Clinical Governance

for Mental Health Services in Higher Education

UMHAN

University Mental Health Advisers Network

What is Clinical Governance?

Clinical Governance for Mental Health Services in Education is based on the concept of Clinical Governance, introduced into the NHS in the late 1990s. It is a collective term for activities that sustain and improve standards, contributing to the safe and effective delivery of interventions within a setting that is providing support.

In simple terms, it is a form of **quality assurance** for mental health support provision.

Does this apply to services in Higher Education?

Although there is a need to differentiate between the responsibilities of Mental Health Services in universities and those of statutory services, specialist university staff provide interventions and support that would be classed as clinical in any other setting, to a student population who reach clinical thresholds. We have used the term "Mental Health Service" to cover all specialist services/teams/individual staff involved in supporting students with mental health conditions.

Universities will already have other governance protocols in place such as corporate governance. However, this does not normally extend to support services delivered to students.

Why do we need Clinical Governance?

Clinical Governance ensures that Mental Health Services operate safely, minimising potential risks to students and staff. All mental health interventions carry the risk of doing harm rather than good and without the parameters of good governance in place it is possible that individual staff and services deliver interventions that are sub-optimal or even harmful. In addition, the principles of Clinical Governance create a climate of trust and confidence in the service, which is vital to ensure students benefit from interventions offered, and that staff feel supported in their demanding roles.

Scope

What activities does this cover?

In the Higher Education setting, "support" includes initiatives to support or improve mental health. These can include, but are not limited to, therapy-based support (e.g. Counselling, CBT), group sessions on mental health and wellbeing issues, crisis response, safety planning, internal support planning, Specialist Mental Health Mentoring and liaison with statutory services.

The principles of this guidance may also be applied to Further Education.

Who does this cover?

Mental Health Service Governance should cover any staff who interact with students specifically on the topic of their wellbeing or mental health, or who manage these types of service within a Higher Education Provider (HEP). This would include Mental Health Advisers, Counsellors, Specialist Mental Health Mentors, Wellbeing Advisers, CBT Practitioners, Disability Advisers (and others with a mental health-related remit). It also includes activities carried out by regulated professions i.e. professionally qualified staff employed by the university in the above roles such as nurses, occupational therapists, social workers and psychologists.

All elements of mental health provision should be viewed and developed **holistically**, even when teams are managed by separate individuals e.g. Counselling, Mental Health Advisory Service, Disability Service (including Specialist Mental Health Mentoring), Wellbeing provision. This ensures that support for students is cohesive and minimises risk.

Duty of care

The exact level of Duty of Care in Higher Education has long been debated, as there is little student-related case law, however, there are multiple responsibilities and duties which fall under different legislation (Health & Safety at Work Act 1970, Consumer Rights Act 2015, Equality Act 2010) (1).

It is possible that staff with professional registration (e.g. social workers, nurses, OTs, counsellors etc.) would be judged to have further Duty of Care responsibilities towards students than those without (2). These staff are required to follow their professional codes of conduct/ethics to ensure they are adhering to their responsibilities as practitioners and to be regarded as fit to practise. This will include but is not limited to the following areas: confidentiality and record-keeping, informed consent and mental capacity (including information sharing), practising safely and decision-making.

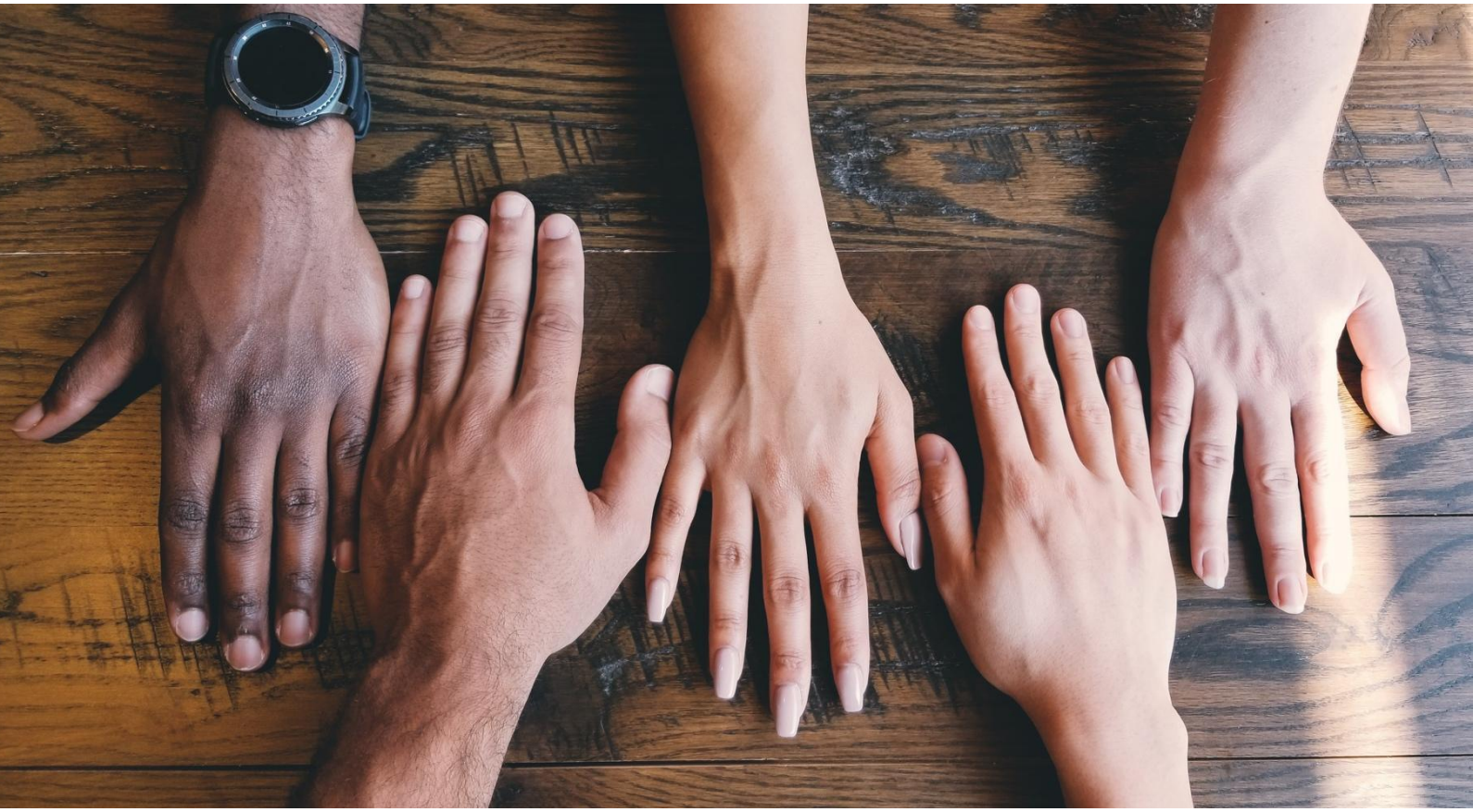
What should be covered in your governance arrangements?

Governance processes can cover a wide range of activities depending on the context in which you are operating, and the extent of the services offered. There is significant heterogeneity in the student wellbeing offer at different HEPs and it is therefore difficult to develop definitive guidance suitable for all contexts. However, we believe that due to the importance of this issue, HEPs should endeavour to cover the key areas highlighted in this document.

How should you consider the issues raised?

Due to the importance of the wide range of issues that need to be considered, and potential for multiple departments to be involved, HEPs should consider creating a specific Clinical Governance committee to ensure that gaps are identified, and appropriate action plans are

created. This might be linked to ongoing University Mental Health Charter or Student Mental Health Action Plan work. Key to the success of any committee will be the involvement of knowledgeable practitioners; this might also include academic staff with experience and interest in this subject area. There should also be a senior management lead with sufficient influence to ensure that action plans are followed and monitored.



Your staff

Assuring the appropriate qualifications, training, supervision and management of the staff delivering mental health and wellbeing services is an important component of your governance arrangements. Appendix 1 provides examples of what might be appropriate in this context.

You may need to consider the core competencies of different professions against the competencies of any role you are recruiting to. For example, if you feel your role requires any form of risk assessment responsibility then you should recruit practitioners who are qualified and trained in this area e.g., Mental Health Nurses, Social Workers, Occupational Therapists. If the role requires therapeutic activity, you may wish to aim recruitment at Counsellors, CBT Therapists, Psychologists.

Culture

The culture of any Mental Health Service should be one of psychological safety, with openness, continual learning and low power distance. As team culture can be deeply ingrained and influenced by individual managers and members of staff, consideration is needed as to how these values are agreed and embedded.

Things to consider include:

- Does the service have a **documented set of values** and expectations? These should guide and link to policies and practices within the service.
- Is **decision making** collaborative and inclusive? Do staff feel able to challenge decisions, in particular where they have concerns about student safety and/or professional practice?
- Are **mistakes** reviewed in a spirit of continual learning and development?
- How is the **wellbeing and mental health of staff** supported within the service and wider university? Tired, emotionally overwhelmed and burnt out staff are significantly more likely to make mistakes, need time off sick and ultimately affects retention. This might include informal and formal opportunities to debrief with team colleagues, interact with peers from external services, and time for reflection and learning, as well as encouraging rest breaks and self-care activities (see supervision and CPD below)

Qualification, experience, supervision and training

- What **qualifications and/or experience** should your staff have and how is that verified? Do you require a specific qualification and which awarding or professional bodies do you accept?
- Do you require your staff to have **professional registration** or professional Membership?
    - How do you enable them to remain registered? E.g., understanding differing CPD and supervision requirements and budgeting for these (see below and Appendix 2)
    - Staff with professional registration may also be subject to different data protection requirements from their professional bodies
- Who is responsible for **background checks** of references, prior disciplinary issues and disclosure and barring service (DBS/Disclosure Scotland PVG) checks?
- How often do you require your staff to have **supervision**? Is this provided for them, or do they have to make their own arrangements? What qualifications should the supervisor have – are there any requirements from the staff member's professional body to maintain their accreditation? Are there arrangements for both management/caseload management and clinical supervision (which tends to cover more personal and practice-based issues, including reflective practice)? How is supervision provided for staff who aren't professionally qualified? If this is different, then what is the justification for this? How is supervision documented? (see UMHAN's supervision guidance for more detail on this subject).
- What are your provisions for or expectations of **continuing professional development** to ensure staff keep their skills up to date? Are there any requirements from the staff member's professional body to maintain their accreditation?
- Frequency and topics of **required training** (mental health specific, first aid, health and safety, safeguarding, risk, fire etc.) (see Appendix 1 for suggested topics)
    - Are all first aiders within the institution adequately trained to respond to medical issues relating to self-harm?

Professional conduct

- Are staff aware of required and **expected professional conduct** in the workplace and more broadly? Are there guidelines issued by their professional body that they should follow?
- What is your process for **identifying and raising concerns** in relation to a member of staff? Whether in relation to their health and wellbeing, their professional conduct or their skill level and effectiveness? Do any existing human resources policies cover your circumstances or are adaptations needed?
- What is your process for handling **complaints** against a member of staff?

Safety of staff

- Do you have a **lone working policy**, which covers all staff working 1:1 with students?
- How do you protect staff against violent, abusive or inappropriate **behaviour** from students?
  - This should be included in any Student Contract
- Do **Fitness to Study** processes allow appropriate weight to mental health practitioners? What happens if a student is allowed to remain on course or to return from an absence against Practitioner advice?

Protection

Insurance

Is **appropriate insurance** in place to cover public liability for any harm students experience that can be attributed to the support they received? Is professional indemnity insurance in place for your staff or do they need to arrange their own insurance? Is the value and nature of the cover appropriate?

- Are you appropriately insured to support **all students, in all locations, including overseas**? The same needs to be considered of students of differing statuses including applicants, those on an interruption of studies, or on placements.
  - More information about providing support for students studying abroad, including legal risks can be found in Support for Students Studying Abroad (AMOSSHE 2020)

The University's existing insurance arrangements for its other business may provide an appropriate level of cover, but an explicit conversation with the insurance office outlining your activities will help to clarify this.

Professional registration and regulation

Are staff adequately protected in terms of their professional registration and regulation? How can staff flag when they have concerns about upholding their **professional standards** and how are they reassured about action taken?

- This might include issues over security of data/notes and information sharing, where Universities deem their information sharing/risk threshold to be lower than statutory services

How might staff be supported if they are investigated by their professional body due to action performed during the course of their university role?

If there is any concern about the conduct of a qualified mental health practitioner these must be referred to the appropriate professional body.

Data and information

The information that you hold about students will often perform a number of functions, from those directly related to delivering support (e.g., contacting students to arrange appointments and documenting details of any assessments or sessions so the appropriate intervention is given), to monitoring service use, to communicating with others about risk or attendance. Accurate data and the ability to create appropriate reports also means that services can assess how accessible their provision is to all members of the student body.

- Are systems able to manage registration/referral information, case notes, outcome measures and other critical information while also flagging key areas such as preferred pronouns, consent to share, safeguarding issues etc?
- Are managers able to create reports to enable them to assess current service provision and to plan for future developments? This might include disability disclosures, demographic data for service users in comparison to the general student population, risk, information about external referrals and to enable benchmarking with comparative services across the sector.

Your governance arrangements should include a thorough **data protection impact assessment**, documenting: the data that you hold about students; your legal basis for having that information; how you store and protect the data; who can access the data and for what purposes. Most universities will have at least one member of staff responsible for compliance under the General Data Protection Regulation (GDPR) and their advice should be sought. However, additional advice may be required from someone with a detailed understanding of the Mental Capacity Act/Mental Health (Scotland) Act. Student privacy notices (as per the GDPR) should include who has access to student records and case notes (e.g., specialist staff, administrators, managers).

Information sharing

In all instances, there should be **clear protocols** on information sharing that include who you share information with (e.g., other parts of the university, GP/NHS professionals, a student's family/trusted contact), for what purpose and how any shared information is protected. This should detail who makes decisions and who shares the information (3).

University information sharing protocols should also refer to the **Mental Capacity Act 2005, Adults with Incapacity (Scotland) Act 2000, Mental Health (Scotland) Act 2003, and Equality Act 2010.** Protocols for practitioners should refer to the Department for Social Care's Consensus Statement on Information Sharing and Suicide Prevention.

> *No single person should be responsible for decisions to share information without a student's consent.*

Many universities have student death protocols, which include clear information sharing guidelines; these may be reviewed and included as part of governance arrangements, and especially to ensure that they are joined up.
Whilst confidentiality is a key cornerstone of trustworthy and effective Mental Health Services, there are also legitimate times when other priorities rise above that of confidentiality, such as actions necessary to mitigate severe risk to a student or another person.

- Who decides if/when to share information with a third party?
- Is it clear to students using your service **when confidentiality might be broken and why**?
- How do you check the identity of those you are sharing information with?
- Are all practitioners clear on their duties under the Equality Act in terms of **disability disclosure**?
- Is it clear to students **what information is NOT shared** with other parts of the university (students often carry a reasonable expectation that university departments communicate and share information with one another and may simply presume this happens)?
- Is it clear to the practitioners in your service what information would trigger **concerns** and how to document this clearly?
- If you outsource or supplement any service provision by using a **third-party provider**, do you have clear written protocols about information sharing, including disability disclosure and escalation of risk? This includes digital and remote support services and partnerships with NHS Services.
- Where students are supported by an external provider without contracted arrangements in place (e.g., funded by Disabled Students' Allowances) do you have clear communication and risk escalation **policies open and accessible to all?**

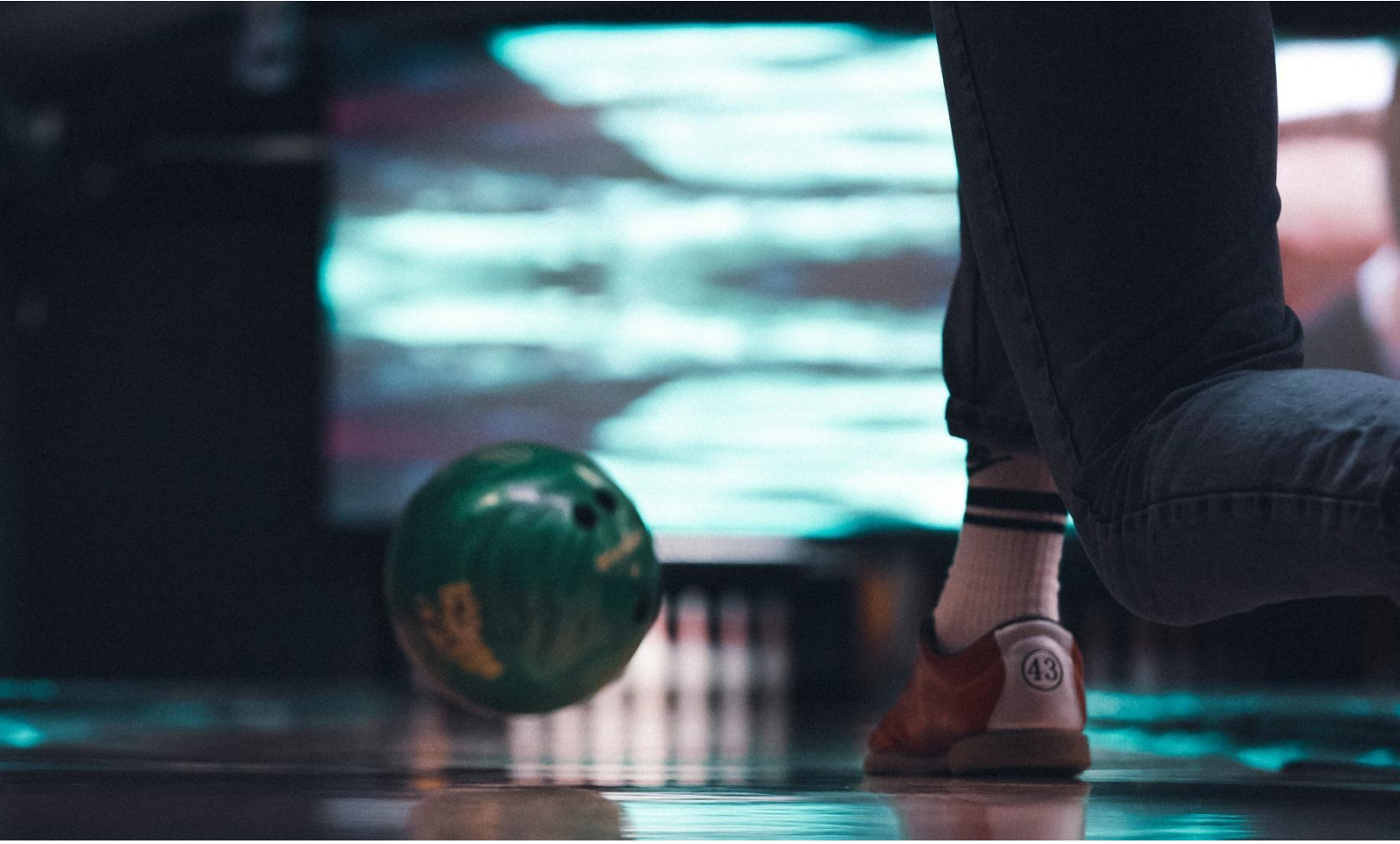
All instances of information sharing should follow the SHARE (4) principles:

- *Seek consent to share information*
- *Have regard to the law, rules and regulations*
- *Always act in the students' best interest*
- *Record all discussions and activities*
- *Ensure service user confidentiality is respected*

Case notes

Clear, accurate and thorough case notes are vital to ensure that student support is consistent, and to provide evidence of what support and interventions have taken place. They are also essential to help managers with decisions about information sharing, to assess risk and to help manage continuity in case of staff absence.

Many practitioners will have **professional registration requirements** with specific detail around keeping notes, including the timeliness and security of the notes. These different backgrounds and training also mean that practitioners may have very different ways of record-keeping. If a standard template is not used then guidance should be given about what information should be included and what is not included (e.g., personal comments, speculation etc.).



It is particularly important to **record decision-making** around referrals (both internal and external), reasonable adjustments, risk assessment and information sharing, both to ensure thorough and sound support for students and that issues of legal compliance are noted.

- Are all staff aware of the **expectations and protocols** around notetaking?
- Are staff provided with enough **protected time** either within or after student appointments and interactions to accurately recall and record notes?
- Are **case recording systems** secure and with appropriate access? Are notes editable and if so, how is this recorded? Who can edit notes?
- Are **case note reviews** regularly undertaken? This should be with regard to how any notes might be accessed and for what purpose, for example by students themselves via a subject access request, or coroners' court.
    - Are notes easily understood by a third party (i.e., line manager)?
    - Reviews can take place in regular line management meetings
    - Case note reviews can also form part of an internal service audit

Service Delivery

Do you have **service protocols** outlining expectations about how the service should be delivered? For example:

- Are there any **required standards** of service provision (for example a response time to emails, waiting time limits, maximum number of sessions offered)?
- Are there policies that are clear to students about **cancellations**? What will happen if they miss appointments without cancelling, or if they frequently cancel appointments? N.B. reference should be made to third party funded/delivered support e.g. Disabled Students Allowances cancellation policy.
- Are there limits over the **frequency** students can access the service?

- Are students clear about their responsibilities e.g. through a **student contract**?
- Are processes flexible and accessible to all Disabled students? How will you agree, provide and fund any reasonable adjustments required?
- Are services accessible to other cohorts of students who may be vulnerable to poor mental health? How are these cohorts identified?
- Do you undertake **Equality Impact Assessments** for all existing practices and new developments?
- Do you need to have processes for monitoring the **fidelity** of service delivery? For example, supervision, team meetings, standardised recording of information that can be audited.
- How do you know **what you are doing is working**? Are there processes for monitoring the effectiveness of interventions? For example, outcomes monitoring with appropriate, standardised measures, satisfaction questionnaires, focus groups or interviews with students who have used the service. How are these analysed? By whom? What expertise do they have to do this? Who receives this analysis? How is it acted upon and how are these actions recorded?
    - How do you measure success? For some students traditional achievement/retention measures may not be appropriate.
    - How would you know if your service became ineffective or adopted harmful practice?
- Managing risk – see section below
- Have you mapped out onward support arrangements for students whose needs cannot be met by your service? Are there **referral processes** in place to transition students between different levels of service both within the university and outside it?
- How is the service **audited**? This could be internal and/or external.

As well as listening to student feedback about the efficacy of the service, the **student voice** should also be at the fore of decisions about service design and delivery, especially in the development of processes and interventions. Co-production best practice guidelines should be followed, including consideration of the emotional impact and potential positive and negative consequences of involvement for students. (5,6,7)

Risk and safety

It is important to recognise that risk taking can have positive as well as negative consequences and can help to enable recovery. University mental health practitioners should empower people to decide the level of risk they are prepared to take with their lifestyle, health and safety. This includes working with the tension between promoting healthy choices, safety and positive risk taking, ensuring that assessment of possible risks has been undertaken by appropriate services, taking into account the particular context-specific issues of Higher Education, and local action taken (See UMHAN's Capability & Conduct Framework).

Recent research around risk assessment suggests that there are multiple factors to consider when assessing risk, including involving family and friends where appropriate:
"There is a growing consensus that risk tools and scales have little place on their own in the prevention of suicide. We suggest clinical risk assessment processes might be improved; by placing the emphasis on clinical judgement and building relationships, and by gathering good information on (i) the current situation, (ii) history of risk, and (iii) social factors to inform a collaboratively-developed management plan." (8)

Recently published NICE Guidelines on **Self-harm: assessment, management and preventing recurrence (9)** are clear about the use of risk assessment and self-harm:

> *1.6.1 Do not use risk assessment tools and scales to predict future suicide or repetition of self-harm*
> *1.6.2 Do not use risk assessment tools and scales to determine who should and should not be offered treatment or who should be discharged.*

Students can present to Mental Health Services with a number of risks. For example:

- **risk to self** - self-harm, suicide, psychosis, financial, homelessness, additional vulnerabilities
- **risk to others** – e.g., threats of violence or terrorism
- **risk from others** – forced marriage, sexual assault, sex work, financial abuse

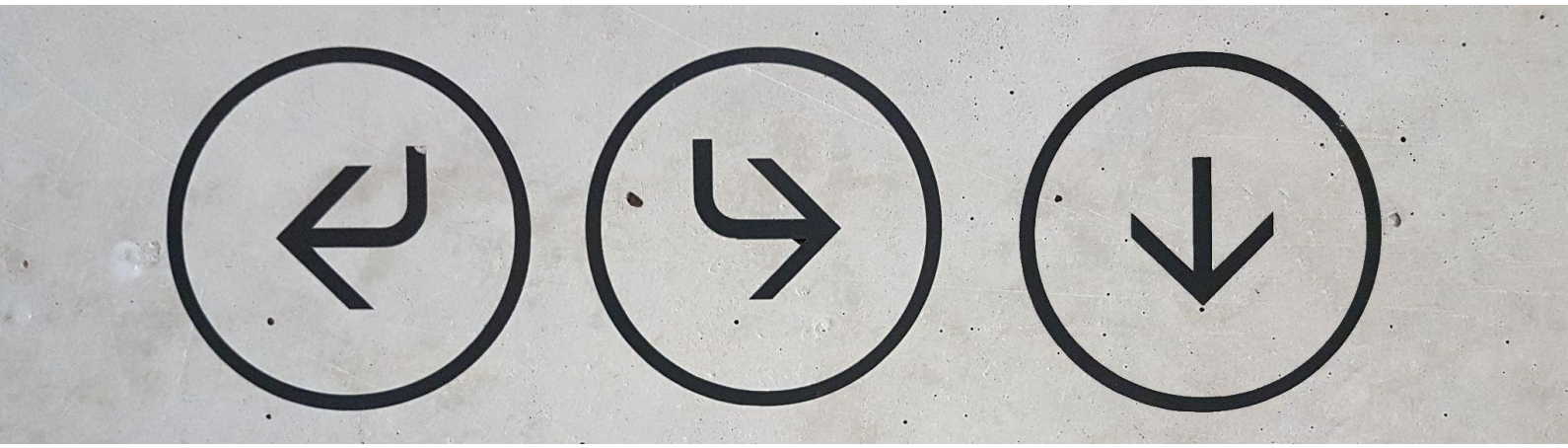
Additionally, in the context of education, students may be at **risk of dropping out or non-completion of studies** for a number of reasons related to their mental health, but which might also include onerous or inflexible university processes. It is important to recognise that there are likely to be instances where the university can mitigate against these risks, for example, by making reasonable adjustments, reviewing student facing processes and undertaking Equality Impact assessments.

In terms of Mental Health Service Governance, it is important to cover:

- The provision and updating of **training** to staff in awareness of factors indicating risk, how to have conversations with students about risk and safety, areas to cover in a risk assessment, actions following from any such assessment (including safety planning), and correct and timely documenting of the assessment.
  - **Safety planning** should be used and reviewed routinely rather than as a response to heightened risk.
- Risk assessment and outcome measures should be **robust and standardised** as much as possible (see Appendix 3). However, they should not be used as the sole indicator of heightened risk.
- Services should set up **review schedules** for students who are identified as being at heightened risk - this may include weekly case review meetings.
- The process for **following-up** with students identified to be at risk. What happens if a student who is identified as being at risk does not respond? How many times is this followed up and by what methods? What happens if they do not respond at all?
- The **level of risk** that can be managed at the university versus that which requires the involvement of external agencies (such as crisis services, non-medical help suppliers, agencies and digital services)
- **Who to inform** about a risk you have identified and how information about risk is shared (e.g., with trusted contacts, other agencies)
- **Support** available **for staff** dealing with individuals presenting with high risk
- The **process for investigating and learning** from high-risk cases and serious untoward incidents (see Appendix 2 for case study examples)
  - This should include a review of any interfacing processes which may have been accessed by the student

Additionally, there should be reference to **safeguarding** and other interacting frameworks used by the HEP.

> Certain areas of student support services may not require formal risk assessment to be undertaken with individual students, but written protocols should be in place to escalate concerns if risk is identified.



Leadership and decision-making processes

Governance arrangements should cover the **leadership structure** of the HEP/Mental Health Service and clearly set out where responsibility sits for different activities. Many Mental Health Services will sit within a wider, non-clinical directorate, however, the leadership of the service itself should be **appropriately professionally qualified** and have the relevant necessary experience to be responsible for the service.

Senior staff should respect the voices, expertise and experience of clinically trained staff, and defer to this expertise where appropriate. Where clinical risk management groups only contain one clinically trained member of staff, significant and appropriate weight should be given to their professional judgement, although decisions should be made collectively.

Senior staff should have comprehensive and up to date knowledge of clinical governance.

Smaller providers may benefit from joining up with other providers or seeking advice from NHS services for support with decision making.

Regular review

The **frequency of review** of governance arrangements should be set out. This may differ for different areas covered. Informal reviews to ensure documents are kept updated with any legislation etc should be made annually, with review by committee as per standard procedures of the HEP. An audit of quality standards should also be regularly undertaken.

Other considerations

Vital to any good governance are clear and defined communications with other areas of the HEP. For example, this may mean clarifying the **role and boundaries** of teams and individuals for other staff, providing information sharing protocols and clear processes.

Deaths and serious untoward incidents

A student death, or serious untoward incident involving a student with a mental health condition, is likely to have a far-ranging impact on family, friends, trusted contacts and staff, but also may be triggering for others outside of the student's immediate circle. This includes professionally qualified and experienced mental health practitioners. HEPs should provide, offer or direct people to specialist suicide bereavement support. **Compassion** should be the overriding principle.

HEPs should be mindful that NHS Trusts/Health Boards will have their own protocols for reviewing deaths and that there may also be an inquest by Coroner's Service (England/Wales/Northern Ireland) or investigation by Police Scotland. These processes are likely to be happening simultaneously and can be stressful for families and all involved. It's important to note that neither investigating bodies routinely disclose their findings to universities.

Research has shown that students who take their own lives are normally not known to specialist university services. Additionally, there are a multitude of reasons why Mental Health Service teams may not even be aware of student deaths by suicide. Some of these factors include:

- The deceased student was not known to the team and the university student death protocol does not trigger any further action from them
- The cause of death may be speculative for a period of time until a coroners' inquest and the inquest report is not obtained
- Information about a student death may rely on information being passed on by family and friends

Even if the deceased student is not known to Mental Health Service teams it is important that they are involved in any review process.

Postvention Guidance (10) designed for the sector provides further frameworks for this work as well as information about inquest and investigation processes for sudden deaths by the Coroner's Office or Procurator Fiscal.

Reviewing student deaths by suicide and serious incidents

Student deaths by suicide may already be part of a complex case review process (see Appendix 2). Any reviews should be undertaken within a culture of learning and continuous improvement rather than seeking to apportion blame.

We advocate for a more transparent review process to ensure learning and actions are shared.

The Postvention Guidance referred to above provides more detailed guidance in this area.

It is important to review any student deaths by suicide in the context of the determinants of poor mental health and research into causes of suicide by children and young people, which suggest there are likely to be multiple, cumulative reasons for suicide (11). It is very likely that universities may not be aware of the full extent of any vulnerabilities for a particular individual, especially as students who die by suicide are not normally known to Mental Health Services.

Similarly, reference should be made to issues of disability disclosure and universities' legal obligations under the Equality Act.

Additionally, due to the relatively low numbers of student deaths by suicide it may be useful to analyse data and research into suicides across the general population - information about suicides may be obtained from Public Health England, Public Health Wales, Public Health Scotland, Northern Ireland Statistics and Research Agency and the National Confidential Inquiry into Suicide and Safety in Mental Health

> *It may be worth contacting your local Public Health Team to see if there is a local/regional strategic group that you could become a member of, to have a coordinated local approach to suicide prevention, intervention, and postvention. Such groups exist in most parts of England (and other parts of the UK) that take a multiagency approach to suicide prevention.*

Some universities have critical incident teams involving senior management, security, accommodation etc and it may be useful for Mental Health Services to provide anonymous data to these teams on hospitalisations and serious self-harm incidents for discussion and development of suicide prevention plans. However, in many instances this data will not be easily collated due to issues with case recording systems and reporting.

About this document

This document has been adapted by kind permission of the author from "Demystifying Clinical Governance for Student Wellbeing Services" written by Dr Lucy Robinson, University of Newcastle.

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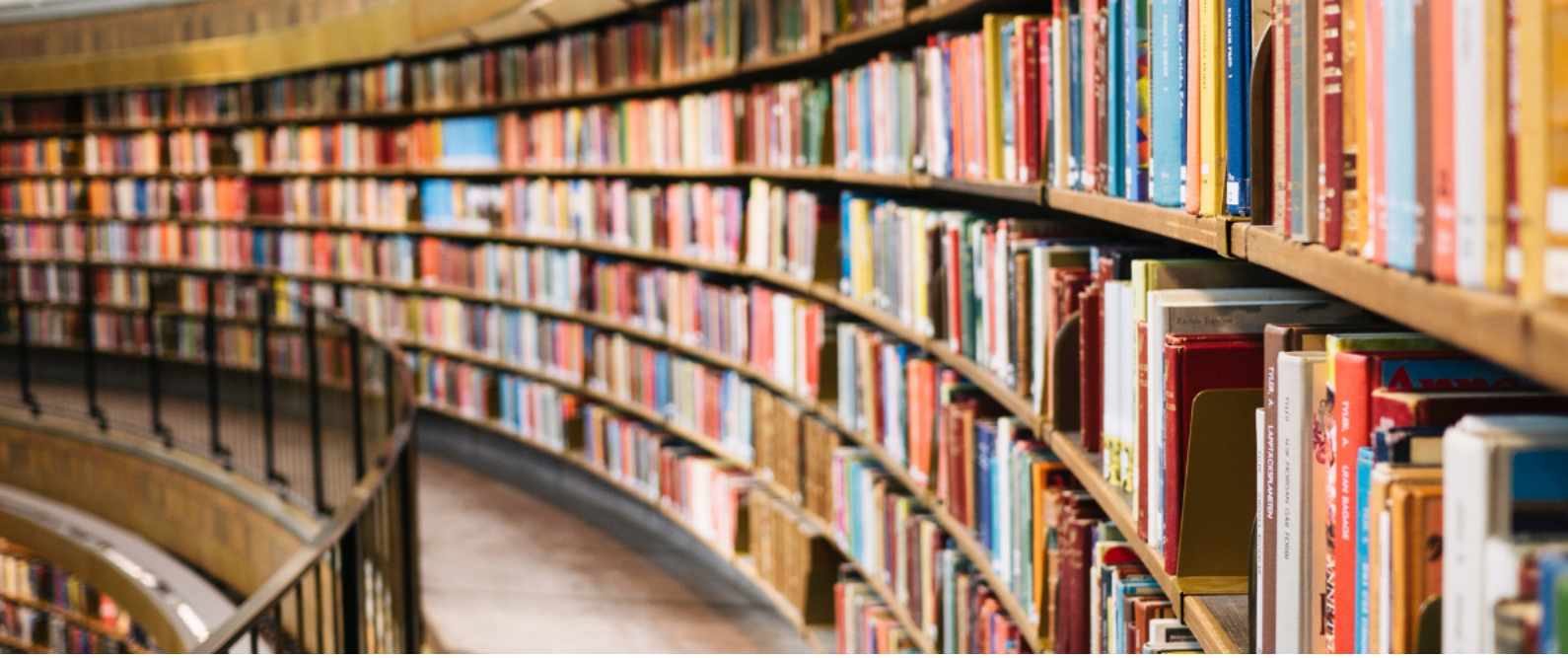
With thanks to Jane Harris (Chair of Heads of University Counselling Services) and Gareth Hughes (Student Minds Charter Content Development Lead and Psychoeducation Lead) for additional feedback on our draft version.



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9 Self-harm: assessment, management and preventing recurrence, *National Institute for Health & Care Excellence, September 2022*

10 Responding to a suicide: advice for universities, *Universities UK, December 2022*

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Appendix 1 - Supporting Staff

Qualifications/experience

The following qualifications and professional registrations are those most commonly held and valued by support services. Mental Health Services are often now multi-disciplinary teams meaning a varied and balanced skill set can be applied to complex situations.
As well as confirming suitable training, additional registration with a professional body indicates that certain professional standards will be upheld, and that skills and knowledge will be kept up to date.

Counsellors

A recognised Degree or Postgraduate Diploma (or equivalent) in Counselling and/or Psychotherapy, including CBT.

- British Association of Counselling & Psychotherapy, Counselling & Psychotherapy in Scotland (COSCA), an accredited counselling course provided by a UK registered body for counselling
- Psychotherapy and Psychological Therapies - PG Dip Psychological Therapies, MA/Diploma Psychotherapy, Other UK Council for Psychotherapy (UKCP) accredited course
    - BPS - Wider Psychological Workforce Register
    - UKCP – National Register
    - British Association for Behavioural and Cognitive Psychotherapies – CBT Register

Counsellors may also be trained as Art Therapists.

Mental Health Advisers

- Nursing – BSc Mental Health Nursing, MSc Mental Health Nursing
  - Nursing & Midwifery Council Nurse member
- Social Work - Certificate of Qualification in Social work (CQSW), MA Diploma in Mental Health Social Work, MA in Social Work, Approved Mental Health Professional (AMHP)
  - Social Work England/Social Care Wales/Scottish Social Services Council
- Occupational Therapy – BSc Occupational Therapy, MSc/PG Dip/PG Cert Occupational Therapy (Pre-Registration)
  - Health & Care Professions Council (HCPC)
- Psychology - BSc Psychology, MSC Psychology, ClinPsyD Clinical Psychology
  - Because of the wide range of fields of psychology study, for courses where there is no clinical element, we recommend that MHAs should have additional work or voluntary experience, or training
  - HCPC – Practitioner Psychologist
  - British Psychological Society (BPS) – Chartered Member, Psychologist Specialising in Psychotherapy,
- Psychotherapy and Psychological Therapies - PG Dip Psychological Therapies, MA/Diploma Psychotherapy, Other UK Council for Psychotherapy (UKCP) accredited course
  - BPS - Wider Psychological Workforce Register
  - UKCP – National Register
  - British Association for Behavioural and Cognitive Psychotherapies – CBT Register

Less frequently, MHAs may be trained in and have experience of Art Therapy, Youth Work, Speech and Language Therapy and more.

The majority of MHAs are eligible for UMHAN's Accredited Practitioner membership which includes adherence to a tailored competence and capability framework, with audits of CPD and Supervision requirements.

Specialist Mental Health Mentors

Specialist Mental Health Mentors must be able to demonstrate that they fulfil the requirements of the current Mandatory Qualifications for the role, as set by the Department of Education.

Providing they meet these qualifications all Specialist Mental Health Mentors are eligible for UMHAN's Accredited Practitioner membership.

Disability Advisers

Disability Advisers come from a variety of backgrounds, with some similarities to MHAs. Some Disability Advisers have a mental health specialism.

- The National Association of Disability Practitioners (NADP) is the professional body for Disability Advisers. Their accreditation scheme aims to provide recognition that agreed professional standards have been met by a practitioner in the development of high-quality policy and provision for disabled students and staff in post-compulsory education.
  - Disability Advisers (Mental Health) are eligible to become Accredited Practitioner or Associate members of UMHAN in addition to NADP.

Training essentials

- **Safeguarding adults/children** (where under 18s are supported) - this should be essential for all mental health practitioners, wellbeing staff and pastoral care staff. Decision-making senior managers should also be expected to understand Safeguarding legislation and best practice with particular reference to information sharing.
- **Record keeping** – with reference to GDPR, the Freedom of Information Act, Mental Capacity Act and professional requirements. All student case records should follow a standard format and language/acronyms where possible.
- **Suicide and self-harm prevention** including safety planning – this should be context specific where possible. For mental health practitioners this should also include regular updates to keep abreast of new research and developments.
    - *Safety planning* – familiarisation with safety planning should be standard for all mental health practitioners, wellbeing staff and pastoral care staff, including academic tutors, and does not necessarily require formal training input.
    - Every Life Matters and Mind Ed have a variety of self-learn courses and clear, concise information on suicide, self-harm prevention and safety planning.
    - *First aid* - nominated first aiders should be confident to attend to self-injury in a non-judgemental manner. This may mean that training packages need to be customised to include this area in more depth.
- **Mental Health First Aid** (MHFA) – to ensure MHFA is most beneficial it should be tailored to the education setting and refer to local policies and processes.
- **Mental Capacity Act (MCA)** - all Mental Health Service staff, and senior leaders involved in decision making and information sharing, should have a thorough understanding of the MCA.
- The Social Care Institute for Excellence has a number of courses including an e-learning course with an overview of the principles of the MCA.

Competence frameworks/Standards of proficiency

These are some of the competence frameworks student mental health practitioners are subject to:

UMHAN - our Capability and Conduct Framework identifies specialist capabilities linked to the education sector
British Association for Counselling & Psychotherapy (BACP)
Counselling & Psychotherapy in Scotland (COSCA)
Health and Care Professions Council (HCPC)
Nursing and Midwifery Council (NMC)
Royal College of Occupational Therapy (RCOT)
Social Work England (SWE)
Social Care Wales (SCW)
Scottish Social Services Council (SSSC)

Supervision

UMHAN - Accredited Practitioner members are subject to supervision requirements which have been benchmarked with equivalent professional guidelines and are an integral part of our membership framework.

We believe that any staff who are involved in the support of students with mental health conditions should receive appropriate supervision, whether they are professionally qualified or not. This not only ensures safe practice, but also provides staff with support for decision making and to protect their own mental health and wellbeing.

UMHAN has produced guidance for line managers which describes the different forms of supervision and the benefits of each.

Members of the following professional membership organisations all have detailed supervision requirements:
British Association for Counselling & Psychotherapy
Royal College of Occupational Therapy
Social Work England
Social Care Wales

Other professional bodies may have supervision requirements which are explicit but not prescriptive in detail.

Appendix 2 - Case Studies

Supervision

University A has a multi-disciplinary mental health service for students providing a range of interventions for students. This includes Mental Health Advisers (MHA), Counsellors and Wellbeing Advisers (not professionally qualified/registered).

The MHAs have a variety of professional backgrounds, including nursing and occupational therapy. All MHAs attend monthly group supervision sessions together, facilitated by one of the Counselling team who has experience in this area. This is a 2-hour session to enable all participants enough time to contribute. Due to revalidation requirements, staff with a nursing background have sought out additional clinical supervision from a former nursing colleague. One of the MHAs with an OT background has also found it useful to have supervision from another OT to be able to discuss how they can use their training and skills in the most effective way given the boundaries of the MHA role.

The Counselling team, who are all experienced practitioners, undertake peer supervision, where they take it in turns to act as supervisor/supervisee (following the BACP peer supervision framework).

A couple of the MHAs and Counselling staff also take it in turns to provide some regular group supervision to the Wellbeing Advisers as well as being available to discuss student issues on an ad hoc basis.

Additional support for students “at risk”

Sheffield Hallam University has a pathway for students who require additional support which is above the usual support model, including for their mental health. The Sheffield Hallam At Risk Pathway (SHARP) includes a weekly multi-professional forum, including staff from different teams across the university. The aim is to create a support plan for students with a variety of needs, which may include specific staff action points or referral to other university processes.

Cases may get escalated to the Cause for Concern forum, which is a fortnightly meeting of more senior staff.

These forums include discussions around information sharing to ensure a shared and accountable decision-making process.

Additionally, students may get referred for Case Management. This is similar to “Care Coordination” within the NHS where a named member of staff is responsible for coordinating an action plan and helping to ensure students can access support from a variety of different services, both internally and externally. Case Managers include staff from different specialist areas within Student Services, including Mental Health and Disability.

Where the Mental Health Service is involved, actions may include a risk assessment, an Occupational Therapy assessment or therapeutic interventions. Case Management is accounted for in staff’s caseload allocation, meaning they are allocated additional time to be able to focus on these cases as required.

Complex case review

This process has been developed by University B as a pilot project.

Complex Case Review (CCR): Process Guidelines

This pilot process was developed to enable staff involved with complex student mental health and disability cases to meet informally and share experiences and learning.
Complex cases are those which involve multiple areas of student support and cause high levels of concern and repeat intervention.
These cases usually include at least one of the following features:

- Repetitive incidents/crises
- Multiple chances given
- Complex needs
- Risk to student
- Risk to peers and staff wellbeing
- Repeated non-engagement with appropriate support
- Course involving multiple academic departments
- Repeated involvement of Police, NHS and parents
- Repetitive misinformation and drawing-in of multiple parties

Ideally cases will only be taken to a CCR when the student has graduated (or been withdrawn) to allow a reasonable passage of time for reflection and learning.

- Any staff member can propose a CCR; these are coordinated by the Mental Health Advisers or Disability Advisers, depending on the needs of the student in question.

- Staff closely involved with the case will be invited by the coordinating Mental Health Adviser/Disability Adviser. These usually include representatives from:
  - Accommodation Services
  - Academic department
  - Disability Support
  - Mental Health Team
  - Any other university area closely involved
- The CCR needs an independent Chair.
- All staff are encouraged to review case notes and attend the CCR with a loose overview of key issues and incidents. It is not necessary for invited staff to pre-submit/collate detailed timelines around the specific case; this is due to the high level of workload involved (these cases usually have a very large number of case records), and because not sharing specific details enables greater wider learning. The process needs to have a clear focus on an individual case to ensure we keep the student and their experience at the forefront of our minds and to avoid our discussion becoming overly theoretical and not relevant to the real world and real cases. However, it is possible to do this productively without requiring attendees to revisit, collate or present detailed case information, thus maintaining a focus on learning outcomes.
- A CCR requires two hours and can be conducted remotely or in-person.
- The Chair takes minutes which are processed and circulated by an agreed party afterwards. Notes are stored separately from student records and the student is not identified in the notes.
- Lessons learned and recommendations are collated at the end of the minutes for future learning and are circulated to relevant departments. All CCR records are held centrally by the Mental Health Team and circulated to a small number of senior Managers.

  The CCR is not an investigation, or a line management intervention. It aims to provide a safe space for involved staff to reflect on management of a complex case, without their own manager present, and without publication of outcomes. Were significant performance issues to arise, the Senior Mental Health Adviser or Disability Adviser would arrange a separate discussion with the involved staff member to consider necessary escalation.

Example minutes

Introduction

The group discussed the case and what features made it suitable for this process.

Lessons from this case

What went well:

- immediacy of response from all parties
- consistency of response
- creation of safe environment in which student was supported
- University gave stability after a very difficult home life
- all involved staff tried very hard to help student
- highly professional response to threats/complaints

- staff reported finding the Mental Health Policy and Fitness to Study Policy protective and supportive, and Mental Health Adviser involvement helpful
- partnership working between accommodation, departments, Disability Support and Mental Health Team to benefit of student

We noted that this case never reached the Fitness to Study process which was, with hindsight, surprising to all involved.

Areas for learning and improvement

This case involved repeat risk incidents: suicide threats, assembly of the means for suicide, attendance at A&E with suicidal ideation. Staff concluded we may have struggled to draw a line and escalate this case at an earlier point, which might have been helpful to both the student and involved staff. Greater clarity and decisiveness are needed re. 'last chances'; sometimes these cases need closure earlier in the process. Those present felt decisions of this kind are sometimes avoided due to fear of complaint/appeal. It was noted anecdotally that we are often reluctant to apply final sanctions where a student has mental health difficulties, but this leniency does not apply in other areas of disability.

This was clearly a complex case from the outset: student had multiple diagnoses, involvement of peers, academic issues (wanting to change course), plus student moved location throughout the academic year. The student's vulnerable home circumstances may have offered a missed opportunity to intervene earlier. Staff queried whether the university should/could ask more formally and consistently about home circumstances prior to arrival to ensure we manage potential risks.

All staff experienced a high level of stress regarding complaints and threat of complaints, including the student going to his local MP/the wider media, and were fearful of consequences. There was a significant impact on involved GSAs. Accommodation Services staff noted support they received was due to positive involvement and attitude of the Residence Manager but raised concern that this is not consistent across accommodation, and other support staff might not have received such interest and support.

We noted the need for very clearly documented responsibility for decisions taken and the need again for a records-management system to ensure comprehensive records in case of complaint or litigation. Note: since the CCR work has begun on procuring a Student Records Management system.
Our discussion again highlighted the need to consider more explicitly the impact of involvement in these 'big cases' on university staff which can often be highly distressing and stressful. Our informal support meeting process more frequently explicitly considers any impact on student peers but does not routinely enquire into the impact on staff wellbeing, partly due to confidentiality; consideration of impact on staff should be made at a staff-only pre-meeting.

Staff training and support: the group noted the ongoing need for mental health training at induction, throughout employment with the university, and tailored to job role. Note: since the CCR a Mental Health Adviser with responsibility for staff training has started in post.

Staff noted the particular difficulties around determining expectations for behaviour where a student has a diagnosis of autism and noted the need for more training and the involvement

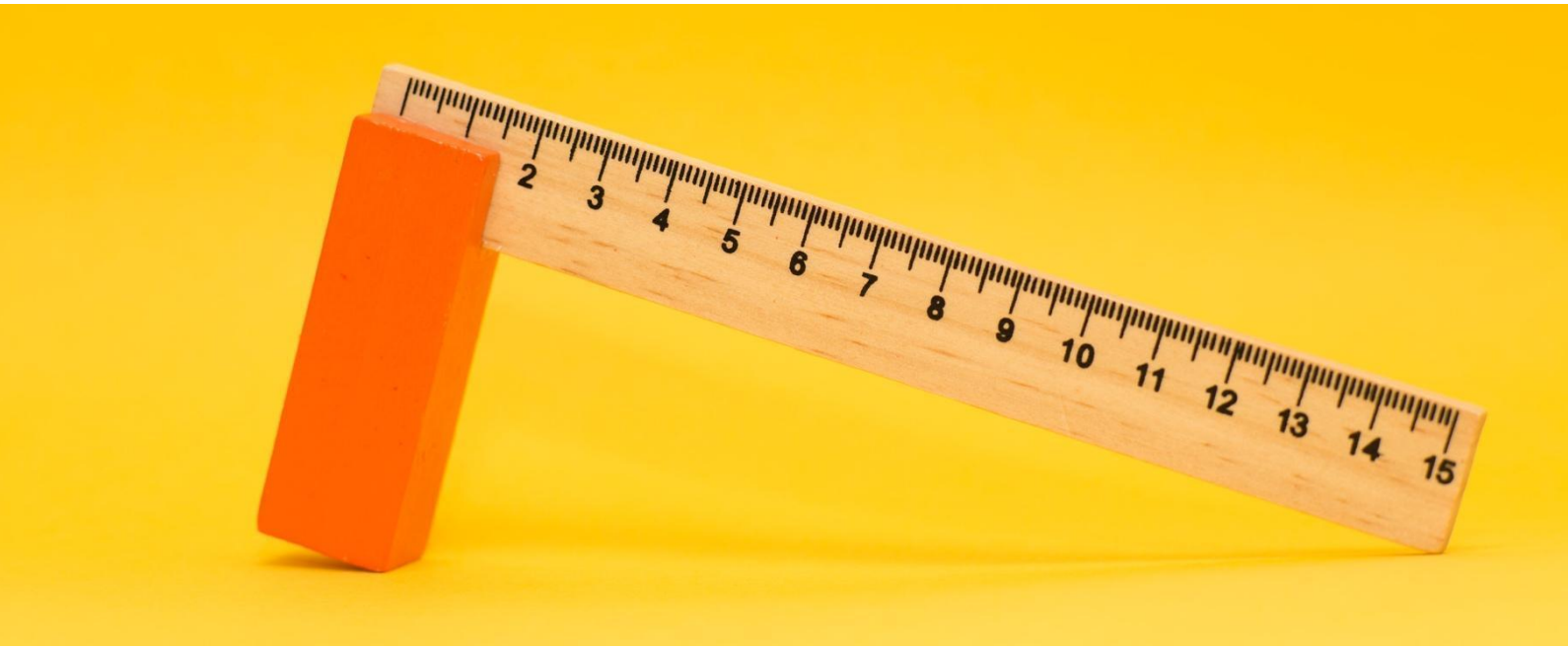
of specialist Disability Support staff to coordinate these cases. Note: since the CCR one Disability Adviser specialising in autism spectrum conditions has been recruited.

Staff identified a need for training to tackle the challenges of interacting/communicating with autistic students; they noted this is not training on autism as a 'condition' but on how to work with those students.

The absence at any point of Fitness to Study proceedings: staff noted cases where crises always rapidly resolve can make it difficult to justify escalation as by the time of scrutiny, the student may present well and agree to support planning. We noted the difficulty University staff have in challenging medical evidence for the context of higher education and accommodation.

Accommodation and Professional Services staff need annually updated information on departmental support staff, names and roles. Departmental staff change particularly frequently i.e., staff in support roles, and boundaries and practice are not consistent. Clarification is needed on departmental support roles ('disability officer' and other job titles) and difficulty identifying responsibility/main contacts for support. In these cases, we need absolute clarity on the lead representative from the academic department/s particularly where students are on combined courses.

All decision-making around complex cases needs to be collaborative, documented and protective of individual staff. Note: it was felt by all to be very helpful for professional and personal development to have a calm reflective space to consider complex cases with the benefit of hindsight.



Appendix 3 - Risk assessment and Outcome measures

The following is a list of some of the risk assessment and outcome measures used by practitioner members of UMHAN. Some services use adapted measures, while others have found it useful to use the common measures used by NHS Mental Health Services, in order to aid referral.

- CORE-OM
- Counselling Impact on Academic Outcomes (CIAO)
- Work and Social Adjustment Scale (WSAS)
- Generalised Anxiety Disorder Assessment (GAD7)
- Patient Health Questionnaire-9 (PHQ9)
- Columbia-Suicide Severity Rating Scale (C-SSRS)
- Counseling Center Assessment of Psychological Symptoms (CCAPS)

The Neurodevelopmental & Disability Team at Newcastle University have created a range of measures adapted for use with Autistic people.

The SCORE consortium is exploring the data that services routinely collect about students who access counselling or mental health teams within the sector.

Appendix 4 - Further reading

- NICE Guidelines on Decision Making and Mental Capacity
- NICE Guidelines on a range of Mental Health and Behavioural Conditions including Eating Disorders, Autism, Psychosis
- NICE Guidelines on Self-harm: assessment, management and preventing recurrence N.B. There is a specific section about assessment in schools and educational settings (1.8.3)
- University Mental Health Charter
- Suicide Safer Universities – developing strategy and examples of Suicide Safer partnerships

Appendix 5 – Checklist

Your staff

Qualification, experience, supervision and training

	Yes	No	Partially met
Staff are suitably qualified for the roles they perform			
Professional staff are supported to maintain and revalidate any registration			
Staff background checks are carried out			
Staff received appropriate supervision for the roles they perform			
Staff receive appropriate training and CPD for the roles they perform			

Professional conduct

	Yes	No	Partially met
All staff are aware of conduct requirements, both internal and external			
Policies and processes are in place for raising concerns about staff			
Policies and processes are in place for raising complaints against staff			

Safety of staff

	Yes	No	Partially met
Lone working policy is in place			
Student behaviour policy is in place			
Fitness to study policies include appropriate practitioner input			

Protection

Insurance

	Yes	No	Partially met
Insurance policies cover all service activity with all students			

Professional registration and regulation

	Yes	No	Partially met
Staff can flag concerns about professional standards in a supportive manner			

Data and information

	Yes	No	Partially met
Systems are able to meet all requirements for safe practice			
Systems allow for appropriate reporting for safe practice and service development			
A data protection impact assessment has recently been undertaken			

Information sharing

	Yes	No	Partially met
The service has clear and accessible information sharing protocols			

Case notes

	Yes	No	Partially met
The service has clear expectations and written protocols for recording case notes			
Staff are given sufficient time to write contemporaneous case notes			
Case notes are adequately reviewed			

Service

	Yes	No	Partially met
There are written protocols for service delivery standards			
Service is accessible to all students			
Equality impact assessments are routinely undertaken			
Fidelity of service delivery is monitored			
Effectiveness of interventions is monitored			
Referral processes are in place			

Risk and safety

	Yes	No	Partially met
Staff are appropriately trained in risk and safety management			
Service has agreed and consistent assessment tools and measures			
There is a clear written process for following up students at risk			
Service has clear thresholds for managing risk and safety			
There are clear written information sharing protocols around risk and safety			
Staff are provided appropriate support which is easily accessible			
There are processes for investigation and learning from serious incidents and complex cases			
All relevant frameworks are integrated and cross-referenced			

Leadership and decision making processes

	Yes	No	Partially met
Leadership structure is documented, with reference to relevant responsibilities			
Leadership is appropriately professionally qualified to manage activities of service			
Senior leaders have a comprehensive and up to date knowledge of clinical governance			

Regular review

	Yes	No	Partially met
Governance documents and activity are reviewed according to a set schedule			

Other considerations

	Yes	No	Partially met
Roles and boundaries of the service and individual staff are clear for external departments			

Deaths and serious untoward incidents

	Yes	No	Partially met
Service has clear postvention policy and processes			