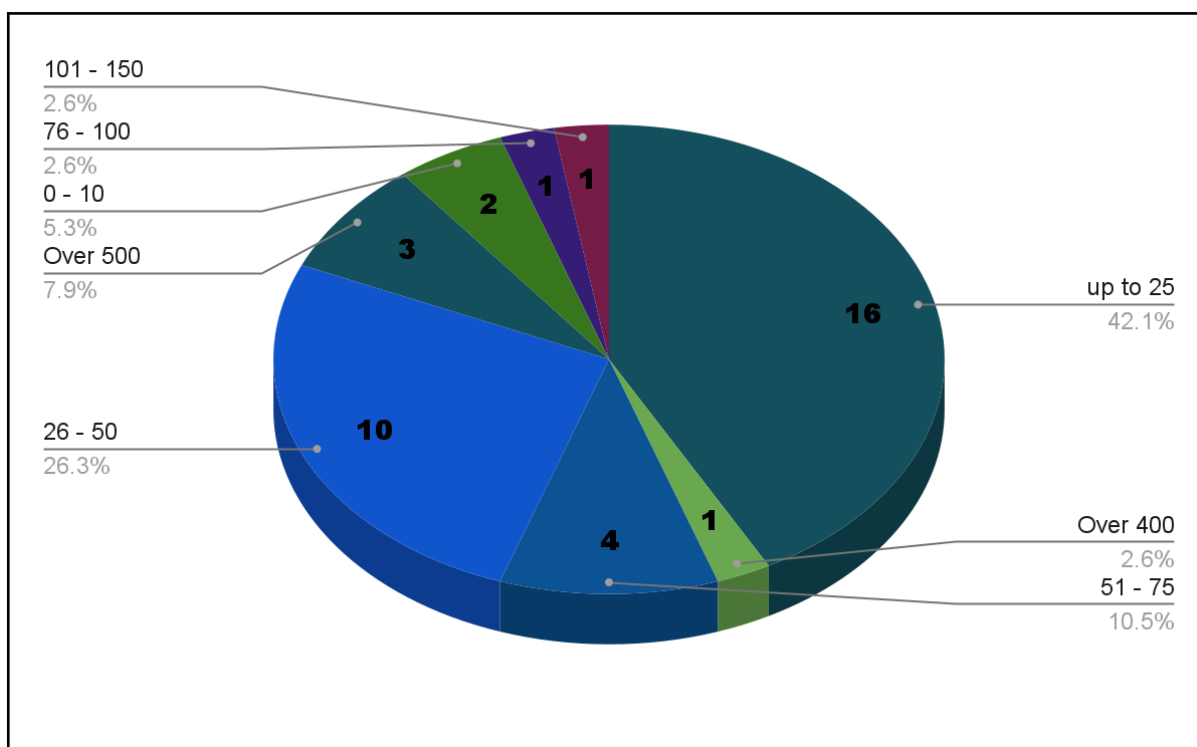
Fig. 8 Number of students on caseload: advisers

Supporting students with mental health conditions and 'high risk' students

The majority of MHAs have crisis response and risk/safety planning in their job descriptions. For 68.4 percent of MHAs, their caseload was made up of up to 50 per cent of 'high risk' students (n=26). Over the last 12 months this proportion had increased for 68.4 per cent of MHAs (n=19) and for 16 members this proportion had stayed about the same (42.1 per cent) compared with three members for whom it had decreased. This data was similar to MHAs responding to the Member Survey 2022 which revealed that 61.3 per cent of MHAs' caseloads were made up of up to 50 per cent 'high risk' students. The numbers of 'high risk' students in their caseload had increased in 2022 for 26.0 per cent of MHAs.

In terms of proportion of caseload consisting of students with mental health conditions, for the majority of MHAs this was between 80 and 100 per cent of their caseload (n=29; 76.3 per cent); for approximately two fifths of MHAs this was 100 per cent of their caseload (n=15).
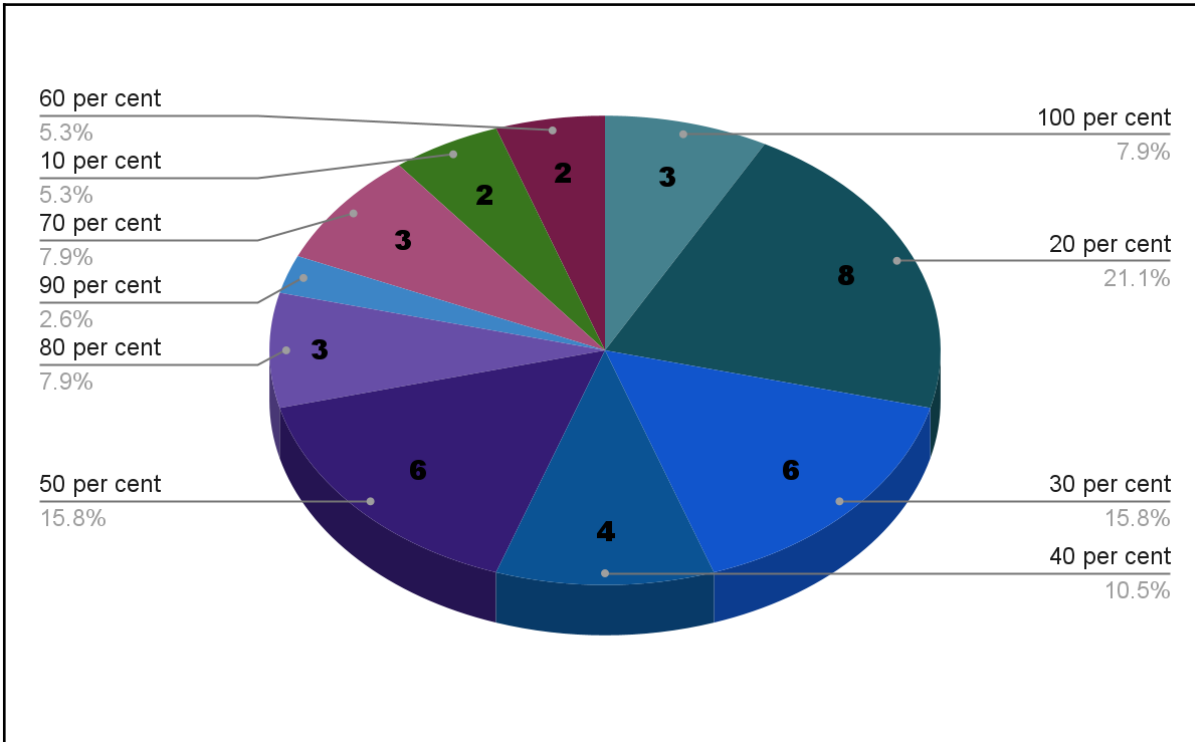
Fig. 9 Percentage of students considered 'high risk': advisers
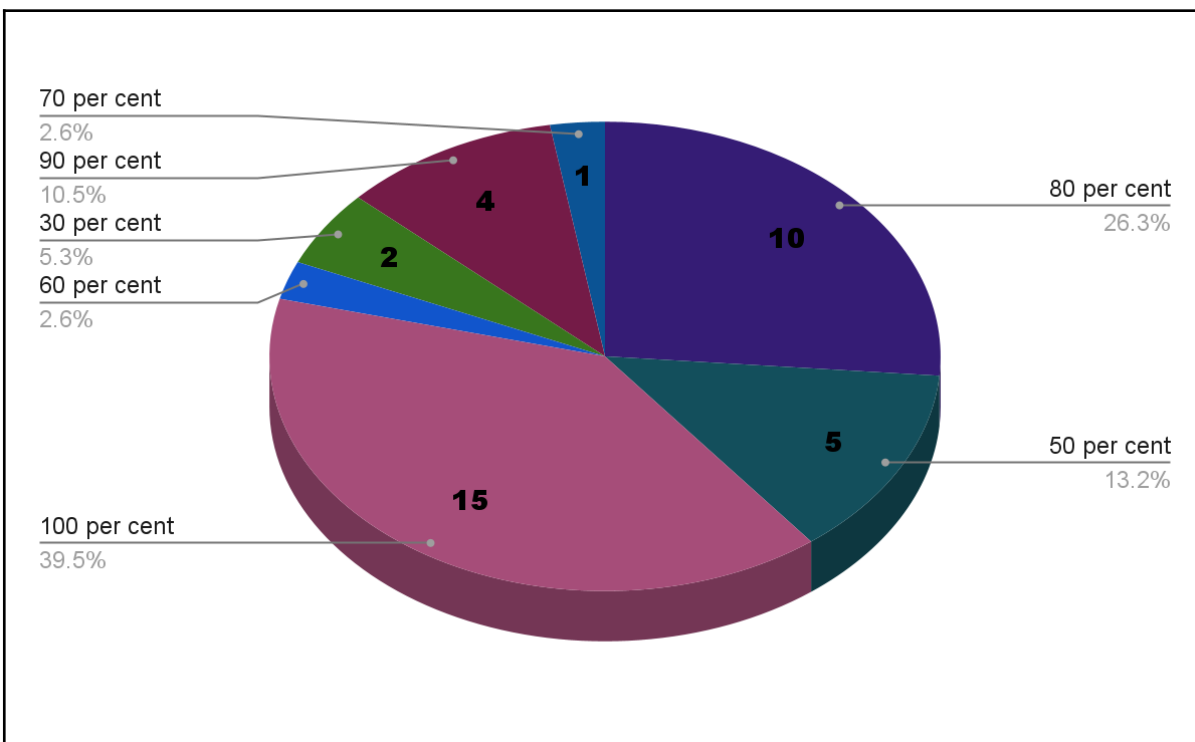
Fig. 10 Percentage of students with mental health conditions: advisers

Nineteen MHAs commented on their caseload. Analysis of the comments revealed a number of common issues experienced by MHAs of which the most repeated observation was that they were dealing with more students who presented with complex needs than in the past:

High numbers of high need students who are hard to support at the same time.

The complexity of the mental health conditions students are presented with has increased significantly over the past few years.

My sense is, as seems to be the case across the sector, that caseloads are increasing and also that complexity of need/situation/ health etc is increasing, which means that caseload numbers are not necessarily the complete picture.

Moreover, their caseload was complicated by the fact that it was harder for students to be referred from primary to secondary services:

Local NHS threshold increasing thus fewer referrals made to local services.

The secondary mental health care in this area of the country is not good which doesn't help.

It was also observed that there was an increase in the numbers of international students and neurodivergent students seeking support for their mental health:

Also an increase in the number of international students seeking MH help, who may not be eligible for NHS or other support.

And a definite increase in students presenting with a likely neurodivergent condition alongside a MH difficulty.

Some members described how their service or they themselves were helping manage their caseload and in some cases, detailed changes in their institutional approach:

My caseload has only reduced this academic year not due to demand (which is as high as ever!) but due to team efforts to reduce caseloads because of how complex and time-consuming casework outside of sessions can be.

My caseload and that of the wider team are too large, however, we are implementing developments that should, over time, foster a cultural and actual shift in the number of students needing to seek our bespoke support (in disability services).

We do not have a caseload at this University as this would make this job unmanageable. In the past, I would work with complex students, students with mental health conditions and risky students. However, in the last year, I had to reset the boundary for my role and am currently only dealing with students that are of high risk.

Monitoring and evaluation of interventions and activities with students
The majority, or 73.7 per cent, of MHAs evaluate their interventions/activities with students (n=28). The most popular type of evaluation was a mixture of both quantitative and qualitative methods (n=17).
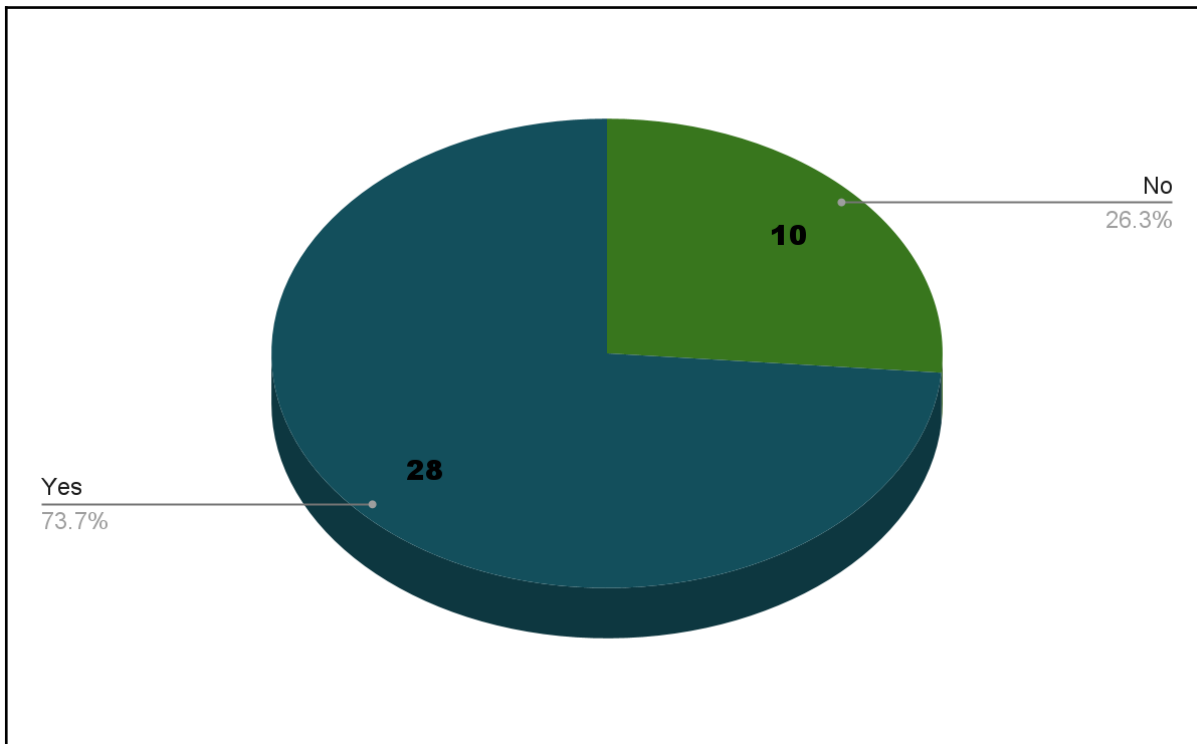
Fig. 11 Evaluation of interventions/activities with students: advisers
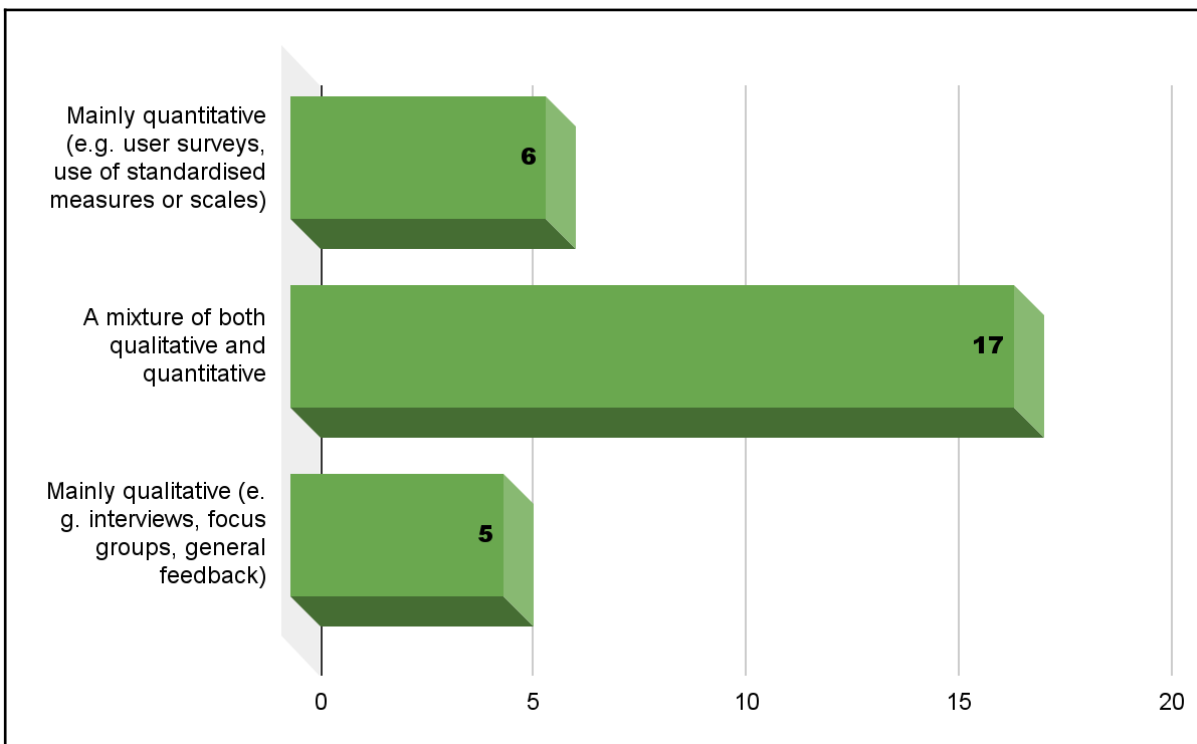
Fig. 12 Types of evaluation: advisers

The quantitative tools used in monitoring and evaluation by MHAs who completed the Members Survey 2023 are presented in the table below (Table 2). Please note that because MHAs could select more than one tool, the total (n=64) exceeds the number of MHAs who completed the survey (n=38). The most popular tool was

service user surveys used by 17 participants (44.7 per cent of MHAs). Other popular tools or approaches included an institutional survey (employer or university) (n=7), CORE-10 (n=7), GAD7 (n=7), other tools (n=7), PHQ-9 (n=6) and institutional evaluation (n=6). The other tools mentioned predominantly include validated scales:

- Work and Social Adjustment Scale (WSAS)

- IAPT Phobia Scale

- CCAPS-32 (Counseling Center Assessment of Psychological Symptoms-32 item)

- Occupational Self-Assessment (OSA)

- PCL-5 (Posttraumatic Stress Disorder Checklist-5 item)

- IES-R (Impact of Events Scale-Revised)

- ILP (Individual Learning Plan).

Monitoring and evaluation tools (includes validated scales)	No. of participants using it	Percentage of all MHAs using it
Service user survey	17	44.7
Institutional survey (employer or university)	7	18.4
CIAO (Counselling Impact on Academic Outcomes)	4	10.5
CORE-10 (Clinical Outcomes in Routine Evaluation - 10 item)	7	18.4
CORE-OM (Outcome Measure version of Clinical Outcomes in Routine Evaluation)	2	5.3
GP-CORE (General Population version of Clinical Outcomes in Routine Evaluation)	0	-
GAD2 (Generalised Anxiety Disorder - 2 item)	1	2.6
GAD7 (Generalised Anxiety Disorder - 7 item)	7	18.4
ONS-4 (Office for National Statistics Personal Wellbeing Questions)	0	-
PHQ-9 (Patient Health Questionnaire - 9 item)	6	15.8
WEMWBS (Warwick-Edinburgh Mental Wellbeing Scale)	1	2.6
Institutional evaluation (university team or project)	6	15.8
External evaluation (consultancy or other external team)	0	-
Other	7	18.4
Total	**64**	-

Table 2: Quantitative monitoring and evaluation tools used to evaluate interventions/activities with students: advisers

Respondents were asked to consider the challenges they faced in relation to data collection, monitoring and evaluation and were able to select multiple responses from a list of options. Please note that because MHAs could select more than one option, the total (n=88) exceeds the number of advisers who completed the survey (n=38).

The most cited challenge was resource related - lack of time (n=24) or it was system related whereby there are multiple systems collecting student data across the organisation (n=22). Lack of staff was another popular challenge (n=14). A lack of monitoring and evaluation culture was a barrier (n=11) whilst lack of evaluation expertise amongst staff was also perceived to be a challenge (n=7).

Other challenges mentioned were both systems related including a poor computer system which made it difficult to engage in data analysis whilst another adviser was waiting for her employer to develop better systems and processes to capture data.
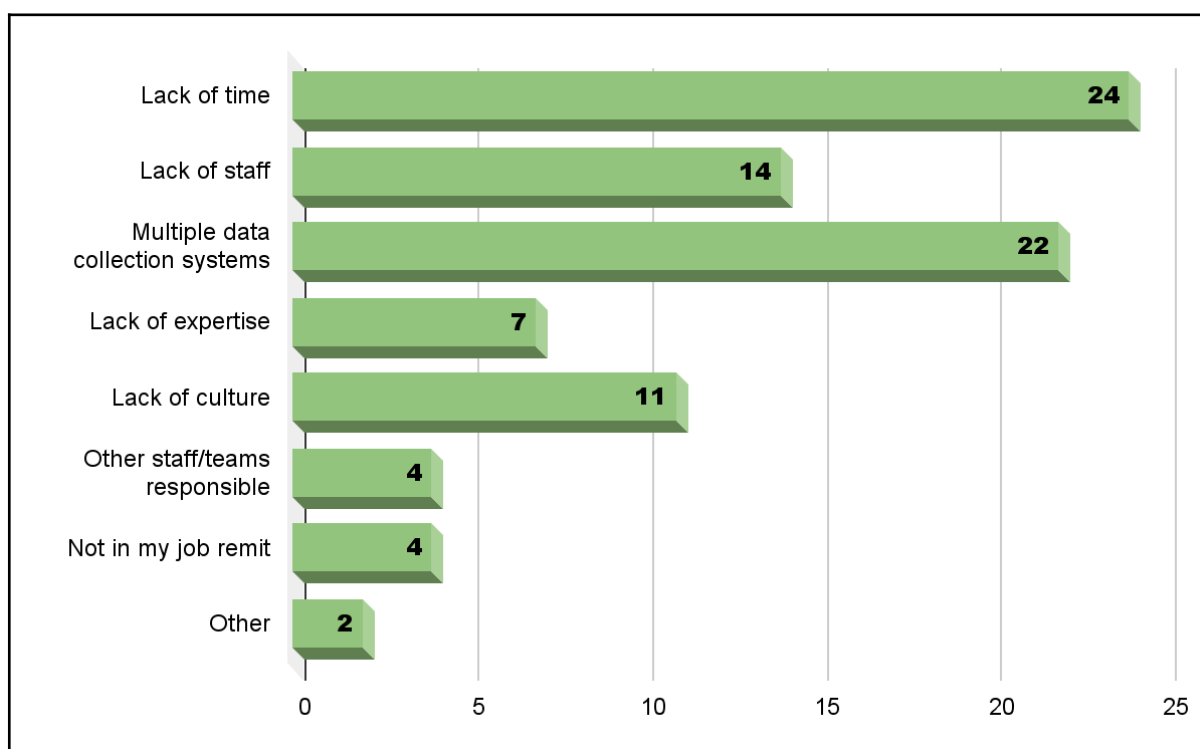
Fig. 13 Data collection, monitoring and evaluation challenges: advisers

Respondents were encouraged to add any comments about data collection, monitoring and evaluation. Five of the MHAs responded to this question. Analysis of the comments revealed that the issues experienced by MHAs in relation to data collection and evaluation were often systems related including a lack of systems, multiple systems with several gatekeepers or systems that are not up to the task:

Our University lacks integrated systems - data is everywhere! In separate systems with separate 'permissions'/authority to access.

Systems are not properly in place for this to occur on a regular basis.

This is new to us this academic year. We are implementing outcome measures but the system we use for data recording does not manage to accommodate outcome measures so its Qualtrics and saving in a PDF - not ideal and can be time consuming.

Other comments related to which data is collected and evaluated and for which purposes. One MHA's service had managed to collect data to make a case to senior management for greater resource, for example:

We have been working hard on producing meaningful stats. This has enabled us to be much more vocal about the students presenting to our service. We were fortunately listened to by senior management and additional funding for staff was provided due to our efforts.

But as one MHA pointed out, it is important to know what to monitor and evaluate and why:

I think our biggest challenge is defining the scope of our service and our duty of care first; and then to look at how we monitor and evaluate the interventions offered.

What works?

Respondents were asked to comment about what they felt was the most effective intervention or activity used in their work. Thirty of the MHAs responded to this question. The key activities which emerged from analysis of the comments included listening to students:

This sounds really simple, but from student feedback, it seems that students value someone to listen to them with a non-judgmental ear more than any other intervention we can offer.

The one-to-one nature of support was crucial in supporting students, as was often the relationship itself:

All this feels best achieved in a one to one setting.

Establishing a trusting and reliable professional relationship with the student.

The use of reasonable adjustments (a key part of the *Equality Act 2010* which requires education providers to provide 'reasonable adjustments' for disabled students and ensure equal access to education. This can include extra support and aids) and liaison with university staff and departments was another popular approach:

Assessing and discussing with students what reasonable adjustments are required to their academic studies, so that they can achieve their potential and goals. Then taking this forward with departments and colleges.

Risk assessment and management as well as safety planning was an important part of some MHAs roles in supporting students. Crisis planning and intervention were also detailed:

Risk assessment and management including safety planning.

A range of therapeutic techniques were deemed effective by MHAs when working with students including Cognitive Behavioural Therapy (CBT) and DBT and working with students on emotional regulation and breathing techniques:

Individual MHA support Including CBT based / trauma informed work.

Providing advice, guidance and signposting to relevant services were also considered effective approaches. Helping students develop strategies to cope was another effective intervention:

> *I know that students find that it is their relationship with their adviser i.e. someone they can meet with, who will listen and support them in thinking through options, strategies etc. is really significant and effective.*

Managers

Caseload

Ten Managers (n=10) completed the Member Survey 2023. Manager members are responsible for MHAs, SMHMs or similar staff such as Disability Advisers who see students with mental health conditions and/or other wellbeing staff. The number of students on Managers' service caseload this academic year requiring a one-off, short term or brief intervention ranged from five (n=5) to over six thousand (n=6030).

For most Managers their caseload has increased by some degree since the last academic year, for three managers this was a significant increase and for a further three this was a minor increase. The caseload had stayed about the same for four of the 10 managers.
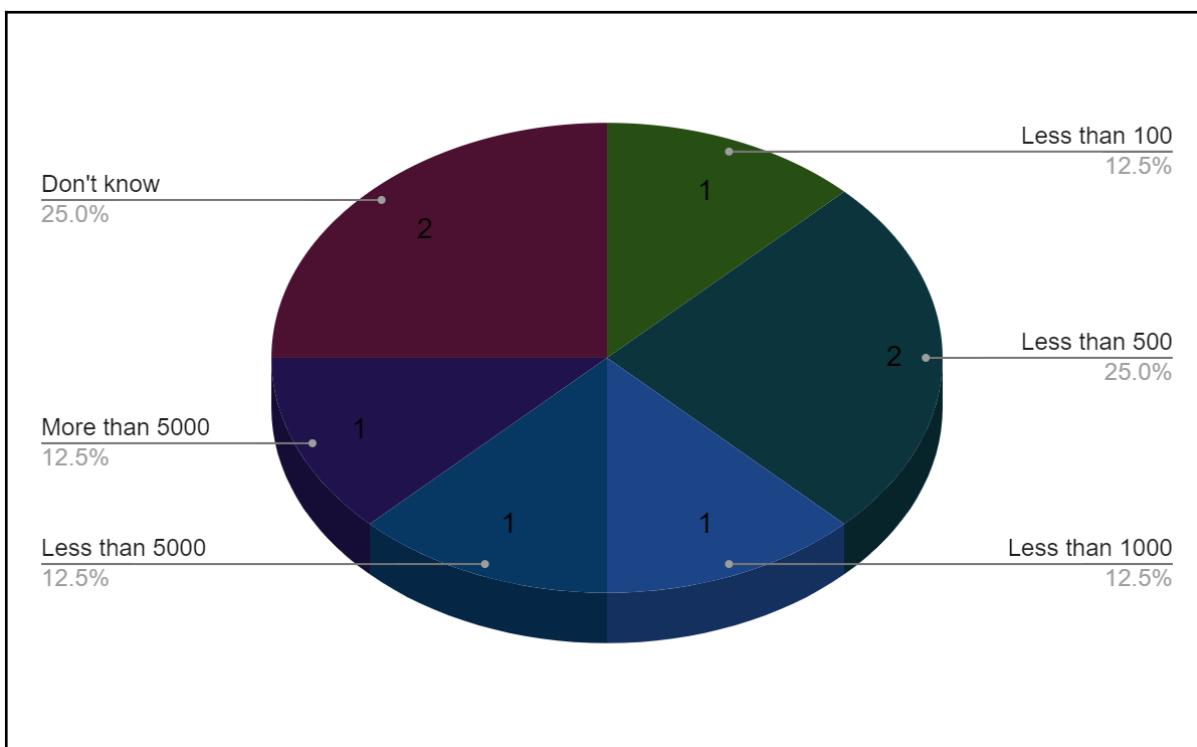
Fig. 14 Number of students on caseload: managers

Supporting students in crisis and 'high risk' students

Managers were asked how many students received crisis support in the last academic year. A mental health crisis is when a student feels that they are breaking point and need urgent help. Interestingly, half of the respondents did not know - they did not collect this data or were unable to retrieve it from the system (n=5). Of the five Managers who had access to this data, this ranged from 3 to 400 students. Over the last 12 months this proportion had stayed about the same for most Managers (n=5) and for four members the numbers had increased slightly.
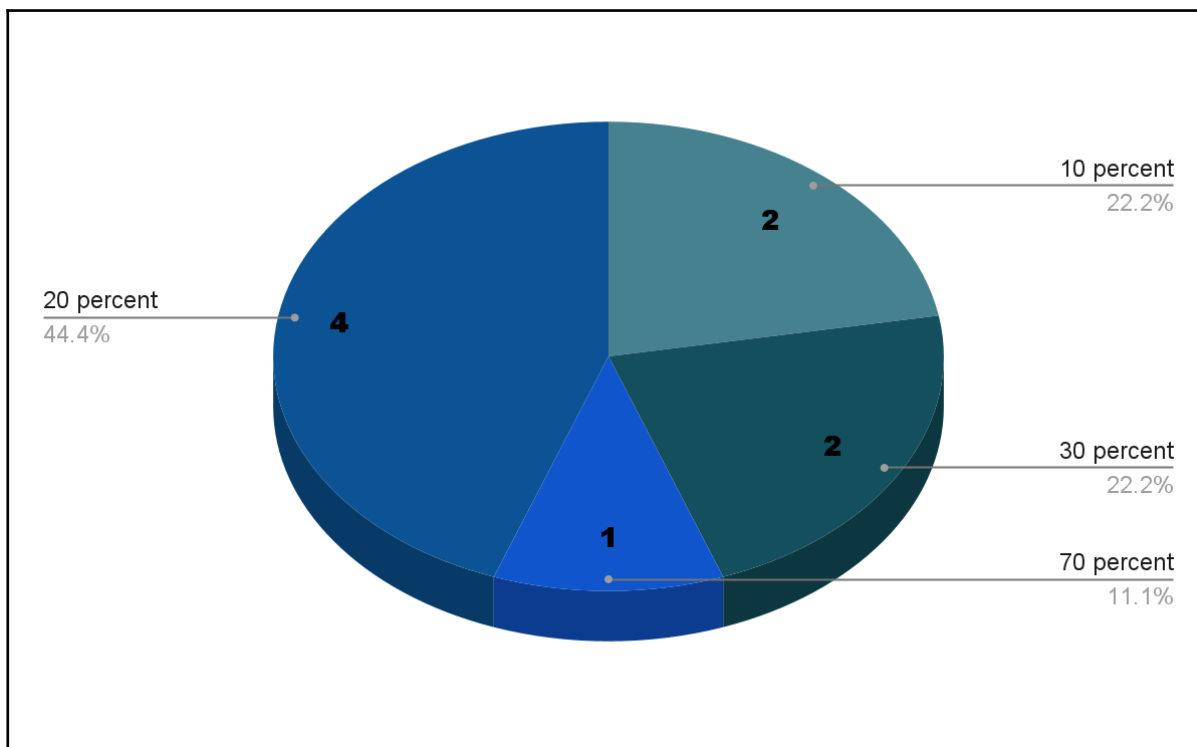
Fig. 15 Percentage of students considered 'high risk': managers

The percentage of students in the total service allocation considered 'high risk' for the academic year (e.g. in terms of deteriorating mental health, severity of mental health condition, suicide, serious self-harm, neglect, abuse, becoming socially isolated or experiencing significant disruption to their education) ranged from 10 to 70 per cent amongst the Manager members who completed the survey with the largest number (n=4) stating that this was 20 per cent of the total service allocation. Over the last 12 months this proportion had stayed about the same for most Managers (n=4) and for three members the numbers had increased slightly. For one Manager, this represented a significant increase (n=1).

Five Managers commented on their caseload (n=5). Three commented in relation to data collection, noting that data in relation to students in crisis was either not collected or was difficult to obtain:

> *We currently do not have data for students in particular crises.*

> *Unfortunately we don't capture the above data that easily, compared to my previous University.*

For one Manager, the data shared was in relation to their online service:

> *This is only representative of our online service and not of the services offered locally across our partnership.*

Monitoring and evaluation of interventions and activities with students

The majority of Managers evaluate their interventions/activities with students (n=9). The most popular type of evaluation was a mixture of both quantitative and qualitative methods (n=8). The quantitative tools used in monitoring and evaluation by Managers who completed the Member Survey 2023 are presented in the table below (Table 3). Please note that because Managers could select more than one tool, the total (n=17) exceeds the number of Managers who completed the survey (n=10). The most popular quantitative tools used were a service user survey (n=6), PHQ-9 (n=3), CORE-OM (n=2) and GAD-7 (n=2).

Monitoring and evaluation tools (includes validated scales)	No. of participants using this
Service user survey	6
Institutional survey (employer or university)	1
CIAO (Counselling Impact on Academic Outcomes)	1
CORE-10 (Clinical Outcomes in Routine Evaluation - 10 item)	1
CORE-OM (Outcome Measure version of Clinical Outcomes in Routine Evaluation)	2
GP-CORE (General Population version of Clinical Outcomes in Routine Evaluation)	-
GAD2 (Generalised Anxiety Disorder - 2 item)	-
GAD7 (Generalised Anxiety Disorder - 7 item)	2
ONS-4 (Office for National Statistics Personal Wellbeing Questions)	-
PHQ-9 (Patient Health Questionnaire - 9 item)	3
WEMWBS (Warwick-Edinburgh Mental Wellbeing Scale)	-
Institutional evaluation (university team or project)	1
External evaluation (consultancy or other external team)	-
Other	-
Total	**17**

Table 3: Quantitative monitoring and evaluation tools used to evaluate interventions/activities with students : managers
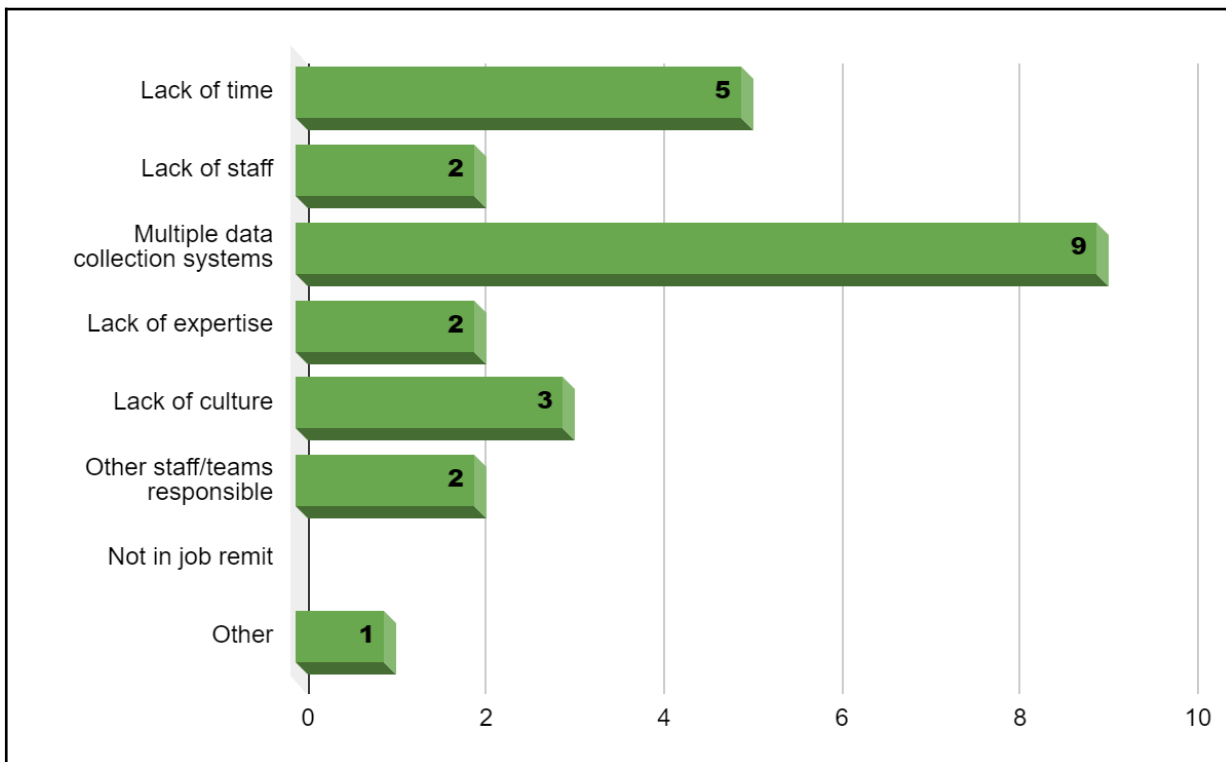
Fig. 16 Data collection, monitoring and evaluation challenges: managers

Managers were asked to consider the challenges they faced in relation to data collection, monitoring and evaluation and were able to select multiple responses from a list of options. Please note that because Managers could select more than one option, the total (n=24) exceeds the number of Managers who completed the survey (n=10).

The most cited challenge was that of systems (n=9) where there are multiple systems collecting student data across an organisation. Lack of time was another popular challenge cited when it came to data collection, monitoring and evaluation (n=5). One Manager noted that survey fatigue was a challenge when it came to data collection and subsequent evaluation:

> *Students are sick of filling in forms.*

Just one additional comment was made in relation to challenges. One Manager detailed how their service was currently researching the most appropriate tools to measure impact, noting that the implementation of CORE-10 (Clinical Outcomes in Routine Evaluation, 10 item measure), an assessment measure for common presentations of psychological distress, did not fit well with their service model:

> *We are currently researching tools to measure the impact of our interventions. CORE-10 has limitations when a one-off bookable appointment system is our model.*

What works?

Respondents were asked to comment on the most effective intervention or activity used in their work. Seven of the Managers responded to this question.

The key activities which emerged from analysis of the comments included individualised support delivered on a one-to-one basis, tailored to the needs of the student:

One to one support and it varies as to the needs of the student and the issues presented.

Listening, displaying empathy, the use of goal-focused evidence-based therapeutic approaches and liaising on behalf of the student were also mentioned by Managers:

Active listening and empathy.

Solution focussed interventions and liaison.

Two Managers were unsure with one citing lack of data to inform this response:

Can't comment yet; new form this year, no data pulled yet. Previously we weren't evaluating at all due to technical issues.

All Members

The following section is based on questions to respondents which asked them about where they worked, how they worked and their plans for the future. These were asked of all respondents to the survey (n=104).

Members were asked to think about the team within which they work (Fig. 17). The largest groups of respondents perceived that their team was well staffed (n=29) or understaffed (n=22). A total of 26 respondents' teams were understaffed either with vacancies to fill (n=15) or new posts being created (n=11). Only five respondents felt that their team was well resourced. This question was not applicable to 17 respondents since many Mentors, for example, are self-employed and work on a freelance basis for agencies and are not employed directly by universities.
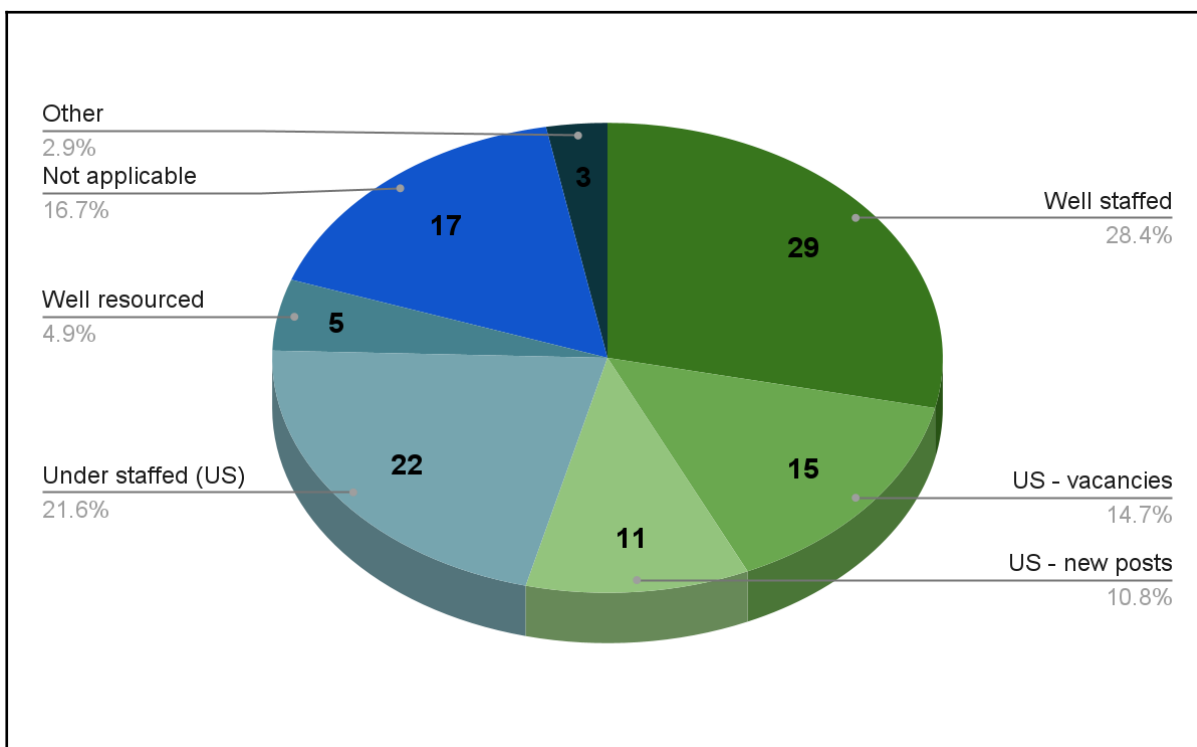
Fig. 17 Staffing of current team: all members

Working Conditions

A flexible working environment was favoured by the majority of UMHAN Member Survey respondents (56.7 per cent) and for almost half, working flexibly, including working from home for a set number of hours was the reality (48.1 per cent). There was some difference of opinion as to whether members felt they worked more effectively at home (n=33) or on campus (n=18) but the key message which emerges from this data is that flexibility in working conditions is preferred by respondents and only a small proportion are currently denied that option (n=7).

Current working practices	No. of respondents
I prefer a flexible working environment	59
I am working from home for a set proportion of my hours	50
I feel I work more productively at home	33
I am able to work on campus when students request face-to-face appointments	28
I am able to choose when I work from home	26
I feel I work more productively on campus	18
I am working from home for health reasons or because I have caring responsibilities	13
I am working completely on campus	13
I am finding that the change of working culture post-COVID 19 has negatively impacted me e.g. I feel more lonely	9
I have not been offered greater flexibility in my working conditions	7
I am finding it difficult to juggle remote and face-to-face appointments	6

Table 4: Current working practices of respondents: all members
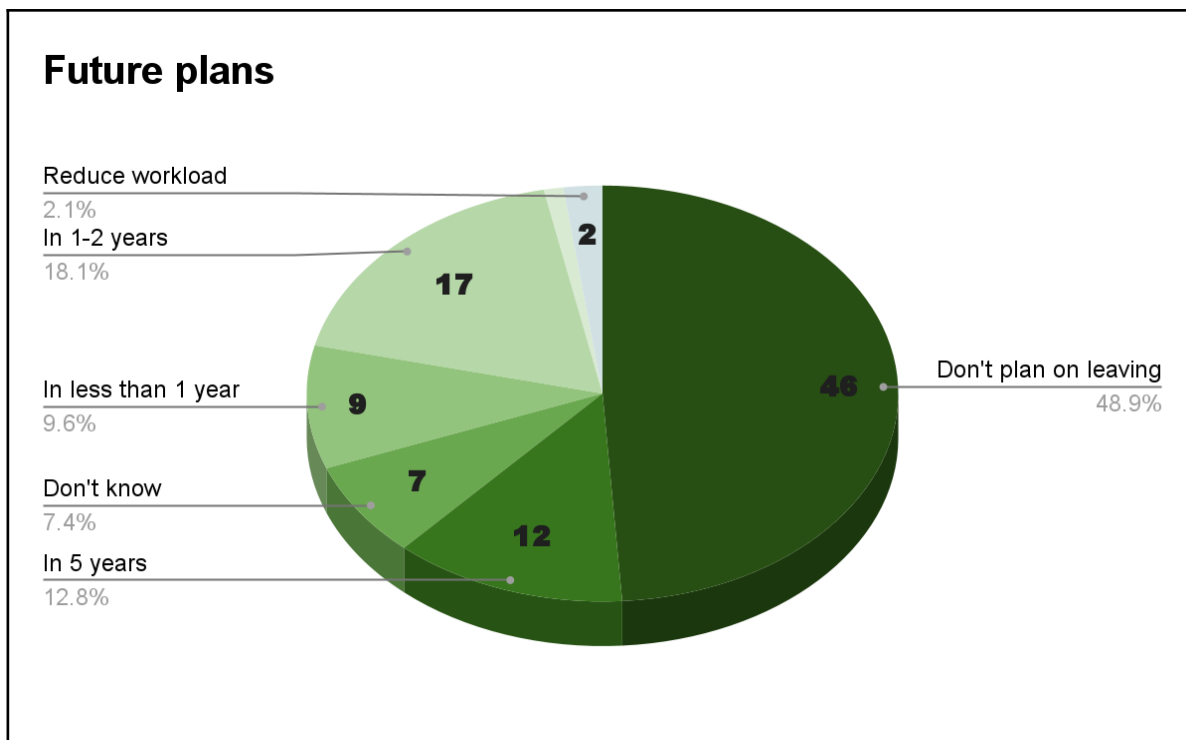
Fig. 18 Future plans: all members

Ninety-three respondents completed the question relating to their future employment plans. This question is designed to gauge recruitment and retention trends in relation to UMHAN members. Almost half of respondents do not plan on leaving their current role in the foreseeable future (n=46) compared with approximately two fifths of members who are considering leaving in the next five years (40.9 per cent in total). This is in contrast with data from 2022 which revealed that approximately a third of respondents were planning to leave their role in the next five years.

In terms of the factors influencing members who are thinking about leaving their current role, pay is the most cited reason (n=20). Other influential factors include workload (n=17), work related stress (n=13), responsibilities of the role (n=11) and lack of career progression (n=11).

Factors influencing members to consider leaving	No. of respondents
Pay	20
Workload	17
Work related stress	13
Responsibilities of the role	11
Career progression (lack of, seeking)	11
Retirement	10
Lack of support (from management, feeling undervalued)	6
Safety	6
Working conditions (environment, precarity)	4
Health/Mental Health	3
Commute	1

Table 5: Factors influencing members' views of leaving their roles: all members

Improving Wellbeing at Work

A total of 74 members responded to the open-ended question asking what would improve their wellbeing at work. Overwhelmingly, responses were in relation to an improvement in members' current working conditions in terms of pay, contracts and workload:

> *Higher rate of pay. Have had no pay rise at all, not even annual inflation increment for five years.*

> *Not being on a zero hours contract.*

More control over the allocation process, not having so many students on my caseload.

Opportunities for supervision, training and progression and acknowledgement and recognition of their role and contribution were also important to many members:

Regular supervision with a counsellor, more training on specific disabilities, more training on tools to support students…

I feel that my team and department greatly appreciates our work, but it remains mostly hidden to the rest of the university, including management. It would be great to have a bit more acknowledgement of the role we play in student retainment and success.

Working environment including desk and office space and better systems including ICT, data collection and administrative processes were also specified:

Having my own office rather than hot-desking.

Resources that support the work that the service does e.g. systems.

Other suggestions to improve wellbeing at work included more staff, greater interaction with colleagues and other teams, time for reflection, support from managers and senior leaders and an organisational culture which supports student mental health:

Having more staff not just in my role but other roles within the team. Quite often we have to hold a lot of students because other services, e.g. Mentoring or Counselling are backed up and the waiting list is too long. This makes our waiting list longer which causes stress as it grows and grows.

Feeling a more integrated part of a team/increased opportunities for non-student interaction.

More time to rest and reflect.

Better leadership 'at the top': increased communication from and involvement with student MH policy and development; more integrity 'at the top'.

The culture of the wider University changing, more recognition for the work we do, better pay.

Flexible working options were also a popular response to this question amongst members who would have liked some, or more, flexibility when it came to working from home:

More flexibility on working from home.

Being able to work from home when not seeing students face to face.

The final question relating to working conditions gave members the opportunity to comment on anything else they wished to share. Thirty-six members responded to this question. Analysis of the replies reveals that there were some mixed views of working conditions with 14 members commenting that their conditions were poor in terms of appropriate space available to meet with students on campus, onerous administrative burdens and high volume of work:

> *We do not have a dedicated space on campus. We had to move out of it over 18 months ago due to a flood. We are now "housed" in old lecturers' offices. They are not therapeutic and look pretty awful (students comment all the time). Who knows when the Uni might find us appropriate spaces.*

> *We lack space for confidential appointments - having to see students in-person in open spaces.*

Nine members felt that their working conditions were good. Some members enjoyed the flexibility of working from home but missed interacting with colleagues:

> *Working from home saves time, money and stress. The disadvantages are that I still very much miss the lovely Wellbeing Team I worked with at Uni.*

> *My working conditions are amazing, especially since I have gone remote-only. Working from home means my environment is always under my control, which in turn creates stability for my students. This was definitely not the case when I worked in universities prior to Covid.*

Pay and staffing were mentioned in response to this question particularly reductions in pay for the same amount of work and large amounts of administrative work which was unpaid. High staff turnover was an issue for some members, as were teams that were understaffed or in fear of redundancy:

> *Pay and conditions are poor, hire and fire and zero hours contracts with a fragmented team leads to high staff turnover and discontinuity in support. I have done the job since 2011 and my hourly pay rate has dropped by over thirty six per cent.*

> *Variable hours mentors are expected to do a large amount of work that is unpaid, it is highly unethical to require tasks to be done (paperwork, admin, CPD, training) and then not pay staff to do them.*

Whilst one member was favourable about the management at her place of work, a small number of respondents did mention that they felt senior management and leadership did not recognise their contribution or value:

> *This role is misunderstood across the uni, our job spec doesn't reflect the complexity of our work, and so neither does our salary.*

> *… do feel overall that the job role is undervalued in terms contributing to retention, achievement and to overall success - as well as wellbeing of the students.*

Current Sector Initiatives and Issues

Higher Education Mental Health Implementation Taskforce (HEMHIT)

A Higher Education Mental Health Implementation Taskforce (HEMHIT) chaired by Prof. Edward Peck, the Student Support Champion, was set up in July 2023. It is made up of bereaved parents, students, mental health experts, related charities, and representatives from Further Education (FE), HE and health. HEMHIT is tasked with overseeing four key areas of activity and reporting on their progress by May 2024:

 1. Develop a plan for better identification of students in need of mental health support and a clear user journey for accessing that support.

 2. Support the adoption of common principles and baselines for approaches across providers, including through Charter memberships.

 3. Develop a 'Student Commitment' for more sensitive student-facing policies, procedures and communications in the sector.

 4. Support sector engagement with the national review of students suicides in HE and explore methods for achieving greater timeliness and transparency on suicide data.

We asked members their views on these areas of activity. We received responses from 66 members. Broadly, their views were positive in the main (n=37) with 24 members expressing mixed opinions whilst five members (n=5) expressed a negative viewpoint.

The work of the taskforce was viewed positively in its demonstration of commitment to improving student mental health support:

> *I think they are vital for maintaining a clear and transparent road map to ensure best practice for students, their families, universities and those supporting students.*

> *Anything we can do to better support students to access support services available is hugely beneficial.*

However, concerns about the taskforce and its areas of activity were focused on:

- oversimplification

- duplication

- resources

- responsibilities

- implementation and buy in.

Interestingly, whilst some members welcomed the taskforce and perceived that consistency across and within HE and providers was important, this was also understood by some to be an oversimplification of the unique makeup and contextual factors influencing the provision offered by providers:

It does feel like current approaches may sometimes vary from institution to institution, so some increased clarity would be valuable.

Whilst common principles etc are good, will these work for all organisations/institutions that fall within HE, FE and Health, with very varied characteristics?

Each University has a very different make-up. Some have gone down the clinical and NHS route, some have gone down the practical support route, some are seeking clinical and NHS qualifications, some seek a wider range of experience and qualifications and some have no requirements.

Some common principles could be useful to formalise as I'm sure we're all working towards the same type of goals, however, I feel it's important that each institution has flexibility to address these principles in the ways they see most appropriate for their type of institution. One size doesn't always fit all.

There was some concern that the taskforce's work was duplicating previous efforts and overlapped with the work of the University Mental Health Charter (UMHC) in some areas:

I'm not entirely sure what more sensitive student-facing policies would include, however, certainly some communications to students could improve from specific departments. It seems like this may overlap with the work Student Minds has already completed with the MH Charter, promoting a whole University approach to Student Wellbeing. If it is the same - is there a need for duplication?

I am a little weary of repetitive new initiatives; we are involved in applying for Charter status and I wish these elements were more joined up as each requires us to do similar work alongside our regular jobs.

The financial resources and outlay required of HE providers in order to meet the taskforce's objectives were perceived to be a barrier:

It's much needed but important that universities are fully supported to meet these areas of expectation (i.e. resourced enough, informed enough).

I agree more needs to be done to reach out/make students aware of services. However, I've worked in a few Universities and they all seem to have a similar attitude: 'we'd love to advertise our services more but we can't because we're already inundated with student demand'. To improve this, Universities would have to be willing to increase the number of FTE staff which would cost a lot. Our demand has gone up 42% in one year and that's without additional advertising or campaigns and without any additional staff.

Moreover, some members felt that the obvious option would be to resource more adviser and mentor posts in HE settings:

I find whilst these are some really great objectives to work towards, there is a need for more mental health professionals already working within HE (in a mental health capacity) to move this forward as we have insight into the day-to-day functioning of wellbeing support in a HE setting.

A straightforward solution is to employ more staff for mental health support and pay them appropriately with full contracts.

Some members were worried that universities would take up some (or more if they were not already) of the NHS' responsibility in supporting students in crisis and wanted greater clarity around responsibilities and remit:

I think there should be common principles and baselines but also a clearer understanding of responsibilities of the institution vs NHS services.

I worry about increased expectations of universities not matched by resource/specialist resources i.e. NHS back-up and access and fear people may leave MHA roles because of it.

I think it's got a good premise, however concerned that "we" are now expected to fill the gap of the NHS / statutory services. We can't be a crisis team so please don't make us one. Also we need to remember that students are adults.

I am surprised linking students into support through NHS streams is not on here.

In principle agree with a review and identification of common principles. I am cautious of the shifting of the management of crisis response from statutory services/NHS to University.

Finally, concerns were expressed about how the taskforce's recommendations would, and could, be implemented, and that there was sufficient support and buy-in from HE providers:

All of this sounds really positive however it is a case of how these key areas are embedded into the day to day running of services - we have lots of guidance but it is not always clearly implemented/monitored/evaluated.

All of these are very necessary as provision varies so much between institutions. Hope there is real buy-in and not just being seen to be doing something and getting boxes ticked.

University Mental Health Charter (UHMC)

We also asked members about their institution's involvement in the University Mental Health Charter (UMHC) (assuming this was applicable to their situation) and if they were personally involved in any way.

The largest proportion of members, just over one third (37.5 per cent) who completed the survey did not know if their institution was participating in the Charter scheme (n=39) whilst 30 members' institutions were currently taking part. This question was not applicable for 20 members (as previously mentioned, some UMHAN members are employed through agencies and may work for multiple institutions). Ten respondents were working at institutions which had received the UMHC Award from Student Minds. Six respondents were involved in some way in their institution's engagement with the Programme, Charter or Award.
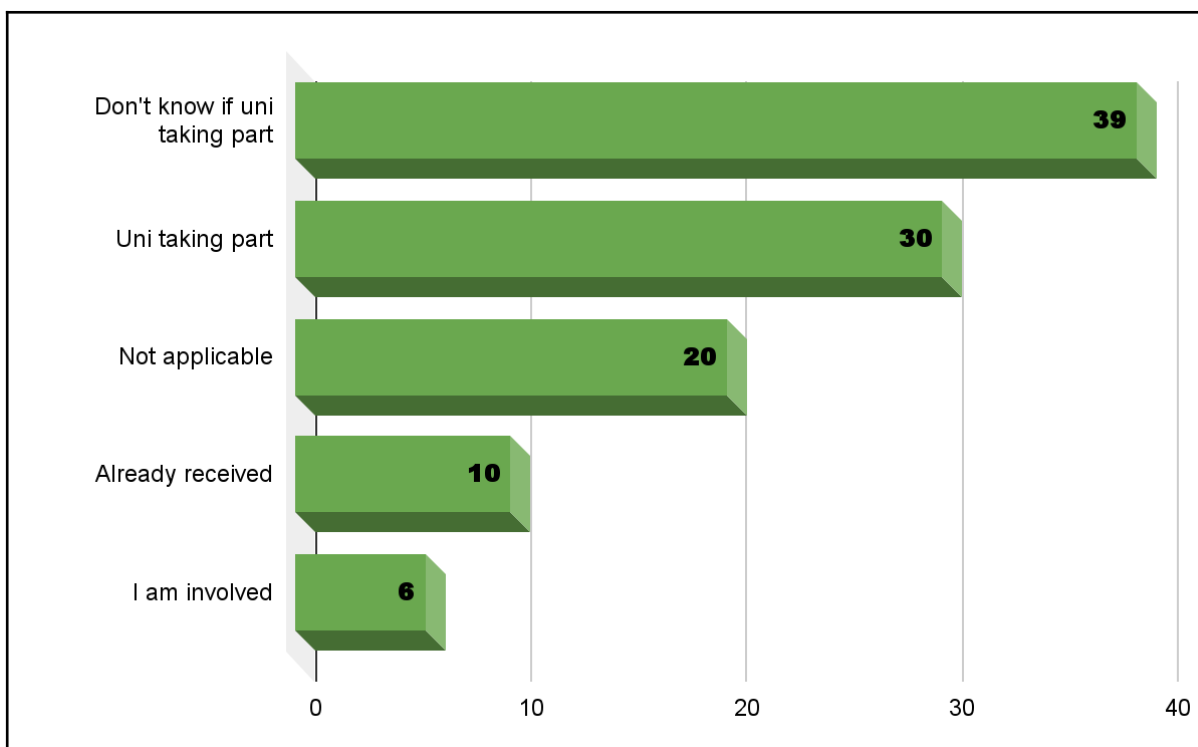
Fig. 19 Participation in the University Mental Health Charter

We also asked members their views of the UMHC Framework, Programme and Award. Sixteen members completed this question. Some members felt that it was a useful initiative but reservations were primarily expressed in relation to the resources (financial and otherwise) required for participation:

> *I appreciate it is costly and requires large time commitment and potentially extra staffing for report development. At my university, it seems out of reach given our financial situation.*
>
> *This is unobtainable for those institutions which do not have large pots of money sitting about to be able to buy into the charter, and if we did we would be using it on staff for increased student support. This is a large scale project which we would just not have time to do, even if we could afford it.*

A lack of evaluative evidence of the impact of the UMHC on student mental health was also highlighted:

Whilst in principle I think the UMHC is a good framework, I don't think it has been vigorously reviewed by independents to see if it brings positive change to the students and staff where universities have signed up to it.

I wonder if it actually has ANY impact on the way that things are done at the uni.

I would like to see evidence of membership improving student experience/outcomes.

At some institutions, members found that they were not involved in the UMHC process:

…the Wellbeing Service hasn't been included in discussions about the implementation of the MH Charter.

The Charter looks brilliant but frontline staff have not been regularly involved in its implementation. It has so far been the project of a contracted worker and at Directorate level.

Further reservations were detailed in relation to the implementation of the UMHC and that it was merely a bureaucratic process carried out to meet external requirements:

I worry it is a new 'badge' with little meaning, and worry about the ongoing work required afterwards.

I think it would be good but my concern is Universities may not engage where there may be cost implications to correct and valid changes that need to be made and Universities may also need to admit that things aren't right or good enough as they are.

Finally, it was noted that there was no alternative charter offered to HEPs, that much of its content was repetitive, and that it would be challenging to engage academics in the process of both application and implementation.

NHS Waiting Times

We asked respondents about their experience of referring students to a range of NHS services and average waiting times. For most members responding to the survey, appointments for GPs were within 1-6 weeks (n=52) or within 1 week (n=30) whilst appointments for other primary care services were more likely to be between 6 and 12 weeks (n=19) or between 1-6 weeks (n=17).

The longest waiting times were for diagnostic assessments for ADHD and ASC with the largest proportions of respondents selecting 2 years + for both ADHD (n=46) and ASC (n=53). Similarly, wait times for DBT - a type of talking therapy, and specialist eating disorder services could be longer than 2 years (n=16 and n=10 respectively).

The quickest wait times were referrals to crisis/acute mental health services with the majority of respondents citing between 24 hours and one week (n=57 in total). The most common wait times for early intervention teams were within 1 week (n=18) and between 1-6 weeks (n=21) and between 1-12 weeks for the community mental health team (n=37 in total).

Referrals	Within 24 hrs	Within 1 week	1 - 6 weeks	6 - 12 weeks	12 - 18 weeks	18 - 24 weeks	24 - 52 weeks	1 - 2 years	2 years +
GP appointment	9	30	**52**	1	-	-	-	-	-
Other primary care	-	4	17	**19**	6	13	11	4	1
Diagnostic appointment: ADHD	-	-	-	3	2	4	4	22	**46**
Diagnostic appointment: ASC	-	-	-	5	1	4	5	12	**53**
Crisis/acute mental health services	26	**31**	9	7	-	1	1	**-**	1
Community Mental Health Team	1	11	**20**	17	10	7	4	1	1
Early Intervention Team	3	18	**21**	8	4	1	1	1	-
Dialectical Behaviour Therapy (DBT)	-	**-**	2	6	9	6	3	13	**16**
Specialist Eating Disorder Services	-	3	7	9	8	3	9	**10**	**10**

Table 6: Referrals to NHS services wait times (n.b. the largest group of respondents has been highlighted within each type of referral for ease of viewing)

Thirty-seven members responded to an open question about waiting times. Our prompts included asking if there were any other services we had not asked about in the section above and if there were any particular cohorts of students that members were concerned about in relation to waiting times.

The responses to this question made for sobering reading. Waiting times for students to be assessed for ASC and/or ADHD were the most frequently mentioned by members to this question (n=14). Noting that with increased waiting times, some students are not formally diagnosed until after they complete their studies and in spite of the Right to Choose (the NHS Constitution gives people living in England the right to choose where to have treatment) some private assessment centres are not currently accepting individuals for their waiting list:

> *Currently unable to refer for autism assessment. Block has been put on so the only means is to go private.*

> *Waiting times for assessments in Autism and ADHD are unacceptable and getting longer. Many parents or students fund their assessments privately as they cannot wait for a NHS referral. Shocking.*

GP's are placing all students on NHS ADHD waiting lists and not utilising the right to choose and opting for private, some students won't receive a diagnosis and adjustments support via DSA by the time they have completed their degree.

…whilst Right to Choose has been helpful for many, I understand that some of the services via RTC are also now stopping referrals as they are inundated.

One member's institution was able to support students with diagnostic appointments, however, whilst another had found that waiting times had reduced because of Right to Choose in their area:

We are fortunate to be able to offer diagnostic assessments for ADHD for DSA purposes which has enabled students to get DSA in place for their studies.

I have noticed recently that ADHD and Autism diagnosis appointments are being outsourced and have much smaller waiting times than before when it could be up to 2 years and now students are being seen within months.

Indeed, the 'postcode lottery', the situation where the level of the quality of healthcare that people receive is different in different areas of the UK was mentioned by members in relation to the services their students were able to access and receive, as this member described in relation to the varying experiences they had observed:

I have other students who really struggle to get timely GP appointments/early intervention support/community MH support and terrible experiences of A&E whereas others seem to have really good experiences. I work with students who come under different local authorities including Plymouth, Devon, Cornwall and it seems to be varied for all in each area.

Our students have mixed experiences depending on where they live. Still very much a postcode lottery.

Referrals by UMHAN members to NHS and statutory services was an ongoing source of concern for many members. Some were unable to refer directly to NHS services whilst others described how their referrals were ignored or not accepted. As one member highlighted, the referral criteria seemed to have become more stringent:

We are unable to refer directly into NHS services and can only signpost the student to their GP.

Currently we have to write letters to GP's for onward referral to things like CMHT [Community Mental Health Team]. Sometimes we have to write 2 or 3 letters with a detailed assessment and saying we've met them regularly and they need onward referral or assessment but some GP's still won't do this. Some are really good and will listen to us but others won't. This impacts on our services but also worsens that student's Mental Health.

Increased prevalence of student's referrals to IAPT [NHS Talking Therapies] or CMHT [Community Mental Health Team] or EIP [Early Intervention in Psychosis] or crisis services, being declined.

In general, wait times are long for students although some members said that there is support in emergencies:

If people's lives are threatened they do get some support and swift, but short of that it has been poor.

My students will get seen within hours if they go to A&E. Otherwise they can wait anything from one week to see a GP to years for an ADHD assessment, and getting referred to CMHT [Community Mental Health Team] can be impossible.

I am often concerned as the Crisis teams in my area are so overworked and many times have called them with a student but got no reply or not got the help needed.

This is an area of huge concern for me. Most of my students with long term mental health diagnosed conditions have to wait usually for weeks sometimes months to get an appointment or see/ speak to someone.

Similarly, experiences of local GPs were mixed:

Our local GP service is "under performing" and has major issues (it is well known in the local area and by other NHS services). They only let students fill in an e-consult during 8 and 8.30am. They do not let them walk in to book appointments and only accept emergencies via the phone (but expect at least an hour wait on the phone line). We as MHAs spend so much time chasing the GP on behalf of students as students are too unwell or exhausted trying themselves.

We have fantastic access to same-day GP appointments.

The complexity of the situation relating to GP registration for students was noted by one member as being particularly problematic:

It's a nightmare not being able to have dual GP registration. You might work and refer someone to CMHT then they are picked up while at home in summer and discharged if they cannot attend. Would love NHS services to speak to each other geographically!

In relation to particular cohorts of students affected by NHS waiting times, in addition to students with suspected ASC or ADHD awaiting diagnostic assessments, the following groups were mentioned by respondents. Students with and/or experiencing:

- Gender dysphoria

- Eating disorders

- Sexual abuse

- Drug and alcohol issues

- Personality disorders.

> *Students with eating disorders often have to wait until they are in the BMI red zone before they can get help when they might not need as much help if they could have been seen earlier.*

> *Students with EUPD [Emotionally Unstable Personality Disorder] or personality disorder traits are having to wait 19+ months for a service in Plymouth that only caters to people up to the age of 23. A lot of the time our students will either age out or graduate from university before getting specialist support or DBT [Dialectical Behaviour Therapy] therapy. These students are often the ones that present as higher risk due to the level of self harm and suicidal behaviours which we end up having to hold for prolonged periods of time as there are no other services that can support them.*

Respondents were asked to select the statements which best described their knowledge and experience of the NHS Choice Framework in England. For members in Wales, Scotland and Northern Ireland this framework is not applicable (n=12). Almost half of the respondents were familiar with 'Right to Choose' (47.1 per cent) and 25 per cent had found it useful in improving access times to diagnostic services (n=26). However, 11.5 per cent of respondents felt that it had not made any difference in improving access times to diagnostic services (n=12).

Statements about the NHS Choice Framework also known as 'Patient Choice' and 'Right to Choose' in England	No. of respondents
I've heard of Right to Choose	49
I have found Right to Choose useful in terms of improving access times to diagnostic services	26
I don't know much about Right to Choose	22
Right to Choose has not made any difference in terms of improving access times to diagnostic services	12
Not applicable	12
Other	2

**Table 7: Knowledge and experience of 'Right to Choose**

UMHAN Membership

Net Promoter Score

This was the first year a question to generate Net Promoter Score (NPS) was included in the Member Survey. NPS is a market research metric which measures customer experience by asking a single question of members - would they recommend the organisation to a colleague. It is generated by calculating the percentage of members who are 'promoters' (those who select a 9 or 10 in response to this question) minus the percentage who are 'detractors' (those who select between 0 and 6).

In this case the NPS for UMHAN was 74.0 per cent - 3.9 per cent = 70.1.

"An NPS over 70 means your customers love you and your company is generating a lot of positive word-of-mouth from their referrals. The higher your NPS is, the more likely it is that your customer referrals will convert into new leads, hence into more revenue for your company" (retently.com, 2023).
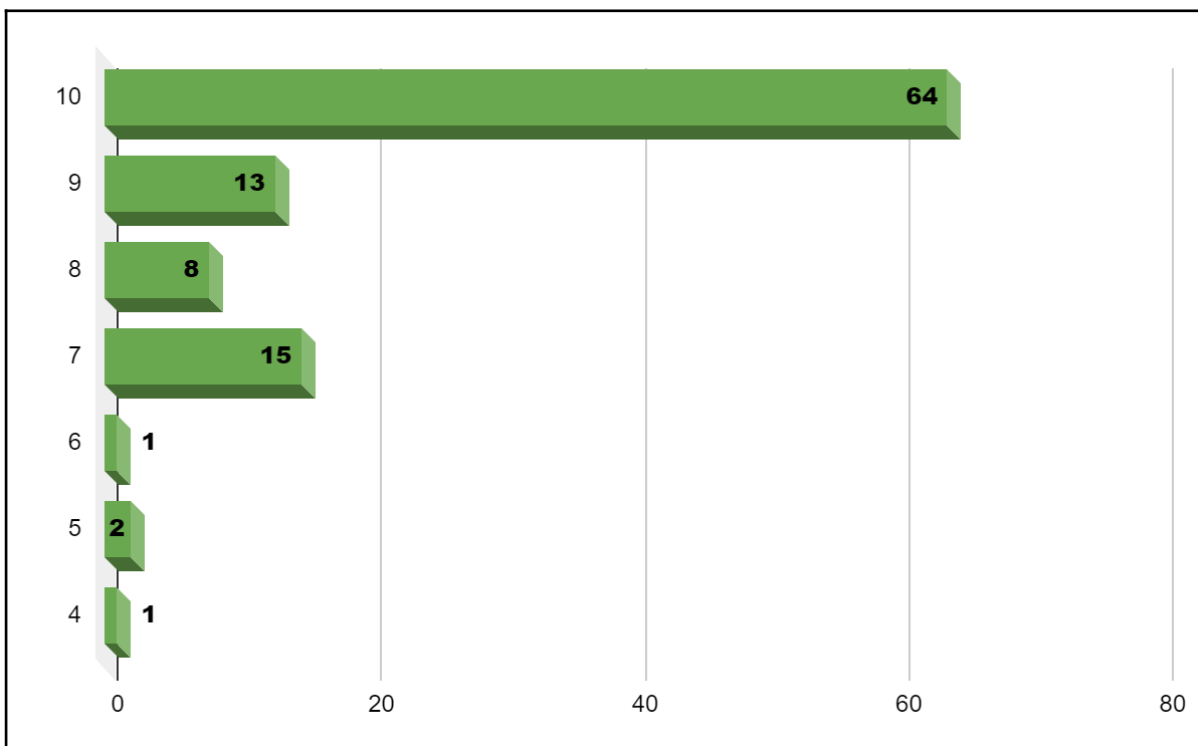
Fig. 20 *On a scale from 0 to 10, how likely are you to recommend UMHAN membership to someone working in a similar role to you? where 0 is 'not at all likely' and 10 is 'extremely likely'*

Membership Benefits

UMHAN has three types of membership; Accredited Practitioner Membership, an audited membership type, subject to UMHAN's supervision and CPD requirements; Manager Membership, open to managers responsible for MHAs, SMHMs or similar and Associate Membership, aimed at staff who have direct contact with students, in either a school, college or university, and through this professional role have an interest in mental health.

Eighty-two survey respondents detailed what they perceive to be the greatest membership benefit of UMHAN. Overwhelmingly, members most value the sense of community UMHAN creates through bringing members together at online meetings and in the forum:

The sense of community and being able to learn from other UMHAN members approaches, and being able to share with them potentially useful experience and knowledge.

Meetings facilitated by UMHAN including the specific job role groups, professional background groups and the Lunch and Learns were also well regarded amongst respondents:

I like the Lunch and Learn sessions as they are good CPD and recorded. The mentor meetings are also really good to keep up to date with what is happening in the sector.

Regular online meetings, both role-based (i.e. MHA) and professional background-based (i.e. OT, Social Work etc.).

They are valued for multiple reasons including the sharing of information between members as well as between UMHAN and members particularly around current sector issues; and for providing a safe space where members can share their experiences:

It's just great. I started out alone as an MHA; it's a community/network, I LOVE the managers' meetings, great solidarity, like-mindedness, shared experiences, and similar challenges. So the meetings come top for me.

The feeling of togetherness, of understanding for the role we do and continued support and training.

Members also value the CPD opportunities UMHAN provides, its resources including the online forum; that the information UMHAN provides is up-to-date allowing members to stay informed, and the supportive nature of the organisation and its reputation:

Honestly the CPD is really great. This is truly one of the most beneficial professional memberships I've been a part of and a really lively, caring, invested community.

The community space and CPD sessions, being able to ask questions and also feel like you are kept up to date by others and by UMHAN.

Friendly support! It's not something I've ever needed to access but I know it's there should I need it. I also greatly appreciated the CPD opportunities and sector-specific information that is available via UMHAN.

For some respondents, membership of UMHAN is a requirement of their job role:

You allow me to continue working in the role.

When asked to state what they liked most about being UMHAN members, of the 66 members who responded, overwhelmingly this was again, community, in terms of being part of a friendly group of similar professionals across institutions having space to meet, share information and resources, and grow with support from UMHAN:

> *Great to have a body which specifically supports the work we do. Most of the staff here are members of professional bodies and UMHAN. UMHAN helps provide consistent direction.*

> *Being part of something that values and supports the development of my role.*

> *It feels personal and it has its members' well-being at its heart.*

For some members being part of UMHAN also means they feel represented, heard and advocated for:

> *That I feel UMHAN understands my role in a way that sometimes my employer doesn't anymore. That you fight not only for us but for the students we work with. That you provide varied CPD opportunities.*

> *Established and trustworthy organisation that focuses specifically on the work we are doing in the sector.*

Resources, Meetings and Continuing Professional Development (CPD)

All Accredited Practitioner members (MHAs and SMHMs) are subject to UMHAN's supervision and CPD requirements.

The most well used resources are the website's CPD resources, publications, membership framework, the Community forum, Lunch and Learn sessions (including the recordings which are made available on the website) and members' meetings (including the recordings). Less frequently used and known resources include the UMHAN jobs board and the blog.

These findings align with data from the Member Survey 2021 which found that members' own CPD and the membership framework were the most used resources (UMHAN, 2021).

Resource	'I use this'	'I do not use this'	'I am not aware of this'
Website resources for CPD	93	8	4
Publications	87	13	3
Membership framework	81	16	6
Lunch and Learn sessions	76	24	2
Members' meetings online	75	23	1
Community forum	72	24	7
Recordings of Lunch and Learn sessions	69	27	4
Recording of members' meetings	55	37	6
Website resources for use with staff/ service development	47	38	16
Jobs board	31	59	8
Blog	30	54	14

Table 8: Usage of UMHAN's resources: all members

In March 2023 UMHAN launched its <u>Clinical Governance for Mental Health Services </u>guidance to support the sector to develop and improve the quality of support and interventions for student mental health. We asked members their views of this resource. Respondents were able to select more than one statement and so the total number of responses to this question exceeds 104. Just under half of respondents had read the guidance (n=47) whilst approximately a fifth had found it useful (n=21) and a tenth had recommended it to colleagues (n=11). Fewer than two fifths of respondents had not read the guidance (n=39). Over a quarter of respondents were either unaware of the guidance or were interested in finding out more about it (n=17 and n=13 respectively).

Opinions of UMHAN's Clinical Governance guidance	No. of respondents
I have read it	47
I haven't read it	39
I have found it useful	21
I was not aware of it	17
I would like to know more about it	13
I have recommended it to colleagues	11
It is not relevant to me	1

Table 9: Awareness and opinions of UMHAN's Clinical Governance guidance: all members

Members were asked to make comments about UMHAN's online resources. Twenty-five members left comments of which the majority were positive and complimentary:

Useful, innovative and a good variety that is always worth using and checking out.

I find the CPD resources very helpful and resources for students are invaluable.

Really good professional community, and I like the online chat forum for up to date ideas of what is going on right now!

They are fantastic - I like that the forum posts come directly to my emails as this means I don't have to log in to see what is happening and find this really useful. I have been able to go in and look for resources as needed as well and can share all the relevant things with my team. Really helpful for staying up to date.

Having the back up of recordings of sessions available to view on the members-only section of the UMHAN website was appreciated for members who were unable to attend:

I have found lots of value in the online resources, I can't often attend online so having the recordings there and easy to find has been brilliant.

I find the recorded sessions really useful, often I can't attend live so being able to go back and ensure I am not missing out is great.

Indeed, lack of time to utilise resources was frequently mentioned in response to this question:

They're great but I confess to not using them as much as I would like due to time constraints.

I enjoy your resources and websites - I would like to use it more but often chasing my tail..!

One comment suggested that navigation of the website could be improved:

I tend to be very busy trying to spend time to find the resources that I need, thus making them as clear and accessible on the website as possible, would be appreciated.

The key reasons for non-attendance at UMHAN's online meetings for just over half of respondents (52.0 per cent) is because members are unable to block out the time in their schedule to attend (n=35) and because they do not have time for CPD (n=19).
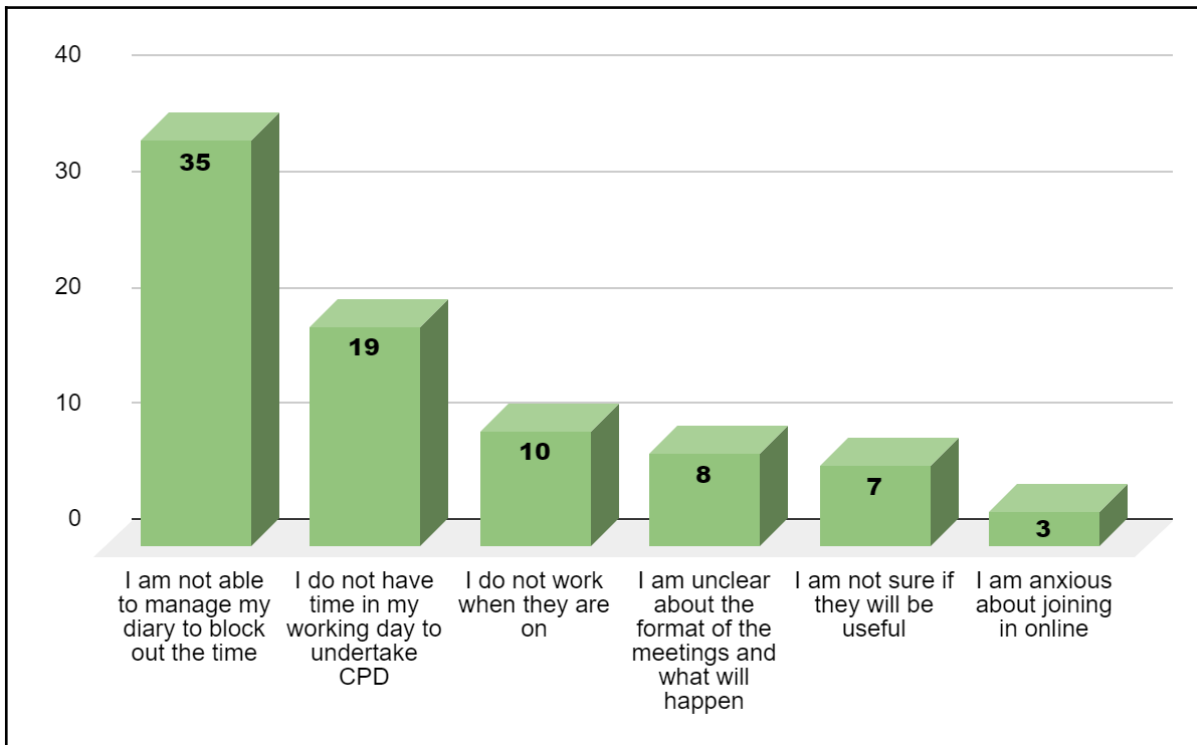
Fig. 21 Reasons why members do not attend online meetings: all members

Preferences for online meetings were almost equally split between members who preferred them during term-time (n=40) and those during vacations (n=34).

If they fall on the days I work, and I've enough notice, I can try to attend. If not, I enjoy watching the recordings so don't feel I miss out too much.

All about the timings. If it's midday or afternoon this is our busiest time for student appointments hence we can't attend.

Depends on the times of them, if they are a 1 hour slot say 10-11 for example it is easier to attend than ones which are 10.30/10.45 starts for example as my appointments are in 1 hour blocks with students and usually start on the hour.

I work part-time so varying days of the week is helpful.

Some mornings, some lunch time, some early eve sessions. Might work.
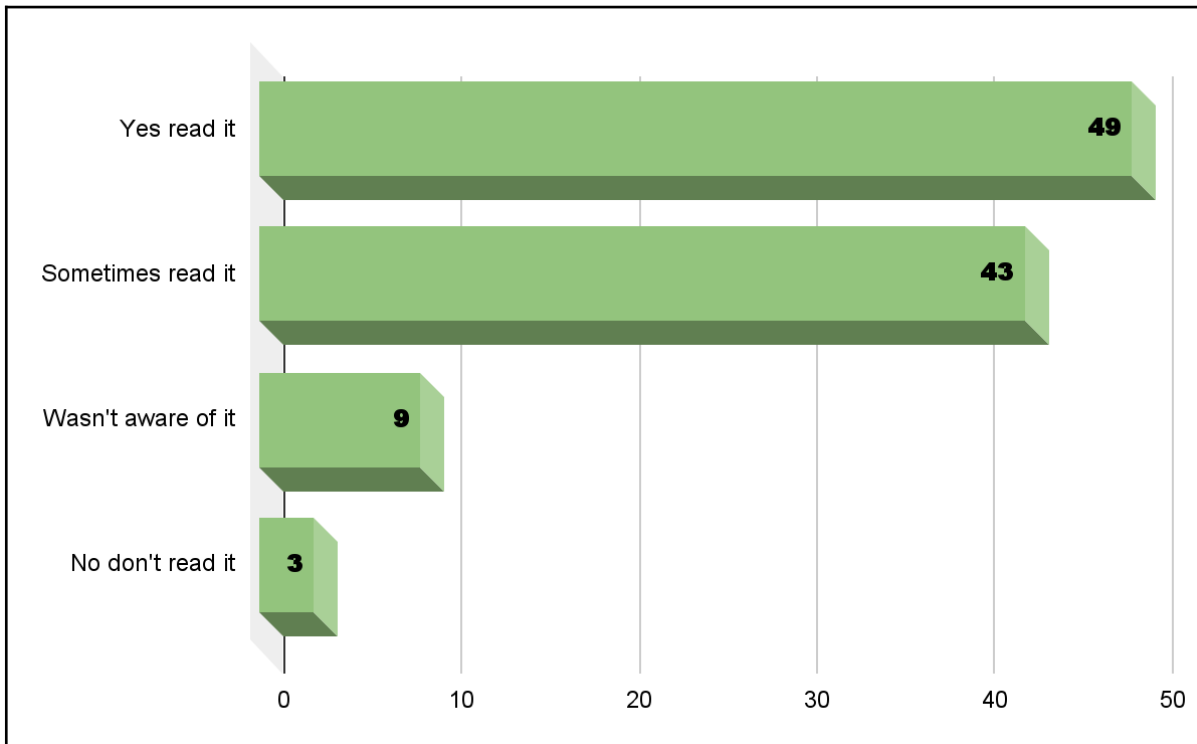
Fig. 22 Readership of the UMHAN monthly newsletter: all members

The majority of respondents read the monthly online UMHAN newsletter (n=92) compared with a minority who are either not aware of it (n=9) or do not read it (n=3). General content and future events are perceived as particularly useful (n=63 and n=60 respectively) whilst what UMHAN is doing (n=40) and sector news (n=40) are also well received by almost two fifths of survey respondents (38.5 per cent).

Respondents were asked to select the statements which best described their experience when it came to CPD. These are displayed in Table 10 below. Please note that because respondents could select more than one statement, the total number of responses exceeds 104.

The largest number of members responding to the survey were in agreement that UMHAN's meetings, training and CPD are useful to them (72.1 per cent), however, almost 70 per cent of respondents struggled to fit in CPD although they did manage to do some (n=70). This is to be contrasted with approximately a quarter of respondents who feel able to manage their time to include CPD (n=27). Approximately two thirds of respondents attend CPD events outside of UMHAN (66.3 per cent). Just under a third of respondents were concerned that they do not spend enough time reflecting on their practice (30.8 per cent) whilst half this number do not feel they are supported to undertake CPD by their employer (n=16).

Comparisons with data from our Member Survey 2022 reveals that just under half of members struggled to fit in CPD (49.3 per cent) compared with almost 70 per cent in 2023. However, this year's findings align with data from 2021 which found that 66 per cent of respondents struggled to fit CPD into their schedule.

Statements about CPD	No. of respondents
I feel that UMHAN meetings, training and CPD (including resources) are useful to me	75
I struggle to fit in meetings, training and CPD but manage to do some	70
I attend CPD events outside of UMHAN	69
I sometimes worry that I don't spend enough time reflecting about my practice	32
I am able to manage my time so that I can fit in meetings, training and CPD	27
I don't feel I am supported to access resources, meetings, training and CPD by my employer	16
I don't feel I am able to attend meetings and training or undertake enough CPD	6
UMHAN meetings, training and CPD are not accessible to me	1
I do not feel that UMHAN meetings, training and CPD (including resources) are useful to me	-

Table 10: Respondents' experiences of CPD: all members

Respondents were invited to make comments about UMHAN's meetings, training and CPD. Twenty-eight members did so of which the majority (n=21) were positive whilst five members made suggestions about what could be improved.

Members described the UMHAN sessions as 'friendly', 'informative', 'useful', 'valuable', 'well-facilitated' and 'supportive':

Meetings are friendly and informative, I will try to attend more.

The UMHAN meetings, training and CPD opportunities are really great and always so appropriate to the role.

I'm really grateful for the offer and have really benefited from organised training and lunch and learns. As someone who is employed by an agency (albeit a good one) and has to fund their own supervision and CPD, I particularly value the no/low-cost CPD that UMHAN provides, especially during a period where the cost of living has gone up but pay has been stagnant for a number of years.

Recordings of sessions were also mentioned as an important resource for those who were unable to attend the live sessions:

Recordings are really helpful - I can plan asynchronous CPD into my timetable

Always useful and I find them interesting and valuable. I attend as many as I can and If I am unable to attend I listen to the recordings and read any information available e.g. surveys, lunch and learn content, presentations etc.

For a small group of members the timings of sessions could be improved as they struggled to attend particularly during term-time, busy times of the day or if they worked part time:

A lot of CPD/meetings are in term time, this is tricky if you have variable hours and trying to work as much as you can while students are active. I generally attend more things when it is quieter i.e. January and June to August.

I would like to increase the amount of CPD I undertake (and have started to block an hour out every other week), however, it's difficult to attend UMHAN meetings / Lunch and Learn due to the timings. Most students tend to aim for mid-morning to mid-afternoon appointments and as we only have two MHA's (myself being one of them) we are often fully booked with appointments.

Making sessions mostly on Thursdays are not helpful to me as I am trying to keep my boundary and not to do anything work-related on the days when I do not work.

Lack of time for CPD, in general, was mentioned in response to this question whilst supervision costs were also mentioned as an issue:

I really struggle to get a supervisor. I cannot afford to pay for one as I work limited hours and a supervisor costs much more per hour than I earn per hour.

Discussion

Student mental health: developments and data

Since our last UMHAN Member Survey report 2022 which revealed an increase in members' workloads and the proportion of caseloads in the 'high risk' category, student mental health sits firmly under the full glare of the spotlight of the media, government and the HE sector. The recent Parliamentary debate on whether there should be a new statutory duty of care for students, triggered by an online petition in the tragic wake of several student deaths by suicide, resulted in the Department of Education stating that universities already have a general duty of care and that to create a statutory duty would be disproportionate. However, the minister did set up the HEMHIT focusing on four areas; better identifying students in need of mental health support; a review of student suicides; compassionate communications and policies; and common principles across providers. This latter area of focus has created a huge impetus for uptake of the UMHC run by Student Minds. That means that all universities should be, if they are not already, moving towards a whole university approach to support the mental health of staff and students.

Recent research from King's College London and the Centre for Transforming Access and Student Outcomes in Higher Education (TASO) using data from the Student Academic Experiences Survey (almost 90,000 students) found that mental health was by far the most common reason someone considered dropping out of university (Sanders, 2023). Other recent research has also highlighted issues in relation to continuation, completion, and progression for students with mental ill health and/or mental health conditions (Bolton and Lewis, 2023; Evans and Xhu, 2023).

In England, HE providers must assess the risks to their students and how they will reduce them in the new Access and Participation Plans. The OfS have highlighted three risks in relation to mental health conditions (OfS, 2023):

- Risk 6: Insufficient academic support

- Risk 7: Insufficient personal support

- Risk 12: Progression from higher education.

There is also work on developing the Disabled Students Commitment from the Disabled Students Commission (DSC, 2023). This is applicable to English HE and has a particular focus on the information, advice and guidance (IAG) provided during outreach to disabled students and support for their transition into HE.

Increasing, complex caseloads: less time for CPD

Supporting students with their mental ill health and/or mental health conditions to transition into, stay and succeed in education has never been so strategically and operationally important. UMHAN members including Advisers, Mentors and Managers and Associates, help students navigate the complexities of student life and life outside of HE, including the academic processes which often negatively affect mental health and wellbeing.

The findings of our Member Survey 2023 have highlighted that in the last academic year, the caseloads for many of our SMHMs, MHAs and Managers have either stayed about the same or they have increased. Mentors and Advisers are routinely supporting anywhere between 30-50 students of which up to half of their caseload is defined as 'high risk'. Mentors have observed an increase in the numbers of students awaiting diagnostic assessments for ADHD and/or ASC whilst Advisers have remarked on the complexity and higher levels of need amongst the students they support. Much of the data regarding caseload in terms of its increasing size and complexity reiterates the findings of our surveys from both 2021 and 2022. Indeed, we argued then that staff needed support to help ensure their practice is safe: "a*ppropriate supervision and CPD opportunities to enable them to properly support increasing and more complex presentations of mental ill health and risk" (UMHAN, 2021, 9). Worryingly, we see again in 2023 that the majority of UMHAN members who completed the Member Survey are struggling to fit CPD into their schedules, as they did in 2021 and 2022.*

Arguably, well-resourced support service teams and staff would not only have the opportunity and time to undertake relevant CPD but would feel supported to do so by managers and senior leaders and yet approximately a third of respondents were concerned that they did not spend enough time reflecting on their practice and a minority actually felt that they were not supported to undertake CPD by their employer. This lack of support for professional development and career progression was one of the reasons cited by UMHAN members who are considering leaving their roles in the next five years, along with low pay, workload, work-related stress and the responsibilities of the role. As we highlighted in our Member Survey 2021 report, access to CPD is vital and for those institutions who are pursuing the UMHC, *Theme 9: Staff Development* emphasises just how crucial this is:

> *Finally, universities have a responsibility to ensure that staff in mental health roles, such as counsellors and mental health teams, are suitably qualified and are able to access appropriate CPD to ensure their knowledge, understanding and skills remain up to date. Clinical practice in mental health is continually evolving and responding to new insights and international evidence shows that ongoing CPD is vital for improved outcomes and safety (Student Minds, 2023, Theme 9).*

There would seem to be something of a vicious cycle when sector data and research suggests that more and not less students will require support with their mental health conditions and yet the sector is losing and will continue to lose experienced and knowledgeable staff who no longer feel supported and valued in the workplace.

This is the first year we have explicitly asked members about referrals to NHS services and average waiting times. As our members frequently convey to us the amount of risk they hold whilst students wait for referrals to other services, we felt it was crucial that we explored this in some detail. Historically, we have found that member caseload is affected by local NHS capacity (UMHAN, 2021). Whilst, importantly, the quickest waiting times were referrals to crisis/acute mental health services, with the majority of respondents citing between 24 hours and one week, for the remainder, more worryingly, they cited anywhere from 1-6 weeks to 2 years or more. The longest waiting times were for diagnostic assessments for ADHD and ASC with most members selecting 2 years plus for both ADHD and ASC. Mentors, in particular, highlighted the escalating numbers of students who are neurodivergent presenting with mental health conditions or awaiting formal diagnoses. This is especially alarming when recent research from Unite Students, for example, found that in a survey of approximately 2000 university applicants, over half of neurodivergent students had experienced depression and almost two thirds had experienced anxiety in the last two years - percentages which were well above the average for all applicants (Shaw and Selman, 2023).

'What Works?': evaluation realities and challenges

Improving support for student mental health has been a focus of research and evaluation for a number of years but has received a recent impetus in the launch of the TASO Student Mental Health Evidence Hub. We first asked members about monitoring and evaluation in our 2022 survey and this year we included more detailed questions to better gauge current monitoring and evaluation practices as well as any issues or challenges pertaining to the collection, monitoring and evaluation of student data.

We found that the majority of respondents are collecting, monitoring and evaluating data in relation to their support for student mental health. Mentors tend to use qualitative tools whilst Advisers and Managers favour tools which generate both quantitative and qualitative data. All groups of members regularly use in-house service user surveys as their main quantitative tool. However, across all groups a range of in-house surveys/evaluations, standardised measures, feedback and other engagement measures are utilised according to the needs of the student and/or of the service and amongst respondents we identified the use of at least 19 different tools. This is in line with research from 2021 which found that almost all HE providers collect a wide range of data in relation to student mental health and wellbeing in order to monitor usage and gauge impact but there were still evidence gaps and a desire to *"learn more about impact, effectiveness and value-added of their services"* (Pollard et al., 2021, 9)*.*

Challenges to the effective collection, monitoring and evaluation of data were fairly consistent amongst members and resources - specifically lack of staff time, and systems - whereby there are multiple systems collecting different types of student data across and within an organisation, were key challenges for all members. Mentors also found that this aspect of the job was not in their role remit. Many members were keen for the impact of their work to be evaluated, where appropriate, but were not necessarily supported to do so within their teams or organisations nor were they included in wider institutional conversations about how best to evaluate mental health support activities and interventions for students. Many UMHAN members are involved in evaluating their own work with students but this is often separate from the wider university. Some Mentor roles, for example, are undertaken by staff who work for agencies as well as in-house which can make data collection and evaluation more complicated because agencies use their own measures and systems.

UMHAN members have insight into the kinds of issues students are presenting with, the students that they are supporting and what works. Mentors cited listening to students, building relationships and employing support strategies tailored to the individual whilst Advisers also felt that listening to students and the one-to-one nature of support was important. The use of reasonable adjustments and liaison with university staff and departments was another popular approach. Managers also felt that individualised support, delivered on a one-to-one basis, tailored to the needs of the student was the most effective intervention. Listening, displaying empathy, the use of goal-focused evidence-based therapeutic approaches and liaising on behalf of the student with other services both internal and external were all mentioned. The support UMHAN members provide to students is personalised and is not a quick fix but is delivered over weeks, months and even years. This makes evaluation challenging. The TASO Student Mental Health Evidence Hub did not have any explicit evidence in its database for the roles of Mentor or Adviser although it does have a good evidence base for counselling, for example, because that is often easier to evaluate whilst complex, longitudinal interventions, initiatives and support are much harder and resource intensive to evaluate effectively.

The UMHC (Theme 18) recommends not only that universities evaluate their services and interventions but that support service staff participate in and lead this research into student mental health (Student Minds, 2023). Our data suggests that there is little of either activity taking place in many institutions at present. Moreover, our data also found that the largest proportion of members who completed the survey did not know if their institution was participating in the UMHC whilst just six respondents were involved in some way in their institution's engagement with the Programme, Charter or Award. This suggests a disconnect between practitioners supporting students on the front line and members of staff responsible for the Charter in their institutions. In much the same way that Student Minds noted *"research into student mental health is often conducted without the involvement of support services staff in design or implementation" (2023, np),* so it would appear is much of UMHC activity.

Conclusion & Recommendations

This report has presented the latest member survey data from the University Mental Health Advisers Network (UMHAN) for the academic year 2022-23. It adds to previous UMHAN member survey reports exploring caseload, working conditions and views of membership. This year we have also explored members' data collection, monitoring and evaluation practices in greater detail and their opinions of key developments affecting university students' mental health including the HEMHIT and the University Mental Health Charter.

The caseloads of many of our SMHMs, MHAs and Managers have either stayed about the same this year or have actually increased. The data regarding caseload in terms of its increasing size and complexity reiterates the findings of both our previous member surveys. Mentors have observed an increase in the numbers of students awaiting diagnostic assessments for ADHD and/or ASC whilst Advisers have remarked on the complexity and higher levels of need amongst the students they support. Indeed, according to members, the longest NHS waiting times they observed were for referrals for diagnostic assessments for ADHD and ASC with the majority of respondents selecting two years plus wait times.

In terms of their working conditions, whilst low pay coupled with increasing caseloads and responsibilities means some members are considering leaving their current role in the near future, a more flexible working environment, post-pandemic, was the norm for most respondents and was generally viewed positively.

The majority of survey respondents are collecting, monitoring and evaluating data in relation to their support for student mental health with many members regularly using service user surveys as their main data collection tool. However, the use of at least 19 different tools including validated measurement scales for a range of mental health conditions including anxiety and phobias, for example, were recorded. Evaluation challenges were fairly consistent amongst members with lack of staff time and multiple data collection systems hampering efforts to successfully measure the impact of interventions and activities.

Amidst increasing focus on support for student mental health within HE and increasing numbers of students accessing support, our Member Survey has highlighted that members and the work they do to support students with their mental health is unacknowledged and unappreciated by university leaders and desperately under-resourced.

Based on our survey findings we would like to make the following recommendations:

- **Practitioner expertise:** Senior HE leaders and managers need to liaise with their mental health support staff directly when undertaking strategic level work on student mental health. Whilst we appreciate HE providers are large and complex organisations, MHAs and SMHMs and their Managers work very closely, on a daily basis, supporting students with mental health conditions. Mobilise them and involve them in institutional work on the UMHC.

- **Support for practitioner CPD:** As part of a university wide commitment to supporting student mental health, it is imperative that MHAs and SMHMs are encouraged and supported by their managers and senior leadership to undertake relevant CPD. Moreover, ensure they have protected time for CPD activity during the working week. As members note the increasing complexity of need they are presented with, it is important that they are able to access the most up-to-date knowledge and information from their communities of peers and experts.

- **Evaluation and research:** There is a sector-wide imperative to establish the evidence base for the most effective interventions and activities to support student mental health. Our members are often excluded from institutional and sector conversations about how best to evaluate what works in their context. We would encourage institutional researchers and evaluators and external evaluation consultants to engage with student mental health teams and incorporate their knowledge, supporting them to engage, participate and facilitate evaluation activity where appropriate and feasible.

- **Equality Act 2010:** The social determinants of mental health are complex, and we believe HE providers should focus on areas they can control, such as their legal duties under the *Equality Act 2010.* Work on student mental health and supporting Disabled students should be better joined up. There are clear duties to create inclusive environments for all Disabled students, including those with mental health conditions, with universal design principles benefitting all students. Reasonable adjustments are an important yet overlooked support mechanism for this cohort, leading to very positive benefits to mental health. Similarly, DSAs are an underused and undervalued component of support for students with mental health conditions and students should be encouraged to apply as appropriate.

- **NHS resourcing:** It is clear that NHS waiting times and thresholds are having a huge impact on students and mental health teams working in HE providers. While we applaud efforts to create better partnerships with NHS services locally, feedback from our members shows that statutory services are struggling to respond to students at all levels of need. Senior HE leaders need to put pressure on the Government to ensure NHS funding remains at the forefront of conversations around student and staff mental health.

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