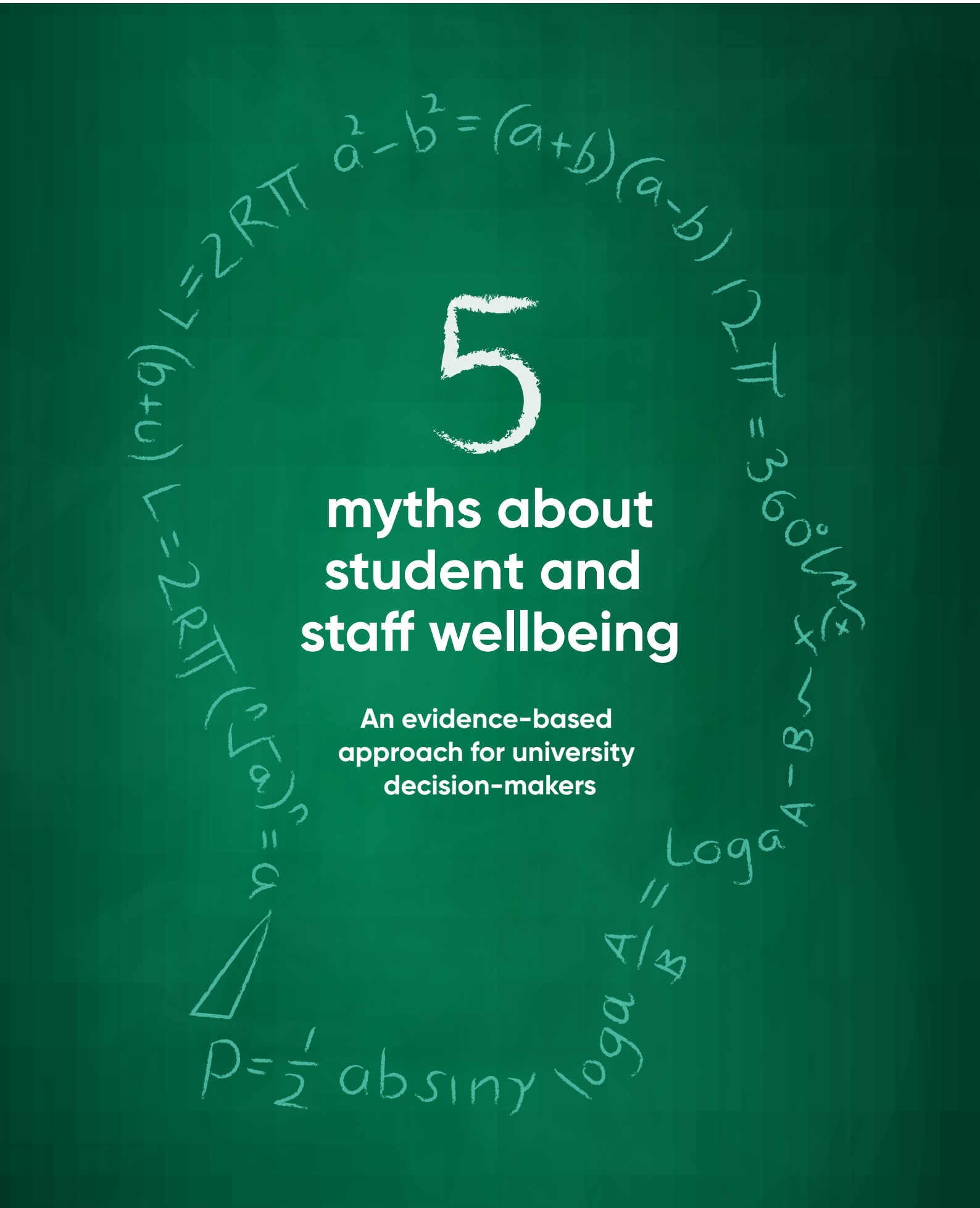
Insights.

Sonder

Sep / 2022

Updated Apr / 2023



5 myths about student and staff wellbeing

An evidence-based approach for university decision-makers

Contents

Introduction

The world of wellbeing can be a maze of shiny objects and misinformation. University leaders, trying earnestly to look after their students and staff, are confronted with conflicting messages at every turn. It's confusing and disorienting.

How can they be sure of the best wellbeing initiatives for their institution? What benefits should they include or exclude? What kind of support delivers the most meaningful value? What does success look like? How can it be measured?

To help university leaders decipher wellbeing offerings so they can design an evidence-based strategy geared toward institutional resilience, this paper dispels five wellbeing myths that may be negatively impacting the wellbeing of their students and staff, as well as costing their institution time, money, student success, and positive staff outcomes.

MYTH 1

Students and staff know how to access wellbeing support

Each year, universities invest significant time and dollars into the wellbeing of their students and staff. Motivated by legal and moral responsibilities - plus a desire to protect their institution's brand and future - health-savvy universities prioritise, fund, and promote wellbeing support services across their on-campus, off-campus, and virtual (learning and working) environments.

However, for students and staff to benefit from wellbeing support, they must understand their support options and know how to access that support. Therein lies a problem.

What the evidence says

Studies show that many students and staff do not fully understand and/or know how to access the wellbeing support services available to them.

Reasons for lack of awareness

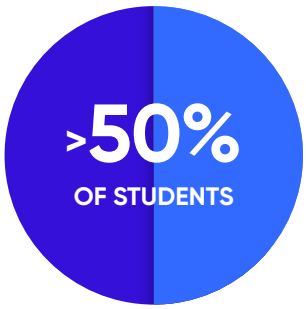
All universities believe they comprehensively promote their wellbeing initiatives to students and staff. So, some likely explanations for a lack of awareness include:

1	**Promotions are not ongoing**	Sporadic educational campaigns and orientation week activities do not facilitate an ongoing retention of information;
2	**Promotions do not feel relevant**	Educational campaigns are not absorbed if they do not feel relevant (e.g. they are not in the language, tone, style and/or channels best suited to each individual);
3	**Support options feel too complex**	Original promotions are seen but not remembered because the support options lack a consolidated, easy-to-remember entry point; and/or
4	**Support options do not feel relevant**	Traditional wellbeing support options are often crisis-only or psychologist-only - which means they don't immediately feel relevant to most students and staff. They can also be perceived as being on the "wrong campus", not for remote students, or not for students offshore.

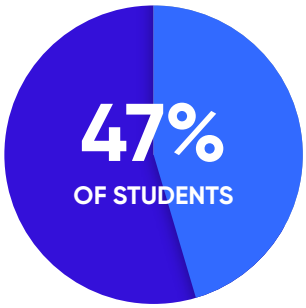
Student wellbeing

Timely wellbeing support for students is important, given that "students experiencing mental illness [and/or poor wellbeing] are more likely to withdraw from courses, or to underachieve, and are less likely to progress," said Universities UK, the collective voice of 140 universities across England, Scotland, Wales, and Northern Ireland.[1]

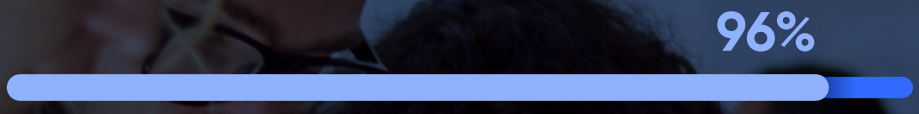
Yet, surveys show that large numbers of students in Australia do not know how to access the wellbeing support provided by their university.



"were unaware of the support services available to them to address a range of concerns from sexual harassment and discrimination to emotional distress".[2]



knew nothing or very little about where to seek support or assistance for harassment.[3]



of prospective international students considered it important that their chosen university offered support for mental wellbeing.[4]

1 Universities UK 2 Journal of American College Health 3 2021 NSSS National Report 4 QS ANZ ISS Report 2022

Staff wellbeing

Timely wellbeing support for staff is equally important, given that "the direct and hidden costs of staff experiencing poor mental health [and wellbeing] are less documented in universities but are likely to be substantial," said Universities UK.[5]

All 39 member universities of Universities Australia rely on an employee assistance program (EAP) as their primary wellbeing support option for staff. Thirty-seven universities outsource their EAP to an external provider, and two provide equivalent counselling services in-house.

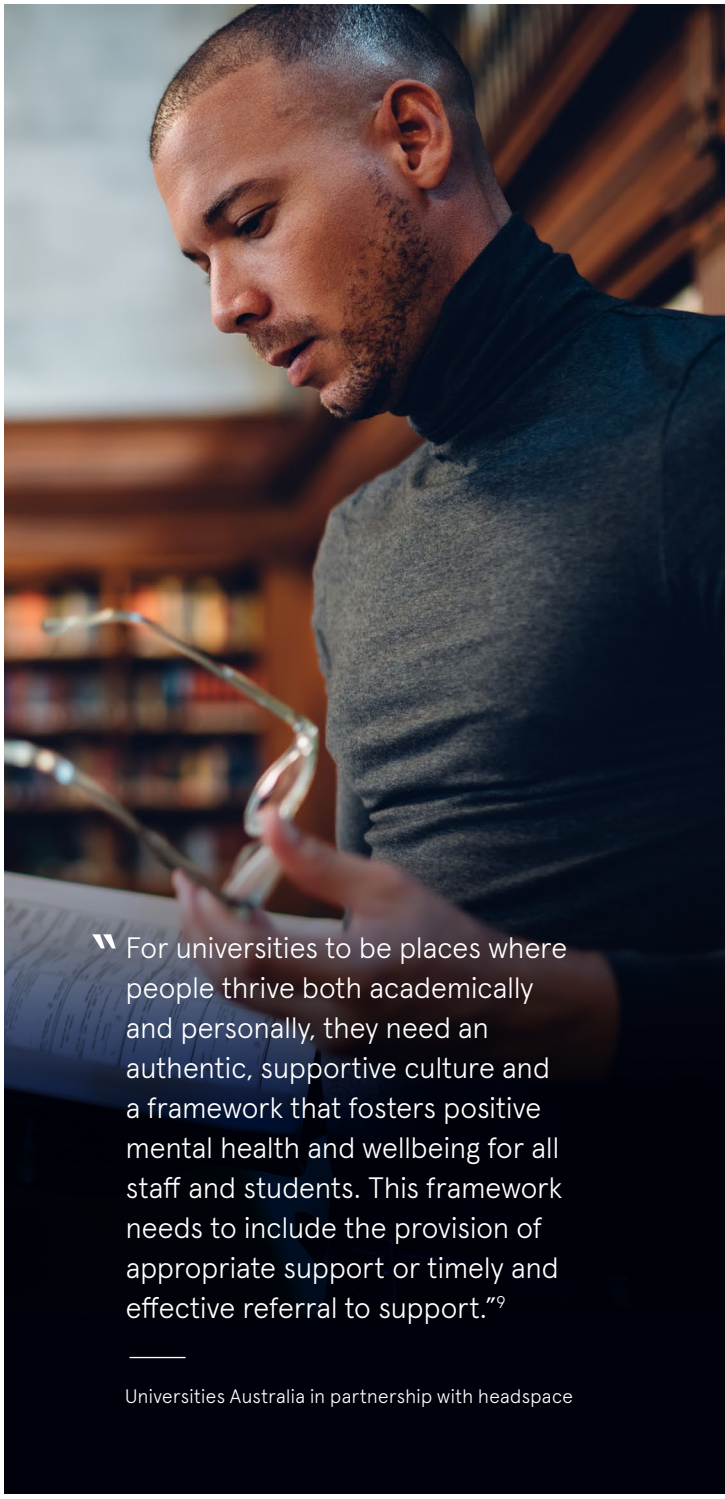
Yet, by its own admission, "One of the main challenges faced by the [EAP] sector is [staff] awareness... only a small number [across all industries] are aware that they are covered, are aware that the service is confidential, or know how to access the service," said the Employee Assistance Professional Association of Australasia (EAPAA).[6]

35%

of staff did not know of the mental health resources available to them.[7]

18%

of staff (who did know of the mental wellbeing support programs provided by their workplace) understood all of the programs available.[8]



> "For universities to be places where people thrive both academically and personally, they need an authentic, supportive culture and a framework that fosters positive mental health and wellbeing for all staff and students. This framework needs to include the provision of appropriate support or timely and effective referral to support."[9]
>
> Universities Australia in partnership with headspace

5 Universities UK 6 Employee Assistance Professional Association of Australasia 7 Beyond Blue (survey conducted by TNS Social Research)
8 Sonder 9 Universities Australia (in partnership with headspace)

MYTH 2

Employee assistance programs (EAPs) meet the needs of all university staff

EAPs have long been a mainstay offering at Australian universities, as well as at 80 per cent of Australia's top 500 companies.[10] But, given that workplaces have changed significantly over the past two and a half years, are traditional EAP services meeting the diverse and growing needs of university staff?

What the evidence says

Sometimes only five per cent of employees use EAPs.[11] Furthermore, the monitoring and evaluation of EAPs have been "insufficient and inadequate".[12]

In 2020, the Australian Government's *Productivity Commission Inquiry Report* recommended that minimum standards be developed for EAPs and the evaluation of these programs.[13] The report also recommended that employers cooperate with Safe Work Australia to share evidence about employer-initiated mental health interventions, to "help all employers choose the most appropriate intervention for their workplace".[14]

In 2021, Comcare released an eight-page guide, *Principles for Better Practice Employee Assistance Programs*, to "provide evidence-informed guidance to help organisations develop [programs] that better meet the needs of employers, workers, supervisors and managers".[15]

10 IBISWorld 11 IBISWorld 12 Comcare 13 Productivity Commission 14 Productivity Commission 15 Comcare

Reasons for low EAP uptake by staff

Common reasons for a low uptake of employee assistance programs include:

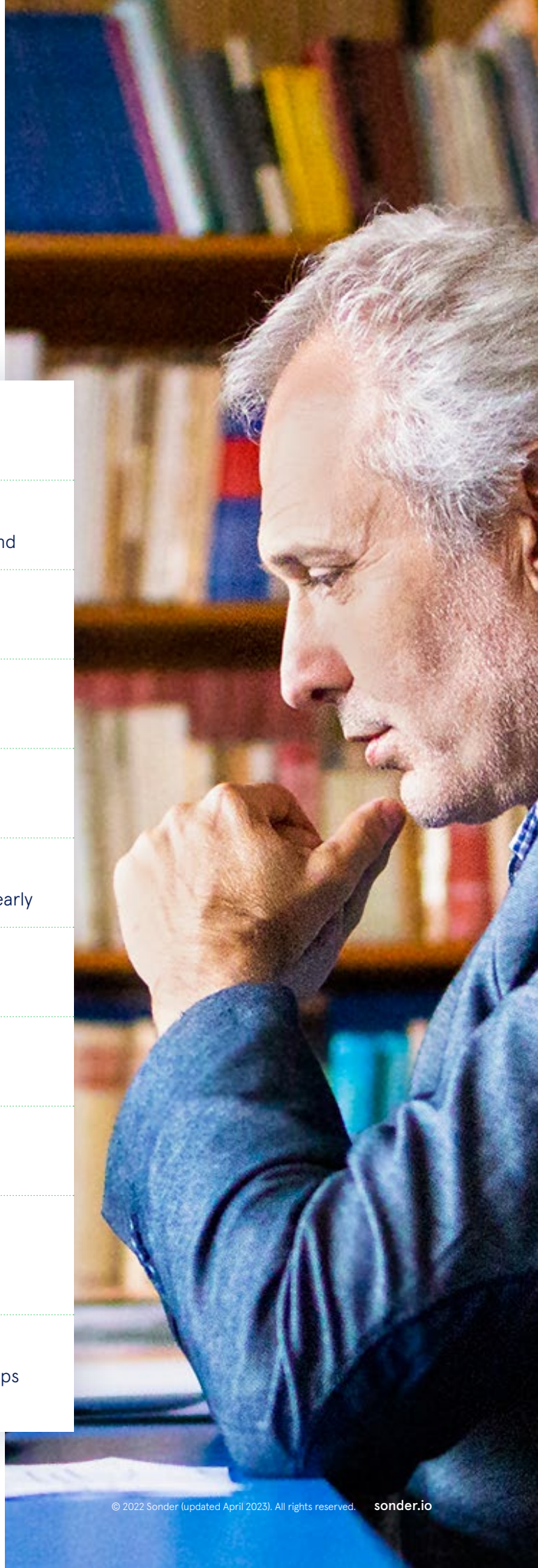
Their use is not built into the culture[16]	The solutions are not the right fit[17]	Poor past experiences[18]
Stigma	Limited access • Long wait times • Reduced care after business hours • Sometimes on-campus only	Quality concerns
Discrimination	Limited coverage • Crisis-only perception • Work-related-only perception • 3-6 included sessions only	Privacy fears
Access barriers	Limited range of care • Psychological or counselling support only • Lack of (or complex navigation to) referral pathways • Reactive rather than preventative	Trust issues
		Delays to care

> "Forty-eight per cent of Sonder members reach out for support after business hours. That's one in two people whose needs would not be met and whose lives might not be saved without a 24/7 service."
>
> ***Dr Jamie Phillips,***
> *Medical Director, Sonder.*

16 Beyond Blue (survey conducted by TNS Social Research), Internal Medicine Journal, SANE Australia 17 Sonder-PwC Australia
18 British Journal of Guidance & Counselling, Australian Broadcasting Commission, Society for Human Resource Management

Checklist for wellbeing support

- **Anytime**
  24/7 access to help (not appointment-setters)
- **Anywhere**
  On-campus, off-campus, in Australia, and beyond
- **Any mode**
  Text, chat, phone, video, and in-person
- **Simplified**
  A single entry point for all support referrals
- **Self-empowering**
  Self-guided tools to supplement human care
- **Proactive**
  Programs that are preventative and build trust early
- **Individual access**
  No shared logins
- **No limits**
  Not capped at 3-6 sessions
- **No unnecessary delays**
  Not everyone needs (to wait for) a psychologist
- **Holistic**
  Mind, body, cultural, social, vocational, environmental, and financial
- **Care continuity**
  Integrated, long-term care with regular follow-ups



MYTH 3

Digital-only is the answer

As the lines blur between our personal, academic, and professional lives, staff are increasingly turning to their employers to better support their mental health and wellbeing.[19] Looking for easy wins and low-effort solutions, many organisations (including universities) are banking on self-help digital tools as the answer.

With between 165,000 and 325,000 health and wellness apps now commercially available,[20] these apps are typically convenient, widely available, highly scalable, relatively easy to implement, and they delegate much of the responsibility back to students and staff themselves.

What the evidence says

Self-help apps can provide valuable initial guidance, but they should complement, not substitute, professional health care and robust clinical governance.[21] They should enhance a student and staff wellbeing strategy, not be the strategy.

19 Sonder 20 NPJ Digital Medicine 21 JMIR Mental Health

Lack of ongoing engagement

Self-help apps risk user drop-off. This can result in delays to care or the absence of care (if there is no human support or ongoing follow-up).

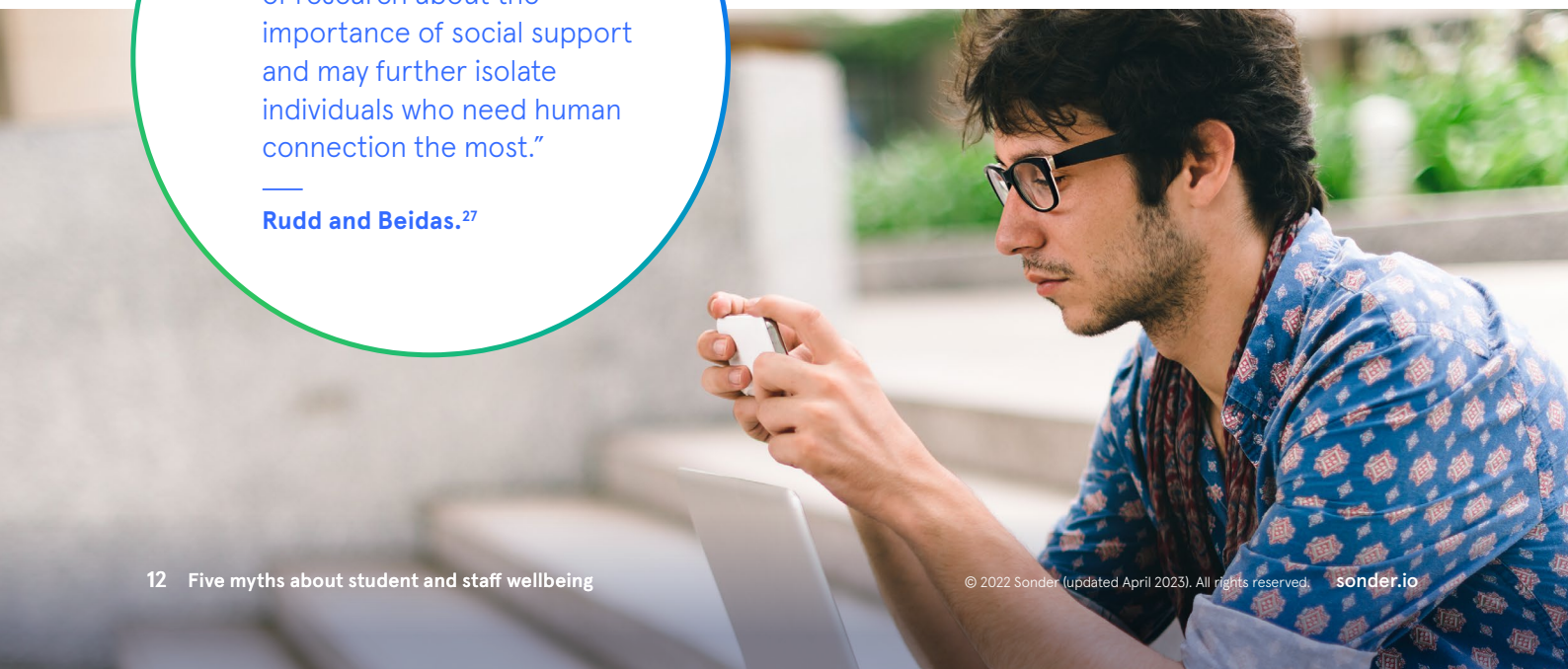
"Widely celebrated as the solution to the supply and demand imbalance in mental health care, digital mental health interventions have flooded the marketplace to supplement specialty mental health care. However, the evidence supporting their efficacy is mixed,[22] and engagement with digital mental health interventions, particularly mobile apps that lack ancillary human interaction, is abysmal.[23] Users are unlikely to use these interventions more than a few times," conclude Rudd and Beidas from the Center for Mental Health, Department of Psychiatry, Perelman School of Medicine, at the University of Pennsylvania.[24]

Carlo, Renn and Areán, from the University of Washington's Department of Psychiatry and Behavioural Sciences, together with Ghomi from the University's Department of Neurology concur: "The vast majority [of health apps] remain largely unevaluated... [and] even when apps are evidence-based, their public health impact is often curbed by poor adherence".[25]

"Furthermore, the movement of specialty mental health care, an intensive public health intervention, from the hands of clinicians and into standalone digital interventions ignores decades of research about the importance of social support and may further isolate individuals who need human connection the most. Given the robust social support literature, it is not surprising that digital interventions with the highest levels of engagement are those that include some form of human interaction," said Rudd and Beidas.[26]

> "Standalone digital interventions ignore decades of research about the importance of social support and may further isolate individuals who need human connection the most."
>
> **Rudd and Beidas.**[27]

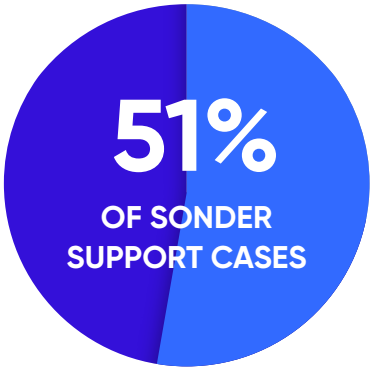
22 NPJ Digital Medicine, Journal of Affective Disorders 23 Evidence-Based Mental Health 24 JMIR Mental Health
25 NPJ Digital Medicine 26 JMIR Mental Health, Journal of Health Communication, Telemedicine and e-Health
27 JMIR Mental Health



Gaps in patient assessment

Digital app users often struggle to fit their circumstances into the predefined categories in an app. Limitations of the tools can also lead to a 'Dr Google' type of self-diagnosis. This represents a dangerous gap in patient assessment because it neglects that many wellbeing issues are complex and multilayered.[28]

For example, "around 51 per cent of our support cases are caused by something other than the issue stated". To illustrate, "self-diagnosed financial stress might, upon professional triage, uncover a need for urgent safety support for domestic violence, plus mental health support for isolation, depression, and suicide ideation, all underwritten by a complex medical problem," says Dr Jamie Phillips, Medical Director at Sonder.[29]



are caused by something other than the self-diagnosed issue

28 Annals of Family Medicine 29 Sonder-PwC Australia

MYTH 4

Wellbeing cannot be measured

Wellbeing advocates often struggle to secure appropriate funding for their wellbeing initiatives. Many times this is because their business cases focus on qualitative rather than quantitative data. This presents a mismatch with budget holders who prefer quantifiable metrics - to satisfy their due diligence, allay their sense of risk, and promote accountability of results.

What the evidence says

The good news is that there is widespread acceptance that wellbeing can be measured, albeit a lack of consensus on a common measurement standard.[30]

There have been at least 30 formal measures of wellbeing developed over the past 50 years, using different definitions and applied to the organisational context.[31] It is not necessary to adopt an existing formal measure, but a university may find it useful to review existing measures when articulating the metrics that will be relevant to their specific institution.

30 International Journal of Wellbeing, International Journal of Business and Social Science
31 Open Publications of UTS Scholars, Wellbeing: A Complete Reference Guide, Work and Wellbeing (Vol. 3, pp.9-34)

How to measure wellbeing

Unlike sales and expense figures, wellbeing metrics do not fit naturally on a balance sheet. Similar to staff performance metrics, wellbeing metrics need work done behind the scenes to define what is being measured, when, how, and why. This upfront effort, together with a concern about choosing the wrong metrics, can deter universities from starting their journey.

However, it's important to remember that wellbeing metrics will evolve over time, based on: a maturing definition of wellbeing; best practices in the sector; and each institution's learnings. The necessity to start, learn, and pivot should trump the requirement for perfectionism at commencement.

Four steps to measure institutional wellbeing might include:

1. **Define what wellbeing means for the university.**

   Articulate what 'good' looks like and show how it relates to other objectives (e.g. retention, revenue, cost, and risk).

2. **Determine the parameters, measurable attributes, and indicators.**

   Be clear on the scope. Draw on both leading and lagging indicators. Formalise data capture.

3. **Start measuring.**

   Establish a baseline, compare it to 'future state' goals, and prepare a gap analysis. Over time, benchmark against sector data. Show progress and learnings.

4. **Review and improve.**

   Embed a process of regular review, consultation, and refinement. To establish ROI, include a correlation between investments and programs.

Wellbeing metrics

Leading indicators ("inputs") help predict future outcomes and events.[32] They "look forward through the windshield at the road ahead". Examples include:[33]

Leading indicators	Specific inputs
High-level support	**Leadership buy-in (as rated by students and staff)** · **Leaders 'walk the talk' about healthy university practices** · **Leaders talk about their mental health and wellbeing** · **Leaders encourage discussion of student and staff wellbeing** · **Leaders commit to best practices in wellbeing**
	Funding · **Amount budgeted for student and staff wellbeing** · **Staff time allocated to wellbeing management**
	Policies and processes (existence and quality) · **Safety and wellbeing policies** · **Flexible and remote work policies** · **Leave policies** · **Diversity, equity, and inclusion policies** · **Bullying and harassment policies** · **Clear and effective change management processes** · **Regular insights gathered and formal feedback loops in place**
Scope	· **Physical health and safety** · **Psychological health and safety** – Including the management of psychosocial risks (see A Simple Overview of ISO 45003) · **Job design** – The level of personal control, autonomy, and decision-making – The level of colleague, team, and management support for tasks assigned

32 Bernard Marr & Co. 33 Bupa, Campbell Institute, Accident Analysis and Prevention, Business in the Community, McKinsey & Company, International Journal of Organizational Leadership, Chartered Institute of Personnel and Development, Report for the National Mental Health Commission

Leading indicators	Specific inputs
Programs and initiatives **The dilemma of choice** Over the years, wellbeing offerings have evolved into a smorgasbord of choice. Whilst this represents positive progress, it has also created a complex landscape for students and staff to navigate - unless they have a single point of entry to their wellbeing services.	· **Professional development opportunities** · **Wellbeing programs and initiatives.** Examples might include: – Gym benefits – Safety services – Social activities – Sleep programs – Health programs – Financial support – Exercise programs – Health assessments – Telehealth programs – Mental health support – Carer support programs – Health insurance or benefits – Onsite or offsite vaccinations
Awareness	· **Amount of visible health-promoting collateral** · **Number and reach of wellbeing information sessions** · **Number of 'speak up' programs and champions** · **Portion aware of the different wellbeing initiatives** · **Portion who understand each wellbeing initiative**
Training	· **First aid (and mental health first aid) training** · **Resilience training** · **Compassion training** · **Workplace Health and Safety (WHS) training** · **Diversity, equity and inclusion training**
Participation and engagement	· **Reach of programs and initiatives** · **Participation and uptake rates** · **Engagement with wellbeing resources** · **Health behaviours (e.g. the number who are meeting the daily physical activity and alcohol consumption recommendations, as well as the number who are smoke-free)**
Satisfaction	· **Focus groups** · **Satisfaction and engagement surveys** · **Employee Net Promoter Score (eNPS)** · **QILT Student Experience Survey (SES)**

Lagging indicators ("outputs") show tangible results.
They "look backwards through the rear window at the road already travelled".[34]
Examples include:[35]

Lagging indicators	Specific outputs
Health	· Prevalence of health conditions · Student support program usage · Staff support program (e.g. EAP) usage · Number of referrals to other third parties for help
Claims and premiums	· Health insurance claims · Workers' compensation claims · Health care spend (including premiums)
Work time	· Annual leave usage rates · Sickness and absenteeism rates · Lost time injury frequency rates (LTIFR) · Lost work days to organisational factors · Return to work rates
Legal and compliance	· Recommended actions from WHS audits · Workplace investigations · Workplace litigations
Attrition	· Peer reviews and 360-degree feedback · Voluntary staff attrition rates · Early student departure rates · Exit survey information

34 Bernard Marr & Co. 35 Bupa, Business in the Community, Safe Work Australia, Chartered Institute of Personnel and Development, Report for the National Mental Health Commission

MYTH 5

Students and staff need psychological debriefing after traumatic events

For years, support programs have prescribed the urgent deployment of a psychologist or trauma counsellor to the scene of a critical incident or traumatic event. Well-intentioned universities keen to exercise their duty of care have traditionally agreed to pay exorbitant rates for a psychologist to be sent on-site to support their students and staff after traumatic events.

What the evidence says

Psychological debriefing may do more harm than good and most people should not need direct psychological support in the first instance.

Psychological debriefing (including critical incident stress debriefing to reconstruct the traumatic event) is not the best clinical practice. The evidence has for some time suggested that "psychological debriefing is ineffective and has adverse long-term effects. It is not an appropriate treatment for trauma victims."[36]

36 British Journal of Psychiatry, Australian and New Zealand Journal of Psychiatry

This sentiment was echoed in the World Health Organization (WHO) literature review (2012) which concluded that "psychological debriefing should not be used for people exposed recently to a traumatic event as an intervention to reduce the risk of post-traumatic stress, anxiety or depressive symptoms".[37]

Several studies also show that psychological debriefing can make symptoms worse:

- A study of police found that those who had psychological debriefing exhibited more hyperarousal at follow-up than those who did not receive a debriefing;[38]
- A study of road accident victims discovered that the intervention group had a "significantly worse outcome" at the three-year mark "in terms of general psychiatric symptoms (BSI)#, travel anxiety when being a passenger, pain, physical problems, [the] overall level of functioning, and financial problems";[39]
- A burn trauma victims study showed 26 per cent had post-traumatic stress disorder (PTSD) at follow-up, compared to 9 per cent of the control group;[40] and
- The Cochrane Review of 11 clinical trials found no evidence that psychological debriefing reduced the severity of PTSD, depression, anxiety and general psychological morbidity, but found "some suggestion that it may increase the risk of PTSD and depression". They recommended that "compulsory debriefing of victims of trauma should cease".[41]

37 World Health Organization 38 The Journal of Nervous and Mental Disease
39 The British Journal of Psychiatry 40 Journal of Traumatic Stress 41 Cochrane
Brief Symptom Inventory

The alternative

Psychological First Aid (PFA) is the modern approach to critical incidents and disasters. Its premise is that people are resilient and in most cases can recover from trauma.[42]

PFA is a "humane, supportive response to a fellow human being who is suffering and who may need support".[43] This involves helping people feel safe, connected to others, calm and hopeful, and ensuring access to physical, emotional and social support.[44] It aims to reduce initial distress, meet current needs, promote flexible coping, and encourage adjustment - and it can be delivered by peers, colleagues and managers.[45]

"Most people recover naturally from trauma, without the need for formal mental health intervention.[46] For individuals who might benefit from trauma support, this is best provided in a style, on a timeframe, and by a practitioner who best suits the needs of that individual," says Sonder's Dr Phillips.

Five principles of psychological first aid (PFA):[47]

- Ensuring safety
- Promoting calm
- Encouraging self-efficacy
- Creating connectedness
- Instilling hope

42 Australian Red Cross, Disaster Medicine and Public Health Preparedness 43 World Health Organization 44 Australian Red Cross
45 Department of Health (Victoria) 46 Annual Review of Clinical Psychology 47 Australian Red Cross, Department of Health (Victoria), Psychiatry

Summary

Six years after 25 Australian universities joined together to form the *Australian Health Promoting Universities Network*,[48] and two years after COVID-19 re-elevated the importance of student and staff wellbeing, today's university leaders and senate committees are prioritising institutional wellbeing. They understand that wellbeing affects: student success; Student Experience Survey results; student and staff retention; staff productivity; and "an organisation's long-term effectiveness".[49]

With that in mind, this paper set out to arm university decision-makers with an evidence-based approach for their wellbeing strategies, as well as a user-friendly overview of wellbeing metrics. It argued that:

1. Many students and staff do not know how to access wellbeing support;
2. EAPs do not meet the needs of all university staff;
3. Digital-only is not the answer;
4. Wellbeing can be measured; and
5. Psychological debriefing after trauma can do more harm than good.

It's now up to university leaders to consider the evidence as they: define what wellbeing means for their institution; determine how to measure it; gather wellbeing data; review their progress regularly; and learn and improve.

The secret to impactful student and staff wellbeing strategies is to take action now and evolve - not wait for next semester, next year, or for the stars to align.

48 The University of Sydney 49 International Labour Organization

About us

Sonder is an Active Care technology company that helps institutions improve the wellbeing of their staff and students so they perform at their best.

Our mobile app provides immediate, 24/7 support from a team of safety, medical, and mental health professionals - plus onsite help for time-sensitive scenarios.

Accredited by the Australian Council on Healthcare Standards (ACHS), our platform gives leaders the insights they need to act on tomorrow's wellbeing challenges today.

ACHS

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Get on-the-ground assistance so you're not alone in difficult times

Sonder specialists

Access our clinical team of registered nurses, doctors, psychologists, and more

Wellbeing resources

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Safety scanning

Avoid unsafe situations and outcomes before they arise

Care in your hands

Let's connect

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