Heads Up: Reporting on Mental Health

UCLU
University College London Union

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Foreword

Everyone knows someone who has had mental health concerns whilst at university. The financial, academic and social pressures placed on students coming into the hustle and bustle of a London university can be very straining on any student's mind. Whilst the rates of anxiety and depression increase by the day, the taboo placed on the topic of mental health is still as strong as ever. Some are scared to speak for fear of saying the wrong thing, some are worried that others won't see them the same way and some just don't know who it is that they should confide in.

This stigma is something that needs to be broken down, as the invisible disability of mental ill health isolates, hides and draws a person away from the great things in life. It turns on a grey filter for 1 in 4 students here at UCL and whilst the Student Psychological Services do an incredible job dealing with students as they come, there simply aren't enough resources to reach out to every student facing such issues.

It is this significant stigma and reduced resources that led to the launch of the UCLU Heads Up Campaign. It looks at making UCL a campus where students from all backgrounds can openly talk about their mental health, where they can be seen immediately if they have mental health concerns and where they can be prevented from reaching a stage of crisis in the first place.

This report examines the responses of thousands of UCL students through a paper survey or a focus group and highlights the extent to which they are aware of the mental health services available, the severity of their mental health illnesses if any, and the link between their mental health and demographic compositions. Through this detailed study, four recommendations have been made to UCL, which all look at working with the Heads Up Campaign to make mental health a priority amongst all individuals on our campus.

I would like to show my deepest gratitude to the various individuals who have made immense contributions to the planning, research and writing of this report, particularly Alessandro Massazza, Vicki Baars, Stephen Garry, Simon To and Sinéad Booth, who are the authors of this study and have worked tirelessly to bring the position of mental health at UCL to light for all who read it.

Let's talk mental health together.

Mehjabin Ahmed

Welfare & International Officer

Recommendations

1. Employ effective communication throughout UCL's support services with the creation of a single reference point. Over half of students that participated in our research could never, or only occasionally, identify where to access psychological support at UCL.

2. Destigmatise mental health through a collaborate campaign delivered by UCL and UCLU. Attitudinal work should be undertaken through an educational and emotive campaign, paying particular attention to the disproportionate level of perceived stigma suffered by male students with mental health difficulties.

3. Identify designated staff contacts who will provide pastoral support. These roles should be on a voluntary basis but include standardised training to enable staff to support students suffering with mental health difficulties.

4. Increase funding to UCL Student Psychological Services by £340,000. This would translate to 6.5 new staff members, necessary to cover the numbers of students accessing the service. This would shorten the waiting list, facilitate follow-up with students and allow for additional support where needed.

1. Introduction

1.1. Research highlights that higher education students typically display higher levels of mental distress than the general population. In a study of 1,208 UK students by Stewart-Brown *et al.* (2000), higher education students scored considerably lower in terms of health status as measured by the Short Form Health Survey (SF-36) than their equivalent non-student age group local population (Stewart-Brown *et al.,* 2000). The most striking difference related to emotional problems, with up to two-thirds of students confessing that anxiety about university studies was limiting their ability to work. Roberts *et al.* (1999) also found that the mental health of two London universities' student populations, as measured by the General Health Questionnaire (GHQ), was substantially lower than that of the general population.

1.2. Research on student mental health in the UK reports various levels of heightened mental distress among higher education students. In a study by Andrews and Wilding (2004), involving 351 UK students surveyed one month before starting university and mid-course, 9% of students who had no symptoms before starting university had depression as measured by the Hospital Anxiety and Depression Scale (HADS) and 20% had clinically significant anxiety by mid-course. A similar longitudinal study by Cooke *et al.* (2006) involving 4,699 UK higher education students also found that, though levels of mental distress fluctuated across the first year of university, it never returned to pre-enrolment level.

1.3. According to Bewick *et al.* (2008), who found that anxiety was higher than depression within their cohort of 1,129 university students, university appears to be an "anxious rather than depressive time" (p. 2). Indeed, in a research paper by Webb *et al.* (1996), students reported strikingly lower levels of HADS-measured depression (13%) than anxiety (54%). However, our datasets do not support this finding, as among UCL university students the rates of depression were higher than the rates of anxiety. Several changes in the university system and in the demographic structure of the student population might have influenced this shift in psychopathological trends.

1.4. In a longitudinal study by Zivin *et al.* (2009) of 2,843 USA higher education students, depression rates (as measured by the Patient Health Questionnaire-9) were substantially higher than anxiety rates at both Time 1 and Time 2 (15.3% vs. 4.75% and 12.93% vs. 6.97%). The National College Health Assessment reported that one in three undergraduate students in the USA reported feeling "so depressed it was difficult to function" at least once during the year. Furthermore, one in ten students had reported "seriously considering attempting suicide" (American College Health Association, 2008).

1.5. In a similar study by Drum *et al.* (2009) of a sample of 26,000 USA university students at 70 different institutions, 18% of undergraduate and 15% of graduate students had "seriously considered attempting suicide" and 6% of undergraduate and 4% of graduate students had "seriously considered attempting suicide" in the past 12 months. These results further highlight the importance of collecting data on the patterns of suicidal ideation and behaviour among student populations. In a study of a large student section at the University of Leicester (Grant, 2002), 40% of the student sample reported sadness, depression and mood changes with 14% of them scoring 2 or more (moderately distressed) on the Brief Symptom Inventory for depression. On the other hand, 23% of them had experienced anxieties, phobias and panic attacks.[1] However, as Grant highlighted in her account of the Leicester Student Psychological Heath Project while much of the previous work on mental health in higher education has focused on particular issues and specific conditions, little work has attempted to provide a more general and broad picture of university students' mental health.

1.6. A more recent 2016 Unite report of 2,169 university applicants and 6,504 current students found that 12% of the respondents identified themselves as having mental health difficulties. Furthermore, 32% of students reported that they had "always or often felt down or depressed" in the previous four weeks and 30%

[1] More information on the Leicester study and on past research on student mental health can be found in the comprehensive volume "Students' Mental Health Needs - Problems and Responses" (ed. Stanley and Manthorpe), 2002.

reported “always or often feeling isolated and lonely”. These results are similar to the findings of our survey with 33.8% of the surveyed male population and 35.2% of the female population at UCL displaying moderate levels of mental distress. As stressed by the Higher Education Policy Institute report, it appears that students in higher education express moderately high rates of mental distress in comparison with the general population, though rates of psychiatric disorders are lower (12% in the Unite report versus 23% of the whole population in the 2007 NHS Adult Psychiatric Morbidity household survey).

1.7. The College Report CR166 (2011) commissioned by the Royal College of Psychiatrists also constitutes a recent and comprehensive review of the literature on mental health in UK higher education. This report called for up-to-date research on the subject of mental health in higher education institutions due to changes in wider socioeconomic conditions within British and global society and shifts in the demographic structure of the university population partially sustained by a widening participation agenda. The research group was particularly struck by “the paucity of recent, high quality research into the nature and prevalence of mental disorder (including drug and alcohol abuse) in the UK student population” (p. 14).

1.8. Finally, the 2016 report “The Invisible Problem? Improving Students’ Mental Health” by the Higher Education Policy Institute presents an excellent standpoint for mental health policy implementation and there are many similarities between their recommendations and those presented in this report.

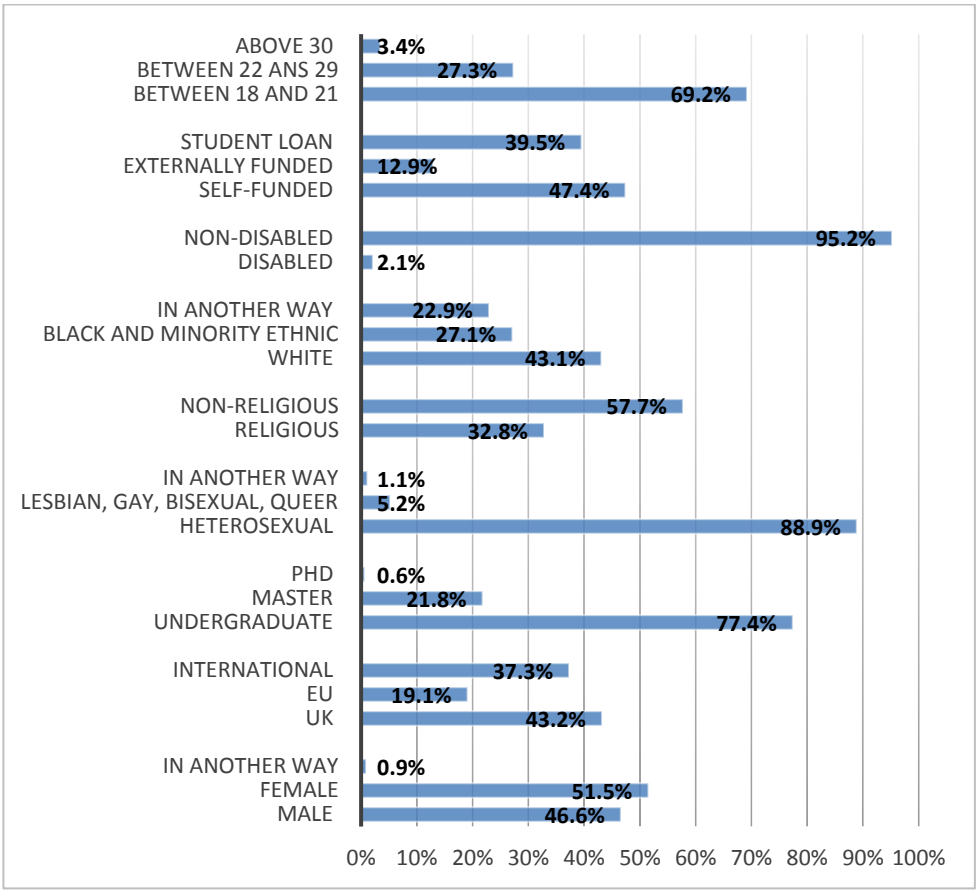
2. Quantitative results

2.1. A detailed description of the study methodology is given in Appendix 1. Briefly, during the months of February and March 2016, we collected mental health data from 2,567 students through a paper-based questionnaire and 314 students through a web-based questionnaire. This sample of 2,881 students represents approximately 7.5% of the total UCL population.

Paper Survey of Students

2.2. The sample of students who responded to this survey is broadly representative of the total UCL population in terms of demographic characteristics (Figure 1). According to UCL Student Statistics, in the year 2015-16 the student population was composed of 42% males and 58% females, 71% home students and 29% overseas students, 53% postgraduate students and 47% undergraduate students and 5.9% students with a reported disability (with 19.2% of the total disabled students reporting a mental health difficulty in the year of 2015-2016). Unfortunately, due to the lack of UCL-wide data on sexual orientation, gender nonconformity, religion and age we were not able to make comparisons between our study sample and the total student population for these characteristics. A limitation of our study sample was the under-representation of PhD students (0.6% of the sample) due to the difficulty in accessing this specific student population. The considerably higher participation of PhD students in the online version of the survey (7.3%) highlights a potential benefit of the web-based method of survey collection among PhD students.

Figure 1: Demographics of Survey Respondents (N=2,567)

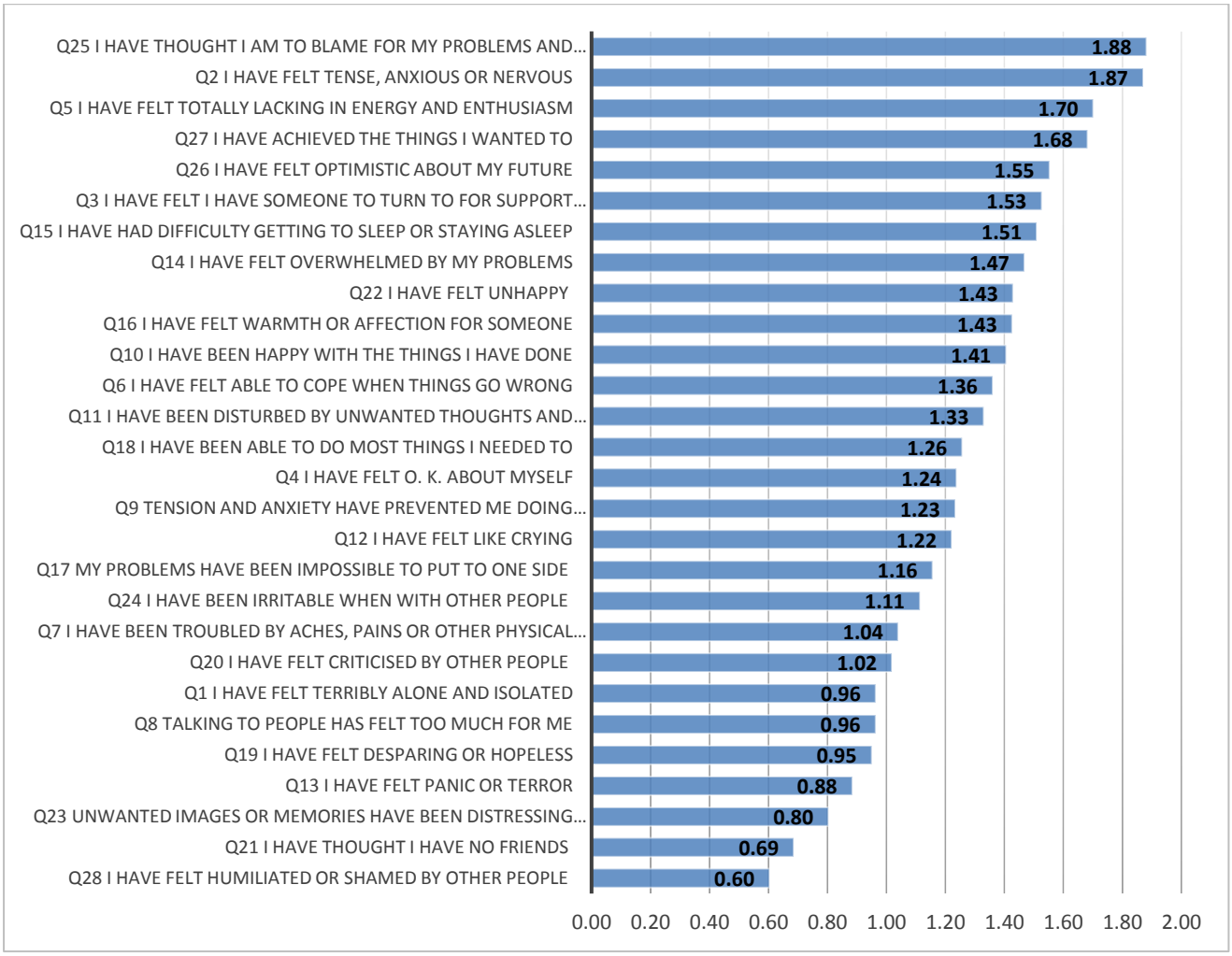


2.3. The paper questionnaire asked students to reply to a modified CORE-OM questionnaire and a set of questions on peer and mental health support preferences at UCL. Figure 2 presents the average CORE-OM scores from the student sample.

2.4. When interpreting the CORE-OM scores a value of 0 corresponds to “no distress whatsoever” and 4 corresponds to a maximum level of mental distress. Figure 2 shows that the highest scoring questions were Q25 “I have thought I am to blame for my problems and difficulties” (mean score=1.88), Q2 “I have felt tense, anxious or nervous” (mean score=1.87) and Q5 “I have felt totally lacking in energy and enthusiasm” (mean score=1.70). Questions with the lowest means scores among our student sample were Q28 “I have felt humiliated or shamed by other people” (mean score=0.60), Q21 “I have thought I have no friends” (mean score=0.69) and

Q23 “Unwanted images or memories have been distressing me” (mean score=0.80).

Figure 2: CORE-OM Mean Scores for Each Question in the Paper Survey



2.5. According to CORE-OM guidelines, the overall expected mean score in a non-clinical population is 0.88 and 2.12 in a clinical population. The overall mean score in our study sample of UCL students was 1.25, higher than would be expected in a non-clinical population (Table 1). This pattern of elevated average CORE-OM scores was evident across all three dimensions of the questionnaire (Wellbeing, Problems and Functioning).

Table 1: Mean Score for CORE-OM Dimensions in Paper Survey

Dimension	UCL Students Paper Survey (N=2567)	CORE-OM Non-Clinical Sample (N=1084)	CORE-OM Clinical Sample (N=863)
Wellbeing	1.36	0.91	2.37
Problems	1.27	0.90	2.31
Functioning	1.16	0.85	1.86
All Non-Risk Items	1.25	0.88	2.12

2.6. The Problems dimension is comprised of four different sub-sections in which specific questions refer to anxiety (Q2, Q9, Q13 and Q17), depression (Q5, Q19 Q22, Q25), physical issues (Q7, Q15) and trauma (Q11, Q23). The Functioning dimension is divided in the three sub-sections of general functioning (Q6, Q10, Q18, Q27), close relationships (Q1, Q3, Q16, Q21) and social relationships (Q8, Q20, Q24, Q28).

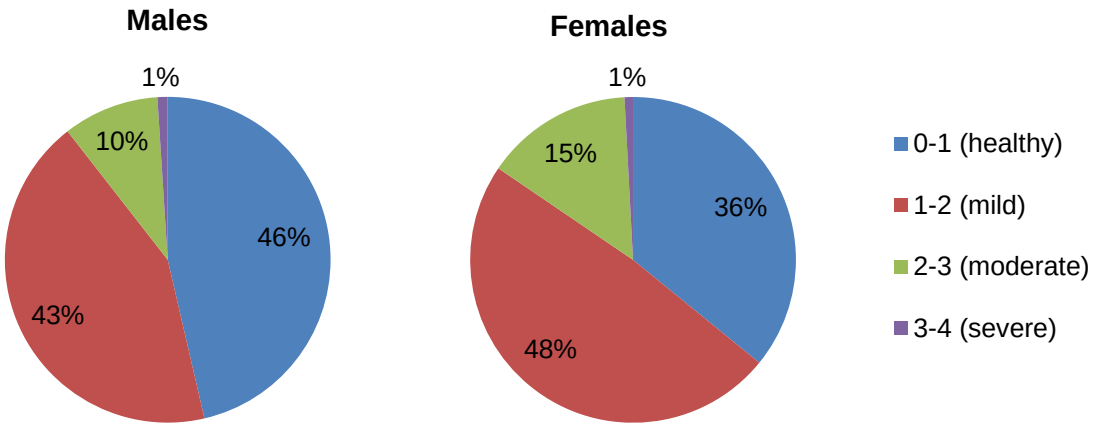
2.7. Within the Problems or Symptoms dimension the most prevalent symptoms shared by UCL students are of depressive nature (mean score=1.49) followed by anxiety (mean score=1.28), physical symptoms, including physical pain and sleep difficulties, (mean score=1.27) and finally symptoms of trauma (mean score=1.06, Table 2). Data from the sub-sections of the Functioning dimension highlight how UCL students scored relatively low on issues relating to social relationship (mean score=0.92) but higher on issues relating to closer relationships, such as friends and support from close others (mean score=1.15).

Table 2: Mean Score for CORE-OM Sub-Sections in Paper Survey

Sub-section	Mean score
Problems dimension overall	1.27
- Anxiety	1.28
- Depression	1.49
- Physical Issues	1.27
- Trauma	1.06
Functioning dimension overall	1.16
- General	1.42
- Close Relationships	1.15
- Social Relationships	0.92

2.8. According to the CORE-OM guidelines, the threshold for clinically significant mental distress is an average score of 1.36 for males or 1.50 for females. Overall, more than one-third of students in the study sample scored above this clinical threshold (33.8% of males and 35.2% of females). The female population had higher levels of mild or moderate mental distress than males, but there was no difference in the level of severe distress, which was 1% for both groups (Figure 3).

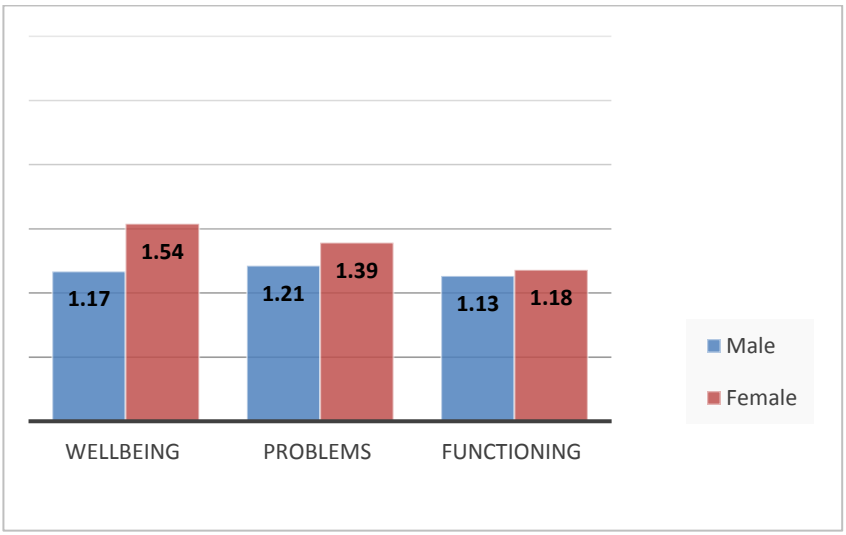
Figure 3: Level of Mental Distress, by Gender



2.9. A greater proportion of students who did not identify as either male or female reported severe mental distress (9% vs 1% for females or males); however, these results should be interpreted with caution due to the small sample size (0.9% of the study sample did not identify as either male or female).

2.10. Following CORE-OM guidelines, clinical thresholds for the Wellbeing dimension were 1.37 for males and 1.77 for females, for the Problems dimension 1.44 for males and 1.62 for females and for the Functioning dimension 1.29 for males and 1.30 for females. The overall average scores for male and female students in our sample were below the clinical thresholds for all three dimensions; however, as Figure 5 highlights, females tend to have higher average scores than males across all three domains.

Figure 5: Mean Scores of CORE-OM Dimensions Paper Survey, by Gender



2.11. Looking within Problems and Functioning dimensions provides further evidence that female students at UCL tend to display higher rates of mental distress (Table 3). The differential between male and female scores is particularly marked within the anxiety sub-section (female-male differential=0.28) followed by depressive symptoms (female-male differential=0.16) and social relationships (female-male differential=0.12). However, in the sub-section of close relationships the male

population scored higher than the female population (female-male=-0.06). This pattern of results was also evident in the online version of the questionnaire.

Table 3: Mean Score for CORE-OM Sub-Sections in Paper Survey, by Gender

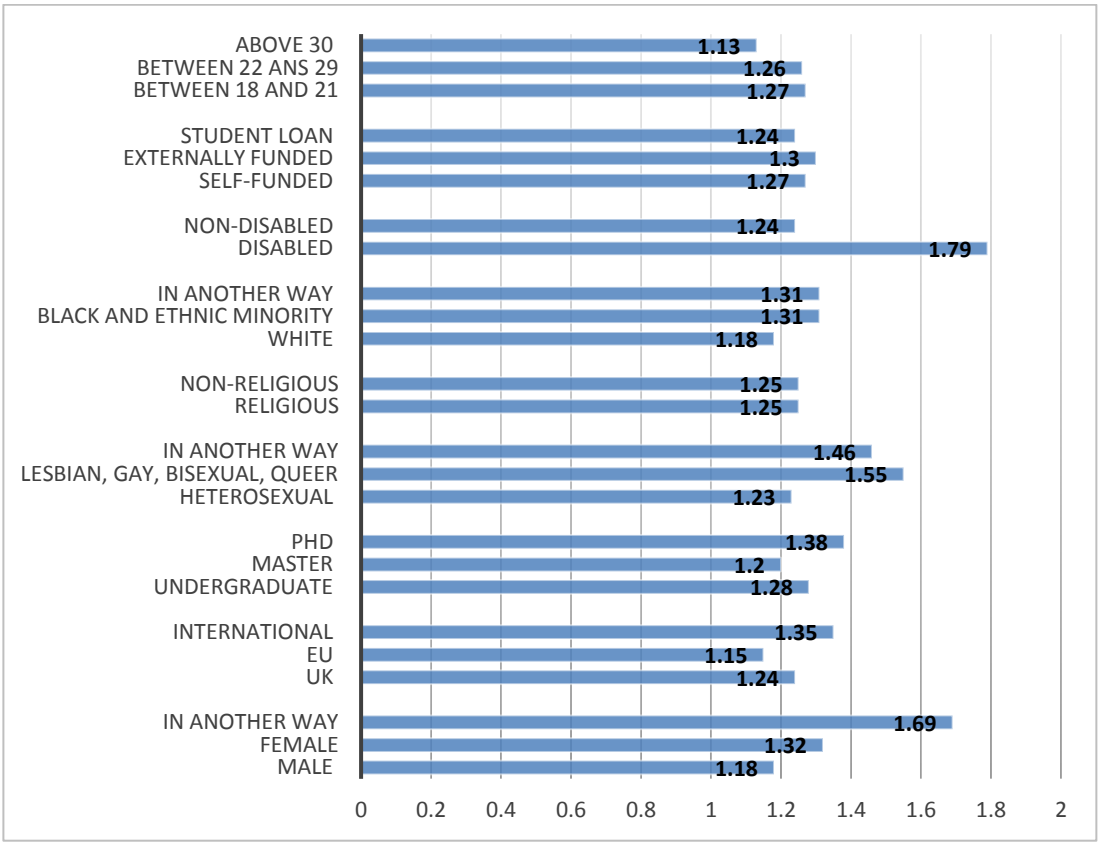
Sub-section	Male mean score	Female mean score	Female-Male Differential
Problems dimension overall	1.21	1.39	0.18
- Anxiety	1.13	1.41	0.28
- Depression	1.40	1.56	0.16
- Physical Issues	1.21	1.32	0.11
- Trauma	1.01	1.10	0.09
Functioning dimension overall	1.13	1.18	0.05
- General	1.37	1.46	0.08
- Close Relationships	1.17	1.11	- 0.06
- Social Relationships	0.85	0.97	0.12

2.12. The mean CORE-OM scores also varied by gender for several questions (i.e. the female-male differential<-0.20). For example, males were less likely to have felt warmth or affection for someone (Q16) or to feel that they had someone to turn to for support when needed (Q13). However, in all the other questions, females displayed higher levels of mental distress than males. In particular, females were more likely to respond that they have felt like crying (Q12), felt overwhelmed by their problems (Q14) and felt tense, anxious or nervous (Q2, female-male differential >0.20).

2.13. In addition to gender, there was variation in average CORE-OM scores by other demographic characteristics. As Figure 6 shows, the demographic sub-groups with the highest average CORE-OM score were: disabled students (mean score=1.79), students who did not self-identify as either male or female (mean score=1.69) and students who self-identified as lesbian, gay, bisexual and queer (mean score=1.55). The sub-groups with the lowest levels of mental distress were: students above 30 years old (mean score=1.13), EU students (mean

score=1.15), students who self-identified as male (mean score=1.18) and finally students who self-identified as white (mean score=1.18).

Figure 6: Demographic Specific CORE-OM Averages for Paper Survey



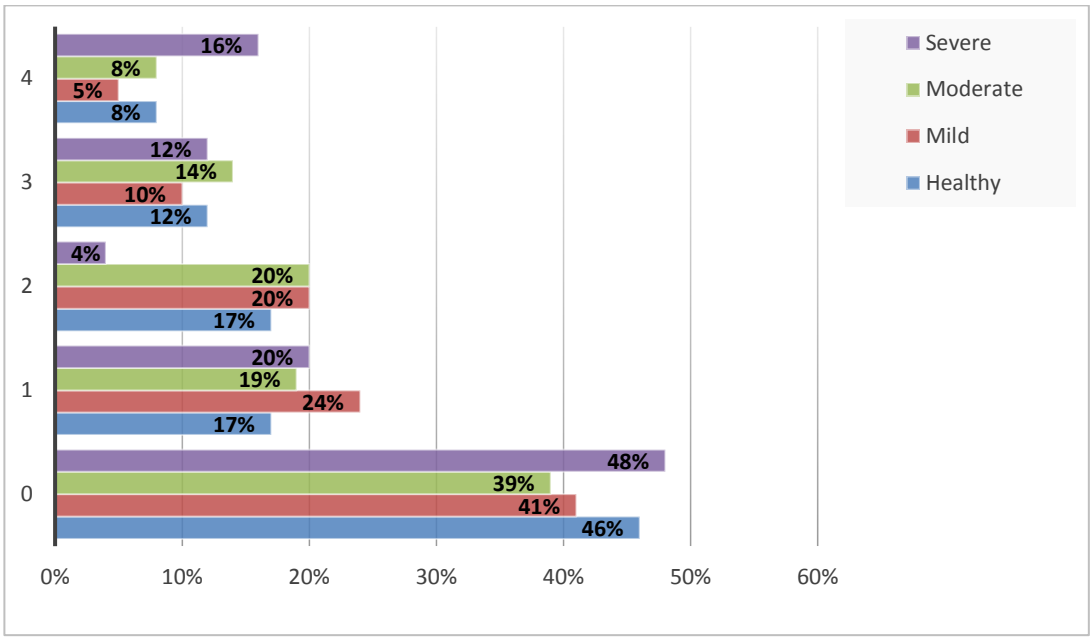
2.14. Besides the modified CORE-OM, the paper questionnaire distributed to the student population also included a series of question focusing on peer and mental health support at UCL.

2.15. The first question asked whether student felt that they knew where to go if they needed psychological support (on a scale of 0 being “not at all” to 4 being “highly aware”). Overall, 20.8% of students replied “not at all” and 35.9% replied “only occasionally”.

2.16. Students with severe mental health difficulties (based on their CORE-OM scores) had higher rates of awareness of the services in comparison to other

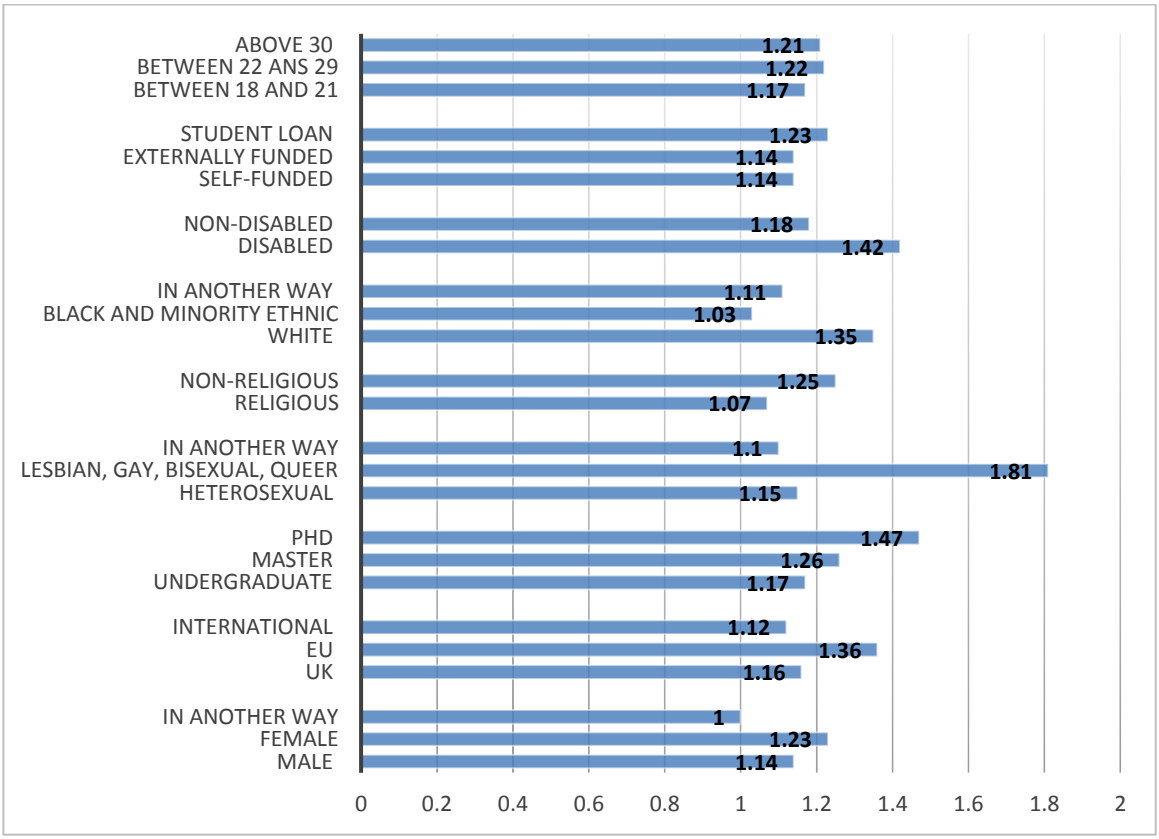
students (Figure 7). For example, 16% of the students with severe mental distress were "highly aware" of the psychological support services available compared to 5% of students expressing mild levels of mental distress. However, almost half of students with severe mental distress (48%) reported being "not aware at all" of where to go if they needed psychological support.

Figure 7: Awareness of Psychological Support Services at UCL (ranging from 0 = "not at all aware" to 4 "highly aware"), by Mental Distress Scores



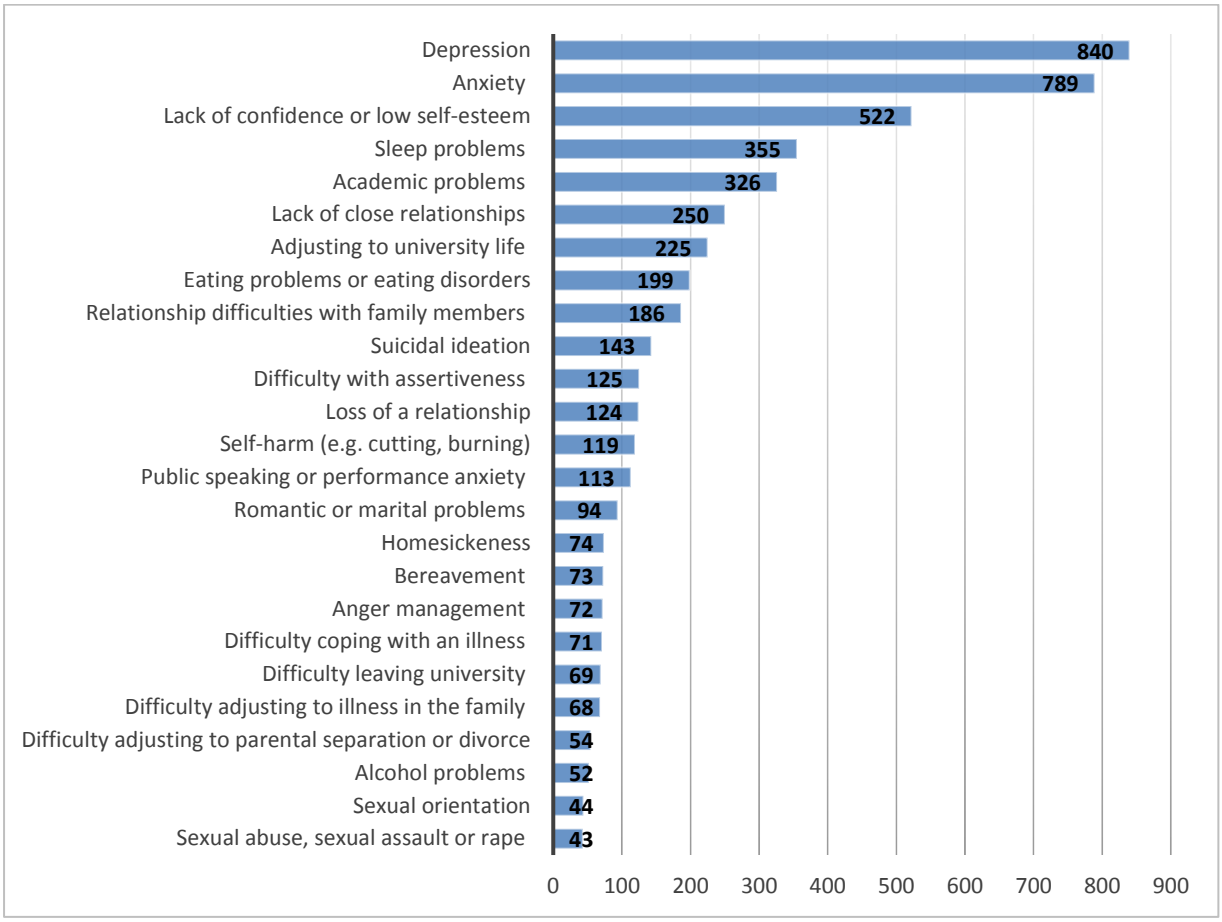
2.17. Lesbian, gay, bisexual and queer students and students with a disability had higher levels of awareness of psychological support services compared to other students (Figure 8). This may be due to higher likelihood of mental health difficulties among these populations. For example, a 2016 YouGov survey reporting that 45% of LGBT students struggled with mental health difficulties versus just 22% of non-LGBT students. Students with the lowest awareness of the support services were students who do not identify as either male or female and black and minority ethnic students.

Figure 8: Awareness of Psychological Support Services by Demographics



2.18. Data from UCL Student Psychological Services represents the most comprehensive and up-to-date source of information related to student mental health at UCL (Figure 9). Of the 2,620 students who registered with UCL Student Psychological Services between 2014 and 2015, 87.6% (n=2,294) presented with multiple problems. The most common mental health difficulties experienced by students accessing UCL Student Psychological Services were depression (16%) and anxiety (15%), a lack of confidence or low self-esteem (10%), sleep problems (7%) and lack of close relationships (5%).

Figure 9: Presenting Problems by Students Accessing Student Psychological Services Between 2014-2015 (N=2,620)



2.19. Among our study sample, the CORE-OM question with the highest average score was “I have thought I am to blame for my problems and difficulties” (mean score=1.88). An increased likelihood of blaming oneself for situations that are out of one’s control may be associated with the widespread lack of confidence and self-esteem expressed by students registering with UCL Student Psychological Services. Additionally, the elevated level of sleeping difficulties evident in the data from UCL Student Psychological Services is consistent with the high average score for the question “I have had difficulty getting to sleep or staying a sleep” among the students in our study sample (mean score=1.51). Finally, academic problems as a presenting problem for students registering with UCL Student Psychological Services correlates with the discussion of mental

health difficulties related to academic performance and stress during the focus groups conducted as part of this study (see Section 3).

2.20. Additionally, there is anecdotal evidence from UCL Student Disability Services that "students predominantly present with depression and or anxiety"; however, students also present with eating disorders, personality disorders, bipolar disorder and schizophrenia.

2.21. The CORE-OM questionnaire does not focus on drug use and is not a focus of this report. However, in January 2016, a drug use survey was carried across UCL out by the drug harm reduction hub drugsand.me.[2] In total, 113 participants completed the survey which was distributed to all UCL Life Sciences departments via email and shared on social media. Overall, 94% of respondents were students and 74% between the ages of 17-21 with 61% of them being male and 39% female. The incidence of drug use was high with 72% of the respondents reporting having tried a class B drug (e.g. cannabis) within the last two years and 39% having tried a class A drug (e.g. MDMA, cocaine, LSD) within the last two years. Only 23% of the respondents had not taken any drugs (except for alcohol and tobacco) in the last two years. The incidence of illicit prescription drug use was also high (24%). Additionally, most of the respondents (58%) were unaware of information on how to reduce harmful effects of drugs. Those results call for future research on the use of drugs among UCL students and on the provision of reliable information so to reduce the possible harm caused by recreational drugs.

Online Survey

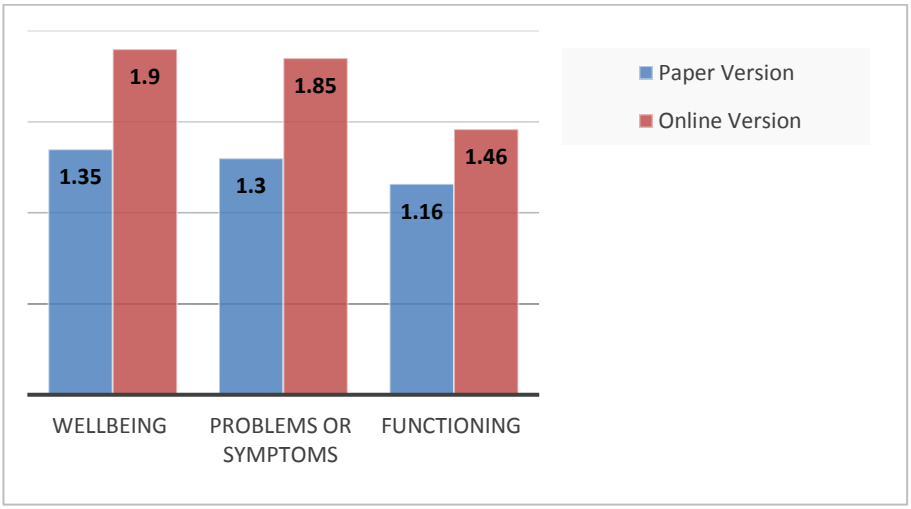
2.22. Students who responded to the online survey (N=314) were different from those who completed the paper questionnaire in terms of demographic characteristics. In particular, 75.7% of respondents identified as female, 16.6% of respondents

[2] This website (developed by UCL students Ivan Ezquerra Romano and Pablo Lubroth and CEU San Pablo student Gabriel Hirschbaeck) provides an excellent source of harm reduction information on several common drugs.

as lesbian, gay, bisexual or queer, 6.3% as disabled and 70% as white. Overall, 7.3% of respondents were PhD students and 64.6% of were UK students.

2.23. The levels of mental distress recorded through the online survey were higher than the paper survey, overall and across the three dimensions of Wellbeing, Problems and Functioning. While in the paper questionnaire the overall, average CORE-OM score was 1.25, in the web-based survey it was 1.69. However, this score is still considerably below the average score for clinical populations of 2.12. The question with the highest average score in the online survey Q2 “I have felt tense, anxious or nervous” (mean score=2.53, Figure 10).

Figure 10: Method Comparison for CORE-OM Dimensions Mean Scores



2.24. Despite the higher average scores, the findings from the online survey were similar to those of the paper questionnaire. For example, in the online survey depressive scores were higher than anxiety scores (mean score of 2.01 vs 1.86) and scores for distress associated with close relationships were higher than the scores for distress associated with social relationships (mean score of 1.39 vs 1.26). The total CORE-OM average score for the male population was 1.52 compared to 1.69 for the female population. Again, the female population was considerably more likely to “have felt like crying” and to “have felt overwhelmed by their problems” but also more likely to “have felt warmth or affection for someone” and “to have felt to have support when needed” than their male

counterparts. Finally, disabled and lesbian, gay, bisexual and queer students displayed higher levels of mental distress in comparison to other groups.

2.25. In conclusion, the students in our study appear to display moderate levels of mental distress, with more severe mental health difficulties evident among some sections of the student population, such as females, lesbian, gay, bisexual, queer students and students with disabilities. The mental health difficulties of UCL students are higher than the non-clinical population's rates suggested by the CORE-OM, though it is still considerably below the levels of a clinical population. However, more than one-third of students in the sample exceeded the clinical threshold of mental distress.

3. Qualitative Results

3.1. These results are based on a series of focus groups involving 36 students in total. A detailed description of the study methodology is given in Appendix 1.

Mental Health Difficulties

3.2. The most frequent theme in focus groups discussions concerned mental health difficulties experienced while studying at UCL (17% of the total conversations, Figure 11). The most common mental health difficulties discussed were academic stress (28.7% of the mental health difficulties thread), depression (22.9% of the mental health difficulties thread) and anxiety (13.7% of the mental health difficulties thread).

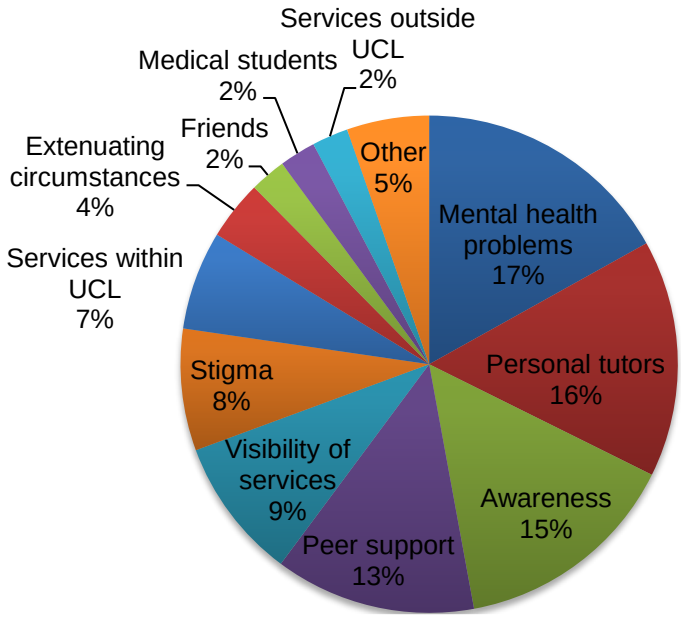
3.3. A second theme that emerged from the focus groups regarded the interaction between students experiencing psychological distress and their personal tutors within departments (16% of the total conversations). In particular participants called for an increased knowledge of mental health difficulties by tutors (76% of the personal tutors thread), potentially via a series of training initiatives, and for a more careful selection of personal tutors by departments (4% of the personal tutors thread). Additionally some students expressed significant levels of concern regarding the possibility of their mental health disclosure being used against them by their personal tutors as a result of stigma (20% of the personal tutors thread).

3.4. The general lack of awareness surrounding mental health difficulties among UCL's student and academic populations and the levels of stigma surrounding mental illness (8% of the total conversations) were also an important theme (15% of the total conversations).

3.5. The fourth main theme related to the insufficient visibility and limited cohesion of the support services at UCL (9% of the total conversations). Focus group participants discussed the provision of support services within UCL (7% of the total conversation), with particular attention to the UCL counselling services (Student Psychological Services) (49.1% of the support services within UCL

thread). There were also discussions of peer support that will be published separately in further report.

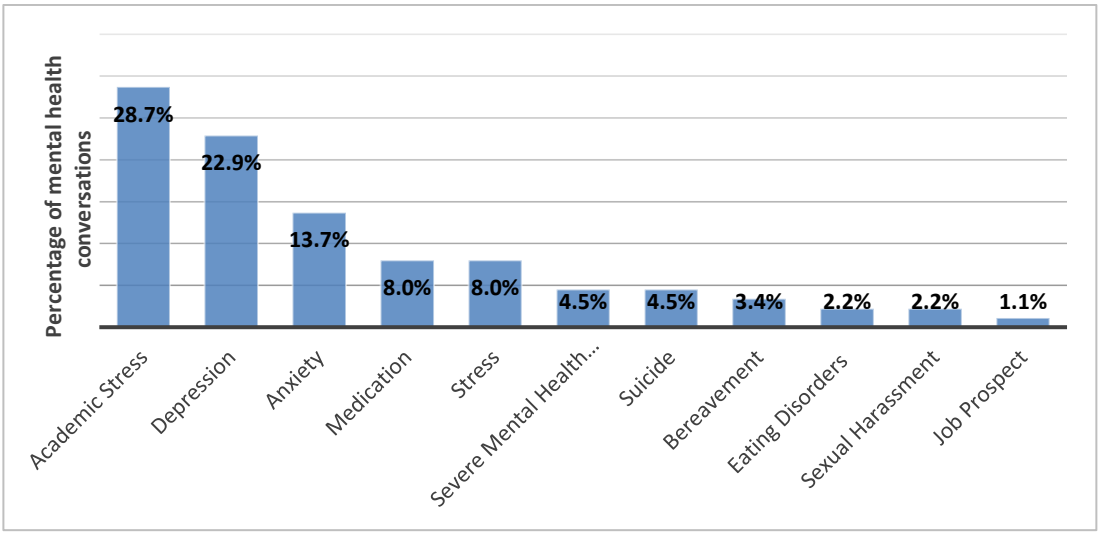
Figure 11: Focus Group Themes



3.6. Participants in the focus group mentioned a variety of mental health difficulties ranging from diagnosed and long-term psychiatric conditions to milder environmental factors such as relationship and family difficulties (Figure 12). However, the most widely mentioned mental health difficulty concerned the elevated levels of stress resulting from academic pressures. In most of the cases, the increased levels of stress were not a problem *per se* but rather a mediating mechanism that triggered symptoms of anxiety, depression and other mental health difficulty. Many participants perceived UCL to be a highly stressful environment due to academic deadlines, peer pressures and competition, future job prospects and perfectionism. According to one participant, the general attitude towards academic performance at UCL was that "*if you cannot stand the heat, just get out of the kitchen".* Following this statement she stressed how:

"When it comes to intense academic work, professors and lecturers always take the attitude "you know, if you can't handle it… just go!" instead of [saying] it's not a problem, you can do it"

Figure 12: Mental Health difficulties in Focus Group Discussion



3.7. Similarly participants often identified themselves and other students as being *"high-achievers"*. This often resulted in unrealistic comparisons and idealistic goal setting, especially as some students felt that they had gone from being *"big fishes in a small pond to being small fishes in a big pond"* in their transition from high school to university. While this insight was virtually ubiquitous, its intensity varied according to departments and academic pathways.

"There is a fear that by going to the uni and saying "oh I am not coping with my work" that they are going to think less of me or they'll kick me out or they're all going to point to that sick person"

3.8. Many participants reported the belief that this level of academic pressure could act as a potential trigger for the development of mental health difficulties, or as a precipitating variable for the worsening of pre-existing mental health difficulties. As one participant wondered, "*isn't it that UCL is just exacerbating everyone's*

problems?" While stress is not inherently negative, intense or chronic environmental adversity is a potential trigger for the development of a vast array of mental health difficulties including mood disorders and substance use disorders (Dohrenwend, 2000). Furthermore, individuals suffering from pre-existing mental health difficulties and entering a perceived-as-stressful environment might display impaired levels of resilience and less effective coping mechanisms in managing external stressors (Kessler *et al.*, 1985). Answering the question of what services they would have liked to see implemented at UCL in the future, a participant responded:

> *"Yeah just like they* [other participants] *were talking, maybe more stress-relief groups, because I think that stress is the number one issue or to talk about resilience and how to cope with, different things"*

3.9. While stress, as related to academic pressures, was the most prevalent topic in discussing the experience of mental health difficulties while studying at UCL other conditions that were often mentioned were depression and anxiety (mostly as generalised anxiety disorder). While depression was more widely discussed than anxiety, they were both often referred to as occurring simultaneously as would be expected given the elevated levels of comorbidity between the two conditions (Hirschfeld, 2001). There was variation in the severity and duration of presenting conditions among participants with some having experienced long-term, severe and clinically diagnosed disorders while others displaying short-lived, sub-clinical or self-diagnosed symptoms. Nonetheless, some commonalities did run throughout the expression of anxiety and depressive experiences among the participants. Firstly, many students reported the difficulty of acknowledging the presence of a clinical problem and the attitude of simply dismissing their feelings as consequences of external stressors was widespread. Connected to this frame of mind was the external and often internalised belief concerning the need to "*power through*" or "*brush off*" one's own mental health difficulties.

"So I don't have depression but I deal with anxiety and, I think for me it was quite hard to realize that I had this problem because I just thought that I was constantly stressed slash I did not really consciously experience it, like I think it was more like psychotic, before I was aware of that problem I was just subconscious, like you know what I mean and, yeah I think as soon as I started dealing with it and it got better but partly with taking medication I realized that it sort of how some things went away sort of thing so I got better. So I think it is hard for people to sort of realize that you have a problem but I think that a lot of people actually do have that problem like I know that in my friendship group other people have started seeing like their GPs and staff about those things, probably as well as you get in third year the stress is just so much and so for a long time just kind of gets too much"

3.10. Besides anxiety and depressive disorders no mention was made of other psychiatric disorders within the focus group discussion. This does not reflect the epidemiological distribution of psychiatric disorders within student populations. The onset of several mental health difficulties (such as schizophrenia, bipolar disorder and obsessive-compulsive disorder) corresponds to the age-span of university students (Kessler *et al.,* 2005). In addition, the widespread availability and use of alcohol and other addictive substances among the student population (Blanco *et al.,* 2008), together with the potential for sexual abuse and unwanted sexual attention common within university culture (National Union of Students, 2011) means many experience substance use problems and trauma-related disorders. Personality disorders and eating disorders are also known to be present in student cohorts (Sinha and Watson, 2001; Yager and O'Dea, 2008). The lack of discussion about mental health difficulties other than depression and anxiety in our focus groups may be due to the small sample size or participants not wanting to discuss these types of mental health difficulties in a group setting.

3.11. When mentioned during the focus groups the attitude towards more severe mental health difficulties was mixed, with one student advocating for an increased

focus on them while others distancing their own mental health difficulties from a more stereotyped view of "*madness*".

"[It would be important] *also not just being able to deal with the small levels of stress but also for like for more advance mental health difficulty not just like talking about mild anxiety not just talking about like mild depression I mean also more serious and also outside of anxiety and depression"*

"Yeah my dad like he works in mental health so my kind of perception of it was quite extreme so like people who are like hearing things and can't be left unattended and stuff like that so a quite difficult for me to acknowledge that I was having like, being quite anxious and stuff like that and quite a lot of time to acknowledge it […] because I think for someone who is uneducated they just have that kind of, like extreme idea that it is just that crazy person who screams stuff in the streets or stuff like that when in reality I think a lot of people are dealing with it but very few of them talk about it, cause I know probably a lot of my friends I can see that they are extremely stressed, so they are probably experiencing similar issues but then nobody talks about it"

Personal Tutors

3.12. While the predominance of mental health difficulties within the thematic analysis was somewhat expected, an unanticipated result from the coding process was the prevalence of discussions focusing on personal tutors and mental health. The main themes that informed the focus group conversations around personal tutors focused on the perceived lack of mental health knowledge and empathy displayed by certain personal tutors. Other topics of discussion concerned the fears of mental health disclosures negatively affecting the student, the personal tutor selection process, the disproportionate emphasis placed on the academic aspects of a personal tutor's role and the variation among personal tutor systems across faculties and departments.

3.13. The views expressed by the participants regarding the capacity of personal tutors to interact with students experiencing mental health difficulties were polarised, with some students expressing high levels of satisfaction with their personal tutors and others recounting upsetting personal experiences. A generalised belief shared by the focus group participants was the lack of basic mental health knowledge manifested by personal tutors. This absence of mental health expertise pertained mainly to two areas. Firstly, personal tutors were unaware of how to recognise and provide immediate and basic support to students experiencing mental health difficulties. Secondly, focus group participants highlighted personal tutors' lack of knowledge related services available within UCL and the signposting procedures.

> *"During the first term I spoke to my tutor and it was just before I was leaving and I was talking about these problems, these symptoms and he just like "brushed it off" as if it was nothing and I think that if he actually acknowledged it at that time in first term I wouldn't be as bad as I am now, I think if he did something about it there that I wouldn't be unwell now"*

3.14. Additionally, students reported that a minority of personal tutors expressed overtly discriminatory and insensitive attitudes towards students presenting with mental health difficulties. Several participants described various anecdotes experienced by themselves or by close friends in regards to how personal tutors had responded to their mental health difficulties.

3.15. One participant mentioned how their personal tutors would at times end meetings with his tutees by ironically asking whether "*anyone was depressed".* Similarly, a personal tutor responded to their student's concerns over how their anxiety might have affected exam performance by stating: "*oh you can apply for extenuating circumstances… but I took amphetamines to get through my exams!"* Finally, replying to a student's email informing them of the student's

decision to interrupt their studies due to mental health difficulties, the tutors was said to have responded "*oh message me at the end of the term so that I know that you are not dead".* These anecdotes were indicative of a generalised belief among participants surrounding the inadequacy of certain personal tutors in attending to their pastoral duties. Although a lack of factual knowledge surrounding mental health difficulties and signposting procedures is understandable (considering the absence of training), inconsiderate, discriminatory and stigmatising attitudes towards vulnerable students are not justifiable.

> *"I am quite lucky as I have a really lovely personal tutor, who she's very kind and she has always been, I disclosed my trans status and my mental health difficulties to her like in first year and she has been so good like, I am third year now and she has been so good, I don't really think that she knows a lot about mental health or anything […] I think that if she had some more knowledge about signposting then that would be perfect, but she knew how to do active listening, she knew how to listen, she would absolutely follow up if you missed a meeting, and like just kind of having that support there that she is kind of "I want to see you, I want to hear about your problems"*

> "*I think making you feel like they actually care a bit, then even if they do not have that much training, just the idea that they want to listen to you […] I think that if you feel that they care then you are more willing to disclose and then you know that they know how to support and then if they have the information to give to you and they are open and they are willing to listen then I think that is just a good thing to have"*

3.16. In response to the general discontent with the perceived lack of factual mental health knowledge and signposting procedures and the occasional blunted emotions expressed by certain personal tutors, focus group participants suggested that some training should be compulsory for personal tutors. The

general argument was that if personal tutors do hold a pastoral responsibility towards their students then it is their duty to be trained to do so sensibly and effectively. Indeed UCL's formal definition of the personal tutoring system is that of a service that "*provides every student with at least one member of staff who gets to know them as an individual, who keeps an eye on their overall academic progress and who is concerned for their general welfare".*[3]

"I found that a lot of the time, my personal tutor is brilliant and they just don't know what support services there are and they don't know what problems you are likely to face and they don't know how to help in any way really"

3.17. When asked to outline what the compulsory training for personal tutors should include respondents generally mentioned three elements. The first and perceived as most essential component of the training was that of acquiring an elementary understanding on how to respond to a student in distress. Frequent references were made to the development of skills such as active and empathic listening. Secondly, participants identified a precise knowledge of the support services available within UCL and a mastery of the signposting procedures as crucial components of the training. Finally, a basic awareness of common mental health difficulties was perceived as a third essential section in the training process.

3.18. We would recommend training programmes to also include the development of skills for the detection of suicide and harm risks and practical procedures to follow when faced with a student at crisis point. It is fundamental to stress that this report is not advocating for a shift of a personal tutor's role to that of a clinical entity, as this could lead to potentially negative consequences for both the student and the personal tutor. However, research within UK higher education system highlights the key "gatekeeper" role played by personal tutors within the

[3] A more detailed description of the personal tutor's role and of their pastoral responsibilities can be found at https://www.ucl.ac.uk/personaltutors/personal-tutor-UCL/role

management of student mental health. In a series of student-wide, longitudinal surveys conducted by the University of Leicester the second most common source of advice for mental health difficulties, following friends and family (65%) was personal tutors (54%) (Grant, 2002). Additionally, the data from the UCL Student Psychological Services reveal how 1 in 10 students is referred to the counselling unit by their personal tutors, a rate just below that of the Ridgmount GP practice (1.1 in 10).

3.19. Personal tutors can often provide an immediate form of initial support to a student experiencing psychological distress. Unlike UCL Student Psychological Services, personal tutors manage a limited number of students and may be more readily able to arrange a meeting with the student even at short notice. The Ridgmount GP practice does also hold a walk-in clinic every morning and every afternoon during weekdays, but students might be more inclined to disclose their mental health difficulties to their personal tutors for two reasons. Firstly, most students may more easily identify personal tutors as a “friendly face” for the communication of personal troubles as they have had previous contact with them. Secondly, some students might not necessarily perceive their mental health difficulties as serious enough to require a clinical intervention or they might feel puzzled by a state of being they have never experienced before. As highlighted in the previous section on discussion of mental health difficulties in the focus groups, a common attitude shared by students first experiencing mental health difficulties is that of denying or minimising their problems. In this situation of confusion, the immediacy and established relationship of personal tutors might therefore shape the preference for a contact with them over a GP or UCL Student Psychological Services. Finally, students experiencing mental health difficulties might be worried about how their difficulties are influencing their academic performance. The internal position of personal tutors within departments and their resulting negotiating capacities could further enhance their potential for simple, preliminary and immediate support to students experiencing mental health difficulties.

3.20. However, as highlighted in the previously presented anecdotes, some students believed that certain personal tutors, no matter the amount of training, would lack the qualities necessary for the provision of pastoral care due to personality and character traits. Focus group participants suggested two potential solutions to this problem. Firstly, they called for improved clarity surrounding the selection process of personal tutors. There was a general consensus on the problematic nature of designating the personal tutor responsibility as a compulsory duty within departments. Students believed that no member of the academic staff should be compelled to hold such a delicate and sensitive role without their explicit desire.

3.21. The second solution proposed by the focus group participants was to provide training to a portion of academic staff members rather than to every personal tutor. This strategy would provide students with a group of academic staff members within every department with a comprehensive expertise of mental health first aid and of the signposting procedures to UCL support services. Personal tutors suspecting the possibility of a student developing mental health difficulties could refer the student to one of the academic staff members equipped with more appropriate knowledge.

3.22. This second solution appears to be concordant with the changes envisioned by UCL for the peer support system in the future. Independent of changes to the peer support system, we support the introduction of a designated staff contact being available to provide students with pastoral support at departmental or programme level. If the role of a personal tutor is to maintain a pastoral duty of care, then failure to do so implies a deficiency in performing the role of personal tutor as a whole. Just as personal tutors would not be allowed to refuse, or provide inadequate, academic support to their tutees, similarly negligence to fulfil pastoral duties should be considered just as problematic. However, an essential precondition for the presence of "*a concern with student wellbeing"* within the personal tutor's role is that this needs to occur on a voluntary basis. We understand the difficulties faced by departments in promoting such a role on a voluntary basis. However, the simple physical presence of a person is not a

guarantee of the therapeutic potential of the meeting as a poorly prepared, and especially an ill-disposed, personal tutor might result in exacerbating and worsening a student's distress. The compulsory nature of mental health training for all personal tutors must be preceded by the voluntary nature of the role itself.

3.23. Another limitation of the personal tutor system identified by the participants of the focus group was the unequal weight given to the academic portion of the meetings to the detriment of personal matters. Focus group participants emphasised the importance of building a personal relationship with their personal tutors rather than exclusively academic connections. The creation of a personal bond between the tutor and the tutee was considered a fundamental precondition for the disclosure of mental health difficulties and for the ensuing management. Revealing a personal history of mental health difficulties can be a daunting experience for many students and therefore an environment characterised by reciprocal trust is indispensable.

"I think that the personal care is quite lacking, yeah, of course you don't want to result in seeing the personal tutors as some kind of parents or something like that but, I think doing some things just to get to know the personal tutors would be a helpful stepping stone"

3.24. However, this does not imply that personal tutors should substitute the emotional network of friends and family. Personal tutors are not being asked to become mental health professionals or significant others in the lives of their students, rather they should simply feel confident with providing basic mental health first aid and signposting when necessary. An example of the risks involved in overemphasising the academic duties of personal tutors to the detriment of their academic responsibilities is the concern shared by some participants over the potential impacts of their mental health status disclosure on their academic and professional future. Certain focus group participants, especially graduate students, reported the fear of unveiling their vulnerabilities around personal tutors

or other members of the academic staff. A common fear concerned the possibility of the disclosure of a mental health difficulties being potentially interpreted as a sign of unprofessionalism or inefficacy. This apprehension intensified when students suffering from mental health difficulties were supposed to hold clinical responsibilities towards others, where mental health difficulties might have hampered their fitness to practice or simply where students were studying for sensitive professions.

"People are very unwilling to come forward because they are worried of how this is going to affect their career, that's why I was very reluctant to come forward and actually when I went to seek help all I got was something reinforcing that, [my tutor] *who was saying "oh so why are you here? You should clearly be incapable" she was just unbelievably horrible. She got out my interview notes and said "well they clearly didn't like you very much at the interview", "why are you here? You are a hazard to patients" and I just could not believe that, I was absolutely not what I needed to hear"*

3.25. In order to overcome those potential barriers to the disclosure and consequent management of mental health difficulties personal tutors should be aware of those concerns and reassure the student on the basis of the confidentiality agreement[4] and on the university's duty of care towards the student. Personal tutors should be familiar with the legal regulations around mental health disabilities as expressed in the Equality Act 2010, the Disability Discrimination Act 2005 and especially in the UCL Student Mental Health Policy. This should provide personal tutors with the instruments to generate a trusting relationship by reassuring the student around the confidentiality of their information and the legal obligation not to discriminate against them on the basis of their mental health difficulties. When dealing with students who might come under the fitness to practice regulations we suggest to proceed with more sensitivity than would

[4] More information on confidentiality- and on its potential breaches when there is a risk of serious harm to the person or others or a risk of a serious crime being committed- can be found on the ReThink website.

otherwise be required and to follow the guidelines articulated by the General Medical Council. It is paramount for personal tutors to bear in mind that the disclosure process can represent an arduous task for many students and should be met with understanding and support rather than discrimination and stigma.

3.26. The last potential barrier that might hinder mental health disclosures and consequent management by personal tutors is a result of the internal structure of personal tutor systems within UCL departments. Currently, no homogenous personal tutor system exists across UCL faculties or even within single faculties. Considerable variation in terms of personal tutors structures exists across UCL with personal tutor meeting being in group settings or face-to-face, compulsory or voluntary, weekly or monthly, purely academic or more focused on personal matters, using structured paper forms or completely dependent on the students raising their own concerns. While different departments might address department-specific problems via their personal tutor systems, this vast disparity inhibits the creation of a shared model of tutoring focused on best practice. Our focus group participants called for personal tutors to be structured in certain preferred ways, including:

- Personal tutor meetings should be on a one-to-one basis rather than in a group setting. Participants believed it was unlikely that mental health disclosures would happen in front of other students, especially at the beginning of courses.
- Personal tutor meetings should be compulsory rather than voluntary. This would incentivise students to attend and place responsibility for organising the meetings on tutors.
- Meetings should be every two months, or at the beginning and end of each term.
- Personal tutors should follow-up students who do not attend a planned meeting. This would further decrease the possibility of certain students "*falling through the cracks.*"

- Personal tutors should be proactive about discussing personal wellbeing with their students who may be reluctant to initiate such discussions. Structured forms that include questions on student physical and mental wellbeing might be useful; however, an overreliance could potentially be alienating for students.
- Personal tutors should be consistent throughout the study pathway. Changing personal tutors disrupted the personal relationship students had built and obliged them to re-start the disclosure process all over again with a new personal tutor.
- Personal tutors should be easily contactable via their UCL email and have clear office hours.

3.27. Mental health research is generally consistent in stressing the importance of early detection of mental health difficulties in order to assure an increased chance of recovery (Duffy, 2000; Singh, 2010). We believe that personal tutors are in a privileged position to intervene within this window of opportunity for better management and prognosis of mental health difficulties among the student population. Simultaneously it is essential to emphasise the importance of maintaining boundaries by avoiding the potential slippage into a clinical or unreasonably personal position.[5] Additionally it is of paramount importance for personal tutors to engage in self-care and to be aware of their own feelings after personal involvements with particularly distressing situations. Support is available for members of staff experiencing mental health difficulties at UCL Student Psychological Services and more information on maintaining boundaries is available at the UCL Occupational Health Service.

3.28. Recent committees and working groups at UCL have discussed the future development of the personal tutoring. While the definitive outcomes of these discussions remain unclear, it is evident that students greatly benefit from

[5] More detailed information on the meaning and importance of boundaries in university life can be found at http://www.ed.ac.uk/student-counselling/staff/personal-boundaries.

pastoral support from a designated member of academic or departmental staff when adequately provided. It is therefore vital that UCL consider the impact of altering the remit of personal tutors in the future. If pastoral elements of the role are to be removed, it is important that student welfare needs are adequately catered for by other means, through a designated member of staff who gets to know a student on an individual basis and is concerned for their general welfare. This member of staff should be adequately trained and have a genuine interest in student welfare and wellbeing.

Mental Health Awareness and Stigma

3.29. Focus group participants with experience of mental health difficulties frequently reported experiences of stigma and identified a lack of mental health awareness as the direct cause for the aforementioned discriminatory attitudes. The understanding of stigma displayed by participants was generally congruent with the definition given by the Time to Change campaign of stigma as *"the perception that a certain attribute makes a person unacceptably different from others, leading to prejudice and discrimination against them".*[6] Stigma was perceived as a pervasive phenomenon operating at different levels of one's own life, from personal tutors, to family and friends up to the point of often becoming internalised. The concerns surrounding the potential discrimination and shame associated with the disclosure of a mental health difficulty also took several forms. However, the two most common worries involved the fear of being discriminated by peers and the potential impact of a mental health disclosure on academic performance.

"I just, I think it is easy to feel when you have [mental health] *difficulties that even though, even when the people around you don't seem like they are inherently judgmental people or anything like that there is still always the fear of not really knowing how they think about those things and not knowing how those people are going to respond to someone having like mental health*

[6] A more detailed description of stigma and its impact on mental health can be found at http://www.time-to-change.org.uk/what-is-stigma.

difficulties, I think that like this can, lead people to feel quite disconnected from their peers that don't have similar issues"

3.30. Besides fears of being judged negatively by friends and family, focus group participants displayed considerable levels of distress regarding the possibility of their mental health difficulties being used against them by academic staff, particularly personal tutors. Having considered how some personal tutors have been responsible of grossly inadequate and stigmatising behaviours towards students experiencing mental health difficulties, this concern is not that surprising. Again, students working towards clinical or sensitive professional positions displayed heightened rates of worries. Concerns surrounding fears of stigmatising consequences following a disclosure of mental health difficulties might constitute overwhelming barriers for students' will to access support services (Kearns *et al.,* 2015).

"I think that a lot of students are afraid of going to student support because they think it will go on their record, it will mean that it will affect their occupational health, maybe they will not be able to be a doctor because they've, you know, because they are not well enough or something"

3.31. In particular, focus group participants acknowledged the potential risks of stigma in further exacerbating pre-existing mental health difficulties. For example, stigma was described as an obstacle to reaching out for help, therefore leading to a worsening of mental health difficulties. The generalised attitudes of "*brushing off*" and "*powering through*" mental illness and the complexities of disclosure with personal tutors further exemplify the pervasive nature of stigma in hindering help-seeking behaviours and personal recovery among the student population.

"It also feels quite intimidating I guess, as for mental health there is a lot of stigma, so you could say that like, I am always afraid of being told "oh just get on with it""

"I would try to reduce stigmatisation because I think that really gets in the way of a lot of progress and aspects of dealing with mental health"

3.32. This process of self-internalisation of societal stigma towards mental health was prominent within the narratives of the participants. Many participants expressed their fears of mental health difficulties "*marking"* them or singling them out from their peers. In particular, a considerable level of concern was expressed regarding the possibility of being labelled as "*mentally ill*". Participants would in general refuse to identify themselves as mentally ill but on the contrary would rather recognise themselves as suffering from mental health difficulties. The feeling of one participant that they had *"this very big fear of being labelled as insane"* was typical of all participants. Another participant stated that *"yeah, that label [of being mentally ill] is just terrifying, I like, I was just convinced that I would have just going to have like, you know, that big red slash through my folder just like "never employ this person, clearly insane, don't ever take them"".*

3.33. The resulting direct negative impact that the internationalisation of stigma had on the mental health of students was observable from the students' narratives. Focus group participants described low levels of self-esteem and/or self-efficacy and increased levels of anger and/or discomfort resulting from the real, or perceived, discrimination they faced due to their mental health difficulties. Those inferences are consistent with the results from quantitative studies analysing the impact of stigma on individuals suffering from mental health difficulties (Corrigan and Watson, 2002).

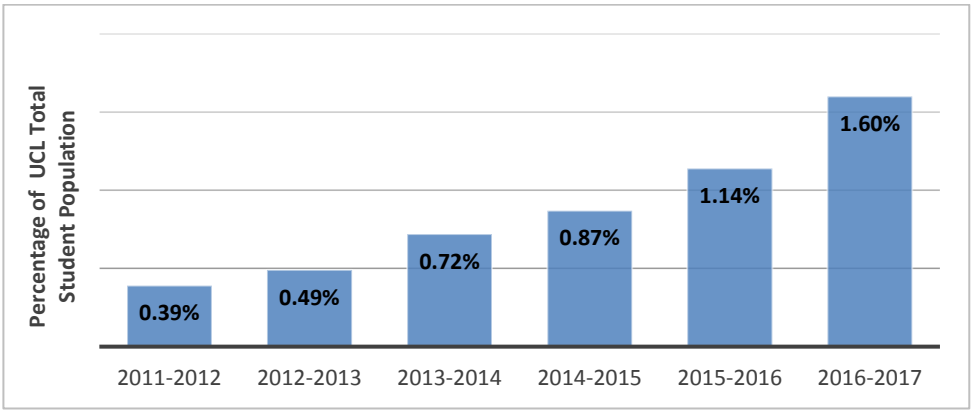
3.34. An indirect and prevalent way in which stigma exacerbated mental health difficulties described by our participants was via limiting access to support services. Focus group participants most commonly referred to three main causal mechanisms through which stigma might have interfered with their intention to access support services at UCL.

- Some participants perceived seeking help and receiving support for mental health difficulties as themselves inherent sources of stigma due the potential connection between help-seeking behaviours and personal weakness.
- Some participants, because of the distorted, and disguisedly stigmatising, view of mental illness discussed above, did not perceive themselves as *"bad enough"* or as needing psychological treatment. This led to the postponement of the management of their mental health often resulting in the intensification and further deterioration of their mental health difficulties.
- Some participants expressed concerns regarding the potential effects that accessing support services at UCL might have had on their academic future performance and working prospect.

3.35. The potential of stigma of negatively influencing help-seeking behaviour and access to mental health support is also evident in the research literature (Kearns *et al.,* 2015). According to Corrigan's review of the literature (2004) stigma is one of the main barriers for people to fully participate in support services due to social disapproval and diminished self-esteem. This is reflected within UCL services by the consistently low rates of access to the UCL Student Disability Services by students suffering from mental health difficulties.[7] While Figure 13 shows a rise in the number of student registering with the UCL Students Disability Services for a mental health difficulty, the rates are still consistently below the expected epidemiological percentages. The NHS Mental Health Network 2016 Update reported that in England around one person every 28 had accessed mental health and learning disability services in 2014/15. The discordance between the number of students registered with a mental health disability and the actual number of students suffering from a mental health difficulties is further illustrated by the significant number of applications for special exam arrangements to mitigate symptoms of anxiety and depression from students who are not officially registered as having a mental health difficulties.

[7] General data on students accessing Student Disability Services can be found at: https://www.ucl.ac.uk/srs/statistics/tables/u/1516.

Figure 13: Student Access to UCL Student Disability Services due to Mental Health Difficulty



3.36. While other variables, such as a lack of awareness of the services by students, might inevitably also affect the rates of access to support services at UCL, stigma was identified as a key obstacle among focus group participants. In particular, several students suffering from mental health difficulties expressed uncertainty on whether their mental health difficulties could be considered a disability by the UCL services. Focus group participants generally associated the term disability almost exclusively with physical disabilities. This resulted in their self-exclusion from accessing services on the basis of an unbalanced vision of health wherein physical disability was perceived as somewhat more serious than mental health disabilities.

> *"People are saying that they don't have* [a disability]*, they are fine, "I'll get through this". In a way by using the word mental health difficulties or even disability it is very stigmatizing… As a person you are like "Oh no I am not that bad!" or you know "It's fine" and I feel that in a way if you are going to phrase it like that, or if you say "We are having a disability meeting group", you might not feel like you are bad enough to go to that"*

3.37. A recurrent theme among focus group participants was that some students did not consider their mental health difficulties serious enough to be considered a disability. As with the concept of mental illness, they generally perceived

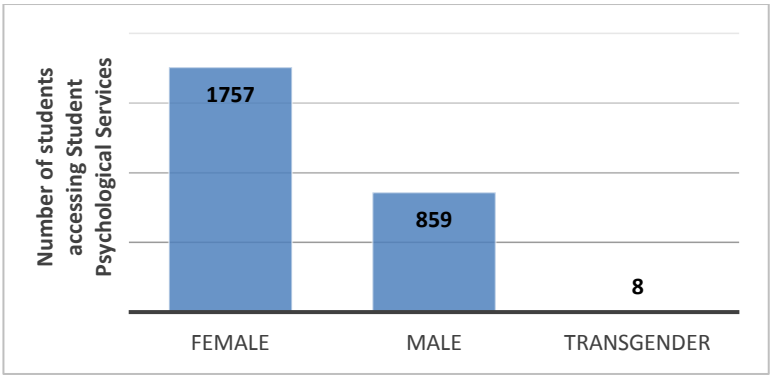
disability as inherent to more severe mental health difficulties rather than anxiety and depression. Additionally, some students did not wish to be identified with the term “disabled” as they perceived this to be a stigmatising process *per se* because of the exclusive association of the term disability with severe mental illness or physical health. While the expansion of the disability status to mental health difficulties was perceived as de-stigmatising for some, others regarded it as a stigmatising process potentially fuelling the discrimination and shame associated with mental health difficulties.

3.38. Particularly debilitating were the levels of stigma experienced by male students experiencing mental health difficulties. According to male focus group participants the disclosure of mental health difficulties was particularly complex in a social environment that often associated mental health difficulties with stereotyped notions of frailty and femininity. The gender conventions depicting masculinity as inherently linked to a courageous, unemotional, imperturbable and uncomplaining nature were identified as significant barriers towards disclosure, access to services and mental health management within the male student population. During most focus groups sessions, except in one group where there was a majority of male students, male participants were generally less vocal during the discussion and expressed a more passive attitude than their female counterparts. Some male participants barely spoke during the entire conversation.

3.39. This differential attitude towards mental health rooted in gender differences is further confirmed by the asymmetrical rate of access to the Student Psychological Services between male and female students. During the year 2014-2015 of the 2,620 students that accessed the UCL Student Psychological Services only 33% of students were male versus the 67% of female students (Figure 14). Data from psychiatric epidemiology generally confirms the presence of gender disparities in mental disorders rates with females being more at risk of developing certain psychiatric conditions, particularly anxiety, depression and

somatic complaints.[8] However, while it is essential to consider the increased vulnerability and susceptibility to mental health difficulties faced by women, it is unclear how this would result in females seeking out help for mental health difficulties twice as much as males. Similarly the gender difference in the number of UCL students, with 46% of the student population being male and 54% being female, is still not sufficient to explain the vast difference in help-seeking behaviours between male and female UCL students.

Figure 14: Access to UCL Student Psychological Services between 2014-2015, by Gender



3.40. The under-representation of the male population in accessing mental health support services is worrying when considering the uneven risk of suicide faced by the male population. Men in the UK are three times more likely to die by suicide than females with a 2014 suicide rate of 16.8 per 100,000 for men versus 5.2 per 100,000 for women. However, rates of female suicide have increased by 8.3% in the UK between 2013-2014 warranting caution when discussing the gender dimension of suicide (Samaritans, 2016).[9] Even though the descriptive

[8] More information on gender differentials for the rates of mental disorders within the global population by the World Health Organization can be found at: http://www.who.int/mental_health/prevention/genderwomen/en/

[9] More detailed information and disaggregated data on suicide epidemiology in the UK and ROI is collected annually by the Samaritans and the 2016 report can be found at: http://www.samaritans.org/sites/default/files/kcfinder/files/Samaritans suicide statistics report 2016.pdf

nature of the data from UCL Student Psychological Services and the limited number of male participants in our focus group cohort hinder precise correlations, we still believe they indicate the need for increased future attention on the problems faced by male student suffering from mental health difficulties.

3.41. Focus group participants generally identified a lack of knowledge and information surrounding mental health as the foundational cause of stigma. Therefore, the most frequent solution proposed to address the presence of stigma within university life was condensed in the practice of "raising awareness", usually through education and the transfer of information regarding mental health. The process of raising awareness around mental health difficulties was perceived as an effective and potent tool for inducing change in how the general public represented mental illness.

"Trying to educate people about it as well because I think a lot of it has to do with, people do not have the knowledge of what, for example, last year we went on these training days with ReThink Mental Illness that taught me so much"

3.42. A lack of knowledge and awareness surrounding mental health difficulties was judged to be detrimental because of the consequent discriminatory and stigmatising attitudes displayed by uninstructed students and academic staff. However, participants identified a deficit of information as also problematic to students suffering from mental health difficulties themselves due to the tendency of individuals experiencing mental health difficulties of dismissing their issues as not serious enough to require professional management. An amplification of information acquired by students was thought to potentially enhance the capacity of individuals to self-identify their own mental health difficulties and seeking appropriate forms of support in a timely manner.

3.43. The focus on information and education as the pathways towards the raising of awareness is a positive starting point for tackling the stigma faced by individuals suffering from mental health difficulties. However an over-emphasis on the practice of raising awareness *per se* might be misplaced, lacking scientific

evidence (Purtle and Roman, 2015) and, at times, ineffective in diminishing discrimination and stigma (Griffitsh *et al.,* 2014). As highlighted by Frieden (2010) in his widely cited health impact pyramid, education is the least effective intervention for encouraging behavioural changes in the health sphere as it requires substantial individual effort and only reaches limited segments of society.

3.44. We believe that education, raising awareness and the transfer of information are necessary but not sufficient pathways to debunk discriminatory behaviours towards people with mental health difficulties. Following Haghighat's (2001) focus on the routes to de-stigmatisation there is a need to arrange anti-stigma campaigns on multiple levels of action so to tackle discrimination from different standpoints. The over-emphasis on a purely cognitive understanding of stigma as rooted in misinformation might correspond to a limited shift in behaviours and structural changes. We suggest that campaigns sponsored by UCL students and staff to reduce mental health should carefully consider, together with the cognitive level, also the affective/emotional level and the legislative/political one.

3.45. The formation of stigma, and its consequent demolition, often occurs in the minds and lives of people through irrational and unconscious processes that might remain untouched by the blows of information and education. The face-to-face contact with someone having personally experienced mental health difficulties has often been considered an effective remedy to an overtly information-based approach (Griffiths *et al.,* 2014). Additionally the promotion of frank and honest conversations allowing for the venting and discussion of fears, anxieties and stereotypes surrounding mental health by the general public is a vital substitute to a top-down informational approach. On the political and legislative side campaigns should pay attention at changing the minds of people as much as on changing the reality and institutional context in which people live. Paramount to any anti-stigma campaign should be the advocacy for more effective and better-funded services within and outside UCL together with the problematizing of an immoderately competitive and performance-focused university environment.

UCL Support Services

3.46. A common topic of discussion among the focus group participants concerned the personal experience of accessing UCL support services and receiving treatment for their mental health difficulties within UCL. Most conversations centred on UCL Student Psychological Services, the university counselling services, and, though less frequently, on UCL Student Disability Services, the support service aimed at students registered with a disability. Students were generally satisfied with the treatment and services offered by UCL support services. However, focus group narratives identified some shortcomings within the provision of support for students experiencing mental health difficulties. In particular, focus group participants lamented a lack of visibility and cohesiveness within UCL support services.

3.47. Students described the process of accessing and acquiring knowledge on the existence of support services at UCL as complicated and confusing. One participant reported how they had had to *"dig"* for information and had to email the services *"with her fingers crossed".* Information surrounding the different types of support available at UCL for mental health difficulties was deemed to be troublesome to access and, once retrieved, often puzzling and ambiguous. When information was available, it was perceived as being at times disconnected with other sources of information, not up to date and ultimately unaccountable. Occasionally the dearth of information was substituted by an abundance of material that further exacerbated perplexity and the feeling of "*being lost"* among the students searching for mental health support. In particular, the information profusion or scarcity generally inhibited the understanding students had of the different function of UCL support services that were often described as non-cohesive with one another.

"I guess publicising it, that is the problem I had. And make it clearer, where do you go, which services you should go to first and how the system actually works"

For me personally [the lack of visibility and confusion within the UCL support services] *just this put me just of and I am in my third year and I feel like well had I known about the disability services even the psychological services that would have helped so much"*

3.48. Considering how daunting and emotionally unsettling many students find the process of seeking out help for mental health difficulties, the procedures for accessing support services should be as simple, coherent and straightforward as possible. Different possible solutions were proposed through the focus group discussions with the aim of simplifying access to both the mental health information and services. In particular, students complained about the lack of a coherent and well organised website presenting all the UCL support services, their corresponding function, the type of services provided and the procedures necessary to gain access to them. Students unanimously recognised searching the Internet as a, if not *the*, major help-seeking pathway. This website could function as a virtual platform for the dissemination of information about mental health among UCL students and for linking together in a coherent structure all UCL support services.

3.49. Social media was also identified as an underutilised tool in the process of intensifying the flow of information about mental health among UCL students so as to facilitate and boost the access to support services. For example, the UCLU Mental Health and Wellbeing Facebook page, now counting nearly seven hundred members, could represent an effective and fast way of communicating and influencing a large pool of UCL students that have actively expressed an interest for mental health. On the other hand the Internet websites of the UCL support services were at times deemed by participants not to be particularly user-friendly, confusing and arduous to navigate. Smart phone apps could be an additional venue for the advertisement of UCL support services by building onto

the existing UCL Go! and UCL iMaps apps. Additionally the ESC Student mental health app represents an excellent tool for prevention and management of student mental health difficulties together with meeting the NHS quality criteria.

3.50. Some students further proposed the creation of a virtual platform that could work as a signposting tool for students experiencing mental health difficulties. Within the aforementioned Internet website linking all UCL support services, students could access a self-assessed mood questionnaire that, according to the results scored by the students, would either reassure the student about the non-clinical nature of their symptoms or encourage the student to seek professional help. Based on the results of the questionnaire and according to the characteristics of the problems expressed, students would be exhorted to access the more suitable services among UCL Student Psychological Services, Student Disability Services, Student Support and Wellbeing, the National Health Service services or the crisis services. Conversely, if the results foreground very mild symptoms the website could suggest the consultation of self-help information on how to cope with specific problems, such as the Mind mental health A to Z pages. The NHS Choices framework has implemented a similar model through the introduction of a several self-assessment tools including a mood, depression and sleep self-assessment tools. Those NHS self-assessment tools could be easily embedded within the UCL support services' website. The implementation of self-assessment tools warrants careful reasoning around issues such as the potential disclosure of suicidal ideation and the consequent duty of care together with the limits of self-assessment versus professional psychiatric or psychological assessments.

3.51. Besides the discussion of general themes shared by the UCL support services as a whole, participants also focused on the single support services, in particular on UCL Student Psychological Services and on UCL Student Disability Services. When discussing UCL Student Psychological Services students generally considered three topics: the waiting list, the completion of the form necessary for accessing the services, and the type of care offered by the services. The waiting

list was ubiquitously identified as the main barrier to the access of psychological care within UCL. Most students that had accessed UCL Student Psychological Services in recent years lamented how they had had to wait for a considerable amount of time, usually several weeks or more than a month, before receiving an assessment by a therapist followed by the subsequent treatment.

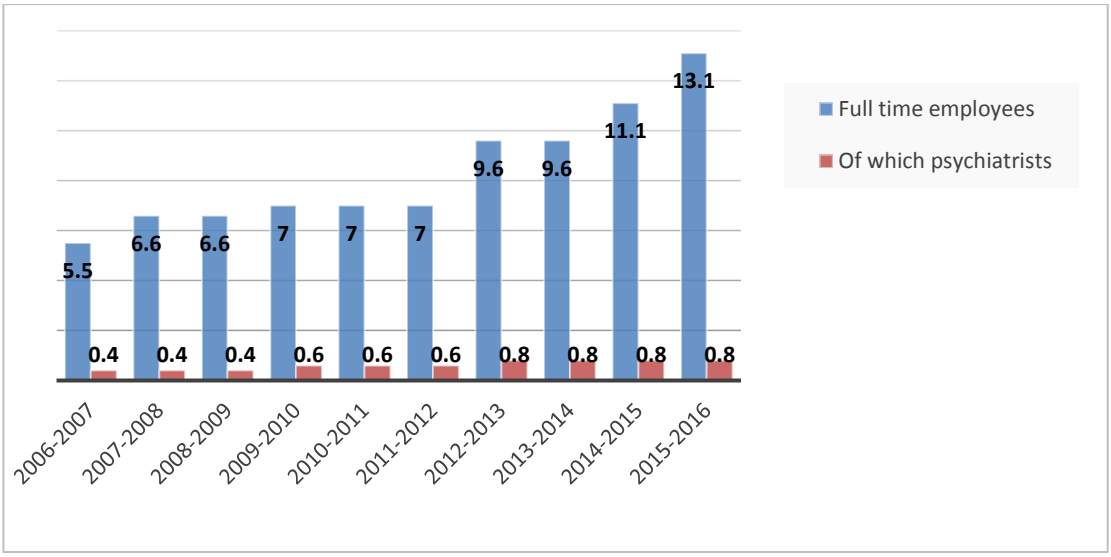
3.52. Focus group participant associated the lengthy waiting times not to a supposed inefficiency of UCL Student Psychological Services but rather to a perceived lack of funding from UCL as a whole towards student support services. As one participant stated, UCL Student Psychological Services were perceived as *"well intentioned but incredibly underfunded".* Additionally students recognised that, while lengthy, the waiting lists of UCL Student Psychological Services were still considerably more rapid than the NHS Improving Access to Psychological Therapies (IAPT) services. According to a report from the UK mental health charity Mind 12% of people suffering from mental health difficulties in England wait for more than a year before receiving talking treatments and 54% wait for more than three months.

"I think it took three months before I actually saw someone in any kind of like helping capacity but [that] *really seems appalling, being pushed around from pillar to post"*

3.53. UCL Student Psychological Services are currently underfunded. The number of therapists has more than doubled from the 5.5 therapists of the year 2006-2007 to the 13.1 therapists of the year 2015-2016 (Figure 15). Similarly, the psychiatric support provided by UCL Student Psychological Services has also doubled in the course of the last ten years. Nonetheless, UCL Student Psychological Services is still struggling to keep up with the increasing student population at UCL, which has been growing with an average of 7.2% every year since 2006-2007 and that only in the year 2015-2016 has increased of 25.4% in comparison with the previous year 2014-2015. According to the Head of the UCL Student Psychological Services, with 13.1 staff members seeing an average of 24

students a week for an average of 6 session, UCL Student Psychological Services, with its current staffing, can only see an average of 2,305 students per year.[10] However in the year 2013-2014, 2,805 students accessed the services, in the year 2014-2015, 2,544 students accessed the services and this year 2015-2016 (from the 1st of August 2015 up to the 18th of June 2016) a total of 2,771 has accessed the services. This meaning that, this year, there has been an excess upon the resources available for UCL Student Psychological Services of at least 466 students.

Figure 15: Student Psychological Services Staffing Levels Between 2005-2016



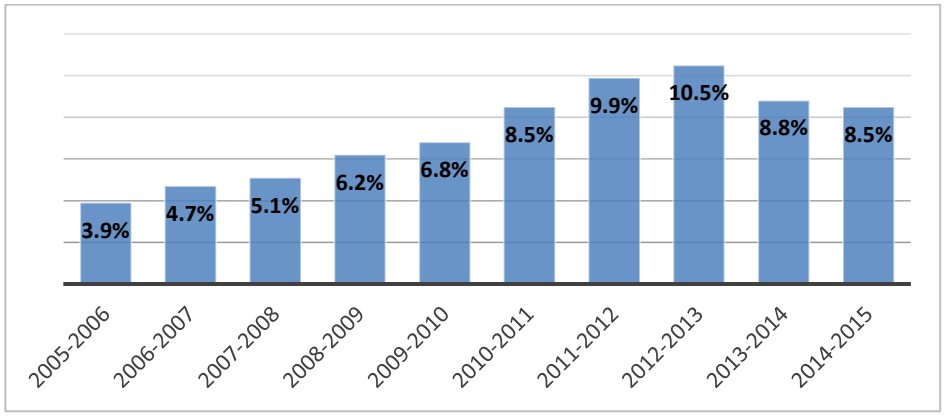
3.54. In order for UCL Student Psychological Services to meet its current student demand there should be an increase of 6.5 staff members. As shown in Figure 16 between the years 2010 and 2015 an average of 9.24% of the total UCL population has accessed Student Psychological Services. The current UCL

[10] Due to annual leave, training, UCL closures and holidays each Student Psychological Services practitioner sees students for 44 weeks a year. Each practitioner does 20 face-to-face one-to-one or group hours each week in accordance with the BACP guidelines. These hours include 5 initial consultations, 13 individual counselling follow-ups and 1 group session a week. This sums up to 24 students a week (18 in one-to-one and 6 in group sessions). Student Psychological Services counsellors can therefore provide 1,056 sessions a year (24 students a week x 44 weeks). As each UCL student is entitled to 6 individual or group sessions, each counsellor can see 176 students a year (1,056 sessions a year / 6 sessions). Therefore Student Psychological Services can currently see 2,305 students a year (176 students per counsellor x 13.1 counsellors).

population (2015-2016) is of 38,313 meaning that it is likely that around 3,448 (9%) will access UCL Student Psychological Services this year. As explained in footnote 15, each UCL Student Psychological Services practitioner can see 176 students a year meaning that 19.1 practitioners would be necessary in order to provide support to 3,448 students (3,448/176 = 19.1). Therefore, considering how UCL Student Psychological Services currently holds 13.1 members of staff, an additional 6.5 practitioners would be necessary. As the number of students accessing UCL Student Psychological Services on the basis of psychiatric conditions has risen from 5% of the total students accessing UCL Student Psychological Services in 2011-2012 to 12% in 2015-2016, of those 6.5 practitioners, an additional 0.5 full time psychiatrist would be needed, as well as 6 additional counsellors. Based on UCL Student Psychological Services' 2015-2016 salaries, London weighting, NHS insurance and pension contributions, UCL would have to increase its funding to UCL Student Psychological Services of £340,000 a year. It is likely that the additional funding provided to UCL Student Psychological Services by UCL would be thoroughly compensated by the decrease in study interruption and withdrawal among students suffering from mental health difficulties. Ruth Caleb, head of the counselling services at Brunel University, calculated that their service was responsible for the saving of 2.5 million pounds a year that would have otherwise been lost due to students interrupting their studies (HEPI, 2016).[11]

[11] These data were collected through the administration of an anonymous evaluation of the service to students concluding their counselling contract. Questions included "Were you thinking of leaving Brunel before counselling?" and "Did counselling hep you to decide to continue your course?" and then translated the number of students who positively responded to both questions into tuition fees for that year. This was done under the assumption that all students were first year undergraduate (did not include the three or more years fees) and home students. Therefore this is a considerably conservative estimate.

Figure 16: Percentage of Students Accessing UCL Student Psychological Services



3.55. The reality is nonetheless more complex as, in 2014-2015, of the 2,620 students who registered with UCL Student Psychological Services 800 (23%) of them had to be referred to crisis, specialist, intensive or open-ended mental health support. It is paramount to highlight that it is not the university counselling service's role that of hospitalising students because of their risk of suicide, of seeing students on a daily basis to ensure their safety, of having their medication regularly monitored in order to prevent relapse or of providing specialist mental health treatment for severe and long-lasting psychiatric disorders. The entirety of the tasks mentioned above lie in the realm of responsibility of the National Health Service. However when such students register with UCL Student Psychological Services they often need to be seen so that appropriate sign posting and referral can take place. At times this might involve the students being seen for several months until the referral takes place due to the waiting lists of the NHS. As a consequence this leads to an over-burdening of UCL Student Psychological Services by students who should receive treatment elsewhere therefore triggering the lengthening of the waiting times for appointments.

3.56. Another theme that was prominent within the discussion of the services provided by UCL Student Psychological Services concerned the Student Psychological Services Registration Form. The registration forms represents, in the vast majority of cases, the only pathway through which students experiencing mental

health difficulties can access the talking therapies offered by UCL Student Psychological Services. The main complaint expressed by participants regarded the bureaucratic nature of the form perceived as an alienating and impersonal task in a moment when human contact was the most needed. Some students confessed that the prospect of having to fill in the form had "*put them off*" from accessing UCL Student Psychological Services. The dread expressed towards questionnaires and forms was not directed only to UCL Student Psychological Services as some students recalled the feeling of disappointment and frustration when presented with the task of completing the GAD-7 and PHQ-9 clinical questionnaires by the GPs at the Ridgmount Practice.

3.57. However, we believe that some of the critiques towards the form stemmed from an outdated recollection of the registration form often in contradiction with the current form. Indeed the most recent (September 2016) form appears to display significant improvements in both content and structure. However, future ameliorations might focus on tackling what participants identified as the impersonality and coldness inherent to assessment forms. For example, the form could be edited so to render it more informal and personal to the students through the inclusion of one or two encouraging lines at the beginning of the form, possibly congratulating the student on reaching out for help and on making the first step. Similarly, an optimistic and promising message could appear upon completion of the form. The aesthetic layout of the form might also profit from a more relaxed structure through a more casual design. Finally the form does appear to be quite lengthy and therefore either it could be condensed or the reasons for its duration be explained. The efficacy and practicality of an online registration form is evident and, considering how thousands of students in a vulnerable point of their lives access the form of every year, the process of rendering the form the most user friendly possible represents a paramount priority.

3.58. Following the waiting list and the registration form another frequent topic of discussion in relation to UCL Student Psychological Services concerned the

nature of the treatment offered. Most students were satisfied with the quality of the therapy they had received and with the progress they had made in managing their own mental health difficulties. However, focus group participants lamented the limited number of sessions offered and what at times was perceived as an abrupt closure with the therapist. Currently, UCL Student Psychological Services offers a maximum of six individual sessions of cognitive behavioural therapy or psychodynamic therapy, or group therapy, at the end of which further arrangements for external therapy might be discussed with one's own therapist. Again, students identified a lack of UCL funding to the services as the chief reason for what was perceived to be an insufficient number of therapy sessions. Other less frequent criticisms regarded personality clashes with therapists, though the majority of individuals reported the formation of a fulfilling and trustful rapport with their therapist.

"I had quite a good experience with the psychological services but I had like psychodynamic therapy instead and it was just making a start but once I've had finished she said that "you could benefit from more of this" and she referred me to the Tavistock which is like one of the best places in the UK where you can have that therapy and I don't think I could have got to go there in any other way and so I was quite fortunate in that."

"If they are going to be giving quick short help then it needs to be clear regression, if people needed there needs to be a clear idea of where they are going from here"

3.59. Following UCL Student Psychological Services, the other UCL mental health service object of ample discussion was UCL Student Disability Services. Students were generally less familiar with the existence of UCL Student Disability Services in contrast with the virtually ubiquitous awareness of UCL Student Psychological Services. Focus group participants often displayed surprise at the description given by registered students of the services offered by UCL Student

Disability Services. In turn, registered students generally expressed varying levels of frustration at having accessed UCL Student Disability Services far into their degree or following an unnecessary deterioration of their mental health. This was predominantly believed to be a result of poor visibility and publicity on the part of UCL Student Disability Services. Additionally, as discussed above, some students suffering from mental health difficulties did not necessarily self-identify with the term disability. However focus group participants registered with UCL Student Disability Services were predominantly enthusiastic about the services they had been offered. In particular, students with mental health difficulties valued the long-term framework of supported provided to them, often contrasting it with the limited sessions of therapy offered by Student Psychological Services.

3.60. Focus group participants registered with UCL Student Disability Services highly prized the introduction of the mentor figure within the UCL Student Disability Services mental health care system.[12] A mentor, while not constituting a replacement for psychological and psychopharmacological therapies, provides regular weekly support to the registered student so to enable students to "*become more independent, feel more confident with* […] *work and have a better university experience"* by "*combining the understanding of the impact of mental health or physical disability on the person's ability to learn, as well as insight into the emotional experience at UCL".* Students usually meet with their mental health mentor for one hour a week during term time, this support is funded through the Disabled Students' Allowance for Home students and approximately 120 students accessed this service in 2015-2016.

"I didn't know I could go to disability services, I didn't know that until final year and that is like a late point in my degree, the final year like, the second half of final year to like finally go to disability services"

[12] More detailed information on the role and function of student mental health mentors can be found at https://www.ucl.ac.uk/disability/who-we-support/mental-health/tabs/mentoring-info-sheet.

"I felt that once I registered with the disability services, which again I didn't know about the existence of until that year, that was when the support kicked in but before that there wasn't really a lot because they tend to assume that if you are not registered then you are having mild problems.

3.61. One of the recurrent criticisms directed towards support services provided by UCL was that of the excessively brief psychological support offered by UCL Student Psychological Services. It might therefore be worthwhile considering a partial integration of the mental health mentoring system within UCL Student Psychological Services care so to present students approaching psychotherapeutic closure with the potential availability of long-term and regular support for their mental health difficulties if deemed necessary. While it would be paramount to emphasise the non-clinical nature of the mentoring figure, the potential access to long-term and regular support following psychotherapy would nonetheless likely result in diminishing fears and complaints of abrupt withdrawal of psychological treatment by assuring a more progressive regression to independency. Furthermore, a partial integration of the mentoring system within UCL Student Psychological Services would reasonably result in amplifying access due to the extensive visibility of UCL Student Psychological Services and to the general identification of UCL Student Psychological Services rather than UCL Student Disability Services with mental health support and care. Finally, while the management of clinical mental health difficulties lies outside the remit of mentors, data from focus groups and UCL Student Psychological Services uniformly confirms the high levels and the psychological toll of academic stress and pressure among students.

3.62. Additionally some students during the focus groups highlighted how a further limitation to the support services offered by UCL institutions is a perceived lack of immediacy in the mental health support provision. This was in general introduced into the discussion by students who had been through some sort of mental health crisis and had perceived a gap in the support systems at UCL.

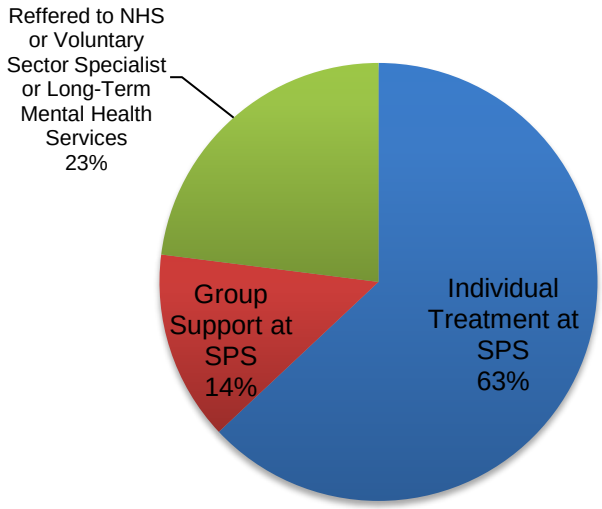
Possible solutions which might be implemented to partially respond to this need include the creation of an online peer support student platform and more frequent in-person peer support meetings, the advertisement of mental health emergency contacts such as the Samaritans and Nightline and a clear and supportive section on the UCL mental health website dedicated to the ways of overcoming and managing a crisis. We believe that UCL Student Psychological Services "Safety Card" represent an excellent starting point but that it should be more easily accessible and advertised and that it should be re-designed in a more user-friendly format such as that of a flier. Additionally the presence of personal tutors trained in mental health first aid and crisis management would further provide a partial solution to the perceived lack of immediate mental health support. Finally some students proposed the creation of a walk-in service, along the lines of the Ridgmount GP Practice, for UCL Student Psychological Services.

"It is not great this thing of having like one meeting a week, one hour of the week, it is obviously a very limited service and also there is issue that a lot of mental health difficulties do not, they evade time. That is one of the most overwhelming aspects of being at university, it is a real part of it, part of the adult world, is that it's less contained but there is also I wouldn't know where to go, apart from A&E and that's not really supportive at the end of the day, I mean I've been in A&E before and it doesn't really get you anywhere, so the idea of more informal settings, like to go in the evenings and things where it's not, where it's a bit quieter […] somewhere where you might actually get listened to and treat you like a person."

3.63. Students are often referred to NHS, voluntary or private mental health treatment by UCL support services. According to data from the UCL Student Psychological Services, in the academic year 2014-2015 nearly one in four students (23%) accessing UCL Student Psychological Services was directly referred to institutions outside UCL for specialist, long-term or more rapid treatment (Figure 17). However the relationship between NHS services and UK higher education has been deemed by the Royal College of Psychiatrist 2011 Report as complex

with students finding it “challenging” to access the services and the NHS often not being “adapted” to the needs of the student population. The Royal College of Psychiatrists called for an increased formalised, and possibly integrated, relationship between higher education support services and the NHS. The 2016 mental health report drafted by the University of York also foregrounded as one of its recommendations the need for a more coordinated interrelation.

Figure 17: Treatment of Students Presenting at Student Psychological Services in 2014-2015



3.64. UCL support services have developed through time long-standing and effective ties with Camden services such as the NHS Camden and Islington psychological therapies services iCope, The Brandon Centre, providing free psychotherapy for young people, NHS mental health community services and NHS crisis services such as the University College London Hospital psychiatry liaison. However, data from the focus groups has highlighted some gaps within the relationship between external mental health services and UCL. In particular, students reported a lack of follow-up by UCL support services after having been referred externally. According to the Mental Health Coordinator at the UCL Student Disability Services “students who live outside of Camden are more difficult to follow up with in terms of outside support”.

3.65. Additionally our research spotlighted a worrying gap in the care system with virtually no guidance whatsoever provided by UCL to students interrupting their studies due to a mental health difficulties and students sectioned under the Mental Health Act. Furthermore no precise data is available as the UCL Student Information System (Portico) does not hold "Mental Health" as a category for students on interruption, though students in this category might fall into the "Medical", "No Reason", "Other Reason" or, rarely, "Death" category. We believe that Portico should update its categories so to include students interrupting their studies due to mental health difficulties. The decision to interrupt studies due to mental health is often a sign of excruciating mental suffering, vulnerability and inability to function. We believe UCL has the potential of easing this process hugely and of accelerating a possible return by maintain some form of connection with the students on interruption and by establishing a low-intensity follow-up system. Additionally we believe that a peer support system for students on interruptions would provide an excellent opportunity for students on interruption to maintain some form of contact with university life and for accessing a form of psychological support within UCL.

"Here at UCL it seemed a bit, because I was referred out [WPF therapy], it kind of meant that when I finished my sessions there was sort of nothing so follow-up from UCL there was nothing really being discussed any more and it was really something that I needed follow-up therapy but it does seem like UCL is a very difficult place to get help"

3.66. The transition between home psychiatric care and higher education mental health support has been featured as a main gap in the links between NHS services and higher education institution. This is exacerbated when the transition from home care to London mental health services is between different national health services. UCL currently comprises of a student population composed for its 29% by international students coming from more than 150 different countries. Besides being subjected to the general stressors of university life, international

students are under particular strain as they move to a different country.[13] Some students might have grown up in countries with highly stigmatising attitudes towards mental illness and further hindering disclosure and timely mental health treatment. Finally, students from diverse cultural background might hold distinct expectation on concepts such as therapy and mental illness therefore warranting inter-cultural expertise.

3.67. Several steps can be taken towards the amelioration of mental health difficulties experienced by international students while studying at UCL. The transition process could be facilitated by early disclosure of mental health difficulties when students enter UCL. Students should be asked to disclose their mental health disability in a moment when they do not feel it could be detrimental to their academic or professional career and particular emphasis should be placed on the confidentiality of disclosure as a tool for rapid, effective and therapeutic support.

3.68. The cultural aspects of mental health could be addressed by establishing ties between UCL Union Clubs and Societies of specific cultural groups or countries and the UCL support services. By establishing a connection with UCL support services societies could potentially play a key role in tackling mental health stigma through culturally sensitive means. In particular, specific emphasis should be placed on the mental health of the Chinese community at UCL, considering that 8% of students accessing UCL Student Psychological Services self-identified as Chinese, the most frequent ethnicity following British students, and of the Asian community more in general as constituting the 46% of the entire UCL international student population.[14]

[13] A thorough report on international students' mental health in UK higher education institutions has been conducted by Young Minds in 2006 and can be found http://socialwelfare.bl.uk/subject-areas/services-client-groups/children-mental-health/youngminds/145729SOS_YM_StudentsMentalHealth.pdf

[14] More specific data on the ethnicity of UCL students can be found at: https://www.ucl.ac.uk/srs/statistics/tables/p/all-years

3.69. Finally, UCL also has a Cultural Consultation Service (CCS) which was launched in 2011. The two co-directors (Dr. Caroline Selai, a Chartered Psychologist and Dr. Sushrut Jadhav, Cross-Cultural Psychiatrist) are both academic members of UCL staff who run the service on a voluntary basis with no funding. The CCS facilitates engagement with those who are reluctant to engage with any professional service. After an in-depth cultural formulation, individual psychological interventions are adapted to each staff member or student's culture, beliefs and expectations. CCS can be accessed by "*any student, or member of staff, experiencing a challenge to their learning and/or teaching, which they think is primarily a cultural conflict*", but is currently insufficiently publicised. However, we believe that it holds considerable potential for facilitating the adjustment of international students suffering from pre-existing mental health difficulties and for the management of cultural aspects of poor mental health. If UCL, values its global nature then there is a need to provide a global and culturally sensitive outlook to the management of student mental health.

"I am an international student and sometimes it is like really difficult to express yourself and emotionally and your emotions in your non-native language and so that could also be a problem, like even when you are trying to research for help you are not managing to express your actual feelings and so I just put it aside and said "okay, this is probably not to work anyways" so I just like stopped [looking for help]*"*

"British people have the stiffest upper lip and they don't talk about their feelings and stuff and I think despite the fact that there are so many international students, you are in a culture where people don't talk about how they feel, no one talks about their feelings so I think that that potentially heighten it [poor mental health] *a lot."*

4. Key Findings

4.1. The surveyed population of UCL students appears to display moderate levels of mental distress, with some sections of the student population expressing more severe mental health problems. 33.8% of the male population and 35.2% of the female cohort exceeded the clinical threshold established by the CORE-OM mental health questionnaire meaning that around a third of the surveyed population expressed clinical significant levels of mental distress. Of the total cohort, 10% of male and 15% of female populations displayed moderate levels of mental health distress and 1% of both populations expressed severe mental health difficulties.

4.2. The most common mental health difficulty displayed by students appears to be depression, followed by anxiety. Future efforts should be made to understand how those conditions impact the everyday life of University College London students, UCL departments, together with UCL support services, should investigate how to best support the academic pathways of students with those specific conditions.

4.3. Psychological distress is considerably higher for females than for males. Females were 5% more likely to display moderate mental health difficulties and 10% less likely to be show low rates of mental distress than males. Future research in higher education should attempt to understand possible reasons behind this and UCL should be aware of the possibility of certain stressors affecting disproportionately the female population.

4.4. Disabled, gender-nonconforming and LGBT+ students expressed the highest levels of psychological distress in the entire student population with strikingly high levels of students belonging to those groups expressing moderate to severe mental health difficulties. We believe support systems and departments at UCL should bear in mind the socio-demographic components of poor mental health together with providing specific types of advice and support for those

demographic groups. Additionally, UCL as a whole should keep working towards a welcoming, accepting and understanding environment for all.

4.5. The predominance of academic stress within discussions on mental health difficulties experienced while studying at UCL demands a reflection on whether acute levels of stress and academic pressure need to be a necessary component of university life. While stress is not *per se* a clinical condition, severe and chronic stressors have the potential to trigger mental health difficulties and/or precipitate pre-existing psychological problems. Departments should carefully consider the structure of their courses, marking schemes and modes of assessments in order to broaden the notion of accessibility by considering the needs and differential perceptions of stressors among students experiencing mental health difficulties.

4.6. A designated staff member should offer pastoral support and receive necessary training to manage students experiencing mental health distress. This training should encompass active, emphatic and non-judgmental listening skills, information on support services available at UCL and signposting procedures, a rudimentary literacy around common mental health difficulties among the student population and their management and recognition of suicidal ideation and/or risk of harm to oneself or others together with knowledge on how to proceed in a crisis situation. We believe that the three-hour long Mental Health First Aid Lite[15] training would meet these requirements.[16]

4.7. Members of academic staff designated to offer pastoral support (currently personal tutors) should acquire this responsibility on a voluntary basis. Ill-disposed and unsympathetic personal tutors and other staff might exacerbate a student's psychological distress because of a lack of personal skills

[15] More details of the Mental Health First Aid Lite programme are available at: http://mhfaengland.org/first-aid-courses/first-aid-lite/

[16] The model which is currently being piloted at the University of Edinburgh appears to be an excellent paradigm to follow. More information can be found at http://www.studentnewspaper.org/all-personal-tutors-at-university-of-edinburgh-to-receive-mental-health-training-by-2018-academic-year/

compatible with the qualities necessary to provide emphatic, non-judgmental and caring support.

4.8. UCL should work to offer consistency in the delivery of pastoral support across faculties and departments. This is currently relevant to personal tutors. We believe students should be provided with designated staff contact offering support on a one-to-one and confidential basis with regular meetings, good availability throughout the academic year and minimal turnover of staff. This support should be offered to students on both academic and pastoral levels.

4.9. The stigma, both perceived and effective, endured by students suffering from mental health difficulties at UCL is a major barrier to their wellbeing. Mental health discrimination impacts on the construction and maintenance of meaningful relationship with peers, hinders the development of professional ties with academic staff and inhibits the personal flourishing of students suffering from mental health conditions. Most importantly mental health stigma can act as a trigger exacerbating pre-existing mental health difficulties and impede the timely access to support services within UCL. Reducing the levels of perceived and experienced stigma among students suffering from mental health difficulties constitutes a chief priority in safeguarding the wellbeing of UCL students.

4.10. Initiatives aiming at a reduction in mental health discrimination should employ a multi-level paradigm in tackling stigma, using an holistic, evidence-based approach. Anti-stigma campaigns should contain not only information but also affective/emotional components, e.g. by providing personal testimonies, and should actively tackle the political and institutional *contexts* leading to mental health discrimination. We suggest the consultation of the World Health Organisation recommendations on effective campaigns for tackling mental health stigma.[17] Such campaigns should also focus on tackling stigma

[17]The document is available at http://ec.europa.eu/health/mental_health/eu_compass/policy_recommendations_declarations/stigma_guidebook.pdf. Additionally if information is used within the campaign particular attention should be

surrounding less common mental illnesses including eating disorders, personality disorders, substance use disorders and psychotic disorders.

4.11. Particular attention should be placed in addressing the disproportionate level of perceived and experienced stigma suffered by male students with mental health difficulties. Due to gender stereotypes widespread in society, male students are at times exposed to an unfair level of discrimination due to mental health difficulties that warrants careful consideration and improvement.[18]

4.12. The access to support services at UCL should be as simple and straightforward as possible. Our results suggest that students would benefit from the creation of a single website containing a clear outline of what mental health support is available at UCL. The website should contain details on the function of each service and access procedures. Additionally, an increased and strategic use should be made of social media, in particular Facebook and Twitter. The Student Support and Wellbeing clip on support services at UCL is an example of effective communication.[19] It would also be useful to print and distribute guides on support services at UCL, such as the guide developed by Project Wellness. UCL students displayed a generalised low awareness of support services. When asked if they would know where to access psychological support at UCL 20.8% of students replied “not at all” and 35.9% replied “only occasionally”.

4.13. We believe that an increase in the funding to the Student Psychological Services would provide some respite from the current state of student overload and allow Student Psychological Services, via an increased number of therapists and staff, to shorten the waiting lists, provide more flexibility in

placed on the correctness and accessibility of the information. More in-depth suggestions on how to plan an effective health communication campaign can be found in the National Cancer Institute Pink Book at http://www.cancer.gov/publications/health-communication/pink-book.pdf

[18] More information of male mental health can be found in the Mind report “Delivering Male. Effective Practice in Male Mental Health” available at https://www.mind.org.uk/media/273473/delivering-male.pdf

[19] The clip is available at https://www.youtube.com/watch?v=Xj3LLovtMmI

regards to the limit of six psychotherapy sessions and enable better instruments for a closer follow-up with students referred for specialists treatment on the National Health Service.[20] More specifically we believe UCL should increase its funding to Student Psychological Services by £340,000 a year which would translate into 6.5 additional staff members allowing Student Psychological Services to meet its current student demand.

4.14. Both the mentoring system at the Student Disability Services and the Cultural Consultation Services should receive considerable more advertisement as they both hold particular potential for the improvement of student mental distress. Thought should be given to whether the mentoring system would be more accessible to students suffering from mental health disabilities if it was under Student Psychological Services rather than under the Student Disability Services. Secondly, the Cultural Consultation Services should engage more with the student community and with other support services at UCL. The creation of an outline of language and culture specific mental health support available in London would already represent a solid contribution to the wellbeing of the international students population. The translation of key information on mental health support into local idioms of distress and into the most spoken non-English languages might further facilitate the access of international, especially overseas, students to mental health support structures.

4.15. Students on interruption due to mental health difficulties or temporarily sectioned under the Mental Health Act should receive some form of low-intensity but structured follow-up from UCL support services and academic departments. Sectioned students and students on interruption often represent the most vulnerable end of poor mental health. At the moment no formal system of follow-up exists and students on interruption are often abandoned in a limbo of isolation. We believe that high quality data should be urgently collected on

[20] The underfunding of psychological services at UK universities has also been foregrounded as an urgent priority by the September 2016 Higher Education Policy Institute report on Student Mental Health available at http://www.hepi.ac.uk/2016/09/22/many-universities-need-triple-spending-mental-health-support-urgent-call-action-new-hepi-paper/.

this group of students and that attention be paid to what factors might make a return to university more likely than others. Academic departments and the student support services should attempt to maintain some form of contact with the student on interruption.

4.16. Our research on peer support preferences has shown that 4 every 10 students would consider the presence of peer support in times of distress somewhat useful. We believe that the creation of a well-structured and coherent peer support system holds considerable therapeutic potential for the student population. This system should be integrated within UCL support structures in terms of supervision and location, take place on a one-to-one basis as well as in groups, be focused on activities as well as on talking, receive solid training and provide an online peer support platform. The Oxford Peer Support Programme represents an excellent example of best practice to follow.[21]

4.17. Due to ethical limitations our research did not include data on self-harm, suicidal ideation, suicidal behaviour and aggressiveness. We believe that achieving a more in-depth understanding of those phenomena represents an urgent priority and that it is paramount for future research to ethically fill this knowledge gap. Data distinguishing between students who are experiencing suicidal thoughts, students who have made plans to end their lives and students who have attempted suicide in the past would be particularly useful as indicators of the risk and severity of the problem. Finally, future research should attempt to access certain student groups (such as the PhD student population) which, due to the practical limitations of our methods, were under-represented in our cohort.[22]

[21] More information on the Oxford Peer Support Programme can be found at https://www.ox.ac.uk/students/welfare/counselling/peersupport?wssl=1.

[22] A comprehensive draft report on doctoral students' mental health was presented in June 2016 by the UCL Doctoral School and will be finalized later in the year.

Recommendations

1. Employ effective communication throughout UCL's support services with the creation of a single reference point. Over half of students that participated in our research could never, or only occasionally, identify where to access psychological support at UCL.

2. Destigmatise mental health through a collaborate campaign delivered by UCL and UCLU. Attitudinal work should be undertaken through an educational and emotive campaign, paying particular attention to the disproportionate level of perceived stigma suffered by male students with mental health difficulties.

3. Identify designated staff contacts who will provide pastoral support. These roles should be on a voluntary basis but include standardised training to enable staff to support students suffering with mental health difficulties.

4. Increase funding to UCL Student Psychological Services by £340,000. This would translate to 6.5 new staff members, necessary to cover the numbers of students accessing the service. This would shorten the waiting list, facilitate follow-up with students and allow for additional support where needed.

Appendix 1: Methodology

The research conducted can be divided into a qualitative section, consisting of 5 focus groups, and a quantitative section, consisting in the administration of a paper mental health questionnaire to 2,567 students and of a web-based survey to 314 students.

Two UCLU staff members chaired the focus groups, attended by a total of 36 students. Every focus group began with a brief introduction to the project. This was followed by the distribution and collection of a consent form together with an anonymous questionnaire on demographics. An average of 5-6 students would participate in each session. The researchers engaged in semi-structured interviews with the participants, loosely following a timetable in order to touch on a series of pre-established topics of conversation.

Throughout the focus group the two researchers stressed that there were no right or wrong answers, emphasised the importance of personal experience and actively attempted to give equal opportunities to everyone to contribute in discussion. After this introductory process the researchers began asking a series of questions on mental health and support structures at UCL. Though those questions were understood as the basis for sparking a discussion, conversations often departed from the topic in different directions depending on the personal experience of each student. The questions were, in order of discussions:

1. What do you think could be done to improve mental health services at UCL?
2. Have you experienced any sort of mental health difficulty while studying at UCL?
3. If yes, what were the services that you accessed and were you satisfied with the service provided?
4. What do you think are the priorities in improving mental health at UCL

Participants were also asked a number of questions about peer support preferences at UCL. Responses to those questions are analysed and discussed in a separate report.

Each focus group took an average of one hour. The event was advertised through different mediums including: social media (Facebook and Twitter), departmental e-mails to students, communication from support services at UCL, posters and flyers. Snacks and drinks were provided to the attending students. Every focus group was recorded with a mobile device while the researchers wrote down in pen the main topics that arose during the conversation. The recordings were transcribed *verbatim* by one of the researchers and then coded with the qualitative analysis software NVivo. Following transcription the files were deleted from each of the mobile devices. The coding process was based on a content analysis of the main threads within each conversation.

In regards to the quantitative section, web-based surveys on mental health, while being faster and less costly than traditional approaches, also have several risks (Heieverang and Goodman, 2011). The most problematic risk was that of a self-selection bias. It would have been very likely that, in the case of a web-based survey, only students experiencing mental health difficulties would have been willing to complete a survey advertised as a mental health survey to improve student support at UCL. A self-selection bias would have hindered the representativeness of the research cohort and would have therefore hampered the validity of any resulting recommendations.

Research was conducted by employing a method utilised by Grant (2002) in the Leicester study on mental health in higher education. Grant had firstly made use of paper surveys rather than online surveys and, secondly, had administered the questionnaires during lecture time. This had allowed the study to receive high response rates. Therefore the UCL Welfare and International Officer contacted the Deans of UCL Faculties highlighting the necessity for up-to-date and scientifically solid research on the mental health of students at UCL and specified that the research was

supported by Student Psychological Services at UCL. The project received the full support of the Deans of the faculties of Social and Historical Sciences, Life Sciences, the Bartlett, Engineering Sciences, Population Health Sciences, Mathematical and Physical Sciences and Brain Sciences. The Faculties of Arts and Humanities, Laws and the Institute of Education did not participate in the quantitative research through the paper survey due to practical (Laws and Institute and Education) and ethical (Art and Humanities) reasons. The Faculty of Arts and Humanities believed that the content of the survey was too sensitive to be distributed in a lecture setting and potentially distressing for students. As a result the Faculties of Arts and Humanities and Laws participated in the survey through a web-based version of the questionnaire on the Survey Gizmo platform.

The survey included a mental health questionnaire followed by six questions focusing on mental health support preferences. The CORE Outcome Measure (OM)[23] survey was chosen to be administered to students. The CORE-OM is widely used in the UK as a clinical instrument by psychotherapists, psychiatrists and mental health professionals. It has also been administered to research cohorts on many occasions and has been found to have good reliability, validity and sensitivity to change (Evans *et al.,* 2002). The CORE-OM is a questionnaire that investigates the frequency of different aspects of mental health distress "over the last week". The scoring structure goes from a minimum of "not at all" to a maximum of "most or all the time". Frequency scores correspond to numerical scores set in descending (from 4 to 0) or ascending (from 0 to 4) order depending on the positivity (ex. "I have felt O.K about myself") or negativity (ex. "I have felt terribly alone and isolated) of the question. The numerical scores provided a gradual measure of distress where 0 corresponded to no distress whatsoever whereas 4 corresponded to a maximum level of mental distress depending on the frequency of mental health symptomatology.

The CORE-OM consists of 34 items which can be clustered in four dimensions:

[23] A complete version of the CORE-OM questionnaire can be found at https://www.sussex.ac.uk/webteam/gateway/file.php?name=core.pdf&site=322

1. Wellbeing (4 questions)
2. Problems or Symptoms (12 questions)
3. Functioning (12 questions)
4. Risk (6 questions)

It was decided that the Risk dimension would be removed from the questionnaire, leading to a considerable reduction of the sensitivity of the questionnaire. An information sheet was also distributed that summarised the different forms of mental health support that were available at UCL. The leaflet included information on Student Psychological Services, the UCL GP Practice, supports at Halls of Residence, peer support groups, Student Disability Services, information on personal tutors, the UCL Chaplain & Interfaith Advisor, the Samaritans and Nightline. We also provided details on emergency contacts and some brief information on crisis situations[24].

It is paramount to stress how throughout this report we are go be referring to students' "mental health distress or mental health difficulties" rather than "mental illness or mental disorder" as the CORE-OM questionnaire only measures the former. We will follow the HEPI 2016 definition of mental health difficulties as "any position below "mental very well" on the mental health spectrum" implying the presence of some symptoms of an illness without a full diagnosis.

Besides the CORE-OM, the quantitative questionnaire also included one question focusing on mental health support at UCL ("Do you feel that if you needed psychological support at UCL you would know where to go?" and five questions on peer support.

Participation in the survey was totally voluntary and this was stressed during the spoken introduction of the survey within lecture theatres and further specified in the

[24] The information sheet and the leaflet with the mental health support information can be found at https://surveygizmolibrary.s3.amazonaws.com/library/228974/FlierandInformationSheetSurvey.pdf

information sheet. Additionally the researchers highlighted how the survey was completely unrelated to the lecture that was talking places and that the choice of completing it or not would have had no repercussion whatsoever on their academic record. The researches decided to randomise the questions within each survey so to create three different versions of the CORE-OM. The reason behind this was that of diminishing the chances of students breaching the confidentiality of other students by looking onto other students' questionnaire. This was communicated to students before the administration of the survey. In addition the size of the font on the questionnaire was reduced so to further impede the chances of students knowing each other's scores. The anonymity of students was further protected by only accessing lectures with an attendance of more than 20 students.

In order to provide a random sample of students we administrated the survey in the most attended lecture of every level (first year undergraduate, second year undergraduate, third year undergraduate, fourth year undergraduates (in a minority of departments) and taught masters) within every participating department. The process of distributing and administrating the survey took an average of 10 minutes in every lecture (with 8 minutes being dedicated to the filling in of the questionnaire by attending students and an additional 2 minutes for the distribution, collection and explanation of the survey and the information sheet). We did not have the means to statistically calculate a precise response rate during the administration and collection of the surveys. However, based on the anecdotal reports of the administrators and on calculations of the return rate of the questionnaires versus the number of distributed questionnaire, we believe that the survey had a strikingly high response rate of around 75-95% of the student cohort.

Following the collection of the data, the completed questionnaires were stored in a locked space and handled under the provisions of the Data Protection Act 1998. Once the full cohort of questionnaires was collected they were sent for data insertion to an external data entry company that had had previous experience with sensitive data and mental health/ psychometric material. The data were entered on an Excel sheet and

following completion of the data entry process the paper questionnaires were destroyed. The data were then analysed through Excel.

The web-based version of the survey was structurally identical to the paper questionnaire. A link to the questionnaire was sent to the administrative organs of each department that had decided not to participate into the standard research and each department circulated the link internally. The time span for the completion of the survey went from the 7th of March to the 18th of April. Only students from the Faculties of Laws and Arts and Humanities could access the survey so to avoid students from other faculties completing the survey twice. 314 students accessed the questionnaire with 195 students filling it in completely and 119 students completing it partially. 8.2% of students from the Faculty of Laws and 5.7% of the students from the Faculty of Arts and Humanities participated in the survey. We believe that the validity of the results collected through this method is considerably weaker when compared to its paper equivalent due to the self-selection bias inherent to online mental health surveys.

The methods utilising in this research project carry some inherent limitations. The first limitation concerns the possibility of the lecture setting potentially skewing the self-reported rates of mental health distress of students due to embarrassment or fear of academic repercussion. However, as highlighted above, we took a series of precautions in order to limit this possibility as much as possible. Another limit is that of the time constraints which were imposed on us by the distribution of the survey during lecture time. Though very much dependent on the availability of single lecturers, the survey distribution rarely, if ever, exceeded the 15 minutes. This meant that, at times, we were forced to collect the surveys when a very small minority of students was still completing it. However, due to the very limited amount of students who did not finish on time, we believe that this did not significantly affect the results.

A further limit to the distribution of the surveys during lecture time is that of the possibility of the sickest students being absent from the lecture theatre due to their severe mental health conditions. This might have led to the results of the survey questionnaire being biased towards more positive averages. Another important

limitation is the near to total lack of mental health data on the PhD students population. This is because of the fact that the biggest strengths of our methods, that of distributing the surveys in lecture theatres, was infeasible with PhD students as they tended not to attend any lecture or to be accessible in sizeable groups. The completion of the survey through its web-based equivalent represents a further limit due to the inherent self-selection biases inherent to online mental health surveys. Other limitations to our methods include the flawed design of the survey in regards to the mental health support questions, the lack of precise response rates and, finally, the total absence of data regarding suicidal thoughts and suicidal behaviour, self-harm and aggressiveness towards others.

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