UMHAN Member Survey 2024:

Insights into student mental health support in Higher Education

UMHAN

University Mental Health Advisers Network

Acknowledgements

Thank you to all the UMHAN members who completed the Member Survey in 2024. We appreciate your input and support.

About this report

This report was written by Dr. Rachel Spacey, Head of Research and Engagement at UMHAN in February 2025.

The member survey was devised by Sam Gamblin and Rachel Spacey.

For more information about this report please contact: rachel@umhan.com

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Executive Summary

This report presents the findings of the UMHAN (University Mental Health Advisers Network) Member Survey 2024, conducted online between August and November 2024. The survey gathered feedback from 92 UMHAN members (a 13% response rate) on their experiences during the 2023/24 academic year. Respondents included Mental Health Advisers (50%), Specialist Mental Health Mentors (40%), Managers (5%), and Associate Members (4%). All the members who completed this year's survey work in Higher Education.

Key findings include:

- **Student Mental Health:** Concerns were raised regarding waiting times for NHS services, particularly for students awaiting autism/ADHD (Attention-Deficit Hyperactivity Disorder) assessments and those needing ADHD medication. Members also highlighted difficulties in referring students to NHS services.
- **Workload and Staffing:** A significant proportion of staff (35%) feel their teams are understaffed, compared to 30% who feel well-staffed. This represents a shift from 2023, when more members felt their teams were well-staffed. Caseloads for Mental Health Advisers varied, with most working with up to 50 students, and many reporting an increase in complex presentations. Specialist Mental Health Mentors reported steady or increasing caseloads, with the majority supporting students with mental health conditions.
- **Working Conditions:** Flexible working was highly valued, with 61% of members preferring this arrangement. However, some members reported a lack of flexibility and poor working conditions.
- **Future Plans:** While 34% of members plan to stay in their roles, 23% are considering leaving within the next two years, citing pay, lack of progression, and work-related stress as key reasons.
- **Data Collection, Monitoring and Evaluation:** Most members engage in routine monitoring of their activities with students using a mix of quantitative and qualitative tools. However, challenges such as lack of time, difficulties in gathering student feedback, and multiple data collection systems were commonly reported. Evaluation of the effectiveness of support was generally conducted at team or service level, with similar challenges.

The findings of this report inform the UMHAN Board of Trustees and will guide UMHAN's efforts to advance mental health support in Higher Education.

Introduction

About UMHAN

UMHAN, the University Mental Health Advisers Network is a UK-based charity dedicated to supporting and advancing mental health support in Higher Education (HE). Established in 2001 as an information-sharing network and officially registered as a charity in 2003 (number: 1155038), UMHAN plays a crucial role in maintaining and raising professional standards for mental health professionals working in universities and colleges.

At UMHAN, we adhere to the social model of disability, recognising that people are limited by societal attitudes and structures than by their mental health conditions. We use the following definitions of mental health, adopted from the Office for Students (2019), the independent regulator of HE in England:

- **Mental health conditions:** These are clinically diagnosable conditions, varying in severity and requiring different treatment approaches.
- **Mental ill health:** This is a broader term encompassing mental distress that may or may not be related to a specific diagnosable condition.
- **Wellbeing:** This is an even broader concept, referring to individuals' thoughts and feelings about their overall quality of life.

As a charity we aim to articulate the practical and strategic benefits of the specialist roles we represent and disseminate this information and guidance for best practice across the sector whilst promoting the rights and interests of students with mental health conditions. Our campaigns and collaborative work help us to achieve these aims.

UMHAN's core members are Mental Health Advisers (MHAs) and Specialist Mental Health Mentors (SMHMs), all of whom possess postgraduate and/or professional qualifications and extensive experience in the field. We also expanded our membership to include Managers of these professionals, as well as other education staff with a mental health focus (Associate members). Our membership of approximately 700 individuals from over 150 organizations includes professionals with backgrounds in Occupational Therapy, Nursing, Social Work, Counselling, and Psychotherapy. Whilst most of our members work in HE, we also have members working in Further Education (FE) and in schools.

This report presents the findings of the UMHAN Member Survey 2024. For more information about UMHAN, including our priorities, and how to join, please visit our website: https://www.umhan.com/

Survey Design and Analysis

We conducted our 2024 Member Survey online via Google Forms between August and November. This year's survey, which focused on the academic year September 2023 to August 2024, was expanded to include more in-depth questions about data collection, monitoring, and evaluation. We also explored member perceptions of some recent developments and issues in HE mental health support.

UMHAN members were notified and encouraged to participate through email, Community Forum posts, and at member meetings. The survey covered key areas such as roles, caseloads, working conditions, and UMHAN's membership benefits. E-vouchers were offered as a prize draw incentive. All data was anonymized and securely stored. Quantitative data was analysed in Google Sheets and qualitative data was manually analysed. Comparisons were made with previous UMHAN member survey data where possible.

Findings

Survey Respondents

A total of 92 UMHAN members responded to the 2024 Member Survey, resulting in a 13% response rate (based on average August to November 2024 membership). This is slightly lower, albeit relatively consistent, with previous rates of 17% (2023), 16% (2022), and 15% (2021).

The survey results reflect a range of perspectives within UMHAN. Half of the respondents were MHAs (50%), with 40% being SMHMs. Managers made up 5% of responses, and Associate Members 4%. When considering these numbers as a proportion of UMHAN's overall membership, the survey captured responses from 14% of MHAs, 20% of SMHMs, 7% of Managers, and 5% of Associate Members.

Following the approach of prior surveys, we included separate sections on caseload and evaluation for MHAs, SMHMs, and Managers. This distinction recognises that the roles of MHAs and SMHMs can vary and are not always clearly defined. By providing specific data for these roles, we aim to enhance awareness of their scope and crucial importance in supporting students (UMHAN, 2022). Associate Members, who have direct contact with students in educational settings and an interest in mental health, were not asked these

questions as their roles do not always involve one-to-one support for students with mental health conditions.

Mental Health Advisers

About

Each university provides mental health and wellbeing services in ways that may slightly differ, but these services are usually staffed by mental health professionals, which may include MHAs, Disability Advisers, Mental Health Mentors, Wellbeing Advisers, and Counsellors. The core role of a MHA is to support students facing emotional or psychological distress or personal challenges arising from a mental health condition. While job titles and specific duties can vary between universities, MHAs generally coordinate support for students with mental health conditions and function as a consistent point of contact throughout their academic journey. MHAs typically possess qualifications in fields like Nursing, Occupational Health, or Social Work, along with substantial experience supporting individuals with long-term mental health conditions. Further information on the MHA role and its benefits can be found in our recently published research.

Caseload

Forty-six MHAs participated in the 2024 Member Survey. The role of an MHA, and those in similar positions, can vary by institution. Some MHAs manage strictly defined caseloads, allowing for in-depth work with students, while others are expected to support any student referred into the service. Some MHAs work independently as the sole support person for students with mental health conditions at their institution, while others are part of larger, multidisciplinary teams (UMHAN, 2021).

The largest proportions of MHAs worked with up to 25 students (41%) and between 26-50 students (33%) whilst fewer worked with between 50 and 100 students (15%). Comparison with data from previous Member Surveys suggests that the proportion of MHAs now working with between 26 and 50 students has increased (from 20% in 2022, to 26% in 2023, to 33% in 2024) whilst the number of MHAs working with up to 25 students is consistent with last year's findings (37% in 2022, 42% in 2023, to 41% in 2024).

Over the last 12 months, half of MHAs reported that their caseload had stayed about the same (50%) or had increased (22%). It had decreased for 15% of MHAs whilst 6 MHAs did not know (13%). Compared with last year's data, the proportion of MHAs finding it had stayed about the same was similar (47% in 2023, 50% in 2024) whilst the proportion of those finding it had increased was smaller (47% in 2023, 22% in 2024).

The percentage of MHA's caseloads made up of students with mental health conditions which are diagnosed, long term or expected to be long term is similar to last year's survey: 89% of MHAs responding to the survey had a caseload which consisted of at least half of students with mental health conditions compared to 95% for 2023.

In terms of the percentage of their caseload that was considered 'high risk' this varied greatly but taken together, for 67% of MHAs this was between 10% and 50% and for 33% of MHAS it was between 60% and 100% of their caseload. Again, the proportions were relatively similar to those reported in 2023 - 70% and 30%, respectively. For almost half of MHAs this proportion had stayed about the same (48%) but had increased for 44% - also similar proportions to 2023 (42% and 50% respectively).

MHAs were able to comment on their caseload. For most MHAs, the demand for services fluctuates depending on the time of the academic year and in some cases, it exceeds capacity:

Currently student risk and caseload numbers reduced as start of academic year following the summer break. Likely to increase again over the next few months.

Varies throughout year and many are year on year returners.

Some MHAs struggled to report their caseload to us due to the service model in operation at their institution:

It's hard to say exactly what my caseload is as we run a single session therapy model, so I see 12 students a week at least (not including duty) as I'm part time and that is a combination of assessments and MHA appointments. Some students I only see once, others I see more regularly.

Always a bit difficult to quantify caseload in this role, as I may see a student for one session and not see them until many months later - normally in a crisis or with some issue re RA [reasonable adjustments] *in exams etc.*

Complexity of issues amongst students was another common theme:

Over the last four years there has been a reduction in crisis presentations, however, an increase in complex presentations.

In our workplace, we implemented a four-week follow-up period for initial assessments, which significantly reduced our caseloads under the Mental Health Team, as our teams counselling team also do the initial assessments. Much could be accomplished within this four-week follow-up, such as applying for DSA [Disabled Students' Allowances]*, for instance. However, over the past 12 months, I've noticed a significant change in the level of risk within our caseload. The cases have become more diverse, manic, and chaotic.*

Indeed, it was observed that there had been changes in risk, possibly as a result of the current cost of living crisis with more students using coping mechanisms such as drinking:

This increase in risk may be due to various factors, such as the cost of living crisis and other changing circumstances. I've observed that the students we work with are struggling much more with dangerous coping mechanisms, such as alcoholism (many requiring Turning Point) [a national health and social care provider that specialises in mental health and substance misuse] *self-harm, and suicidal ideation.*

Whilst in one service, criteria for risk had decreased so staff had more actions and reporting to do as well as needing to inform trusted contacts:

Over the last couple of months, the criteria for risk have decreased so we have more actions and reporting to do. There is a need to inform trusted contacts as well which makes the job challenging.

Data collection, monitoring and evaluation

This year the number of questions exploring data collection, monitoring and evaluation were increased to better differentiate between the processes.

In relation to monitoring which we defined as '*an ongoing process that involves regular collection and analysis of relevant information as part of a mental health/wellbeing assessment and/or to measure progress that might be done daily, weekly, monthly or quarterly etc.*', over half of MHAs undertook routine monitoring (54%) whilst almost a fifth undertook it on a more ad-hoc basis (20%). The same proportion selected 'no, but I'd like to' (20%).

Tools used for monitoring were frequently a mixture of those eliciting both quantitative and qualitative data (51%) although 'mainly quantitative' was also well used (35%). Of the quantitative measures used in monitoring, outcome measures and validated scales were cited by over half of MHAs (59%) whilst service user surveys (50%) and session feedback forms (44%) were popular tools.

Of the outcome measures and/or validated scales used by MHAs to monitor progress/change, the most popular was CORE-10 used by 44% of MHAs. Other tools used included PHQ-9 (14%), GAD-7 (14%), CIAO (11%), WSAS (8%), CCAPS-34 (3%), OSA (3%) and CORE-OM (3%). CORE (including both CORE-10 and CORE-OM) was also the most commonly used outcome measure reported in the 2022 survey by 29% of MHAs and by 14% of MHAs in 2023.

MHAs were asked to consider why they used these particular outcome measures and/or validated scales. For most MHAs, the measures used were a management or service decision although compatibility with NHS measures, that the tool was evidence based for a specific profession, user friendliness (for students) and to adhere to the University Mental Health Charter, were all important considerations:

Quick and recognizable for NHS staff should referrals be required.

Management led. So that we have some qualitative data for the Mental Health Charter.

This was decided on some time ago as an outcome measure that best captured the input of the different roles within the mental health and wellbeing team.

To evidence progress to the student - we found it was user-friendly.

They give the data we need to triage and well evidenced as an outcome measure. Validated for use by my different professions (as we have a range of professionals in the team).

The greatest challenge MHAs faced in relation to monitoring were resource related - primarily lack of time (61%). The difficulties involved in getting students to provide feedback (50%) and multiple data collection systems in use (48%) were also significant challenges. The scope of monitoring, in that members are unclear as to what they should be measuring, by whom, when and what for, was an issue for about one third of MHAs (35%). Some MHAs felt that the challenge was a cultural one in that there was no culture of monitoring (35%), and lack of staff was another resource related challenge (26%). Other challenges were of an organisational nature whereby other staff and/or teams were responsible for data collection and monitoring (15%), there was a lack of skills and knowledge in relation to monitoring (13%) or different teams or individuals were responsible for this (13%).

MHAs were asked if they evaluate the effectiveness of their activities/ interventions with students. Evaluation was defined as '*an assessment of whether what you have been doing is making the difference you intended it to over a longer period of time. This might be done annually or as part of a service evaluation or evaluation project*'. The majority of MHAs did evaluate their work with students (58%) whilst a third did not (31%) and 11% did not know. Most evaluation was at team or service level (76%) with a small proportion undertaken institutionally (17%) rather than being undertaken by individual members of staff (4%).

The biggest challenges MHAs face in relation to evaluation include lack of time (44%), difficulties in getting students to provide feedback (40%), lack of staff (33%), multiple data collection systems (28%) and lack of an evaluation culture (26%) closely followed by lack of expertise (23%). For some staff, this was not in their job remit (16%) or was the responsibility of another team (16%).

These challenges resonate with data from 2023 where the most cited challenge by MHAs was resource related - lack of time (63%) or was system related whereby there are multiple systems collecting student data across the organisation (58%).

Other comments from MHAs regarding data collection, monitoring, and evaluation expressed concern about selecting the most appropriate evaluation tool from numerous available outcome measures, particularly in relation to its fit with the student experience.

Some MHAs expressed that they would like some clarity and guidance around the most effective approach(es) to monitoring and evaluation whilst others shared that their team or service did not have the resources to effectively monitor and evaluate impact or that whilst their service collected data on some aspects of their role, it did not cover all aspects of their work.

It was also suggested that other forms of data might be more useful in relation to measuring the impact of MHA support such as qualitative feedback from students or institutional retention and achievement data. Some MHAs highlighted that their institutions had multiple software systems and data streams which made this kind of work exceedingly difficult. Finally, it was noted that gathering feedback from students was often difficult to achieve.

Some MHAs noted that their services were in the process of developing better monitoring and evaluation systems, were looking into the use of ROMs or this was a work in progress:

It is difficult to find an evaluation tool that measures the specifics of the service we provide reliably - when [there are] so many variables in each student's well-being journey.

Our monitoring is used mainly for statistics for yearly outcome measures. They are not always accurate. CORE is a blunt instrument and when anxiety is high, English is a second or third language, or students believe they have to score highly to get a service (as in NHS) the results are skewed. Student retention and achievement and their longer explanations of what has helped or not need to be valued more.

Our service collects data but not from all aspects of support that would be really important in [understanding] if the support does have a direct impact on retaining students. We don't have data collection on the support to study process and the effectiveness of this. This is due to so many different systems across the organisation.

I believe there's a need for more emphasis on monitoring services and evaluating their effectiveness, and an approach which doesn't rely on students voluntarily completing feedback forms, as they often don't do this.

A clearer mission for what to be monitoring and what to do with that data would also be helpful.

In our team we use discussion based evaluation, but we don't have an effective way to record this or evaluate data in a helpful way to support our intuitive thoughts, feedback and discussions.

Most effective intervention

In terms of their most effective intervention(s) when supporting students with mental health conditions, MHAs tended to favour the one-to-one nature of the support they provide which is personalised whilst being responsive (where possible). It was also important that students were supported to think about their personal goals and what success might look like for them:

Providing a personal service, aiming to be responsive in a timely way and offering to meet all students, if requested.

As part of safety planning, I do focus on occupational goals and participation, linking into motivation to achieve tasks they want and notice success for themselves.

Being a specific contact, offering a space to be heard and to reflect, using existing strengths/strategies and building on them.

Behavioural activation style approach, motivating student to do more both academically but also personally. Many students are lonely and depressed, and I try to help them to do small things.

Overall, simply providing a listening ear can make the difference between a student feeling seen and heard versus feeling their issues were not taken seriously. Sometimes, there is little within our remit of intervention that we can do, particularly if they are a final-year international student. However, that doesn't mean the student does not benefit from having a safe space to reflect and make clear plans for what can be done.

Helping students develop their confidence to approach/communicate with others including health professionals external to the university or advocating on behalf of the student to professionals and/or teams was an important approach. Psychoeducation (learning about and understanding mental health and wellbeing) was also an important component of much of MHA's work with students:

Helping students manage anxiety by finding ways of soothing themselves physiologically.

Many students come with anxiety, particularly around academic work, self-confidence, and self-care, so teaching students to treat themselves with compassion and prioritise self-care often addresses the most common complaints.

Reflections - 2024 versus previous member surveys

MHA members are working with more students than they were in 2023 and whilst their caseloads are relatively stable for most (albeit increasing for some), members reiterated the complexity of issues amongst students and some changes in risk.

MHAs report using outcome measures in their practice more than they were in 2023, particularly CORE-10, on the advice of management, because of its ease of use and to contribute to evaluation practices as set out in the University Mental Health Charter. However, in using such measures to evidence not only improvements in the mental health of the individual students they support and the impact of their team/service, but MHAs also struggle to find the time to do so and are hindered by multiple data collection systems within and across services in HE; key issues reported in the 2023 survey. Moreover, some

members feel that there is a lack of clarity and/or guidance in relation to which tools to use and why. This year especially, members have reported difficulties in getting students to give feedback on the support they receive. From a professional perspective they agree that it is the 1-2-1, personalised nature of the work that they do which helps improve students' confidence, advocating on their behalf or supporting them to do so and setting and working towards goals is effective for many of the students that they support.

Specialist Mental Health Mentors

Thirty-seven (n=37) Specialist Mental Health Mentors (SMHMs) completed this year's member survey.

About

SMHMs empower students with mental health conditions to thrive at university. They hold specialised mental health qualifications and provide crucial support usually funded by Disabled Students' Allowances (DSAs). DSAs are non-means-tested allowances that assist with extra costs arising from disabilities, including long-term mental health conditions. SMHMs collaborate with students facing various mental health challenges, focusing on improving self-management skills and fostering acceptance of diagnoses. They also work to identify and address underlying issues like perfectionism, fear of failure, and anxiety that can impede

study. Research shows that Specialist Mental Health Mentoring significantly benefits students' functioning, academic performance, and overall university experience (Matthews, 2020).

Employment arrangements

This year we asked SMHMs about their employment arrangements – they could select more than one option. Whilst the majority were employed by a university (62% in total) this included members who were also employed by an agency(ies). Almost half, 47% of SMHMs were employed by an agency - again this included members who also worked for a university or were freelance.

Employment arrangement	*No.*	*%*
University	15	41
Agency	5	14
University and an agency	5	14
Freelance	5	14
University and more than one agency	3	8
Agency and freelance	2	5
More than one agency	1	3
More than one agency and freelance	1	3
Total	37	

Table 1: Employment arrangements of Mentors

Caseload

The largest proportion of SMHMs had between 21 and 30 students on their caseload (30%) and 11-20 students (30%). Approximately a quarter were supporting up to 10 students (24%) whilst 14% were working with between 31 and 40 students. One member's caseload consisted of 75+ students. Comparison with data from our 2023 and 2022 surveys reveals similar, if not growing proportions of SMHMs are working with more students: between 11-20 students (35%) and 21-30 students (20%) in 2023 and between 11-20 students in 2022 (27%).

Over the last year this number had stayed about the same for almost all SMHM members (70%), decreasing for some members (22%) and increasing for 8%. The majority of SMHMs reported that their caseload had stayed about the same in the last 12 months in 2023 (59%) and in 2022 (51%).

The proportion of students with mental health conditions amongst their workload taken together was up to half for 24% and between 60% and 100% for

76% of SMHMs. For almost half of SMHMs (49%) between 90% and 100% of their students had mental health conditions.

The percentage of their students who are considered 'high risk' varied with the majority of SMHMs supporting a caseload of up to 50% (81%) compared to 19% supporting between 60% and 100% of high risk students. In 2023, 76% of SMHMs caseload was made up of up to half of 'high risk' students which is in line with data from 2022 which saw 80% of SMHMs caseload made up of up to half 'high risk' students. However, caution should be exercised when making comparisons with small cohorts.

For most mentors, this proportion had stayed about the same over the last year (68%) whilst for 16% of SMHMs it had increased in contrast with 8% who felt it had decreased. This resonates with 2023 data where the proportion of 'high risk' students within SMHMs caseload had stayed roughly the same for 63% of SMHMs but had increased for 29% compared with 8% for whom it had decreased. Similarly in 2022 the proportion had stayed about the same for 51% of SMHMs and increased for 26%. However, this is in contrast to data from 2021 where the majority of SMHMs indicated that the proportion of 'high risk' students had actually increased (71%).

Comments about caseload highlighted a number of issues and concerns. Some SMHMs are able to control their caseload particularly if they work for themselves or via agencies. This can be particularly important for SMHMs looking to reduce their working hours for personal reasons including their own wellbeing:

I set the number of students I would like to take in agreement with the university.

I have had to keep my caseload low while I recover from my own mental health breakdown.

SMHMs commented that the complexity of need amongst the students they support had increased as had the numbers of students they support who are neurodivergent and experiencing mental health issues:

Seeing a big increase in students with ADHD on caseload in the last year or so.

An increase of students with more complex needs.

Overall, the difficulties students are experiencing are becoming much more complex.

Indeed, it was observed by two SMHMs that the number of students accessing online support had decreased whilst in their experience, agencies seemed to prefer face to face and that students with complex needs might actually prefer face to face mentoring sessions, which had all impacted upon their caseload:

Working only remotely (since Covid/lockdown) I am finding more students require support less frequently i.e. fortnightly rather than weekly. I also feel there has been a significant downturn in high risk cases (notable also in our peer support group), and wonder if this correlates with remote work, i.e. students with more serious issues are seeking in person support.

I find it more difficult to find students to work with online now. The agency is pushing for face to face.

A number of SMHMs also noted that the number of referrals they had received in relation to DSA funded support had decreased:

But worryingly have not had any referrals for over a year. If things carry on this way, I will have to look for a job and stop supporting students, which would be such a shame as I love my job, and I know it does make a difference to students.

I have no new students yet for 24/25 so not sure if DSA2s not coming through just yet.

Data collection, monitoring and evaluation

The majority of SMHMs are engaged in routinely monitoring the effectiveness of activities/interventions with students (62%) and on an ad-hoc basis (22%). This is not applicable for some SMHMs (11%). The majority of SMHMs prefer to use a mixture of tools which generate both quantitative and qualitative data (52%) although qualitative data generating tools are also popular (42%).

Most SMHMs (67%) use a combination of tools including a session feedback form, ILP, service user survey, institutional survey and outcomes measures. Use of an ILP was the most popular (67%) whilst service user surveys (43%), session feedback forms (37%) and institutional surveys (37%) were also well used. Two members used a range of outcome measures in their practice (which included PHQ-9, GAD-7, IAPT Phobia Scale and WSAS) but for the majority, this question was not applicable.

Comments from SMHMs in relation to monitoring revealed that some members use certain measures because they find them useful but are not required to do so whilst some use measures mandated by a manager, service or institution:

I am not required to utilise any of these scales with my students, but I will often have access to their needs assessment report which will describe and assess a students' needs.

I use them myself, not required by employers but can be helpful to understand/ monitor or serve as a useful starting point.

This is what my line manager suggested.

These are measures the university asks us to use.

The greatest challenge SMHMs faced in relation to monitoring were lack of time (52%), the difficulties involved in getting students to provide feedback (24%), that data monitoring is not applicable to the mentor role (24%) as well as other staff/teams being responsible for this (21%).

In relation to evaluation, this was undertaken by 85% of SMHM members, this compares with 73% of SMHMs who evaluated their interventions/activities with students in 2023. The majority of evaluation was undertaken by the SMHMs themselves (52%) and/or by the team or service (52%) whilst some was undertaken at an institutional level (17%).

The biggest challenges to evaluation were lack of time cited by half of members (50%) whilst for approximately one third it was not part of their role (37%). Difficulties in gathering student feedback were also relatively common (27%) whilst other resource related issues included lack of staff (20%), lack of evaluation skills (20%), multiple data systems (20%) or that it was the responsibility of other teams (20%). In 2023, the most cited challenge was that SMHMs do not have data collection, monitoring and/or evaluation in their job remit (45%). Other challenges were resource related (lack of time) (24%), organisational - in that other staff or teams were responsible for this activity (24%) or it was system related whereby there are multiple systems collecting student data across the organisation (20%).

Several SMHMs left comments about their experiences of data collection, monitoring and evaluation which revealed that some members undertake it as part of their own practice:

Data gathering/evaluation is carried out by myself during sessions at set points during the academic year. Often there is little time to conduct properly, or I feel answers may be biased and students feel put in the spot to provide positive answers.

I do this for my own professional practice and my own working ethic. My employer does not value monitoring, data collection or evaluation unless it is directly linked to DSA monetary outcomes or specific requests from senior management to "prove" the value of student support. Sadly, the employer only values numbers/quantity of support, and not the actual delivery or quality. Student surveys are used annually but feedback is not cascaded nor is individual feedback acknowledged.

When you work for a small agency, it is difficult to know if there is any evaluation being done, hence doing my own.

For some SMHMs, undertaking any kind of monitoring and/or evaluation is challenging since they are not compensated financially for the time taken to perform it nor are they mandated to do so:

These questions are quite hard to answer as a variable hours mentor, we are paid for what we do in the time with the student and a lot of the feedback/evaluation is not done by us other than discussing if what you are doing is working for the student.

Most effective intervention

SMHMs were asked to describe what they perceived their most effective intervention to be when supporting students with their mental health. It was clear that what works best for the student is being listened to as part of a regular, personalised, empathetic and one-to-one relationship in which the student and mentor come up with practical strategies to support the student. This might include elements of psychoeducation or activities to which the student is held accountable in order to help them progress:

Meeting with the student regularly and supporting them to make a real difference. This might be a practical solution, or discussing 'next steps' etc.

Not placing targets and objectives on them as this can often make the student more stressed (but it seems to be what organisations are more interested in). The support is holistic and suits the needs of the student.

Active listening and empathy to assist with creating realistic strategies for managing stress and workload.

Listening to needs, support to make tasks/things more manageable to manage overwhelm.

Regularity and accountability, which builds trust.

Reflections - 2024 versus previous member surveys

The caseload of SMHM members has remained relatively stable or increased although this year we have seen a small number of members report a substantial decrease in the number of students they are supporting due to delays in DSA assessment. The proportion of high risk students is relatively consistent with last year's data. Again, the complexity of issues students present with was remarked upon as is the number of students who are neurodivergent with mental health conditions.

In relation to monitoring and evaluation, the measures used by SMHMs are based on their utility and are often employed even though they are not mandated or required by either the agencies or institutions which employ mentors.

As was observed in 2023, the challenges faced by SMHMs include lack of time and difficulties in gathering feedback from students. Moreover, for many members, monitoring is not required.

Members largely agreed that mentoring is effective because it provides personalised support for students with mental health conditions which is empathetic, regular, 1-2-1 and provides an element of accountability for the student.

Managers

About

UMHAN's Manager members provide oversight and guidance to a variety of staff who support student mental health. This includes MHAs, SMHMs, Disability Advisers, and other wellbeing professionals. Manager members operate within Higher or Further Education settings and have a significant focus on mental health within their roles. Examples of titles held by Manager members include ‘Mental Health and Wellbeing Manager’ and ‘Student Support Manager’. In the 2024 survey, five UMHAN Managers participated, representing 4% of the Manager membership.

Caseload

Managers are asked to specify their workload rather than select from a range, and as such, amongst this group of members this was from 395 to 4000 students. For all five respondents, the numbers had stayed about the same this last academic year.

In 2023, the number of students on Managers’ service caseload (60%) requiring a one-off, short or brief intervention ranged from 5 to over 6000 and most Managers caseload had increased by some degree.

In relation to the numbers of students within their institution who had received crisis support during the last academic year - when a student feels that they are at breaking point and need urgent help, ranged from 66 to 500 students although one manager noted that this was not recorded in a way that was easy to measure. The numbers of students receiving crisis support had increased for 4 of the 5 managers - for two this was a significant increase and for two it was a minor increase.

In 2023, of the Managers who had access to this data, this ranged from 3 to 400 students and this proportion had stayed about the same or increased slightly for most Managers.

The percentage of students in the total service allocation that were 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, varied ranging from between 10% and 60%. This proportion had increased for two managers (slight) and was about the same for one manager as their comments reveal:

Numbers are similar but complexity and level of risk is increasing.

Advisors and myself have large caseloads of students which means that time cannot be dedicated to providing in-depth support.

In 2023 the percentage of students in the total service allocation considered 'high risk' for the academic year ranged from 10 to 70 per cent and over the last 12 months this proportion had stayed about the same or increased slightly for most Managers.

Data collection, monitoring and evaluation

Four of the five Managers routinely undertake monitoring (80%), The tools used are mainly quantitative (50%) such as service user surveys (80%) and institutional surveys (40%) with CORE-10 the only outcome measure routinely used by one service:

Part of the CORE package and widely used in the sector/field.

The greatest challenge to effective monitoring is lack of time (100%) followed by multiple data collection systems (60%), difficulties in gathering feedback from students (60%) and lack of staff (40%).

All five Managers responded that their services evaluate the effectiveness of their activities/interventions with students (100%) compared to 90% in 2023. This is conducted at team/service level (100%) and institutionally (60%). The biggest challenges are resource related - lack of time (100%), multiple systems collecting data (60%), difficulties in gathering feedback from students (60%) and lack of staff (40%) and lack of evaluation expertise (40%). In 2023, the most cited challenge was multiple systems collecting data (90%):

It's difficult to do when there is not an adequate student recording and monitoring systems for service.

The National Review of Higher Education Student Suicides

We asked Managers three questions in relation to The National Review of Higher Education Student Suicides, being conducted by NCISH (National Confidential Inquiry into Suicide and Safety in Mental Health) funded by the Department for Education. They are conducting an independent national review of suspected suicides (and non-fatal incidents of self-harm) in England that occurred during the 2023/24 academic year. However, the small number of managers responding means that the data is indicative only.

Managers were asked if their institution undertook its own reviews (formally or otherwise) into student suicides prior to the national review for which two responded 'yes' whilst one did not. No institutions had developed a formal process following the review and no Managers responding to the survey have been involved in any reviews. For one Manager, these questions were not applicable since they are not based in England:

We have a suicide safer policy and a postvention policy, but we are not in England.

Reflections - 2024 versus previous member surveys

Manager members' caseload was about the same when compared to data from 2023 although the number of students receiving crisis support had gone up to 500 which was an increase for most managers. The proportion of students who are high risk - between 10 and 60%, was about the same.

Monitoring and evaluation primarily involved quantitative data collected in relation to service and/or institutional impact, with CORE-10 the most cited routine outcome measure in use.

Lack of time, multiple data streams and difficulties in obtaining feedback from students were key issues for Managers. Whilst all Managers undertook some form of evaluation (more so than in 2023) this was at team/service level. Again, lack of time, data systems and difficulties getting feedback hampered evaluation efforts.

Working Conditions

Data regarding members' workplaces, work practices, and future career plans were collected from all 92 respondents and are presented in this section.

Team resource

When asked about team staffing, 35% of staff reported understaffed teams, while 30% felt their teams were well-staffed. Under-resourcing was an issue for 26% of respondents, and 14% indicated their teams were understaffed with vacancies. In contrast, 2023 saw 28% of respondents reporting well-staffed

teams, 15% reported understaffing with unfilled positions and 21% were understaffed.

Comments highlighted that some members worked in teams that were awaiting new staff or were managing as best they could since staff who had left the service were not being replaced:

We are, however, waiting on a manager, and that presents issues.

A number of staff left but were not replaced, the uni in general suffered massive academic sackings, which has led to a culture of cuts.

Capacity issues might arise because whilst a team might have a sufficient number of MHAs, for example, there is no wider team support, as this member explained:

The team is staffed well in terms of advisors - but it feels we are not resourced well with "institutional capacity" e.g. support for IT, comms, wider systems integration, service development. Lack of time is also a factor. Very casework focused, making it difficult to focus on wider issues that are likely more beneficial in the long-term.

Work location

Members were asked about their preferences in relation to work environment which revealed the following:

- 61% prefer a flexible working environment
- 56% work from home for a set number of hours
- 37% feel that they work more productively from home
- 29% can work on campus when students request face-to-face appointments
- 29% can choose when they work from home
- 22% feel that they work more productively on campus
- 16% work from home for health reasons
- 13% have not been offered greater flexibility.

The following comments illustrate the disparity in working conditions, with some members expressing dissatisfaction with inflexible and suboptimal environments, in contrast with members reporting satisfaction with flexible work arrangements:

The institution I work for is resistant to allowing flexible working. This has led to many colleagues choosing to leave the University for other Universities that offer greater flexibility.

I have no natural light and poor O2 supply in the ex-storage cupboard that was my room. I decamp to confidential study rooms in the library. I would rather work on campus all the time but appreciate this isn't always what the student wants. Also, when my earnings drop, I can't afford the journey there or rent and need to leave [city].

As I've been more than 19 years in practice supporting students in universities throughout UK and Europe - post covid I began working from home and have found I waste less time travelling, booking rooms, with meetings. I find I am much more productive and can be more flexible if a student needs to see me urgently as I no longer need to book rooms on campus.

I love working from home and find my students prefer to work remotely as it suits their schedules better and no need for room bookings.

Future plans

While 34% of UMHAN members intend to stay in their roles for the near future and 24% are undecided, 23% are contemplating leaving within the next two years. Retirement accounts for 3% of members' plans, and 6% have opted to reduce their hours.

We include this question to track recruitment and retention trends within UMHAN and in 2023 data showed that 49% of respondents planned to remain in their current positions, 7% don't know and 25% were considering leaving in the next two years.

Three SMHM members made comments in response to this question all of which noted that because of a decrease in the numbers of students they were seeing they were considering leaving:

Due to delays in DSA assessments this year, I have a very reduced case load and am considering leaving the role.

Might be forced to leave due to lack of referrals and students to support.

Dependent on opportunities.

Consideration of responses by the two largest groups of members - MHAs and SMHMs revealed that future plans were largely similar. However, a slightly

larger proportion of MHAs were not planning to leave in the near future compared to SMHMs (37% to 32%) but were considering leaving in the next year (11% to 3%).

Members who are thinking of leaving their role at some point in the future were asked to consider the reasons for leaving. Fifty-three members completed this question and were able to select more than one option. The key factor was pay for 44% of members whilst lack of progression was also a motivating factor for 40% of respondents. Work related stress was an issue for 30% of members whilst the same proportion felt that they would like a change in the future. Feeling undervalued was cited by 25% of members responding to this question. Pay (20%) and workload (17%) were the key factors in 2023.

Members were asked a follow up, open question to this - 'What would improve your wellbeing at work?' 63 members responded. The free text responses were thematically analysed, and the following themes were identified which tie in with the reasons cited for leaving:

Feeling valued

- Support for CPD
- Progression opportunities
- Wellbeing support for staff
- Feeling valued by the institution
- Better working conditions
- Better work facilities
- Better pay
- Improved resourcing (e.g. time, staff)
- Factoring additional costs
- Job security
- Greater flexibility and/or autonomy.

Some members felt that their contribution to supporting student mental health was not demonstrably valued by the institution and that this could be seen in ways such as there being little support and/or time to undertake CPD, lack of opportunities to progress in their career, lack of wellbeing support for staff, poor working conditions including the physical environment or lack of facilities such as car parking for members who worked on campus. Low pay was cited especially by SMHM members as were the additional costs they accrued, for example, by providing 1-2-1 support in person on campus as opposed to online (which incurs travel and parking costs). Job security was also an issue for some

SMHM members. Lack of resourcing was cited in relation to a lack of administrative support for their roles, numbers of staff or time available to do anything other than see students such as the related administration. Finally, some members were unable to work as flexibly as they would like and would have preferred more autonomy in relation to their timetable and location:

More pay. I have not had a pay rise at all for 5 years. I consider my rate of pay now to be poor.

One of my contracts for a university is a 'casual contract' although I have worked for the same university since 2015 and have always had a regular caseload of students to mentor for them. I would feel more valued if I was eligible to attend their staff development/CPD events and be included/be a target audience for example, in their newsletters as a 'casual' employee.

Less micromanaging of my time by management and having more autonomy over my diary.

A culture of checking in with staff. I work as part of a university disability service, but we have no sense of staff wellbeing and checking in on mentors. We are very much lone workers and any checking in is something that we as a group have organised informally to support each other in our roles. I believe a lot of this is to do with the contract types and pay. Mentors do not get paid for any work completed in between student sessions so often this type of work becomes neglected and support for our roles is unfunded and therefore non-existent.

Wellbeing days for staff, wellbeing sessions catered to staff that we can attend, resources to check in and utilise, flexible working and condensed hours being something you can request easily.

Opportunity in the day/week to look after my wellbeing and not necessarily use lunch break for activities such as a walk. A reduced caseload would also probably help as would factors that are not easily controlled such as traffic/parking.

Boundaries and working relationships

- Whole institution approach to mental health
- Connection and/or communication with other colleagues/teams
- Reduced caseload
- Clear boundaries
- No holding of risk
- Less risk management
- Better management

- Better supervision.

Additional themes identified in the comments could be suitably grouped under the umbrella of boundaries and working relationships. These comments tended to refer to the higher levels of risk amongst students that members are dealing with as well as feeling that relationships with other colleagues and teams could be better, this was particularly the case for mentors who often work for agencies or are freelance:

More social interaction with other mentors, etc.

Better communication between department management and mentors.

Better connection communication between colleagues. More space for MHA / Counselling - better crossover in our job share.

Lower caseload, no 'holding' of high risk students.

Less emphasis upon risk management.

Members were asked about attendance at UMHAN's meetings - if they don't normally attend why is this?

★ 'I am not able to manage my diary to block out the time' - 48%
★ 'I do not have time in my working day to undertake CPD' - 41%
★ 'I do not work when they are on' - 26%

For most of the members responding to this question, non-attendance was primarily related to their role - they are unable to manage their diary to allow them to attend (48%) or they do not have enough time for CPD (41%). For about a quarter of members responding, their reason for not attending was that they do not work on the day the meeting(s) is held (26%).

Members were asked to select from a number of statements describing their CPD:

★ 'I feel that UMHAN meetings, training and CPD (including resources) are useful to me' - 73%
★ 'I struggle to fit in meetings, training and CPD but manage to do some' - 63%
★ 'I attend CPD events outside of UMHAN' - 60%

★ 'I sometimes worry that I don't spend enough time reflecting on my practice' - 31%
★ 'I am able to manage my time so that I can fit in meetings, training and CPD' - 30%
★ 'I don't feel I am supported to access resources, meetings, training and CPD by my employer' - 7%
★ 'I don't feel I am able to attend meetings and training or undertake enough CPD' - 4%
★ 'I do not feel that UMHAN meetings, training and CPD (including resources) are useful to me' - 2%.

The majority of members feel that UMHAN meetings, training and CPD are useful to them (73%) but at the same time, 63% struggle to fit in CPD, although they do manage to do some. Small numbers of members feel unsupported by their managers to attend CPD (7%) whilst 4% do not feel that they undertake enough CPD.

Finally, members were able to make any additional comments about their working conditions. Upon analysis, the majority were negative in nature (n=9) and the remainder were positive (n=7). The negative aspects of working conditions referred to by members included poor treatment, being understaffed and their services being driven by targets. Other issues included poor organisational communication, lack of CPD opportunities and unsupportive management:

We are understaffed which puts a strain on other team members, then management wonders why people are sick and stressed.

Trying to force KPI's on us now - very worried about this when work becomes about targets rather than helping students.

Variable hours mentors are not treated fairly in terms of pay, we do a large amount of unpaid work such as admin and this is not reflected in the pay, it is expected we do this for free.

The contract is zero hours. Work and income are unpredictable. This is very stressful. This year so far there have been fewer allocations from both my agency and university work, which is making finances tight. The market is also not monitored for mentor pay. My agency work pays fairly (£33p/h) but my university work is severely underpaid. I get £15p/h for the same role at a university. This means that I often have to prioritise agency work to maximise earnings during term time. Many of my colleagues do the same, which means that students with university in-house NMH support in place are

missing out on support and become the second tier of priority for a lot of workers in the sector.

Members who were positive about their working conditions frequently referred to the importance of flexible working and the impact that this had on their wellbeing:

Having flexibility at work (the option to work remotely as needed/wanted) is very important to my wellbeing at work and job satisfaction.

Reflections - 2024 versus previous member surveys

Consideration of the questions pertaining to members' working conditions revealed an increase in the proportion of members with understaffed teams compared to 2023. This year, more members were in favour of flexible working conditions whilst the proportion who are working from home had increased.

Plans for the future highlighted that members felt less certain that they would stay in their roles in the short term (down from 49% to 34%) or were less likely to know (an increase from 7% to 24% in members stating 'don't know'). Reasons for leaving were similar to 2023 although the proportions of members citing pay had increased (from 20% to 44%), whilst lack of progression and workload were also key factors.

To improve wellbeing members wanted to feel valued which could be demonstrated in support for CPD, progression opportunities, wellbeing support, better working conditions, better pay, job security and flexible working. Boundaries and working relationships were also important factors - members felt that a whole institution approach to mental health was key to this was collaboration and communication between teams working with and supporting students, clear boundaries (with regard to responsibility), no holding of risk and regular supervision for mentors and advisers to support their own wellbeing and practice.

Referrals to other services

Due to ongoing concerns from our members regarding the increasing difficulty of referring students to NHS services, we incorporated questions about referral experiences and average wait times in both the 2023 and 2024 member surveys.

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	7%	37%	55%	-	-	-	-	-	-
Other primary care	-	1%	13%	27%	13%	17%	17%	13%	-
Diagnostic appointment: ADHD	-	-	4%	-	1%	4%	7%	61%	24%
Diagnostic appointment: ASC	-	-	3%	-	1%	4%	7%	60%	25%
Crisis/acute mental health services	43%	46%	7%	3%	-	-	-	-	-
Community Mental Health Team	-	13%	22%	31%	13%	9%	13%	-	-
Early Intervention Team	4%	20%	41%	20%	-	4%	6%	4%	2%
Dialectical Behaviour Therapy (DBT)	-	-	2%	13%	6%	8%	19%	44%	8%
Specialist Eating Disorder Services	-	2%	24%	13%	11%	9%	17%	20%	4%
Drug and Alcohol Addiction support	4%	20%	43%	9%	9%	9%	4%	2%	-
Gender Clinic	-	2%	2%	8%	4%	-	2%	60%	22%

Table 2: Referrals to NHS services wait times

For most members responding to the survey, appointments for GPs were within 1-6 weeks (55%) (57% in 2023) or within 1 week (37%) (33% in 2023) whilst appointments for other primary care services were more likely to be between 6 and 12 weeks (27%) (25% in 2023) or between 18 and 24 (both 17% respectively) or 24 and 52 weeks (17% and 15% in 2023).

The longest waiting times were for diagnostic assessments for ADHD (Attention-Deficit Hyperactivity Disorder) and ASC (Autism Spectrum Condition) with the largest proportions of respondents selecting 1 to 2 years for both ADHD (61%) and ASC (60%). Interestingly in 2023, the majority of respondents

indicated wait times for both ADHD and ASC diagnosis were longer than two years (57% and 66% respectively). Wait times for Dialectical Behaviour Therapy (DBT) and the gender clinic were also likely to be between 1 and 2 years (44% and 60% respectively).

The quickest wait times were referrals to crisis/acute mental health services with the majority of respondents citing within one week (46%) or 24 hours (43%) compared with 41% and 34% in 2023. The most common wait times for early intervention teams were within 1-6 weeks (41%) (37% in 2023) and between 6-12 weeks for the community mental health team (31%) (28% in 2023).

We received comments from 30 members regarding waiting times for NHS services and their concerns about specific student populations. These revealed shared anxieties about lengthy waiting times, the difficulty of navigating referrals to NHS services, slow response times from services, a shortage of community psychiatry services, and a sense that NHS services are generally inadequate:

I no longer feel that Crisis services and Early Intervention Teams are responsive enough.

Waiting time for NHS services, remain high in the area and this is worrying for all students who are requiring further support from external services.

They are so long that we end up holding complex case students indefinitely.

Students often can't pre-book, waiting times are long, even crisis services don't respond as quickly as you would expect.

A lot of services do not accept direct referrals from us and due to demand instead request that students are referred via their GP practices.

Horrendous. Working with students in obvious need of support with no support - we are all they have.

GP's and CMHT [Community Mental Health Team] *do not have the capacity to see high risk students quick enough e.g. Over a week to see a GP after 2 suicide attempts*

Emergency services are quite delayed in seeing students in crisis.

There are inadequate services for students with persistent Mental Health problems. Even if they see the CMHT [Community Mental Health Team] *they get discharged too*

quickly and they are not providing the type of support the student needs. Students are just told to go to A&E if they are in crisis, then they get discharged quickly again. Students describe needing a sanctuary safe place they can visit when in crisis which they do not need to have a referral for.

Lengthy waiting times were a particular worry for students awaiting assessments for ASC and ADHD, as well as those who require ADHD medications, according to survey respondents:

ADHD/ADD assessments can be over 4 years depending on where a student lives. Times vary immensely for services in different regions.

ASC/ADHD currently 4-5 year waiting list.

Waiting times for ADHD/Autism and more than 2 years, some 3 - 5 years.

Like many others, my main concern is ADHD students being unable to access suitable medication despite official diagnosis of the condition. Once meds are prescribed, they are not always available and this lack can radically affect a student's mental states, causing chaos in coursework and exam grades, not to mention the distress of the individual student.

Students needing assessment or support around ADHD, autism, or gender identity are rarely able to access those services in a timely manner and will have finished their time at university before they are offered an appointment.

Other groups mentioned include students needing DBT, students with eating disorders, students with personality differences, students awaiting gender clinic assessments and students experiencing trauma:

Students needing trauma support such as DBT rarely are able to access affordable or effective services.

Students who have experienced trauma and are on the waiting list (18months+) for specialist psychotherapy, are offered nothing whilst they wait, and this can be a very difficult time.

Wait times for gender-affirming services and neurodiversity testing are absolutely unacceptable. The lack of accessible services drives the industry of private providers who are unregulated and prey upon the vulnerability of young people who are unable to access services any other way. There is also a significant lack of accessible DBT services for people with trauma or who are labelled with "emotionally unstable

personality disorder", which can lead to these problems getting worse, and erode trust in service providers amongst those people who most need services.

Students with diagnosed or suspected EUPD or other personality difficulties seem to face many obstacles to appropriate treatment.

Eating disorder support is non-existent- we have to refer to GP, we cannot make direct referrals anymore, and there is no community support for lower level if not accepted by ED teams, and don't feel like I can do anything for them other than provide the BEAT information.

In conjunction with an academic at the University of Bristol, Dr. Myles-Jay Linton, we asked UMHAN members two questions related to informing a student's emergency contact when there are serious mental health concerns. Members were asked if they worked in a university with a formal written policy that allows designated staff to inform a student's emergency contact when there are serious mental health concerns:

- 46% responded 'yes'
- 28% were 'unsure'
- 17% responded 'no'
- 10% responded 'not applicable'.

The follow up question explored the factors that might influence whether it would be appropriate to inform the emergency contact of a student experiencing serious mental health concerns to which 46 members responded.

Of members who had responded 'yes' - their institution had a formal policy, the factors that might influence informing the emergency contact were primarily because the student had given their consent for the university to do so, and that the student was in crisis and therefore judged to be at risk:

Significant immediate risk to self or other.

If the student has mental health concerns, at serious risk, not being managed by NHS/student that cannot be contacted.

If attempts have been made to intervene with the student directly and these have been unsuccessful, and the student has previously given consent for an individual to be contacted in situations where there is concern about a student's ability to maintain their own wellbeing.

Severity of mental health and impact on students and others. Having gained consent from the student and where the student has been clear that they want trusted others such as parents to be involved.

Members explained how the impact of the risk on others, what was known about the relationship between the student and their emergency contact were also key considerations:

Known risks from emergency contact- recent estrangement, etc.

It depends on whether the cause of serious mental health concern it as a result of the emergency contact. If so, other appropriate steps would need to be taken such as A&E, GP, alternative trusted contact for the student.

Concerns regarding their safety and contact being unsuccessful with the student.

Less frequently mentioned factors included it being a manager/senior management decision, and/or liaison/discussion with safeguarding colleagues:

Consent, exploration with a safeguarding team.

Manager input - can have different view from professional working with student.

The capacity of the student was noted by some members:

Consent, Age, whether they have capacity.

Things such as capacity, level of risk, engagement etc.

Amongst members who had stated 'no' their university did not have a formal policy; they referred to risk as the key criteria:

Risk to the student or others.

We would use the principles of data protection, risk to life and consent.

I believe the University stance is that we will not contact emergency contacts but can be contacted by them and if students agree consent, we can discuss our actions with emergency contacts. We do ask students when we meet them if they would give us a contact of someone, they consent to us talking to if needed, but they often say "no".

If the risk is high concerning a student, we contact relevant agencies for support/intervention, if they need to contact emergency contacts, they will follow their procedures to do so.

Consent was the second factor whilst a lack of engagement with the university and prior involvement with statutory services were also seen as indicators of risk:

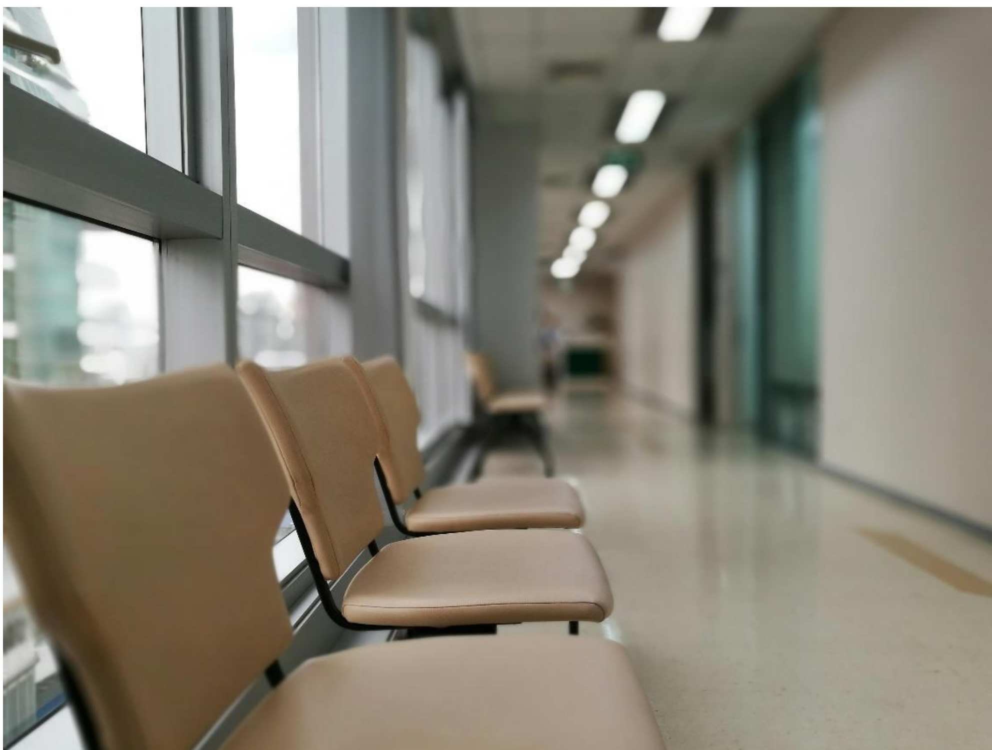
Clear risk of harm to self or others; visits to hospital during crisis (A&E) extreme distress and repeated use of services externally and internally with little improvement and/or disengagement from study.

It's not very clear due to policy limitations. If the student were to be living at home and had experienced serious mental health concerns or had been sectioned their emergency contact could be contacted.

Reflections - 2024 versus previous member surveys

Consideration of this year's member survey data with 2023 reveals that waiting times for GP appointments have stayed about the same, however, waiting times for ASC/ADHD diagnostic assessment are still long (between 1 and 2 years) although this is shorter than was reported in 2023 possibly because of Right to Choose in England which allows NHS patients to choose their own provider for assessments if the waiting time is too long and/or in-house diagnostic support.

Overall, waiting times are consistent with those reported in 2023 with lengthy waits, difficulties in referring students to NHS services, slow response times from the NHS and a shortage of some therapeutic services.



Discussion

The 2024 UMHAN Member Survey provides valuable insights into the experiences and perspectives of mental health professionals supporting students in HE. The lower response rate compared to previous years (13%) may affect the generalisability of the findings, but the data gathered still provides a rich picture of the current state of mental health support and practitioners' experiences in HE.

The survey highlighted the diverse roles of MHAs and SMHMs with varied caseloads and responsibilities. The increasing complexity of student needs, including a rise in neurodivergent students with mental health conditions and those experiencing mental health crises, was a recurring theme.

Caseload management remains a significant challenge, with many MHAs and SMHMs reporting fluctuating demand and caseloads that sometimes exceed capacity. This can lead to staff burnout and the finding that a substantial portion of caseloads consists of high-risk students further emphasises the need for adequate staffing and resources.

The survey also revealed inconsistencies in data collection, monitoring, and evaluation practices across institutions. While many MHAs and SMHMs engage in monitoring and evaluation, the methods and tools used vary. Standardising some of these practices where applicable and/or providing clear guidance and resources could aid practitioners in demonstrating the value and impact of mental health support services.

Concerns about waiting times for NHS services, particularly for specific cohorts such as those awaiting ADHD/ASC assessments or gender-affirming care, were prominent. These delays place additional pressure on university mental health services and, indeed, many staff reported feeling their services were under-resourced and understaffed. Pay and lack of career progression were also identified as significant concerns, potentially contributing to staff turnover. Providing support for CPD, especially protected time to undertake it as well as career advancement opportunities, and improved working conditions could enhance staff wellbeing and retention.

The findings on emergency contact procedures highlight the complexities and sensitivities involved in sharing information about students' mental health concerns. While many universities have formal policies in place, the application

of these policies depends on various factors, including student consent, level of risk, and the nature of the relationship between the student and the emergency contact. Further clarity and guidance in this area could be beneficial for staff.

Conclusion and Recommendations

The results of the survey paint a comprehensive picture of the challenges as well as the triumphs within university mental health support. While the dedication and commitment of our members are evident in their efforts to provide personalised and effective support to students, the survey also highlights systemic challenges that require attention. From managing increasing and complex caseloads to navigating complex NHS referral pathways, and advocating for adequate resources, our members are operating in a demanding environment.

The findings related to staff wellbeing, particularly concerns about pay, progression, and work-related stress, must be addressed to ensure the sustainability of this vital workforce.

In summary, mental health professionals face several challenges in supporting students in HE:

- **NHS waiting times:** Long waiting times for NHS services, particularly for specific cohorts (e.g., those awaiting ADHD/ASC assessments or gender-affirming care), put additional pressure on university services.
- **Increasing complexity of student needs**: Students are presenting with more complex mental health issues, including a rise in neurodivergent students and those experiencing crises.
- **Caseload management**: Many professionals report fluctuating and often overwhelming caseloads, with a significant portion comprising high-risk students.
- **Resource constraints**: Staff often feel under-resourced and understaffed, leading to work-related stress and burnout. Concerns about pay and lack of career progression contribute to staff turnover.
- **Data collection and evaluation**: Inconsistencies and challenges in data collection, monitoring, and evaluation practices exist across institutions. Standardising some elements of these practices and providing clear guidance is needed.
- **Emergency contact procedures:** Complexities and sensitivities surround informing emergency contacts about students' mental health concerns. Clarity and guidance in this area are recommended.

UMHAN is committed to using the insights gained from this survey to inform our strategic direction, collaborating with our members, the Board of Trustees, and

sector partners to create a more supportive and effective system of mental health support for students in higher education.

Recommendations for UMHAN:

1. **Advocacy for adequate staffing and resources:** UMHAN should continue to advocate for increased funding and resources for university mental health services to address understaffing and resource constraints. This could involve lobbying government agencies, HEPs, and other relevant bodies. In particular, UMHAN should continue to advocate for increased capacity within NHS services.
2. **Best practice and guidance:** Develop and disseminate best practice and guidance documents for data collection, monitoring, and evaluation of mental health services. While some progress has made in relation to this in recent years through external partnerships and CPD opportunities for members, this might include an appraisal of specific outcome measures, evaluation tools, and strategies for gathering student feedback.
3. **CPD and training:** Continue to provide professional development and training opportunities for members on topics such as data analysis, evaluation methods, leadership skills, and strategies for managing complex caseloads and working with high-risk students.
4. **Addressing pay and progression:** Although UMHAN is not a trade union, we will continue to advocate for fair and competitive pay for mental health professionals in HE, as well as clear pathways for career progression. This could involve conducting salary surveys, developing job descriptions, and promoting the value of these roles within institutions.
5. **Research and data collection:** Conduct further research on specific issues raised in the survey, such as the effectiveness of various interventions, and the reasons behind staff turnover. We will continue our conversations with a range of external stakeholders in relation to the collection and sharing of relevant data on student mental health and service provision.

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Contact Us

Email	admin@umhan.com
Website	www.umhan.com
LinkedIn	linkedin.com/in/umhan/

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