UNIVERSITY of York

Student Mental Ill-health Task Group:

Report to the Vice-Chancellor

March 2016

CONTENTS

EXECUTIVE SUMMARY

1. ***The prevalence and severity of mental ill-health among students at UK universities has been increasing and continues to rise.*** Evidence comes from national data on students reporting a mental health condition at the time of admission, student wellbeing surveys, suicide data and sector-wide evidence from student support services.

2. ***The prevalence and severity of mental ill-health among students at the University of York has been increasing and continues to rise.*** Evidence comes from a range of sources, including Open Door, Health Centre and ambulance call-out data. We were also provided with soft information pointing to a heightened sense of pessimism in the wider student community.

3. ***NHS mental health services are regularly failing to meet the needs of vulnerable people including students.*** While the government has made improving mental health services a priority, mental health services are struggling from the combined impact of rising demand and chronic underinvestment. Evidence comes from a variety of sources, including NHS England. Within the higher education sector, evidence from the leaders of student services points to serious gaps in mental health provision, with delayed and inappropriate NHS support for students in need of care.

4. ***These shortfalls in NHS mental health provision are evident at the University of York***. They have been exacerbated by additional pressures in York and N Yorkshire, including the sudden closure of Bootham Park hospital in autumn 2015 along with other mental health provision. While the data are incomplete, they suggest those living in York, including York students, face particular difficulties in accessing early interventions (e.g. psychological therapies), crisis intervention and both inpatient and outpatient care.

5. ***The higher education sector recognises that student wellbeing is the foundation of learning and future success.*** A university experience that is enriching and

fulfilling depends on positive mental health and access to support during periods of mental ill-health. A range of frameworks, good practice guides and online resources are now available to enable universities to improve their policies and practices.

6. ***Our recommendations are framed by the twin pressures we have identified: increasing, and increasingly complex, mental health difficulties among students at a time of increasing gaps in NHS provision.*** They are framed, too, by an appreciation that the University needs to give much greater priority to the mental health and wellbeing of students.

7. ***We make two overarching recommendations: to (i) take immediate steps to improve University support for student mental health and (ii) ensure a high-level and coordinated approach to improve mental health services for students in York and N Yorkshire.***

8. ***Our Action Plan is designed to deliver these objectives*** within the next 12 months**.** It includes 8 areas of internal action to improve University policies and provision and 3 areas of external action to drive forward improvements in local mental health services for students.

1 TASK GROUP TERMS OF REFERENCE AND MEMBERSHIP

1.1 Terms of reference

Purpose: to consider actions that the University can take to better support students whose wellbeing is compromised by severe mental ill-health.

Remit:

- To consider and assess evidence relating to students with, or at risk of, severe mental ill-health
- Based on this evidence, to make recommendations to better support this group that the University could action within 12 months
- To consider and assess evidence relating to the wider experience of mental distress in the student community
- Based on this evidence, to consider whether recommendations can be made to improve student well-being that the University could action within 12 months

Reports to: Vice Chancellor via PVC for Teaching, Learning & Students

Confidentiality:

- Task Group discussions, including notes of meetings, will not be shared beyond the Group's members; its report will be for the VC and PVC (as above)
- the Task Group will not have access to personal data (i.e. information relating to an individual); all information will be in an aggregated form and/or anonymised
- should data enable the indirect identification of individuals by a Task Group member, strict confidentiality must be maintained

Duration of Task Group: Jan-March 2015

1.2 Membership

Rob Aitken - Director of Colleges and Senior Lecturer in Politics

Brian Fulton – Dean of Faculty for the Sciences

Hilary Graham – former Head of Department (Chair)

Anne Haversham – Manager, Open Door Team

Ben Leatham - President of YUSU

Jenny McAleese – Member of University Council and Chief Executive of The Retreat

Peter Quinn – Director, Student Support Services

John Robinson - PVC for Teaching, Learning & Students

Mark Roodhouse - Chair of Board of Studies, History

Rasha Salah El-Din - President of GSA

Angela Simpson - Head of Nursing, Health Sciences

1.3 Acknowledgements

We would like to thank Andy Chapman, N Yorkshire Suicide Prevention Co-coordinator for his willingness to support the Task Group and share information on the N Yorkshire Suicide Prevention strategy.

We would also like to thank the following for providing information and advice, and within a very tight timeframe:

Phil Andersen (Research Administrator, PC-MIS, Health Sciences)

Jaime Delgadillo (Visiting Research Fellow, Health Sciences)

Marian Hilditch (Data and Process Quality Manager, Registry Services)

Louise Johnston (Managing Partner, Unity Health)

Alistair Knock (Business Intelligence Development Manager, Planning Office)

Bill Mackintosh (Business Analyst, Business Intelligence Unit)

Dean Macmillan (Senior Lecturer, Health Sciences/HYMS)

Stephanie Prady (Research Fellow, Health Sciences)

Jen Wotherspoon (Assistant Registrar: Student Progress, Registry Services).

1.4 Working methods

The Task Group drew on its own resources, including access to advice (see Acknowledgements). It worked to ensure that evidence was identified and reviewed, and recommendations developed and agreed, within a 3-month timescale.

Specifically:

- We sought out relevant evidence on student mental health and ill-health. We drew on published studies using clinically-based measures of mental ill-health together with evidence using broader measures of distress. We also noted evidence on the impact on other students of mental distress and suicide within the student community.
- We considered recommendations for good practice in supporting student wellbeing.
- We considered evidence relating to the mental health of York students, focusing particularly on those with, or at risk of, severe mental ill-health. We also considered evidence relating to University services and procedures to support students with, or at risk of, severe mental ill-health, together with information on mental health services in York and N Yorkshire.
- We received a briefing on the North Yorkshire Suicide Prevention Plan.

The Task Group met three times in Jan, Feb and March 2016.

1.5 Key terms

There are no agreed and universally accepted definitions of mental health and ill-health.

Mental ill-health: terms like mental illness, mental distress, mental health difficulties and mental ill-health are widely used and variously defined.

We use the term mental ill-health to describe a range of psychological difficulties that most people do not expect to endure in the course of their everyday lives. Instead, the difficulties lie beyond what would be seen as part of ordinary life and normal development.

'Mental ill-health' therefore includes long-term mental illnesses and psychiatric conditions that may be classified as a disability within the 2010 Equality Act. It also includes emerging ill-health conditions which are likely to require ongoing support. The term includes common mental disorders such as depression and anxiety, self-harm, eating disorders and behavioural disorders (e.g. obsessive-compulsive disorder) as well as psychoses, bipolar disorder and schizophrenia. We recognise that these conditions can co-occur and have a wide range of underlying causes that can act singly or in combination.

Mental health: we found the description of mental health offered by Universities UK (UUK) to be helpful.

Mental health encompasses emotional resilience to enable us to enjoy life and survive pain, disappointment and sadness, and an underlying belief in our own, and others', dignity and worth. It also allows us to engage productively in and contribute to society or our community[1].

It is increasingly recognised that positive mental health and mental ill-health are not opposing positions on a continuum. As England's Chief Medical Officer notes, they are distinct experiences and should not to be defined in terms of each other[2].

2 STUDENT MENTAL ILL-HEALTH: NATIONAL PATTERNS

2.1 Mental ill-health and suicide among young adults

The student community in higher education is a young community. Over 80% of full-time students (undergraduate and postgraduate) at UK universities are under the age of 25[3]. Over half are aged 20 or under[3]. Part-time students (25% of the total student community) tend to be older; over 60% are aged 30 or over.

Students in higher education make up a large proportion of young adults in the UK. In England, over 300,000 of those aged 18 to 30 enter higher education a year and participation rates for those domiciled in England reached 47% in 2014[4]. The mental health of students is therefore a key aspect of the mental health of the young adult population as a whole.

The premier source of evidence on mental health and ill-health in England is a national survey conducted every seven years. The most recent evidence relates to 2007[5]; the 2014 survey will be published later in 2016. Among young adults aged 16-24, around one in six had a recent experience of a common mental disorder, such as anxiety or depression[5]. Women are more likely than men to screen positive for a common mental disorder; among those aged 16-24, the prevalence was 21% among women and 12% among men.

Around one in five (21%) of adults aged 16 to 24 reported having ever thought about suicide[5]. Older adults are less likely to report having had suicidal thoughts over their lifetime – despite the fact that they are looking back over longer time periods. For example, one in ten of adults aged 65-74 report having thought about suicide[5].

Suicide risk (as opposed to suicidal ideation) is highest among adults in middle age (45-59 years), and this is true for both men and women. Rates of suicide are higher among men (16.8 deaths per 100,000) than women (5.2). However, the increase in suicide in England in 2014 was driven by an increase in female suicide[6].

The origins of mental ill-health in adulthood often lie in childhood. Most adults with mental illness experience their first episode of mental illness before the age of

16 and most adults accessing mental health services will have had a diagnosable disorder before the age of 18[7].

2.2 Mental ill-health among students

We noted the paucity of high-quality evidence on the mental health of students in the UK. This is particularly surprising given the size of the student population, the high participation rates among young adults and UK equality legislation that is opening up opportunities for students with mental health conditions to go to University and receive ongoing support. While the overall proportion remains small, the numbers of students who declare a mental health condition at the time of admission have been increasing. In 2012/13 (the latest available year), 1% of students, and 11% of students recording a disability, declared a mental health condition[8]. As Universities UK (UUK), point out this positive trend suggests that those with mental health difficulties – a group who have often faced various forms of discrimination and exclusion - are gaining entry to higher education in larger numbers[1].

There is evidence that, at any one time point, a significant proportion of students (over one in four) in the UK are experiencing clinically-recognisable mental ill-health[9]. A larger group report facing difficulties and challenges. For example, in an online and non-random survey run by the NUS in Autumn 2015 to inform the House of Commons All-Party Parliamentary Group on Students[10], nearly eight in ten respondents indicated that they had experienced mental health difficulties over the previous year[11]. There is evidence that, in line with patterns in the general population (see section 2.1), female students are more likely to meet the threshold criteria for depressive and anxiety disorders and male students are at greater risk of suicide[12].

Personality traits have been identified as important factors in student mental ill-health. Increasing attention is being given to perfectionism, a multidimensional concept that includes self-oriented and other-oriented dimensions. Self-oriented perfectionists are seen to set excessively high standards for themselves and be

intensely self-critical ('I want to be perfect in everything I do'). There is evidence that this dimension of perfectionism is either associated with positive outcomes (e.g. self-esteem, resourcefulness, perceived personal control) or is unrelated to negative outcomes[13]. Other-oriented perfectionists perceive that other people, particularly significant others, are imposing excessively high standards which need to be met in order to please them ('other people expect me to succeed in everything I do'). It is this form of perfectionism that is more consistently associated with negative outcomes (e.g. lower self-esteem, depression, anxiety, hopelessness)[13]. Through their work with students here, the Open Door team have become aware of possible links between perfectionism and mental distress and ill-health. Practitioners are now able to record perfectionism as the main presenting problem for students using Open Door services (see section 4.2).

Most of the evidence that we located on student mental health came from cross-sectional studies of undergraduates. Longitudinal studies are needed to take account of pre-entry mental health and to track patterns post-entry, including possible associations with university and programme characteristics (e.g. enrolment size, assessment procedures, staff-student contact, student support services) and personal circumstances (e.g. financial pressures, family expectations). Studies that include graduates as well as undergraduates are needed to identify potential differences in patterns and stressors, for example, graduates may have greater financial and family responsibilities and are expected to take greater responsibility for structuring their work and monitoring their progress.

The University is well-placed to help address the lack of robust evidence on student mental health and ill-health, particularly given its strengths in mental health and educational research. While not included as an action in the Action Plan, we would encourage research groups with relevant expertise (e.g. the Mental Health and Addictions Research Group in Health Sciences/HYMS and the Psychology in Education Research Centre in the Education Department) to consider ways to establish a longitudinal study of student mental health. We would recommend that the study includes a pre-entry baseline and both graduates and undergraduates.

A possible model is a UK-based longitudinal study with pre-entry measures of mental health[14]. The study at a north England university followed undergraduate students from pre-entry (summer before entry) and through their first year. It used a standard measure of psychological wellbeing (GP-CORE[15]) to track changes across this transition period. The proportion of students identified as vulnerable (e.g. low subjective wellbeing and depressive symptoms) increased following arrival at university and, while levels of strain declined towards the end of the first year, they did not return to their pre-university level[14]. As this suggests, the transition to university can be stressful, with a range of life changes happening together. Evidence presented to the All-Party Parliamentary Group on Students by Student Minds noted that:

> *Students can lose a valuable network when they move to university – moving to an unfamiliar location, away from friends and family – but also experiencing delays in new support. The academic environment can cause problems too, including through the culture of assessment, the pressures to achieve employability, regular lack of sleep and poor diet.*[16]

The transition can be particularly challenging for students with poor mental health and who are already interacting with NHS mental health services in their home area. There can be a dual transition to negotiate: from child and adolescent mental health services (CAMHS) to adult mental health services (AMHS)[17] and from one geographical area to another. As highlighted in the Student Minds 'Transitions' campaign, both transitions can be beset with difficulties and add to the pressures on a group of students in particular need of mental health support[18].

In addition, the last 10 years have seen changes in students' experience of higher education with the potential to adversely affect their mental health[19]. Here, we highlight three factors.

Firstly, there has been the rapid withdrawal of financial support for home students and an increasing reliance on loans and, in consequence, an increase in student debt. Recent changes to student loans are set to further increase the debt burden. The

Institute for Fiscal Studies (IFS) estimates that the average debt on graduation among the 2012 cohort will be £44,000 (2014 prices) compared to around £25,000 if the pre-2012 system had still been in place[20]. While the IFS estimates that around three quarters of these graduates would not repay their loans in full[20] (more than double the proportion under the old system), the total real value of repayments will be around 75% more because more graduates will be repaying their loans for a longer period. As noted in the Royal College of Psychiatrist's report on student mental health, international students can also face financial problems; in addition, they can carry the academic expectations of families on whom many may depend for financial support[19].

Secondly, the current cohort of students faces a more difficult labour market than earlier generations of students, with a higher risk of unemployment and insecure employment for those graduating with arts and humanities degrees than those studying medicine and subjects allied to medicine[21]. There is evidence that mental ill-health (for example depression) adds to potential employment difficulties, via its association with factors that impact directly on a student's employment prospects, including lower grades and withdrawal from study[22]. UK universities are giving increasing attention to 'employability' and, particularly, to ensuring that the university sector furnishes graduates with the skills that employers are seeking – but employability strategies may not address students' deeper concerns about the future and their ability to build sustainable and rewarding careers.

Thirdly, the virtual environment created by electronic communication technologies can expose young people and students to pressures that previous generations of students avoided[23]. Its negative effects were highlighted in the recent Health Select Committee on adolescent mental health[24]. The virtual environment changes as new technologies emerge and gain and lose popularity. Alongside established peer-to-peer technologies (texting, Facebook) are social media where users are often unknown to each other (e.g. Twitter) or anonymous (e.g. Yik Yak). Together, these communication platforms have become sites of cyberbullying (acts of aggression that causes harm and distress) and victimisation within the student population (school and university); abuse can be targeted at both individuals and social groups. While

we found few studies, we noted evidence that anonymity is conducive to social media abuse, and communication technologies where individuals are known to each other may help protect against it[25].

These three factors, among others, are an important backdrop to the continuing rise in student mental ill-health. Confidential feedback[26] given in Jan 2016 to the association of leaders of university student services (AMOSSHE) sheds light on the challenges facing students and staff seeking to support them. Responses were received from 54 higher education institutions. Comparing 2015 with 2014, 80% of respondents reported that they had observed a 'noticeable increase in complex mental health crises' among their student population. Nearly 90% reported working on critical/serious incidents with the police and/or coroner during 2015; two thirds (68%) noted that they had worked on three or more such incidents in 2015. Just under half (47%) reported one or more student death in 2015 that had been found to be suicide or suspected to be suicide prior to the coroner's inquest.

2.3 Suicide among students

Data on student suicide in England and Wales (among students aged 18 and over) were released by the Office for National Statistics for the period 2007 to 2011, following a Freedom of Information request from UUK. Across this period, the number of suicides among full-time students rose from 57 to 78 among men (an increase of 37%) and from 18 to 34 among women (88%)[27] (see table below). It should be noted that, while the overall number of students also increased across this period, the relative increase in suicides far outstripped the relative increase in student numbers[3].

Student suicides in England and Wales (aged 18+), 2007 to 2011[abcd]

Year	2007	2008	2009	2010	2011
Male	57	74	76	90	78
Female	18	21	33	37	34

Source: Office for National Statistics

[a]Figures are for deaths registered in each calendar year
[b]Data for England and Wales include deaths of non-residents
[c]Data relate to those classified as full-time students at death registration
[d]Suicide defined using the International Classification of Diseases Tenth Revision (ICD10) codes X60–X84, Y10–Y34

2.4 Students supporting those at risk of mental ill-health and suicide

Understandably, a student's mental health difficulties can impact on the lives and wellbeing of friends and peers in the wider student community. Friends are often aware when a student's mental health is under strain – and the student (rightly) often turns to their friends for support. A report from the Equality Challenge Unit noted that 75% of students experiencing mental health difficulties talk to their friends[28], and those in a support role have a range of information and support needs. A recent study by Student Minds (research design and sampling frame not given) focused on this group of 'supporters' (n=79). Over 40% of supporters felt they were the primary source of support and over 70% had helped their student friend with accessing formal support. Nearly half reported that they were themselves experiencing mental health difficulties[29].

3 STUDENT MENTAL ILL-HEALTH: NATIONAL POLICIES AND SERVICE PROVISION

3.1 National mental health policies

UK health policies are giving increasing emphasis to promoting mental health and supporting those vulnerable to ill-health. In 2011, the government declared that there could be 'no health without mental health', and outlined a strategy to promote wellbeing, invest in prevention and to improve outcomes for people with mental health problems[30]. Key elements of the strategy were the development of community-based and patient-focused services and improved transitions between services.

Building on this strategy, 2012 saw the publication of England's cross-government strategy, *Preventing Suicide in England*. It aims to reduce suicide and improve support for those at risk, including those affected by suicide[31]. It again emphasises the importance of mental health promotion, prevention and early intervention. In 2013, England's Chief Medical Officer devoted her annual report to public mental health[2].

Improved access to psychological therapies (IAPT) has been integral to the delivery of the government's mental health policy. Piloted in the late 2000s, the programme has been rolled out in England with an aim of equitably treating people with common mental disorders using evidence-based talking therapies (largely cognitive behavioural therapy but also including interpersonal and brief dynamic interpersonal psychotherapy, and counselling and couples therapy for depression)[32]. The IAPT programme aims to treat 15% of common mental disorders prevalent in the community, or, allowing for patient choice, 72% of those identified in primary care[33]. However, demand currently outstrips provision, leading to long waiting times[33]. Questions have also been raised about whether IAPT interventions are sufficiently sensitive to cultural diversity, and about the need for cultural adaptations to enable inclusive and equitable access to talking-based therapies[34].

This point was also made with reference to Open Door provision via student feedback to the GSA.

3.2 Mental health policies in universities

An increased emphasis on mental health is evident, too, in the higher education sector. In 2005, the UUK/Guild of HE Mental Wellbeing in Higher Education Group published a framework for university mental health policy[35]. In 2011, the Royal College of Psychiatrists (RCP) published their influential report on student mental health[19] and, in 2015, UUK published the *Good practice guidance for student mental wellbeing in higher education*[1], updating guidance issued in 2000[36].

Universities have built on these frameworks and guidelines. By 2008, over half of universities (54%) had a formal mental health policy in place and a further 29% were in the process of developing one[1]. Some universities have separate policies focused on student mental health (e.g. Leeds, Swansea[37]) and some have a combined policy for staff and students (e.g. St. Andrews, Glasgow Caledonian[38]).

3.3 Mental health services provision

Evidence suggests that the NHS is struggling to provide mental health services that match the ambitions laid out in government's policy documents. The imbalance in expenditure on physical and mental health is one factor; MIND estimates that local authority spending on mental health amounts to 1% of their total public health budget[39]. The shortfall in current provision has recently been acknowledged by NHS England in a report by the independent Mental Health Taskforce (published Feb 2016[26, 40]). As the most recent and authoritative assessment of NHS services for people experiencing mental ill-health, findings from the report are quoted in the box below.

NHS England: Mental Health TaskForce report Feb 2016[40]

'Of those adults with more severe mental health problems 90 per cent are supported by community services. However, within these services there are very long waits for some of the key interventions recommended by NICE, such as psychological therapy, and many people never have access to these interventions'.

'Almost one-fifth of people with care coordinated through the Care Programme Approach (for people with more severe or complex needs) have not had a formal meeting to review their care in the previous 12 months'.

'Only 14 per cent of adults surveyed felt they were provided with the right response when in crisis, and that only around half of community teams were able to offer an adequate 24/7 crisis service'.

'Only a minority of hospital Accident & Emergency (A&E) departments has 24/7 cover from a liaison mental health service, even though the peak hours for mental health crisis presentations to A&E are between 11pm and 7am. Too often, people in mental health crisis are still accessing mental health care via contact with the police'.

'Admissions to inpatient care have remained stable for the past three years for adults but the severity of need and the number of people being detained under the Mental Health Act continues to increase, suggesting opportunities to intervene earlier are being missed'.

'The number of adult inpatient psychiatric beds reduced by 39 per cent overall in the years between 1998 and 2012. For children and young people, average admissions per provider increased from 94 in 2013/14 to 106 in 2014/15. Bed occupancy has risen for the fourth consecutive year to 94 per cent. Many acute wards are not always safe, therapeutic or conducive to recovery. Pressure on beds has been exacerbated by a lack of early intervention and crisis care, and the resulting shortage leads to people being transferred long distances outside of their area'.

'Years of low prioritisation have led to Clinical Commissioning Groups (CCGs) underinvesting in mental health services relative to physical health services but the degree of the disparity has largely been obscured by the way spending on mental health conditions is grouped together and reported, unlike spend on physical health care, which is disaggregated by specific conditions'.

3.4 Mental health service provision for students

In feedback to open-ended questions in the study organised by the association of leaders of university student support services (AMOSSHE)[26], two themes emerged.

In line with the findings of NHS England's Mental Health Taskforce and summarised in the box above[40], the first theme related to the increasing pressures on, and gaps in, NHS provision. It was noted that 'the absence of statutory service support is palpable' and 'the NHS often release students to us who are not fit to be looking after themselves…essentially we end up on 'suicide watch''.

The second theme related to the university's duty of care, particularly in the context of the lack of NHS care for vulnerable students. It was recognised that universities had a duty of care to meet students' educational needs, including pastoral care. However, difficulties in accessing mental health services (with long waiting times for specialist services, limited out-of-hours care and students discharged without support after an attempted suicide) placed a moral duty on staff to extend this care to fill gaps in NHS provision. In consequence, 'staff feel the heavy weight of responsibility and are stretched dealing with complex cases', a situation 'we are finding it very difficult to get senior managers to understand'. The pressures on support staff, particularly counselling staff, security and other support staff, was a common concern.

4 STUDENT MENTAL ILL-HEALTH: PATTERNS AT YORK

4.1 Introduction

No one source of evidence can provide a comprehensive picture of mental ill-health among York students. We therefore identified, requested and considered a range of relevant data. All the data we received were anonymous.

We present evidence from Open Door and the University health centre, together with information relating to Leave of Absence, ambulance call outs and student deaths. We also consider 'softer' evidence on student wellbeing at York. It is important to note that we had no access to data from other universities. It is therefore not possible to know if student experiences elsewhere are similar or different to the ones captured in the data we present below. However, the patterns in the York student community are consistent with the wider evidence presented in sections 2 and 3, suggesting that the mental health difficulties among York's students will be found in other student communities.

In line with patterns across the higher education sector, the evidence that we considered points to the increasing prevalence and severity of mental ill-health among York students. **Taken together, it makes a compelling case for the University to take immediate steps to improve its support for student mental health (see Recommendation 1 of the Action Plan).**

The Action Plan notes work already in progress to improve the missing student protocol and to improve policies relating to mitigating/exceptional circumstances. Completing ongoing work is the first Action in the plan.

The Action Plan goes further and identifies seven further Actions. These include Action to improve the 'first contact' support that staff can provide to students at high risk of harm and Action to strengthen the capacity of academic departments to identify and support students whose health and personal circumstances give cause for concern. While the mental health of staff is not part of the remit of the Task Group, it was clear to us that providing support and, not infrequently, crisis

intervention, for students with severe mental ill-health can also take a toll on staff, including support staff (e.g. security staff and Open Door practitioners). We would encourage the University to note, assess and address these impacts.

Another set of Actions in the Action Plan focus more directly on students, both those experiencing mental health difficulties and those supporting other students. The Action Plan includes the development of an integrated website on student mental health, a 'one-stop shop' providing students with access to web-based information, including self-help guides, information on first contact points and crisis support, and accessing additional personal support. The Action Plan also includes Action to ensure there are mechanisms for user feedback on current provision, including Open Door, the Health Centre and College-based pastoral support, with this feedback used to monitor and inform service provision.

4.2 Open Door services

Open Door offers support to students with issues that, lying beyond the range of ordinary everyday experiences, they are struggling to deal with. It offers an initial assessment that can be followed with interventions designed to meet the needs of the student e.g. access to self-help materials and brief (1-3 session) solution-focused interventions. As this suggests, the number of students with follow-up appointments is significantly smaller than the overall number of appointments.

In addition, the team offer a 'case management' approach for students with longer-term and/or more complex mental health difficulties. The NHS remains responsible for the health care of students, including psychiatric treatment and care. However, short-notice appointments are provided for students identified to be at high risk of self-harm and suicide.

Open Door appointments: As the Figure below indicates, there has been a marked increase in demand for Open Door services. Between 2010/11 and 2014/15, the number of students seen by Open Door practitioners increased by 46% (1278 in 2010/11 to 1867 in 2014/15). In 2014/15, 12% of York's students were Open Door

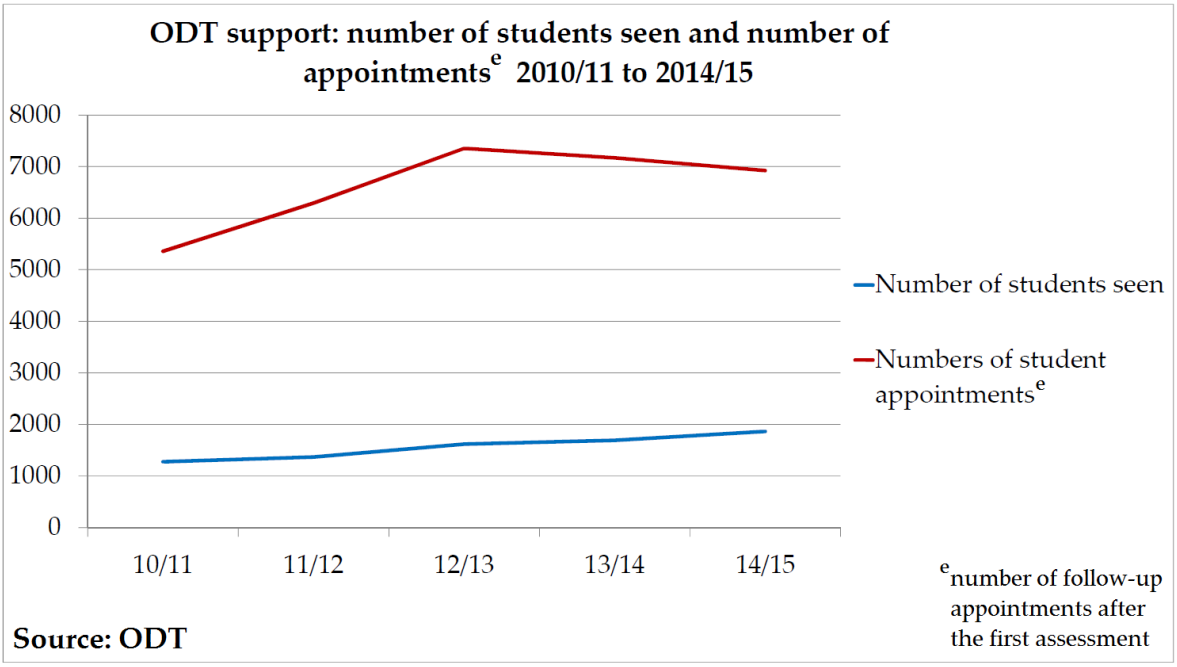
users (i.e. had one or more appointments). Evidence for the current academic year (1012 students seen to 4 March 2016) suggests that the number of students seen by the ODT will reach 2000 in 2015/16.

There has also been a marked increase in the number of follow-up appointments provided by Open Door (see Figure below). This increased by 29% between 2010/11 (5359) and 2014/15 (6922). For 2015/16, the number of follow-up appointments to date (to 4 March) puts the total on track to reach 8000 across this academic year.

Both sets of data need to be set in the context of overall student numbers. Between 2010/11 and 2014/15, the student population at York increased by 9% (from 14985 to 16285). As this suggests, it is greater need rather than larger numbers that is driving up demand for Open Door services.

Access to these services is, of course, dependent on the Open Door capacity; support (number of students and number of appointments) can increase in response to need only if provision increases too. The increasing demands for and pressures on the Open Door service have been recognised by the University, with provision increased in 2015/16 to include a fixed-term two-year post from summer term 2016 and provision for additional sessional staff hours. The enhanced provision is designed to enable the University to maintain Open Door as a service to help students facing issues that lie beyond ordinary experience.

Short-notice appointments, made available for students identified to be at high risk of self-harm and suicide, provide another measure of student need. From term 1 of 2014/15 to term 1 of 2015/16, these appointments increased from 63 a term (term 1, 2014/15) to 88 (term 1, 2015/16). From term 2 of the current academic year, the provision of short-notice appointments has been changed, to target the service solely on basis of risk of harm. This involves a day-by-day practitioner assessment to ensure that students at immediate risk are seen as a priority and as soon as possible. On this more targeted basis, 52 short-notice appointments were provided in term 2.



Open Door: profile of users: The profile of Open Door users is broadly in line with the broader population of undergraduate and post-graduate students at York. In 2014/15, the proportion of undergraduate, PGT and PGR students supported by the ODT was respectively 86%, 5% and 9%. In comparison in 2014/15, undergraduate, PGT and PGR students represented 76%, 16% and 9% of the York student community as a whole.

In 2014/15, female students made up a larger proportion (65%) of Open Door users than male students (35%). Four in five (80%) of users were aged 18 to 25 years. Of the remaining fifth, 17% were aged 26 to 35 years and 3% ≥36 years. Information on ethnic background relies on pre-set and relatively broad categories. The majority of users (71%) described themselves as white British, with few other groups representing more than 5% of students. Students recording their ethnic background as 'other White' (not white British or white Irish) made up 11% of users and 5% of users were Chinese. Sexual orientation is also included in the information that Open Door invites users to record. Not all students record their sexual orientation. Of the students in 2014/15 who elected to do so (n=775), 12% identified as LGBT (lesbian, gay, bisexual, transgender).

Open Door Team users: profile of need: Open Door uses PCMIS HE, a student mental health case management system for higher education institutions[a], to support and improve its services. As one of the first universities to use a case management system, it has enabled the Task Group to gain a deeper insight into student mental ill-health than would be possible at many universities. Based on anonymous data, we considered a range of measures of student need.

The Open Door practitioner provides an assessment of the main presenting problem based on the initial assessment with the student. In 2014/15, the most common presenting problems were anxiety and depression. These were, respectively, the presenting problems for 24% and 15% of users at their first appointment. Other common problems were relationship difficulties (6%), family difficulties (5%) and academic difficulties (4%). However, Open Door practitioners have been aware that perfectionism has been a feature of student presentations since the service started in 2008. It has become more of a concern recently because of its association with risk (see section 2.2), and was added to the recording system in 2014/15. In that year, it was identified as the presenting problem for 4% of users.

The table below lists the five most common presenting problems that students brought to Open Door in 2014/15 by term. In line with the patterns above and consistent with patterns in the UK population, anxiety and depression are the major issues for which students are seeking help in each term. In term three, factors that may been seen as more directly related to academic work and assessment (stress and academic difficulty) are among the five most common presenting problems. This may relate to procedures governing mitigating circumstances; changes to these

[a] PCMIS HE: http://www.york.ac.uk/healthsciences/pc-mis/he/

procedures may therefore see a corresponding change in the profile of main presenting problems in term three of the current academic year (2015/16).

Open Door students: five main presenting problems by term (2014-15)

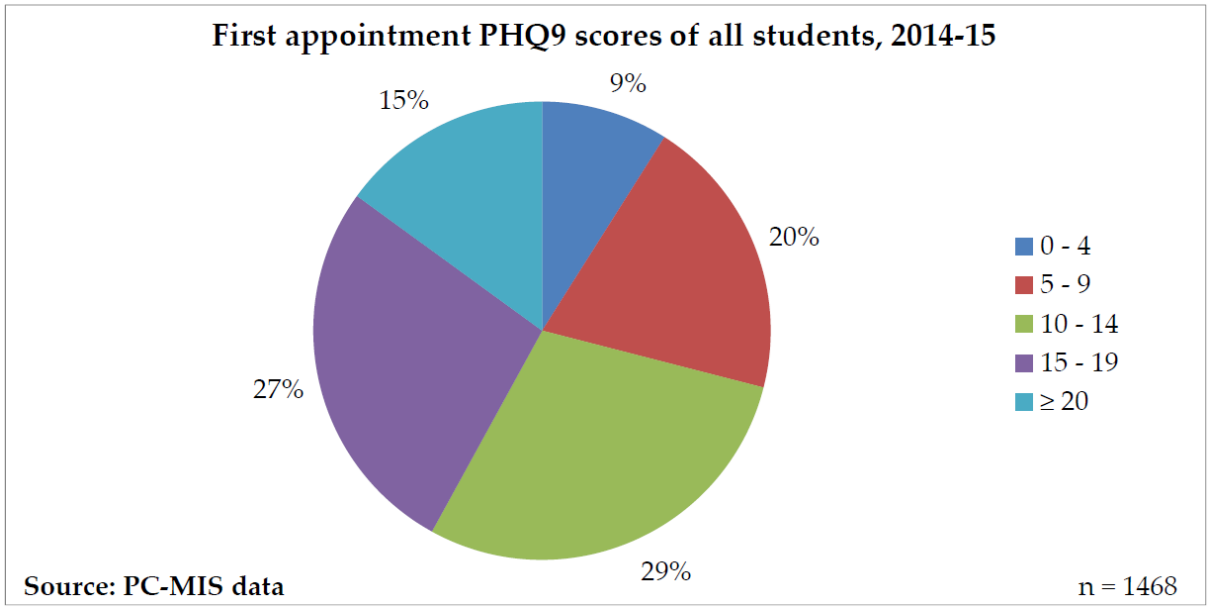
Term 1[f]	Term 2[g]	Term 3[h]
Anxiety	Anxiety	Anxiety
Depression	Depression	Depression
Relationship Issues	Bereavement	Family Problems
Academic difficulty	Family Problems	Stress
Bereavement	Relationship Issues	Academic difficulty

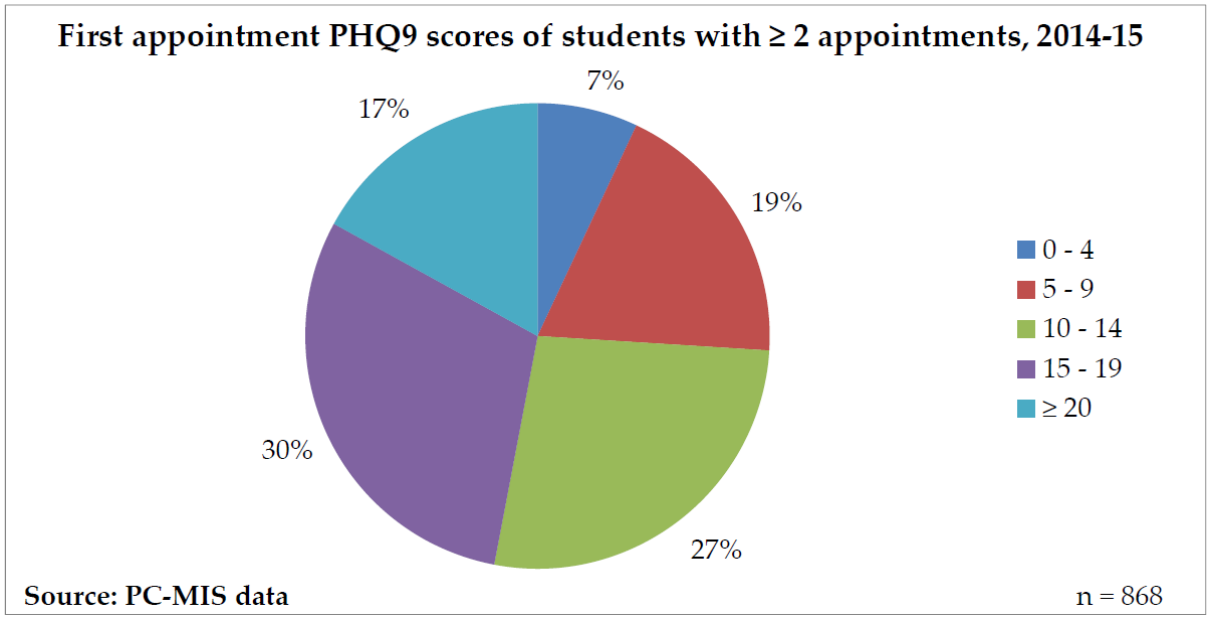
[f] Covers period 01 Sep – 31 Dec
[g] Covers period 01 Jan – 31 Mar
[h] Covers period 01 Apr – 31 Jul

Open Door invites users to complete two widely-used and clinically-validated measures of mental ill-health: the 9-item Patient Health Questionnaire (PHQ9) and the 7-item Patient Health Questionnaire Generalized Anxiety Disorder Scale (GAD7). We were provided with aggregated data for 2014/15; in that year, only one student did not complete the questionnaires. The data relate to the PHQ9 and GAD7 profiles at first appointment for (i) all users in 2014/15 and (ii) the sub-group of users who had more than one appointment.

The Patient Health Questionnaire (PHQ9) is a depression scale that, with the same nine items, can establish provisional depressive disorder diagnoses as well as grade depressive symptom severity. Scores range from 0 to 27 and are grouped into broad categories: 0-4 (no depression), 5-9 (mild depression), 10-14 (moderate depression), 15-19 (moderate severe depression) and 20-27 (severe depression). A cut-off of ≥10 is used as a threshold for clinical depression.

The Figure below describes the depression scores at first appointment for all users and for those with two or more appointments. With respect to this dimension of mental ill-health, two broad patterns can be noted. The first is that a high proportion of students had scores that met the depression threshold of ≥10 at their first visit: 71% of all users and 74% of users seen more than once by the Open Door team had scores that met the threshold. Secondly, students offered further appointments have poorer mental health profiles than the larger group of all users. In that group, nearly half (47%) were identified as having moderate severe or severe depression (i.e. PHQ9 scores of ≥15).

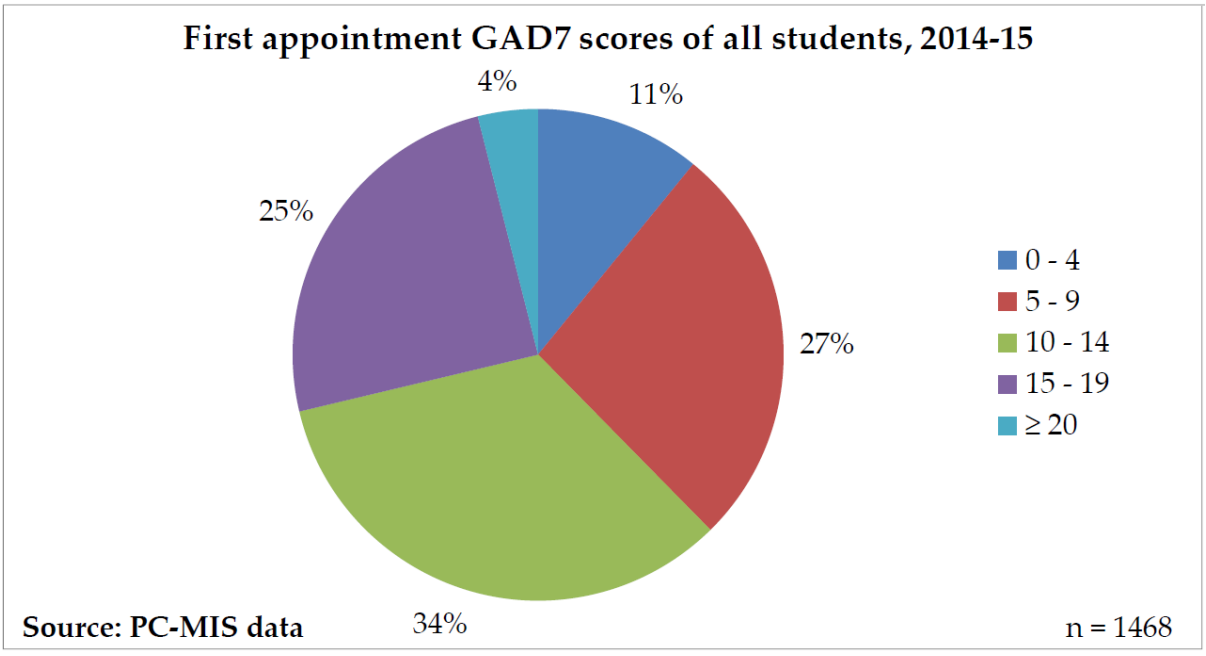


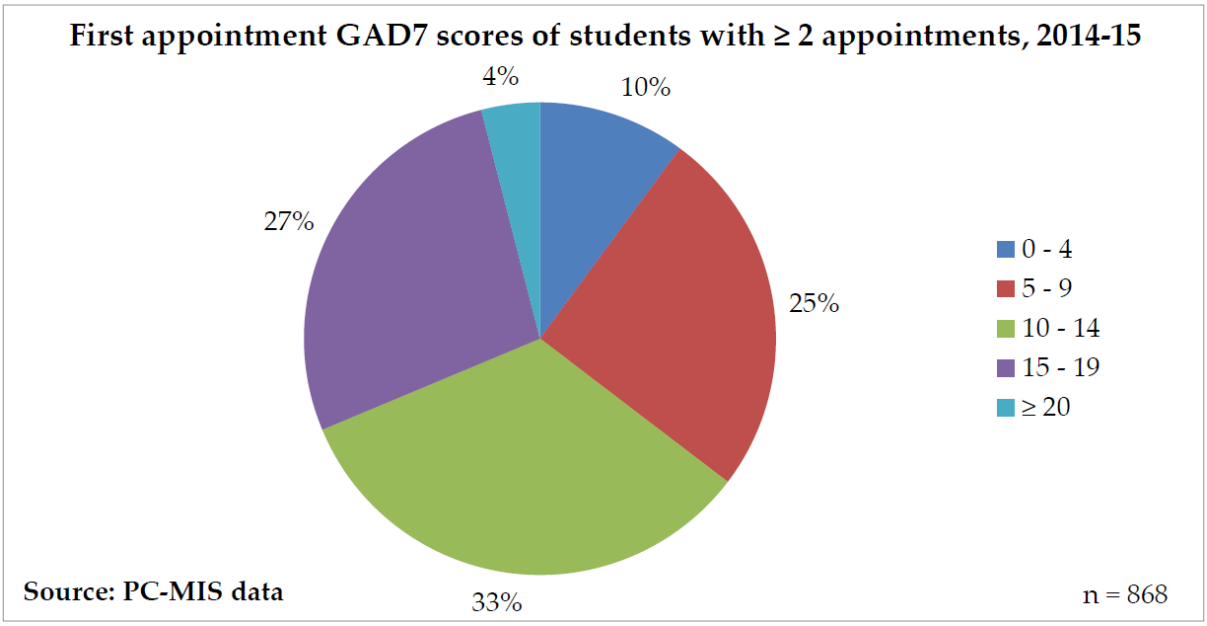


One item in the PHQ9 refers to suicidal ideation and self-harm ('had thoughts you would be better off dead or of hurting yourself') over the past two weeks. Possible responses are 'not at all', 'several days', 'more than half the days' and 'nearly every day'. In 2014/15, 18% of Open Door users and 23% of those offered further appointments responded that they had had these thoughts more than half the days or nearly every day.

The 7-item Patient Health Questionnaire Generalized Anxiety Disorder Scale (GAD7) is an anxiety scale which ranges from 0 to 21. A threshold of ≥8 is often used to identify both generalised anxiety disorder and other anxiety disorders including social phobia, post-traumatic stress disorder and panic disorder. In 2014/15, at first appointment for all users, 74% of students had scores above the anxiety threshold of ≥8. Among those with additional appointments (n=868), 75% had scores above the anxiety threshold of ≥8.

The figure below provides more detail on the anxiety scores at first appointment for these two groups of Open Door users. With respect to this dimension of mental ill-health, differences between all users and those with follow-up appointments are less marked.





4.3 Other evidence on student mental ill-health

Health Centre data: Another source of insight into students' experiences of mental ill-health comes from data held by the Health Centre. The data point to an increase in the prevalence of diagnosed depression among students, and a doubling of prevalence since Mar 2013 (data on other disease categories with high prevalence are given for comparison). Some caution may need to be exercised in interpreting these data; questions have been raised about the NHS Quality and Outcomes Framework (QoF) depression register used in general practice, including its validity as an aid to GP diagnosis and patient care[41, 42].

QoF data on depression among students (based on disease register data) 2013-16

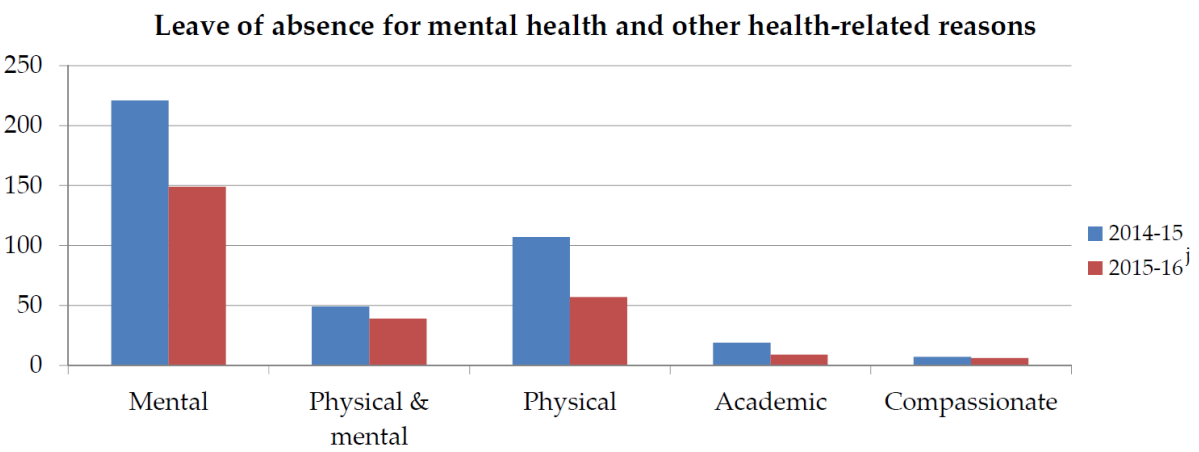
Condition	Mar-13	Mar-14	Mar-15	Mar-16	% change[i]
Depression	423	546	738	862	+ 104%
Asthma	407	430	480	429	+ 5%
Diabetes	40	43	47	58	+ 45%
Hypo-thyroidism	41	36	38	31	- 24%

Source: Unity Health, campus health centre

[i]between March 2013 and March 2016

Leave of Absence: Student mental ill-health is known to be associated with difficulties with studying and withdrawal from college/university. Consistent with this evidence, mental ill-health is a major reason for Leave of Absence among York's students. Information on LoA approvals related to mental ill-health (code 07) and to physical and mental health (code 08) is given in the table below for 2014/15 and for 2015/16 to March 2016. Information on other health-related reasons for LoA are given for comparison.

Based on the single-reason mental health code (code 07), mental ill-health made up 25% of all LoAs in 2014/15 and 25% of all LoAs to date in 2015/16. As is widely recognised, Tier 4 visa requirements place particular Leave of Absence restrictions on international students. Tier 4 visas are issued to students studying in the UK; leave of absence breaches this requirement and students are required to leave the country until they are in a position to return to study. LoA data are therefore likely to be a less reliable measure of student mental ill-health for York's international student community.



Ambulance call-outs: We were provided with data drawn from Security Reports. The data were searched for terms including self-harm, harm and suicide; some misreporting is possible with respect to the 'harm' category. The evidence should therefore be seen to provide additional background information. It points to an

upward trend in ambulance call-outs and in both the number and the proportion related to self-harm and suicide attempts.

Ambulance call-out data 2014-16

	2014	2015	2016[k]
Self-harm/ Attempted suicide call-outs	22	43	12
Above, as % of all call-outs	14%	32%	50%
Total number of call-outs	158	134	24

Source: Security Reports [k]to 8th February 2016

4.4 Student deaths

In 2014, three students died; two students died in February and there was a further student death over the Christmas vacation. The coroner's inquest found that two of the deaths were from natural causes and one was a suicide.

In 2015, there were four deaths, one prior to the Autumn term and three further deaths during the Autumn term. In 2016, a further student death occurred in January. To date, two inquests have been arranged to take place in April with the remaining inquests still to be confirmed.

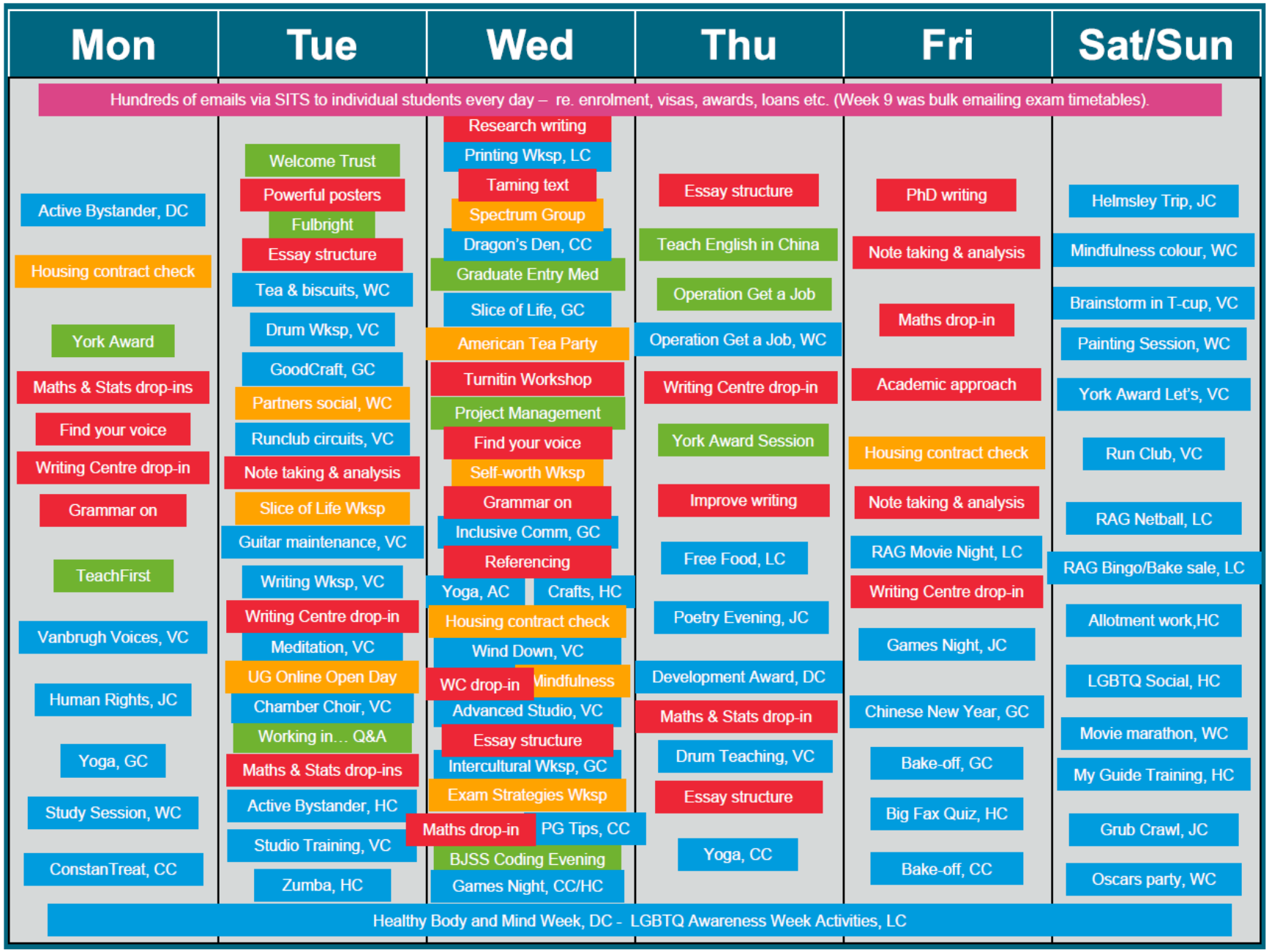
4.5 Wider evidence on the wellbeing of York students

The Task Group were briefed by YUSU and GSA on a range of concerns relating to student mental ill-health that had been raised by their members. They include the need for stronger mechanisms for user feedback on University-based services, including Open Door (e.g. facilitating support groups for students suffering stress to complement therapeutic interventions like CBT) and the Health Centre (e.g. ensuring more systematic feedback than that currently provided by the Patient Participation Group). Enhancing mechanisms for feedback on mental health-related provision is an Action in the Action Plan.

Through YUSU and GSA, a wider range of concerns were raised. Many of these concerns are evident in the wider population of students studying in the UK and have been noted in section 2. They include the impact of student ill-health and suicide on other students. The Action Plan includes an Action to ensure that students affected by the distress of other students have ready access to information, including signposting on how to access support for themselves. Other concerns related to a cluster of present and future anxieties around debt, employment and family ambitions and often expressed through, and reinforced by, a concern with perfectionism and academic performance.

While the Task Group did not investigate these wider pressures on York students in depth, we noted that the York student journey is characterised by its increasing complexity and intensity. The figure on page 33 describes the range of University events and services delivered for students in a single week from 22 to 28 February (Week 8), and includes communications, workshops, development opportunities and social events. We also noted that policies designed to help students navigate their university journey and go onto further success can – inadvertently – add to a sense of university life being one of multiple pressures. One example is the increasing emphasis on employability ('a term you will hear and see often at university'[43]); the first aim of the University's employability strategy is to expect and support students 'to consider and plan their future options from their first point of contact with York and throughout their time here'[44]

YUSU also highlighted issues related to social media, including anonymous social media platforms and, in particular, the geo-social app Yik Yak. The app enables users within a 5-mile radius anonymously to access, post, view and vote on comments (i.e. without others having to know them). While designed to give 'you a feed of all the casual, relatable, heartfelt and silly things people are saying around you'[45], YUSU noted that it can be a vehicle for negative and pessimistic messages. It can also be a source of virtual abuse and bullying. In consequence, banning the app has been under active discussion in a number of US high schools and universities. The Action Plan includes an Action to promote positive social media interactions.



Source: Marketing Matrix Group 2016

4.6 University student support and governance structures

The University's strategy has the interests of students at its heart. Two of the three Key Objectives relate directly to the student experience: 'outstanding teaching and learning' and 'an outstanding and valuable experience'. An outstanding experience, both of learning and of wider university life, depends on positive mental health and on access to support during periods of mental ill-health.

Campus-based universities like York are widely seen as particularly well-placed to deliver an integrated approach to academic study and pastoral care. The campus is the setting where a student's academic study, social and cultural life, sports and leisure activities come together with their medical care and pastoral support and, often, their accommodation[19]. It therefore offers a range of channels through which to enrich student life and promote student wellbeing.

The University's college system provides an additional and widely-valued channel. Colleges have a focus on creating a supportive environment for students, with college staff working with student leaders within colleges to promote student wellbeing. Closer college/Open Door liaison is also being developed, with college staff liaising directly with a linked Open Door practitioner. Early indications are that this more integrated system of student support works well; it is therefore being rolled out across colleges.

Along with colleges and Student Services, there is a third important arm of student support: academic departments. Their role appeared to be less well-integrated into the framework of student support. As the University's student mental health policy recognises[46], 'supervisors and other staff within academic departments may play a significant role in identifying signs of emerging difficulty', for example through a marked changes in a student's attendance, engagement in class and/or academic performance.

Managed via their Boards of Studies, academic departments have a range of committees concerned with students' academic progress and fitness to study. For

example, departmental Mitigating/Exceptional Circumstances Committees feed into the University's policies around academic mitigation and special cases and, for students on professional programmes, Fitness to Practice Committees are aligned to the requirements of external validating bodies. However, neither has a remit of student support. We were also advised that supervisors and departmental support staff can be unsure about the boundaries of their role and, in particular, how to respond to students in need of professional help.

The Action Plan therefore includes Actions to improve Departments' capacity to identify and support students whose health and personal circumstances give cause for concern. Three actions are recommended: (i) the establishment of Department-level student support committees, (ii) more clearly signposted guidance for supervisors and relevant support staff on pastoral responsibilities and referral pathways for students perceived to be at risk and (iii) the inclusion of mental health awareness in PGCAP and other POD provision.

A university environment that helps to promote mental health, prevent ill-health and facilitate access to services is implicit in the University's Vision for Key Objective 3. The Vision is 'to ensure that the University of York offers an environment in which students can optimise their academic and personal potential…we want our students to enjoy their time at York'[47]. While not referring explicitly to student mental health, the operational objectives to achieve this Vision are all about a health-promoting university environment: 'we will provide outstanding pastoral and support services', 'we will listen to our students', 'we will support and develop our colleges' and 'we will provide facilities that enhance the students' experience'[47].

This focus on student wellbeing is integral to the university's traditions and ethos, and is a cornerstone of the University Strategy as whole. We therefore noted with concern that it is not underpinned by strong governance structures.

Responsibility for the student experience – of which their wellbeing is an essential part - is built into the roles and responsibilities of the University Executive Board (it

is tasked with developing strategies related to the student experience[48]). Among the UEB members, the PVC for Teaching, Learning and Students has responsibility for enabling students to have an 'overall experience [that] is enriching and rewarding'[49] and the Registrar has 'overall responsibility for the central support services of the University'[50], services that provide essential building blocks for student mental health and wellbeing. These include Student Support Services, Campus Services and Health, Safety and Security.

However, the only University committee with terms of reference that relate directly to students' overall experience at York is the Student Life Committee. Its terms of reference[51] include overseeing 'progress in addressing Key Objective 3 of the University Strategy' to offer all our students an outstanding and valuable experience and identifying 'the needs of specific groups of students'. The Committee is relatively new. Jointly chaired by the Registrar and the YUSU president, feedback to the Task Group made clear that the Committee is working well. However, it occupies an anomalous position in the University's governance structure; it reports to the Finance and Policy Committee and, via that Committee, to Council.

We could find no committee that has the promotion and monitoring of student health and wellbeing among its core responsibilities and with reporting lines that run upward through the UEB and Senate.

A key Action Point therefore relates to strengthening the governance of student mental health and wellbeing. This requires direct reporting lines to Senate, via the UEB, and to Council. We suggest that the role of the PVC for Teaching, Learning and Students should explicitly include responsibility for promoting student mental health and wellbeing. With the Registrar and the YUSU president as co-chairs, we regard the Student Life Committee as having the potential to deliver on revised terms of reference that include the promotion of student mental health and wellbeing, thus aligning the committee more squarely with the University's Vision and Strategy. With its ToR appropriately recast, its reporting lines should run directly to Senate (via the UEB) and Council.

Stronger governance structures should be complemented by (and detailed in) an enhanced university student mental health policy. The University's student mental health policy[46], like policies at other universities, describes the current structure of services but does not lay out future ambitions and actions. It has also been 'largely superseded by the Fitness to Study Policy'[46], which again describes provision and procedures[52] rather than setting out objectives for the future and a plan and course of action to achieve them. Therefore, the development of an enhanced University of York student mental health policy is included in the Action Plan. As noted in section 3, there are now a range of frameworks and templates to guide such a policy[1, 35].

Mechanisms for student feedback on current provision should precede and inform this enhanced policy. As noted earlier (section 4.1), ensuring these mechanisms are in place is included as an Action in the Action Plan. Other Actions will also directly support the policy, including the development of an integrated website for student mental health and wellbeing. As well as signposting University services and sources of support, the website would bring together web-based information and support aids. These include ones provided by the NHS[53], Samaritans[54], Mind[55], Student Minds[56], Mental Health First Aid[57], Cruse[58], ReThink Mental Illness[59] and Papyrus[60]. Among these resources and sources of support are ones for people supporting friends and family with mental ill-health and/or who have been affected by suicide. Examples include the NHS resource 'Help is at Hand' and Student Minds' 'Look after Your Mate' initiative. Some of these web-based resources are available through University-hosted websites; others are currently only available through external sites. An integrated website would help students find their way to the information and support that they feel best meets their needs.

5 MENTAL HEALTH SERVICES FOR YORK STUDENTS

The shortfalls in mental health services evident across the country have been described in section 3.1. These shortfalls are particularly evident in York, including the service gaps and delays highlighted in the recent NHS mental health taskforce[40] (see box in section 3.1). This section details some of the particular challenges for York students, including those at York St John University and York College, seeking and needing support for mental health difficulties.

Notwithstanding these pressures on York's mental health services, the Task Group noted the importance of UoY students registering with the University's Health Centre as soon as possible after their arrival. Non-registration introduced further difficulties and delays in accessing local services.

Improved access to psychological therapies (IAPT) services are less well developed in York than in other areas and long waiting times (18 months wait for initial appointment and subsequent waiting list for treatment) mean that these services are, in practice, not available for York students. In addition, we found evidence of inequities in student access to mental health services. Information provided to Student Services indicates that Leeds students have reasonable access to psychological therapies (IAPT). Leeds students also have greater access to secondary mental health care, including community psychiatric nursing and psychology, and appropriate safe inpatient care. The Durham and Darlington IAPT service is run by Tees, Esk and Wear Valleys NHS Trust (TEWV). Via contacts at the Durham and Darlington IAPT service, we have been advised that the Durham and Darlington IAPT service provides 'substantial bespoke provision for students'. Now that York's mental health services are run by the same Trust (i.e. by TEWV NHS Trust), there is a real opportunity to match this bespoke provision for students in York.

Existing inadequacies in provision have been exacerbated by the closure of Bootham Park hospital in Oct 2015, after an unannounced inspection by the Care Quality Commission (CQC) concluded that patients were at significant risk of harm. As of

30 March 2016, Bootham Park Hospital remains closed to inpatients. Thus, despite having the 'Single Point of Access' (which the University negotiated with the local provider), it has invariably been the case that students are admitted to hospital out of area. This is particularly problematic for international students for whom the alternative of a return to their home NHS provider is not an option.

These multiple pressures on inpatient and outpatient care are making it more difficult for students to combine academic study with medical treatment. This includes the pressures on students who spend two to three days a week accessing care (e.g. outpatients care) at locations outside York.

It was reported at a meeting of the CAMHS executive on 22nd March that the 'Section 136'[61] Suite (closed following the closure of Bootham Park Hospital and reopened on 16th December 2015) remains in operation and outpatient services (re-opened at Bootham Park Hospital more recently) continue, although there are significant waiting times for students and other members of the York community. However, there are no plans to reopen inpatient facilities at the Hospital site. Instead, from 'summer' 2016, Peppermill Court will provide male and female inpatient facilities. The current proposed judicial review would consider how the decisions around the hospital closure were made and is unlikely to impact on service provision.

Given the multiple issues related to York's mental health services, a strong University voice is urgently required. Representing the largest student community in the city, the University has a particularly important role to play in pressing for action to improve services for the York student community. The University should be actively leading a co-ordinated approach to improve mental health services for students in York and North Yorkshire (see **Recommendation 2 of the Action Plan**). There is scope for working jointly with other higher education providers and with the student unions in York. The student unions are establishing a Student Unions' Collective Project, which YUSU is leading, to highlight and seek to address inadequacies in mental health provision in the City. The first meeting is in week 1 of

the summer term and will focus on sharing knowledge and experiences and planning joint lobbying activity.

There are two developments on which the VC and senior colleagues can build. The first, as already noted, are the new providers of mental health services, Tees, Esk and Wear Valleys NHS Trust. With the Clinical Commissioning Group (CCG), there is an opportunity to press for improved transition arrangements for students in contact with mental health services prior to arrival at the University and for increased provision of IAPT services for York's students.

A second positive development is the North Yorkshire Suicide Prevention Plan. In response to the government's 2012 suicide prevention strategy[31], North Yorkshire County Council's Suicide Prevention Group has developed a Suicide Prevention Plan for N Yorkshire and York[62]. The Plan is built around five recommendations. These include reducing the risk of suicide across the North Yorkshire population, particularly targeting high-risk groups; recognising that 'multiple stresses multiply risk'; enhancing service provision in relation to common stressors; and better supporting those affected by suicide in North Yorkshire in the days, months and years after a death. The North Yorkshire Suicide Prevention Plan also recommends improving data collection and monitoring and investing more in training and awareness. All of these relate to the needs of York's students, and can therefore support the University's Action Plan. To ensure this happens, maintaining and strengthening links with the Suicide Prevention Plan Implementation Group is included in the Action Plan.

6 RECOMMENDATIONS AND RESOURCES

We make two overarching recommendations. Transparency is built into both. Delivering on the recommendations will require clear lines of reporting and responsibility and open communication of progress to students and staff. Our Action Plan is designed to deliver the recommendations over the next 12 months and Action updates should be provided across (and beyond) this period.

Recommendation 1: take immediate steps to improve University support for student mental health

Actions:

1. Complete ongoing work related to student mental ill-health
2. Enhance mechanisms for student feedback on current UoY mental health provision
3. Establish an integrated UoY website for student mental health
4. Ensure support for 'first contact' staff providing crisis support for students
5. Improve Departmental capacity to support students
6. Take a proactive approach to social media abuse
7. Strengthen University governance structures for student welfare
8. Review and implement a UoY Student Mental Health Policy

Recommendation 2: ensure a coordinated approach to improve mental health services for students in York and N Yorkshire

Actions:

1. Establish formal channels of communication between UoY and TEWV Foundation Trust
2. Build closer links with local agencies to better support students experiencing mental ill-health and those supporting them
3. Lead the momentum for improving service provision for York's 30,000+ students and the wider York community

Resources

Delivering the Action Plan will require upfront resources. While not within the remit of the Task Group, it may be helpful to note our assessment of resource needs.

1. Resource officer with mental health knowledge and IT skills (gr6/gr 7 100% FTE for 12mths)

The officer would support and drive forward actions requiring dedicated time and skill. These include supporting the integrated websites plus signposting and scoping exemplars for a University mental health policy and providing broader support for the Action Plan.

2. Ensuring sufficient resource for the ODT

While improving wider support for student mental health (recommendation 1) and pro-active engagement to improve local NHS provision (recommendation 2) will help to ease pressures on the ODT and the users it serves, it is clear that the team will continue to shoulder the burden of student distress. As noted in section 4, additional resources have been provided for ODT from summer term 2016 on a fixed-term basis. However, we recommend a more systematic review of the demand for and staff resource available to Open Door to ensure student needs are appropriately met without undue pressures on staff. A bid to UEB for additional support for the team may follow.

3. Other resources to support the Action Plan

Communication strategies will be required to support a number of Actions (e.g. the roll-out of the integrated UoY website and action to address social media abuse). Resources cannot be assessed at this stage. UEB should therefore be open to bids for funds, and to offering help to YUSU to prepare a bid to support work on social media abuse. There may also be opportunities for DARO to identify sources of external expertise and resources to progress this Action.

University of York Student Mental Health Action Plan

Recommendation 1: **take immediate steps to improve University support for student mental health**

Recommendation 2: **ensure a high-level and coordinated approach to improve mental health services for students in York and N Yorkshire**

Recommendation 1: take immediate steps to improve University support for student mental health

This requires the following Actions:

1. **Completing ongoing work related to student mental ill-health**
2. **Enhancing mechanisms for student feedback on UoY mental health-related provision**
3. **Establishing an integrated UoY website for student mental health**
4. **Ensuring support for 'first contact' staff providing crisis support for students**
5. **Improving the capacity of academic departments to identify and support students whose health and personal circumstances give cause for concern**
6. **Taking a proactive approach to social media**
7. **Strengthening University governance structures for student welfare**
8. **Developing and implementing a new UoY Student Mental Health Policy**

Objective	Actions	Action by...	Timeframe	Update (i.e. log of actions completed)	Lead
1. Complete work currently in progress related to students experiencing mental ill-health	Complete and disseminate missing student protocol	Student Support Services; AHoC Alcuin College; Registry Services	by June 2016	New guidance on the 'assumed withdrawal' process was issued this term and a Missing Student Protocol is under development, both of which need to feed into exceptional circs information and awareness raising	Peter Quinn/ Jim Irving
	Ensure changes to mitigating/exceptional policy (e.g. removing ODT routine involvement in supporting applications) are communicated to relevant teaching and support staff		by June 2016	This is ongoing during AY 2016/17	Asst Registrar
2. Enhance mechanisms for feedback on mental health-related provision	Institute mechanisms for collecting and collating user feedback on mental health-related services (e.g. Open Door services, Unity Health, incl. its Patient Participation Group) and provision (e.g. Mental Health First Aid courses, College-based pastoral support); Use user feedback to inform service improvements (e.g. reducing missed OD appts) and Univ investment (e.g. wider roll-out of MHFA)	Open Door manager, College Heads/AHoCs, Univ Medical Advisor, Rachel Barber (YUSU), Peter Gorbert (GSA)	by Jan 2017		Director of Colleges with Manager of Open Door and Disability

3. Establish an integrated UoY website for student mental health Linked across relevant sites, this should provide a 'one-stop shop' for student access to web-based information, including self-help guides and how to access additional support to: (i) promote positive mental health (ii) help with mild/transitory mental ill-health (iii) support those affected by the distress of other students, incl. info on first contact points and accessing crisis support It should also emphasise the importance of all students registering with the Health Centre	Review web-based information & support aids available via Univ websites (on/accessible thru YUSU, Colleges, Open Door, GSA, Health Centre etc) Review web-based information & support aids available via other sites (e.g. voluntary agencies/NHS) Informed by student feedback, select & integrate web-based information and support aids, including clear sign-posting Develop and roll-out a communication strategy to publicise the website	Open Door nominee, Internal Comms Team and Web Team nominees, YUSU/GSA, College Heads and student college leads, other UofY staff with relevant expertise	Mar 2015 to Mar 2016; roll-out from Mar 2017		Internal Comms Team and Web Team Lead (advised by Head of Open Door and Disability)
4. Ensure support for 'first contact' staff providing crisis support for students (signposting, information, training, protocols, support)	Provide an integrated package of information, training, protocols & signposting for staff aware of and/or supporting students in distress (e.g. MHFA, Safetalk training) for 'frontline' staff (in Colleges, Library, Depts etc)	Helen Selvidge (HR); Jo Hardy (HSSD); Denis Fowler (HSSD)	Mar-Dec 2016; roll-out from Jan 2017		Director of Health, Safety and Security with Asst HR Director

5. Improve Departments' capacity to identify and support students whose health and personal circumstances give cause for concern	Institute Departmental student support committees across all Departments	Template development by: 3 HoDs/BoS Chairs, 3 Dept Managers (1 per Faculty), then action by HoDs/BoS Chairs	Mar-Dec 2016; roll-out from Jan 2017		Academic Registrar
	Review guidance to supervisors and relevant Dept support staff to ensure clarity regarding pastoral responsibilities and referral pathways for students perceived to be at risk	Registry Services	Mar-Dec 2016; roll-out of new guidance from Jan 2017		Director of Student Services
	Include student mental health awareness in PGCAP and other POD provision	Head/nominee from Academic Practice and HR Learning & Dev't teams	Mar-Aug 2016 to be incorporated into PGCAP from Sept 2016		Head of Academic Practice, Lead for HR Learning & Dev't
6. Take a proactive approach to social media abuse	Use internal and external (e.g, DACO) expertise to develop an approach to harnessing social media for positive interactions and making students aware of how negative social media usage can be tackled. This could include active bystander training and peer-led initiatives to reclaim social media	YUSU/GSA, College Heads/Asst HoCs, External Relations	Mar-Dec 2016; roll-out from Jan 2017		YUSU/GSA nominees with Director of Student Support Services

7. Strengthen University governance structures for student mental health and wellbeing	Establish clear lines of responsibility and reporting, incl. to Senate and Council. This should include responsibility for ongoing monitoring of student mental health (e.g. ODT data), user feedback (see Action 2 above) & Univ provision to enable Univ to have services in line with best practice	PVC Teaching & Learning and Registrar with YUSU/GSA	Mar-Dec 2016; to Senate Jan-Mar 2017		UEB
8. Develop and implement a new UoY Student Mental Health Policy	Seek out UK/international exemplars of mental health policies that include clear objectives, actions & monitoring Establish a staff/student policy development group. Policy should be clear on UoY/NHS duty of care to students Policy should emphasise student registration with Health Centre	Senate-approved policy development group, to include student representation plus staff with relevant MH expertise	Mar 2015 to Mar 2016; to Senate Apr-June 2017		Chair of the policy development group

Recommendation 2: **ensure a high-level and coordinated approach to improve mental health services for students in York and N Yorkshire**

This requires the following Actions:

1. **Establishing high-level channels of communication between UoY and statutory service providers to press for improved mental health provision**
2. **Building closer links with local agencies to better support students experiencing mental ill-health & those supporting them**
3. **Leading the momentum for improving service provision for all York's students**

Objective	Actions	Action by...	Timeframe	Update (i.e. log of actions completed)	Lead
1. Establish high-level channels of communication between UoY and statutory service providers (TEWV, CCGs, City/NY Health & Wellbeing Boards) to press for improved mental health provision	Establish direct links between Univ leaders and leads of statutory services Resolve concerns about the TEWV's duty of care to the student population of York Seek ways to improve transition arrangements (incl possible dual GP registration for students) Press for student IAPT provision to at least match standards elsewhere in the region Involve Director of PH for York (when apptd)	Director of Student Services; Univ. Medical Advisor; VC	by June 2016		VC

2. Build closer links with local agencies (voluntary and statutory) to better support students experiencing mental ill-health & those supporting them	Ensure UoY representation on key NHS and LA boards and committees, including CCG, CAMHS, Health and Wellbeing Boards, NY Suicide Prevention Group Review links with local voluntary agencies e.g. York Mind, Cruse to assess potential for closer working	Director of Student Services, UEB, Unity Health, UoY staff with relevant expertise Student Services, Chaplaincy, UoY staff with relevant expertise			Director of Student Services Director of Student Services
3. Lead the momentum for improving service provision for the 30,000+ students in the York area	Acting with the local MP and through Higher York, highlight and press for action to improve mental health services for York students, including inpatient York-based care	PVC Teaching & Learning, Director of Student Services, with other York HEIs & Chair & Assoc Director Higher York; YUSU/GSA with other York student unions	Alliance building Mar-Dec 2016; potential campaign from Jan 2017		VC Director of Public Health for York (tba); consider possible Chancellor input

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    N.B. The section allows a police officer to remove a person they think is mentally disordered and 'in immediate need of care or control' from a public place to a place of safety, in the interest of that person or for the protection of others. The place of safety should be a healthcare setting like a psychiatric hospital or, in exceptional circumstances, a police station.

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