Mental Health Risk Assessments Across Services in Higher Education

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Introduction

This project has been supported by AMOSSHE, the Student Services Organisation under the #amossheis20 Research Awards. It was born out of interest in the various processes that the sector has used to contain and manage risk to students' wellbeing, and recognition that particularly in relation to mental health this task has grown more complex and urgent over the years.

Such a project can become a vast undertaking. Keeping to the reality of the funding timetable gave some natural restrictions and this might best be seen as a summary report that concludes with the author's sense of the direction the sector might usefully take based on participant responses. It is divided into an outline of the methodology, a summary of the main findings, a discussion of the emergent themes and the guidance resulting from that. It is intended to be a functional reference document and is hopefully suitably short and to the point.

I am of course extremely grateful to the participants who gave generously of their time and thought, and they are listed at the end of the document. The generalisation necessary for the report has undoubtedly blunted some of their specific observations and that is a loss.

Methodology

16 Universities were enlisted through an AMOSSHE email request. The only limitations were a minimum student population of 12,000 and an even distribution of pre- and post- 1992 Universities. This was to see whether significant differences in culture affecting practice might emerge; in the event they did not, and the results have been amalgamated.

I asked that the person(s) in the institution who understood themselves to be responsible for Mental Health Risk Assessment (MHRA) policies and practices should respond. Sometimes the task was delegated. Each respondent was asked to complete a questionnaire followed up by a 45 minute phone call with the interviewer to elaborate on their responses.

The material in the questionnaire and the interviews was summarised and common/frequent themes noted. These are set out below with a summary guideline based on the responses. Because the survey made no attempt to be representative, comparative and numerical data is not shown, but a sense is given of whether the result was frequently or infrequently sited. Each place had its own terminology and I have taken the liberty of grouping titles together under labels that I hope will suffice – counsellors, disability advisers, wellbeing practitioners, mental health advisers, and so on.

Many participants queried what was meant by a mental health risk assessment. Their answers divided into three areas: risk of suicide, risk of harm to self or others; risk to academic progress. In discussion this refined down to:
- Significant risk of suicide
- Risk of harm to self where this seems indicative of an underlying disorder and/or has the potential to escalate into greater harm
- Real risk of harm to others
- Academic risk where this seems indicative of an underlying disorder

Detailed findings

Who has responsibility for/involvement in Mental Health Risk Assessments in your institution?

1. Responsibility

Counselling was the most frequently cited service, sometimes as a single service and sometimes part of a wider well-being or crisis structure. Mental Health Advisers were also frequently cited, located in both counselling/wellbeing and disability services. Responsibility tended to cohere around these two areas, and therefore around those who managed them.

Where medical services were more integrated into support services they were more frequently involved in risk assessments. Where the risk was deemed sufficiently serious they were always involved, but sometimes as a result of an assessment rather than being asked to contribute to one.

Other parts of the University – Occupational Health, Health and Safety – were involved in relation to placements, for example. Chaplaincy and Security were particularly involved in assessing risk out of hours.

Some teams assessed risk for the purpose of their own work and the assessment stayed within the service; for others it would trigger a referral into a risk management process that took it beyond the individual service.

2. Involvement

Those who might be involved in MHRAs were a much longer list than those who took responsibility for them. Where the list went beyond counsellors, mental health advisers, wellbeing practitioners and sometimes disability advisers it was usually in the form of those who contributed to case conferences called either by the Heads of these services or the Directors of Support Services: for example academic staff, security officers, wardens, chaplains, administrators – those who had contact with the student and could help to build up a rounded picture of them.

Who has overall responsibility for Mental Health Risk Assessments in your institution?

Heads of Counselling, Mental Health Advisers, Heads of Disability, Directors of Support Services, Heads of Wellbeing, Health and Safety, Vice Chancellors and Senior Managers were all cited, and some places had no-one as being in overall 'charge'. There was however a general sense of hierarchy, that a sufficient level of risk would trigger an upward discussion. The discussion tended to stop wherever the protocol stopped and where the departmental management limits were.

Are there any issues when risk assessment procedures or responsibilities cross management lines?

Generally institutions felt that they negotiated the different management lines of their services well. When there was a student crisis people just pulled together. What was important was to have someone doing the pulling. When difficulties were encountered they were

between faculty-based and central services; when there was overlap in service provision; and over child protection issues and the different cultures of those involved (HE/NHS/legal profession).

How are MHRAs coordinated across services when more than one service is involved?

Case conferences were the most frequent method of coordination. These were either called as required in response to an identified need, or there was a standing, regular meeting to which people could bring students they were concerned about. The trigger was when the concerns about the student were broader than the department supporting them could address. Some systems had ways of flagging up risk that would alert relevant others who would then follow up on the case. Some flags were available to reception/admin so that they could be aware of prioritising the student if they contacted the service.

Confidentiality between services where risk was identified was managed one of three ways:

a) On a need-to-know basis, with the student being asked each time by each department for their agreement to share information

b) By shared confidentiality agreements that operated across several departments; this was not uncommon in Disability services where there was often a need to disclose in the student's best interests, and was becoming more common in services that grouped under Wellbeing headings.

c) By recognising where risk as it were 'trumped' confidentiality, something admitted by all professional codes. The judgement is about the point at which the concern about risk is sufficient to override confidentiality and to whom it should be broken.

The greatest difficulty was knowing when students were being seen by other services. This was eased when services used central record systems with points of shared access, and pre-agreed confidentiality exchange agreements.

Confidentiality was even at its most restrictive point held by the professional service rather than the individual, so there was always the capacity to consult with the Head of Service. Sometimes this confidentiality was assumed to extend to the Director of Support Services.

What written material do you go to for guidance?

- Internal procedures (risk assessment forms, emergency case protocols, crisis intervention)
- Mental Health Policy
- Disability specific protocols
- Fitness to Study/Practice Policy

There is an increasing interest in Fitness to Study Policies that help to deal with issues of the student's ability to continue at University and provide supportive options to this.

Some places had no relevant written guidance. Many relied on and had confidence in the experience and expertise of their practitioners. Some practitioners made use of external risk assessment measures eg, CORE (Clinical Outcome in Routine Evaluation) as part of clinical judgement. Others were in the process of developing policies to guide staff responses across the board.

Where policies existed they were usually put together by, or in consultation with, subgroups including counselling, mental health, disability, student representatives, student advisers, residences and academics.

What can trigger a Mental Health Risk Assessment?

- Suicidal ideation
- Significant incidents of self harm
- A serious mental health episode
- Reports of concern from others
- Observed difficult or worrying behaviour
- Self neglect
- Harm to others/violence/aggression
- Alcohol/drug use
- Eating disorders
- Vulnerability – at risk from others

Many people not used to working with mental health risk will naturally find it hard to assess the level at which something should be worrying. The key is assessing risk that is above the average level of distress/disturbance that students might be expected to present with over the course of their time at University.

What is included in a Mental Health Risk Assessment?

Not an exhaustive list, but it gives a flavour of what is covered and what is generally meant by an MHRA.

- Assessment of immediate danger to self or others
- Past history – personal, family and medical
- Current situation – personal, family and medical
- Thinking processes
- Mood and behaviour
- Symptomatology
- Functioning – academic and personal
- Recent factors affecting mental state
- Student's perception of their situation
- Protective factors
- Ability to engage with support
- Support available

All of these things may result in a clearer understanding of *levels* of risk – it is not as simple as yes/no.

What is the purpose of a Mental Health Risk Assessment?

For students:
- To identify and measure risk
- To help services prioritise resources
- To protect the student and reduce risk
- To improve timely access to treatment
- To make more informed judgements
- To facilitate a return to studies wherever possible
- To raise awareness within the institution of the student's need for additional support
- To enable a review of progress
- To avoid the student slipping through the support net between services
- To fulfil a duty of care to others
- To facilitate planning to support the student holistically

For staff:
- To share the thinking and decision making; serious risk should not be carried by a single person
- To ensure the University is carrying out its duty of care
- To develop good practice

Are students involved in the Mental Health Risk Assessments?

One participant queried how a risk assessment could be carried out without the student present, and this highlighted the different types of risk assessment. A clinical one would of course need the student's presence; however, one called to assess whether there was a risk to be investigated might not, and one called about a student who refused to attend might still need to go ahead; and sometimes it depended on the formality of what was deemed to be a risk assessment.

Students were included in MHRAs wherever possible.

Themes

It is clear that there is no standard MHRA policy. Policies commonly found in Universities are Fitness to Study, Mental Health Policies, Emergency Procedures. Risk assessment may feed into these policies but is not shaped by them. Bespoke is the order of the day, with departments and services operating systems that work well for them in relation to their particular situations. Where Heads of support departments came from one institution into another there was some importing of and learning from past policy and practice, so it is possible that more common standards will develop over time.

What an MHRA was, and was for, was often discussed. Some respondents took a formal and clinical model and were careful to consider clinical competence and mental health training in those considered equipped to make assessments; these more often referred to NHS back-up. Others took a more institutional duty of care approach and focused on the risk in a less clinical fashion – to the best of everybody's knowledge and judgement, was the student at significant risk and what was an appropriate response taking duty of care into account?

The issue of who took overall responsibility was food for thought. Each service had a clear idea of its own practice but it was the overall picture that could be cloudy – at what points did one stop, or start, cascading upwards?

What could be seen as deficiencies in written policies and protocols were often seen as being overcome by the strength of the various support service components working together in the students' best interests. Even where policies did exist, this collaborative approach was what made them work. Co-location and shared management facilitated this, but was not a pre-requisite where the will was there, and indeed could not ensure it if the will was not there.

Recommendations

1. Clear lines of responsibility for MHRAs are helpful. Where the riskiest work is undertaken by practitioners at several removes from senior management, the practitioner needs the security of knowing that their decisions are seen by the University as safe, and the University needs to be assured that it can vouch for the decisions of its practitioners. Risk management is an institutional responsibility.

2. Each University needs to know what it means by a MHRA. There are many risks that are not related to mental health, and many mental health concerns that are not related to risk.

3. An MHRA policy will generally focus on the safety of the student. There needs to be clarity about its use in relation to aligned policies such as Fitness to Study/Practice.

4. An MHRA policy should consider:
   - The conditions under which a formal MHRA is appropriate, bearing in mind that students at risk can present to any member of the University, from tutors to caretakers, and to any support department.
   - A standard risk assessment form to guide the practitioner. This need not replace the practitioner-specific aspects of risk assessment, but will ensure that sufficient information is gathered for the University to have the information it needs for decision making. Professional services can then base their tailored risk assessment forms on this.
   - A clear process for a mental health risk assessment: who may be involved in this, when and why it needs to go beyond the individual, how a group may be pulled together and most crucially who is responsible for coordinating and concluding it.
   - The roles that various people may be expected to undertake; for example tutors and wardens may be advisory, GPs may be diagnostic, counsellors may be risk assessors but not diagnosticians, mental health advisors may guide on diagnosis and treatment options.
   - A flowchart of responsibility relating to circumstance.
   - The system for monitoring, follow up and 'discharge' , and the information sharing and record keeping that flows from this.

5. As some of the difficulties in coordination arose out of the necessary chaos of crisis, there is merit in considering a regular meeting to which complex/risky cases can be brought for consideration, with all relevant people present including the student. There appear to be some advantages to having this opportunity clearly in the mind of the assessor (counsellor/MHA/other) when they are alert to risk in a student.

6. The level of confidentiality exchange that services believe is acceptable to themselves and their students within each professional code needs discussion. In situations of risk the ability to share information to gain a whole picture is generally valued and can improve decision making and possibly student safety. This needs to be measured against any possible reaction by students against information sharing that might prevent them accessing services.

7. The use of external measures of risk can be helpful.

8. Regular training updates for practitioners who are in a position to undertake MHRAs so that there is a common sense of what is expected and a confidence in the skills to do it. Similarly, awareness training and access to information for those in contact with students about when to be alert to a possible need for a risk assessment is helpful.

9. Communication is key to managing risk and any policy must ensure that it has considered all stakeholders in managing risk.

10. Clear, simple, accessible guidance for non-clinical staff in relation to risk will always support the process by which risk assessments can support students.

Acknowledgements

Celebrating 20 years

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