Member Survey Report 2022

Introduction

At UMHAN we regularly survey our members on issues such as caseload, working conditions and feedback on their membership. Results are presented to the Board of Trustees to inform development work.

This year, in addition to standard questions, we included 2 additional sections: one on role tasks, and another on evaluation. The roles of Mental Health Adviser (MHA) and Specialist Mental Health Mentor (SMHM) are not well defined or understood, and we hope data about tasks performed will help improve awareness of the scope and importance of both roles. Collating more information about how members and services evaluate their work will, we hope, help to provide insight into a frequently discussed topic in the sector, and to establish a more consistent approach.

This survey period has covered a time of flux and recovery; members have been reporting unusual patterns of student referrals/registrations, appointment access and student mental health presentation throughout the year. As such, the survey data may also demonstrate unusual patterns that may not continue in the coming academic years.

Summary

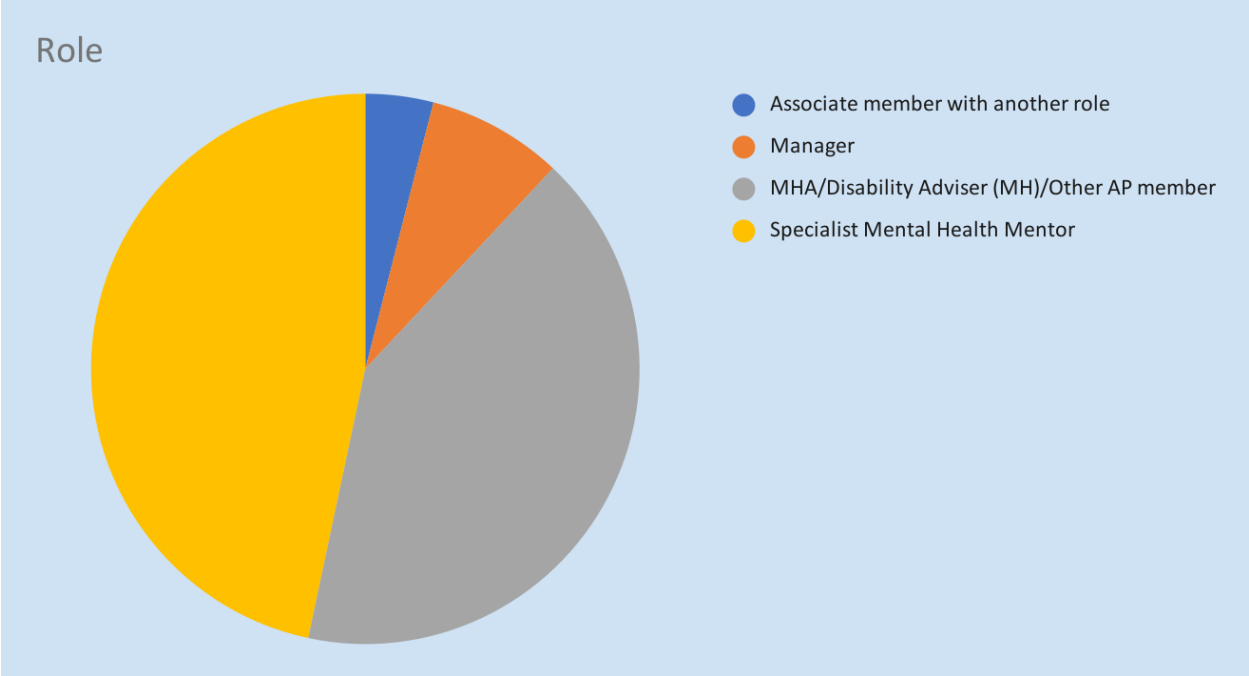
Key points from our survey findings are:

- 81% of MHAs had 50% or more proportion of their caseloads in the high risk category
    - 26% of respondents said that this number had increased over the past 12 months
- Risk assessments and mental health/wellbeing assessments are the most commonly performed tasks by MHAs.
    - Psychoeducation/ psychological interventions were felt to be the most effective task
- 58% or respondents felt their service was under-staffed
- Just over a third of respondents plan to leave their role between now and 5 years time

The respondents

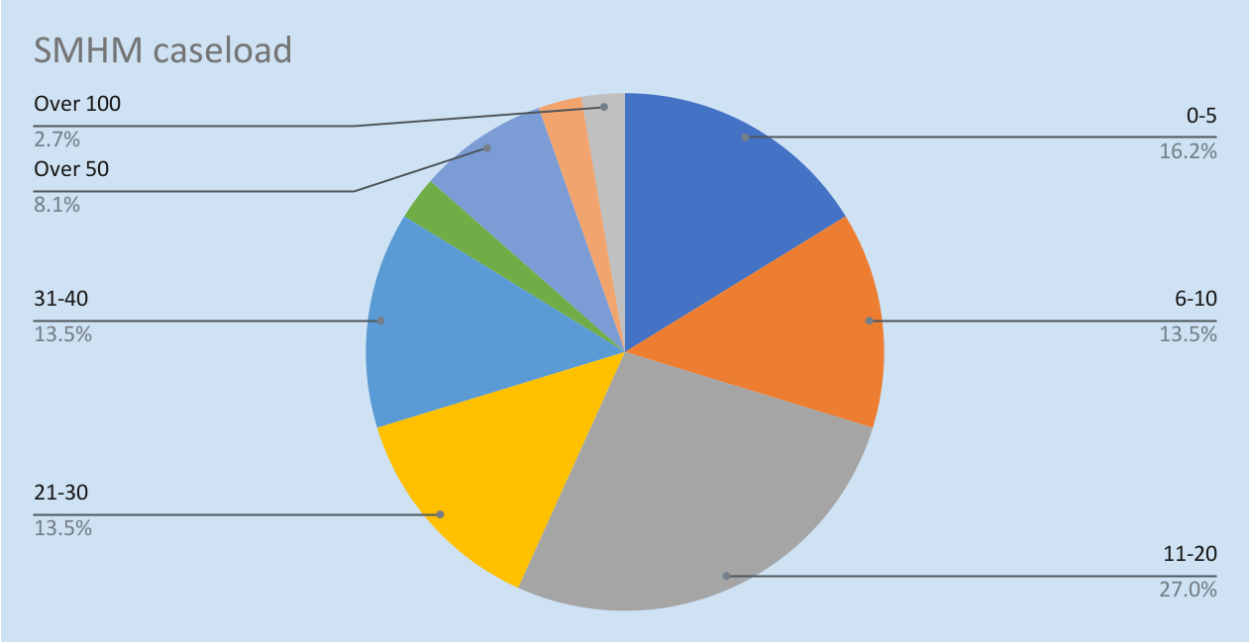
This survey was sent to all members in June 2022 with several reminders sent over the summer period.

We had 75 respondents, which was 16% of our membership at the end of September. The respondents' roles are roughly proportionate to the total number of members of that role type. Sections about caseload were divided by 2 types of membership: "Mental Health Adviser" and "Specialist Mental Health Mentor".



Caseload - Specialist Mental Health Mentors (SMHM)

37 respondents to the survey were Specialist Mental Health Mentors. The majority of mentors work with DSA-funded students only, however, some are directly employed by universities to work with other students, meaning that they may perform tasks outside of “normal” mentoring work e.g. training for staff and group work.

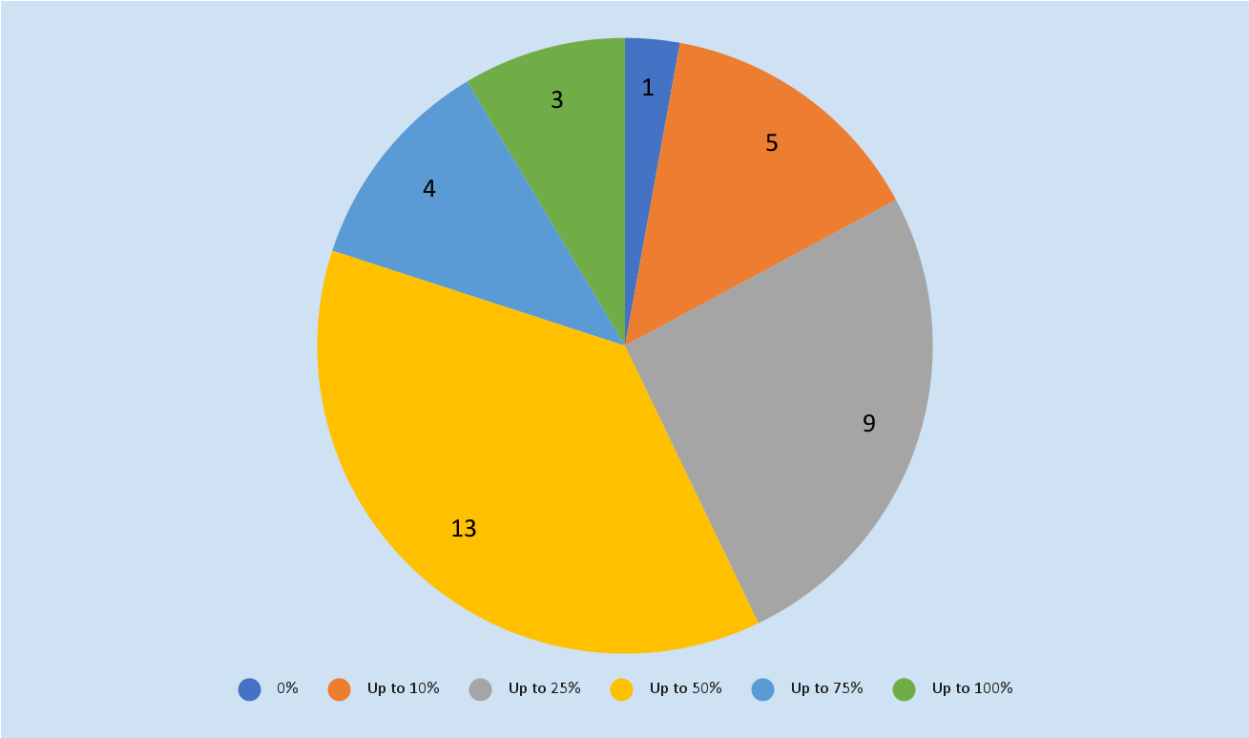


Q: How many students are on your caseload?
37 responses

29% of respondents said that their caseload had increased over the past 12 months, while for 51% their caseload stayed roughly the same. This is not surprising as due to the nature of the work: students are largely given 1 hour time slots, on a regular basis, meaning there is not much room for movement in the caseload of someone’s working day.

Supporting “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.



Q: What percentage of these students are considered "high risk"? (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)
35 responses

Specialist Mental Health Mentors may perform risk assessment/crisis planning, care planning, signposting and collaborative working with GP, MHAs and other external agencies.

26% of respondents said that this number had increased over the past 12 months, and 51% said it had stayed the same, in comparison to a 71% increase in 2020-21.

> *"Whilst the majority of diagnosis are anxiety and depression the other diagnosis can include, OCD, Bi-polar disorder, borderline personality disorder, psychosis, PTSD, social anxiety disorder, ADHD, dyspraxia, dyslexia, ASD, chronic fatigue/fibromyalgia, emotionally unstable personality disorder, eating disorders, CPTSD and generalised anxiety disorder."*

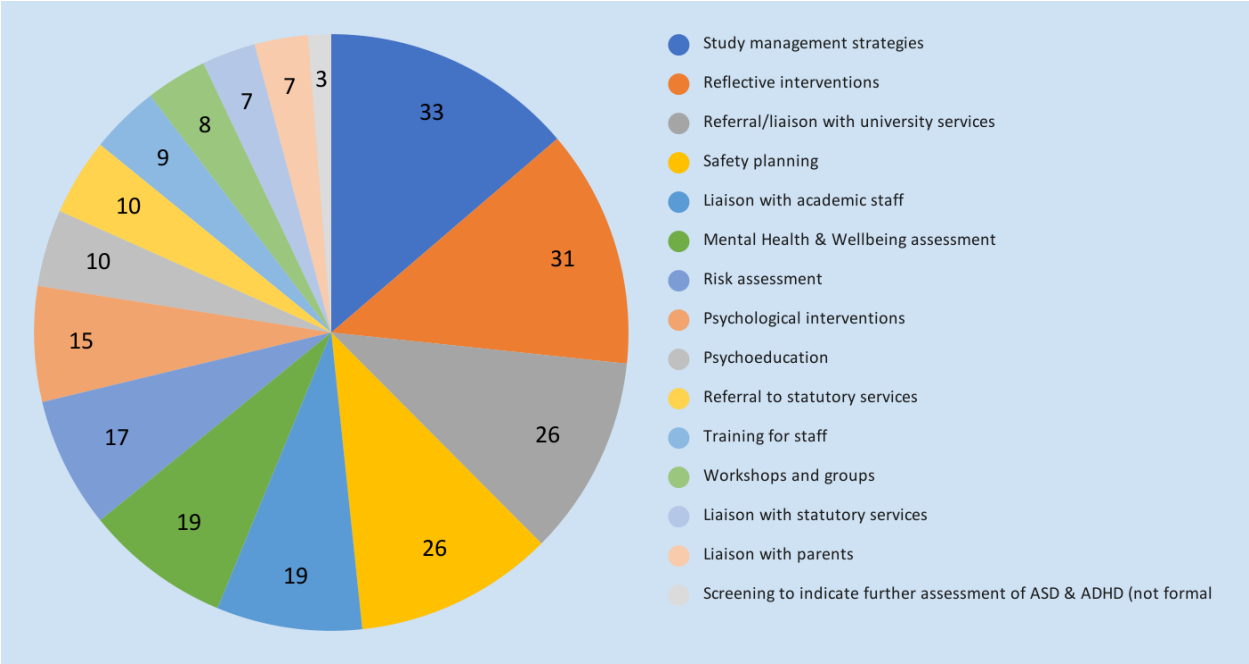
> *"The students' conditions are often multiple, whereas they would have one condition only about 15 years ago"*

UMHAN
University Mental Health Advisers Network

Role tasks - SMHM

We gave respondents a list of interventions/activities common in both the role of SMHM and MHA and asked them to indicate which they performed.

There is a lack of detailed common role description for SMHMs. In some universities, there is a significant crossover between both roles, with some MHAs also working as SMHMs.



Q: Please tick which of the following interventions/activities you perform…
35 responses

The Department of Education describes the SMHM role as follows:
"Specialist mentors provide highly specialist, specifically tailored, one to one support which helps students address the barriers to learning created by a particular impairment...This could include a range of issues, for example, coping with anxiety and stress situations, how to deal with concentration difficulties, time management, prioritising workload and creating a suitable work-life balance." (Non-Medical Help Services Reference Manual v6).

They provide support that is: highly specialist, tailored to an individual's needs and diagnoses and enables students to address the barriers to learning created by a particular impairment. It is primarily provided for students with mental-health conditions or those with an autism spectrum diagnosis.The role often involves working with complex and challenging students across the spectrum of mental health conditions, and thus there is a requirement to understand how the

mental health condition impacts the student across their academic life. This can include the impact of medication and externally provided interventions.

The majority of SMHM who responded to our survey say they commonly perform study management strategies and reflective interventions as part of their role, knowing how the student's individual mental health condition impacts their studies.

We also asked respondents what they felt their most effective intervention/strategy was with students as a free text response. Interestingly, the most frequently stated "intervention" was not specifically task-orientated but was around the concept of building trust and forming relationships with the mentee (14 responses). This is a fundamental aspect to the work as it allows for the concerns and challenges facing the student to be discussed openly and for the work to effectively meet its goals.

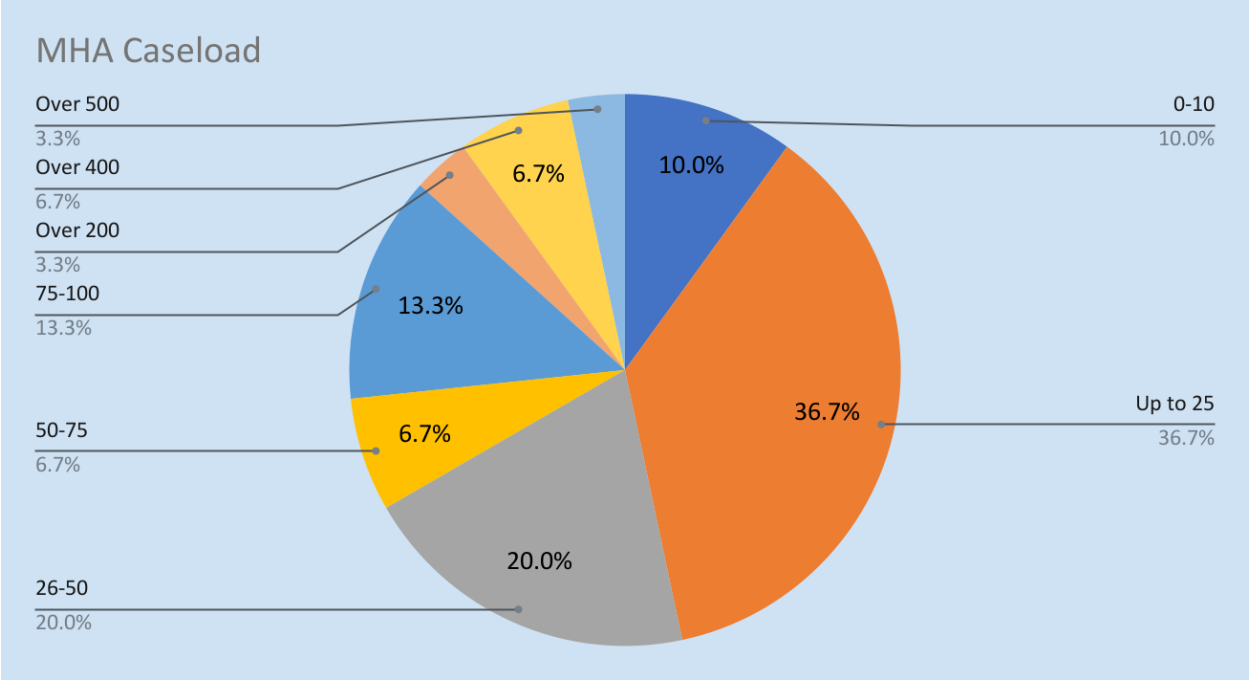
Next were study/time management interventions, followed by psychoeducation/psychological interventions. Respondents also felt that reliability and continuity were an important aspect of their effective work with students.

> "*Demonstrating effective understanding of the student's experience and building trust; Once trust is established the most commonly requested support is assistance with managing time effectively."*
>
> *"Safety Planning and Study Management"*
>
> *"Strategies based on DBT - distress tolerance, staggered intervention, grounding etc in order to better manage academic stressors such as anxiety, panic attacks, attendance, triggers, burnout."*

Evaluation - SMHM

15 SMHM respondents evaluate their interventions/activities with students, 9 by qualitative measures, 1 by quantitative and the rest by a mix of both. There was no consistent measurement tool cited.

Caseload - Mental Health Advisers (MHA)



Q: How many students are on your caseload?
30 responses

Mental Health Advisers, 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 some are expected to have contact with any student referred into the service (which can then mean contact and support is limited). Some are the sole person responsible for students with Mental Health Conditions at the University, whereas others are part of large multidisciplinary teams. An additional factor in caseload management is the capacity of local NHS services.

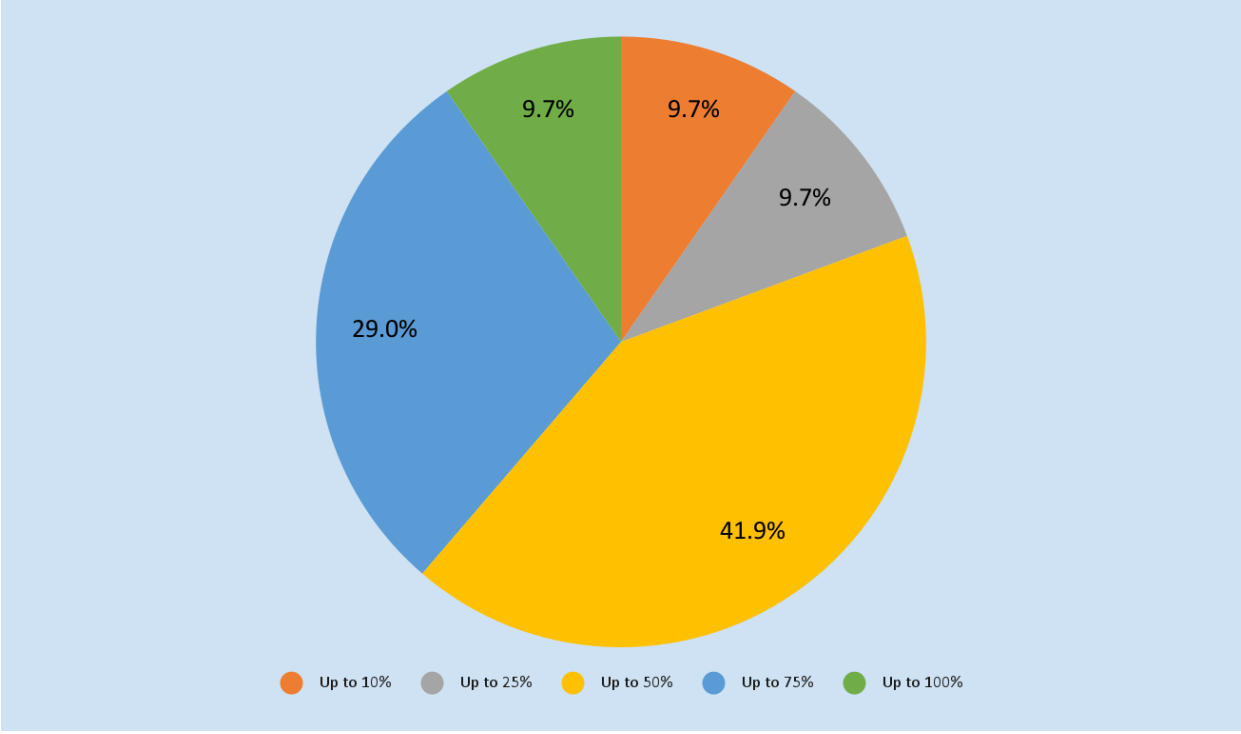
> *"due to the lack of access to MH services, has meant that there has been an increase in our service 'mopping up' for the NHS - i.e.: for those students who are discharged from A&E - (often in crisis / after attempts to end their lives) referrals are not made to the crisis team / home treatment team, the students are most often given 'a leaflet' and told to access the 'uni counselling service…there appears a theme in a lack of access to Primary care IAPT talking therapy (several of our students have been told they are 'too complex' for their service) and if they are accepted there are very long waiting times (8-9 months+ for step 3)"*

"Caseload has gone up and the crisis cases we deal with are far more complex than ever before so are taking a huge amount of adviser time. We are battling with the NHS referring cases back to us where they actually need secondary care services"

39% of respondents said that their caseload had increased over the past 12 months and 69% said that the number had stayed the same in comparison to a 63% increase in 2020-21. This may reflect the fact that services are developing more sophisticated caseload triaging/allocation models meaning that individual advisers now have more restricted caseload numbers.

Supporting "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.



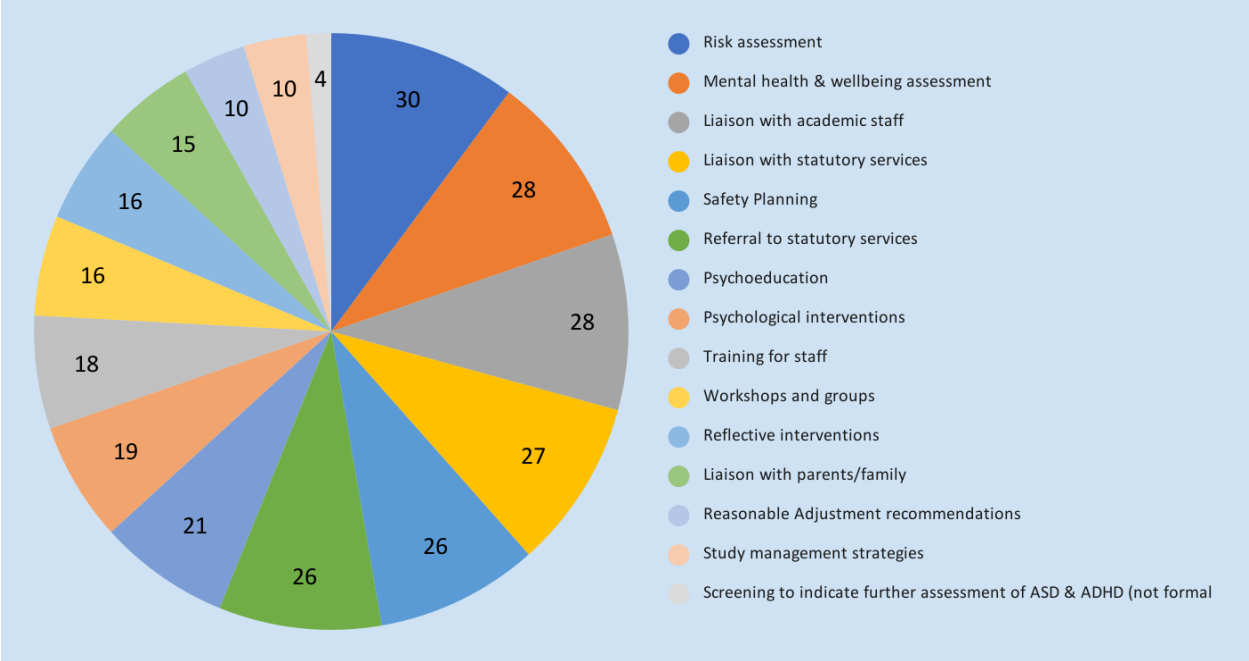
Q: What percentage of these students are considered "high risk"? (e.g., in terms of deteriorating mental health, severity of mental health condition, suicide, serious self-harm, neglect, abuse, becoming socially isolated, or experiencing significant disruption to their education)
31 responses

The majority of Mental Health Advisers have crisis response and risk/safety planning in their job descriptions. In comparison to figures from 2020-21 we can see that a much higher proportion of MHA caseloads are now taken up by high risk cases; last year 48.2% had 50% or more proportion of their caseloads in the high risk category, with 80.6% this year. This correlates with anecdotal evidence from member meetings. 26% of respondents said that this number had increased over the past 12 months.

> *"The severity of mental ill health and associated risk in the student population has substantially increased over the last few years that I have worked in this dept"*

It should be noted that both MHAs and SMHMs are used to managing continual and increasing risk. Members have told us that it can be difficult to communicate this risk to the NHS. Community teams are simply not responding. Additionally, there is a long wait for specialist provision such as Dialectical Behaviour Therapy for students who might be deemed to be most "risky". It is therefore understandable that services have to hold this risk rather than a student having to interrupt their studies while waiting for treatment. Members have also expressed concerns that non-clinical staff can be risk averse, meaning they are much more likely to think they should share sensitive information.

Role tasks



Q: Please tick which of the following interventions/activities you perform…
30 responses

We gave respondents a list of interventions/activities common in both the role of SMHM and MHA and asked them to indicate which they performed.

The difference in roles between SMHM and MHA can be clearly seen, with MHAs routinely undertaking assessments of risk and mental health/wellbeing, and undertaking internal and external liaison as required.

It should be noted that where tasks appear at the lower end, this is because staff in the wider student services team will often have defined responsibilities in this area e.g. liaison with parents or making reasonable adjustment recommendations.

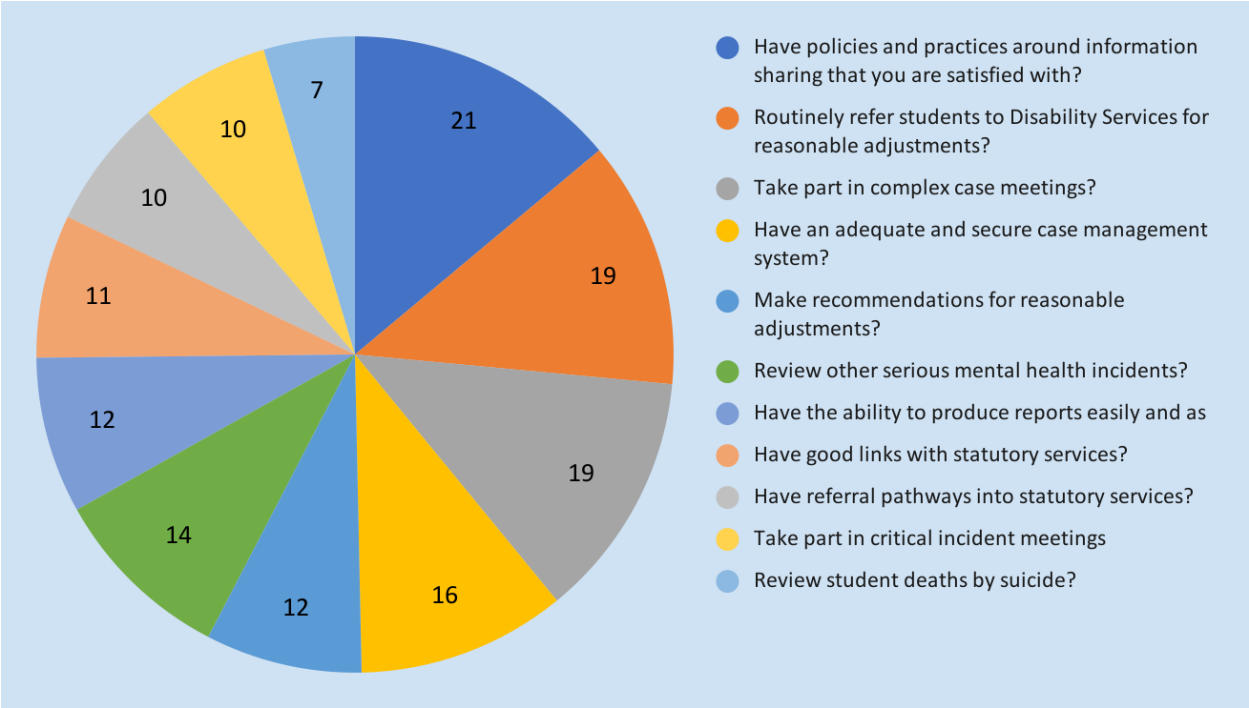
Again, we also asked respondents what they felt their most effective intervention/strategy was with students as a free text response. The most frequent response was psychoeducation/ psychological interventions (11 responses), followed by risk assessment/safety planning and advocacy/liaison with statutory services. Reasonable adjustments, reflective interventions and the relationship between staff/student were also mentioned several times.

Multiple responses explained how effectiveness of interventions varied from student to student:

> *"Unsurprisingly, I believe that it really depends on the particular student and what their needs are. I have students that my work is almost solely helping them navigate statutory services, while other students benefit from the accountability of regular meetings and psychoeducation.*"

We also asked the following question to help understand how services are responding to important themes in student mental health.

Fairly low responses to all of these areas indicates ongoing issues of resourcing for mental health services; many operate in "fire-fighting" mode, rather than having the time to develop services and have more strategic influence. One of the main risks to this approach is that new policies and strategy are developed by those without clinical training and experience; not only can this create operational challenges, but it hinders the development of service staff, leading to disempowerment and retention issues (see Working Conditions section below).



Q: Do you/your team…
30 responses

Evaluation - MHA

21 MHA respondents evaluate their interventions/activities with students, 5 by qualitative measures, and the rest by a mix of both qualitative and quantitative. CORE was the most common measurement tool, cited by 6 respondents.

> *"we have struggled with measures because do not feel that a lot of them are reflective of the points at which students come to use our service (e.g. often at low points, so each set of data we obtain reflects this, rather than measuring any change that may be linked to the intervention or support received). But this is also something we are trying to incorporate more into our general feedback to help with this."*

All respondents

Future data collection

We asked all respondents “Is there particular data you feel would be useful to record which you do not already capture?”. The main themes were types of cases, effectiveness of interventions and the retention impact of MHA/SMHM on students with mental health conditions.

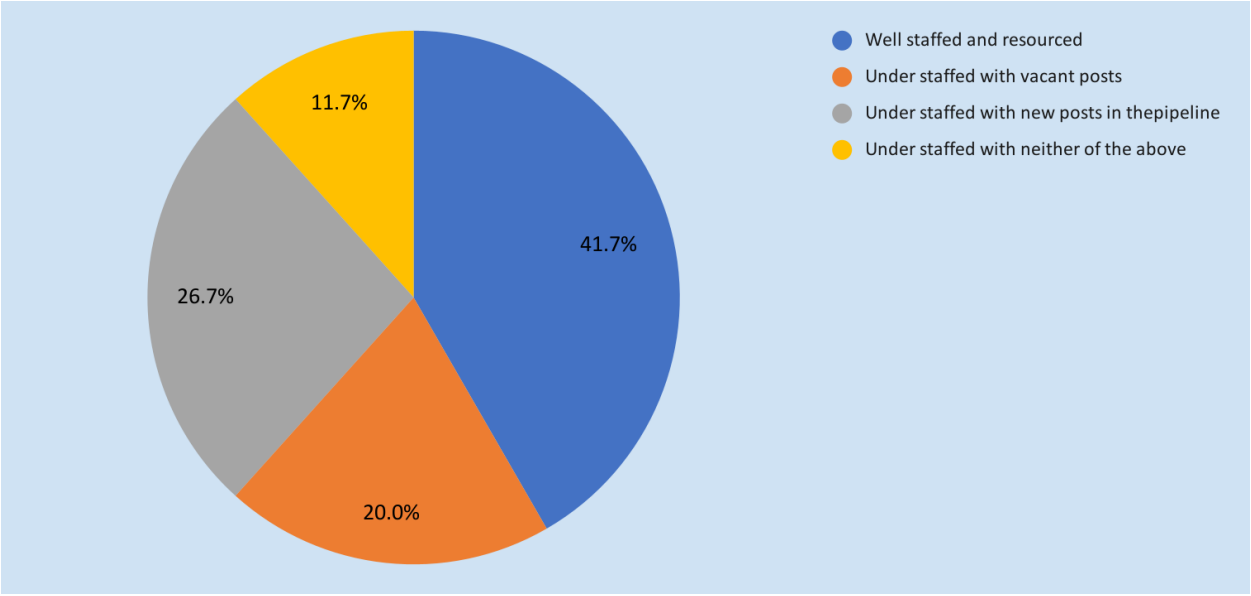
With much coverage in the press about student suicides, we feel it is important to demonstrate the vital work members undertake on a daily basis to help keep students safe and well. By more accurately portraying the work done by mental health practitioners, there is the potential for multiple benefits - encouraging more disclosure by a wide variety of students as well as positively impacting staff wellbeing and improving staff retention.

As previously highlighted by UMHAN, this is currently hampered by poor case management and data collection systems within the sector.

Working Conditions

We asked all members about their working conditions during the next academic year.

Staffing



Q: If applicable, do you feel your team is…(60 responses)

In response to members' feedback during the year about issues with recruitment we first asked about staffing.

As shown by the graph, less than half of respondents felt that their service was well-staffed and resourced. The majority feel they are understaffed - which puts enormous pressure on existing team members. Many teams are finding that they are having to advertise posts multiple times, due to a lack of suitable applicants.

A later question about member well being elicited several comments about resourcing:

> *"... we have to manage huge risk associated with mental health but are also responsible for wellbeing issues such as housing, sexual assault. Due to low staffing numbers we are not able to cover all of these issues."*

> *"We are hoping to increase the well-being support team at the Uni and my managers have requested in the business plan for a new MH Practitioner role to be approved. This would be amazing and a help to all staff and students if approved. We are a small university so not having some of the resources that larger uni's have with regards to MH Practitioner Teams can lead to increased stress and demand on the mentors/counsellors and wellbeing Teams at times."*

The adequate resourcing of university mental health services has been recommended by multiple reports during the last decade, from Breaking the Silence, by the National Union of Students Scotland in 2011 to the 2021 Royal College of Psychiatrists' Mental Health of Higher Education Students Report which says

> *"Demand for counselling and other services is substantial and seems to be growing inexorably. There are clear links between mental wellbeing and academic performance. There is growing pressure on NHS mental health services as a result of a range of factors, including increased recognition of conditions such as ADHD and autism spectrum disorders, and growing numbers of international students.*
>
> *It is important to ensure that services based in both HEIs and the NHS are given sufficient resources to meet these demands."*

Worryingly, just over a third of respondents plan to leave their role between now and 5 years time. The most common reason for this was pay-related (this is largely an issue for SMHM members, many of whom have seen their pay decrease year on year in real terms). The other

most common cited reasons were around work-related stress - unmanageable workloads, responsibilities of the role, and feeling unsupported.

Until resourcing is appropriately addressed it seems likely that retention and recruitment will continue to be issues in the sector, as will staff wellbeing.

Wellbeing

We asked members “What would improve your wellbeing at work?”. Not surprisingly, an increase in pay was mentioned by many SMHM respondents.

> *“That my pay was returned to where it was when I began, much more is expected of me and I receive about half of what I had when I joined the team…It is an interpersonal relationship with student, I put no commercial value on that; however various bodies finance and evaluate my worth and status, my wellbeing is not made better by being undervalued financially.”*

> *“I am paid £5 per hour more than the cleaners but expected to support Suicidal students. We are employed by the university, but out of DSA funds, so we are only paid for the mentoring hours we do. We could add so much more to the team, but are prevented from any other work and not permitted to attend any meetings, training or department activities. We are very badly treated and have not received any CPD.”*

> *“Better pay, my roles banding was 're-banded' and reduced prior to me applying for the position, I did not realise all other universities locally my role is still the higher band - so I could get significantly more money literally down the road”*

> *“Access to university facilities and feeling more part of the University. I am a resilient person but truthfully our conditions as mentors have deteriorated hugely in the 8 years I have been working for the Universities. One of the Universities is supportive the other 2 not. Rooms and appropriate spaces to work are hard to find and often get changed without notice, for example through the agency and a room suggested more than 20 minutes walk away…as the agency that does the booking has no idea of the size of the campus. I enjoy walk and talk on Campus although it doesn’t suit all students especially those with Chronic fatigue or certain disabilities. I really stay now for the students as I enjoy the work. I have retrained as a Counsellor to earn more.”*

MHA members also mentioned pay and conditions, but with a greater focus on flexibility and development opportunities:

"Improved staff resource to manage demand for services"

"Better staffed service"

"Clearer boundaries of what our team offer"

"More flexibility around when I am on campus or at home, currently I have set days."

"Our team would welcome opportunities to work more flexibly but managers have opposed this without a clear rationale."

"More time and space to learn from colleagues, better training and career progression opportunities, service aspirations to deepen quality of practice"

Our survey also shows us that many members are unable to attend meetings and CPD, designed to support the sharing of best practice and updating knowledge and skills because they are too busy and can not protect the time to attend. 16 respondents said "I am not able to manage my diary to block out the time" and 10 said "I do not have any time in my working day to undertake CPD". 37 respondents said that they struggle to fit in meetings and CPD, while 13 said they did not feel supported by their employer to access resources, meetings and CPD.

Flexible working

We asked members' views on their current working arrangements.

We received multiple comments from members about the benefits of being able to work more flexibly:

"Remote working has allowed me to see students in a more flexible way, both for me and the students. It is easier to meet with medical students for example when they are remote sessions and easier to arrange ad hoc/extra sessions with all students. Also a better work/life balance for me."

"the increased flexibility has had a very positive effect on the students who can choose weekly how they prefer to meet me"

Diversity

The diversity of staff in student services has been a hot topic in the sector this year, and our survey found that 39 respondents did not feel that their service staffing reflected the student population in terms of diversity. Many teams had tried to recruit more diverse staff but had found

that there were a lack of diverse applicants. Other reasons cited were that the recruitment process did not allow for widening the search area, or that geographical challenges potentially had an effect e.g. diversity of the local population. Some teams had not tried to recruit specifically to increase diversity.

UMHAN has started monitoring equality data from new applicants, and this would seem to reflect the sector more generally, with the majority of applicants still being female, white and heterosexual.

Many of the professions represented in student mental health staffing, such as nursing and social work have also historically been dominated by the same make up of workers, and so this does in turn place potential limitations on the recruitment of a more diverse workforce. In some areas, diversity is increasing, such as nursing (Registration Data Reports - NMC). However, in some instances, where for example, the local population does not reflect the student population in terms of diversity, it may be time for HEIs to consider whether new ways of working, such as remote provision, can be used to attract more diverse applicants.