Information Sharing and Student Suicide

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UMHAN
University Mental Health Advisers Network

Introduction

The British Association for Counselling and Psychotherapy - Universities and Colleges division (BACP-UC) and University Mental Health Advisers Network (UMHAN) represent the majority of mental health practitioners working in student mental health, with nearly 880 members between us (378 and 501 respectively). This includes staff with years of practice in university mental health services but also in external mental health support providers and statutory bodies.

We welcome the recent focus on student suicide and information sharing practices by the Government and sector bodies such as Universities UK - this is long overdue despite university mental health services being longstanding and well-developed.

Student suicide is an understandably emotive topic; in addition to the loss of an individual, the impact is felt deeply by family, friends, peers and a wide range of staff.

There is an urgent need for universities to develop explicit and clearer policies around information sharing. We are concerned about the potential impact on students' trust in mental health support at university when “opt in” schemes for consent are introduced. Students need reassurances that their confidential information remains so; and our member survey shows an accurate picture of how and when information is currently shared - with the student at the centre.

Additionally, as Mental Health Practitioners, our members encourage students to talk about their mental health to family and friends whom they trust where appropriate within the context of the individual’s circumstances. It’s important to note that not all parental and family relationships have a positive impact on wellbeing and mental health - family relationships are the biggest presenting problem within Child & Adolescent Mental Health Services (1), while poor family functioning and poor parental mental health are among the main factors to influence poor mental health among children and young people (2). Furthermore, recent research has shown that some parenting styles may increase mental health difficulties and negatively impact a young person’s ability to develop coping strategies “*Those who experienced over-control and over-indulgence were more likely to have a mental health problem or engage in self-harm or suicidal behaviour. In particular, over-control was related to self-harm, while those who were over-indulged were more likely to have suicidal thoughts, plans or attempts.”* (McLafferty, M. & O'Neill, S 2021)

There are different thresholds across the UK for support from and admission into specialist NHS services; this can lead to Universities holding substantial risk without the staffing, structure or governance to do so safely.

The purpose of this document is to explore the complexities of what is being intimated by external bodies and Government in terms of creating different information sharing practices for adult students than the rest of the population, alongside highlighting the need for an accurate reflection of what is already happening “on the ground”.

Forewords

Piers Wilkinson

Disabled Students' Commission, Student Voice Commissioner

As an individual who has been representing disabled student voices in various positions – both nationally and within higher education institutions (HEIs) – for the better part of the decade, it is a pleasure to help introduce this report. Mental health is a particularly challenging topic for students to talk about, and ensuring that disabled students have confidence and trust in higher education institutions for when they need to access support services is essential. Particularly when fitness to study and fitness to practice processes can be triggered as a result of disclosing mental health challenges, and coupled with the existing societal stigma, it is important for institutions to get it right when it comes to information sharing. As a disabled person with lived experience of mental health challenges, I have been following this particular area of tension for a while now, and welcome the recommendations within this report and share the common goal that we all have towards reducing disparity in policies, experiences, and practice between institutions. I know how well HEI's place disabled students at the heart of support service delivery, and collectively we can work together to ensure good practice supports the great work that goes on within the sector.

Ensuring the autonomy and independence of disabled students experiencing mental health challenges is a vital part of how we as a sector must respond to the topic at hand, alongside ensuring student safety and well-being. Understanding the myriad of backgrounds and identities that students within HEI's have, and embedding intersectionality into policies, procedures and practises such as information sharing is vitally important. The findings and recommendations from this paper are a useful tool for professionals and non-professionals alike in continuing the progress and embed good practise in a supportive, transparent and culturally competent manner, especially as we navigate through the rising mental health crisis we are currently experiencing.

In particular, I welcome the recommendations towards professionalisation and better collaborative working with the NHS within the education sector, so that we can support students with timely and effective support before they reach a crisis point, and information sharing becomes a discussion. Finally, as an individual who has at times not had the best of relationships with family members and whose mental health challenges could have been worsened by improper and unsupportive information sharing, I truly value and appreciate the work that is being done on this topic towards supporting individuals like myself – whether you are a professional, organisation, or contributed to this report – and taking time to consider the impact that blanket information sharing policies might have.

Forewords

Professor Andrew Reeves

Professor in Counselling Professions and Mental Health, BACP Senior Accredited Counsellor/Psychotherapist and Registered Social Worker

I welcome this much-needed and invaluable report, Information Sharing and Student Suicide, conducted by two of the leading mental health associations in the university sector. BACP: UC and UMHAN, through the delivery of counselling, psychotherapy and mental health advisory services, have been embedded within university communities for many decades and have been leaders, through practice-based evidence, of highly-specialised and student-focused mental health support for those most at risk. The tenet of the success of such services is that of trust and, in turn, confidentiality is a central tenet of trust building. Any move to undermine or compromise the trust built between student and helper will, without doubt, undermine the very efficacy of those services and skills used to determine risk and inform the most appropriate responses.

The recommendations outlined in this report are built on 'ground-up' evidence and provide a theoretical and practice structure through which support can be further enhanced in a student-focused way, building on the important principles of a university-wide responsibility for student care.

Forewords

Professor Ann John

Professor in Public Health and Psychiatry at the Swansea University Medical School. Chair of the National Advisory Group to Welsh Government on the Prevention of Suicide and Self-Harm

Suicide is one of the leading causes of death in young people in the UK and the second leading cause of death among 15-29 year olds globally. Any death by suicide is felt deeply by family, friends and the wider community, but particularly so in a young person. Universities have an important part to play in mental health improvement, emotional literacy, self-care and suicide prevention.

Most mental illness emerges before the age of 24 years which means the average age of students overlaps with the peak age of onset for mental health problems, as such universities are places where students are likely to first experience mental health difficulties, and/or first seek help. Young people moving to university may lose supports from friends and family at home and such transitions may be particularly challenging. Those with pre-existing mental health problems may struggle both with GP registration and linking with specialist mental health services in their new place of residence. One approach to overcome these difficulties is to allow dual registration at home and in university General Practices to facilitate access and referral to appropriate services. Another, as recommended in this report, is to adopt a whole university approach with improved collaboration or even integration with specialist NHS mental health services, training and awareness across students and staff and adequate provision of university support and counselling staff.

Universities should urgently develop clear policies around information sharing and involving family members in the mental health support of students. These policies underpin trust and confidentiality which are fundamental to building and maintaining therapeutic relationships. While ‘opt-in’ to contact family members has been adopted by some universities with the broad support of students, as this survey highlights, such decisions are fluid and should be consistently re-explored as part of therapeutic work with students. This ensures their consent for contact, as adults, and their best interests are central to any decisions about their care.

The university environment provides an important opportunity to promote healthy behaviours and life skills that will help students respond to life’s challenges as well as transition into employment. The recommendations within this report should be welcomed. They are based on the voices of those delivering care in universities and are consistent with latest guidance provided by Universities UK. Both focus in an empowered way on opportunities within universities for suicide prevention and encourage a whole-university approach to mental health, building resilience, support structures and suicide prevention.

Summary

This report details survey results from UMHAN and BACP-UC members during the summer of 2021. We undertook a joint survey of our members and received 78 responses, just under 10% of our membership. The majority of responses were from Counsellors, Mental Health Advisers and Specialist Mental Health Mentors, who constitute the bulk of our membership. The questions were jointly developed by UMHAN and BACP-UC and the survey was sent out to all members via email, our community forum and newsletters. The survey was open from July-September 2021. Due to the anonymous nature of the survey, it is not possible to provide detail on the number of institutions represented.

The results demonstrate how frequently practitioners manage risk to life by their direct work with students using therapeutic tools, practical support (such as safety planning) and knowledge of and liaison with statutory services. It also shows how carefully the issue of consent to share information is dealt with by practitioners, within the context of mental health capacity, student safety and legal requirements.

However, the results also highlight potential issues around decision-making by non-clinically trained staff and a lack of support for practitioners.

Perhaps most shocking is the low numbers of respondents who feel that they have appropriate systems and processes in place to help best manage risk and prevent student suicides. We believe that these are basic and fundamental issues which need addressing urgently by the sector.

Our recommendations:

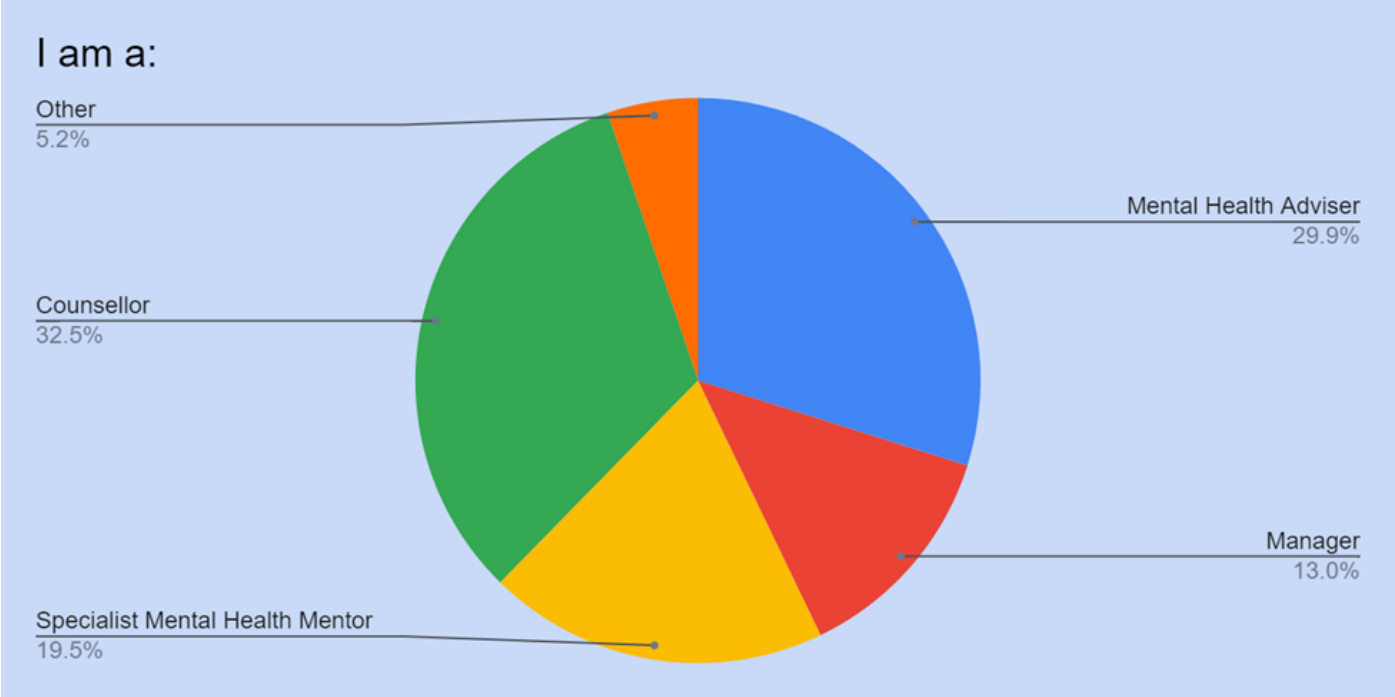
- Clear information sharing principles
- Review of decision-making, including when to safely involve parents or significant others
- Working with the NHS - clarifying boundaries and establishing processes
- Review of data collection and case management systems
- Mental Health Service Team Governance
- Common Codes of Practice across the sector
- Appropriate CPD for staff

Further research into the effectiveness of existing provision.

Member survey

We undertook a joint survey of our members in the summer of 2021 and received 78 responses, just under 10% of our membership. The questions were jointly developed by UMHAN and BACP UC and the survey was sent out to all members via email, our community forums and newsletters. The survey was open from July-September 2021. We note that many staff within the sector are term time only and experience high demand at peak periods which might contribute to a low response rate.

Job role



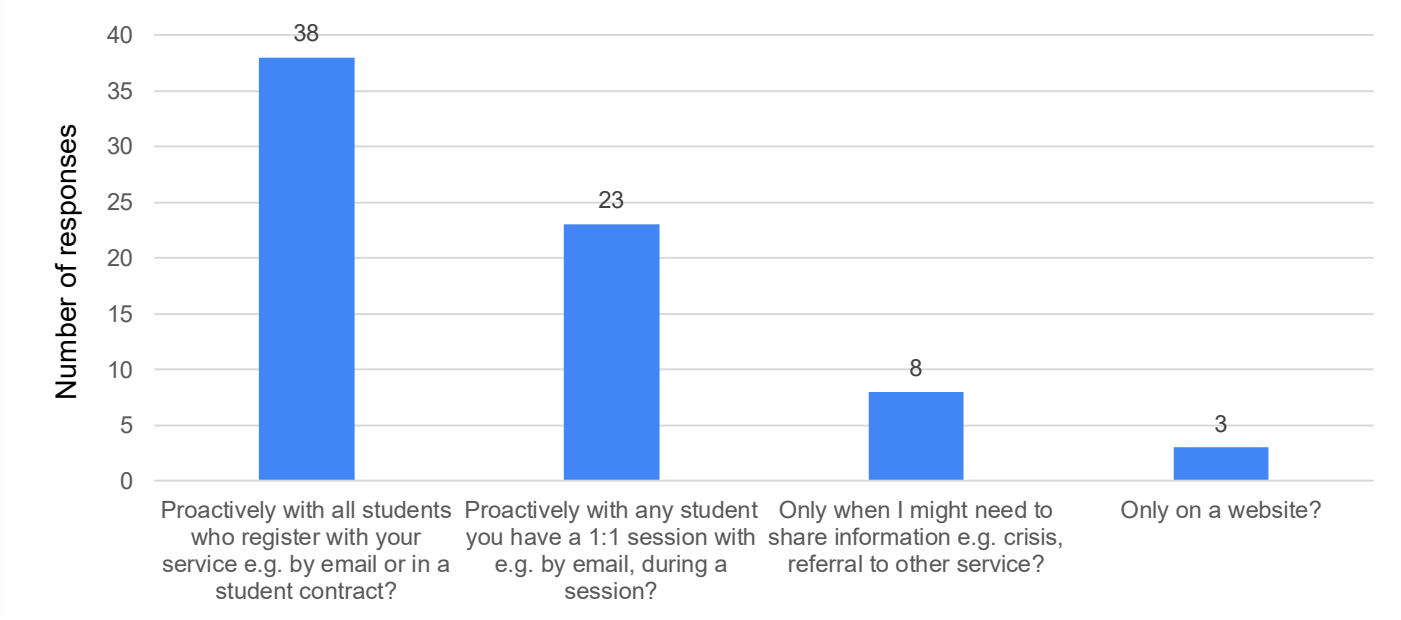
Students are supported by a range of mental health practitioners in universities, and so responses have been split between those employed directly by universities and those employed by a 3rd party.

Survey - University Staff

Information sharing policies

Our survey found there are already a large number of institutions which have information sharing policies already in use, with 83% of respondents employed by universities stating that they already had policies about sharing information with parents and 3rd parties. These policies are being shared with students as they register with mental health support services.

Do you share this policy

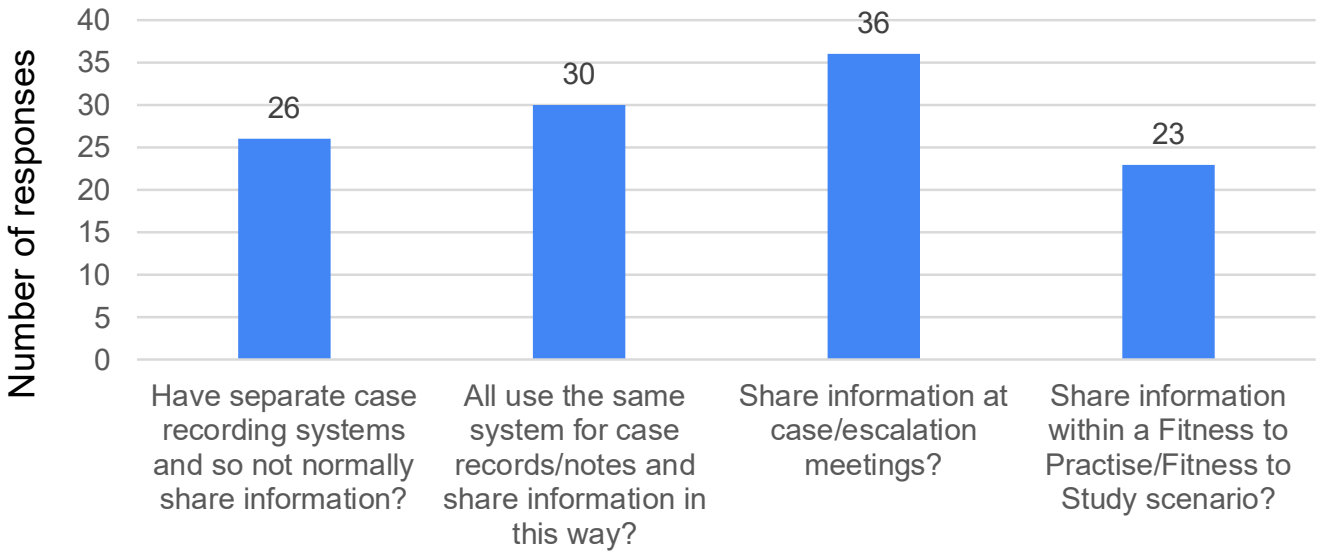


Survey - University Staff

Information sharing within teams

We then asked members about information sharing within their own teams. It's notable that a large number do not share case recording systems at the current time.

Within any wider teams of MH practitioners, do you:

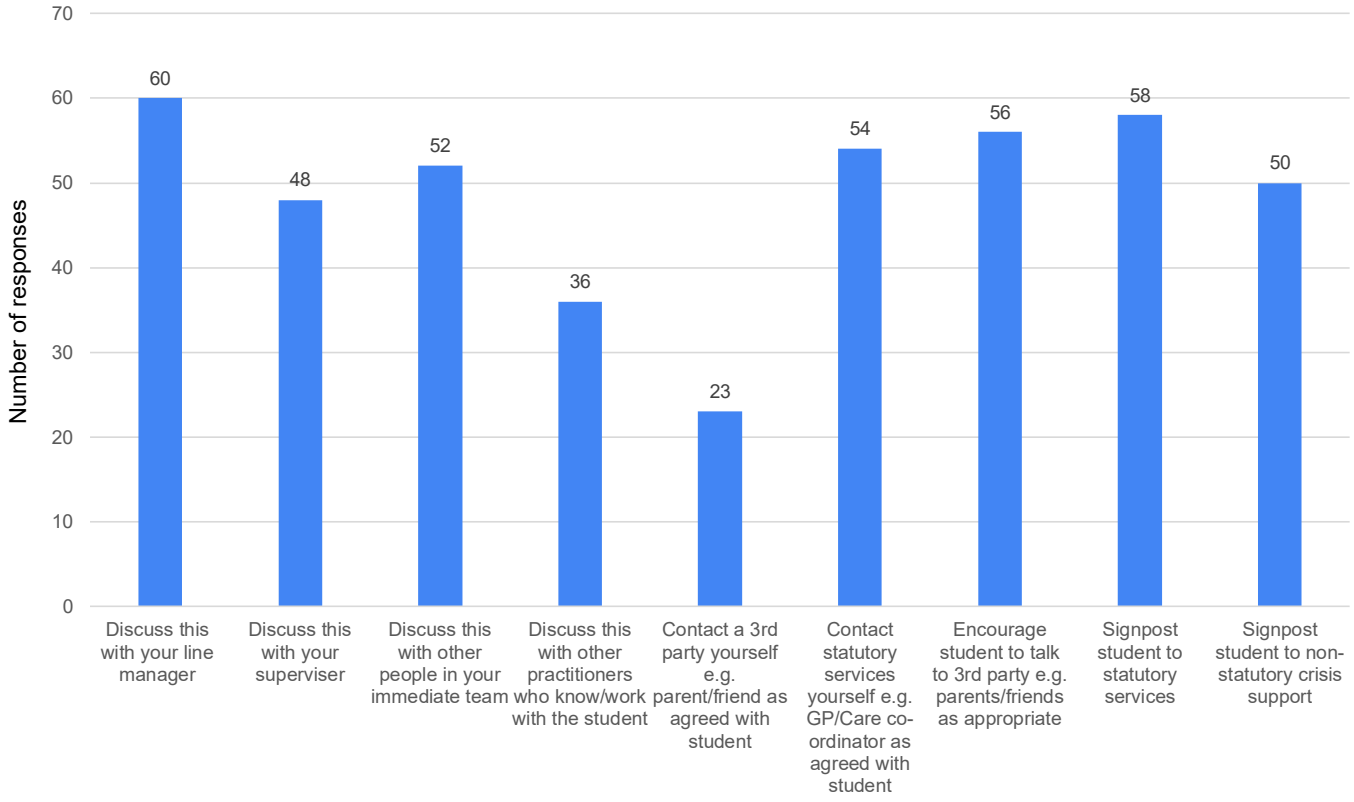


Survey - University Staff

Concerns - University staff

As shown by the graph below, university Mental Health Practitioners interact with statutory services to ensure students receive the support they need - this is often a key part of their role, and in some cases includes direct referral routes into specialist services.

If you are concerned about a student do you:



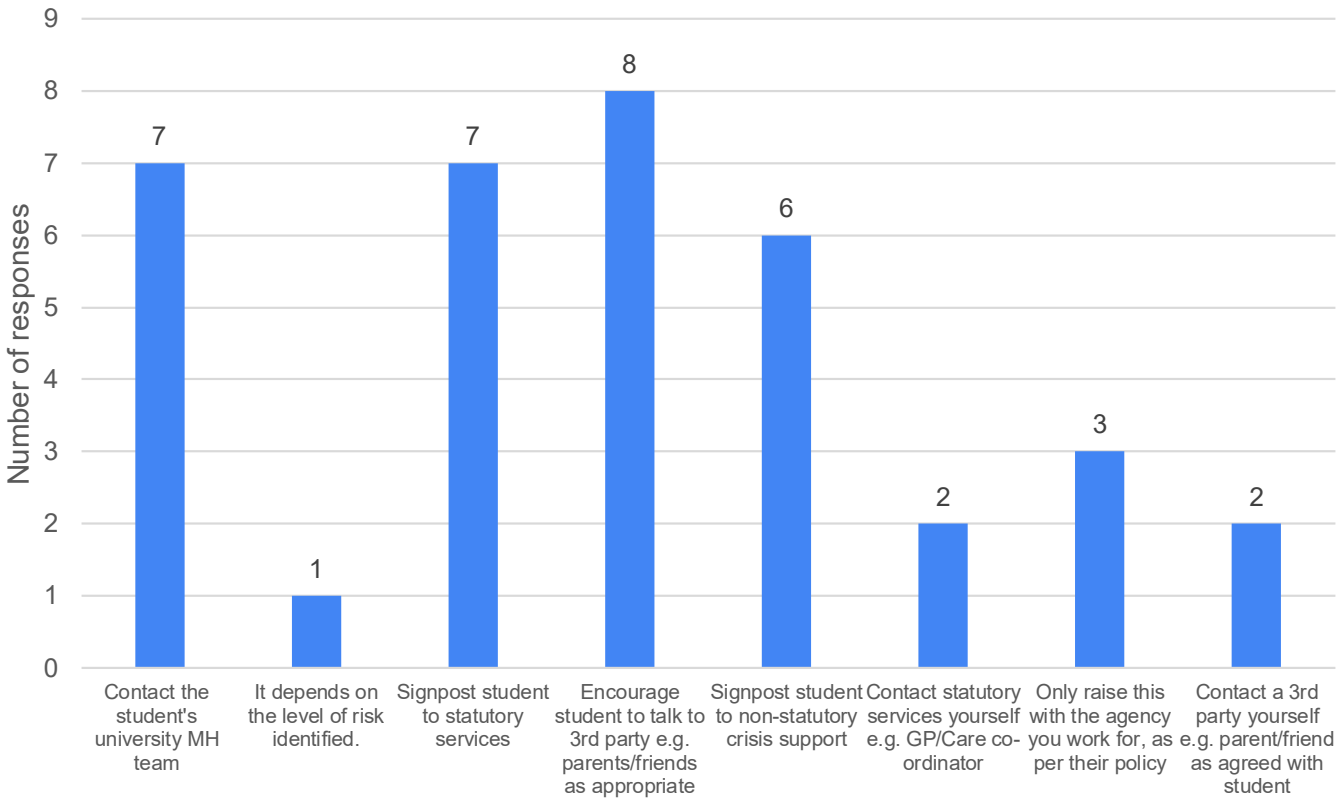
Survey - External/Self-employed Staff

Self-employed staff and those employed by external mental health support providers are normally Specialist Mental Health Mentors, funded via Disabled Students Allowances. Although a small number of responses (10 responses out of a total of 78), this may suggest that many agencies do not have clear written policies about information sharing. This is confirmed by anecdotal comments from Mentors attending UMHAN member meetings. There are concerns across our memberships about inconsistencies around how risk is managed and communicated within employment agencies, with the potential for students at high risk of suicide to be missed.

Only 2 members employed by an external mental health support provider were aware of a current information sharing policy, with both self-employed respondents having their own policy. It should be noted, however, that the number of each of these respondent types was small and so may not be indicative of the wider picture, with 6 respondents employed by an external organisation and 2 who were self-employed.

Concerns - External/Self-employed staff

If you are concerned about a student do you:



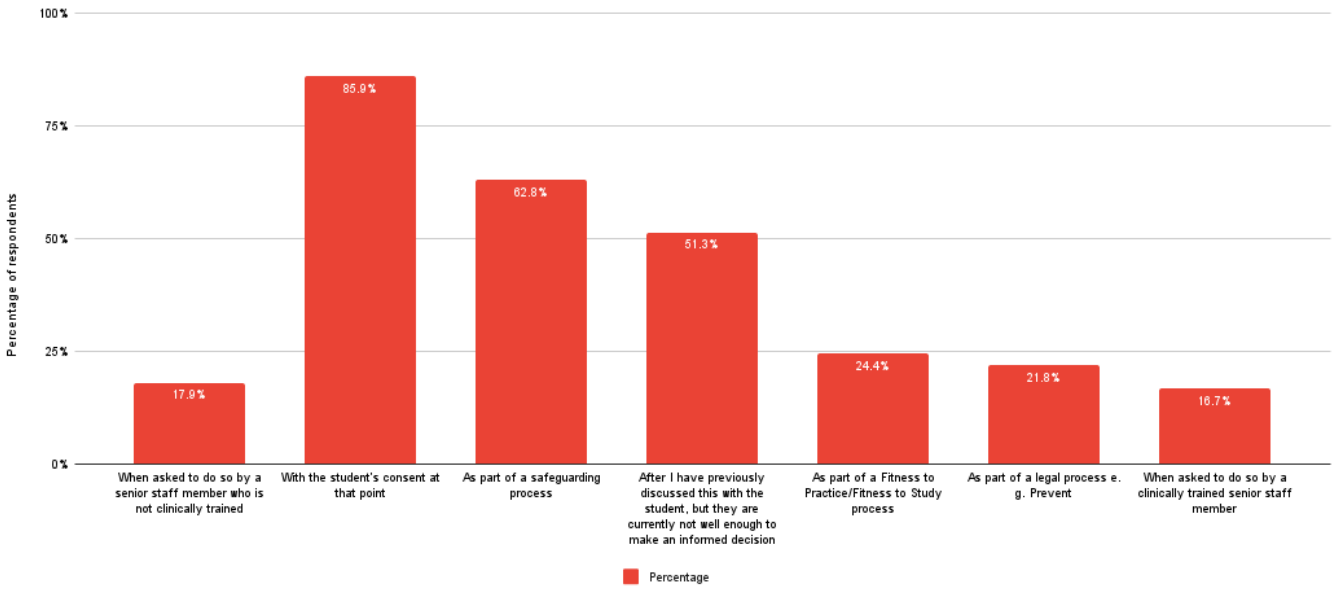
Survey - All respondents

Despite this being an increasingly debated policy among senior leaders, only 40% of respondents stated that they already had a pre-emptive system of consent in place (e.g. all students are asked to opt-in at registration).

Breaking confidentiality

We asked our members about their experiences of having to break confidentiality. By “third party” we normally mean parent, family member, friend (or other next of kin), healthcare professional or emergency services. In some instances this would also mean sharing sensitive information within the university.

Thinking about your own personal experience, when have you had to break confidentiality and share information with a 3rd party?



We also asked what practitioners’ preferred way of “breaking confidentiality” would be. An overwhelming 91% of respondents stated that their preferred way to share information would be with the students’ consent at the time. The second preferred alternative was “After I have previously discussed this with the student, but they are currently not well enough to make an informed decision”, with 51% of respondents also choosing this option. 12% selected “When asked to do so by a clinically trained senior staff member” with only 3% preferring to do this “When asked to do so by a senior staff member who is not clinically trained”.

Survey - All respondents

These responses show that the overwhelming majority of Counsellors, Mental Health Advisers and Specialist Mentors who completed the survey adhered to the principle of right of choice for students they work with, aiming to discuss any instances of information sharing with the student, at the time.

“My experience of breaking confidentiality, including when I have worked in statutory services, is that discussing it with the client at that point if at all possible is the most transparent and ultimately helpful way to break confidentiality, even if they disagree. At registration, people do not necessarily make informed decisions about this - they are just filling in a form. Having the discussion at the time is when it is real and present. There are scenarios when you may break confidentiality without a discussion, for eg safeguarding situations where a discussion might put someone at greater risk, or if the person cannot discuss the situation for some reason (in too much distress/shock, unconscious etc) but I believe these should be the exception not the norm.” Head of Counselling.

“I have had situations where breaking confidentiality involved client considerations and relationships outside of the counselling room. These seem the most difficult to manage. People go a long way to protect and spare those they love from difficult news, disappointment and harm, even if it is to their own detriment. I think it is important for us "professionals", tethered to organisations of one description or another, to consider the enormity of violating any individual's right to make bad decisions, even if the law and our own conscience back us up.” Counsellor.

“I haven't personally had experiences where I have had to break confidentiality when I know this would be contrary to the student's wishes, but I am aware this sometimes happens for risk management. I am aware of one case in my team where a student felt very angry and disengaged from therapy. I feel it would be a skilled task to repair the therapeutic relationship after this and not always possible, a high level of support should be offered to practitioners attempting this.” Mental Health Advisor.

“The majority of time I am extending confidentiality with the consent of students.” Counsellor.

“It is important to consider, ideally with a group of MH professionals who know the student, the holistic situation of the student in terms of risk, family circumstances, possible consequences etc before sharing information with an emergency contact. The emergency contact also needs to be appropriate (and not an ex-partner for example). Sharing information with 3rd parties who are medical practitioners can be done in a more straightforward way, though on the same basis of consent or vital interests.” Head of Wellbeing.

It is clear that a lack of clear policy is creating issues for students, practitioners and universities as a whole.

“Without a current safe and agreed protocol, we are often in the difficult situation of having to escalate to seniors or discuss breaking confidentiality. Having an agreed protocol or policy, which is legally and ethically supported, will make us a lot more assured of our practice and be able to challenge potential considerations for breaking confidentiality.” Mental Health Advisor.

“At my uni the term 'case-by-case' used by managers masks the fact that there is no coherent policy” Counsellor.

Survey - All respondents

Managing risk more effectively

We asked a free text question "What do you think would help your university/employer manage risk more effectively?"

This is a sample of the responses received, which highlight the most important themes:

- **An adequate case management system**
  - Mental Health, Wellbeing and Counselling teams are often made to use systems which have been already adopted by other teams within the university, but are not sufficient for complex case management or accurate reporting.

"A proper Customer Records Management system; we currently share a system unfit for purpose plus share it with counsellors who have a different threshold for information sharing from MHAs." Mental Health Advisor.

- **Better links and clearer boundaries with statutory services**
  - As recently identified by the Thriving Learners report (4) parameters around duty of care are unclear. Anecdotal evidence from our online discussion forums and member meetings describes how students are frequently referred from crisis services back to the university with no handover and the expectation that the university is offering more support than they have clinical responsibility for.

"Dedicated pathways for students to access appropriate risk-assessment (including terms of confidentiality) and clear discharging 'duty of care'. We have had instances of CMHT's calling the university to ask for them to check on someone because they are concerned about a student that hasn't turned up to their appointment - rather than call statutory services or attend themselves. This seems highly inappropriate." Mental Health Advisor.

"Closer working / two-way information sharing with the NHS; Better resourced NHS so that students can be more easily referred for help/treatment in a crisis." Head of Wellbeing.

- **Clinical experience and appropriate training**
  - Senior management and in house legal services often do not have the appropriate training or experience to assess risk within a clinical mental health context or the complex legislative framework
  - This includes non-medical help suppliers and other agencies
  - This may lead to "knee-jerk" reactions based on fear, reputational management and pressure from 3rd parties
  - We can also speculate from anecdotal evidence from our online discussion forums and member meetings that this leads to engagement and conduct issues being unfairly attributed to mental health issues, and vice versa. This is particularly true of Fitness to Study and Fitness to Practise procedures - indications of mental health changes are not always picked up through symptoms and behaviour presenting to someone without mental health knowledge, however there is also the risk that fear of mental health conditions and suicide can mean some behaviour is wrongly attributed. This can lead to inappropriate responses and a lack of support. We can only assess risk and other factors in the moment however risk can change.

"Recognition from SMT that risk cannot be eliminated and risk is fluid and changeable with no one evidence-based 'tool', process or way of working that can eliminate risk." Counsellor.

"The agency staff need to be more proactive and aware of information sharing and its implications. Often students are allocated who are already presenting at risk with very little information shared appropriately. It is often not until I have concerns or the student displays symptoms or shared talk about suicide that I am aware of the level of their mental health condition." A Specialist Mental Health Mentor.

- **Staffing**
  "To ENGAGE with it - or rather to give counselling services the resources to engage with students who feel suicidal - more counsellors! Lots more. Repeated risk assessment does not help people who feel suicidal." Counsellor.

  "A social work qualified practitioner in student support senior management coordinating safeguarding." Mental Health Advisor.

  "Having a specified person dedicated to responding to students at risk." Specialist Mental Health Mentor.

  "More time and space for individual and team reflection on clinical work and personal care." Counsellor.

- **Clearer policy and information sharing**
  The most frequent response to this free text question was on the theme of the need for clearer guidance, policy and information sharing.

  "A review of circumstances pertaining to student's suicide, involving all those most concerned and connected with him, with a view to revising procedures as appropriate." Counsellor.

  "Clearer operational guidelines. Standardised guidelines across the sector." Mental Health Adviser

  "Clear procedures that involve partnership working between different support services." Disability Advisor/Learning Support Tutor.

  "Effective safeguarding policy. Clear and consistent communication. Clear boundaries and limitations on differing departmental student support expectations. Open and regular conversations around risk." Counsellor.

  "A consistent process of when to raise concern." Mental Health Advisor.

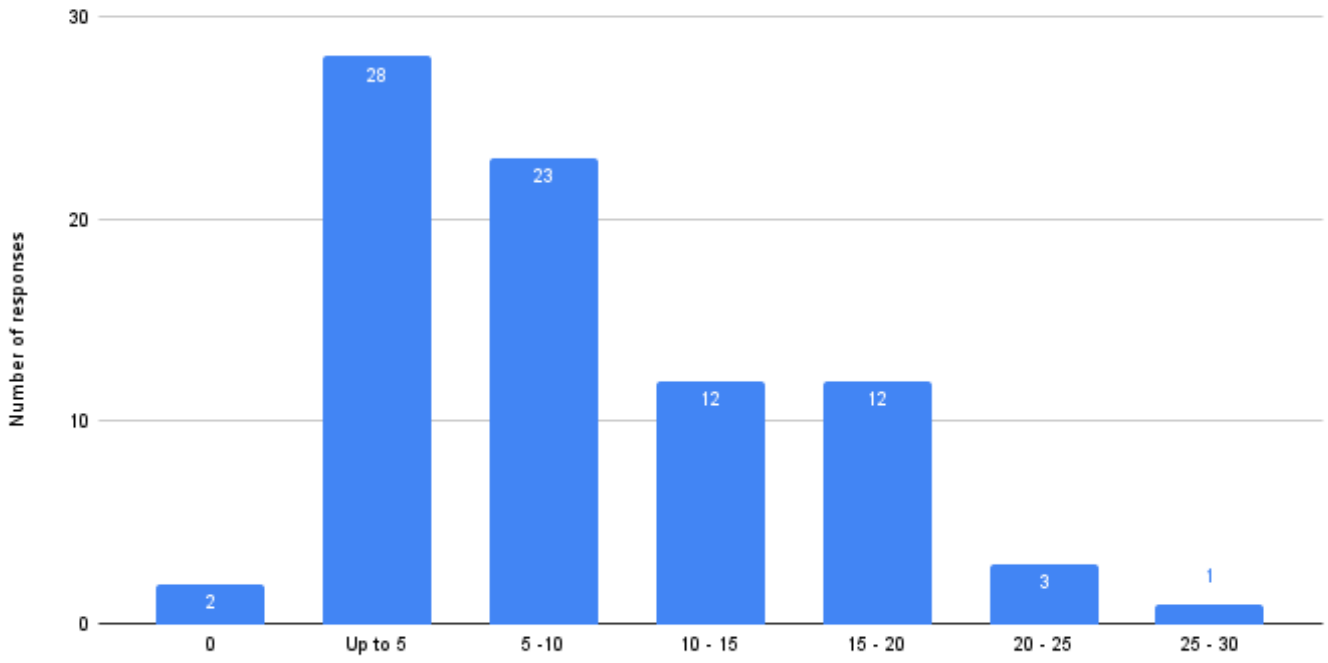
  "Be more open with staff, including zero hours contracts staff. We're considered outsiders so can't see the information records of students." Specialist Mental Health Mentor.

Survey - Suicide

Supporting students with suicidal thoughts and plans

The following responses demonstrate how qualified mental health practitioners in universities are already supporting students with suicidal thoughts in their everyday work.

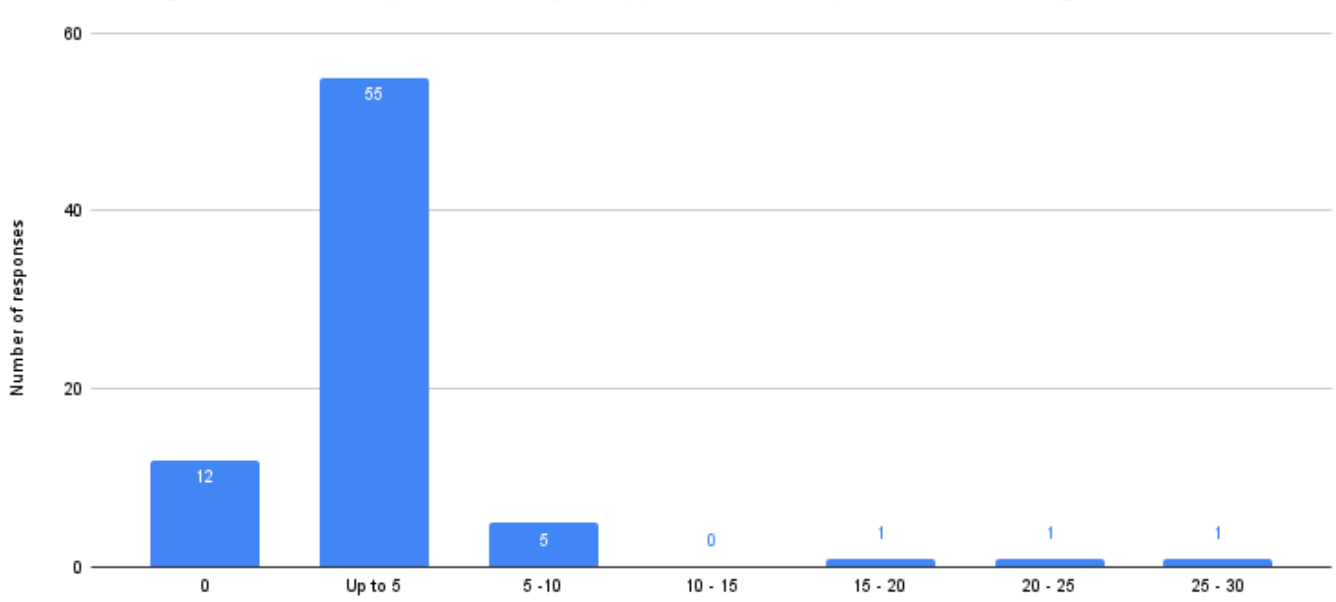
In an average month, how many students do you support who express suicidal thoughts?



The data in this question and the following two does not allow us to determine the proportion of students from an entire caseload who express suicidal thoughts. However, we can infer from comments that for some teams this is a high number: “Most of our students express suicidal thoughts”, “As a team, could be hundreds, 25-30 in weekly case review”, “Sometimes more than 100 per month are seen due to expressing suicidal thoughts “

Survey - Suicide

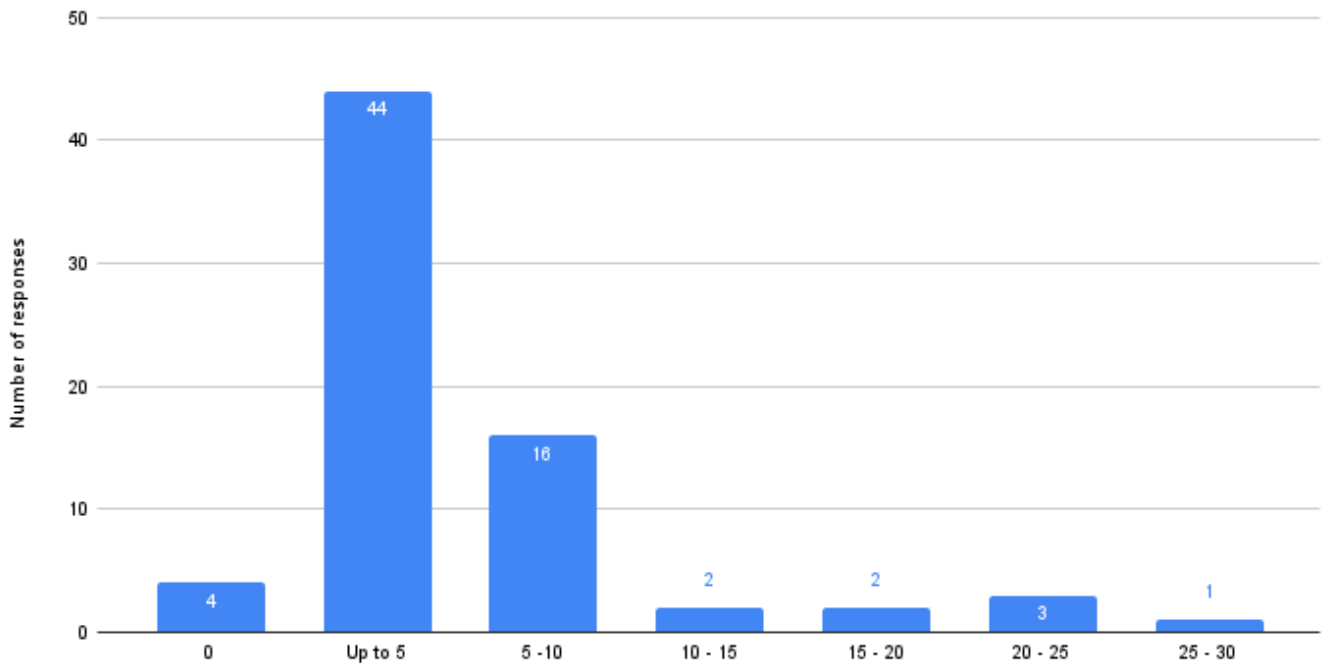
In an average month, how many students do you support who have a plan as well as thoughts to end their life?



Safety planning

Safety planning is an important aspect of suicide prevention, and is a practical tool to keep students safe.

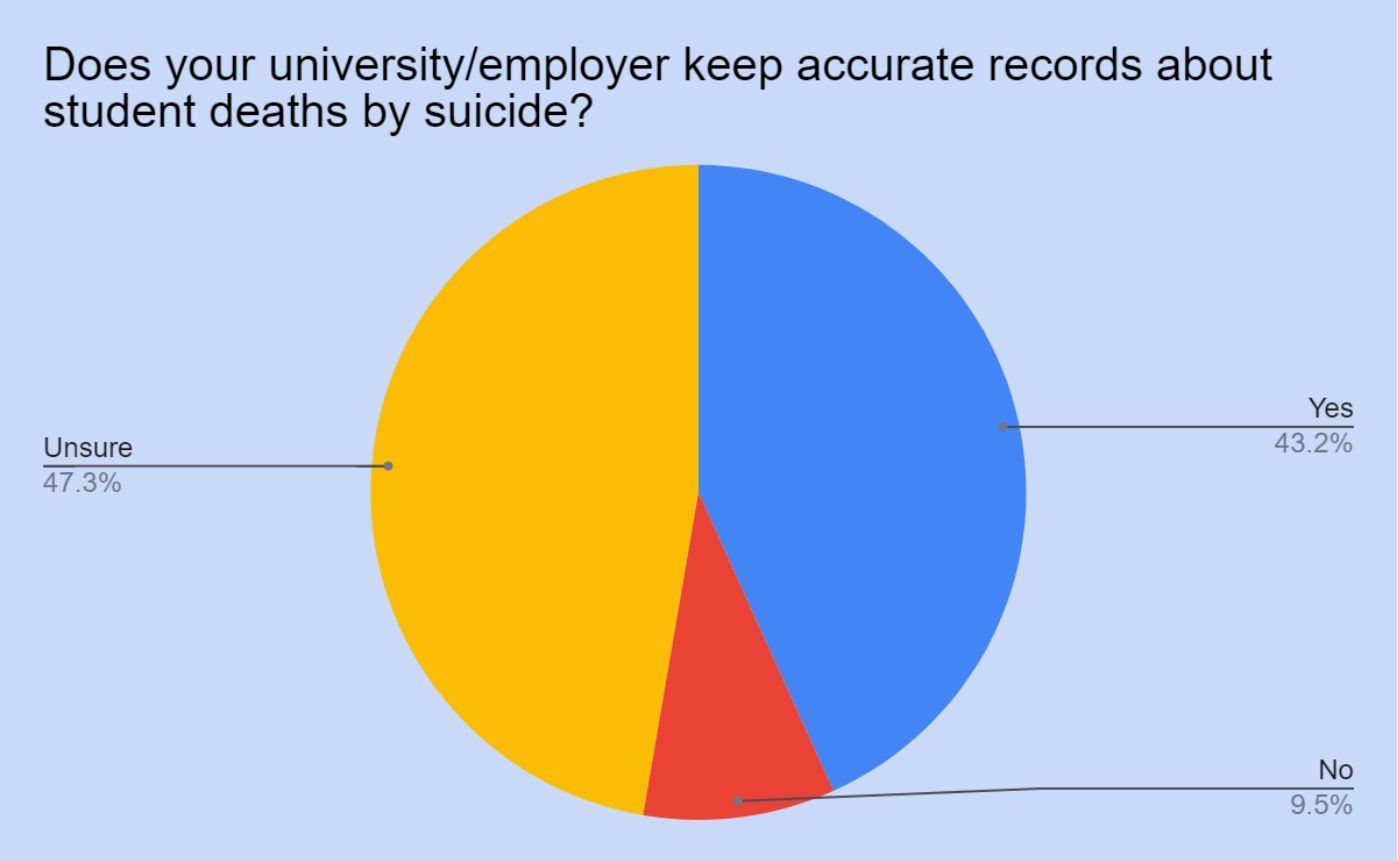
In an average month, how many students do you support with their own risk/safety planning?



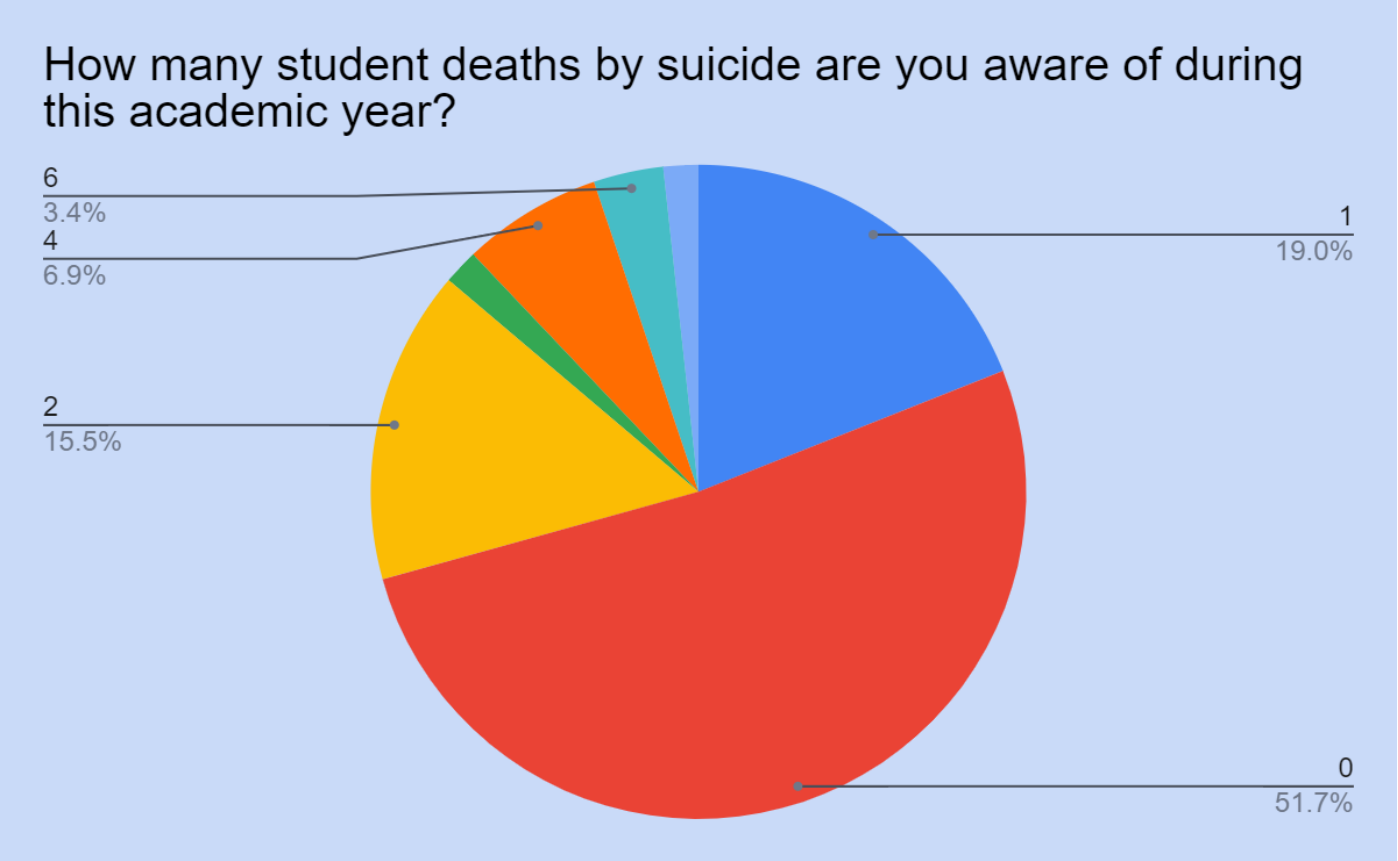
Survey - Suicide

Record keeping

From anecdotal discussions with members, we were aware that student deaths are not currently well-documented, or reported, and that information from coroners' reports is often not filtered down to practitioner level.

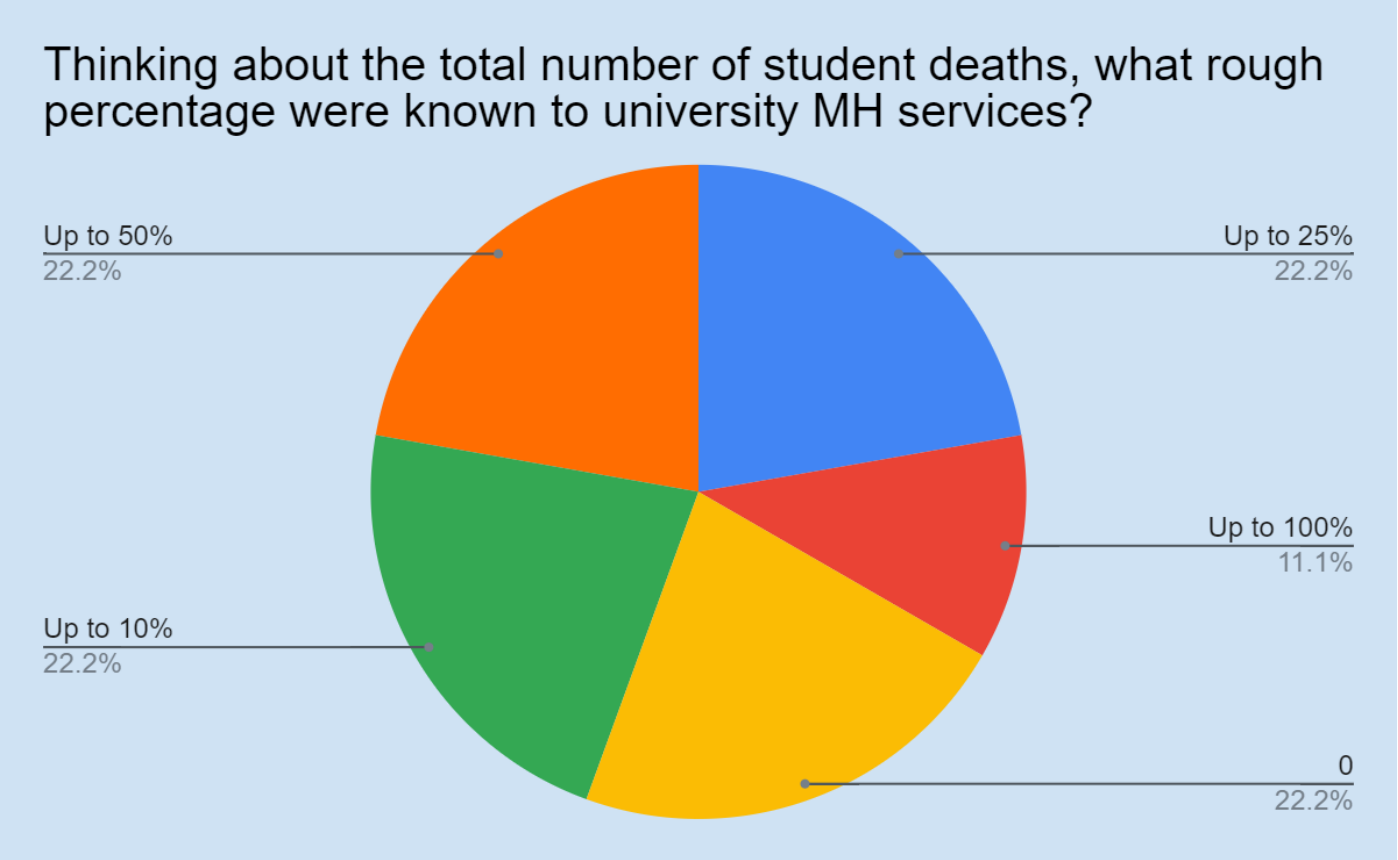


Survey - Suicide



Responses have not been disaggregated by university, so multiple responses may be from the same institution. We are also aware that some practitioners are not informed about student deaths, or the cause of death.

Survey - Suicide



"I am aware when this happens, but I do not keep a tally. I know that it is very rare for students to complete suicide who have had contact with our service. We have a mental health team who are much more involved with each faculty in managing the risk of suicide to the most vulnerable students." Counsellor.

Survey - Final thoughts

We asked members for any additional thoughts on the subjects of information sharing and student suicide.

“At best, information sharing creates a support network that will help someone to live long enough to see the other end of what oppresses them.” Counsellor.

“I think there is a risk that organisational, professional and personal attitudes towards information sharing can become subject to our own inability to manage the anxiety when faced with someone in crisis. I feel we must guard the space that allows us to ask: "Is this in the best interest of the client? What am I hoping to gain from this action?” Counsellor.

“HE is in danger of following the trend of medicalising all distress. University counselling services are best placed to work with students who are not seriously mentally ill but who are experiencing suicidal thoughts/intent. We need sanctuaries where students can take time out. Safe spaces where they can talk about how they feel. We are increasingly pushed into incredibly short term interventions and for a suicidal person and their counsellor this is challenging. Suicidal feelings are often an attempt to react to a seemingly impossible situation - students need help to be able to think about their situation and what they are feeling rather than being left to act on their feelings.” Counsellor.

This comment highlights how the language of “Zero Suicide” initiatives may lead to a blame culture rather than one supportive of postvention and good governance. Instead we believe universities should adopt Papyrus’ statement ““We believe that many young suicides can be prevented". Counsellor.

Discussion

As the survey was anonymous we do not have information regarding which organisations or nations responses were from; however, the discussion and recommendations are based on legislation in England and Wales. Some of this paper will still be relevant to colleagues across Scotland and Ireland however we recommend further work to ensure recommendations are relevant for all 4 nations.

Policy and procedure

A review of current examples of university information sharing policies shows they rarely indicate that the student's permission will be sought at the time of disclosure, or that the specific circumstances of the disclosure will be discussed with them. Additionally, some policies are framed in terms of safeguarding, automatically classifying any student with a long term mental health condition as in the "at risk" category. This is contrary to best practice, as demonstrated by our members, and as described by the NHS and other regulatory bodies.

"I have known some students with "severe and enduring mental health conditions" that have been able to manage their symptoms, and recognise triggers… and have good safety plan adherence etc., yet, could easily fall into the "adult at risk" category. Conversely, those who may have mild symptoms of anxiety, but who lack insight or the ability to regulate their emotion would not fit the category, but could be high risk due to impulsivity."

Some university policies refer to the Information sharing and suicide prevention: consensus statement by the Department of Health and Social Care which is considered best practice. This statement sets out duties to assess mental capacity, with guidance that "Consent and confidentiality should be part of the core narrative with service users throughout the course of their treatment and support." (5) However, some existing university policies, including those with an "opt in" model, state that it is a student's duty to keep information up to date on a central system, with a presumption that this is so. This shows very little understanding of the nature and impact of many common mental health conditions, and again, is contrary to best practice.

Although our members may have extensive experience of all areas of mental health service development and delivery, due to extremely high caseloads many are prevented from full involvement with this at university level. This means that in many cases, universities have made decisions about provision without fully understanding the extent of what is already being provided or is needed, and by staff without any expertise in mental health. Every effort should be made to enable the specialist staff already employed by universities to have better control over their workload, to enable them to participate in development work.

We recognise that external consultants may need to be employed, and they should be experts in the field - this might include individuals who have recently left a role in student mental health, or professional bodies and statutory services.

Discussion

Existing guidance and expertise

Our members are Mental Health Practitioners with in-depth training and registration with professional bodies where both are bound by well-developed principles and guidance around confidentiality and disclosure. By comparison, universities' understanding of these principles is in its infancy. This includes knowledge of the legal context, such as GDPR and the Mental Capacity Act 2005 (MCA).

Recent discussion around student deaths and information sharing has hinted at treating students differently than other adults. We believe that universities should abide by key principles already established by the NHS and other statutory services for over 18s. As adults, a lack of mental capacity as defined in the MCA should be the only time when this decision is taken for someone else.

Legal services and "authorisers"

Where decisions are made to break confidentiality without a mental health capacity assessment, and where there is no "vital interest" we question whether university legal services and other "authorisers" are appropriately trained and experienced to be able to advise in cases of disclosing information in the public interest. (16.25 Mental Capacity Act). This is especially when different staff practitioners are regulated and registered by different professional bodies, and are therefore bound by different regulatory conduct frameworks - there may be far reaching implications.

"After breaking confidentiality as requested by senior management due to the student being unaccounted for and at risk of suicide, the student subsequently raised a breach of confidentiality with the NMC. I had to provide statements, as did my employer regarding this. This led to increased stress and time spent completing paperwork/ awaiting outcome of NMC decision." Mental Health Advisor.

Recognising the importance of existing provision

We believe that the continuing work of mental health practitioners in universities should be recognised as having a positive impact on suicide rates in the student population, which are lower than the national average. (6) A recent report by Shout also showed lower than average suicidal ideation among service users identified as students (7). To our knowledge, there are no studies which investigate this link, or the work of the wider mental health teams within universities and due to the lack of consistent data collection and reporting there is sadly no immediate prospect of this being possible. We do know that between 17-41% of students who died by suicide were known by psychiatric services (3, 6) and we believe the focus should be on the accessibility of NHS services to those who are at highest risk. This should be highlighted to and considered by Clinical Commissioning Groups/Integrated Care Systems.

Both self-harm and previous attempts at suicide are known to be risk factors for suicide (8) Counselling and Mental Health Services deliver a range of specialist interventions around self-harm both to individuals and groups. Alongside accommodation services and Specialist Mental Health Mentors, they are also the staff most likely to have contact with students who have recently made a suicide attempt.

It should be acknowledged however, that caseloads are high and becoming increasingly more complex leading to practitioner "burn-out"; data from the US (9) further underlines that from a UMHAN member survey (10).

Discussion

Sharing information with parents or family members

We're concerned about the increasing use of opt-in consent schemes, where students are asked to make this choice at registration before even starting their course, and without a thorough understanding of the implications of "ticking the box". Although such policies may mean that in certain circumstances emergency contacts are able to offer and provide support to students who are struggling, this sort of information sharing without any additional discussion with the student should only be undertaken in the most extreme circumstances.

Trained mental health practitioners should always seek to encourage students to talk about and share information about their mental health appropriately, however it should be acknowledged that in many instances and for a complex variety of reasons, students may choose not to share this information with parents, family and carers. Students may nominate a next of kin who is not a parent or family member. Importantly, practitioners may well work with a student to improve their relationship with parents or family members, with the result being they feel happier to discuss their mental health with them.

Importantly, even in the most supportive households, parents and family may be ill-equipped or resourced to support seriously unwell young adults, and may well themselves feel under immense pressure to be able to respond appropriately.

A recent survey of students at University of Bristol (11) found that, *"mature students, students from a black, Asian or minority ethnic background and international students were significantly less likely to opt in. Students who reported higher levels of anxiety and depression symptoms were also less likely to opt in". This would suggest that more consideration needs to be given to supporting and working with these groups. Particularly as anxiety and depression are a key part of suicidal ideation and behaviour.*

We believe that decisions to share information about any adult to a 3rd party should be made with an informed discussion at the time, unless their lack of mental capacity has been assessed by a trained professional. A University may employ only a limited number, or no appropriately trained professionals. This is in line with current legislation and guidance by statutory bodies.

We are aware that some agency staff are forbidden from liaising directly with university staff, instead raising any concerns with their employer.

The following comments sum up the thoughts of some of our members:

"Students may legally be adults but they are still young and inexperienced people and this has to be factored in." Counsellor.

Discussion

"I do not think there is a need for an opt-in for system regarding contact with parents, as has been adopted e.g. by Bristol University, for the following reasons:-

- It is not necessary because we already have a system whereby in an emergency situation managers can take a decision to contact parents or obtain explicit consent to do so from a student as/when needed.

- There is confusion over what constitutes an emergency requiring the disclosure of information, with some institutions saying such a situation must be "life or death", while others say there must be simply a "threat" to wellbeing. Similarly that confusion will exist between individuals within an institution (and I have already see this happen in my own institution, with some senior managers being incredibly risk-averse, whilst others will prioritise student confidentiality unless they deem parental contact an absolute must).

- Our students are all over 18 and we should be treating them as adults and encouraging them to live as independent adults. This approach is potentially infantilising.

- Students could be coerced into signing an opt-in consent by their parents and it may not be what they really want. Or they may sign it without fully considering the repercussions. Or they may change their mind or have forgotten they ever signed it.

- I think it presumes that all students come from families where the parents are supportive and well - meaning. This is not the case, and in fact many of the students we deal with in Wellbeing come from toxic family backgrounds which have been contributory to poor mental health (and even sometimes the main cause of)." Mental Health Advisor.

"My concern is that students will agree before starting university that their next of kin (NOK) can be contacted, either because we never think we will be in crisis or because a parent is leaning over them. I wonder if students wouldn't talk openly to a counsellor for fear of NOK being contacted. My understanding is that they have the right to change their mind, so in a crisis can withdraw consent and that we have to ask again before phoning a NOK - so I'm not sure why we would insist on signatures at the beginning of the university career." Counsellor.

"Asking an emergency contact to intervene can have a limited or short-term effect only. Many parents (inappropriately) want the university to take over the care of their children and want/need respite from them. Other parents have poor relationships with their children or limited influence, or are unable to get help from the NHS themselves for their children. We should always consider contacting them and should always contact them when the circumstances are appropriate, but we need to manage our expectations." Head of Wellbeing.

Recommendations

Clear information sharing principles

As well as clear guidance and protocols for staff, Universities need to develop carefully thought out principles about how much information is shared if anything is disclosed. These should be based on the Caldicott Principles “Share the minimum necessary to provide safe care or satisfy other purposes.” (12) This may mean that parents and family may not be satisfied with the amount of information shared, and so staff should be supported and trained to be able to adequately respond to further queries.

As information sharing is often a two way process, it should also be clear how third parties can provide information to the university. This will include concerns from parents, relatives, friends, support workers and agencies about individual students.

Decision-making

Currently there are non-clinically trained staff in senior management who are making decisions about sharing sensitive mental health information. Wherever possible, these decisions should be made by the most senior clinically-trained member of staff, with support from senior management and legal services as required. This should never be the responsibility of one person. Some institutions already employ specialist social workers who are trained to assess capacity and they should be involved in this process.

It should be acknowledged that whoever makes the decision to disclose information about a student, this can be a stressful situation, and they may need debriefing and further support. Clinical supervision is key to support staff working in this complex area and is often used to support decision-making. Staff should be appropriately remunerated for this responsibility.

Some institutions employ a sole Mental Health Practitioner, or even outsource all of this specialist support. In these instances, consideration should be given to alternative arrangements - perhaps partnerships with local NHS and statutory services could help to provide decision-making input at such times?
All decision-making should be well documented, including evidence of any discussions and advice taken.

The following principles from the Mental Capacity Act 2005 should be adopted universally:

- assume a person has the capacity to make a decision themselves, unless it's proved otherwise
- wherever possible, help people to make their own decisions
- do not treat a person as lacking the capacity to make a decision just because they make an unwise decision
- if you make a decision for someone who does not have capacity, it must be in their best interests

Recommendations

Working with the NHS - clarifying boundaries and establishing processes

Recent studies have found that between 16 and 41 per cent of the students that died by suicide had contact with the NHS for reasons of mental health at some point in their lifetime, though this contact was not always recent (3, 6). The focus of efforts in this area should be on appropriate information sharing with the NHS to ensure a joined up approach.

We also encourage representation from Higher Education Institutions at their local/regional multi-agency suicide prevention group.

Clarity is urgently needed around the role boundaries and responsibilities of university teams, to avoid situations such as students being discharged inappropriately to university services.

Data collection and case management systems

In a recent UMHAN meeting a member described the system at their institution - they highlighted how unlike working in the NHS, there is no way of flagging issues around consent to share and in fact practitioners have to search back through individual case notes to find out whether a student has already provided consent or indeed been explicit about who not to share information with.

Case management systems should urgently be reviewed to ensure they are fit for purpose. Such an important and high profile area requires consistent data collection, reporting and review, to ensure student safety, good mental health service governance and provide a robust evidence base as to what works (13).

- Work by the Student Counselling Outcomes Research and Evaluation (SCORE) consortium should be supported to develop measures appropriate to a multi-disciplinary Mental Health Service team

Mental Health Service Team Governance

Governance structures and processes should be formulated to include and support both clinical and non-clinical teams who support student mental health within Higher Education.

- A working group of UMHAN members from a range of clinical backgrounds is currently drafting guidelines to be shared with the sector

Common Codes of Practice across the sector

Common Codes of Practice should be drawn up with expert legal input, so that smaller providers are protected. This also means that all students have trust that their best interests are being considered, and they are clear on their rights to confidentiality. The Common Codes of Practice might include risk management and data collection.

Recommendations

CPD for staff

All university staff should receive mental health awareness training tailored to the university setting and with reference to their institution's policies and processes. This is particularly important for non-clinical managers responsible for mental health risk and safety. Clinically trained staff should receive up to date training on suicide prevention/intervention/postvention at least every 3 years.

Further research into the effectiveness of existing provision

As mentioned in the discussion points above, current statistics would indicate that university mental health teams have a positive impact on student suicide rates and this should be a priority area for research.

- We welcome the announcement from the Office for Students about funding for research into "what works" in student mental health but without tackling fundamental data collection issues first we feel this project will have limited success

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NHS Confidentiality Code of Practice

Case Studies

Cardiff University

Cardiff University recognises that it is the responsibility of the institution as a whole to promote positive mental health as part of its duty of care and dedication to good practice. Suicide is one of the most serious issues it may face. Attempts to maximise suicide safety can be seen as both a professional and a moral responsibility, and efforts must be comprehensive and engender a whole-University approach.

The purpose of our Suicide Safer Policy is to provide a single, joined-up strategy which reflects best practice and aligns to the guidelines laid out by the Universities UK Suicide Safer Universities framework (2018), and which supports the objectives of the Welsh Government's Talk to me 2 strategy (2015-20) and the Cardiff and Vale of Glamorgan Suicide and Self Harm Prevention Strategy (2021-24). This Policy will also feed into a wider whole-University Approach to Mental Health strategy being developed in accordance with the Universities UK #StepChange framework (2020).
Whilst the primary focus of this Policy is the Cardiff University Student & Staff Community, the value of engaging with the wider community as part of collaborative efforts to create a Suicide-Safer Society for all, is strongly recognised and supported.
To deliver and achieve the purpose, this Policy identifies four key strategic objectives: *'Prevention'; 'Intervention'; 'Postvention'; and 'Review'.*

Prevention
The Prevention arm of the Suicide Safer Strategy aims to increase awareness, understanding and compassion within the University community and beyond, and to reduce the stigma associated with talking about suicide. It aims to rigorously publicise the various support available, and to catch people before they reach the point of potentially planning or attempting suicide - as well as to reduce access to means, materials and opportunities for carrying out suicide attempts.

'Prevention' also aims to equip all members of the University Community with the knowledge and skills to support another person who may be at risk of suicide - engendering confidence through training, and the ability to engage with and link a person at risk to appropriate, timely support.

Intervention
'Intervention' aims to recognise and act on warning signs and vulnerabilities, to develop and implement clear support pathways for distressed students and to establish collaborative local care pathways into statutory mental health services and NHS crisis intervention teams for students at potential risk of suicide.

The 'Student Intervention Team' (SIT) is a dedicated team with explicit responsibility and the professional capability to intervene in crisis situations. SIT officers are able to provide preliminary assessments for students in distress to determine the urgency of their need for support/treatment and the nature of

treatment required, and to facilitate the most appropriate onward support. Team members also carry out risk assessments on an ongoing basis and can provide stabilisation support as needed.

When the SIT officer meets a student, they will review protective factors which includes an exploration of students support network / next of kin, and if the student wishes us to call that person (assuming they have capacity, and helping them to make their own decision). This discussion takes into consideration the mental health capacity act, we would only every break confidentiality if the student doesn't appear to have capacity and breaking confidentiality is deemed to be in their best interests. This would then be very carefully documented.

Postvention

The immediate aftermath of a suspected suicide can be stressful, confusing and highly emotive. Critically, death by suicide can increase the risk of suicide among others and, therefore, requires a rapid and nuanced response.

The Postvention arm of the strategy aims to ensure that there is a plan in place, agreed templates for communications and a nominated lead to facilitate an effective, appropriate, sensitive and timely response in the tragic event of a suicide or suspected suicide.

Review

The Review arm of our strategy uses data collected on student suicides and suspected suicides based upon the involvement of the University's Student Health and Wellbeing Service.

Case Studies

UMO

UMO safeguarding

Safeguarding is a foundational pillar of the UMO mode of specialist mentoring. For over a decade UMO has refined, improved and evaluated its safeguarding protocols and information-sharing to ensure best practice when working in the role of specialist mental health mentor or ASC mentor supporting students in HEIs.

Typically, students referred for Specialist Mental Health Mentoring have a diagnosed mental health condition, and whilst working to the social model, we recognise that some students may present with significant risk; it is paramount that our safeguarding procedures are rigorous whilst allowing our mentoring work to be effective and supportive.

The UMO safeguarding team regularly review and assimilate the work of sector-wide bodies and initiatives such as ***Suicide-safe universities (Universities UK/Papyrus), Step Change (Universities UK), and the University Mental Health Charter (Student Minds)*** *to embed recommendations into UMO protocols.*

Our safeguarding work follows four strands:

Joined-up working - partnering with HEIs

Our clinicians have close contact with the Mental Health Advisor or Disability Advisor at the HEI, ensuring dialogue with the Disability/Wellbeing Department regarding any student identified or presenting as at risk. Clear and open channels of communication are critical in a two-way flow of information about the student; we are informed if we are being sent a referral for a student potentially more at risk or who is known to be struggling, in turn we are able to provide post-session updates, if necessary. Such open dialogue is done with transparency and care and with the consent and full involvement of the student.

As part of the UMO onboarding process, when working with a new HEI, safeguarding protocols, guidance and information sharing, including emergency contacts, is a key component before referrals can commence.

2) Our initial registration and assessment forms help our clinicians ascertain up to date details about the student including current mental health, relevant medication, care plans and support network (e.g. psychiatrist, Community Mental Health Team), specific triggers or signs of declining mental health.

3) UMO employs a permanent member of staff whose duty is to respond to safeguarding issues, in collaboration with the designated specialist mentor, when they are identified. The safeguarding officer is a source of direct advice and guidance to the specialist mentor, informing the mental health/disability

advisor at the HEI at the same time, to ensure transparency and continuity of care. In addition, our safeguarding lead provides professional support to specialist mentors.

4) For supervision purposes (a compulsory mechanism for ensuring standards), UMO commissions external highly qualified and experienced mental health practitioners (e.g. former consultant psychiatrists, former heads of mental health service,) who understand the nature of our work and the complexity of how students with mental health conditions present. They provide a regular safe space for our staff to discuss and talk about risk assessment and safeguarding issues; this is a core component of refining and driving best practice.

A core value for UMO is to always strive for processes and frameworks that are as thorough as they can be, student-focussed, joined-up with the HEIs and supportive of our staff so they can effectively raise and tackle concerns wherever and whenever risk is identified. As a result, safeguarding runs through our organizational structure, from recruitment through to service delivery and impacts everything we do for our client organizations, the students themselves and our staff.

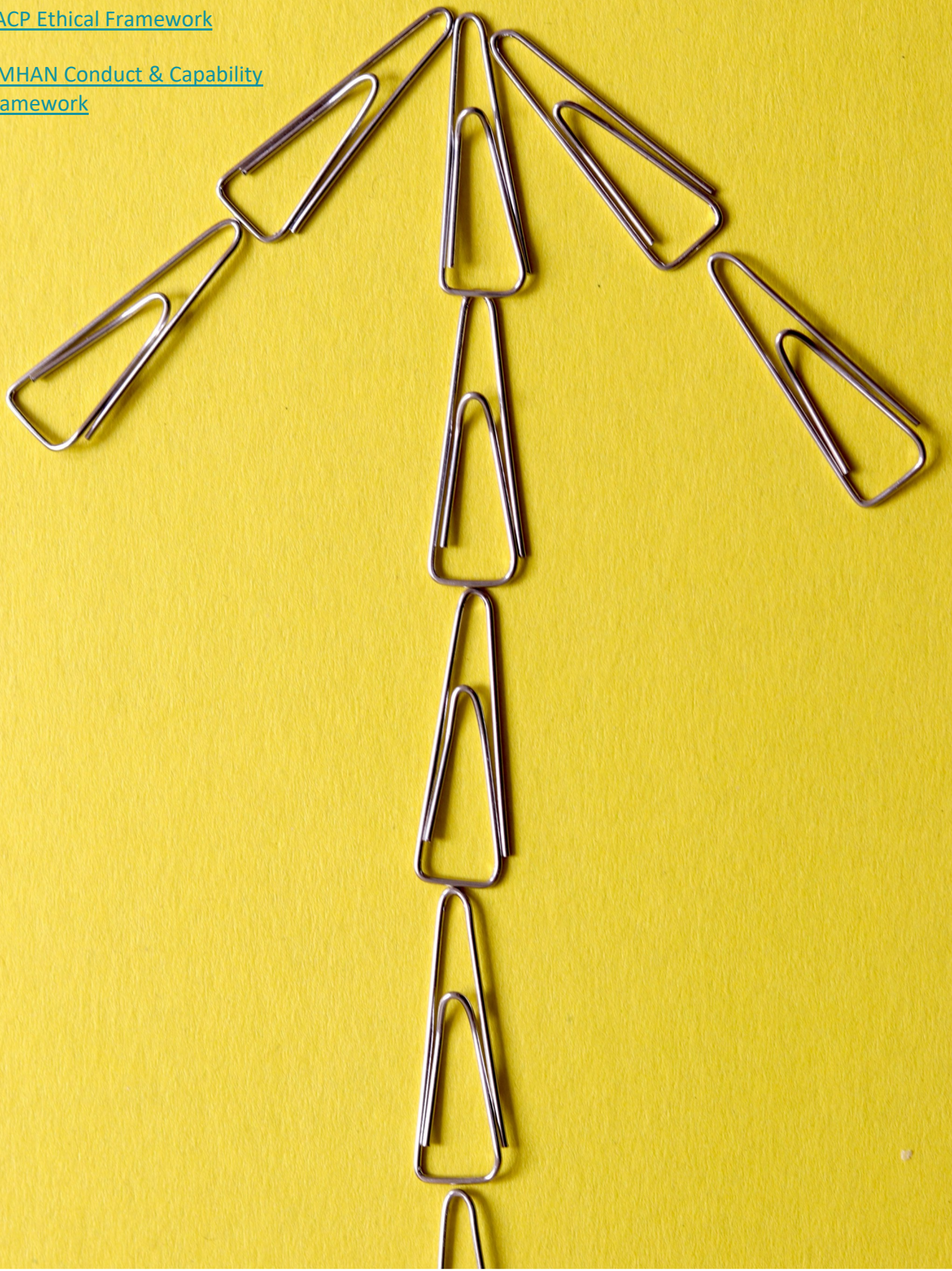
Professional body guidance

Social Work Professional Standards Guidance

Health Care and Professions Council Guidance on Confidentiality

BACP Ethical Framework

UMHAN Conduct & Capability Framework



Further information

About University Mental Health Support

There are many different models of specialist mental health support at universities, with varied structures. Job titles and descriptions also vary. At larger universities, this will often include:

- Counsellors
- Mental Health Advisers
- Wellbeing Advisers
- Specialist Mental Health Mentors
- Disability Advisers (who may have with a speciality in mental health)

In smaller institutions it may be that all mental health support is outsourced, or there is a sole practitioner who covers a variety of functions. You can read more about the types of support available on the UMHAN website.

About University Counselling Services

Many universities have had in-house counselling services for some time, this began with Leicester in the 1950's and then Keele in the 1960's. In the last fifteen years increasingly the pressure on services around waiting times and the complexity of presenting problems within student communities has seen the 'model' of student counselling evolve. Indeed Mair (2015) suggests that practitioners have created a short term model specifically adapted for Higher Education. Increasingly institutes are outsourcing provision to either complement or provide in-house, and embedded, services.

Teams are often diverse in modality with Cognitive Behavioural Therapy, Psychodynamic and Humanistic (Person Centred and Integrative) being the most common. Practitioners are usually accredited by BACP (British Association for Counselling and Psychotherapy), BABCP (British Association for Behavioural and Cognitive Psychotherapy) and UKCP (United Kingdom Council for Psychotherapy).

Mair, D. (2015) Short Term Counselling in Higher Education. Routledge, Abingdon, Oxon.

About Mental Health Advisers

The role of Mental Health Adviser (MHA) was developed in the early 2000s, after reviews of counselling provision identified increasing levels of complexity and risk. Typically, a MHA will be able to coordinate support for students with mental health conditions and act as a point of contact for the duration of their studies. They will normally have a professional background such as Psychiatric Nursing, Occupational Health or Social Work and/or extensive experience of supporting people with long-term mental health conditions.

Further information

Mental Health Advisers may work alongside the disability services or counselling services, but their role is very different to a counsellor. The focus of the role is to support students in managing the impact of their mental health condition during their time at University, removing barriers to successful study. This may include, for example, adjustments in the learning and teaching environment, and formal academic assessments so that the specific effects of a student's difficulties can be taken into account (e.g. extra time if a student has concentration or processing difficulties).

MHAs will also often have direct contact with local statutory services and be involved in crisis management and safety planning.

About Specialist Mental Health Mentors

Specialist Mental Health Mentors work to help students achieve their full potential at university while also mitigating the impact their mental health condition might have on them.

Mentors can work with students with a range of mental health conditions, and will help them improve their self-management competences, as well as helping them come to terms with their diagnosis. They can help explore the underlying causes that hinder effective study, such as perfectionism, fear of failure and anxiety.

The Specialist Mental Health Mentor role is normally funded by Disabled Students Allowances (DSAs). You can learn more about DSAs on the Government's website. Some Universities may fund specialist mentoring as an interim measure, while students are going through the DSAs application process, or for students who are not eligible for this funding. The Mental Health Adviser for any University should be able to provide detail on what is offered at their particular institution.

You can read more about the roles of Mental Health Adviser and Specialist Mental Health Mentor on the UMHAN website.

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UMHAN
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