Promoting Mental Health: Students' Perspectives and Experiences of a University Environment

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Acknowledgements

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Abstract

The aim of this flexible, multi-method case-study (after Yin 1994, 2003), was to elicit the 'student perspective' on issues relating to mental well-being within the Higher Education Institution setting. It has been guided by the ideology of the health promotion model, the concept of salutogenesis and the Health Promoting University initiative.

Phase One consisted of eleven focus group discussions involving fifty one self-selecting participant undergraduates and a semi-structured interview conducted with the lead medical practitioner of the Medical Centre on site. In Phase Two, a quota sample of 806 undergraduates completed a questionnaire. The three datasets were analysed according to a facilitative and complementary approach (Brannen 2004) and in keeping with assumptions of the paradigms from which they originated. The qualitative data were analysed within the framework provided by Miles and Huberman (1994) and the survey was analysed using the Statistical Package for Social Sciences (SPSS).

The findings demonstrated that this multi-site university may have specific difficulties with regard to the provision of equal access to the support services. Reduced pastoral care could pose risks to the mental well-being of some students whereas the allocation of students to a personal tutor might increase levels of social capital and reduce symptoms of 'anomie'.

Conclusions of the study suggest that HEIs need an understanding of the concerns of students and their help-seeking behaviour in order to define 'health assets' and minimise 'health deficits'. Overall, the development of co-ordinated institutional support service provision - that is responsive to the needs of a diverse student body - facilitates and supports the creation of a salutogenic environment that both promotes and sustains mental well-being. Health education programmes need to address the persistence of stigma and discrimination. Attention should be focused on health protection measures so that all groups of students are treated equally and fairly in order to counter-balance a possible residual biomedical approach to health promotion from within the medical sector provision.

As a case-study of one university, the findings may be theoretically generalisable to other similar multi-site HEIs in their mental health promotion provision.

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INTRODUCTION

My strong commitment to young people's mental well-being spans more than two decades.

Becoming a member of a charitable organisation named PAPYRUS (that campaigns to prevent suicide in young people and to promote mental health and emotional well-being) coincided with unremitting national concern regarding the unprecedented high rates of suicide among young people which had peaked in the 1980s, in particular in young males. The involvement of Nicky Stanley and Jill Manthorpe in research and collaborative work with PAPYRUS (especially in the field of pastoral care) acted as a catalyst and directed my interest towards student mental health at a time when two of my own children were entering higher education. Concurrently undertaking a dissertation for my master's degree in Education, I was concerned to learn whether Higher Education Institutions' provision of services to support and promote undergraduates' mental health was commensurate with students' needs. A notable conclusion of this work was the great variation in the quality and provision of support services across HEIs and indeed how these services were organised. A common framework (albeit generalised) within which to implement, structure and operationalise such an undertaking was noted to be lacking.

My considerable length of service in general practice has provided me not only with an insight into areas of tension between policy makers and service providers with regard to health promotion but also the opportunity to evaluate several health promotion activities implemented as a result of contractual imperatives. For example, analysis of the attendance figures for the various 'health check' clinics set-up as a consequence of the 1990 GPs' Contract demonstrated a disappointing outcome in terms of opportunity up-take. Along similar lines, the futility of service provision that does not meet the needs of the service users became evident from knowledge acquired formally and experientially.

The conception of this study was, therefore, initiated by concern about young people's mental well-being, influenced by personal knowledge and experience of health promotion in practice, and sustained by a firm belief in the pursuit of an holistic approach towards the academic *and* emotional development of young people.

Chapter 1

Background overview and the development of the conceptual framework

The mental health of young people has been a cause for national concern for many years (Madge and Harvey 1999, Office for National Statistics/ONS 1998a, 1998b, 2000, Meltzer 2000, Mental Health Foundation 1997, 1999, 1999a, 2003, Samaritans 2001, Appleby 2001). Epidemiological review confirmed there has been an overall increase in mental ill health in young people in the 15-24 age-group since 1973 (ONS 1998a, Hawton et al. 1998, Hawton et al. 1999, Fox and Hawton 2004). Fortunately, the dramatic increase in young male suicides in the mid 1980s, (compared to a fall in female suicide rates in the same period), has abated and in 2003 suicides in England and Wales (not Scotland) for both males and females were the lowest they had been since 1973. Figures produced by the Office for National Statistics (2001, Meltzer 2002) demonstrated the first decrease in male suicides in the 15-24 age-group since 1998. Recent research (Biddle et al 2008) confirms that suicide rates in young men (15-24 and 25-35) have steadily declined since the 1990s and are now at their lowest for almost thirty years. Female suicides are also at their lowest recorded level since the 1970s. Furthermore, an interesting trend has been noted in suicide behaviour of young people. There is now far less difference between the sexes in their chosen method of suicide. Suicide by hanging (formerly the preferred method of males) has increased among young women and has now overtaken self-poisoning. Self-poisoning has increased in males who are now less inclined to hang themselves. Of note, incidents of self-harm and attempted suicides (parasuicides), previously overwhelmingly a problem in females, are now also increasing in males (ONS 2000, Hawton et al. 2002).

Although suicide rates have generally fallen in England and Wales over the last 15 years, other forms of mental health problems, such as deliberate self-harm (DSH) and parasuicides – said to be the precursors of completed suicide – are on the increase (Royal College of Psychiatrists 2003, Fox and Hawton 2004). In 2000 Meltzer found suicide ideation to be more prevalent among young people than older people and indeed mid/late adolescents and young adults were noted to have a higher incidence of recorded self-harm and parasuicide than the rest of the population. Researchers in the field of adolescent mental health (Meltzer 2000, ONS 1998b, 2001) warn that the documented deterioration in young people's mental health is associated with the concurrent increase in drug-taking and alcohol abuse, in particular in young males. Although this work acknowledges the

considerable relevance of such findings to the mental health status of young people, it does not intend to make any new contributions to this huge and complex area.

Despite the changing demographic profile of students, young people in the 16-24 age-group still make up the majority of the student body in the UK (Higher Education Statistics Agency/HESA, 2007, personal communication via telephone and e-mail, February, 2008). With the present government's policy to further widen access to higher education, coupled with their expressed intention to increase the number of under 30 year olds attending university by 50 per cent by the end of the decade, the Royal College of Psychiatrists (2003) warn many more undergraduates could develop depression and eating disorders, self-harm and attempt suicide, especially at a time in their lives when those with a predisposition to severe mental disorders (such as schizophrenia and manic depression) are most at risk.

Furthermore, despite the fact that the student population has doubled since the 1980s (Committee of Vice-Chancellors and Principals/CVCP 1995) – without a commensurate increase in funding or staffing levels – the pastoral role of Higher Education Institutions/HEIs (previously an integral component of British university education) has been steadily declining; to the point where some universities are no longer allocating students to a personal tutor (Universities UK 2002). This places extra pressure on the support services and university academic staff. Consequently, academic staff who are already having to cope with increased workloads have reported a growing number of students turning to them for help for which they often feel inadequately trained and prepared (Stanley et al. 2000).

Reports produced over the last decade or so, by Phippen (1995), CVCP (2000), Universities UK (2002) and the University Counselling Services (AUCC 1999, 2001, 2002), and most recently by the Royal College of Psychiatrists (2003), have focused attention on the plight of students in higher education and on their mental health status. In 1999, AUCC reported that 63 per cent of University Counselling Services had noted an increase in psychological problems among students, 15 per cent of whom were assessed as being at risk of suicide. This was stated as being a 5 per cent increase on previous estimates. Rana et al. (1999) were also of the opinion university counselling services are sometimes used inappropriately by over-stretched NHS services, in particular because in many cases students' presenting symptoms were so severe they warranted medical intervention:

" There sometimes appears to be an implicit assumption that university counselling services will be able to make up for shortfalls in the provision of psychological treatment and support within the NHS" (p.7).

The mental health status of young people

Extensive literature reviews undertaken over many years had resulted in a considerable amount of material being amassed in the fields of health psychology, medical sociology, health promotion and mental health. As background to the study, many of these topic areas were re-visited and re-appraised before being narrowed down to the mental health of young people in general and the mental health of students in particular. A computer search was then undertaken via Ovid, Medline and the Cochrane Library, including the British Library's BLAISE-line, to identify relevant English language papers and abstracts under the search terms using, firstly: 'mental health of young people', 'mental health problems in young people' and then 'student mental health' and 'student mental health problems'. Numerous White Papers and some Acts of Parliament, as well as guidelines and policies directed at Higher Education Institutions, were also identified as being relevant to the context of the research.

A number of text-books, in particular those on seminal works, such as Antonovsky (1987) and Durkheim (1952) were accessed through the British Library. Direct contact was established with organisations and individual researchers on the telephone (Meltzer, telephone conversation October 2003, HESA June 2008) and by e-mail (Mental Health Foundation, September 2003). For the most part the searches were restricted to research undertaken in the UK. Samples that did not include young people over the age of 16 or which emanated from colleges of further education (rather than higher education institutions) formed part of the exclusion criteria. The computer search therefore concentrated on the 16-24 age-group (presently accepted as being the period of late adolescence and early adulthood, Apter 2001), and revealed a complex combination of personal, social and environmental factors that impact on the mental health of young people and which are also age-specific.

Due to the vastness of its scope, adolescent psychology is another specialist field of enquiry that has not been entered into here, save to make a few points that are considered to be particularly relevant to this work. Erikson (1980), for example, proposed the adolescent is confronted not only by physical, sexual and psychological change but also with the critical task of developing a sense of identity. Associated with this process is the acknowledgement that peer groups (which can have both positive and negative influences)

take on a special significance during this period (Piaget 1972 and Erikson 1980). On the positive side, successful peer groupings can provide an immensely important support function. Piaget (1972), however, also recognised that unfavourable comparisons with peer groupings (regarding the projection of the desired self-image) can result in loss of self-esteem - a condition that is consistently associated with depression, anorexia, suicidal ideation and episodes of self-harm (Hawton 1992). In striving for independence and identity, adolescents often replace some of the values learned in childhood with the values of their adopted peer group (Coleman and Hendry 1990). Coleman and Hendry (1990) believe the pressure to conform to unfamiliar values and behaviours may result in conflict which can be both the cause and the consequence of depression in young people. This view is commensurate with Durkheim's concept of 'anomie' (see Appendix 2). Durkheim's (1952) seminal work on suicide suggested that depression can be caused by a rapid transition from one set of established social norms and values to a new set of unfamiliar norms and values. The Royal College of Psychiatrists (2003) and Meltzer et al (2002),concluded a suicide act may be precipitated by the disinhibiting effect of alcohol and drug abuse, as these substances can significantly affect thinking and reasoning. Moreover, during this developmental period relationships can be particularly intense. Guthrie et al. (2001) found 70 per cent of cases of self-harm were precipitated by a relationship problem.

Is student mental health worse than the age-matched non-student population?

According to the Royal College of Psychiatrists (2003) the mental health status of the UK's student population is becoming progressively approximated to the mental health status of young people in the general population, for despite the rapidly changing profile of students in UK HEIs since the 1980s, the majority of the student body (at 64.2%) still falls within the 16-24 year age group, as the following HESA student records data breakdown demonstrates (personal communication via telephone and e-mail, February 2008):

Table 1: Percentages of undergraduates in each year-group for the academic year 2006/2007 (HESA)									
Age	16	17	18	19	20	21	22	23	24	25+
%	0.2	0.8	10.9	14.9	15.1	10.4	5.6	3.6	2.7	35.9

Smith and Cowie (1992) maintain students are more likely to be in an extended moratorium period than working youths. The Samaritans (2001) found 56 per cent of young men who attempt suicide have employment or study problems. Rickinson and

Rutherford (1995, 1996) also believe young adults who are undergoing developmental transition and straining to master new age-related stresses of academic demands are particularly vulnerable, some more so than others but especially those who already have mental health difficulties. The Royal College of Psychiatrists (2003) warn that typical adolescent risk-taking behaviour will place a significant number of students at risk of developing mental health problems whilst at university especially as the first episode of schizophrenia can be drug and/or stress induced. Anorexia nervosa has also been linked to high academic achievement and stress provoking situations (Fox and Hawton 2004).

A number of studies have found that students have poorer psychological and physical health than the non-student population of the same age. A survey conducted by Roberts et al (1999) of 360 British university students (using the Health Survey SF-36 and GHQ-12) revealed that the mental health of students was significantly below that of the age-related population norms. Another survey of two London Boroughs commissioned by the Mental Health Foundation (1999) demonstrated that 30 per cent of the students sampled had poorer General Health Questionnaire scores than the non-student population, 44 per cent of whom had poorer social functioning scores.

As has already been documented, concern over student mental health was also amassing from within HEIs themselves. In 2002, acknowledgement of this situation prompted a coalition of ten voluntary organisations including Samaritans, MIND, the National Union of Students and PAPYRUS to approach the Committee of Vice-Chancellors and Principals (now Universities UK) and SCOP (Standing Conference of Principals) to undertake research into student suicide and DSH. Its aim was to establish trends and examples of good practice to reduce student mental health difficulties and ultimately to prevent suicides. Although Universities UK (2002) reported student suicides were similar to those for the general population, they conceded there were epidemiological problems associated with drawing firm conclusions.

Problems with ascertaining the true extent of mental health problems in young people

It became apparent from the critical review that the most consistent weakness in the cited literature sources arose from difficulty in obtaining reliable data, both with regard to the mental health status of young people in general and to the student population in particular.

For instance, a declared major difficulty encountered by the Universities UK team of researchers was with respect to obtaining 'valid' and 'conclusive' data on the mental health problems of students. The first difficulty surrounds the definition of a student, partly

because the Higher Education Statistics Agency (HESA) and the Office for National Statistics record student suicides under the category of their last paid employment. Some studies have focused on university students, others refer to students on vocational courses at colleges of further education. Some are concerned with issues around living away from home, while others include students living at home. Furthermore, some reported samples differ in terms of the age of students and such differences render comparisons between findings problematic. Also, significantly, another issue concerns the definition of a mental health problem. Some studies, say the Royal College of Psychiatrists (2003), are concerned with 'disorder', while others are concerned with 'problems' – indicating a difference between the two in terms of threshold (higher for disorder) and methodology (disorder implying clinical diagnosis, whereas problematic symptoms and behaviours are usually based on self-report). However, although mental health is now defined as psychological well-being instead of the absence of mental illness, definitions of mental illness are still notoriously difficult to establish (Mental Health Foundation 1999a), being characterised by a multitude of disturbances of functioning – in mood, behaviour or development. For example, the term depression means different things to different people. Officially classified by health professionals as a type of mental illness, depression describes patterns of psychological symptoms or behaviour causing acute or chronic ill-health, personal distress or distress to others. It is also a condition that varies tremendously in its severity, being graded professionally as either neurosis (the milder form which can be treated by general practitioners or psychotherapists) or psychosis, the more severe form which is almost always treated by a psychiatrist. For this reason every piece of research should clearly define all the terms it uses, in order that the reader is left in no doubt about the meanings ascribed to these terms by the researcher(s). Only then can the reader make an informed judgement about whether the investigation adds to the knowledge base of other studies in the same field. Furthermore, the Royal College of Psychiatrists (2003) stress the subject of mental health is a rapidly changing field and epidemiological data quickly become out of date.

Statistics are further complicated by the fact that many adolescent deaths may be associated with drug-related mortality - particularly among young males between 16-24 - which may or may not have been intended (ONS 1998b). Similarly, statistics on self-harm are notoriously unreliable as many incidents are treated at home and are therefore not included in official statistics (Hickey et al. 2001). The condition of anorexia nervosa also distorts official figures due to the protracted course of the illness.

Hawton et al (1995a, 1995b) also found that when deaths with open verdicts were taken into account, the suicide rates for students at Oxford University from 1976 to 1990 were similar to the rates for the same age group in the general population. Likewise, Collins and Paykel's (2000) study of student deaths at Cambridge University found rates similar to those for 15-24 year olds in the general population. However, I would suggest these studies, which relate to the Universities of Oxford and Cambridge, may not be representative of the wider student population (not least because of the more exacting entrance requirements demanded of prospective Oxbridge undergraduates), but also in much the same way that the conclusions drawn from this study cannot automatically be applied to any other HEI. It is likely, however, that certain aspects of some HEIs are not significantly different from those in other institutions and there may well be areas of convergence, sufficient to warrant consideration of the recommendations made.

A noteworthy conclusion of the Royal College of Psychiatrists (2003) was that students are not at increased risk of suicide, and may be at a reduced risk – especially male students. Indeed, Hobbs (2002) suggested the rates of suicide among students could be lower than in the general population. Moreover, in their summary, the Royal College of Psychiatrists (2003) state that although students report higher levels of **"mental health symptoms"** (their emphasis), there is no evidence to confirm that students are more likely to suffer mental illness. The Royal College does, however, acknowledge that today's undergraduates are under greater pressure than ever before:

> "It is probable that a number of these students are subject to more predisposing risk factors and more vulnerability factors than students of 20 years ago" (Royal College of Psychiatrists 2003, p.13).

Reasons proposed for the vulnerability of students to mental health problems

Students have gone from being an exclusive fraternity to a 1.6 million strong industry. Not only has the student population doubled since 1983/4 but also the demographic profile has altered considerably. They are also, according to Stewart-Brown et al. (2000), an under-researched demographic group:

> "…there are few surveys of the health of students at university and other higher education institutions" (Stewart-Brown et al 2000, p. 492).

The Royal College of Psychiatrists (2003) stress the point that there are many more students in the higher education system now from a diversity of cultures, educational and social backgrounds than ever before. Although higher education students have always

faced potential risk factors for mental ill health, (such as isolation, lack of peer support and academic pressures), the Royal College argues that undergraduates taking up university places previously were more likely to be advantaged in terms of academic ability, family background and material wealth. Consequently, the widened access to higher education to those from hitherto under-represented socio-economic disadvantaged groups (such as non-traditional and ethnic minority backgrounds) has collectively put susceptible/vulnerable undergraduates at risk of developing mental health problems. This lends support to Apter's (2001) findings that students from 'non-traditional' backgrounds may have no familiarity with higher education institutions or the demands of advanced study. Specifically, they may feel isolated from the majority of students and alienated from both the culture of the institution and the families and communities from which they come.

Moreover, universities recruit overseas students from all parts of the world. In 2001, Dooris estimated over 200,000 overseas students came to study in UK universities from over 180 countries. Certainly the numbers of international students have increased in the last twenty years with European countries participating in Erasmus and Socrates exchange courses. This has resulted in the student population becoming increasingly heterogeneous. Furthermore, students from overseas can experience all the problems of 'home' students, such as financial worries, academic pressures and forging new relationships, but with the added dimension of having to come to terms with homesickness, a different language, and adjusting to a different culture. They may experience racism, feel isolated and alone and experience varying degrees of 'anomie'. The Royal College of Psychiatrists (2003) suggest international students, and ethnic minorities, are at greater risk of developing mental health problems whilst at university than home students.

However, Bradley (2000) argued the extent to which overseas students require more help to adjust than 'home' students is open to debate. She believes some 'home' students - from backgrounds markedly different from the received middle-class culture of the more established campuses - may experience a form of culture shock and feel excluded from the mainstream to a greater extent than some international students who, conversely, might have little difficulty adjusting. Furnham (1997) describes culture shock as "individuals lacking points of reference, social norms and rules to guide their actions and understand others' behaviour" (p.16). Significantly, Bradley (2000) also found that overseas students often felt marginalised and isolated from home UK students, that their relationships with them were superficial and that it was often difficult to know who was actually a friend. Most importantly, many overseas students felt alienated from their host counterparts

because they did not feel they fitted in with the typically British 'pub and club' student culture.

Wade (2002) further argues we do not take the concepts of homesickness or culture shock seriously enough. He found symptoms of 'anomie' were most apparent in 'freshers' when they first start at university (the participant student profiling was not disclosed). Wade learned that 'freshers' often feel 'the outsider' and 'different' when values and norms of different sets of peers are at variance with their own.

Jacobson (2002) identified growing competitiveness, heightened aspirations for achievement and material security as contributors in the development of mental health problems in students. To these factors, Apter (2001) adds feelings of isolation and academic pressures, breakdown of the nuclear family support network, a longer period of financial and emotional dependency and also unprecedented levels of financial debt. Grant's (2002) research ranked issues that impacted on student stress levels according to students' own assessment. These issues included the categories of study concerns, careers issues, adjustment to student life, personal development and relationship problems. Financial worries came among the highest of all stressors. This finding was reinforced by Roberts and Zelenyanski (2002) who reported financial concerns as being most problematic, and to a lesser degree: academic problems, time pressures and interpersonal relationships. Significantly, Roberts and Zelenyanski found a direct correlation between financial stress and ill-health – both physical and mental. Stewart-Brown et al. (2000) also demonstrated that financial concerns were considerably more apparent in students than in the age-matched non-student population. In 1995, Hodgson and Simoni had already identified that financial problems in students related to poor academic performance, poor psychological functioning and depression.

Debt and juggling part-time work were identified by the Unite/Mori (2004) report as being the worst aspects of university life. The consequence of student poverty has also been widely publicised by the National Union of Students (1994). The level of subsidy to students has fallen sharply as student numbers have increased and the state's financial provision to students has come under progressive attack. This began with the maintenance grant being frozen and yearly reductions of ten per cent, culminating in the introduction of tuition fees and the abolition of the mandatory grant - all measures implemented in stark contrast to the recommendations of the 1997 Dearing Report. The contentious issue of loans and tuition fees has added to student debt problems and many students have moved into sizeable debt, some of whom take up part-time employment outside the university to

stem the potentially worrying spiral of financial hardship (Stanley and Manthorpe 2002). A consequence of working such long hours off campus can be missed lectures and not meeting course-work deadlines. In 1993, Lindsay and Paton-Satzbury had found almost 60 per cent of students worked regularly during term-time with a third working over 20 hours per week, 20 per cent working at least 30 hours and some students working up to 50 hours a week. Roberts and Zelenyanski (2002) also found a correlation between working long hours and increased risk-taking behaviour, such as alcohol and drug abuse with one in five students taking illicit drugs and one in five students meeting the criteria for problem drinking levels (Zelenyanski 1999). Students who had considered abandoning the course for financial reasons also had poorer physical as well as poorer mental health.

Although Grant (2002) proposed there was no evidence from her 1999 Leicester Study to conclude that heavy drinking is a symptom of mental health problems in students, the Royal College of Psychiatrists (2003) claim the increase in the use of alcohol and drugs among students in higher education, both reflects and causes increased mental health problems. They question whether the worryingly high rates of suicide ideation might be associated with the growing evidence that cannabis use predisposes to anxiety and depression. Meltzer et al's 2002 study supported Charlton et al's (1993) findings that both substance abuse and drug-related mortality have been steadily increasing among teenagers since 1984. Cannabis/drug abuse is acknowledged to be one of the largest causes of university drop-outs. According to research conducted by the ONS (2001) more than half of all students are regular users of cannabis.

Apter (2001) found that students were concerned not to worry their parents about problems they were experiencing, preferring to struggle on alone rather than cause them anxiety. This, she said, added to students' isolation and the feeling of helplessness. She sees a link between these feelings of isolation and being unable to ask for help and the steadily rising cases of parasuicide, DSH, eating disorders, alcoholism and drug abuse. O'Sullivan (NUS Disability Officer) concurred that many students with mental health problems feel unable to seek help (personal contact in November, 2004), and although there has been a correlation between suicide ideation and deliberate self-harm in the student population, interestingly no association has yet been found to link suicide ideation or DSH or parasuicide with examination times (Universities UK 2002).

The Royal College of Psychiatrists propose the increased numbers of students seeking help with mental health problems may reflect the increasing numbers of students entering higher education, the progressive approximation of the characteristics of the student

population to the general population and the increasing willingness of young people seeking help for a range of emotional and mental health problems. Although there is reason to conclude suicide rates are no higher in students than in the general population (in fact, Hobbs 2002 suggests students may actually be afforded some protection), the Royal College supports Stewart-Brown et al's (2000) view that students' mental health may well be a cause for concern:

> "although there are limitations to the data, there are reasons to believe that rates of mental health problems (of the student population) are high and possibly increasing" (Royal College of Psychiatrists 2003, p. 14).

The limitations imposed on this statement, however, are due to there being no agreed age differentiating adolescence from adulthood and also because the data amassed from cumulative activity within HEIs represents only those students who attend formal support services. I would further suggest that the above citation actually contradicts an earlier comment made by the Royal College, as presented on page 7, that students report higher rates of 'mental health symptoms' which do not necessarily go on to develop into mental health problems. My concern here is the use of the term 'mental health symptoms' – a somewhat strange choice of words when the topic of discussion was concerned with mental health problems. Instead the reader is left wondering what precise state of mind would constitute a mental health symptom Would not the term 'mental illness symptoms' reflect a more accurate description of the issues under consideration and be more consistent with related research, the findings of which formed the basis of the Royal College's report?

I would suggest, therefore, that a lack of uniformity with regard to the definition of both a 'student' and a 'mental health problem' renders a reliable assessment of the extent of the mental health status of students somewhat problematic. In consideration of this point, I have aimed to define and to provide some background to the definitions of terms which have been used throughout this study (see Appendix 1)

Development of the conceptual framework and theories of influence

Having established there is concern about the mental health of students, the question arises about how best to approach this phenomenon and how best to deal with it within the university environment. Tinklin et al. (2005) maintain the need to understand mental health in environmental, as well as individual terms, is just beginning to take hold in the higher education sector. This, they state, has been greatly influenced by ideas in the field

of health promotion, including the directives encapsulated in the White Paper (DoH 2001) which states :

> "The inter-relationship between social, environmental and political influences and their effect on individual and community health, is increasingly being recognised. As a result mental health promotion requires a co-ordinated approach, bridging these boundaries, directed at specific settings where problems arise, aimed at improving the health of whole communities" (p. 129).

It is the principles of health promotion ideology that have provided the basis of the framework within which to conduct this research. In addition, it was the identification of research relating specifically to student mental health that led to a broadening of this framework to include other related concepts and theories. For example, accessing Dooris' papers on the Health Promoting University (1998, 1999, 2001) not only caused me to consider the closely connected concept of social capital but also introduced me directly to Antonovsky and his concept of salutogenesis (1979, 1987, 1996) and more recently the work of Morgan and Ziglio (2007) from which I became familiar with their Assets Model and the terms 'health assets' and 'health deficits'. Closely aligned to the promotion of health and health related matters are relevant legislation and White Papers of influence. The issue of stigma has also been included for the reason that perceptions of stigma affect help-seeking behaviour, a very brief overview of which is found in Appendix 3.

The Health Promoting University initiative and the concept of Salutogenesis

The concept of health promoting universities emerged as part of what has become known as settings-based health promotion which focuses on carrying out health promotion within particular settings. Its root lies within the public health movement ideology as defined by the World Health Organisation – in particular the WHO Health for All strategy documents (WHO 1984, 1985, 1986) and the Jakarta Declaration of 1998. The latter drew upon the work of theorists concerned with the creation of positive health, such as the work of Antonovsky (1979, 1987, 1996) whose notion of salutogenesis has been pivotal in the development of the setting-based approach. The Ottawa Charter (WHO 1986) served as a catalyst to shift health promotion away from problems characterised by particular behaviours or specific 'at risk' individuals/groups towards environments and settings by concentrating on the creation of environments supportive of health strengthening community action, the development of personal skills and the reorientation of health services. Settings-based health promotion allows for dove-tailing of co-ordinated and comprehensible health education work in particular community settings with specific

preventive services and health protection measures tailored to the needs of its community and opportunistically presented by particular settings.

Within the UK a settings based health promotion initiative has been further endorsed by Saving Lives: Our Healthier Nation (DoH 1999) which built on The Health of the Nation (DoH 1992) to provide an opportunity to address the apparent need for prevention, and in particular the development of strategies to reflect health as more than just an absence of physical and mental ill health. A health promoting institution (such as an HEI) is envisaged as a system whose performance will be improved by embedding a commitment to the holistic physical and mental health of students, staff and the wider community within the structure of the organisation.

The philosophy underpinning the Health Promoting University (HPU) initiative emanates from the conceptual neologism of salutogenesis (the origins of health) proposed by Antonovsky (1979, 1987). The central consideration of this initiative is an emphasis on salutary factors rather than focusing on disease or risk factors precipitating disease, and always in consideration of the entire person. The salugogenic model reflects the principles of the social model of health through the recognition that an individual's psycho-social environment can impact on health status. It is therefore diametrically opposed to the biomedical model which proposes that health is best achieved by identifying and preventing determinants of disease.

However, Antonovsky (1987) conceded the main flaw in his salutogenic model was that it is primarily an orientation upon which to implement its ideal – and as such it lacked a practical framework. For this reason Dooris (2001) stresses the importance of adopting a strategic approach that can be achieved through an agenda for action to enable the development of a theoretical framework and a focus towards areas of work that can be achieved in practice.

The HPU initiative firstly identifies underpinning principles, such as holism, participation, equity, sustainability, co-operation and social justice – drawn from principles laid down in Targets for Health for All (WHO 1985) and Agenda 21 (United Nations 1992). Secondly, a framework is devised incorporating methods and techniques to implement policies and procedures to promote a healthy environment and to identify the over-arching aims of the initiative (such as incorporating a commitment to holistic health within the HEI's culture) and to set objectives to produce an agenda for action. It is however a highly structured generalised model, the details of which will vary according to each individual HEI.

Nevertheless, the general framework encompasses some key principles and strategies (such as the rejection of the view that health promotion should focus on persuading people to adopt certain 'health' behaviours) and has led to a number of similar projects being initiated within other UK HEIs. (Information on how to set up a health promoting university project is published by the World Health Organisation, Tsouros et al,1998). Importantly, Dooris' Health Promoting University initiative introduced the link between theory and practice.

In this regard, Dooris (2001) maintains it is essential to integrate a commitment to and a vision of health within the routine policy-making and planning cycles of the university. The first task in the development of a theoretical framework is *to gain an understanding of what is in place, what gaps there are and what characterises the organisational context* and then to set objectives to form a broad agenda for action. Dooris says these objectives should include policies to support the healthy personal and social development of students. The university should be presented as a supportive, empowering and healthy workplace that creates a health promoting environment within a multidisciplinary team across all faculties and departments. Integral to the HPU is a recognition that the quality of the physical environment will affect the health and well-being of those within its scope. It is, therefore, important to create environments that are sustainable and supportive to health, such as green, visually attractive and safe campuses which include pleasant accommodation and a good transportation network. Achieving these goals means working closely with other agencies (sometimes in the wider community) to develop an integrated strategy.

The term 'sustainability' is used consistently throughout Dooris' HPU model to emphasise two points: firstly a recognition that health is dependent on environmental and socially sustainable human development as articulated in Agenda 21 of the United Nations (1992) document, and secondly a concern to ensure that health promotion interventions are themselves sustainable in the way they are set up and implemented.

The HEI also has a commitment through the 'Duty of Care' directive to support the personal and social development of students. Health promotional activities to enhance students' personal and social development should be embedded within the curriculum and should involve substantial investment in support services. Such activities would include the development of life-skills to empower students to take control over their health, as well as equipping them to achieve their full potential as individuals, citizens and members of the community.

The HPU therefore rejects the view that health promotion should be about behaviours. Instead it seeks to provide a supportive environment which enables students to gain knowledge, explore possibilities, and make informed choices. Specifically applied to HEI settings, such an approach provides a significant potential for universities to develop and demonstrate the core values that are intrinsic to a health promoting organisation; namely empowerment, autonomy and community participation. In particular it represents an holistic socio-ecological model of health that is part of an interdependent eco-system to provide students with an environment that protects them from health damaging factors. Health promotion should seek to redress inequalities in health by encouraging equity of opportunity to enjoy good health. Most importantly, stresses Dooris, the university (as a health promoting organisation) will need to establish an integrated approach to mental well-being between its different departments. He proposes any attempt to promote student health within a holistic framework needs to recognise the complexity of the university setting as an organisational whole and in turn recognise that the university is influenced by broader local regional national and international issues.

Finally, Dooris (1999) suggests HEIs should regularly review their Mission Statement and if necessary reformulate policies for developing their potential as health promoting places of learning, especially as in an increasingly competitive market universities need to satisfy their 'customers' and their workforce.

The Asset's Model.

A more recently developed model concerned with the promotion of the population's health is the Assets Model devised by Morgan and Ziglio (2007). Morgan and Ziglio's Assets Model draws on a number of current ideas (in particular that of salutogenesis) to investigate the key factors or health assets which support the creation of health, as opposed to 'the deficit' (biomedical) model which, they argue, retains its pathogenic focus on disease. Although they concede the 'deficit' model is valuable in identifying levels of need and priority, they too maintain it fails to seize the potential to create and sustain health. Morgan and Ziglio (2007) propose more needs to be done to redress the balance between the more dominant deficit model and the less well-known (and understood) assets model. The assets model acknowledges a general shift in policy thinking over the last years from a disease prevention model targeting morbidity and mortality to a more all encompassing general health and well-being model. Clearly the values and principles of the assets model reflect those originally articulated in the Ottawa Charter (WHO 1986).

Morgen and Ziglio define 'health assets' as meaning the resources that individuals and communities have at their disposal which protect against negative health outcomes and/or promote health status (Antonovsky 1996 refers to 'salutary factors'). A health asset can be defined as any factor (or resource) which enhances the ability of individuals, groups, communities and social systems to maintain and sustain health and well-being. These assets can operate at the level of the individual, group, community and/or population as protective factors to buffer against life's stressors. At the individual level health assets include: focusing on protective factors which build resilience to inhibit high-risk behaviours, such as social competence, resistant skills, positive values and self-esteem. At the community level it includes family and friendship, supportive networks and community cohesion. Putnam (1993) demonstrated that cohesive communities, characterised by strong bonds and ties, are more likely to sustain health even in the face of disadvantage. The cohesiveness of a community can be measured by the evaluation of strong and positive interacting networks and their positive impact on well-being and may be viewed as a 'health asset'. At the organisational level attention would need to be paid to the implementation of environmental resources necessary for promoting physical, mental and social health participation opportunity, social justice and equality.

Although Morgan and Ziglio's (2007) Assets Model does not focus on students and HEIs in the way that Dooris' HPU model does, it does nevertheless have much to offer in the sense of broadening the approach to include the consideration and investigation of key health assets that support the creation of health. By doing so, an assets approach to health embraces a salutogenic notion of health creation and promotes a multi-method approach using a set of salutogenic indicators.

The 'assets model' also incorporates the idea of 'asset mapping' (Bauer et al 2006) to establish salutogenic indicators, such as health promoting or protective factors that create the necessary conditions for health. It searches for the foundations of positive patterns of health rather than the search for negative outcomes. Such a salutogenic perspective allows identification of those factors which keep individuals from moving towards the dis/ease end of the health and illness spectrum. It can help to identify the combination of health assets that are most likely to lead to higher levels of overall health and well-being. Morgan and Ziglio (2007) say a salutogenic approach would include the need to identify those health promoting or protective factors (assets) that are the most important in creating and maintaining health.

Morgan and Ziglio (2007) further comment that all policy makers should re-conceptualise the notion of health to: raise the self-esteem and resourcefulness of the individual to improve and sustain their own health, and to provide mechanisms to ensure all policies and programmes take account of positive attributes already existing in the individual and community. Moreover, the 'assets model' is the alternative way of approaching research in the health fields which Morgan and Ziglio argue is still dominated by a positivist biomedical approach to understanding what works (a view also held by Cowley in 1995).

Significantly, the HPU, the salutogenic approach and the 'assets model' collectively amount to the encouragement of social capital which can significantly improve the mental health of a given community population.

Salutogenesis, Social Capital and the Community

The salutogenic principle, espoused by Antonovsky (1979, 1987, 1996) encompasses the notion of social health capital as a macro perspective by identifying forces that influence health across populations, such as socio-economic factors and health service policies (as well as individual competence and coping mechanisms). This view focuses on activities that build and create health rather than merely seeing it as the destructive forces of disease.

In keeping with the HPU initiative (Dooris 1998, 1999, 2001), this research will consider the university within the perspective of a community setting. There are, according to Morrow (1999), as many definitions of community as there are community theorists. Communities are coherent areas, both physically and socially defined, within recognised boundaries that share several characteristics; these being: 1) a unique geography, spatial characteristics, and a built environment, 2) social ties providing social support, solidarity, sentiments and common activities and 3) services to support people in their daily lives.

Morrow (1999) proposes interest in social capital can be traced to the work of Bourdieu (1986), Coleman (1988) and Putnam (1993, 1995). Each author has defined social capital in different ways. Coleman (1988) was among the first to bring the term social capital to widespread attention. Putnam (1993), who expanded on many of Coleman's themes, defines it as a key characteristic of community including *the individual's sense of belonging to their community*. This extends to co-operation, reciprocity, trust and a positive attitude towards community institutions. Bourdieu (1986) defines social capital in terms of social networks and connections. He posits that an individual's contacts within

these networks results in an accumulation of exchanges, obligations and shared identities that, in turn, provide potential support and access to resources.

Social capital is therefore concerned with the collective resources to which individuals, families and communities have access. Putnam (1995) believes it consists of :

> "features of social life such as networks, norms and social trust that facilitate co-ordination and co-operation for mutual benefit" (p. 67).

As such it is produced when community groups and social activities engage a wide range of people to reduce inequalities within the community through the building of policies which emphasise equality. Egalitarian communities, state Wilkinson (1996), have strong social networks, less social stress, higher self-esteem, less depression and anxiety and a higher sense of control. Wilkinson further proposes that communities with high levels of social capital will have denounced discrimination or exclusion on grounds of age, race, ethnicity or disability and rejected any form of exclusivity. With regard to HEIs, the Royal College of Psychiatrists (2003) encourage Students' Unions to organise and run campaigns to reduce stigma. They say universities have a unique responsibility to "educate for global citizenship" (p. 43) since they produce the next generation of decision makers and policy makers. This, the Royal College claims, occurs through the transfer of cultural norms and values.

Most importantly, social capital refers to those features of a community or society which promote cohesion and a sense of belonging (Putnam 1995). Social cohesion (the invisible glue) is generated by social network interaction which binds communities together, gives them a shared sense of identity and enables them to work together for the benefit of the whole community. Community participation can be measured through civil engagement which refers to individual participation in the community for reasons over and above meeting basic survival needs. In this regard, Putnam, (1993) argued there has been a notable decline in co-operative actions for mutual benefit over the years and this has led to a present-day decline in social capital.

Consequently, a social group with a high level of social capital is likely to be cohesive and to have well-developed networks of communication and mutual support. Importantly, Putnam (1995) proposes the level of social capital can be measured by individuals' perceptions of the local environment. This view provided substantial backing for specific avenues of enquiry in this work and resulted in several focus group and survey questions

with this as a focus. Social capital is moreover a concept which links factors such as social relationships, social support networks, reciprocity *and health.*

Social Capital and its relationship to health

Putnam (1995) suggests the concept of social capital has grown out of the recognition that health-related behaviours are shaped and constrained by a range of social and community contexts. Ultimately, social capital is associated with improved health and greater self-reported well-being. It involves the participation of individuals in social networks and the strengthening of social cohesion through activities based on principles of trust, mutual reciprocity and common purpose (Cooper et al 1999). Stewart-Brown (1998) echoes the view that social capital is essential for emotional well-being, as does Morrow (1999), who believes the extent to which people *feel they belong to a community* will significantly impact on health and well-being.

Of special relevance to this work, Berry and Rickwood (2000) suggest the individual's experience of living in a healthy community will depend on the level of social support the individual receives. They further propose social support is especially beneficial to the individual with regard to mental health (less so with regard to physical health). Perceived social support can counteract feelings of low self-esteem, hopelessness, powerlessness and can enhance the individual's ability to devise ways of coping or coming to terms with stress and/or stressors. Famously, Brown and Harris (1979) found social support plays an important role in moderating the effects of stress on mental health. By the same token, lack of social support in times of stress can lead to poor health-related behaviours such as increased smoking, alcohol consumption and drug abuse. Niven (1994) found that levels of perceived support have the greatest effect on mental health when individuals believe they are under stress. Consequently, the presence of social support can have a direct effect on health by protecting/buffering individuals from the effects of stress (Cohen and Wills 1985).

In 1987 Madge and Marmot argued too little attention has been paid in social capital research to the personal meanings which events and relationships have for individuals. Berry and Rickwood (2000) are in favour of measuring the nature and extent of people's connection with their community at an individual level. They define personal social capital as a psychological construct of logically linked social behaviour: community participation, social support and trust in others. Individuals who have more personal social capital, they propose, will participate in their communities to a larger extent, have more social support, greater trust in others, and less psychological distress than those with less support.

More than fifty years ago, Durkheim (1952) proposed the level of social integration or cohesion in a community can potentially affect an individual's mental health. In fact, it was Durkheim's (1952) seminal work on suicide that elevated the social perspective of mental illness from a mere subcategory of biological forces to provide an explanation of mental health problems (see Appendix 2). According to Coleman (1988), *Durkheim's concept of 'anomie' represents the absolute antithesis of social capital.* He further argues factors associated with 'anomie' (such as social detachment and alienation) have soared in societies over the last 30 years. (Antonovsky 1987 referred to Durkheim's concept of anomie as a 'lack of social rootedness').

Social capital is therefore said to promote psychological health, whereas social disengagement ('anomie') can cause psychological distress. Dooris (1999) concedes a sense of cohesiveness is essential for the promotion of health and the ideology of salutogenesis, especially in reducing the consequences of isolation and anomie and the tackling of problems associated with stigma and discrimination which, according to the Royal College of Psychiatrists (2003), still confer social disadvantage.

Interestingly, Cohen (1988) proposes a vital factor which protects people in their environment is *the belief that they will be supported if the need arises.* Indeed, the level of access to resources in the community to which the individual has access is important to health and well-being and this notion has had an impact on several lines of enquiry in this study.

Identifying links between social capital, the social model of health, the health promotion model and related legislation/governmental directives

In 1999, Morgan et al proposed social capital was increasingly being used as a framework for action in public health and for tackling health inequalities. In the health arena the WHO (1998) Jakarta Declaration had highlighted the need to understand and address those factors which affect health, such as education, unemployment and the local environment. The Jakarta Declaration (WHO 1998) also made the claim that health promotion can build social capital.

Over the last century societies have passed through an epidemiological transition that has resulted in an unprecedented change of emphasis from illness being something to cure to being something to prevent (Sarafino 1994). Along with the immense technological and scientific advancements of the nineteenth Century, societal attitudes towards health and illness have changed irrevocably and gradually the dominant biomedical model of

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healthcare was challenged by a wider vision which took into account a more holistic treatment of health needs. This emergent ideology evolved into the social model and shifted the focus away from the vacuum of health behaviours alone to wider issues of social policy and social structures by building on inter-agency commitment.

At the highest level of international involvement, (the Alma Ata conference in 1978), all member states of the World Health Organisation committed to the fundamental principles underpinning the ideology of health promotion. In essence these were:

- the inclusion of the population as a whole in the context of their daily lives (as opposed to focusing on people at risk of specific diseases)

- action on the causes or determinants of health to ensure the total environment (beyond the control of individuals) is conducive to health

- the engagement of all agencies involved in the health of the community

- the aim to support the principle of self-help and the important role of health professionals in health promotion.

According to Ewles and Simnett (1999) the concept of health promotion was conceived in the 1970s, born in the 1980s and matured in the 1980s. As a term it was first coined by Lalonde in 1974 (Humphrey, 1984). Naidoo and Wills (1994) argue there is so much confusion and controversy about definitions of health promotion (having been ascribed so many meanings), that as an ideology it has become virtually meaningless. Without doubt, the health promotion model is complex and frequently misunderstood.

Tannahill (1985) remarked governments have often added to the confusion by using the term health promotion when they refer specifically to screening clinics in primary healthcare which, he argued, are very different activities from the holistic and political concept of the WHO (1984). He further commented it is not uncommon for individuals or even entire communities to have a discussion about health promotion and be referring to different things. In fact, Downie et al. (1996) maintain health promotion has become a dazzling band-wagon gaining momentum with all and sundry clamouring aboard without giving sufficient thought to what it is actually about. It is, therefore, important to have an understanding of the distinctions between its factions and to further clarify and identify terms often incorrectly associated with the concept. For example, Downie et al. (1996) maintain the standardised classification of prevention is less than ideal because the focus again falls on the treatment of disease rather than on the promotion of health.

The difference between these components of health promotion is subtle but of great significance. Health protection measures affect everybody through environmental issues, whereas illness prevention measures are largely directed towards the individual (or groups). Most significantly, such procedures actively look for disease. Consequently, because illness prevention is mostly undertaken within primary care (as indeed is a measure of health education) it is still intrinsically bound-up with the medical profession and, according to Antonovsky (1987), still dominated by the biomedical model of health.

Tannahill (1985) devised a model of health promotion which consists of three interlocking and interconnected components. He maintained it is important to differentiate between the three components of: *health protection, health education and illness prevention,* each of which (for the purposes of this study) will be considered separately. In fact, these three arms of health promotion are discrete subject areas in their own right. Health protection usually occurs at the macro level of society and can be viewed as the descendant of the great old regulatory public health measures. It is mostly concerned with environmental issues and legal and fiscal aspects of every day life (such as the wearing of seat-belts and the most recent restrictions on smoking in public places, DoH 2006). It also covers policy decisions, such as those concerned with mass vaccination programmes. Health protection is important because it aims to reduce hazards in the environment and increases the chances of living in a positively health promoting environment. Health education, on the other hand, can be directed at both the macro and micro levels. An example of this would be the nationwide 1980s AIDS advertising campaigns, and the individual instruction on sexual health which often takes place within the fields of education and health. Illness prevention, however, mostly concerns the individual and often consists of screening procedures that are usually undertaken in a medical setting, such as hospitals, mobile units or primary care.

Downie et al (1996) stressed the importance of preserving the balance between each of these components, as failure to do so often results in the positive dimension in health promotion getting lost. Naidoo and Wills (1994) add it is not helpful to debate about whether any one of these facets of health promotion is more important than the other. Health promotion is a process which enables and empowers individuals to take more control over aspects of their health through both education and illness prevention measures whilst at the same time providing an environment which protects every individual within it from health damaging factors.

Furthermore, the wider vision of health promotion, pioneered by Lalonde in 1974, recognises the holistic approach towards people's health needs that cannot be achieved through screening (illness prevention) and education alone. In particular the social model of health builds on inter-agency commitment and involvement and, from a policy response perspective, attention has been focused on ways in which social capital might be built or regenerated and used as a resource in the promotion of health. Such an approach was incorporated into a plethora of White Papers and government directives that not only attested to concern over the mental health status of the general population (DoH 1992, DoH 1998, DoH 2000, DoH 2001, DoH 2002) but which also attempted to build into these national policy documents a shift in emphasis from the biomedical approach to healthcare to that exemplified by the incorporation of ideologies compatible with the social model. In particular, "Making it Happen: A Guide to Delivering Mental Health Promotion" (DoH 2001) encompassed an ethos of positive mental health, as opposed to concentrating on the identification of disease. This echoed the definition of 'health' as proposed by the World Health Organisation (1948) and is compatible with Antonovsky's neologistic concept of salutogenesis (1979, 1987, 1996).

Bridging the macro and the micro: Mental health problems in young people and coping strategies

In addition to the above stated policy response to the nation's mental health problems, this work also considered, albeit briefly, the individual's response to mental distress and in particular their coping strategies. The Royal College of Psychiatrists (2003) warn that the stresses of university life might exacerbate pre-existing emotional and psychiatric problems in some students and precipitate disorders in others. They also make direct reference to personality traits/dispositions and coping strategies by proposing the individual's resilience to the pressures of student life is mediated by factors internal and external to the student. Notably, the Royal College suggest students with higher self-esteem, *an internal locus of control* and good problem-solving skills fare better than their counterparts without such attributes.

Much theory of mental illness causation has been couched in psycho-analytical, psychosocial and cognitive terms but also in terms of social network (buffer) systems and interpersonal relationships. Central to most theories is the individual's ability, or inability, to cope with (perceived) stressful situations and until relatively recently there was a fairly rigid nature/nurture divide among some of the giants in the fields of psychology and sociology regarding the aetiology of mental health problems and coping mechanisms.

There are indeed a whole range of theories which increase our knowledge about coping mechanisms. Appendix 2 provides a very brief overview of some of the major contributors in this field and demonstrates the considerable overlap among many of these theories. Due to his influential concept of salutogenesis and his own coping mechanism theory, Antonovsky's Sense of Coherence (SOC) has been afforded special considerable below.

Antonovsky and the SOC

In 1979 Antonovsky formulated the salutogenic model of health which rejected the dichotomous premise upon which health and illness are viewed (from within the biomedical perspective), preferring instead to view the matters of health and illness on a multi-dimensional health ease/dis-ease continuum. His salutogenic orientation focused rather on what factors sustain health (and in particular in identifying coping resources) as opposed to concentrating solely on the aetiology of a given disease, in particular because at the dis-ease end of the spectrum the focus is typically placed on the medical problem rather than on the person. He stressed the importance of starting from a consideration of how health is created and sustained, and posed the question: what causes some people to prosper and others to fail or become ill in similar situations? Antonovsky concluded it was an individual's generalised resistance resources (GRRs - any property of a person which facilitates coping) which help the individual 'make sense of the world' cognitively, instrumentally and emotionally. Collectively, GRRs form a sense of coherence which enables the individual to cope with life experiences by responding and adapting to situations in a positive way. He described an individual's sense of coherence as a major determinant of maintaining one's position on what he called the health ease/dis-ease continuum. In keeping with the holistic approach to health, Antonovsky located his theory firmly in the person's own context and culture.

However, Antonovsky rejected the idea that the SOC is a personality trait. He preferred to refer to it as a dispositional characteristic, because :

> "The trait approach focuses on the particular individual, disregarding both the cultural-historical context of the development of the orientation and the importance of the socially structured situations in which the orientation comes of expression" (1987, page 183).

He maintained those with a strong SOC would be able to choose whichever coping strategy would best 'fit' the problem: "What the person with a strong SOC does is to select the particular coping strategy that seems most appropriate to deal with the stressor being confronted" (1987, p.138)

There are three main core components of the SOC. Antonovsky named these components: Manageability, Comprehensibility and Meaningfulness. *Manageability* relates to the extent to which individuals believe they possess the resources to meet demands which may be both internal (as a predisposition) and external to them (such as a resource accessible from family, friends and the community). *Comprehensibility* is the extent to which an individual can make sense of a situation – even one of disadvantage – to gain strength to deal with it in a positive manner in order to resist the threat to health. *Meaningfulness* involves participating in the creation of one's own health through the emotional as well as cognitive senses by viewing events positively and not always negatively and to set these into the context of daily life.

Antonovsky proposed major life experiences provide the initial propelling force in a person's life in the direction of developing a stronger or weaker SOC, a strong SOC being crucial to successfully coping with life's stressors. An individual with a weak SOC is more likely to blame someone or something else for their 'bad luck':

> "What I have proposed is that people with a strong SOC will do better than those with a weak SOC in coping with these (stressful) problems; in that when a problem is not soluble they will be able to go on living with it more adequately" (1987, p. 148).

Adolescence, he proposed, is an era that reverses, stabilises or strengthens this direction and during early adulthood the location on the SOC continuum becomes more or less fixed. The adolescent can only have gained a tentatively strong SOC which may be useful for short-range prediction about coping with stressors and health status. It is with entry into adulthood with long-range commitment to persons, social roles and work that the experiences of childhood and adolescent are reinforced or reversed in both directions.

Essentially, Antonovsky's salutogenic orientation concentrates not on risk-factors but on coping mechanisms whereas the pathogenic orientation views stressors as pathogenic risk-factors which can be reduced, inoculated against or buffered. The pathogenic orientation leads researchers, practitioners and policy makers to concentrate on the specific disease diagnosed or on the prevention of specific diseases, particularly among high risk groups. Indeed, critics of the biomedical model maintain the emphasis on physiological factors actually diverts attention away from social and psychological factors, whereas the social model locates the root of the disorder in social systems and networks and environmental factors. Nevertheless, Antonovsky does not advocate abandoning the pathogenic

orientation altogether. Rather, he suggests, the two approaches to health should be seen as complementary and not oppositional.

Antonovsky did, however, concede that his SOC theory owed much to earlier coping theories, in particular Kobassa's personality based notion of hardiness (Kobassa et al.1982) and Lazurus' (1975) transactional model of stress. This was indeed evident from reading "Unravelling the Mystery of Health". Ultimately, though, where Antonvosky differs from some of the other theorists in this field is that (in keeping with the social model and the ethos of the health promotion movement), he focused on the positive side of health. Furthermore, what Antonovsky adds to these other theories of coping with his proposal of SOC is the additional dimension of relating these 'dispositional' characteristics to the individual's environmental, cultural and social setting. However, although all the above mentioned facets of Antonovsky's SOC coping strategy (including his 1987 'Sense of Coherence' Questionnaire) are impressive and undoubtedly worthy of consideration in other areas of research, it was decided from the outset not to restrict the aims of this research to coping mechanisms per se, for the reason that the focus here involved a much broader consideration of inter-dependent social and environmental factors.

Coping Strategies and Help-seeking Behaviour

Whereas coping strategies are individualistic, help-seeking behaviour can be applied to both the individual and social groups. The term psychobiology has been ascribed to the scientific study of the relationship between biological processes and behaviour (Niven 1994). Within this category comes patient compliance and help-seeking behaviour. Sociological models of help-seeking behaviour abound and for reasons of word restriction these are beyond the scope of this work. (Appendix 3 however provides a brief overview of a few of the theories most relevant to this work). The following is therefore based on issues arising from the literature review and set within the context of relevant social, cultural and situational factors.

Differences between home and overseas students in help-seeking behaviour

Grant (2002) found there were differences in the help-seeking behaviour of home and international students, as did Bradley (2000). For example, international students were more inclined to seek the help of specialist advice as opposed to institutional staff. Okorocha (1998b) found the uptake of counselling services was low among international students compared to home students. This was suggested by Furnham (1997) as being

largely due to the fact that international students preferred to seek help and support from peers of similar cultural backgrounds rather than from other students from the host country. Okorocha's (1998a) study also highlighted the fact that difficulties can arise with overseas students if they cannot express themselves fully in the second language.

Help-seeking behaviour on behalf of 'others'

Lago (2002) found many students' help-seeking behaviour was on behalf of others and not for themselves. He maintained friends and peers are often the first to notice signs of distress in others but they often do not know how to deal with the situation and find it difficult to know where to turn for the most appropriate help. Indeed, an understanding of the problem and/or its severity might be impossible for them to assess and many will need advice themselves about how to respond.

For these reasons, the difficulties involved with seeking help on behalf of another should not be under-estimated. Symptoms of depression or other mental health difficulties are often first noticed by others, mostly friends or peers (but also tutors/lecturers). The involvement of friends/peers of those experiencing mental health problems highlights the importance of targeting awareness raising initiatives within the student population as a whole, rather than focusing on vulnerable students (Grant 2002). A student experiencing distressing and possibly frightening symptoms may find it difficult asking for help, especially as social isolation is negatively correlated to help-seeking behaviour and depressives are often less likely to help seek of their own volition. Moreover, there is evidence to suggest that concern for another student can itself be a cause of anxiety. Lago (2002) says students who harm themselves, who have eating or personality disorders or depression can cause immense apprehension to those around them, sometimes affecting the mental stability and academic achievements of others. For this reason, Stanley et al (2000) suggest the support services should take into account both the needs of the troubled students and of those supporting the troubled student.

Stanley and Manthorpe (2002) also stress that young people should be educated about mental illness so that they can recognise the symptoms in themselves or in someone they know. They should also be made aware of how to respond and the most appropriate support service should be immediately and easily accessible. Wade (2002) maintains external sources of information will influence individuals' ability to understand issues and make informed decisions. In particular this emphasises the importance of widespread health education measures.

Significant 'others' and persons of contact in times of emotional need

Grant (2002) found students sought help from a wide range of sources - both official and unofficial - and although the primary source was family and friends, within the institution it was the staff in students' academic department, and especially personal tutors, who were held in the highest esteem. In addition, Stanley and Manthorpe's (2001) research found hall-wardens, the university's counsellor and the GP were also highly regarded, as were peers who were said to provide an invaluable source of support for each other. Interestingly, the Royal College of Psychiatrists (2003) made a distinction between friends and peers when it came to recognising the presence and severity of psychology problems in other students.

A survey of students at the University of Leicester (Grant 1999) found the personal supervisor was the second most frequently identified source of help for students with psychological problems, with only friends and family being cited more often. In fact, a noteworthy point arising from the University of Leicester project was that students are most likely to seek help from those with whom they have the most frequent contact on a regular basis.

Grant (2002) listed persons of contact in relation to students' help-seeking behaviour with, again, a majority of the sample (65%) seeking help firstly from family and friends. Fox et al (2001), too, identified family and friends as students' main support network, with the second most popular source of help being personal tutors (54%), followed thirdly by the Student Health Centre (40%). Interestingly, the University of Leicester study identified that other sources of help, such as the Careers Service, Welfare Service, Learning Centre, Students' Union, institution staff (porters, cleaners and secretaries) were ranked at the lower end of the scale - as was the Counselling Service, with only 7 per cent of students willing to access help from this source, compared to 40 per cent of students favouring the Student Health Centre (Grant 2002). Another noteworthy finding from a survey conducted in 2000 for the MIND OUT for Mental Health Campaign (DoH 2003), revealed that 55 per cent of the 16-24 year old respondents said if they had a mental health problem, they wouldn't want anyone else to know. Biddle et al. (2004) found that even when young people perceived themselves to be having mental health problems they did not seek help.

Significantly, Stanley and Manthorpe (2002) maintained it is important to understand the issues and concerns that have the greatest impact on students' well-being, when putting programmes and services into place, stressing it is vital to consult with students about the appropriate course of action. Crucially, some students may find it more difficult asking for

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help than others and different individuals need different types of support. For example, night-time phone line support and internet chat rooms offer initial contact to those who feel unable to seek out face-to-face help. Harvey (2002), too, stressed the importance of listening to students' needs, views and even misconceptions, so that resources are not wasted on schemes that have no appeal to them.

Other proposals to account for the reluctance of some to access help centred around the issue of stigma as a potent barrier to help-seeking behaviour (Stanley et al 2000 and Stanley and Manthorpe 2002).

Help-seeking behaviour inhibitor(s): Stigma

Related to help-seeking behaviour is the issue of stigma and discrimination, for the reason that perceived stigma can represent a significant barrier to accessing help.

The present government's Social Exclusion Unit proposes stigma associated with mental illness is 'alive and well' and still frequently encountered (www.socialexclusionunit.gov.uk/mental_health/mental), a claim attested to by the research findings of Arthur et al. (2000), Jorm (2000) and a plethora of White Papers, campaigns, and health directives aimed at reducing its incidence. If indeed proof were needed of the enduring existence of negative consequences and the social damage that can result from mental health problems, it is to be found in all the Department of Health documents intent on improving the mental health of the population. For example, Making it happen: A guide to delivering mental health promotion (DoH 2001) is committed to reducing discrimination associated with mental health disorders, as is the National Service Framework for Mental Health (2000) which places a duty of care on health and social services to reduce stigma and discrimination. More recently, the Department of Health (DoH 2003) announced a £1 million campaign called MIND OUT that aims to challenge discrimination.

The MIND OUT for Mental Health: Stop the Stigma Campaign (DoH 2003) is a major awareness and action campaign working to stop the stigma and discrimination surrounding mental illness. Co-ordinated by the Department of Health, MIND OUT for Mental Health works with a wide variety of partners from statutory authorities, the voluntary sector, business, media and youth organisations to bring about positive shifts in attitudes and behaviour surrounding mental health issues. In particular it targets employers, the media and young people because young people are said to have the most dismissive attitudes

towards mental illness. The campaign also works with the National Union of Students to encourage awareness and action on mental health issues and discrimination in colleges and universities. According to this campaign there is far too much misunderstanding and lack of awareness about the reality of mental illness. Consequently, making people aware of the facts is considered to be a very powerful way of taking action.

Stigma has, for many decades, also been the focus of considerable sociological research. Some of the major theories (of relevance to this work) are summarised in the following table:

Table 2: Mental Illness and Stigma : Influential theories

Theorist	Integral component of the theory
Oliver's Disablement Model (1996)	Oliver called for a move away from the medical model of disability (which views impairment as the main source of disability) towards the social model (which views the environmental barriers – including stigma- as the major source of disablement). He proposed discrimination, avoidance and exclusion issues form the handicap rather than the disability itself.
Goffman (1961),(1963)	Goffman drew attention to the consequences of a medical diagnosis of mental illness on individual stigma bearers. He proposed it is only after the diagnosis is known by those interacting with the stigma bearer that the stigmatising effects become apparent. The fear of resultant discrimination and prejudice is a significant barrier to accessing help, especially from 'official' sources.
Scheff (1966),(1975)	Scheff's 'labelling theory' drew attention to the impact of formal (medical) labelling of mental illness and the way social meaning and response (such as prejudice, discrimination and alienation) produce a change in the individual's self-concept and behaviour (secondary deviance). The fear of being labelled represents a reluctance to disclose a mental health problem.

The consequences of stigma on mental well-being

Kai and Crossland (2001) concur with the above named theorists that mental illness is stigmatising, socially limiting and disempowering. Kai and Crossland's respondents confirmed that living with a mental health problem in the community meant living with the

fear that they would be alienated and socially excluded if others found out about their illness.

To add weight to the assertion that Scheff's (1966) sociological theory still applies today, attention has been drawn to the negative representations of mental disorders which currently predominate in the perceptions of the general public and in the media.

In their work of 2002, Stanley and Manthorpe commented: "a climate of concern about madness has been fuelled in the UK by media......" (p. 24), a view shared by The Royal College of Psychiatrists (2003) who suggest politicians react too hastily to the public's stereotypical perceptions of those with mental illness as being out of control and potentially dangerous. As well as having a powerful effect on public opinion, sensational and negative media coverage can have a direct impact on the confidence and self-esteem of people with mental health problems. In addition, labelling not only leads to a self-fulfilling prophecy scenario (such as secondary deviance, Scheff 1966) but also to prejudice and discrimination. Prejudice (which comprises affective, cognitive and behavioural components) describes a special type of attitude, negative evaluation or behaviour towards members of a social group that usually results in some form of harm to the subject(s) of that group. Prejudicial actions or behaviours are called discrimination. Discrimination may take the form of avoidance or it may result in more extreme actions such as exclusion from jobs, education or relationships (Porter 1997).

The fearful, stigmatising and ill-informed attitudes surrounding mental illness mean that people with mental health problems can experience very real prejudice in their daily lives. They can, for example, encounter difficulty getting a fair deal from employers, from finance and insurance companies when they are looking for loans, insurance or mortgages (Read and Baker 1996). In fact, only 13 per cent of those with long-term mental health problems gain employment compared to 35 per cent of physically disabled people. Other noteworthy conclusions of Read and Baker's 1996 survey were that 52 per cent of people with a mental health problem admitted they had concealed their psychiatric history for fear of losing their jobs, with 34 per cent stating they had been dismissed or forced to resign (a finding supported by the Mental Health Foundation, de Ponte 2000). De Ponte's (2000) survey also revealed that 42 per cent of people didn't tell some members of their family that they had a mental health problem, 74 per cent didn't mention it on an application form, 19 per cent didn't tell their GP, and 55 per cent of 16-24 year olds said if they had a mental health problem they would not want anyone else to know. Read and Baker (1996) had also

found expectations of discrimination were high among young people with mental health problems, especially among some professions.

Meltzer et al's (2000) study supported conclusions drawn from earlier studies (Pilgrim and Rogers 1993) that society still stigmatises those in contact with mental health services (especially the involvement of secondary psychiatrist services) and that this attitude extends to the use of anti-depressants, as well as to the diagnosis of depression. In 1997 the Royal College of Psychiatrists launched a five year campaign targeted primarily at the general public whose attitudes were said to differ significantly from those of health professionals (Paykel et al. 1997). This high-profile campaign aimed to reduce the stigmatisation experienced by people with mental health problems and to close the gap between professional and public assessment of treatment. However, subsequent research has uncovered that mental ill health (including depression) is still severely stigmatised both by lay-people *and* healthcare staff (Chaplin 2000). Geddes (1999) also found that survivors of suicide attempts and self-harmers often received less sympathy from healthcare professionals because they are deemed to be directly responsible for their own plight. In 2001, the Royal College of Psychiatrists also conceded that some health professionals' attitudes to self-harm, eating disorders and substance abuse are particularly negative. Cowley and Billings (1999) proposed the personal style and attitude of health professionals was important in either enhancing or inhibiting salutogenesis. They suggested the additional component of coping with a healthcare professional's negative attitude when seeking help places an extra burden on those already struggling with their own resources.

According to Stanley et al (2000), if mental health problems among students are to be de-stigmatised, support services need to be available through a wide range of access points which together form a co-ordinated approach to meeting a variety of needs. The next chapter considers such support services within the student environment. It also looks at the university as an institution bound by frameworks that constitute its operational imperatives, at the component parts which collectively make up those systems and at the specific setting within which this research has been conducted.

Chapter 2

Students' Environment: The University and the Support Services

As has already been established, the landscape of higher education within the UK has changed beyond recognition. The mid 1980s saw a period of major upheaval, with a massive expansion in student numbers, an overall reduction in funding, increased inter-institutional competition, greater accountability and pressures to widen access to under-represented groups (Royal College of Psychiatrists 2003). By the early 1990s numbers in full-time education had increased by 55 per cent (CVCP 1995). This restructuring of higher education in the UK has been justified by successive governments on the grounds that the country needs to possess a modern system capable of delivering mass higher education, in order to remain economically competitive (Roberts and Zelenyanski 2002).

However, successive governments have failed to match the documented increase in student numbers with real spending (Roberts and Zelenyanski, 2002), particularly with respect to providing a commensurate increase in staffing or resources. In fact, the growth of student numbers in higher education has corresponded with a reduction in the unit of public spending per student and this may well have resulted in less support per student (Universities UK 2002). Furthermore, the role and remit of HEIs has also been steadily changing over the last decade for reasons that include political, cultural, socio-economic factors and legislative imperatives. Review of the statutory obligations placed on universities to provide welfare and support services revealed that long-term mental health problems were formerly considered under the 1995 Disability Discrimination Act. Funding councils require all institutions to have clear-cut policies set out in a "Disability Statement" (Higher Education Funding Council for England 1996, 1999). In addition the Quality Assurance Agency/QAA (1999) and CVCP (2000) set out codes of practice designed to assist institutions in making the appropriate provision for disabled students including those with mental health problems. According to CVCP (2000) every effort should be made to ensure students with mental health difficulties are supported by every means possible so that they are able to achieve their full potential and continue in study. To this end, it is estimated that 80 per cent of universities now have their own working parties on student mental health with a growing number recruiting mental health co-ordinators to oversee this area (Royal College of Psychiatrists 2003).

HEIs have a 'Duty of Care' responsibility to all students but in particular to those who are most vulnerable. If a student offered a place on academic merit has declared a disability

on their Universities and Colleges Admission Service (UCAS) application form, they should be referred to the central support system for comprehensive pre-sessional information on the support systems available to them and an assessment of their disability or specific needs in relation to their chosen programme of study (CVCP 2000). For students declaring a mental illness this should include relevant medical-psychiatric reports. It is of mutual benefit to both student and HEI that this assessment is done prior to admission, especially for course programmes with professional requirements such as medicine, teaching and law. Sometimes students are reluctant to declare a mental illness or disability but with pre-sessional information and clear confidentiality and disclosure policies, students should be made aware of the advantage of early disclosure (Higher Education Funding Council for England 2003). These advantages include eligibility for Department of Education and Employment/DfES awards and appropriate academic and personal support (DfES 2003). All students have the choice not to disclose a disability but they might have to forfeit extra academic support if the disability is not declared at admission (Rickinson and Turner 2002). Nevertheless, the Committee of Vice-Chancellors and Principals (2000) urges HEIs to accommodate students' needs wherever they can throughout their course of study.

Legal frameworks to reduce stigma and discrimination within the HEI environment

With regard to legal frameworks and HEIs, two recent Acts of Parliament have been particularly influential with respect to the implementation of policies and procedures to improve the experience of disabled students (including those with mental health problems) whilst at university. Firstly, the 1995 Disability Discrimination Act requires organisations to reduce discrimination through policies which challenge prejudicial attitudes, and secondly the 2001 Special Educational Needs and Disabilities Act places the onus on HEIs to anticipate student mental health needs in terms of pre-admission and admission requirements. In this regard, Universities UK (2002) recommends advance information should be provided for students accepted to university to prepare them for the realities of university life and to encourage those with pre-existing mental health problems to disclose these before admission. Ideally, state Universities UK, preparatory information made available to new-intakes of students would mean important signposting of sources of further information which could be accessed if needed on arrival, or preferably discussed prior to admission.

However, as the Royal College of Psychiatrists (2003) point out HEIs' 'duty of care' obligations can really only be discharged if students declare known health concerns,

whether prior to or at the time of admission - though they stress transition takes time and students need on-going opportunities to become familiar with what is available to them. For although all universities have 'freshers' week and other induction sessions on support services (such as Nightline, peer support groups, clubs and activities) there is, they suggest, often too much information to absorb during a short period at the beginning of term.

Issues of Disclosure

The fear of stigma can result in a reluctance to disclose a mental health problem and can represent a significant barrier to accessing help.

The Royal College of Psychiatrists (2003) report concedes the first hurdle those suffering mental health difficulties have to surmount involves the issue of disclosure. Niven (1994) maintains stigmatising conditions will often inhibit individuals from seeking help because they fear an unwelcome and judgemental response. This view is echoed by Stanley and Manthorpe (2002) who suggest a major consequence of this is the impact this will have on students' willingness to seek help. Porter (1997) suggests any condition that attracts stigma is regarded with special fear because its causality is unclear. Such a reaction, states Porter, is frequently associated with intense and often irrational fear of the unknown, the unexplained and misunderstood. The fact that nearly 80 per cent of the Mental Health Foundation (2001) respondents wanted to know more about mental health issues calls for this issue to be addressed more formally in terms of health education within an HEI's health promotion directive, in particular to dispel damaging myths about mental illness.

Not declaring a known disability could have serious consequences and could at worst lead to students dropping out. For this state of affairs to improve, the Royal College of Psychiatrists (2003) maintain the perceived benefits of declaring a mental health disability would need to outweigh the perceived drawbacks. They cite, as an example of this, the condition of dyslexia. Because it has now become socially acceptable (and many would argue beneficial – due to the personal allocation of lap-top computers, extended course-work deadlines, extra time in examinations), the numbers of students declaring the disability have increased considerably. Information gleaned from HESA (Retrieved June 2005 from info@statistics.gov.uk) (for first year students only) demonstrate that there has been a substantial increase in the declaration of the 'condition' of dyslexia, which rose from 4,403 declarations between 1998-1999 (HESA 2000) to 11,865 in 2003/4 (HESA 2005). Furthermore, although students are often reluctant to declare a mental health problem or a physical disability, many are now becoming aware of the advantages of early

disclosure. Through improved pre-admission information and a clear policy on confidentiality issues, the Royal College of Psychiatrists (2003) propose the number of disclosures about mental health problems might increase accordingly. This has been supported by HESA (2000, 2005) whose data indicate a three and a half fold increase in declarations of a mental health difficulty between 1998 and 2004 (298 declarations between 1998-1999, and 1,065 declarations between 2003-4).

Notwithstanding these encouraging increases in the numbers of declaration, the Royal College of Psychiatrists (2003) maintain anti-stigma campaigns are still urgently needed to improve perceptions of mental health issues. Stanley et al. (2000) propose the lack of visibility of mental illness make it one of the most significant barriers to raising awareness and understanding among students and young people. They urge HEIs to raise awareness about the destructive nature of stigma and to implement measures to eliminate stigma in the student population. According to a study conducted by www.mindout.net (retrieved June 2004) much could be achieved through health education to demystify mental illness and promote mental health, especially as 79 per cent of young people surveyed said if they knew more about mental health problems they would be less afraid of them. Certainly, all the time mental health and mental illness continue to be misunderstood, students with mental health problems will refrain from identifying their needs prior to admission.

Pastoral Care

> "You cannot prevent the birds of sorrow from flying over your head but you can prevent them from building nests in your hair". Chinese Proverb
> (cited in Nelson-Jones, 1997, p. 361)

The increase in student numbers coupled with a drop in funding has resulted in higher staff-student ratios, which Heads of University Counselling Services (HUCS) (2002) associate with the rise in students experiencing mental health difficulties. The Royal College of Psychiatrists (2003) concede there has been a steady erosion of the pastoral ethos that hitherto underpinned the mentoring and support structure in UK HEIs. Grant (2002), too, concurs that in some universities academic and pastoral support may be more difficult to access now as the movement towards mass provision of higher education gathers pace.

One of the direct results of the enormous expansion of higher education over the last two decades has been the dilution of the traditional personal tutorial system, whereby students are assigned to a member of the academic staff who then takes some responsibility for their welfare. Historically this model of the pastoral care system was especially significant

when the age of majority was 21 years. Then personal tutors acted 'in loco parentis' and provided guidance to young people living away from home.

The Heads of University Counselling Services Working Group (1999) also see the increased pressures on staff to generate income and perform research as reducing time available for pastoral duties with students. They argue that, in some institutions, modularisation of the curriculum has led to the loss of stable peer groups, instability in staff-student relationships and generally contributed to greater fragmentation in the student experience. This has resulted in personal tutors and lecturers not getting to know their students and therefore not being able to detect changes in behaviour and early signs of distress. Wade (2002) suggests today's students need more support, particularly at the beginning of their undergraduate life, not less. Harvey (2002) recommends that first year students should be contacted by their personal tutor in the first month, especially in light of Rickinson and Rutherford's 1995 and 1996 studies which highlighted the impact of the personal tutoring system in facilitating students' initial adjustment to higher education and their subsequent progression and achievement. However, where student numbers have risen significantly, many HEIs have opted for an identified member of staff taking pastoral responsibility for a large cohort of students rather than operating the personal tutor system.

In those HEIs that do provide the personal tutor system, the increase in student numbers places extra pressure on already heavily committed academic staff. In their 2000 research Stanley et al. identified higher levels of stress among staff than at any time in the past, due to the expectation placed on them to be research-active, to generate income and to respond to a plethora of quality assurance demands. They urge HEIs to provide more support to lecturers and personal tutors. Stanley et al's 2000 research undertook a survey of academic staff at the University of Hull to establish their level of contact with students with mental health problems. The importance of personal tutors was established in this work, as was the support roles of other university staff. It also revealed there was often a lack of support for staff seeking help from other departments on behalf of a student and this was partly explained by difficulties with confidentiality issues. Other problems included: difficulties getting some students to accept help and staff members' own lack of personal skills and appropriate training in dealing with such problems. Importantly, it established the need for adequate training for all members of staff (and not exclusively personal tutors) to deal with students presenting to them with mental health problems. This initiative is supported by Dooris (1998) who believes a university environment conducive to health will include the well-being of staff and a positive attitude towards pastoral care. Dooris (1998) warned that

an organisational culture that is characterised by high levels of staff stress and low morale will be transferred informally to students.

Grant (1999) found that students seeking help and advice on personal/emotional matters were more likely to approach their tutors/personal tutors than any other member of the academic staff. In fact, Grant's research demonstrated that personal tutors were second only to family and friends as the first person(s) of contact in times of emotional distress. Stanley et al. (2000) found students perceived academic tutors to be non-stigmatising:

> "The stigma attached to using formal services provides a strong argument for protecting the role and function of the academic supervisor or tutor who provides a front-line non-stigmatising form of support for all students" (p. 4).

They also suggest that counselling services are seeing more students with more severe forms of mental health problems because students are turning to their personal tutors with less severe problems in the first instance. Furthermore, pastoral and/or academic staff have an important role to play in the detection of depressive symptoms and other mental health problems, including eating disorders. Yet again, due to the modularisation of many courses, regular contact with some lecturers is now lost.

However, Bradley (2000) suggested personal tutors and academic staff might not always be seen by students as the best person to approach with mental health problems, for reasons of 'divided loyalties' - especially with regards to course-work assessment and maintaining the required professional distance. Another sensitive area is with regard to role confusion and the issue of confidentiality. Confidentiality problems were identified as a major issue in the effective delivery of help for students in need (Stanley et al. 2000). Academic staff reported it was difficult to obtain feedback from the counselling and medical services in particular due to codes of practice involving confidentiality. Other areas of conflict include 'professional suitability and fitness' which touch on real difficulties faced by lecturing professionals and students preparing for professional qualifications in the nursing, teaching and law sectors. HEI teaching staff can be torn between the responsibility of being gate-keepers of their profession and acting in the best interests of their students. This also extends to supplying references (Clothier 1994). Another view is that the adult status in law of 18 year olds makes the ethos of 'in loco parentis' out-dated (suggesting an unacceptable paternalism), while others (Jobes et al 1997 and Apter 2001) argue the need for emotional support has never been greater.

The transformation of a relatively well-funded elite higher education system into a comparatively poorly funded mass system has resulted in significantly worse staff-student ratios, requiring a re-thinking of how pastoral and other personal support are delivered. This has been offset to some extent by an expansion in the range of specialist central support services. Grant suggests academics are gradually relinquishing their role in respect to personal support and referring students with personal concerns to these central support providers. On the other hand, Stanley and Manthorpe (1999) found some students were concerned that if they used a student service it would be recorded on their records and, in addition, the perceived stigma attached to accessing some formal support services could affect students' willingness to seek help. In particular, it was concluded that the quality in the provision of support services varies between HEIs, as does the extent of students' engagement with the provisions made. Notably, some universities no longer provide the personal tutor system.

The Royal College of Psychiatrists (2003) also argue that vulnerable students might need higher levels of support in order to achieve their potential. They stress the role of student support services and the pastoral care provided by many members of university staff are becoming increasingly important, not only to the emotional well-being of undergraduates but also to the retention of students in higher education. They further argue government pressure to widen access to high education to under-represented groups has resulted in greater demands being placed on support services with no corresponding increase in resources. Tinklin et al.(2005) demonstrated that non-traditional entrants to higher education place greater demands on support services and Naylor and Smith (2001) made a clear link between low socio-economic status and 'dropping out' of university. They comment that losing students is financially perilous to HEIs. About 28,000 or 8.1 per cent of students who start a degree course drop out in the first year and 22 per cent of students fail to graduate (www.timesonline.co.uk/universityguide, retrieved December 2007). A lack of interaction with tutors is one of the most commonly cited reasons for undergraduates leaving university.

The Support Services

> "Partnerships work best when the players have a shared picture of what they are working towards (Wertheimer 1997, p. 74).

According to the Association of Managers of Student Services in Higher Education/AMOSSHE (2001), support services are the corner-stone of the student support network. Such student support services comprise several agencies, offering both practical

and emotional help to students. Universities UK (2000) provide guidelines on the provision of support services, but these are guidelines only and not enforceable statutes. Although all universities provide a support network, significantly the provision of such services will vary tremendously between universities – depending not only on financial resources but also on the underlying ethos of the individual institution.

Significantly, Stanley and Manthorpe (2002) argue the support services are becoming increasingly important, due to the decrease in pastoral care and personal tutor support and the fact that HEIs no longer act 'in loco parentis'. To be most effective support services need to be available and easily accessible through a variety of access points. All such services need to be provided in a format that is usable by everybody irrespective of their gender, ethnicity, social status, disability and culture, especially as the government's widening participation policy has resulted in an increasingly diverse undergraduate population, as highlighted in the Dearing Report of 1997. Bradley (2000), who found a difference between the help-seeking behaviour of home students and overseas students, proposed overseas students were less likely to ask for help and more likely to consult specialist advice such as that provided by the International Students Service.

Yorke's (1999) study also suggested there needs to be awareness of what services are available, their whereabouts and specifically what they provide. Awareness of the availability of support services appears to be particularly important in the area of student retention. For example, Yorke's (1999) survey of 2,500 undergraduates, (who withdrew from their course in the first year), demonstrated that the way in which students *feel they are supported* during this initiation period is crucial to retention and withdrawal rates. Closely aligned to this was the extent to which students were happy or unhappy with their immediate environment. Jobes et al (1997) believe the risk of mental health problems (and indeed of suicidal ideation) in vulnerable youngsters is most apparent when there is insufficient 'goodness of fit' between the changes and challenges faced by young people and the available support resources which can be accessed in their time of need. For this reason, stated Lago (2002), there needs to be a seamless service within HEIs so that support services can be accessed and activated appropriately in times of student distress.

Okorocha's (1998b) study found overseas students believed information about support services should be reprised after induction week as there was too much information to take in during the first few weeks of term. There was also the suggestion that concerns over their welfare and well-being were perfunctory and that once the information has been imparted there was no reinforcement at a later date.

Of note, the 2001 AMOSSHE report recommended good co-ordination of support services and the practice of acquiring student feedback as a means of monitoring service provision. Street (2000) and Yorke and Thomas (2003) stressed it is important that support service providers know what young people are thinking and how they feel, especially as student support services are often not used until they are needed in a crisis situation. Furthermore, there are apparently a lot of misconceptions about what some support services aim to do. According to Katz et al (1999) a large number of respondents admitted they did not understand how helplines worked. Some thought counselling resulted in confessions being reported to parents and tutors and others considered the Samaritans to be the last resort – a telephone on a bridge rather than a source of help at any time. The organisation MIND has set up a 'Studentsinmind' project offering a confidential e-mail service to students – pitched mostly at males - who are said to prefer such contact (www.mind.org.uk, accessed September 2006). MIND maintains there needs to be a wide range of support services available using a variety of approaches to reach the maximum number of students.

Sharing Information and Confidentiality Issues

Confidentiality issues affect all parties involved with the HEI: the personal tutor/lecturer, the specialist support services, administrative staff, as well as students' families and friends. Confidentiality is the bedrock of a trusting relationship. Such trust enables full disclosure of the extent and nature of the problem between two parties. It is also worthy of consideration as a factor in help-seeking behaviour, since it is unlikely a distressed individual will seek help from a source that does not take confidentiality matters seriously. Confidentiality is not only a two-way process it is also an area of discussion with significant overlaps. Firstly, it involves consideration of the individual who wishes to have information about themselves (be that medical or non-medical) kept in the strictest confidence and their right to have these wishes respected, and also that of the professionals, privy to such information and who are bound by professional codes of practice.

Stanley et al. (2000) and Stanley and Manthorpe (2002) wrote extensively on the conflict of interests encountered by members of staff and support service personnel in the university setting. They found there were cases of failed communication between support services in the care of students with mental health problems. For example, some of the personal tutors surveyed reported both the medical centre and the counselling services had been non-responsive in matters appertaining to concern about students with mental health problems. In the most recent of their collaborative work on student mental health (2007),

Stanley and Manthorpe say there is lack of evidence that university staff services (including tutors) work together with a student in crisis and their family and friends, and there often appears to be a lack of co-ordination between the various sources of help that are available. Furthermore, some respondents in their (2007) study felt confidentiality is pointless when the level of distress is severe, since an inability to seek help or talk about the problem impacts on the ability to give consent. Confidentiality issues also impact on a wider circle of individuals, (such as the family and friends of someone who is depressed) in that they wish to help and become involved, but are conscious of not compromising the person's right to self-autonomy.

Confidentiality, therefore, is often perceived as being a barrier to good communication between agencies and services and this extends to outside agencies, too (Lago 2002). A response to the findings of Stanley et al's (2000) University of Hull project was that communication could be improved by HEIs through the identification of a key named person (such as a Mental Health Co-ordinator) who could provide a point of contact for both internal and external support services.

Essentially, different agencies have different codes and practices of confidentiality. In 'the real world' (Robson 2002) there needs to be a balance between honouring the obligation to uphold professional codes of conduct related to confidentiality and the risk posed to the student (or others) if other help is not sought when needed. Ideally this entails not breaching a confidence without the student's explicit consent but there may well be complex questions to be resolved about privacy and the rights of an individual, and such issues should be discussed with the students themselves. Essentially permission should first be obtained from the student for liaison with other parties, such as personal tutors, lecturers, the GP or counsellor, and students should also be encouraged to consult with key members of the university personnel so that mental health difficulties do not impede health or academic progress.

Matters appertaining to 'confidentiality' are also interpreted variously by different members of staff and in different contexts. For example, in the majority of cases any information revealed to a GP (or any other primary care team member) is strictly confidential and may not be revealed to a third party without the express consent of the patient. In the case of the student, third parties would include members of the university, educational authorities, family and friends, or employers (Harvey 2000). For this reason, Rickinson and Rutherford (1996) say there should always be clearly defined policies and

procedures (about the sharing of information between various support services) from the outset, especially if the code of confidentiality needs to be contravened – such as when a student poses a risk to him/herself and/or another. Stanley and Manthorpe (2002) also claim there is little knowledge about whether students are apprehensive with regard to medical information disclosed to a GP being passed to others in the university system. This is important in terms of recognising potential barriers to presentation and treatment uptake.

Because the focus of this work is concerned with the promotion of mental well-being, the next part of this chapter takes a closer look at a few of the support services specifically dedicated to this end: The Students' Union, the Disability and Equality Unit, the Counselling Service and the University Medical Centre. Not only is the University Medical Centre a key support service to students, it also comprises two elements of the health promotion model; those of health education and illness prevention. In order to contextualise the University Medical Centre within the setting of the study, this next section aims to define general practice (briefly) and to consider the issue of promoting mental health within its remit. It also critically reviews the ongoing debate concerning the perceived gulf between health promotion and illness prevention.

Following on from this overview, the research is then placed in context (Yin 2003) with a description of the specific setting within which the study has been conducted, and an account of the informal interviews conducted with the other support services under review.

General practice, general practitioners and primary care services

The majority of healthcare in the UK is provided by a primary care service. General practitioners (GPs) work in the primary care sector within the boundaries of Primary Care Trusts. Primary Care Trusts are groups of primary care providers which may include several GP surgeries. The formation of Primary Care Trusts was heralded in by the White Papers: New NHS (DoH 1997) and the NHS Primary Care Act (1996) which described the future shape of health services across the country. This document emphasised the increasingly important role of primary care and announced the formation of new Primary Care Groups (PCGs) to replace the commissioning groups and fund-holders set up by the previous administration. This has now been updated and revised by the White Paper 'Our Health, Our Care, Our Say (2006) with the re-positioning of general practice as a small business that both provides and commissions services.

Over the last couple of decades the role and remit of general practice has, to some extent, been re-defined by a plethora of White Papers, government directives and initiatives. Examples of these are: The Health of the Nation (DoH 1992), Our Healthier Nation (DoH 1998), The National Service Framework for Mental Health (DoH 2000), Making it Happen: A Guide to Delivering Mental Health Promotion (DoH 2001). An expressed aim of all these documents was not only to target mental health as a priority area (and to improve the quality, access and range of services within general practice), but also to establish primary care agencies as significant partners in the delivery of mental health promotion. The National Service Framework for Mental Health (DoH 2000) set standards (in particular Standards Two, Three and Seven) to define service models for *promoting mental health* as well as treating mental illness. Another theme shared by these papers was the greater involvement and extended role of the practice nurse/nurse practitioner in health education and mental health promotion.

Young people and general practice

The National Suicide Prevention Strategy (DoH 2002) aimed to encourage young people to use GP services, commenting that although most young people usually seek help from family and friends, many do consult with their family doctor.

Approximately ten years ago Walker and Townsend's (1998 and 1999) research had proposed an aim of primary care should be to improve the mental health of late adolescents and young adults through the earlier recognition of problems, especially as a large proportion of young people with mental health problems remain unrecognised and untreated (Paykel and Priest 1992). More recently Jacobson et al. (2001) found most GPs still have poor awareness of the health needs of young people beyond the more high profile areas of drug-abuse and unwanted pregnancy and he argued there is a paucity of research concerning the presentation behaviour of young people (in general) to their GPs, and of students in particular. Walker and Townsend (1999) also proposed GPs (said to be the most trusted of health professionals) are often the first port of call for young people with any health problems.

Jacobson et al. (2001) also support other earlier evidence (Kramer et al 1997) that young people perceive GPs to be more concerned with physical problems than emotional illness. He claims many young people report problems establishing a rapport with their GP. They do not see GP services as being sensitive to their needs and many young adults have developed negative views of their general practitioner as a consequence. A greater input is

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therefore needed before a trusting relationship can be established and this is particularly the case if the doctor exhibits a paternalistic approach. Ironically, although young people may require more time in the consultation, they actually receive less (MacPherson et al.1996).

Jacobson et al. (2001) further comment that due to the documented evidence of the increasing rates of depression and DSH in young people under 25 (supported by Appleby et al 1999, Appleby 2001 and Hawton et al. 2002), all health professionals need to be able to recognise, manage and follow-up mental health problems in young people. In 1999, however, Geddes highlighted a lack of training in risk assessment in primary care staff (including GPs) and in accordance with Jacobson's recent appraisal of this subject area there is reason to believe little has changed in this respect over the intervening years.

Stigma and General Practice

Kendrick et al. (1996) maintains the GP is the preferred health professional for those with psychological problems due to the perceived lack of stigma attached to a visit to the doctor's surgery. This view was shared by Kai and Crossland (2001) who claim there is less stigma associated with seeing a GP than seeing a psychiatrist. Kai and Crossland's subjects said they preferred the general practice setting because they felt their problem became anonymous. In particular this research demonstrated that *the fear of stigma* appears to influence how patients engage with the health services. Consequently, Kai and Crossland (2001) recommend the care-setting should be carefully evaluated when orienting services.

The University Medical Centre

The University Health Service started after World War II and was probably, according to Milner (1974), the first attempt to offer a form of counselling to students by non-academic staff. Since then the welfare support system provided by most universities comprises a more specific range of services, such as a dedicated counselling service, as well as other support services working together to promote the mental well-being of its student population.

University doctors are general practitioners, experienced in the care of students. They know the HEI system well and are integrated into university life. College doctors treat students with mental health problems and can refer students onto other agencies, such as

the Community Mental Health Team.   Part of their remit is also to provide medical certification at the time of consultation - should this be necessary. Most HEIs also have a nurse who will see students on all aspects of healthcare and who may also refer students on to the doctor, the student counselling service, or other agencies.

Some practices are based on university campuses, other practices used by university students are situated within the neighbouring town or city.   General practices off campus will usually see students due to the proximity of halls of residence, or because students live within their catchment area. Silverman et al. (1997) stressed the critical role of a campus-based health service in both promoting and sustaining mental health.   Rickinson and Rutherford (1996) agree the benefits in having a medical centre on site cannot be overstated (either on a local funding basis or as an NHS general practice which rents accommodation on campus) and urge HEIs to actively encourage registration with the university's Medical Centre, if one exists on site.

Registering with the University Medical Centre and the Declaration of a Mental Health Problem

Student registration with the university medical centre has implications for both the individual student and for the practice (in terms of capitation funding).

A survey of UK universities in 2002, undertaken by the Heads of University Counselling Services (HUCS) found that 82 per cent (of the two-thirds of HEIs that responded) had on-campus medical provision where students could register with a GP.   The remainder had nursing/health advisory care only.   Significantly not all students registered with their university Medical Centre – only 27 per cent of the HEIs had 76 per cent of undergraduates registered with their university practice and nearly 7 per cent had under 10 per cent of the student population registered with them.

All students should be encouraged to register with the UMC as, in their role as university medical officers, GPs advise on student health issues, assess students in crisis and negotiate leave of absence from campus. Such provision also extends to the important issue of continued care in the case of pre-existing mental health problems, as well as in terms of being able to 'reach' as many students as possible in situations where early medical attention would improve prognosis – outbreaks of meningitis or mumps, for example. Harvey (2002) expressed concern about the lack of new students' contact with local health care provision:

"Perhaps all students should be required to register with either the student health service or with a local GP with formal notification of this so that each is aware of the other's existence" (p. 77).

Indeed, Jacobson (2002) demonstrated that many young people are unaware of the regulations concerning registration with a GP's practice, often preferring to remain registered with their 'home doctor', simply because they do not know how the system works.

It is a great strength of the primary care system that GPs are able to build up a holistic profile of a registered patient under their care, as opposed to seeing patients as temporary residents on an ad hoc basis when their need is possibly acute. Crucially, GPs at university practices are at a disadvantage because they probably will not have sufficient contextual and background information about individual students on their list to enable the detection and early recognition of those potentially 'at risk' of developing mental health problems (Jacobson 2002). Hawton et al (2002) suggest a major role of GPs in the prevention of self-damaging behaviour is in the detection and treatment of depression and in the aftercare of 'deliberate self-harm' (DSH) patients; an increasingly common presenting problem for GPs (Houston et al 2003). Both Hawton et al (2002) and Houston et al (2003) suggest improved follow-up care (perhaps by primary care staff and/or specialist nurses) may reduce the likelihood of a recurrence in these conditions. Certainly, for young suicide attempters (in particular in young males, Tylee 2004) follow-up and adequate aftercare are very important if repetition and risk of suicide are to be prevented. Walters and Tylee (2003) maintain GPs are ideally placed to sustain patient contact and increase compliance through the establishment of medication review and monitoring systems. Appleby et al (1999) stress the need for more research in order to increase compliance and to prevent loss of contact with service providers. Jacobson (2002), suggests this is an area of concern for everybody involved in young people's mental well-being:

"there is no evidence available on how often GPs should follow-up people in general and students in particular with mental health problems" (page 137).

Importantly, university GPs can only act on information provided to them and this raises several pertinent questions. For those who do declare a mental health problem but who do not register with the university Medical Centre what happens with this information? Is the Medical Centre informed? For those who declare a mental health problem and do register with the practice, what steps are taken by the practice to ensure follow-up care and monitoring?

Promoting students' mental health in general practice : How best to achieve this aim

According to Jacobson (2002) there are several gaps in the present approach to student mental health:

> " ... *most research has not been conducted with any focus on students in relation to primary medical care*" (my emphasis). Clearly there are huge gaps in our knowledge base and these would benefit enormously from more research and more evaluation" (p. 139).

The Royal College of Psychiatrists (2003) also insist the documented prevalence of mental illness makes the establishment of intervention programmes worthwhile, but crucially opinions are divided about the best method of approaching health promotion within general practice. Harrington (2000) also supports the view that preventive strategies could be used very effectively in primary care but concedes, too, there is a woeful paucity of research about which interventions GPs should offer and which are the most effective. Shooter's (2002) critique of the National Service Framework for Mental Health concluded there is still too little emphasis placed on the effective implementation of strategies with regard to primary care involvement in mental health promotion.

Indeed, a computer search via Ovid into Medline, Cinahl, and the Cochrane Library revealed that, unlike other prevention clinics such as immunisations, asthma and diabetes, there is a notable lack of clinics specifically concerned with mental health - probably, suggests Kendrick (2000), because clinics concerned with mental health issues have not hitherto attracted fees. In 1996 Westman and Garralda suggested the establishment of such clinics would be facilitated by extending chronic disease management payments to depression and although their research suggests there would be a favourable uptake of such clinics they, too, admit the majority would not attract payment and the costs of running such clinics could be prohibitive. By contrast, Walker et al. (2002), evaluated the effectiveness of inviting adolescents to general practice consultations to discuss health behaviour concerns (and to develop plans for healthy lifestyles) and concluded that such an intervention could be implemented relatively inexpensively. Walker et al. (2002) also found such an intervention to be well received by the adolescents, forty per cent of whom accepted the invitation for a consultation (with a practice nurse). Ninety seven per cent of these 'attenders' said they would recommend the intervention to a friend.

In 1998, Walker and Townsend set out to evaluate whether primary care is, in fact, a suitable setting in which mental health problems in adolescents can be prevented by early detection and treatment. Their conclusion was that primary care does indeed offer a setting

for mental health promotion but that further research is needed to determine the most cost-effective ways of using such opportunities.

Types of proposed services/interventions to promote mental health in general practice

The purpose for carrying out the following literature search was to establish current thinking on different types of service delivery to promote mental health that could potentially be offered to students through the university's Medical Centre. The aim was not to provide a complete review of all the available evidence but to be able to inform the next (data collection) phase of this investigation.

The computer search for types of interventions deemed to be of value in promoting (mental) health revealed a broad range of potential service types. It was decided to limit the exercise to those services/interventions that could be adapted to mental health, starting from the year 2000, initially using the search terms: Well-person clinics/Walk-in clinics/Telephone triaging/E-mail triage (to gain an understanding of each of these topic areas) and then searching again adding 'in general practice' to each term. An inclusion criterion was that studies must be related to a British general practice. A considerable variation in topic area volume was noted. For example, there was a plethora of information concerning telephone triaging in general practice (ranging from the role and remit of nurses, whether this service reduces GPs' workload and the evaluation of this service to parents of young children), all of which were considered to be irrelevant in this instance and as such amounted to the exclusion criteria. Other areas of focus were relatively unevaluated - in particular that related to the use of E-mails.

Therefore, in order to gain further insight into both the views of students (as service users) and the perspective of the university's Medical Centre (as service provider), the following discussion aims to highlight the key features of each potential service, to consider the advantages and disadvantages of each and to evaluate them on account of their adaptability and relevance to mental health and the student situation.

Well-Person/ Mini Clinics

In 2000 Kendrick had declared the time was 'ripe' for a trial of depression mini-clinics in primary care. Kendrick has provided a considerable amount of research material on this type of intervention and remains convinced that depression is best managed in the same way as other chronic diseases (that is within specific chronic management clinics), not least because of the opportunity these provide for health education. Nevertheless, he

concedes there are many obstacles towards implementing best practice - possibly due to a medical model approach to depression management. In conclusion, Kendrick et al. (2007) urge GPs to engage, explore and negotiate patients' perceptions on treatment options. Searches for further evaluation of well-person clinics, at the outset of this line of enquiry, drew a blank.

However, as the previous literature review so clearly documented, I would suggest there might be a stigma attached to attending such clinics and some might object to their names being on a disease recall register. Furthermore, such clinics have also been accused of attracting the 'worried well'. Certainly, not all practitioners are convinced of the value of health promotion interventions in primary care or in screening measures in general (Kendrick, M, 2006). In 1990 Waller et al reported on poor attendance figures for health check clinics, with less than 50 per cent of those eligible to attend actually taking up the offer. They also found evidence to support Tudor-Hart's (1971) Inverse Care Law (see Appendix 3). However, Waller et al's (1990) study took place in just one Oxford general practice which, according to their own description, was made up of a socially diverse population - a point of compatibility with regard to a diverse student population - but nevertheless probably not typical of other general practices.

Walk-in clinics and triaging

Based on the NHS initiative to improve access to primary healthcare, the Walk-in clinic is, by contrast, a source of considerable research material. The original policy announcement was made in April 1999 and by September 2001 forty centres had opened in thirty towns in England. The key features of walk-in centres are that there is no need for an appointment and opening hours are usually extended beyond those normally existing in general practice. Salisbury et al (2002a) maintain they are intended to provide a service that meets the need of an identified population by way of their convenience factor. This might well appeal to students, in particular because of the 'impulsivity' characteristic of young adults' behaviour. In addition, the walk-in clinic maximises a skill-mix of staff (though they are often run by nurses) and there is an opportunity for health education through the support of patients in caring for themselves.

However, Salisbury et al (2002a) suggest this type of service could undermine continuity of care and lead to a duplication of work, or even inappropriate care as patients have been noted to approach different agencies with the same problem. This would, of course, not apply to students registered with the university's Medical Centre. Other problems are those revolving around accountability and the attitudes of other local health professionals

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(particularly GPs) who were perceived as being the most important potential barrier to the success of walk-in clinics. Furthermore, Salisbury et al. (2002b) concluded that walk-in clinics improved access to care but not necessarily for those with the greatest need, thereby yet again supporting Tudor-Hart's (1971) Inverse Care Law. In addition, they may increase access primarily for the higher socio-economic groups, are expensive to run and need high levels of staffing. Some have nurses with formal nurse practitioner training, others operate with less highly trained nurses on the basis that their remit to assess and advise is supported by clinical software, rather than to make an autonomous diagnosis. Doubts have been raised about the appropriate level of training needed for nurses especially as the software has been adapted from telephone triaging (such as that used by NHS Direct) as opposed to face-to-face contact (Salisbury 2002b).

In particular, Salisbury (2002a) noted walk-in centres were utilised by a higher proportion than normal of young adults and most importantly young males – another point worthy of consideration from the perspective of encouraging young people to attend.

Telephone Triaging

In recent years there has been a growth in the use of telephone consultations for health problems in general practice (Bunn et al.2005). Broadly based on the principles underpinning NHS Direct, this practice is now being used in general practices throughout the country and, according to Bunn et al. (2005), caller satisfaction with NHS Direct is said to be high. Bunn et al.(2005) undertook a systematic review to evaluate the effects of telephone consultations on safety, service use and patient satisfaction. Their conclusions were that, although telephone consulting appeared to have the potential to reduce GPs' workload, further evaluation was needed to ascertain its effect on service usage and patient satisfaction.

I would suggest the main criticism directed at NHS Direct was that with regard to the up-dating of medical records and this was seen as particularly relevant to the mentally ill who are often disadvantaged by an effective lack of liaison between different agencies in providing an adequate service. However, undertaken as a service within general practice itself this would not arise and Munro (2000) maintains it has become a popular way for some patients in dealing with concerns that might otherwise exacerbate anxiety and mental distress.

Other studies bring into doubt the effectiveness of dealing with mental health issues in this way. According to Payne (2003), only 3 per cent of the NHS Direct workload is taken up with calls relating to mental health and these calls were also recorded as being more complex than other calls.

Although some telephone consultations are performed by doctors, much is now carried out by practice nurses using computer-based clinical support systems. Another aim of Bunn et al's (2005) systematic review was to compare telephone consultations by different groups of healthcare professionals. It was not possible for them to comment on this aspect of their research due to methodological differences in comparing the studies reviewed.

Importantly, Bunn et al (2005) found that telephone consultations may have the potential to increase access for those who are unable or reluctant to present in person. In fact they say that patient satisfaction and safety issues may be the most important considerations with regard to this type of service provision.

E-mail

E-mail is an established method of communication in business, leisure and education and is well established in a number of university counselling services. According to Kane and Sands (1998) and Moyer (2002) there is a lack of published work to evaluate the impact of e-mail services to patients within UK general practices and this was borne out by my own searches. One study of interest, undertaken in an urban general practice in Dundee, Scotland, entitled "E-mail consultation in general practice" (retrieved November 2003) concluded that there is an unmet need in general practice for clinical triaging through this medium as patients welcomed this way of seeking doctors' comments and advice without having to attend a formal face-to-face consultation. However, the value of this study was very limited, not only because the name of the practice was withheld but also because it was conducted on a very small sample (150 patients) and undertaken in an urban setting, in contrast to the community setting of the student population.

An obvious disadvantage of this type of service is with regard to patient confidentiality. The Samaritans' E-mail Service (www.icthubknowledgebase.org.uk, retrieved August, 2006), however, point out this fear has proved to be unfounded. Through technical expertise and strict codes of practice, established by the Samaritans from the outset, patient confidentiality is safeguarded and the initial barrier to service usage has been overcome. In fact, their e-mail service, established in 1999, has proved to be very popular with young people, many of whom find it easier to express their feelings using e-mail than speaking on

the phone or having a face-to-face consultation. Katz et al. (1999) had found young males in particular preferred to communicate via e-mail, another point pertinent to its usage by the student population.

In summary, review of possible health promotion interventions in primary care/general practice has led to the firm conclusion there is a need for further research in this area - due mainly to a lack of consensus among researchers about how mental health promotion can best be implemented. Jacobson's stance is with regards to whether the potential benefits to students outweigh any cost of running such clinics, Appleby et al (1999) see the benefits of future research being concerned with increasing compliance (by finding out why some would not attend such clinics) and Kane and Sands (1998) and Moyer et al. (2002) share a desire to evaluate the impact of e-mail services to patients within UK general practices.

Walker et al. (2002) argued the majority of studies into student mental health have addressed health issues in isolation of wider social and political influences and have been restricted to a particular topic area or focused on screening, rather than addressing commonalities and cross-influences between different groups of young people. Furthermore, reviews based on the assessment of methodological quality have indicated many limitations imposed on conclusions drawn, which Walker et al. (2002) argued has resulted in the evidence-base for health promotion in young people remaining relatively small, despite great enthusiasm, effort and commitment. Most notably Kelly (1992) claimed all such interventions need to take some account of the patient's perspective because there may well be important unintended consequences of such interventions which could negate and/or reduce their effectiveness.

General practice as an agent of health promotion: An opportunity seized or an opportunity missed?

As has already been documented, the key role of primary care in mental health promotion has been recognised by successive governments. The document Promoting Better Health (DoH 1987) set the scene for major changes to the working contracts of GPs in general practice, culminating in the 1990 Contract (DoH 1989) which encouraged GPs (through cash incentives) to run health promotion clinics and health checks.

Within the remit of the 1990 contract was the introduction of funded health promotion clinics. The funding for such clinics was not cash limited and particularly fund-holding practices were keen to increase the range of services. However, the choice of the clinics

implemented was not generally based on a comprehensive researched knowledge of the specific needs of the practice population but rather on the interests and beliefs of the clinical professionals undertaking them (Ewles and Simnett, 1999). According to Ewles and Simnett (1999) the majority of the clinics implemented were again directed at disease and disease processes and aimed largely at physical illness. Moreover, claimed Kelly (1992), there was little attempt to address the needs of patients who were not regular users of the practice. By 1992 it became clear that the open-ended approach to health promotion clinics (in terms of both financial reward and scope) could not continue, and after only two years of operation a new health promotion contract was introduced in 1993 for which GPs received remuneration at a fixed price.

Critiquing the influence of the national imperatives and initiatives on health promotion, Hunter (1999) claimed the 'Health of the Nation' (HOTN) (1992) had failed over its five year life-span to realise its full potential on a number of conceptual and process-type flaws. Due mainly to the fact that it lacked cross-departmental commitment and ownership (being viewed more as a Department of Health initiative), Hunter argued the aims of the HOTN initiative have had little impact on the implementation of policies at a local level. The ethos of the document at the local level especially was perceived to be a disease-based "medically-led" approach which Hunter argued presented a major barrier to ownership by agencies outside the health sector.

Stewart-Brown (1999) also expressed disappointment with regard to the 'medical model thinking' apparent in the HOTN document, which she maintained constituted a significant barrier to the successful implementation of interventions to impact on mental health. Stewart-Brown (1999) also argued the content of this paper effectively moved towards the identification and targeting of risk factors as the foundation for health promotion activities within general practice, instead of adopting the holistic approach to health recommended by the very policy making documents that had embraced such a change of emphasis.

Health promotion versus illness prevention: the on-going debate

Over the last few decades there has been considerable debate concerning the appropriateness of the social model of healthcare with respect to the implementation of health promotional activities in general practice (Bunton et al.1995). In fact, health promotion in general practice has more often than not become synonymous with illness prevention and the implementation of screening programmes. Jones (1994) proposed this is because the medical model for prevention has largely been determined by the medical

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profession and is bound within a rather rigid biological framework. It tends to marginalise and ignore the importance of much wider social and environmental issues about health chances and how other important factors interact and impact on health status.

Since 1990, primary health care teams have been working on a contractually imposed basis carrying out specifically those duties and types of standardised health monitoring that are specified in White Papers and GPs' contracts of employment. However, from the outset many GPs (Kendrick 2006) have vociferously voiced their doubts about the value of inappropriate health checks. A survey of GPs carried out by the General Medical Services Committee/BMA in 1992 found 70 per cent of GPs interviewed admitted they were not convinced of the value of the health promotion clinics that they had been called upon to undertake - even though most of the health promotion practised in general practice is not carried out by GPs but by nurses, three fifths of whom felt they needed more training.

Certainly, much criticism has been levelled at the illness prevention aspect of health promotion because it is mostly associated with the medical model (Downie et al 1996), especially with regard to screening for illness and the identification and targeting of those "at risk".

Furthermore, the 'life-style change' approach, exemplified by the special clinics imposed on general practitioners in the 1990 contract, has raised pertinent ethical considerations. One of these amounts to a 'victim blaming' scenario which can result in counterproductive feelings of guilt, resentment or a sense of failure - all of which can lead to a loss of the individual's self-esteem, rather than an enhancement of it. For example, Jones (1994) found some individuals blamed themselves for lack of will-power in conforming to standardised norms of health behaviour. Also, because screening is often directed towards symptom-less individuals, the ethical issues involved in any screening activity are considerable (such as false negatives and false positives), including those of an iatrogenic nature as described by Illich (1975). Furthermore, because screening seeks to identify an unsuspected disease or a pre-disease condition, an effective intervention needs to be available to the 'patient' (Downie et al 1996).

Of note, substantial criticism of health promotion and screening programmes in general practice has not only confirmed that inequalities between social groups still exist but that they are, in fact, widening (Kendrick 2000). Cowley (1995) maintained the disease-oriented, biomedical approach of the Oxcheck Studies (the most renowned of the pilot study for illness prevention programmes called the Oxford Heart and Stroke study) can

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actually disadvantage people from less educated backgrounds and those from minority or lower socio-economic groups, and might further alienate such groups from attending in the first place or from follow-up.

Putting theory into practice - Health Promotion in General Practice : Reality or Rhetoric?

Bunton et al. (1995) maintained there are significant problems within the health promotion movement itself which, he maintains, is riven with contradictions in theory and in practice. According to Bunton et al. (1995), the health promotion movement is essentially a political one which has never managed to solve the diametrically opposed key philosophical differences at its core.

Central to these differences is the perceived rejection of the biomedical model (born out of "modernism" and dominated by rationality and science and the belief in the ultimate discovery of scientific truth) as the basis of health promotion and reliance instead upon notions of holism and complete social and physical well-being as premised upon a social model of health. Postmodernism (Giddens 1990) heralded in the social model and abandoned the notion of science travelling towards an end in which knowledge and science might be methodologically and epistemologically unified. Rather postmodernism proposes there is no guarantee of finding the ultimate and absolute truth as reality consists of chaos and change.

But for all the talk of empowerment, Bunton et al. argue, the experts (the medical profession) remain firmly in control of the discourse on health promotion, and the much-vaulted break with the medical model is more apparent than real.

In 1995 Cowley reviewed two major health promotion intervention studies that took place in a general practice setting and which had concluded that nurses are less effective than doctors in influencing people to make the necessary life-style changes. Although Cowley was critical of the papers on several counts, (not least because health was never clearly defined), she was of the opinion the studies in question merely reinforced the arguments that oppose the use of the medical model in health promotion assessment. Cowley argued both studies were so heavily influenced and dominated by the medical model (by focusing on ill health, not health), that they failed to take into account the wider social and economic factors influencing an individual's behaviour. Furthermore, Cowley (1995) maintained linking prevention activity solely to disease, rather than health, increases the professionalism of medicine and the medicalisation of everyday life. She suggests the

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implication that individuals cannot achieve health without medical approval seems more likely to impair than improve overall health in the long-term by undermining autonomy and increasing dependence (resonant with Illich 1975). Furthermore, Cowley (1995) suggests the disappointing results gained from both these studies were not due to the input of the practice nurses who undertook the health promotion clinics but due instead to the underlying assumption that health is best achieved by treating it as a disease.

Nevertheless, Cowley (1995) suggests the medical model should not be abandoned as a framework within which to implement health promotion interventions altogether, but used as an adjunct to the social model to encompass a more holistic treatment of people's health needs. Doing so, she suggests, would take account of social factors outside of GPs' control, such as poor housing, redundancy, being in low socio-economic groups, all of which will affect psychological health. Jones (1994) also argued that primary health education can be pointless if other issues of socio-economic importance are not taken into account. In the context of this research, it highlights the futility of treating a depressed student who feels alienated from his own culture/ background, who has money problems, is malnourished and who has to return to sub-standard housing.

Furthermore, Cowley (1995) maintains reliance on the risk factor approach to health promotion only serves to emphasise the moral dimension of health, viewing illness as a kind of punishment for not following a 'proper' way of life. This, she suggests, is closely aligned to the traditional preventive approach to health education which supports a paternalistic professional expert view of health promotion and which depends on the belief in the superior knowledge of health professionals who dispense good advice and instructions. "Patients" who follow this advice are deemed to be behaving sensibly and to be exercising choice.

Furthermore, models of health promotion implemented in general practice are largely assessed quantitatively as opposed to qualitatively, due mainly to the fact that modern biomedicine was established on the basis of scientific objectivity (famously disputed by Kuhn 1970) and hypothetic-deductive research methods. The social model of health, on the other hand, extends to a qualitative measurement as well which both incorporates and stresses the close relationship between an objective assessment of health in terms of conditions and a subjective view as regards to individual health experiences which, according to Jones (1994), strongly influence our perceptions of health.

Signposting the latest position: new avenues or further diversions

During the course of conducting the literature review on matters appertaining to Department of Health mandates governing general practice funding (and the policies and directives ensuing from these), yet another change has been made to funding arrangements and service(s) provision in general practice. This has had implications for the status of health promotion clinics and how mental illness will be managed.

The New GP Contract (British Medical Association/National Health Service, 2003) was implemented on 1st April 2004, approximately a year after commencement of this work. Aspects of this Contract that are deemed to be relevant to this work are discussed below:

All General Medical Services (GMS) provide essential services. Additional services include some *illness prevention* measures such as cervical screening, vaccination and immunisation, child health surveillance, and enhanced services for those not provided through essential or additional services. These might include more specialised services undertaken by GPs *or nurses with special interests* and may include services which address special needs and innovative services that are being piloted and evaluated. Primary Care Trusts (PCTs) will be free to commission whatsoever enhanced services they consider appropriate to meet local health needs.

Mental health comes within the clinical domain of the Quality and Outcomes framework of the contract. Each domain within the framework contains a range of areas described by key indicators which are further split into: *Structure* (is a disease register in place), *Process* (is the indicator being measured and an appropriate intervention being made, *Outcome* (how well is the condition being controlled) (Para:3.8). It is further stated that the New GMS Contract has the potential to help GPs reach targets set out in the National Service Framework for Mental Health (2000). But yet again the 2003 GP Contract appears to be more concerned with pre-existing conditions than the promotion of physical and mental health. For example, GP practices will be required to set-up systems for risk management and perform audits as part of the clinical governance arrangements. Forty one points (points translate into funding) apply to five categories relating exclusively to severe mental health problems (such as schizophrenia, bipolar and unipolar affective disorders, psychoses, dementia). There are seven quality points available to practices that produce a register of people with severe long-term mental health problems who require, and agree to, having regular follow-up.

So, in real terms, what opportunities have been created through this New 2003 GP contract for implementing (mental) health promotion activities in general practice and how does this specifically apply to the University Medical Centre and the promotion of students' mental health? Theoretically an opportunity does exist, for under the terms of the Quality and Outcomes framework of the New 2003 GP Contract practices will be rewarded for surveying patients' needs and taking account of them (1.30, page 5). Consequently, new programmes and initiatives would introduce the possibility of employing staff to deliver a new service that addresses this issue. Indeed Enhanced Services (those not provided through essential or additional services) might include more specialised services to address special local needs or requirements undertaken by GPs or nurses with special interests:

> "Practices will be rewarded through the Q&O Framework for surveying patients' views and taking account of these. "Enhanced Services" may include services addressing specific local health needs or innovative services that are being piloted and evaluated" New 2003 GP Contract (paragraph 1.32, p. 5).

Critical review of the New 2003 GP Contract, tends to reinforce Cowley's (1995) contention that too much attention is still being placed on disease identification and not actually on promoting health, although there is provision for new initiatives which could, in theory, include any of the previously named potential activities. Indeed, if these initiatives are not grasped what is this saying about the willingness and keenness of general practice to become more involved in health promotion work? Perhaps more contentiously, even though general practice is hailed as the 'logical' setting for health promotion is this actually happening, or is there reason to suspect rhetoric still reigns over reality? Indeed, how is health promotion perceived by this Medical Centre, especially in the context of the university setting.

It is with these considerations in mind that the UMC was treated somewhat differently from other UH support services, both at the research design stage and during the subsequent data collection process. As the literature suggests, there appears to be a tension between this particular service provider, service users and policy makers. It was hoped that a more formal, structured approach to the interview conducted with the UMC would provide a deeper understanding of the reasons to explain this phenomenon.

Setting the research in context: Moving from the general to the specific

Up to this point, the commentary has set the scene for a generalised environment typical for most students. This next section, however, focuses on the uniquely specific environment that the subjects of this research were exposed to, a situation that would undoubtedly influence the views, opinions and experiences of undergraduates within this context.

The following firstly describes the physical setting and boundaries of this work.

The particular context here is a post 1992 university in the south-east of England, situated within easy reach of London, in a county of natural beauty and charm that boasts a plethora of historic places of interest on its doorstep. It is served by a rail network that has connections to central London and intercity links and its location allows easy access to major motorways serving the north of England and the Midlands.

At the time of writing, the university is organised into 6 Faculties, 23 Schools and it runs 170 courses. It is a multi-site institution, totalling approximately 20,000 students and 2,000 staff, comprising three distinctly different campuses, two of which are easily reached by the same road and rail network. These two campuses (of which one is a very new state-of-the-art purpose-built site) are approximately one kilometre apart; linked by paths, cycle routes and a shuttle bus service. The third campus is six miles away, reached from the other two campuses either by car or public transport bus service.

The university's mission statement encompasses a commitment to provide all students with the skills and knowledge necessary to achieve their full intellectual potential and to equip them in building a successful and worthwhile future. Such an undertaking occurs within an holistic approach to personal and intellectual development and takes place in a multi-cultural environment that enables students to live, study and enjoy life. The opportunity to become involved in a diverse and enriching social life is provided by a combination of venues off campus and to events, clubs and societies that take place on campus. The university's policy regarding social activities reflects the needs and interests of different cultural and social groups. A reciprocal arrangement with universities all over the world provides 'home' students with the opportunity of experiencing a different culture and language, and by the same token students are welcomed from countries worldwide to study at this location. A designated department and team of staff are dedicated to supporting international students during their stay in the UK. They are also available to help and

advise students prior to taking up their place, and are responsible for the organisation of an 'Orientation Week' immediately on their arrival. Overseas students also have the opportunity of participating in 'host programmes' (spending time with a British host family) and improving their English language skills through the courses run on campus specifically for this purpose.

The University of Hertfordshire (UH) offers some of the best sporting facilities in the country and an award-winning Learning Resource Centre (LRC) that is open 24 hours a day, seven days a week. The facilities and services provided by the LRC are designed to assist and support students in gaining the most benefit from their course of study as well as providing access to the university's networked electronic services. The university's Learning and Information Services provide staff, students and researchers with integrated computing and media services through both on-line study resources and through campus Learning Resource Centres. The student intranet is accessible on and off campus. Every student has a personal portal which provides profiled information based on the individual's programme of study. It includes learning resources, personal information management tools, group work facilities, e-mail facility and communication with course tutors.

Accommodation (guaranteed to all first year undergraduates and overseas students) consists of purpose-built student flats (comprising approximately 6 students) and flatlets, some with en-suite facilities. Privately rented properties are also available off site in the vicinity. Information regarding living off campus is provided by a specialist team who also advise on a number of specially adapted rooms for disabled students who, in some circumstances, may be entitled to occupancy of their room for the entirety of their course.

UH provides a full range of support services to meet the needs of its diverse student population. Although not a definitive list, examples of such services have been named in Appendix 8, devised specifically for the benefit of focus group participants and survey respondents taking part in this research. In keeping with a varied student community, the university has a purpose built multi-faith and multi-cultural centre, as well as a communal room for collective prayer and worship. The Chaplain's office is situated within this centre.

This university is a dedicated equal opportunities institute with a Students' Charter and staff devoted to supporting and enabling disabled students and international students with special needs. A clear statement is issued about drugs and alcohol use/abuse in the Pocket Guide issued to all students. Whilst it is recognised that the many different experiences associated with being away from home for the first time can be stressful, the university

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operates an anti-drugs strategy that prohibits the use of recreational drugs within the university boundaries. As part of its health education programme, drugs education seminars are run for the purposes of informing all undergraduates about the dangers of drug abuse. By the same token abuse of alcohol that leads to unacceptable behaviour is also not tolerated on campus.

Identifying gaps in the knowledge base: What this study endeavours to contribute

This investigation has drawn on a number of influential works: the concepts of salutogenesis (Antonovsky 1985, 1988, 1996), the Health Promoting University Initiative (Dooris 1998, 1999, 2001) and other key relevant works of researchers which have focused on student mental health problems/needs; in particular the research of Stanley and Manthorpe (2000, 2001, 2002, 2007). So, having reviewed relevant literature appertaining to student mental health, described the students' environment and having set this research in context, the aims and objectives mentioned hereafter evolved to formulate:

> **The Purpose Statement:** To contribute to the knowledge and understanding of students' mental well-being within a university environment, from the student perspective.

Ewles and Simnett (1999) claim it is common for insufficient attention to be paid to users' views and needs. Importantly, the 'user-voice' has links with health-related beliefs and behaviours. Kelly (1992) maintains the perspective of the individual must be taken into account for any health promotional activity to be effective. He stressed it is crucial not to make the assumption that the meaning ascribed to the 'activity' by the instigators will be the same as that of the recipient. Kelly (1992) further stressed that health promotion interventions, such as opportunistic screening provision or well-person clinics, need to take account of the patient's perspective because there may well be important unintended consequences of such interventions which could negate and/or reduce their effectiveness. Making It Happen (DoH 2001) also made reference to moving beyond medical or clinically driven definition to engage with the lived experience of service users as this will influence the way that mental health promotion is planned, delivered, monitored and evaluated.

Antonovsky's notion of salutogenesis has profoundly influenced how health promotion is envisaged. The ethos of his model is entirely consonant with the ethos of the social model and the initiatives and directives of the numerous WHO charters. But on Antonvsky's own

admission his ideology was essentially conceptual and lacked a practical footing. Dooris (2001), building on Antonovsky's ideology, produced a template on which to model a strategy for putting such theory into practice and devised six objectives which formed a broad 'agenda for action' (p.5). The Health Promoting University initiative is indeed highly structured but does not focus on mental health per se, nor does it primarily seek the student perspective on issues relating to their mental well-being within a settings-based environment.

Stanley and Manthorpe (2002), on the other hand, do subscribe to the 'user voice':

> "the user-voice perspective is now widely accepted as important in the design and delivery of all services (p. 31).

Stanley and Manthorpe make a considerable contribution to the knowledge-base on student mental health needs in the HEI environment. Their 1999 project (funded under the Higher Education Funding Council for England's Special Initiative) identified ways in which the HEI and staff were responsive to students' mental health needs. Their research in 2000 focused on severe mental health problems among students and the views and experiences of personal tutors in response to students presenting to them with such problems. 'Making Use of Hindsight' does not specifically focus on students but on identifying factors that could pre-dispose young people to suicide (some of whom were in higher education) and the development of appropriate services and prevention strategies. Their 2002 research explored the needs of students with mental health problems and the ways in which HEIs can respond effectively in preventing suicide, whereas their most recent research undertaking 'Response and Prevention in Student Suicide' (2007) concentrated on suicide prevention in the context of young people in higher education. Clearly their focus has been predominantly on the prevention of student suicide and not on salutogenic factors as the premise upon which to build mental health.

In summary, therefore, this study aims to explore:

- The views and experiences of students in relation to their mental/emotional health and well-being in the university setting.

- Students' help seeking behaviour in relation to their emotional/mental well-being within the context of the university setting and the identification of factors that would encourage/discourage students from accessing help.

- Students' experience of the support services and their awareness of the role, remit and accessibility of these services.

However, although the focus here is on the student perspective, this study also aimed to provide an interface between service users (the student body) and services providers (the university's support services). To this end, official aspects of the macro perspective are considered here in relation to some of the support services most involved in students' mental well-being: The Counselling Service, the Disability and Equality Unit, the Students' Union and the University Medical Centre.

To this end, the Students' Union, the Equality and Disability Unit and the Counselling Service were approached informally to elicit their 'official' perspective, but in light of the issues raised in the literature review, the University Medical Centre was reviewed formally (having submitted for and received permission from the LREC to do so). This decision was based on factors appertaining to 'health behaviours' from the micro and the macro perspectives. Firstly at the micro level, why were students not turning to their GPs in the first instance instead of a counsellor? Were there inhibiting factors to accessing the Medical Centre? In 1994 Niven argued more attention should be placed on addressing the reason for the resistance of individuals in seeking help in times of need. He maintained any barriers prohibiting the access of agencies of help should be identified, especially as the uptake of screening procedures and health checks are often disappointingly low. This argument has more recently been supported by Waller et al (2005) and Grant (2002) who maintains an understanding of the concerns of students and their help-seeking behaviour is essential to the development of institutional provision that is responsive and sensitive to the needs of a diverse student body.

Secondly, at the macro level - general practice (as an agent of illness prevention) is one of the three inter-connected components of the health promotion model. HEIs will need to consider this agency as an integral component in the implementation of mental health promotion strategies. Moreover, legislative imperatives and official guidelines place primary care at the centre of health promotion. In the context of this enquiry, therefore, were there health promotion activities in place at the medical centre? If not what are the perceived barriers prohibiting the provision of such services - especially in light of the recent opportunities afforded by the New 2003 GP Contract. Furthermore, in terms of the Health Promoting University initiative just how integrated into the university's overall structure is the UMC? Does the alleged orientation of general practice and health promotion towards a biomedical rather than a social perspective of health in any way impede its integration?

To achieve these objectives, the following aim was added to those mentioned above:

- To explore the perspective of the University Medical Centre with regard to the promotion of student mental health, as well as that of other relevant support services.

Operational Definitions: Health, Mental Health, Mental Illness and Health Promotion

Due to the subject area of this work, constant reference is made to the above named terms. An attempt to define these terms was therefore made from the outset and these appear as Appendix 1. However, in accordance with the focus of this study, health promotion has been defined more explicitly within this chapter.

Prior (1993) claimed unambiguous definitions of the above terms are virtually impossible due to the many social dimensions associated with their meaning. Definitions of any kind are also subjective, age and culture specific and intrinsically linked to the precise period of time in which they develop. Consequently, a definition will incorporate not only the preconceived ideas and values and social mores of a particular culture but also a given representative group in that society, such as socio-economic status, gender or ethnicity.

With regard to terminology relating to mental health/illness, the negative connotations often associated with these terms renders a definitive description especially difficult. According to Stewart-Brown (1998) lay people are more comfortable with the terms psychological and emotional well-being than with the term mental health which they associate with mental illness. For this reason students completing the Questionnaire were asked to consider their own mental health status in terms of the positive emphasis placed on it by the World Health Organisation's definition of 1948 and conversely a number of adjectives (derived from the focus groups discussions) were supplied to suggest the opposing emotion – see Appendix 22, Briefing Sheet).

The next chapter defines and describes the research strategy undertaken to effect this study and reflects on issues concerned with the philosophical, epistemological and ontological assumptions which guided and underpinned these decisions. It also covers the ethical imperatives commensurate with such an undertaking.

Chapter 3

Research Design

An extensive literature review of issues appertaining to student mental health in a settings-based environment, conducted in the last two chapters, culminated in the intention to explore the 'user' perspective by eliciting students' experiential and personal accounts of the systems in place to promote their mental well-being within the university setting, as well as eliciting the macro perspective from key support services. This chapter sets out to present an explanation of the rationale behind the design of the study to achieve this objective.

Research design is concerned with decisions about the application of the most appropriate methodology to answer the research aims. This involves consideration of methods of data collection, data analysis and data interpretation.

Morse (2004) proposes *the purpose* of the research (be that description, explanation, exploration, evaluation, or to effect change) should guide the choice of methodology. A methodology is a set of rules and conventions which give structure to the enquiry and against which claims can be evaluated. In addition, a methodology will instruct researchers where to focus their research activity, how to recognise and extract knowledge, and how ontological and epistemological principles translate into guidelines that determine the direction of the study. Ontological, epistemological and methodological principles of the same nature are organised into paradigms which together constitute the domain within which the research is conducted. A paradigm is also a philosophical stance that underpins the study and describes the assumptions and values the researcher brings to the research enterprise. Research design should also consider what measures will ensure the study's competence and what the sample strategy will entail, for example – from whom will the data be sought, where, how and when. And finally, no research design is complete without consideration of ethical issues.

This investigation has been conducted as a case study (according to Yin 1994 and 2003), consistent with the characteristics of a flexible design (after Creswell 1994), underpinned by assumptions of the qualitative paradigm and using multiple methods of data collection.

This study clearly differs from *any* qualitative research for the following reason: it is embedded in a theoretical framework that fits with case-study criteria. For example, as discussed towards the end of the last chapter, the aims of the study clearly state the objective was to seek out the views and experiences of students concerning their emotional well-being in the context of their experiences within this particular university setting. This is synonymous with Yin (1994):

> "A case study is an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident" (p.13).

Yin (1994) further informs his reader:

> "you would use the case study method because you deliberately wanted to cover contextual conditions – believing that they might be highly pertinent to your phenomenon of study" (p.13).

Indeed, the views of UH students on their emotional well-being would not have been relevant to the purpose of this study *unless they were based* on their experiences at the University of Hertfordshire. In this respect the context was integral to the outcome. Moreover, the intention to set participants' responses in context was clearly evident from the briefing information supplied both verbally and in written format to all those who expressed an interest in becoming involved (see Appendices 6 and 22).

Other theoretical frameworks within which to conduct this research were afforded consideration; these being ethnography, phenomenology and in particular grounded theory. However, consideration of grounded theory (Glaser and Strauss 1967) resulted in the recognition of a fundamental tension between Yin's version of the case study and grounded theory methodology. Yin (1994) suggested the case study benefits from the prior development of theoretical propositions to guide data collection and analysis (see later 'Literature Review'), whereas Glaser and Strauss (1967) proposed a grounded theory approach should have no pre-conceived ideas or hypothesis. This was clearly not the case here. Neither does Yin's approach lend itself to the requisite epistemological considerations of ethnography as described by Lincoln and Guba (1985), Fetterman (1989), Atkinson and Hammersley (1998) or the phenomenological standpoint as discussed by Husserl and Heidegger (1964). My own epistemological and ontological stance was firmly committed to a conceptual framework provided by a literature review of related studies. Grounded theory, on the other hand, is best suited to studies where there is a lack of theory and concepts to describe what is going on.

The methods (the tools and techniques) of data collection and data analysis have been covered separately in Chapters 4 and 5. All other considerations related to research design have been addressed here.

Figure 1: Diagrammatic representation of the Case Study Design
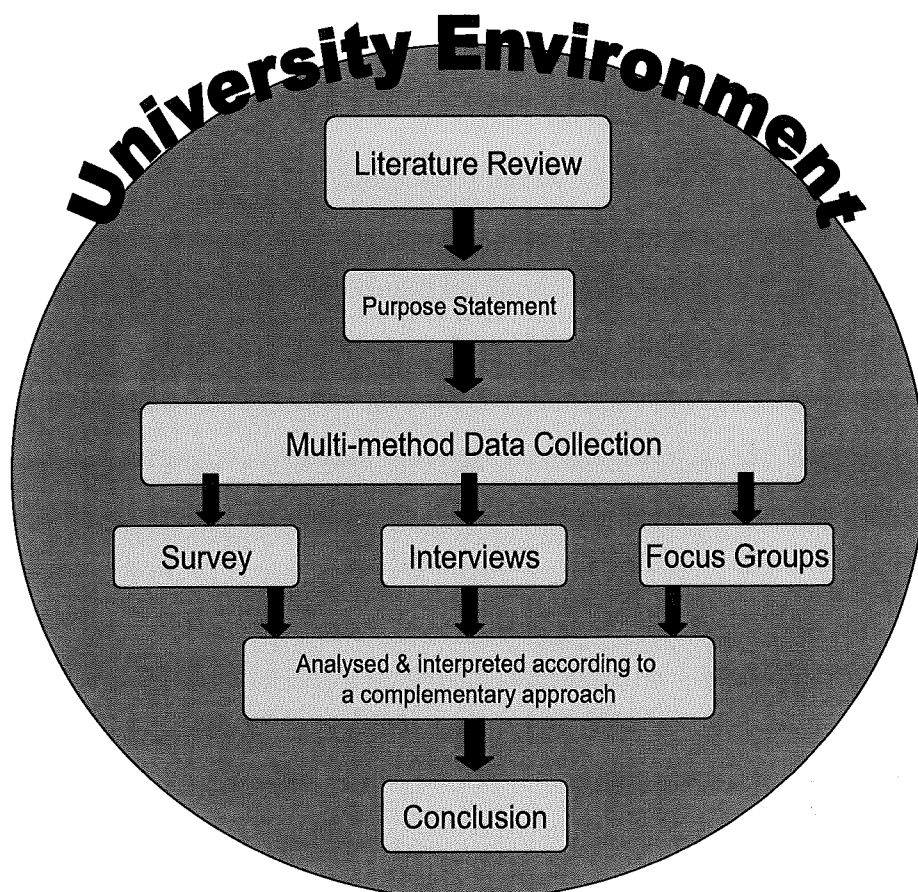
Case study design (after Yin 1994 and 2003)

Yin (1994) described a 'case' as being the situation, the individual, the group, organisation, neighbourhood, institution or whatever it is that is being studied taking its context into account. Yin (2003) advocated the case study *as a research strategy* for the development of detailed intensive knowledge and in-depth analysis of a single case or multiple cases involving an empirical investigation of a particular phenomenon or concern within its real life context. Such a strategy, he declared, guides the investigator through the processes of

data collection methods and specific approaches to data analysis and interpretation, often using multiple sources of evidence. This study is an embedded single site case study, taking place at one HEI bounded by its geographical location (as opposed to a multiple case study involving several HEIs). It involved more than one unit of analysis; these being - the student body, the University Medical Centre and support service personnel. Because each unit of analysis (with the exception of the lead medical practitioner at the Medical Centre) comprised a varying number of participants (for example, fifty one focus group participants and 806 survey respondents), the participants within these units of analysis will be referred to hereafter as 'multiple cases'.

Yin (1994) maintains the case study should be undertaken following a set of pre-specified procedures. He summarised four commitments to this end: to bring expert knowledge to bear upon the phenomenon studied, to round up all the relevant data, to examine the rival interpretations and to ponder and probe the degree to which the findings have implications elsewhere. Yin states case study research does not preclude some kind of generalisability beyond the specific setting studied and this may be thought of as the development of a theory which helps in the understanding of other cases. This is referred to as analytic or theoretical generalisation.

Both the 1994 and 2003 accounts of Yin provide guidance on carrying out rigorous case studies. Yin (2003) supports flexible study design :

> "at this (design) stage in the research process you still may not have finalised your ideas about the type of case study format to be used and the type of structure to be followed " (p. 157).

He further comments that case study plans can change as a result of the initial data collection and the researcher is encouraged to consider these flexibilities. Nevertheless, although aspects of the design of the study may change as the research progresses, a generalised strategy (as outlined below) should be built into the design of the study from the outset:

Table 3: A Generalised Strategy in a Case Study Design

The Strategy	Purpose and Process of the Strategy	Undertaken here in:
An Overview	Incorporating relevant readings about the topic including context, perspective and setting, issues under review and relevant findings from other sources.	Chapter 1 and Chapter 2
Decisions about field procedures	To include schedules of data collection and the justification of methods used; to keep the reader informed about the details of every process.	Chapter 4
The Case Study Questions	The researcher needs to keep the specific research questions/aims in mind while collecting the data. (See Appendices 7a-h, 10, 22)	Chapter 4/5
Data Analysis	In single case studies, the units of analysis and justification thereof must be stated (Chapter 4).	Chapter 5
Interpretation of the Data	Interpretation of the findings should involve cross-referencing conclusions back to original questions/aims and vice-versa to discern whether a link exists, as well as the identification of interested audiences.	Chapter 6
The sample(s)	Issues relating to the sample size and type.	Chapter 3/4

According to Yin (2003), the case study protocol is a major tactic in maintaining a chain of evidence which increases the reliability and construct validity of case study research. The need to follow a framework is supported by Miles and Huberman (1994) whose protocol was adopted for analysis of the focus group data. Yin (1994) recommends Miles and Huberman to readers undertaking case study research.

The Flexible Design and Methodological Underpinnings.

How case-study researchers contribute to reader experience will depend on their notions of knowledge and reality which are, according to Robson (2002), expressed as the researcher's epistemological and ontological assumptions.

This study has been framed within the assumptions of the qualitative paradigm and the characteristics of a flexible design. This includes fundamental characteristics such as evolving design, the presentation of multiple realities, the researcher as an instrument of data collection and a focus on participants' views.

A characteristic of flexible design (Creswell 1994) is that the study is informed by an understanding of an existing tradition of enquiry. As already stated, in this instance a case study strategy (according to Yin 1994 and 2003) has been adopted. Although Creswell

(1994) maintains flexible designs can be successfully brought together from a variety of theoretical positions and from several traditions, he supports the view they are best undertaken within the theoretical assumptions of the qualitative paradigm, especially if the researcher seeks to understand (or explore) an issue or problem, as opposed to seeking a causal explanation - for which, he suggests, a fixed design would be more appropriate.

A 'generalised' qualitative paradigm consists of constructionist ontology and interpretive epistemology (Robson 2002). Stake (1995) concurs that most contemporary qualitative researchers nourish the belief that knowledge is constructed (from experience) rather than discovered. Consequently, qualitative researchers concentrate on the construction of meaning based on culturally defined and historically situated interpretations and personal experiences. Interpretism emphasises the production of meaning and the importance of the special views, opinions and perceptions of people as they are experienced and expressed in every-day life.

Qualitative research begins by accepting there is a range of different ways of making sense of the world. It is specifically concerned with the meanings of those being researched rather than of those performing the research (more typical of the quantitative paradigm). Indeed a generalised quantitative paradigm, underpinned by the philosophical tradition of positivism and based on strict rules and procedures, is depicted by characteristic assumptions that objective knowledge (facts) can be derived from direct experience or observation and by testing hypotheses to develop universal laws. Qualitative research, on the other hand, uses an inductive and interactive process of inquiry and considers values in context as part of the phenomenon being investigated. This clearly contrasts starkly with quantitative research which relies on context stripping in order to remove as many extraneous contaminating variables as possible from the research environment. In particular, the inclusion of context and the identification of informants' beliefs and values capture the holistic injection by preserving the complexities of human nature (Morse 1994).

Furthermore, the interactive process of inductive enquiry enables the researcher to gain insight into the focus of research from the perspective that categories often emerge from informants rather than being predetermined by the researcher. In fact, Creswell (1994) proposes the major differences between the two paradigms are those of opposing perspective due to the fact that meaning often differs drastically between researcher and informant. Creswell cites as an example the emic perspective of the qualitative researcher which entails eliciting meaning, experience or perception from participants' point of view,

and the opposing etic perspective of the quantitative paradigm which concentrates instead on the researcher's viewpoint.

Consequently, qualitative research begins with an intention to explore a particular area, collects data via observation and interviews and generates ideas from these by the process of inductive reasoning. This is in direct contrast to the deductive (positivist) approach which has a predetermined conceptual framework usually involving hypothesis testing in a cause and effect manner and which, through measurement, generates data and by deduction draws a conclusion. Stake (1995) summarises what he sees as the most noteworthy differences between the qualitative and quantitative paradigms: 1) the distinction between explanation and understanding as the purpose of the inquiry, 2) the distinction between a personal and impersonal role for the researcher and 3) a distinction between knowledge discovered and knowledge constructed.

The ontological assumption of the qualitative paradigm is that reality is concerned with the subjective world and the human experience of both the researcher and the research participants. Epistemologically the qualitative assumption is that the researcher interacts with those being researched and the methodological assumption is an inductive process that is context bound and informed by the personal voice.

The purpose of this enquiry has been to explore the views of students on issues appertaining to their mental well-being in the context of a university environment. It is therefore set in 'the real world' and indeed in context. It was conducted within a specific time-scale, on young people who just happened to be in this context and who brought with them to the investigation their own unique perspectives based on personality characteristics, varying socialisation processes, cultural and ethnic backgrounds. In keeping with the previously mentioned 'criteria' associated with a qualitative undertaking, this study has proceeded inductively, having considered the research of others in related fields and having interacted with students directly to elicit their own views and experiences.

Furthermore, the qualitative researcher actively reports his/her own values and biases and by so doing contravenes the quantitative assumption that research is objective and value/bias free. A citation from Miles and Huberman 1994 (whose methods of data collection and analysis have been adhered to in this work) endorses a qualitative underpinning to case study research:

"... a case always occurs in a specified social and physical setting. We cannot study individual cases devoid of their context in a way that a quantitative researcher often does" (p. 27).

The philosophical underpinning of this work

Qualitative research places emphasis on conducting research in 'real world' situations. Robson (2002) proposes there is consonance between 'real world' research and the philosophical position of 'realism'. An assumption underpinning this philosophy is that there are no facts beyond dispute and that knowledge is taken to be a social and historical product that can be specific to a particular time, culture or situation. In fact, argues Robson (2002), critical realism and purely relativistic approaches (which consider science to give but one of a number of equally valid accounts) can encompass a range of post-positivist methodological approaches to social sciences.

Hammersley (1996), however, maintains it is important to get away from the superiority of one methodology over another as this merely perpetuates the quantitative versus qualitative dichotomy. Rather, suggests Hammersley, it is preferable to see the two methodologies as complementary and not as competitive. More recently, Brannen (2004) concurs that qualitative and quantitative paradigms are no longer incompatible and she agrees there is now a distinct move away from dichotomy towards convergence. She further suggests this will ensure the right methodology is brought to bear on the right question.

Consequently, there is a call for a pragmatic approach using whatever philosophical or methodological approach works best for a particular research question. Robson (2002) maintains there is a helpful compatibility between the pragmatist and the realist which rests on some shared assumptions that include: the value-ladenness of enquiry, the theory-ladenness of facts, and that any particular set of data is explicable by more than a single theory. Furthermore, pragmatism is a philosophical tradition (associated with the works of Dewey, 1960), proposing there are no absolutes and that human knowledge is inevitably holistic. A pragmatic approach seeks to find common ground between often diametrically opposed paradigms and it has much in common with realism which also purports to take a scientific approach to investigation. According to Murphy (1990), Dewey in particular adopted a scientific approach to the question of human problems. Indeed, conducting this piece of research within a scientific approach has been fundamental to the design process.

I support the view that there are no absolutes and that no one single philosophical approach to social science research can provide the definitive answer. There are, of course, variants

(different schools of thought) to all the major research philosophies. For example, realism is variously labelled as 'scientific realism', 'critical realism', 'fallibilistic realism', 'subtle realism' and 'transcendental realism'; each variant stressing particular features. And yet there are aspects of specific frameworks which have considerable rapprochement with other frameworks. Robson (2002), for example, believes a rapprochement exists between some versions of constructionism and the realist framework, as indeed it does between some aspects of realism and pragmatism.

I have been especially influenced by Cherryholmes (1992) who compares and contrasts the features of scientific realism and pragmatism. He stressed both share a number of assumptions about science, language and the world. Both are opposed to positivism/empiricism but with different points of emphasis and interpretation. A realist's approach makes the assumption that the outcome of an action follows from mechanisms acting in a particular context. Key assumptions of realism are that there are no unquestionable facts beyond dispute, that knowledge is a social and historical product, (as too does constructionism) and that facts are theory-laden. Cherryholmes comments that there are few major disagreements among pragmatists themselves as to these broad themes of realism. However, research undertaken in a pragmatic tradition not only seeks to clarify meanings but also looks to consequences. Therefore, pragmatists believe choices about what to research and how to go about it are conditioned by where we want to go in the broadest sense.

One noteworthy difference between the two positions (realism and pragmatism) is that in their search for reality, scientific realists are romantics and pragmatists are realists, for they (pragmatists) believe the search for reality is a misguided and impossible search, in particular because realists believe the task of science is to invent - and test - theories to explain 'the real world'. So whereas scientific realism takes this up as their challenge, pragmatists believe we should give up the idea of ever being able to pin-down "underlying causal entities". Specifically, scientific realists are not interested in consequences or in what is 'workable' but in seeking reality.

Nevertheless, both pragmatists and realists agree that scientific research always occurs in social, historical, political and 'other' contexts (as again do constructionists). However they differ in their opinion about the focus of this belief. Pragmatists take the view that because researchers are part of this social context we can never be emphatic that the findings will explain 'the real world', whereas realists claim to do so.

So, unlike the realist, the pragmatist will not pretend to have the answer to finding 'reality' – a concept that is very dear to the school of realism. Moreover, pragmatists deny that grounded meaning and truth can be determined once and for all. It is only by observing the consequences of our beliefs, they say, that we know whether something is workable. Importantly, the pragmatic researcher will accept that the findings of their study might not be 'the truth' and are sceptical of scientific realists who in their search for the truth make the claim their findings provide a true picture of what the world is like and the assumption they have arrived at 'the truth'. In fact, pragmatists state researchers cannot know whether their current findings are closer to or further from reality than previous findings.

So far, through a brief overview of current thinking on the choice of methodology, I have considered, discussed and justified my choice of methodology and have declared the ontological and epistemological positions which have guided my choice of design. Yin (2003) comments:

> "some investigators distinguish between quantitative research and qualitative research – not on the basis of the type of evidence but on the basis of wholly different philosophical beliefs ….. although some believe that these philosophical beliefs are irreconcilable, the counterargument can still be posed – that regardless of whether one favours qualitative or quantitative research, there is a strong and essential common ground between the two" (p. 15).

For the reasons already expressed, I have conducted this work within the assumptions of the qualitative paradigm, having expressed my eclecticism and a compatibility with some common epistemological and ontological assumptions linking constructionists, realists and pragmatists but with an emphatic leaning towards a pragmatic stance on reality. Furthermore, in keeping with realism and pragmatism, I have pursued a scientific approach to the research focus.

Measures to ensure rigor and the scientific process

With their reliance on quantitative data and statistical generalisations, fixed designs are considered by their proponents to be more "scientific" than flexible designs. According to the experimental and positivist traditions, the following criteria need to be fulfilled in order that the research outcome is considered to be 'trustworthy':

- **validity** (assuring the methods of data collection actually measure what they set out to),

- **reliability** (the replication value – would the same results be achieved were the study to be repeated at a different time, place) and

- **generalisation** (could the findings be transferred with confidence to another population other than to those involved in the study).

Fixed design researchers often criticise qualitative methodology for its absence of standardised means of assuring reliability and validity, such as checking inter-observer agreement, the sole use of quantitative measurement, explicit controls for threats to validity and the opportunity fixed designs hold for direct replication.

In answer to these critics, in 1985 Lincoln and Guba (pp. 294-301) made a strong case that such conventional criteria for assessing the 'trustworthiness' of quantitative data are inappropriate when dealing with qualitative data. They proposed four alternatives (tests) by which qualitative data can be scrutinised:

- **Credibility:** this corresponds to internal validity; that is has the subject of the enquiry been accurately identified and described. Lincoln and Guba (1985) recommend performing co-vergent validity testing which involves comparing the data collected from one source with another already validated source, or using triangulation which can improve both the credibility and dependability of qualitative data (see page 91 for a further discussion on this issue).

- **Transferability**: relates to external validity. There does not however appear to be any test of transferability recommended by Lincoln and Guba. Robson (2002) suggests it might be acceptable to leave this decision to a later researcher's judgement on how well the findings of the first study compare in similarity with a subsequent study.

- **Dependability:** corresponds to reliability, which implies similar results would be obtained, were the study to be repeated.. Lincoln and Guba (1985) propose if the process of data collection is made clear, well documented and safeguarded against bias, the process itself would serve as a test for dependability.

- **Confirmability** relates to objectivity and involves creating an audit trail to allow an independent auditor to make a judgement as to whether neutrality has been assured.

Reading on this issue - that is whether quantitative tests (validity, reliability and generalisability) or qualitative tests (credibility, transferability, dependability and confirmability) best suit this study's pursuit of 'trustworthiness' - highlighted several inconsistencies between writers with regard to the terms used. Creswell himself, writing on qualitative design, referred to 'validity' and 'reliability', as does Yin.

Interestingly, Stake (1995) commented that Yin adopts an altogether more quantitative approach to case study research. I would suggest Stake's remark is possibly a reflection on Yin's more rigorous, scientific approach (and the detailed strategy he recommends), and in particular because he gives examples of using both qualitative and quantitative data collection methods.

Prejudices against case study research often include concern over the lack of rigor in following systematic procedures. Another concern is that they provide little basis for scientific generalisation. To the first comment Yin (1994) championed the cause for scientific rigor by way of extolling researchers to be explicit about the methods used and the precise procedures adopted in data analysis. Creswell (1994) agreed the researcher must make explicit his/her own assumptions and persuasions from the outset so that the study can be judged accordingly. Secondly, Yin (2003) maintains case studies are generalisable to theoretical propositions and not to populations or universes. The goal in performing a case study, Yin stresses, is to expand and generalise theories. This he calls analytic generalisation. Moreover, an aim of the case study is to uncover contextual conditions because they are believed to be pertinent to the phenomenon under investigation (consistent with 'real world' flexible, qualitative assumptions), whereas an experiment deliberately divorces a phenomenon from its context.

Robson (2002), too, argues both fixed and flexible designs can be scientific provided they are carried out in a systematic, principled and rigorous fashion. Adopting a scientific approach means being explicit about assumptions, about how the research has been undertaken and being able to justify decisions on design and choices associated with methodology and methods.

Yin (2003) maintains the quality of a piece of case study research can be judged by certain tests and the development of case study design needs to maximise on (four) conditions related to design quality (see Table 4 below). He recommends the implementation of the following tactics to establish whether these criteria have been met.

Table 4: Meeting the Criteria of Scientific Rigor in Case Study Design (Yin 2003)

Tests	Case study strategy	Phase of research in which strategy is used
Construct validity	Use multiple sources of evidence	Data collection
	Establish chain of evidence	Data collection
	Have key informants review draft of case study report	Composition
External validity	Use theory in single-case studies	Research design
Reliability	Use case study protocol	Data collection
	Develop case study database	Data collection

The following terminology has been adopted hereafter in this work for reasons of consistency with Yin's case study protocol:

Construct validity: Areas of criticism have related to the subjectivity of much case study enquiry both in the data collection and reporting stages. Yin (2003) maintains this can be mitigated by the application of the 3 tactics identified in the Table 4 above.

(Internal validity: According to Yin 2003 this only applies to causal or explanatory case studies and not to descriptive or exploratory studies which are not concerned with making causal claims).

External validity: This test deals with whether the study's findings are generalisable beyond the study being conducted. Instead of relying on a statistical generalisation to larger populations (such as studies based *exclusively* on a survey sample), case studies rely on analytical generalisability whereby the researcher strives to generalise a particular set of results to some broader theory.

Reliability: Although the commonly held meaning of this term is to replicate a previous investigation using the same procedures as described by an earlier investigation (and arriving at the same findings and conclusions), Yin's (2003) stated goal is to minimise errors and biases through the rigorous documentation of the procedures followed. Yin concedes that in the past case studies have been poorly documented making external reviewers suspicious of reliability factors. Miles and Huberman (1994) support Yin's claim that a case study protocol will minimise criticism by making as many steps as possible operational, by creating an audit trail and establishing a database, all of which they confirm markedly increase the reliability of the case study.

I have therefore chosen to conduct this case study according to Yin (1994) and (2003) (as opposed to Stake 1992), due entirely to Yin's clearly defined protocol and procedures which pursue a scientific approach.

The Literature Review:

According to Creswell (1994), some writers would argue incorporating theory into the beginning of a qualitative study presents a challenge to the inductive process, in as much as this is more in keeping with quantitative methodology and the presentation of a set of propositions to be tested hypothetically. Indeed, Morse (1992) says some researchers view a literature review in qualitative work as a possible contaminant – a risk to the inductive and creative processes, while others are not comfortable with total dependency on cited informants. Creswell (1994) however maintains it is possible to use theory and literature in modes unassociated with the accepted approaches of their paradigms. Interestingly, he comments that a model which presents a substantial literature review suggests a type of quantitative approach that appears frequently in qualitative studies aimed towards more quantitatively oriented audiences - such as research destined for professional journals. As has been documented earlier, performing a literature review is entirely commensurate with the assumptions of both realism and pragmatism. Most importantly, it is integral to the case study.

Yin (2003) claims a literature review provides a sound theoretical background to a study as a basis from which new ideas and theories emerge. He maintains the case study researcher must have a thorough understanding of the theoretical issues because analytical judgements are made throughout the data collection phase. Indeed, he insists the researcher must also be able to interpret the information as it is being collected, since without a firm grasp of the issues it is not possible to know when a deviation is acceptable, or even desirable - the point being that case study data collection is not merely a matter of recording data in a mechanical fashion (as it is in some other types of research). Yin further stresses the importance of reviewing all the available literature related to the study, as this will communicate to the reader the purpose of the setting for the investigation. This may include the rationale for the proposition being investigated and the broader theoretical relevance of the inquiry. All relevant topics should be cited, although the bulk of the overview should be devoted to the substantive issues being investigated. The stated ideas from the theory development will cover the questions, propositions, units of analysis and logic connecting data to propositions. In similar vein, Morse (1992) proposed another advantage of using a combination of literature sources is that it provides a balanced

overview of the topics under consideration which can – in keeping with the inductive model of thinking – often shed light on the problem as new theories emerge during the data collection and analysis stages. She also maintained literature searches should be thorough and complete enough to give the researcher the confidence and knowledge to discuss the major theoretical perspectives that are pertinent to the enquiry.

In fact the role of theory development, prior to any data collection, is one difference between case studies and other frameworks of enquiry, such as ethnography (Lincoln and Guba 1985, Fetterman 1989, Atkinson and Hammersely 1998) and grounded theory (Glaser and Strauss 1967). Typically these frameworks deliberately avoid specifying any theoretical proposition at the outset. Cherryholmes (1992), on the other hand, supports the view that a pragmatic researcher might approach his/her study with a review of research in support of the subject matter, although pragmatists concede plausible explanations of the subject matter can be achieved through a variety of ways - even by approaches that seem to be based on contradictory assumptions and arguments. Importantly, however, the pragmatic researcher considers the research literature in light of both the opportunity and constraints previous findings might impose because these could be the basis for future avenues of enquiry.

Marshall and Rossman (1999) also maintain the researcher cannot write about the significance of a study without knowledge of related literature and provide an account in support of its usage. They maintain a thoughtful and insightful discussion of related literature builds a logical framework, from which the theoretical framework and key concepts that guide the tentative new research will emerge. Once the overall question(s) has been identified the choice of methodology becomes logical. As the researcher conceptualises the research problem, he/she locates it in a tradition of theory and related research. Initially, they stress, this may be intuitive, chosen because of underlying assumptions, how the researcher sees the nature of reality and how the research question will fit into this framework. Then the researcher will identify the area of knowledge that the study intends to expand on. Marshall and Rossman (1999) suggest the next step is to critique previous work that relates to the general research question as this will lead to a more precise problem statement because it will have demonstrated the specific area that has not been adequately explored. So, as an introduction, the literature review not only provides a useful back-up but also serves to frame the problem and provide a rationale. This in turn leads to the purpose statement and establishes the direction of the study (as identified on page 62).

In summary, the literature review accomplishes four broad functions. Firstly, it demonstrates the underlying assumptions behind the research question(s) and shares with the reader the results of other studies that are relevant. Secondly, it demonstrates the researcher has identified some gaps in previous research and that the proposed study will fill a demonstrated need. Thirdly, it provides a framework for establishing the importance of the study as well as establishing a benchmark for comparing findings. It also demonstrates that the researcher is knowledgeable about related research and the intellectual traditions that surround and support the study. Finally, the review refines and re-defines the research questions by embedding those questions into larger empirical traditions.

Sampling Strategy within the Case Study Design

A consideration of sampling strategy is integral to research design. Three samples were integral to this work: the focus groups, the survey sample and the University Medical Centre's representative. Each sample will be dealt with separately as it arises, including a discussion on matters relating to sample size and type. The matter of sample 'characteristics' is considered below.

The only specification about sample 'characteristics' called for here was that students were UH *undergraduates*. This specification was due to the fact that the majority of undergraduates still fall within the 16-24 age range (see Table 1, page 4). This duly classifies young people as being within the late adolescent/early adulthood category. The first chapter of this work established that not only has the mental health of young people in the 16-24 age-group steadily deteriorated over the last two or three decades but that the pattern and expression of mental health problems in young people has also been changing. Most importantly, this age-group is said to be experiencing the highest rates of co-morbidity (symptoms of physical and mental illness) amongst the population as a whole (Kings Fund 2003).

It is for these reasons that this work has concentrated exclusively on undergraduates. Indeed, it was a pre-requisite for participation in this research that students confirmed this status – see the Briefing Sheets associated with both the focus groups and the survey (Appendices 6 and 22) and the recruitment displays (Appendices 4 and 5). It is acknowledged post-graduates will have their share of emotional problems but these may well be due to different circumstances and for different reasons (they might be coping with raising a family as well as with their studies). Consequently, this work concentrated on

mental/emotional issues that are age-specific and related to the maturation process. Wilson, Director of YoungMinds (personal communication, October 2001) stresses the maturation process will vary considerably between individuals; some young people will be mature, self-confident and well-adjusted at the age of 18, others will not.

Ethical Considerations in the Study Design

Yin (1994) stressed ethical issues need to occupy the researcher's initial considerations. Robson (2002) says the research community and those using the findings of research have a right to expect that research is conducted rigorously and in an ethically defensible manner. According to Naidoo and Wills (1994) the four widely accepted ethical principles are: Respect for the individual's autonomy, Beneficence (effecting good), Non-maleficence (doing no harm) and Justice (being fair and equitable). The practice of justice applies to the equitable treatment of every individual regardless of race, class, ethnicity or disability. At all times the welfare of the subjects must be the researcher's prime concern, particularly with regard to avoiding any affront to dignity, embarrassment, lowered self-esteem or loss of autonomy.

Bauman (1993) extends this view to include: consent, confidentiality and trust, as codes of practice. According to Bauman the bedrock of ethical procedure is informed consent – a principle which arises from the subject's right to freedom and self-determinism and incorporates the subject's right to withdraw from the study at any time. This aspect of ethical practice was rigorously adhered to from the outset and formed an integral part of the design of the study. Bond (1997) concedes beneficence and non-maleficence also extend to the concept of informed consent, in that the individual must be informed and made fully aware of the implications of any action that might cause him/her harm. Bond (1997) maintains a researcher is guilty of a breach of trust when the true purpose of the study is deliberately concealed. However, Ryen (2004) suggests the line between informed and uninformed consent is often unclear as, in order to avoid bias, researchers are often reluctant to give subjects too much information. This was not the case here. Focus group participants were provided with assurances on all the above mentioned points. Not only were these issues addressed formally on all briefing sheets (see as examples, Appendices 6 and 22) they were also communicated verbally before the commencement of each focus group session. Furthermore, at the end of each session, students were reminded of the availability of the Counselling Service, should they have been affected by any of the issues raised during the session. To reinforce this assurance, Counselling Service leaflets were left on the table for students' retention. Similar precautions were also transmitted in written

format in the Questionnaire Briefing sheet and the Medical Centre was also keep fully acquainted with the aims of the study and its progress.

Bond (1997) adds that research subjects not only have a right to confidentiality but also to expect that the researcher is trustworthy. Trust refers to the relationship between the researcher and the participants which according to Ryen (2004) is an essential element in building good relations and rapport with participants. The issue of confidentiality involves two aspects: Firstly, the steps taken by the researcher to protect the identity of the participants, and secondly with regard to promoting a mutual respect for confidentiality between group members in group undertakings. In particular, this relates to the focus groups in Phase 1 of the data collection stage and was achieved by the articulation of "ground rules" at the beginning of every focus group session, as well as in written format. Furthermore, warns Morse (1994) confidentiality not only includes protecting participants' identities but also includes the safe-guarding of any data (photographs, tape-recordings) that might uncover the anonymity of the subjects. This point was also covered (see Appendices 6 and 22)

In reality, state Naidoo and Wills (1994), most decisions concerning ethical principles combine features of utilitarianism (that actions should result in more good than harm) and deontological considerations – respecting a universally held moral code of conduct. For example, ethical considerations apply not only to the research subjects but also to honesty in the reporting of the data. Seale et al. (2004) claim examples of unethical practice concerning the withholding of information (that does not fit into the research hypothesis) have existed for decades. Such malpractice not only casts a shadow over the researcher's integrity but also reflects on the validity of the study. In keeping with the scientific approach, (and Yin's and Cresswell's guidelines) the reporting of pitfalls and difficulties encountered throughout the execution of this study have been scrupulously reported.

In terms of the application of ethical codes of practice to the concept of health promotion in the university setting, it is helpful to consider these in relation to the model's three inter-locking components (health protection, health education and illness prevention). In respect to illness prevention, Naidoo and Wills (1994) concede that the preventive measure of screening constitutes an ethical tension between beneficence and non-maleficience, for although it is seen as 'good', screening procedures are not always without 'harm' and often the pressure to ensure up-take of screening measures sometimes means individuals are not as fully informed as they ought to be. This point informed Question 23 of the

Questionnaire (Appendix 22) and has relevance for the Medical Centre as a support service.

In the field of healthcare, the balance between beneficience and non-maleficience is often taken as harm minimisation, such as acknowledging a client's right to self-autonomy and accepting their decision to continue a specific form of risk-taking behaviour (such as drug-abuse, unprotected sex) whilst at the same time informing them of the consequences of their actions. Downie et al (1996) insist respect for individuals to determine how to live their own lives must remain paramount and suggest health promoters (in their role as health protectors) will need to guard against an unacceptable paternalistic and victim-blaming approach. These two points have relevance not only for the researcher but also for all agents involved in health promotional work within the context of the university community: the support service network teams, the Medical Centre's team and the University's mission statement with respect to health related codes of practice within the institution.

Ethical issues deal with ethical practice but, as a subject in its own right, ethics is socially constructed and governed therefore by the ontological, epistemological and methodological criteria of the paradigm upon which it is based. The ethical stance towards research practice varies across paradigms and Ryen (2004) recommends adopting a pluralistic model as a middle ground for resolving apparently different ethical codes of practice which extend not only across paradigms but also across cultures. Accordingly, and in keeping with a pragmatic approach, a pluralistic model has been demonstrated here (as referenced by the documented appendices) and as such was written into the design of the investigation from the outset.

Approval to proceed with this research was granted by the UH Ethics Committee in April 2006.

Naming the university

The substance of this research has been influenced by other research related to student mental health conducted within the HEI environment. Using the University of Central Lancashire as a case study, Dooris developed and established a strategy called the Health Promoting University Initiative (see Chapter 1). In so doing the University of Central Lancashire became one of the first universities in Europe to establish a practical framework to implement Antonovsky's conceptual neologism of salutogenesis – a positive approach to health encapsulated in the social model of health and the WHO Charters.

According to Dooris, a number of universities have since sought to apply the settings based approach to health promotion within the context of higher education.

Stanley and Manthorpe conducted a study at the University of Hull concerned with staff responses (academic and personal tutors) to students presenting to them with mental health problems. The findings highlighted the need to prepare and train academic staff (and other university staff) to deal appropriately and confidently with students' mental health difficulties. Stanley and Manthorpe's considerable contribution to this area of interest has added weight to the growing recognition of the increasing severity of mental health problems in undergraduates. Some of their recommendations on the provision of training and support for academic tutors and staff have been implemented by other universities, including at least two support services at UH.

Grant undertook the Leicester Student Psychology Project on the student body of the University of Leicester in the context of understanding issues and concerns that had the greatest impact on students' well-being. Grant's work added to the knowledge-base of student help-seeking behaviour, in particular with regard to named persons and services of contact. Roberts and Zelenyanszki (2002) surveyed the student population from both Westminster College and Imperial College, London, to ascertain the consequences of financial problems on students' mental well-being. Their findings supported evidence produced by the National Union of Students.

The above named works are by no means an exhaustive list of the research undertaken within the field of student mental health. What these examples highlight however is the fact that the named researchers conducted the research on their own student body. Naturally what applies to one HEI does not necessarily apply to another but there are common factors to all universities (in particular because the mental health of the student population mirrors the declining mental health of the non-student population) and the findings of one study might well be of benefit to another. Certainly, the universities named here have complemented the work of each other, adding to the development of a broader, more complete picture of a multifactorial problem in a complex environment.

Having critically reviewed the above mentioned publications, a discernible gap in the knowledge-base was noted. What this current study hopes to contribute to the cannon of named works of research in this field, is *'the student perspective'* on matters appertaining to their mental well-being in a settings-based environment. In particular it aims to encourage other HEIs to pursue a salutogenic approach to health promotion.

Importantly, Yin (2003), too, is in favour of naming the case. He concedes there are times when the case study and its informants should not be identified, such as when the research is on a controversial topic or when anonymity serves to protect either the 'real' case and/or its 'real' informants. On the matter Yin (2003) remarks:

> "First you should determine whether the anonymity of the individual alone might be sufficient, thereby leaving the case itself to be identified accurately" (p. 158).

Yin further stresses, however, that 'case' anonymity is not to be considered a desirable choice. Not only does it eliminate some important background about the case but it also makes the mechanics of composing the case difficult. The cost of undertaking such a procedure, he warns, should not be under-estimated.

Permission to name the university in this study was sought and granted by the Vice-Chancellor in April 2008.

The next chapter covers the methods of data collection (and the justification thereof), a description of the execution of these undertakings in discrete phases and also the sampling issues as related to each method employed.

Chapter 4

Methods of Data Collection and Preparatory Steps for Data Analysis

Significant features of a flexible design (according to Creswell 1994) include the use of multiple data collection methods, a rigorous approach to data collection and data analysis, and a detailed description about how the data are collected and summarised.

This chapter firstly provides a critical appraisal of multi-method data collection, justification of the methods chosen, detailed accounts of the execution of each stage and the steps taken to prepare the resultant data-sets for analysis and interpretation.

According to Brannen (2004), a multi-method strategy will need to employ a variety of samples, methods of data collection and types of analysis to address different aspects of the research question or subject area, to allow for different levels of knowledge and understanding. Notably, Brannen suggests ontological and epistemological assumptions and theoretical considerations are highly relevant to the choice of research methods and may result in the use of methods which have traditionally arisen from either quantitative or qualitative paradigms. Brannen further argues the old assumption that methodology must be inextricably linked with methods - that a quantitative study must only use typically quantitative methods (such as surveys or experiments) or that a qualitative study must only use observations and in-depth interviews - is now totally out-moded. She adds that pragmatists have long argued a false dichotomy existed between qualitative and quantitative approaches and current thinking encourages researchers to make the most efficient use of methods from both paradigms in understanding social phenomena. Both realists and pragmatists (who wish to characterise what they are doing as scientific) accept there are fundamental differences between natural and social phenomena. In particular, this means different methods need to be used for different subject matters. This was famously expressed by Bhaskar (1978), who said:

> "one can no more set out to experimentally identify the causes of the French Revolution than one can contemplate interviewing a gene" (p. 30).

A major strength of the case study data collection process, claims Yin (2003), is the opportunity it provides to use many different sources of evidence. This is supported by Robson (1999):

> "case study is a strategy for doing research which involves an empirical investigation of a particular contemporary phenomenon within its real life context using multiple sources of evidence" (p. 178).

Yin (2003) also expounds the view that case studies can be based on any mix of quantitative and qualitative evidence. For example, he suggests a case study data collection method can be built into the research design along the lines of a formal survey to produce quantitative data as part of the case study evidence. This type of data collection method would follow the sampling procedures used in regular surveys and would be analysed in a similar manner. The difference, emphasises Yin (2003), would be in the survey's role in relation to other sources of evidence; that is to say it would amount to only one component of the overall assessment.

In fact, Yin (2003) proposes studies using multiple sources of evidence are rated more highly in terms of their overall quality, than those that rely on single sources of data. Moreover, by using a mixture of data collection methods in an inclusive and pluralistic fashion, much less pre-specification takes place as the design evolves and develops in line with the research progress, as befits a flexible design. Silverman (2000) further maintains good quantitative research is often preceded by good qualitative inquiry and he believes it is important nowadays for researchers to be able to deal competently with data derived from both approaches. For instance, Silverman (2000) suggests qualitative methods (such as in-depth interviews and focus group interviews) can be used to provide a description and understanding of a situation or a behaviour, in order to discover the most comprehensible terms or words to use in a subsequent survey questionnaire. Typically, then, a combined method study is one in which the researcher uses multiple methods of data collection and analysis, drawing on both qualitative and quantitative data collection procedures, where appropriate. The methods of data collection used in this study were focus group discussions, interviews and a survey.

Multi-method research is also concerned with ways in which the qualitative and quantitative elements of the study are introduced into different phases of the research process. Brannen (2004) says when researchers work with different types of data within the same research project, the way they use these data will vary according to the phase or aspect of the research in which the researcher brings the different datasets into play. In this investigation, the dataset emanating from the qualitative focus-group interviews has informed the design of the self-completed questionnaire in the second quantitative phase of the study (see Appendix 17). Creswell (1994) also proposed mixed method studies are useful in bridging the 'micro' and the 'macro' to become an interface for both perspectives. The informal interviews conducted with support service personnel created such an interface between the micro aspect of the study (individual student's views gained

from the focus group discussions) and the macro (the policy decisions of the collective), such as the university's key relevant support services; these being the Counselling Service, the Disability and Equality Unit and the Students' Union - as well as the formal interview undertaken with the lead representative of the university's Medical Centre.

Using qualitative evidence: Addressing the perceived threat posed to scientific rigor.

Clearly each method of data collection has its strengths and weaknesses and careful consideration has been paid, not only to choosing the most applicable method but also with regard to addressing the criteria of scientific rigor. Of note, Silverman (1993) proposes qualitative research has long struggled to gain acceptance in the research world largely because positivist scientists have argued qualitative practices lack the all important criteria of scientific rigor, for the reason that qualitative research deals with subjective experiences of people in specific contexts - the products of which could be said to be merely an assembly of anecdotes and personal impressions. Quantitative methodology, on the other hand, is represented (for example) by randomised controlled trials with their focus on hypothesis testing through experimentation.

Robson (2002) concedes the main difficulties with qualitative data are with respect to researcher bias and also within the sphere of data analysis. Another criticism of qualitative research findings is that they pertain only to the limited setting in which they were obtained, from which no generalisations can be made, and which are therefore *not transferable* to another sample population. Greenhalgh and Taylor (1997) argued this is essentially true of any methodology. They also suggest that although an undoubted strength of the quantitative approach lies in its reliability, the strength of qualitative research lies in its validity, or in their words 'closeness to the truth'. They (Greenhalgh and Taylor) believe this is especially true of a multi-method approach that includes qualitative methods, as these are more likely to touch the core of what is really going on. In his support of flexible design studies, Robson (2002) argues multiple methods provide a more complete picture, for although fixed design studies establish relationships (and the consideration of a wider audience) they are thought by many to be weak in establishing the reasons for them. Furthermore, Greenhalgh and Taylor (1997) suggest the credibility factor of qualitative data can be enhanced by including pertinent verbatim quotes from interviews - though they stress these should be indexed so that they can be traced back to source.

Ensuring rigor and a scientific approach

In the last chapter I justified my decision on undertaking this study within Yin's 1994 and 2003 accounts of case study, in particular because his account was presented as a strategy within which to follow a protocol commensurate with scientific rigor. The terms proposed by Lincoln and Guba (1985) as being more appropriate for the tests of assurance with regard to qualitative methods (credibility, transferability, dependability and confirmability) were rejected in favour of using Yin's (and Creswell's 1994) use of the terms reliability, validity and generalisability.

Creswell (1994) says threats to validity in the qualitative paradigm relate to inaccuracies or incompleteness of the data. In the first phase of the study, this point was addressed by the following:

> **Data recording methods**. Creswell maintains most common pitfalls with qualitative data are associated with transcription errors. In Phase I of this work, the audio-tapes were transcribed by an independent source to guard against researcher bias and to enhance internal validity. Additionally, I listened to the tapes repeatedly in order to deepen my understanding of students' responses. This involved paying attention to periods of hesitancy, the tone of voice, participants' stress and intonation – all of which can be missing from written transcriptions.

> **Interpretation** : The main threat to validity is often associated with not considering alternative explanations or understanding of the phenomenon(a) being studied. This can be countered by actively seeking data not consonant with the theory (negative case analysis, Miles and Huberman 1994). Instead, I used another of Miles and Huberman's recommended procedures – that of cross-case analysis, also recommended by Yin (1994) (For examples of this practice, see Appendices 14 and 15).

Lincoln and Guba (1985) discuss other threats to the validity of flexible designs as being reactivity, respondent biases and researcher biases. These issues are discussed later. In summary, Lincoln and Guba (1985) stated reliability in flexible designs involves being thorough, careful and honest in carrying out the research, detailing what has been done and leaving this open to scrutiny by others.

Problems with multi-method data analysis

Brannen (2004) warns that the resultant datasets of multi-method studies cannot be linked unproblematically and she says it is important to consider the most suitable approach with regard to the interpretation and validation processes. In fact, Hammersley (1996) suggests there is a tripartite classification of the ways in which researchers employ different types of data in the processes of interpreting their data. These can involve either: 1) *Triangulation* (where two or more methods are used to corroborate different dataset findings and/or to test one source of information against another; for instance one type of data - usually quantitative - is used to corroborate another type, typically qualitative), 2) *Facilitation* – the collection of one type of data in order to facilitate the design of another and 3) a *Complementary* approach when different sets of data are employed to address different but complementary aspects of an investigation.

Reflecting on the most appropriate way of combining the qualitative and quantitative datasets in this work, all three of the above approaches were considered. Hammersley (1996) maintained the main reason for using triangulation is when the results of (say) a large scale survey, focus-group interviews and a period of observation are compared for features of convergence. Yin (2003), too, appears to favour triangulation in the evaluation of multi-method case studies. He discusses four types of triangulation : data sources (data triangulation), different evaluators (investigative triangulation), of perspective to the same dataset (theory triangulation) and of methods (methodological triangulation). Notably, he describes these conditions as being in pursuit of corroboration.

However, because the qualitative datasets emanating from the first phase of this study were not intended for corroborative purposes but rather to facilitate the survey design undertaken in the second phase, the process of triangulation was rejected from the outset. The second approach, proposed by Hammersley, *(facilitation)* was considered more relevant to this phase of the study. Brannen (2004) defined the specific usage of *facilitation* as:

> "….when qualitative interviewing methods are first employed in preliminary pilot work in order to help design a large-scale pre-coded survey" (p. 314).

Furthermore, Brannen proposes multiple methods can also be used in a complementary fashion to enhance interpretability. For example, a qualitative account may be the major outcome of a study but it can be enhanced by supportive quantitative evidence used to buttress and perhaps clarify the account. This third *(complementary)* approach can also

extend to awarding equal weight to the datasets in the analysis and presentation of the material, since they proceed as separate but parallel exercises. Indeed, all three datasets produced here present valid and discrete findings in their own right. Most importantly, Brannan strongly advises that datasets emanating from a multi-method study should be treated as complementary entities and not as compatible or corroborative entities. Accordingly, the datasets resulting from the different methods of collection in this investigation have been used *to facilitate and complement* analysis and interpretation, rather than to corroborate it. Brannen (1992) further proposed that datasets analysed according to a complementary approach add scope and breadth to a study, as they can produce both overlapping *and* different facets of a phenomenon which emerge developmentally; in particular when the first method is used sequentially to help inform the second.

Justification of data collection methods and procedures

Data collection has been undertaken in two discrete phases. Phase 1 deals with qualitative data collection methods (informal interviews, the focus group discussions and a semi-structured interview) and Phase 2 deals with the quantitative survey. Table 5 below summarises the data collection methods, recruitment methods, participant numbers and response rates.

Table 5: Data Collection: Methods, Sources and Responses

Data Source	Method of Collection	Recruitment Method	Number of Participants	Response Rate
SUPPORT SERVICES Students' Union Equality & Disability Unit Counselling Service University Medical Centre *permission to interview other Medical Centre staff other than Lead Practitioner was not forthcoming.	Unstructured interviews Unstructured interviews Unstructured interviews Semi-structured interview	Direct contact Direct contact Direct contact Direct contact	1 1 1 1	100% 100% 100% *
STUDENTS	Focus Groups Survey	Advertising Internet *Multi-method*: Advertising Internet Direct contact	51 806	Approximately 25% of initial response 100% (Quota sample)

Decisions on the choice of methods are discussed below, as is the detailed execution of each stage and finally the steps taken to prepare the data for analysis.

Phase 1: The Collection of Qualitative Data

The collection of data from student support services and the student body

As has already been established case study research takes place in context. Yin (2003) suggests this implies reference to specific policies, management strategies and services, as well as the physical environment of 'the case'. To this end, official aspects of the macro perspective are considered here in relation to some of the support services most involved in students' mental well-being. It is acknowledged that the student support services network comprises a number of different agencies, each with their own focus. However, in keeping with the aims of this research, the following areas of student support have been considered in more depth. Informal interviews (for the most part unstructured) were conducted with members of the Students' Union, with the Equality and Disabilities Unit and the Counselling Service, and for reasons explained on page 59 a formal semi-structured interview was undertaken with a Medical Practitioner Representative (MPR) at the University Medical Centre (UMC).

The Interview

According to Silverman (2000), the face-to-face interview is a flexible and adaptable way of providing rich and illuminating material, a special insight into the subjective voice and lived experience. The purpose of the interview is to interact with a specific person (or people) in order to understand their experiences, opinions and ideas or, as in this instance, to ascertain information regarding the role and remit of these support services in their pursuit of students' mental well-being. Interviews can be structured, unstructured and semi-structured. Structured interviews consist of predetermined questions with fixed wording usually in a pre-set order, such as those used in interview based surveys, whereas unstructured interviews have no set questions, just a general area of concern whereby interviewers let the conversation develop within this area.

However, Pope and Mays (2000) claim no interview is entirely devoid of structure; if it were the data amassed would probably be irrelevant to the research question. Semi-structured interviews have predetermined questions but the order may be modified based on the interviewer's perception of what seems most appropriate in the context of the conversation. This type of interview is most suitable when the researcher is familiar with the boundaries, the domain and the components of a phenomenon but is unable to anticipate all the possible responses. As the aim of qualitative research is to discover the

interviewee's framework of meanings, the interviewer needs to remain open to the possibility that variables may emerge that are very different from those expected at the outset.

Semi-structured interviews, therefore, are conducted on the basis of a loose structure consisting of open-ended questions that define the area to be explored and from which the interviewer may diverge in order to pursue an idea in more detail (Pope and Mays 1995). Because semi-structured interviews are not as rigidly devised as the completely structured interview, they permit the interviewer a certain amount of scope with regard to how the interview is conducted. In addition, it allows for the possibility of clarification with question difficulty or ambiguity (Yin 1994 maintains this can be avoided if the questions have been well devised), and although the semi-structured interview can be time-consuming and costly it has earned its place as the respected middle ground between the self-completed questionnaire (based on a fixed sequence of mostly closed questions) and the unstructured interview with its fluid agenda and open-ended questions.

Interviews can be used as the primary or only approach in a study yet they can also lend themselves to use in combination with other methods in a multi-method approach. Importantly, the semi-structured interview is widely used in flexible designs (Robson 2002). It was my choice as the method of data collection when interviewing a medical practitioner at the University Medical Centre. The same considerations were brought to bear on the format of the interview as were taken into account for the focus-group interviews – these being question compilation and matters appertaining to interviewer techniques and pitfalls.

Yin (1994) stressed considerable attention needs to be placed on question wording. Posing multiple-barrelled questions (asking more than one thing in a question), use of jargon or ambiguity of content, leading or biased questions should all be avoided. The interviewer's task is to draw out all relevant responses to encourage the inarticulate or shy and to be neutral towards the topic while, at the same time, displaying interest. The interviewer should facilitate without overly directing the interviewee's responses. Interviewers need to work at establishing a suitably relaxed and encouraging relationship which communicates trust, reassurance and even likeableness (Yin 2003). Attention focused on interviewing practices boil down to rapport and neutrality. Yin (1994) says if interviewers do not achieve neutrality they will unduly bias the interviewee's account and contaminate the data.

Above all, a competent interviewer will need to apply counselling skill techniques, such as active listening, paraphrasing, probing (a device to encourage the interviewee to expand on a response), prompting (which involves encouraging the respondent to produce an answer) and summarising. Summarising is particularly useful in picking up on any misperceptions on the part of the interviewer of what the respondent has said and by the same token any misunderstandings on the part of the respondent of what was being asked.

However, it is also acknowledged face-to-face techniques raise pertinent issues of interviewer bias. One example is the way in which responses are coded and recorded, the hidden dangers of selective hearing and the tendency for interviewers to record answers that support their own preconceived ideas and views. Tape-recording the interview has obvious advantages in avoiding these pitfalls and in addition will pick up on and stimulate interpretation of speech inflections, tone of voice and potentially significant pauses during conversations. However tape-recording can be intrusive and inhibitive to subjects and such a method will not pick up on respondents' body language which can provide vital clues on inconsistencies witnessed by the interviewer between verbal and non-verbal responses. Such inconsistencies might prompt the interviewer to reflect on the possibility of an insincere response.

Because face-to-face interviews are interpersonal events there is a need for the interviewer to be self-aware especially with regard to inadvertently influencing the interviewees by way of mannerisms, speech, social class and most importantly approach. My own style has been influenced by the Humanistic tradition which endorses a positive and optimistic view of human nature and heeding Rogerian core conditions of empathy, congruence and unconditional positive regard (Rogers 1961). Moreover, the Person-Centred (Rogerian) approach assumes a phenomenological standpoint whereby individuals are seen as acting according to their own subjective awareness of themselves and the world. In particular I was alerted to the danger of bringing to the interview personal prejudices and attitudes and in psychoanalytical terms the issues of transference (whereby the interviewee projects onto the interviewer their feelings, fears and attitudes derived from their own experiences) and counter-transference where this process is reversed.

Execution of data collection from the macro perspective: Interviews

The informal interviews took place over a period of several months and were initiated by personal contact with the named support service personnel via e-mail communication shortly after commencement of the study. On first meeting each member of staff, the aims and objectives of my research were made clear to them. Their involvement in assisting with building my knowledge and understanding of their specific roles and remit within the support network system was voluntary. I expressed my appreciation of their input and kept in contact with each of the departments throughout the duration of the research. The content of each of the interviews was recorded from note-taking, and a variety of other information sources, such as student handbooks, leaflets and websites. The reporting of these data is undertaken in the next chapter.

In similar vein, the university's Medical Centre was informed of the nature of the study by letter shortly after the research was commenced. This letter included a request to interview members of the practice. The Medical Centre was also kept informed as to the progress of the study, in particular with regard to issues pertinent to the practice, arising out of the preliminary focus-group findings. The requested interview with a member(s) of the practice team was arranged in advance over the telephone with the practice manager, who at the same time informed me that the interview would be conducted with the lead medical practitioner (MPR) of the practice. This was because the lead practitioner represented the practice's collective policies which were common to all practice staff and bound by contractual imperatives. It was further conveyed to me that my request for an interview of one hour's duration would need to be reduced, due to pressure of work commitments on the lead practitioner's time.

The rationale behind the interview questions was based on specific issues and themes that had been brought to light during the literature review, as well as from my background in medical sociology and twenty years' experience in general practice (see Appendix 11). The actual interview guide questions (see Appendix 10) were submitted to the appropriate LREC. I attended the LREC hearing and permission was duly granted to proceed with the interview.

The reduced time allowance, however, necessitated my reducing the number of questions posed and a separate sheet was devised to incorporate one of these questions (Appendix 10b). This was left with the MPR for return in an SAE and was duly received completed.

All appropriate ethical considerations were attended to: a consent slip was signed prior to the interview and the GP was informed of his right to withdraw from the interview at any time. A letter, thanking the MPR for his participation in the research, was sent shortly after the interview had taken place.

On reflection, it is possible tape-recording this interview was perceived to be intrusive and, perhaps, with hindsight I should have followed Yin's (2003) advice with regard to this method of data recording. Although he concedes tape-recordings produce a more accurate rendition, he also warns against using this method:

> "if the investigator is clumsy with mechanical devices to the extent that the recording causes distraction during the interview itself" (p. 92).

Certainly, I had experienced difficulty setting up the recording equipment, as I had not had the luxury of visiting and assessing power point availability and the positioning of tables and equipment prior to this interview, compared to the focus-group interviews. I was also acutely aware of the time constraints and keen not to allow the interview to over-run the agreed length. This had undoubtedly presented a limitation with regard to the questions posed; indeed I had omitted to pose one of the questions (Question 8) listed on the Question Guide (see Appendix 10). Moreover, I was not on 'neutral' territory, the interview being conducted in one of the consulting rooms within the University Medical Centre.

Execution of data collection from the micro perspective: Focus Groups

> "The opportunity to have a voice in the topic of study makes participants feel important and empowered" Morse (1994, p. 240).

The definition of a focus-group, according to Morse (1994), is the use of a semi-structured group session moderated by a group leader and held in an informal setting; the purpose of which is to collect information, (in a single session), on the personal experiences, opinions, beliefs and perceptions of the group members related to the designated topic. Although focus-groups may provide group members with a sense of social support this is not their intended function, the main objective being to stimulate discussion through the dynamic processes occurring within the group which, through analysis and interpretation, uncover the meanings and norms which underlie the group's answers.

Bloor et al. (2002) also support the view that focus-groups provide more than merely the generation of information and the collection of views. They can, Bloor et al say, yield data

not only on the meanings that lie behind such views but also shed light on uncertainties and ambiguities. In everyday life, the normative order underlying behaviours and opinions is rarely articulated and a group setting can provide prompts for individuals to respond to the views of others, to challenge what is being said and to express subjective feelings. Bloor et al. (2002) believe focus-groups work best for topics that people *could* talk about in their everyday lives – but significantly do not. In essence, the focus group is a socially legitimated occasion for participants to engage in "retrospective introspection" and for the group leader to attempt to tease out previously taken-for-granted assumptions.

The development of the focus group technique was first credited to the research programme of Merton and colleagues in the mid 1940s (Bloor et al. 2002). Underlying this technique is the rationale that with proper guidance from the focus group leader group members can describe the rich details of complex experiences and the reasoning behind their actions, beliefs, perceptions and attitudes. They are therefore ideal if thinking and feeling and not just behaviour is needed, as the group dynamics will be a synergistic factor in bringing the information out. Moreover, the promotion of a safe environment can considerably enhance the quality of the data elicited and in particular the perceptions and opinions of individual group members are often enriched through the vehicle of group interaction.

Focus-groups have provided data for highly influential studies in a range of social sciences. They are often used in an exploratory way, when researchers are not entirely sure what categories, links and perspectives are relevant. Seale et al. (2004) say they should be considered for: needs assessment, to explore a new concern, or to obtain item generation for questionnaires. Silverman (2000) commented that this method of data collection has become popular in the caring professions where complex issues are best explored through a qualitative approach, and in particular in health research where it has been successful in providing insight into beliefs and attitudes that underlie behaviour as, for example, in issues relating to patient compliance.

According to Bloor et al. (2002), the most important characteristic is the nature of the group itself as expressed through the interaction of the members, the flow of the discussion and the evolution of the experiences described. A special feature of the focus-group is that one group member's response will elicit another response from another member and this is the great strength of this technique as a means of data collection. Group members are interactive dynamic suppliers of information and participation is interactive in the sense

that a member's contribution exists in a social context and is affected by previous statements or other factors. This was apparent during analysis of the data, as has been demonstrated on pages 155-156, 161-162 and 164-165.

Marshall and Rossman (1999) propose this method of data collection assumes that individuals' attitudes do not form in a vacuum. They say people often need to listen to others' opinions and understanding in order to form their own. Consequently, they say one-to-one interviews may be impoverished because the participant may not have reflected on the topic and feels unprepared to respond.

In effect, focus-group work may be built into a multi-method study design at any stage. Morse (1994) proposes focus-group discussions have their uses at the beginning, middle and end of projects. For example, they can be used as an adjunct to other methods (especially in pre-pilot work), as an alternative to in-depth interviews in the initial phase of a large survey study, as an extension of a survey, as an interpretative aid to survey findings or to inform the development of the later stages of the study. In this study the focus-groups *facilitated* the survey design. Importantly, focus-groups provide a forum for volunteers to play an active role in the research process by way of deepening and enriching the researcher's understanding of the topic.

This method of data collection is entirely compatible with both the qualitative paradigm assumptions and those of case study as it is socially oriented, taking part in a natural real-life atmosphere (as opposed to having experimental surroundings) and allowing the researcher/facilitator the flexibility to explore unanticipated issues as they arise. Positive features are those gained from the rich experiential knowledge of the individual members as expressed through the group dynamic.

However, Bloor et al. (2002) suggest the group dynamic is not only affected by the group chemistry but also by the personal needs of its members and the skills of the leader. As a result, the interactional nature can also have negative as well as positive features due to powerful psychosocial factors. These include: first impressions of other group members, prejudices and preconceptions, both of which can greatly affect contributions made by the individual to the group discussion and the behaviour of individual members towards each other. These processes (sometimes called reactivity or respondent bias) represent major pitfalls of the focus-group method because they increase the potential for censoring and conforming. In conforming, group members may adjust their contribution to be in line with

the perceptions of other group members and in some circumstances, a genuine response may be inhibited on account of a type of censoring due to lack of trust either towards other group members or the facilitator. Group members might also conform or censor their input in order to be socially acceptable, or they may also reframe their experience in the light of the ongoing dialogue. Group cohesiveness, age, the socioeconomic status of members, and the effect of the facilitator on the group are all additional factors.

Notwithstanding these potential pitfalls, Marshall and Rossman (1999) believe the results of focus-group discussions have high face validity because the method is readily understood, the findings appear believable and they can increase the sample size by interviewing more people at one time. Morse (1994) suggests one objective of using focus-groups might be to perform triangulation, that is to use the data generated by the focus-groups to compare with other data on the same topic, gathered by other methods, in order to replicate the researcher's findings. Again this was not the intention here, the stated purpose of the focus-groups being to *facilitate* the development of the survey. However, the focus-group data-set was also viewed as an 'equal' piece of research in its own right, *complementing* the other two data-sets in interpreting all the data.

The above comments, I believe, justify the use of focus group discussions as the vehicle of qualitative data collection undertaken in this work.

About the Focus-Group Interviewer/Facilitator.

According to Yin (1994), qualitative case study is characterised by the researcher spending time on site, being personally involved with the operation of the case and reflecting on the meaning of what is going on. Another feature of the case study, Yin says, is that the actual data collection should not be 'farmed out' to an assistant because of the need for the continuous interaction between the theoretical issues being studied and the data being collected. He adds, the main way to stay on target is to understand the purpose of the case study and to know when a deviation is acceptable or even desirable and this is not always possible if 'others' are used in the interviewer role. Seale et al. (2004), on the other hand, say it is perfectly acceptable for the leader of the discussion group to be someone else other than the researcher, but I nevertheless followed Yin's advice here and undertook all the focus group facilitation myself in order to safeguard scientific rigor, especially the reporting of detail for scrutiny by others.

The skill of the focus-group leader is vital to a successful outcome of the discussions. He/she will endeavour to create a 'permissive' environment, asking focused questions in

order to encourage discussion and the expression of differing opinions and points of view. This is achieved through the careful eliciting of information relevant to the subject area(s). The use of counselling skills are invaluable in achieving this, especially with regard to covering pertinent ethical requirements, such as informed consent and confidentiality, as well as the transmission of trust and empathy. Macnaughten and Myers (2004) agree empathy is essential in getting participants to voice what is distinctive about their own view.

The session introduction should include an explanation of the purpose of the study, the planned use of and storage of the data, and the conditions of confidentiality. Facilitators should lay down ground-rules at the outset, requesting that all participants respect and keep confidential each other's views. All these issues were fully addressed. Interestingly, Morse's (1994) view is that formal written consent is not usually required prior to the session because participation is voluntary and taking part constitutes consent. However, in order to comply with UH requirements, written consent was secured before the commencement of this part of the study. Seale et al. (2004) also say it is important to make it clear from the outset that there are no correct answers and respondents should be discouraged from formulating answers they think the facilitator might approve of. Indeed the facilitator should mention he/she is keen to hear a range of different viewpoints (all of these points were meticulously covered; refer to Appendices 6 and 22).

Another craft of a focus-group facilitator is to provide sufficient structure to ensure the group continues to address the topic whilst not inhibiting the natural flow of group interaction. The session structure comes from the guideline questions developed by the researcher and the leader's style of facilitation. The amount of structure and leader guidance varies with the preferences and professional experiences of the researcher/facilitator who will monitor the group interaction and adapt plans accordingly. There are, according to Bloor et al. (2002), two main facilitator styles: The interventionalist style which raises topics directly, calling on some participants and holding off others, cutting off lines of talk that seem unproductive, challenging some apparent contradictions or vagueness. (For example, a group may be moved on to the next question if they appear stuck on one aspect or if the group members drift off target). A non-interventionalist leader, on the other hand, lets participants talk on, even when they wander from the topic guide. Although my own style was undoubtedly more interventionalist than non-interventionalist, I certainly did not practise "holding others off" in the sense that some participants were prevented from having their say. On the contrary, I was most keen

to involve all participants willing to take part, even though I was committed to keeping responses relevant to the topics under discussion.

Nevertheless, the qualitative assumption of 'researcher as instrument' makes for the risks involved. According to Seale et al. (2004) the charge of interviewer bias has been levelled particularly at non-standardised interviews. An area for concern, with regard to any type of interviewer-led means of data collection is the effect of the interviewer on both the responsiveness of the respondents and the manner in which the data are gathered, as both these factors will affect validity and reliability. Reactivity is taken as being ways in which the researcher's presence may interfere in some way with the setting or the behaviour of the people involved. Researcher bias refers to the assumptions and preconceived ideas which might be brought to the research setting and which could adversely affect interviewees' responses. Facilitator self-awareness, in particular, is absolutely crucial to a successful outcome, as interviewers may inadvertently bring their own prejudices to the sessions. As a trained youth worker, qualified in counselling skills and working with young people, I was very conscious of these issues and took steps to limit these potential pitfalls.

In addition, Merton and Kendall (1964) advise interviewers to avoid misdirected probing and prompting, and to keep guidance and direction to a minimum. As the facilitator's role is specifically to encourage group members to respond to each other, it is important for the facilitator to be alerted to comments that contradict previous comments. The facilitator needs to continuously weigh the potential to be gained by following leads from the group which might sometimes mean deviating from guideline questions. Moreover, although the facilitator should encourage responses, she/he should not endorse or agree with comments but remain neutral through the monitoring of his/her own non-verbal behaviour.

All these points were attended to. (It is to be noted the 'Prompt Sheets' were not used until students had responded freely on the specific subject topic, see Appendices 7c, 7d, 7e,7f). In particular, I took care to provide an atmosphere in which subjects felt comfortable enough to freely express their views. Most notably, I heeded Bloor et al's warning never to ignore the cultural context in which the interview takes place. The demographic profile of the focus-group participants was indeed culturally diverse (see Appendix 20) and importantly differences in views and experiences proved to be a very significant finding of the data analysis. Particular attention was paid to the fact that all participants were treated equally, made to feel valued, and were welcomed into a 'safe' environment.

Even if the group discussion is going very well, Bloor et al. (2002) recommend that it should not last longer than 90 minutes. Finally, a leader should perform a plenary part to the session by paraphrasing and summarising points made and opinions expressed to check understanding. This provides an opportunity to clarify and correct incorrect data (in keeping with good counselling skills). Debriefing could include a short recapitulation of the purpose of the session and the reiteration of matters pertaining to confidentiality. Bearing students' welfare in mind (and in compliance with Ethics Committee approval) the focus-group sessions were restricted to one hour's duration. Because they all went so well and did not finish before the allotted time, the debriefing part of the sessions was not as complete as it might have been at every session. Nevertheless, students were always thanked for their contribution and made aware of the Counselling Service's brochure, (copies of which were placed on the table in front of them), in case they had been affected by something mentioned during the session.

Examples of how I strove to overcome bias to enhance internal validity included: having the data transcribed verbatim by an independent source, not being selective when analysing data, (that is not looking for data to support pre-conceived theories or views), using the same room, same time of week for each session and attending to self-awareness issues.

The focus-group sample

As qualitative case study researchers do not aim for a representative sample of a population, but rather try to generate discourse that will extend the range of understanding concerning a specific topic, they recruit groups that are defined in relation to the particular conceptual framework of the study. Consequently, members of the group should be selected according to common experience that relates directly to the research topic. In this case it was the shared experience of university life, the use/awareness of the support services or problems with depression, loneliness, or befriending another student with mental health problems. In keeping with a salutogenic approach it was as much about defining what keeps undergraduates emotionally robust as it was about identifying factors that cause emotional distress. Moreover, identifying the factors that keep students mentally robust serves the purpose of strengthening the avenues of support that probably already exist.

Bloor et al. (2002) comment: where focus groups are aimed at developing questionnaires, participants should be approached from the same sample frame as those who will be approached for the survey. Accordingly, the target samples for both phases of the

investigation, involving the focus-group interviews and the survey, were derived from the student body of the University of Hertfordshire. Robson (2002) adds, decisions about the sample will also reflect epistemological concerns about the nature of the data being collected, as well as more practical issues regarding ease of access and recruitment.

The size of the individual groups is important. Smaller groups reflect a more natural setting for discussion and allow sufficient time for input by each group member. Also, with a smaller group the leader can more easily manage the group dynamic process and give equal attention to each member. The usual size of the group ranges from between 5 to 12 per session (Bloor, in fact, maintains the optimum is 6-8). However, really small groups could result in a question and answer session rather than a discussion which gains in its own momentum. A purposive sample of 50 self-selecting UH undergraduates was decided upon. Although approximately eight to ten students were invited to each session, in real terms the size of the groups was determined largely by however many students turned up on the day (see Appendix 20, Demographic Profile).

The Recruitment Process

Most aptly, Dickert and Grady (1999), say successful research will depend on the ability to recruit research subjects. My first attempt at recruitment of a non-probability, self-selecting sample for focus group participants was by way of an advertising campaign which consisted of specially designed posters, flyers and table-top invitations (see Appendix 4) which invited volunteers to contact me for information and details of venues and times. I designed these myself but had them professionally printed. Mindful of preventing bias by placing these in areas frequented only by certain Faculties, the publicity material was to have been displayed on all three campuses in places frequented by students from a variety of Faculties, such as refectories, learning resource centres, Students' Union bars (for the table-top invitations and flyers), and prominent notice-boards near these sites for the posters and flyers. Not only had this method been approved by the Ethics Committee but I had also written to all the Deans of Students and Heads of Faculties informing them of my research and seeking their permission to display these items in the vicinity of their Faculty. In order to encourage students to participate the advertisements included the offer of lunch.

My first attempt at recruitment for the focus-groups failed. This was thought to be due to faulty distribution of the advertising literature across all three campuses. Due to reasons of time constraint and the enormity of the task, I had accepted a member of staff's offer of

help to strategically distribute the 40 posters, 1,000 flyers and 50 table-top invitations on all campuses. However, after some lapse of time and having received only two responses, it became evident the advertising material had not actually reached the other campuses and those displayed on College Lane had been confined to one corridor. The two respondents from this first attempt were replied to individually and subsequently offered places when, after the second attempt, demand to run the focus-groups was sufficient.

Reflecting on this unsuccessful attempt to recruit focus group participants, I conducted a computer search for similar research cases and came across a paper by Dickert and Grady (1999) whose work had been conducted within a clinical setting. According to Dickert and Grady (1999) the tension which exists between the need to recruit subjects and the obligation to offer certain types of protection has made recruitment an ethical challenge. One of the ethical issues concerns the type of inducement investigators should use to recruit subjects. The predominant concern is that payment of subjects might represent undue inducement and in order to counteract such concern, they considered three different models of payment: the market model, the wage-payment and the reimbursement model. Relating this paper to my own study, the logic behind the wage-payment model (payment being set according to the labour market) seemed appropriate, due to the well documented financial plight of students and the fact that many students are compelled to work long hours off campus. Nevertheless, it remained a concern that paying students could mean volunteers did not actually care about or support the goals of the study. However, Dickert and Grady (1999) say adopting the wage-payment model reduces the concern over undue inducement because most potential subjects are likely to have other options for earning similar amounts of money but they choose to participate in research.

The Faculty's Marketing Department was also consulted. Members of the marketing team drew on their own experience and suggested an on-line approach to recruitment, as students spend so much time on the computer. The university's visual learning platform (Studynet) was considered to be a suitable vehicle of student recruitment and this decision necessitated a second application to the University's Ethics Committee for permission to attract student participation in this way and also to recompense students for their time. The Ethics Committee's approval was subsequently received but with the stipulation that students travelling from St. Albans to take part in the focus groups be offered an additional £5 as reimbursement for travelling expenses (reinforcing Dickert and Grady's reimbursement model).

The entries placed on Studynet, (under the two headings of: 'Support Services' and 'Events') retained the principle of self-selection by appealing to those with a genuine interest in the subject area, and proved to be successful (see Appendix 5). These entries produced a steady response until eventually the required sample number was achieved. Students making initial contact with me via my university e-mail address were replied to personally and sent the Briefing Sheet (see Appendix 6) which set out the ethical imperatives. Approximately 200 e-mail responses were recorded over this period. About half this number communicated interest in participating and they were then allocated on a first-come, first-served basis to the next scheduled focus group. Students were sent an allotted time and place to attend for the focus group, together with directions on how to find the room. Every effort was made to transfer students to another scheduled session if the initial time or date was not suitable. Of those respondents who said they would attend, approximately half (51) actually did so.

The decision as to when and where the focus groups were undertaken was based on Bloor et al's (2002) recommendations; these being: the chosen venue should be free from interruptions or surveillance and with no background noise. Furthermore, says Bloor, ambient surroundings are important, as is the provision of food which can help as an ice-breaker. This was certainly true. I had provided a variety of refreshments and used this time to full effect, introducing myself to the students, answering any questions they might have, and putting them at ease. Most notably Bloor et al. stressed accessibility of venue is also important to participants. This also proved to be of particular relevance here and arrangements were made through the appropriate departments to secure a room for the duration of these group sessions. However, for the first focus-group session the only available room had been very difficult to find, especially for those coming from the other campuses and this had resulted in only three students attending. Thereafter it was fortunately possible to secure a more accessible room for the remaining sessions and this alteration resulted in higher numbers per session.

Execution of the focus group discussions

In total eleven focus groups were conducted over a period of approximately three months. There was a hiatus in the proceedings due to the Easter vacation. Students were handed their remuneration at the onset of the discussion group, refreshments were provided on each occasion and prior to commencement of each session students were again verbally informed of their right to withdraw from the discussion at any time – without having to give a reason why. This was duly recorded on the tape-recorder and transcribed.

Participants were also assured of anonymity and that the tapes would be kept securely under lock and key for seven years, after which they would be destroyed. Students were handed a copy of the questions which were also articulated to them to take account of hearing impairment and reading difficulties (see Appendices 7a – 7g). All students were happy with the arrangements and not one student left before the scheduled time for the reason that they felt uncomfortable.

Every focus-group took place on a Wednesday afternoon at 2.00 and 4.00 pm, as this time was designated to sporting activities on College Lane and de Havilland campuses and the day being entirely free to law students at St. Albans campus. Hence the choice of Wednesday afternoons supported my decision to offer students payment, as it was quite possible some of the participants had given up working off campus to participate in the research.

Of the total 55 volunteers, four had to be turned away; two because they were post-graduates and not undergraduates – despite every communication stressing this point - and two because they had already participated in a previous session! The resultant 51 participants represented the focus-group sample.

Recording of focus-group data

Silverman (1993) maintained audio-recording is the obvious choice because verbatim transcriptions avoid pitfalls of inaccurate or selective transcribing though, as with every method of data collection, there are disadvantages. The main disadvantages are that recording the discussion proceedings can increase anxiety in participants and inhibit total honesty. For example, the informant may feel he/she needs to be "interesting or dramatic" and this can alter the account.

Notwithstanding this point, and after some deliberation, it was decided the benefits of tape-recording outweighed the drawbacks, especially as tape-recording of the discussion allows greater interaction during the interview than note-taking and because it provides a detailed account of the verbal interaction. Nothing is lost or overlooked as it might be in note-taking. It also provides the means of registering pauses, stressed or overlapping speech which can indicate emphasis or strength of meaning. Added to this is the benefit of repeatedly listening to the tape-recording which acts as a means of checking and refining analytical themes and picking up on any missed information, whilst simultaneously reading through a textual version of the interaction. As has been previously mentioned this aspect

formed part of my overall analytical process. (Students were informed in advance that the sessions were to be tape-recorded - see the Briefing Sheet, Appendix 6).

Furthermore, Bloor et al. (2002) refer to "indigenous coding systems" whereby the researcher, as facilitator, is exposed to the everyday language of the group - of considerable benefit when formulating survey questions. Focus-group data may thus provide a resource for survey designers as it may enable them to contextualise some pertinent survey questions, such as accessing everyday language of research subjects, so that the terms and/or phrases used in a subsequent survey are ones that will be understood by the sample population. This point was of particular relevance with regard to students' own definitions of terms associated with health and mental health and as such was incorporated into the Briefing Sheet of the Student Questionnaire (see Appendix 22, first paragraph).

Of note, Bloor et al say the collection and recording of self-completion data from group participants (such as age and sex) may be particularly important where focus groups are part of a multi-method research design – for the purposes of establishing how far and in what ways the focus group members differ from other samples generated by other methods in the design. For this reason, the recording of some relevant demographic information about students (that maintained students' anonymity) was written into the design of the study from the outset. Indeed, as Bloor suggested the collecting of unidentifiable demographic data can act as an ice-breaker and this was duly incorporated into the 'welcoming' stage of each session, together with completion of the 'Consent Slip' and the payment to students.

Data Collection Techniques

The objective of the focus-group is to stimulate discussion and, through subsequent analysis and interpretation, to understand the meaning and norms underlying the group's answers. To this end, Brannen (2004) says various 'aids' or techniques can be devised by the researcher, or adapted from referenced works. She says some researchers start with a clear theoretical framework (such as the literature review in this work), and then draft the topic guide to facilitate the groups so that the resultant discussion can be used directly in the writing-up.

Consequently, the facilitator's questions are an attempt to concentrate the group's attention and interactions on a particular topic, and this often occurs through performing a task or a focusing exercise. Bloor et al. (2002) believe the setting of focusing exercises gives the

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group impetus (as well as being very effective ice-breakers) and he encourages researchers to devise their own exercises, specifically tailored to the research topic. Bloor writes of ranking exercises, whereby the group is offered a list of statements and is asked to agree amongst themselves a ranking of the statements in order of importance to them. The ranking serves to illustrate the deep differences, along with some important similarities, in the opinions of different groups. Members of the group can be asked to rank each question according to a scale of: very important, important, not very important, not at all important. This idea was incorporated into the survey design with the use of attitude scales (see Questions 4, 10, 11, 14c, 17, 20, and 21 in the Student Questionnaire, Appendix 22).

Another of Bloor et al's (2002) recommendations is that researchers devise exercises that explore both the positive and negative aspects of the topic under review as this achieves a balanced, multi-faceted coverage of relevant issues. This idea was adapted to formulate the True and False Statements (see Appendix 7g). As a devise this not only proved to be very popular but it also provided the opportunity to present students with a referenced feedback sheet for their retention.

Vignettes are a different kind of focusing exercise. Vignettes are hypothetical cases or scenarios with particular features which make them suggestive of real life situations to respondents who are then asked what course of action should follow (Brannen 2004). Brannen writes extensively on this type of technique which she says is commonly used in both surveys and qualitative interviews. A vignette was incorporated into the focus-group discussion questions, (see "Scenario" in Appendix 7b). Again this device generated a considerable amount of animated discussion, the responses from which were incorporated into Question 16 of the survey (see Appendix 22).

Finally, the use of a flip-chart can function as an aide-memoir, as a vehicle for recapitulation or for a "brain-storming" exercise that opens up a multitude of avenues to explore. In this case, a flip-chart was used for the Prompt Sheets (see Appendices 7c, 7d, 7e, 7f). Due to the time constraints imposed by the length of the sessions, these were all prepared in advance and used repeatedly throughout the entirety of the sessions to safeguard internal validity.

Development of Guide-line Questions

Denzin and Lincoln (2000) state the purpose of a case study is not to represent the world but to represent the case, or the issues under investigation. They add, it has a conceptual

structure and is generally designed around a number of research questions that are the issues, or that have thematic lines. Stake (1995) supports the view that the interviewer needs to have a research-question based set of questions worked out in advance:

> "the qualitative interviewer should arrive with a short list of issue-oriented questions possibly handing the respondent a copy, indicating there is concern about completing an agenda" (p. 65).

Yin (1994) also states there should be a set of substantive questions at the heart of every research inquiry. Having explored the research topic, he says, the researcher then formulates guideline questions to guide the initial development of themes and categories in data analysis. Each question should be related to another source of reference. Drawing on these authors' approaches and the literature review, I compiled a topic guide for the focus groups which is presented in Appendix 7 (a-h).

Phase 2: Collection of Quantitative Data - The Survey

According to Fowler (1993), the purpose of a survey is to produce quantitative or numerical descriptions of some aspects of the population of the study. The survey is a collection of standardised information from a specific population devised in a structured way, often in the form of either an interview or a questionnaire. Well suited to descriptive studies, the survey can provide a simple approach to the study of attitudes, values and feelings and yet can still be adapted to collecting generalisable information. Although most surveys are carried out for descriptive purposes, Fowler (1993) states it is possible to go beyond the descriptive to the interpretive – to use the survey to provide explanations of the phenomena studied and the patterns of results obtained.

According to Fowler (1993), the survey typically involves the collection of data in standardised form from a relatively large number of individuals and the selection of a representative sample of individuals from a known population.

Designing the Questionnaire

Survey questions must be designed to answer the research question(s). They need to be good measures which are reliable (providing consistent measures in comparable situations) and valid (answers corresponding to what they are intended to measure). According to Oppenheim (1992), good survey design involves decisions about question order, question wording and question types, answer coding and analysis. Other considerations include the sample frame and the size of the sample. Using a quantitative tool, such as a survey, also involves decisions about whether or not to use a probability sample and whether to use an

appropriate statistical test to establish whether differences in responses are due to differences in respondents' views and opinions and not merely due to chance. As ever, ethical issues should occupy the researcher's first considerations.

The main Student Questionnaire was devised from the focus group responses, the literature review and the revised pilot study. It was divided into three associated parts and each section was prefixed by a short explanation of that section's purpose. Advice was taken about the selection of a suitable colour for some of the pages (in this instance the actual question laden pages of the questionnaire) as suggested by the pilot study respondents critique. The colour green was settled on – for ecological and calming connotations.

Oppenheim (1992) recommended commencing with factual (demographic) questions, though he suggested the collection of data about personal details should be kept to an absolute minimum. Oppenheim (1992) says decisions about what demographic variables to include is determined by preceding work, such as a semi-structured interview or focus groups (or other methods of data collection) as well as the theoretical framework of the study. Some of the items in Part I of the questionnaire were included for purposes of sub-group cross-tabulation (such as comparisons between males and females, between the different campuses, and home students and overseas students). Other items were included to make comparisons between the demographic profiles of the focus group participants and the survey respondents (such as the representation of faculties and courses, year of study, ethnicity and religious affiliation).

Clearly worded, concise and easily understood questions are vital, especially with a self-administered questionnaire as there is no (or restricted) access to a researcher for assistance with question difficulty - compared to unlimited access to the interviewer in the semi-structured interview. Oppenheim (1992) advises: keep language simple, keep questions short, avoid double-barrelled questions, asking two questions at once, leading questions and questions in the negative; and wherever possible include a 'no opinion' option.

Importantly, Oppenheim (1992) recommended cutting down on open-ended questions which can be time-consuming to analyse. Furthermore, he comments open-ended questions make excellent precursors to the survey and are most likely to have been used in unstructured or focus group types of data collection. Indeed, the focus group findings – derived from open-ended questions - have informed a large proportion of the questions posed in the survey.

Meeting the criteria of scientific rigor

Surveys work best with standardised questions where it is possible to be confident (after careful piloting) that the same questions mean the same thing to different respondents. Attention to the careful wording of questions to maximise the extent to which people in comparable situations will answer questions in similar ways will enhance reliability. The extent to which the answer given is a true measure and means what the researcher expects it to mean refers to the validity of the research. Consequently, if the questions are incomprehensible or ambiguous, the exercise is not only a waste of time but they also pose a threat to the internal validity of the study, as information gleaned would not truly represent what respondents were thinking, feeling or doing.

The main Questionnaire in this study consisted entirely of closed questions. Highly structured closed questions can generate frequencies of response amenable to statistical treatment and analysis and enable comparisons to be made across groups in the sample. They also enable patterns to be observed. However, the type of statistical analysis depends on the type of questions posed

Question type, data type and relevant statistical measurement

Survey design will also include consideration about data analysis, data presentation and where applicable the appropriate statistical measurement. Because nominal and ordinal data yield to non-parametric testing (where few or no assumptions can be made about the distribution of the population), the descriptive statistics produced here are represented mostly by the mode and displayed as percentages in the forms of graphs and tables (see Chapter 5).

Questions which ask for subjective attitudes, opinions and feelings cannot be measured in the same way as factual information (such as how many times a year had the respondent visited their GP) and there are four different ways in which the measurement of survey answers are carried out. These different kinds of data are called: *nominal* (people or events are sorted into unordered categories), *ordinal* (people or events are ordered or placed in ordered categories along a single dimension, such as very good, good, fair, poor), *interval* data (numbers are attached that provide meaningful information about the distance between ordered stimuli or classes) and *ratio* data (numbers are assigned so that ratios between values are meaningful as well as the intervals between them – often related to distance, weight or pressure). No ratio data were produced in this survey.

Specific question types will lead to one of the above named data types. The following question types were used in the Main Questionnaire (see Appendix 22).

Questions 3, 5, 7, 8, 9, 13, 14b, 15, 18 and 22 used *Dichotomous* – highly structured, closed questions. This question type is useful for funnelling (Questions 5, 7 ,8, 9,13,18, 22) or used as a sorting device. Dichotomous questions lead to nominal data which are represented by the mode/frequencies and which have been displayed here as graphs and tables. Statistically these data can be processed using chi-square and cross-tabulation (see Chapter 6). *Multiple-Choice Questions,* on the other hand capture likely ranges of responses to statements. To remain mutually exclusive, however, the categories need to be discrete, with no overlapping. Multiple choice questions were used in Questions 16,19 and 23. They, too, also lead to frequencies of responses, chi-square and cross-tabulation. *Rank Ordering Questions* are used to identify priorities, enabling a relative degree of preference. A ranking or ordering of the items/options presented (for example first and last) was considered to be the most suitable choice for Questions 1,6,12a,14a. They lead to ordinal data and are represented by the mode/median/frequencies and again are displayed as graphs and tables. *Rating Scales* (such as Likert scaling) are used to identify the degree and intensity of responses. They measure each item/option separately. This survey made use of the 'Semantic Differential Scale' (Osgood et al. 1957) which places an adjective at one end of the scale and its opposite at the other end (such as most interesting, least interesting). Importantly this type of question fuses measurement with opinion, quantity and quality but interval data makes no assumption about equal intervals between items/options (unlike ratio data). Rating scales produce data that is responsive and sensitive to respondents' opinions and feelings and are particularly useful for tapping attitudes, perceptions and opinions. For this reason questions 4, 10, 11, 12b, 14c, 17, 20 and 21 used this type of question.

Disadvantages of the questionnaire

Data can be affected by the characteristics of the respondents, that is their knowledge, memory, experience, motivation and personality. Respondents will not necessarily report their beliefs and attitudes accurately. There is also likely to be a social desirability response bias, that is people tend to respond in a way that shows them in a good light. All these points were taken into account when analysing the survey data.

Getting the survey completed

According to Fowler (1993), the choice of the data collection method is difficult, as there are strengths and weaknesses to all the main approaches. One of the most common decisions is concerned with whether the interviewer should pose the questions, or whether the survey should be self-administered. In addition, if respondents are to read and answer the questions themselves – are the completed questionnaires to be posted to the researcher, or collected from an agreed location.

Decisions about how to administer (and collect) the questionnaire depend largely on the time and resources available. The options considered were: *self-completion/administration* (respondents fill in the answers themselves), *face-to-face interviews* (interviewer completes the questions in the presence of the respondents), *telephone interviews* (interviewer carries out the interview over the phone), *postal questionnaires* and *computer based surveys*. In fact, several approaches to the survey completion were undertaken, as will be documented later.

Each of the above options was afforded due consideration. Telephone interviewing, however, was rejected from the outset as students would have been difficult to reach on land-lines due to the popularity of mobile phones. I had even considered the postal questionnaire (despite response rates being reputedly low, Fowler 1993), due to initially intending to conduct a systematic stratified survey (for an explanation of why this was abandoned see page 116).

Fowler (1993) maintains *face-to-face or personal interviews* are possibly the most effective way of enlisting co-operation due to the possibility of probing for responses, for clarification of questions, for establishing rapport with respondents and for gauging the sincerity of responses. The disadvantages, however, are that this method is more costly and time consuming, it needs trained staff, it carries the risk of interviewer bias and the possibility that personal characteristics of the interviewer might antagonise the respondent. Due to the considerable number of questionnaires needed to meet the quota sample (805), this approach was also rejected.

Self-completion questionnaires, on the other hand, are said to be a quicker method of meeting survey sample targets especially if time is an important factor. They are also very useful when response categories are numerous or complex and for sensitive topics. Furthermore, because most self-administered questionnaires afford anonymity, respondents

are more likely to be sincere in their response. In addition, internal validity is said by Oppenheim (1996) to be increased because the questions are standardised and not subject to an interviewer's biases and vagaries in question posing. For these reasons, self-administered questionnaires usually use closed questions. And yet, with self-administered (and postal) questionnaires ambiguity and misunderstanding of the survey questions may not be detected as, unlike the interview administered survey, the interviewer will not be present to respond to any queries.

There has been a rapid expansion in *internet and e-mail survey* completion and Robson (2002) argues it has a lot to recommend it. Within this method the questionnaire is completed and returned on line to the researcher. It is less costly and the rate of response is favourable because of the convenience factor of completing a survey whilst on-line. However, web-based surveys can be difficult when representative samples need to be achieved and quality control is not possible. For this reason it was not possible to use this method exclusively, but together with the self-administered approach, individually and 'en masse' (at events and functions), the e-mail survey completion method was also used to reach the targeted number of completed questionnaires.

Sampling : The Quantitative Survey

Purpose of sampling and the search for typicality

According to Robson (2002), the quality of research not only stands or falls by the appropriate methodology but also by the suitability of the sampling strategy. As a sample is a selection from a population, it is imperative the sample is representative of the target population from which it is drawn. Silverman (1993) says decisions about sampling need to be taken early on in the design stage and should include the following: the sample size, the representiveness and parameters of the sample, recruitment and the type of sample to be used.

Types of sample

The two main methods of sampling are the probability and non-probability sample. The major differences being that with a probability sample the chances of members of the wider population being selected are known, whereas in the non-probability sample they are not. Any sampling plan where it is not possible to specify that every member of the population has an equal chance of being included is called a non-probability sample and because this type of sample does not necessarily represent the wider population, no generalisations about the wider population can be made. Examples of non-probability

samples are: convenience, quota, dimensional, purposive, snowball and self-selecting. Specifically each type of these samples seeks to represent itself or instances of itself in a similar population, rather than attempting to represent the whole population. On the other hand in probability sampling, inferences and generalisations can be made about the wider population because it is possible to specify the probability that any member of the wider population could be included in the sample. Types of probability samples are: random samples, systematic samples, stratified, cluster, stage and multi-phase samples.

Miles and Huberman (1994) affirm that many qualitative researchers employ non-probability rather than probability samples. They seek out groups, settings and individuals where and for whom the processes being studied are most likely to occur – which is, of course, entirely compatible with case study assumptions. At the same time a comparison of groups, concepts and observations might be necessary as the research seeks to develop an understanding that encompasses all instances of the case under investigation. In this instance, the quota sample was chosen because focus-group analysis had identified differences between specific sub-groups; that is between campuses, the sexes and between home and overseas students. Initially, it had been intended to use systematic stratified sampling, (such as the cluster sampling method) by way of firstly determining the total number of people in the sampling frame and then dividing this by the number of respondents to be selected from each of the 'cluster' groupings (that is male/female, home/overseas students on each of the three campuses). Using this sampling method, it had been proposed to select every 'nth' student from the Faculty register and to put a Questionnaire into every 'nth' student's pigeon hole, using a postal return system for the completed questionnaires. However, on learning that up to four students share the same pigeon-hole, this method of sampling was abandoned since the Questionnaire would then need to be addressed to one of those students, thereby jeopardising student anonymity. In fact, Silverman (1993) describes the quota sample as being the non-probability equivalent of stratified sampling. Like a stratified sample, a quota sample strives to represent significant characteristics of the wider population but unlike stratified sampling it sets out to represent these in the proportions in which they can be found in the wider population by seeking to give proportional weighting to selected factors/characteristics/strata to reflect the weighting of these characteristics in the wider population.

Therefore, the aims of the quota sample are: to create a representative sample to specify quotas or targets of particular types of people that need to be included to represent the population, to decide on a sample size and set the quotas (target numbers), and once the

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sample is defined to approach people in the sampling frame until the quotas have been filled.

The sample size of the survey

Silverman (1993) says the optimum sample size is determined to some extent by the types of sample being used and the data collection methods employed in the research. For example, quantitative methods will require a larger sample, particularly if inferential statistics are to be calculated and this is achieved according to the level of accuracy and the level of probability that the researcher is prepared to accept. Formulae have been developed to help choose the sample size by power tables/power calculations; for example random sample sizes can be calculated according to tables using a mathematical formula which indicate the appropriate size of a sample for a given number of the wider population. However, Robson (2003) says this is a matter of judgement as well as mathematical precision.

Generally speaking, with exploratory research a large sample is not necessary - although with nominal data the sample size may well need to be larger than for interval or ratio data especially if sub-groups are to be analysed. Silverman (1993) warns too small a sample may be biased due to an over-representation of a particular characteristic. However, with a quota sample, such criteria (which involve consideration in other samples) do not apply. For instance, there is no need to over-estimate the size of the sample to account for non-returns as recruitment of respondents continues until the target quota is reached. Taking factors of homogeneity and heterogeneity of the sample into account does not apply because this is accounted for in the quota sample method.

Most importantly, Robson (2002) advises seeking statistical advice prior to deciding on sample numbers to ensure confidence. This was indeed undertaken and resulted in an increase of 16 per cent of the *initial sample number of 700* (see Table 6 Column 3), in order to achieve a minimum of 50 students in each sub-category.

Calculation of the Quota Sample (after Robson 2003)

The following aims were considered when devising the quota sample :

1) To identify those characteristics which appear in the wider population which must also appear in the sample, that is to divide the wider population into homogenous and discrete groups.

2) To identify the proportions in which the selected characteristics appear in the wider population, expressed as a percentage.

3) To ensure that the percentaged proportions of the characteristics selected from the wider population appear in the sample.

The method employed to calculate the quota sample quotients

Having identified the stated characteristics (which appear in the wider population and which should also appear in the sample), I then obtained the total number of undergraduates registered at the University of Hertfordshire (**16,980**), following by the 'Count of Registered Undergraduates' already broken down into the characteristics of: Campus, Fee Status and the Sex of the students. These figures were supplied by the university's Academic Registry (see Column 1 and 2 of Table 6). The workings proceeded as follows:

Step 1: Calculation of the percentage of each sub-category entry to the total undergraduate population (**16,980**). Presented in brackets in Column 2 of Table 6.

Step 2: Calculation of that percentage of **700,** presented as the first figure in brackets in Column 3. (Refer to the previous sub-section entitled 'Sample Size' for an explanation of this figure).

Step 3: Increase this figure by 16 per cent to ensure a minimum count of 50 students in each sub-group (again refer to sub-section on Sample Size). This calculation resulted in the second figure in brackets in Column 3. A total sample of **805** was established with the final addition of the figures in brackets to represent the number of students needed in that sub-category, indicated in Table 6 by the emboldened figures to the right of Column 3.

Please note the counts of EU students and international students were totalled to represent the category of overseas students.

TABLE 6: Calculation of the Quota Sample Quotients

SUB-GROUP CATEGORY	Actual Count of Undergraduates as per Academic Registry		Calculation of sample number based on a total sample of 700 (plus an increase of 16% to achieve a minimum sub-group number of 50)	
COLLEGE LANE				
Males Home	4560	(26.89%)	(188+30)	**218**
Males Overseas	780	(4.6%)	(32+5)	**37**
Females Home	5370	(31.66%)	(222+35)	**257**
Females Overseas	850	(5.01%)	(35+6)	**41**
DE HAVILLAND				
Males Home	1490	(8.78%)	(61+10)	**71**
Males Overseas	390	(2.3%)	(16+ 3)	**19**
Females Home	2140	(12.62%)	(88+ 4)	**92**
Females Overseas	400	(2.3%)	(17+3)	**20**
ST. ALBANS				
Males Home	320	(1.89%)	(13+2)	**15**
Males Overseas	70	(0.41%)	(3+1)	**4**
Females Home	550	(3.24%)	(23+4)	**27**
Females Overseas	60	(0.35%)	(3+1)	**4**
Totals	16,980	100%		**Total 805**

There are however disadvantages to using a quota sample, one of which has been experienced in this study. Disparity in the size of one (or more) of the sub-groups can result in such a small number that statistical analysis is rendered impossible. This was the case with overseas male and overseas female students on the campus of St. Albans (see Table 6 above). According to Coolican (1993), the sample size will also be constrained by time, money and the number of researchers involved. Such factors have indeed represented restraining forces throughout the course of this work.

The survey sample was therefore calculated according to the criteria of a quota sample within a non-probability framework.

Sampling error and non-sampling error

According to Yin's tests of scientific criteria, any method of sampling must be *valid* – that is to say the sampling process must accurately reflect the data needed to answer the research question - and *reliable,* that is the sample process could be repeated a number of times with similar outcomes.

Although the degree of reliability of non-probability samples cannot be measured, Coolican (1993) proposes the main advantage of a quota sample is that it looks similar to that of the population in terms of key characteristics. No population listing is required, only information about the population characteristics with which to define the quotas needed. However, there is a risk of selection bias in that those from the sampling frame, who are not physically near the sampling point, do not enter the sample (a point discussed with the students reps at the initial meeting). Coolican concedes filling some quotas may prove difficult. This indeed proved to be the case, especially as so few overseas males and overseas females were needed on one of the campuses. Nevertheless, despite all efforts to reduce sampling bias, Coolican (1993) maintains:

> "the simple truth is that a truly representative sample is an abstract ideal unachievable in practice" (p. 26).

Whereas sampling error can occur when the selected sample is not a perfect representation of the overall population, non-sampling error describes all elements of error arising from other aspects of the research process, such as (in this the quantitative phase of the study), survey design, question wording, faulty coding schema and data inputting. In order to minimise non-sampling errors, the following was undertaken: the survey questions were repeatedly checked (by the statistics department) for validity, the questionnaire was standardised (all respondents had the same questions in the same order), the survey was self-completed, counteracting any researcher bias with regard to influencing or incorrectly recording responses. The coding schema (see Appendix 18) was also checked and verified by the statistics department. Furthermore, because I had undertaken the entire transference of (coded) data from questionnaire to computer data file (SPSS), a random check was made by a member of the statistics team who also performed a 'sweep' of the entered data to detect obvious errors. A few mistakes were noted and these were corrected accordingly.

Ethical considerations of conducting a survey

As with all research, the survey should be carried out in ways designed to avoid risks to participants and the researcher should ensure no individual suffers any adverse consequence as a result of participation. Relating specifically to survey research, respondents should be informed about the purpose of the questionnaire and what is expected of them. Another key issue is to minimise any risk of breach of confidentiality. Furthermore, when a project is completed the researcher is responsible for the secure storage of data until its eventual destruction. Reference to Appendices 6 and 22 will

confirm all these matters were attended to. In all other respects the issues governing ethical conduct in research have been fully covered previously.

Piloting the Student Questionnaire

Oppenheim (1992) warns:

> "sloppy design and inadequate piloting will lead to wasted effort and misleading results" (p. 50).

Design of the pilot questionnaire took into account all the measures previously mentioned consistent with good survey design. It was divided into three sections : "About You", "About You and Your Environment" and "About You and Your Help-seeking Behaviour". Part I was concerned with demographic details, (as per the focus groups) and the Questions in Part II and Part III of the questionnaire were devised partly on the basis of the literature review and partly on the focus group data analysis findings.

Recruitment of the pilot questionnaire sample

Recruitment of volunteers to complete the pilot questionnaire was again undertaken via an entry on Studynet due partly to the relative success of the second attempt at recruitment for the focus groups and secondly out of consideration of the time of year this was undertaken. This was towards the end of the first term making it easier to communicate with interested students via e-mail over the Christmas vacation. To compensate students for their time, all students returning a completed questionnaire were entered into a Prize Draw to win a Tescos voucher worth £50. A self-selecting sample of approximately 90 students responded and were forwarded the Briefing Sheet, Questionnaire and Critique Sheet. Of this number 33 students completed the questionnaire on line and returned the questionnaires to me at my university e-mail address. The questionnaire was downloaded for analysis purposes but to ensure anonymity no check was kept of which questionnaire corresponded to which student. Every student was e-mailed a raffle ticket number (allotted sequentially) and the corresponding number was stapled to the downloaded copy of the questionnaire. Because there was an insufficient number of responses before the Christmas break (having aimed at achieving 50) each student was informed that the raffle draw would take place sometime on their return. This was actually undertaken during the second week of the new term by a member of the Students' Union (to safeguard impartiality) and both the winning number and every one of the unsuccessful participants was informed of the outcome on the same day. The prize voucher was collected from an independent member

of the department, who having checked the winner's identity against that supplied by the researcher, secured a receipt.

The pilot questionnaire was amended with the help of the statistics department. Although there were face-to-face consultations with members of the statistics team, much of the guidance took place via e-mail. This ensured there was a record of what was suggested and the alterations made. Examples of some of the changes made include the following:

Question 4 of the pilot study read:

"What problems in particular could make you feel depressed/unhappy/ anxious whilst at UH? Students were asked to "please tick as many options as are appropriate to you"

Money problems ( )
Feeling homesick/missing family and friends ( )
Academic concerns: about coursework, being continuously assessed, exam pressure ( )
Health concerns ( )
Feeling socially isolated ( )
Concerns about your self-image ( )
Worries about your own (or others') behaviour, such as excessive drinking and/or drug taking ( )
Working long hours off the university campus ( )
Wanting to protect your family from your worries ( )
Not having approachable and helpful lecturers ( )
Having to provide emotional help and support to others ( )
Not knowing who to turn to in times of emotional need ( )
Anything that makes me feel stressed. ( )

On the advice of the statistics department, this question was changed to a rating scale to determine a more precise reflection of students' feelings on the issues presented. Also some of the options (2, 3, 7) were not 'mutually exclusive' and in fact asked more than one question at a time. To rectify this, it was decided to: add 'missing family and friends' to a separate question (which appears in Question 10 in the main survey), to split the items in option 3 to produce discrete entities and to pose the items of excessive drinking and drug taking as separate questions. These appear in the main survey as Questions 5 and 6. The last item was omitted because it was too vague and added nothing to a greater understanding of what particular problems caused this sample of UH undergraduates the greatest concern.

Question 19 (Question 15 in the main questionnaire)
Induction Week (Abbreviated to IW)

Students were asked to "please tick **one** of the options only"

IW was very helpful. I became familiar with all the support services available ( )

IW was helpful but I'd like to have been shown round and told more about the support services ( )

IW was quite helpful but I've forgotten most of what I was told and I'd like to have it repeated ( )

IW wasn't helpful at all and I'm still not sure what is available to me and where it is ( )

On reflection it was thought the instruction to tick just one of these options would not produce a meaningful response as some respondents might feel inclined to comment on more than one statement. For this reason, students completing the main survey were asked, instead, to state whether they either agreed or disagreed with each statement. Again it was pointed out each of the options in this question contained more than one issue and so each statement was re-worded to reflect one theme only. I was advised these alterations would produce more accurate and meaningful responses which would also be easier to analyse.

Amendments to the pilot survey resulted in the product of the Main Questionnaire (Appendix 22). The revised questionnaire was pre-tested (Yin 1994) on 50 undergraduates with the help of the student reps, so that feed-back could be obtained and this resulted in some minor adjustments, as documented below.

There were no major changes necessary to the questionnaire wording or sequence of questions. However, the feed-back session resulted in minor changes, mostly to the question instructions. For example, directly under the heading of PART 1, the word 'undergraduate' was emboldened, put into upper case and changed to a different font, as it was thought this was not sufficiently 'obvious'. In similar vein where the instructions called for a specific response, such as in Questions 3, 23 (when only one response was requested), the word 'one' was emboldened and put into upper case, as was the word 'first' in Questions 16 and 19. Also, with respect to Questions 7, 8, and 9, the third option 'I'd rather not comment' had not been emboldened to match the other two options (thought to be a printing error) and this was amended accordingly. There was however an additional part to Questions 7, 8 and 9 which had been omitted during the typing process and this was added as A). The third part of Question 22 was changed from a Yes/No option to that of "please tick as many options ..." in order to produce some uniformity to the question as a whole. Where the instruction included ticking as many of the options as appropriate, (Questions 5, second part, and Questions 18, 22) the word 'many' was also emboldened. The final, revised version is presented as Appendix 22.

The Main Survey: Methods of Completion and Return

Fowler (1993) maintained it is not uncommon for a combination of methods to be used in getting a survey completed. In fact, a combination of several methods is likely to yield a higher response rate. The target sample of UH undergraduates was indeed achieved via a combination of completion and collection methods. Of particular interest, however, was Fowler's (1993) proposal concerning the utilisation of group administrators in getting questionnaires completed and returned to the researcher, which he stressed had several advantages. This method is relatively low cost, it provides the chance to explain the study and answer questions and it has high co-operation rates. This notion inspired me and I decided on a strategy of enlisting the help of student representatives (reps). Student reps are young people who have declared a commitment to furthering the student cause; they are reliable, dependable, have integrity and are sensitive to the ethical issue of 'non-malificience'. Written permission to recruit student reps for help with achieving the quota sample target was submitted to the Ethics Committee. The letter also included the matter of recompensing the student reps for their time and effort and permission was duly granted.

Recruitment of Student Reps and Questionnaire Completion

The assistance of the Students' Union was sought for the purpose of recruiting student reps to help with getting the main questionnaire completed. A member of the Students' Union e-mailed all student reps with a recruitment notice. This produced seven responses from interested students. A meeting (attended by five student reps) was arranged in a room at the Students' Union to brief the volunteers about the purpose of the study, to provide assurances as regards their own welfare and to impart the terms and conditions appertaining to their involvement. All five remained happy to assist and duly signed the 'Terms and Conditions' slip. At this first meeting each student rep was handed ten questionnaires to be completed as the pre-test (Yin 1994). In particular they were asked to get feed-back from respondents as regards difficulty of completion and another meeting was scheduled for return of these. At the second meeting one student rep decided he could not continue due to increased course-work. He was thanked for his valuable contribution. The meeting concluded with constructive feedback of problem areas and the five student reps were paid in cash, as per the agreed sum. A future date was made to meet again to distribute the main questionnaire once the amendments had been made.

At every subsequent meeting student reps were encouraged to take only as many questionnaires for completion as they felt comfortable with. The number taken varied

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between each of the reps as did the number of completed questionnaires returned. I met the student reps regularly (at times convenient to them) over a period of two months to exchange the completed questionnaires and their payment. There was, however, a hiatus of several months due to the onset of the summer vacation. Achievement of the target quota therefore took two attempts, the first taking place throughout May and June 2006 and the second between December 2006 – January 2007. (It would not have been appropriate to have presented 'freshers' with the survey questions at the beginning of their first term, some of which concerned their 'lived' experience of the support services). Furthermore, a third questionnaire completion undertaking was necessary when (after data inputting had commenced) 33 questionnaires had to be abandoned due to incompletion/insincere responses. The value of the 'prize draw' was reduced on each of the two subsequent attempts at questionnaire completion to reflect the fewer numbers of respondents involved, out of fairness to the respondents participating in the first attempt.

Table 7 below sets out the situation after the first and second attempts at questionnaire completion. The target number (805) was finally achieved by the end of February 2007

TABLE 7: Breakdown of survey completion totals after 1st and 2nd attempts				
SUB-GROUP CATEGORY	Actual Count of Undergraduates as per Academic Registry	Target Sample Size	Numbers achieved at 1st attempt (end June 2006)	Shortfall, achieved after 2nd attempt (January 2007)
COLLEGE LANE				
Males Home	4560	218	178	40
Males Overseas	780	37	34	3
Females Home	5370	257	132	125
Females Overseas	850	41	40	1
DE HAVILLAND				
Males Home	1490	71	68	3
Males Overseas	390	19	19	-
Females Home	2140	92	86	6
Females Overseas	400	20	19	1
ST. ALBANS				
Males Home	320	15	9	6
Males Overseas	70	4	4	-
Females Home	550	27	8	19
Females Overseas	60	4	4	-
		805	601	204

Achieving the target quota entailed a multi-method approach. Some student reps used the 'collection later' method, others got the questionnaires completed opportunistically. This involved approaching students directly on each of the three campuses (for example, as they were entering the refectories) and through 'stands' set-up on Events Days, run by the Students' Union. Another method of questionnaire completion was via the university's e-mail system (being completed on-line and downloaded on receipt), while others were returned to me in the internal mail.

Breakdown of the methods of return were as follows: 206 completed questionnaires through student reps (and my own efforts), approximately 100 via e-mail, and 500 via the Students' Union outlet (events days).

Steps taken to prepare the data-sets for analysis.

Within Creswell's (1994) framework for flexible design, data analysis often takes place in stages, involving multiple levels of abstraction. Most importantly, Brannen (2004) stresses the importance of analysing and interpreting the resultant data in relation to the assumptions of the paradigm from which they were generated. Consequently, the data analysis of the two qualitative datasets are considered here according to the phases in which they were conducted and (in line with Brannen's 2004 advice) undertaken according to their particular paradigmatic assumptions.

In keeping with Yin's (2003) protocol, this translates into the maintenance of meticulous records of data collection and by documenting the process of analysis in detail. Pope et al (2000) maintain much of the criticisms levelled at qualitative work rests with the researcher who neglects to provide an adequate description of their methods, especially with regard to data analysis. They suggest this is because in many forms of qualitative research the raw data are collected in a relatively unstructured way - such as tape-recordings and/or transcripts of conversations.

As regards choosing the most suitable methods of analysing and interpreting the data, the researcher will be guided again by the purpose of the study and its theoretical framework. Yin (1994, 2003) maintains there is no prescribed way of analysing case study data. Miles and Huberman (1994), however, provide a general framework for conceptual qualitative analysis which is especially useful in case-study research and which has been adopted here. Such an approach to qualitative data analysis involves data reduction, data display and

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conclusion drawing. Specifically these flows of activity form a continuous iterative process which will lead to ideas of how the data-set may be displayed and which may suggest tentative conclusions.

Miles and Huberman (1994) propose Yin's case study analysis formula gravitates to more fully codified research questions, more standardised data collection procedures and more systematic devices for analysis. To this end Miles and Huberman (1994) list a classic set of analytical steps:

1) giving codes to the initial set of data,

2) adding comment, reflecting (memoing),

3) going through to identify similar phrases, patterns, themes and differences between sub-groups,

4) identifying sets of generalisations that cover consistencies discerned in the data,

5) taking these themes onto the next wave of data collection or linking these generalisations to a formalised body of knowledge in the forms of constructs or theories.

Attending to scientific rigor: Documenting the process of analysis in detail.

In order to fulfil the criteria of scientific rigor, the following details are submitted for scrutiny and the appropriate appendices notated to confirm the execution of this process.

Data analysis of the focus group discussion groups was undertaken within the theoretical framework of a case study according to principles expounded by Yin (1994) and within a 'generalised' compatible analytical structure as proposed by Miles and Huberman (1994). Reference to other works, such as Morse (1994), Pope et al (2000), Denzin and Lincoln (2000) have been incorporated to justify the processes involved.

Preparation of the focus group data-set for analysis

Stage1: Coding/Indexing

Before starting any analysis, the raw data must be processed. All eleven focus group discussion tape-recordings were transcribed. Morse (1994) says a full and thorough audio-transcription needs to include all speakers and all speech including that which is unfinished and interrupted. This was achieved through the verbatim transcriptions of the primary data.

Once the transcription was complete, the next stage was to index (code) the data in order to make them manageable for interpretation and to bring together under one heading all data relating to a particular theme. This involved the process of reading the transcript repeatedly, listening to the tape-recordings and assigning index codes which relate to the content of the data and which are of significance to the analytical framework of the research. Morse (1994) recommends the analyst is mindful of the context of any extract of speech and follows the arguments of individuals and the group through the transcripts.

The first level of coding is the device for summarising often descriptive segments of data which come from the conceptual framework, themes and research questions. In this instance these codes were derived from the guideline questions which served as the initial categories and provided a common structure for analysis across sections. Text segments are identified as empirical evidence for template categories and for this reason it is important to give a code a name that is close to its concept, as codes are in effect retrieval devices. Not only are codes applied to a section of text to classify or categorise it, they are also descriptive units of meaning, in that it is not the words themselves but their meaning that matters. For the focus group coding schema, see Appendix 12.

Methods of data storage and retrieval: Indexing/coding is a means of making data manageable so that they can be stored and retrieved either manually or by computer packages. Miles and Huberman (1994) suggest the analyst can allocate several index labels to the same piece of text and to extracts of text of different sizes, such as a sentence, a paragraph or a page of data. For instance, a paragraph can be allocated four different index codes. A software package such as Nud*ist works on the codes that the researcher has entered into the computer. The main benefit of these qualitative data packages is that they can retrieve all text about a particular code. Manually this can be done, for example, by a card index system or by photocopying, cutting and pasting.

The intention had been to use Nud*ist as an aid to the focus-group data analysis process but due to the terrorist attack on London's Underground on 7th July 2005 the day-course I was attending at the University of Surrey had to be abandoned. I needed to have the data analysis well under way by the end of the summer vacation in order to meet other pre-specified dead-lines and so transference onto the next available course (the following September) was not an option.

On reflection and further reading on the subject, I came across a paper by Pope et al (2000) who proposed that although software packages can be helpful in organising the mass of raw data into manageable chunks, the repeated physical contact with and handling of the data has much to recommend it. The process of re-reading the data and sorting it into categories means the researcher develops an intimate knowledge of the data that is invaluable, even if the process is laborious and time consuming. A computer package may be a useful aid initially but no package is capable of perceiving a link or defining an appropriate structure for the analysis. This requires the researcher's analytical skills in moving towards propositions about the data. I chose to follow Pope et al's (2000) advice and analysed the focus group data manually.

Stage 2: Production of a 'multiple case' themed format to perform cross-case analysis

The verbatim transcripts were re-typed (through the process of cutting and pasting) to produce multiple case transcripts related to the themed indexed schema. This was undertaken for the explicit purpose of cross-case analysis and included an indication of the sex of the speaker for purposes of sub-category analysis. For the purposes of data reduction the facilitator's speech was excluded. However, to minimise any ambiguity in interpretation resulting from this exclusion, where necessary the reduced transcripts were annotated accordingly - for example, where the facilitator used probing to elicit further comment.

One aim of studying 'multiple cases' is to increase 'generalisability' and to reassure the audience that events and processes occurring on one occasion are not wholly idiosyncratic. It has been argued the pursuit of generalisability is inappropriate for qualitative studies, although Miles and Huberman maintain it is necessary to transcend radical particularism for the reason that cross-case analysis can deepen the understanding of the issues under review. This rationale is compatible with Yin's (1994) replication strategy - that is if a finding holds in one setting also holds in a comparable setting it is considered to be more robust. The 'generalisation' impact comes in a match to the underlying theory NOT to a larger population and is often considered in terms of theoretical generalisation.

By the end of this stage, the verbatim data arising from the focus group questions (the themed and now coded material based on the conceptual framework), had been cut and pasted from the original transcription to form separate sheets (for ease of cross-analysis) for each of the topic areas (see Appendix 13). According to Miles and Huberman (1994),

conceptual frameworks/research questions have a focusing role. Qualitative researchers often look for themes that cut across cases and this becomes clear with cross-case analysis. This is sometimes called pattern clarification. Interviews conducted several times with different individuals assist the researcher in identifying trends in the perceptions and opinions expressed and which are revealed through careful systematic analysis.

Stage 3: Building the Matrix and Data Display

Matrix building was commenced after repeated reading of the data as at Stage II.

Data display: Data display produces a useful means of achieving data reduction and focuses viewing on a dataset as opposed to ploughing through many pages of script. A display is not the complete field notes but rather condensed and distilled data presented in visual format. Developing a matrix will automatically further reduce the data and will involve a deal of selection and condensation from the mass of original transcriptions. Such formats can be in the form of matrices with defined rows and columns or networks with a series of nodes with links.

Building the matrix: Miles and Huberman (1994) state there is no fixed canon for constructing a matrix. A matrix is creative and systematic, providing further understanding of the substance and meaning of the database. Decisions involve choosing which types of rows and columns best represent the display and further analysis of the data. Robson (2002) expands on the concept of displaying data in a matrix and describes several different types. The one to fit the purpose of analysis here is presented as the 'thematic conceptually clustered' matrix. This type of matrix has rows and columns arranged to bring together themes conceptually, for example items that derive from the same theory or relate to the same over-arching theme. Such a format displays all the relevant responses of key informants on a sheet and allows an initial comparison between responses and between informants. 'Multiple case' analysis (in this instance represented by the individual focus-group participants) lends itself to cross-case analysis and provides some preliminary standardisation and a set of content-analytic themes.

It is important in the understanding of cross-case analysis to be able to look for similar and dissimilar responses within the same codes/indexes that represent themes. To this end, a two dimensional matrix was prepared with each of the themed indexed categories represented by columns, and the multiple cases being represented by the rows. A column

to the far left indicated the specific focus group from which the data emanated. According to Miles and Huberman (1994), the cells of the matrix's central column include either a summary, or paraphrasing or a quotation lifted from the verbatim transcripts produced by Stage 2. I chose to use a combination of all three of these suggestions and this further reduced the data and made them more accessible to interpretation. I also included the sex of the respondent (M = male and F = female) for the purposes of sub-category analysis. Miles and Huberman (1994) maintain the strength of qualitative matrices lie in their inclusion of text, as well as getting a colleague to review the matrix, (with the decision rules and memoing strategy), to check the procedural accuracy. This was duly undertaken by members of the department's team.

Some difficulties arise with focus group data because scripts often contain speech which is unfinished as participants are interrupted or because the conversation trails off in a different direction. Consequently, ambiguities can occur and these should not be used in the creation of the conceptual matrix when the data have been further reduced. In this instance, especially with the language difficulties (as reported on page 239) when the intended meaning of the respondent was in doubt, the response was not included.

The column to the far right of the matrix was left for 'memoing' (see Appendix 14)

Stage 4: Memoing and cross-case analysis

Denzin and Lincoln (2000) state the memoing phase aids the process of analysing data through the careful inspection of the data for specific elements or components. With the conceptual thematic matrix, the analyst draws inferences directly from the display data by noting these patterns and themes. Memoing itself takes place when the researcher reads through the raw data and annotates in the margins and/or incorporates interview notes (see Appendix 14). Miles and Huberman (1994) recommend drawing conclusions from the matrix data by starting with a 'squint' analysis down the rows and across the columns to see what jumps out. Then, they suggest, verify and revise this impression through a more careful review.

In preparation for this stage, the 'multiple case' transcripts were read repeatedly to extract meaning from the verbatim responses of the students. This resulted in the development of newly emerging themes and categories which became evident from intensive reading; the frequency of similar responses being noted, the singularity of other responses, the mood and intensity of feelings noted from the choice of words and phrasing and nuances. These

were all reflected on and incorporated with notes made during and immediately after the interviews. This was represented in a separate Extended Memoing sheet and attached for future reference to the 'multiple case' transcripts (see Appendix 15).

Denzin and Lincoln (2000) say memoing is an important process because the theorising and writing up of ideas about codes and their relationships are essentially conceptual (not being just reported data) and are linked to the researcher's ontological viewpoint. Notably, Yin (2003) argues a reflective practitioner should be committed to teasing out meanings from the data to recognise and develop newly emerging issues. One way of performing the next stage is through a process called analytic induction. It is linked to grounded theory [1] and involves iterative testing and re-testing of theoretical ideas using the data. The researcher examines a set of cases and develops hypotheses or constructs and examines further cases to test these propositions (Bloor et al. 2002).

Miles and Huberman (1994) say cross-case pattern findings can be sharpened by reprising literature review findings that conflict with as well as support findings. Multiple cases can also help a researcher find negative cases to strengthen a theory built through examination of similarities and differences across cases. Miles and Huberman (1994) maintain a tension exists between the particular and the universal; in other words reconciling an individual's uniqueness with the need for more general understanding of generic processes that occur across cases. For instance, where a new category emerges, the analyst looks through the existing index codes to identify other cases of either similar or strikingly dissimilar instances. Like other qualitative data, focus group data cannot be appropriately lifted out of context as the context includes the psycho-social setting and the group dynamics. A group has a chemistry and a dynamic that are greater than the sum of its members. Morse (1994) concedes the fact remains that with a different mix of members the data collected would not be replicable and therefore no 'generalisations' can be made - though she maintains it is possible to make a statement of a broad nature. Indeed, because specific data are not transferable across focus group sessions, Morse (1994) says it is more appropriate to examine broad themes. Moreover, although matrices are initially descriptive, they often lead to a summary table.

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[1] Glauser and Strauss coined the term grounded theory to describe the inductive process of coding the data and identifying analytical categories as they emerge from the data. In other words developing hypotheses from the ground or research field upwards rather than defining them a priori. This process involves identifying a theme and attempting to verify, confirm and qualify it by searching through the data. Once all the data that match that theme have been located, the researcher repeats the process to identify further themes or categories.

Stage 5: Summary sheets development

According to Miles and Huberman (1994), the matrix might develop into a series of matrices and then eventually to a summary table for each theme or code/category.

The final setting of an index will also occur at this interpretive stage when the extracts which have been allocated the same code can be compared. At this stage it is important to include all possibly relevant data within an index code and as the analyst works through each case, new index codes are likely to emerge.

A summary sheet was prepared for each themed index code (see Appendix 16). These sheets represented further interpretation of the data and the inclusion of the newly emerging themes in a format that facilitated the linking of categories in support of any tentative conclusions. The summary sheets were instrumental in the preparation of the final 'writing-up' or report stage. The most frequent tactic used for drawing conclusions was noting patterns, clustered themes, making contrasts and comparisons. Initially conclusions needed checking against field notes, or in this instance, transcriptions. The next step was to clarify the conceptual importance of any conclusions and how these tied into previous theories (where appropriate this was undertaken in Chapter 6). Finally, the analysis and interpretation stages culminate in a report which, according to Miles and Huberman (1994), will normally contain a mixture of narrative text and quotations from verbatim transcriptions.

Morse (1994) expounded the view that a detailed analysis of focus group data can stand as a sole source of data, or as one method in a multi-method study whereby the information gleaned serves to inform the next part of the study. This entirely supports the use of a facilitative approach to data analysis (according to Hammersley 1996 and Brannen 2004) and as such this approach was built into the research design. In other words, the 'Focus Group Findings and Summary' (as appears in Chapter 5) stands on its own as an informative document which chronicles the views and experiences of undergraduates on matters appertaining to their mental well-being in the university environment or, as in this case, the findings have been used to facilitate another method of data collection; the survey. In this work, the focus group findings (based on the questions emanating from the literature review and those newly emerging categories) were formulated into "Statements" (see Appendix 17). These 'Statements' were used to devise the questions posed in the pilot questionnaire which, after amendments, formed the basis of the questions posed in the Main Questionnaire (see Appendix 22).

The semi-structured interview : Organising the data for analysis

As has already been stated, there is no clear and accepted set of conventions for analysis of qualitative data corresponding to those observed with quantitative data. Again, I followed the framework after Miles and Huberman (1984) who recommend the presentation of qualitative data in the form of a matrix:

"to encourage the creation and display of innovative and reliable data displays for qualitative data" (p. 79).

According to Robson (2002), the most frequently used method to organise qualitative data is the two-dimensional dual category matrix, where the rows represent one dimension and the columns the second dimension (a simpler version of that used for the focus group analysis). The questions posed to the MPR contained themes that had emanated from the literature review (see Appendix 11) and so the semi-structured interview data-set formed a conceptually themed matrix. In this instance, the column to the left of the matrix displays the question posed to the MPR and to the right of this is the paraphrased version of the MPR's responses (see Appendix 19). To enhance validity the following took place :

- The tape-recording was transcribed by an independent source. The tape-recording was listened to repeatedly and the type-written transcript was read several times.

- A matrix was devised to incorporate the themed questions and the MPR's responses.

- Because there were no cross-cases, the responses were paraphrased, where appropriate, and occasional verbatim citations were inserted to enrich the analysis.

Transcribing the interview was again undertaken by an independent source and due to the relatively small amount of raw data amassed (the interview lasting no longer than forty minutes), the questions (again themed) and the paraphrased responses were organised into a matrix, for consideration in the interpretive stage of the analytical process.

The data-set was organised according to three main themes :

- Issues relating to registration and the declaration of a mental health problem (Questions 1 and 10)

- Issues concerned with confidentiality, liaison with other agencies and departments, and potential areas of conflict (Questions 4,5,6,7,9)

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- Issues surrounding the implementation of mental health promotion activities, according to the latest contractual opportunity (Question 3) and the Medical Centre's views and approach to health promotion (Question 2). Within this category, Question 8 was, unfortunately, not posed to the MPR.

Steps taken to prepare the quantitative data for analysis: The Student Questionnaire

Cleaning the dataset after entry into SPSS (Statistical Package for Social Scientists)

A coding schema was produced prior to assigning the appropriate codes to the completed questionnaires (see Appendix 18). This coding schema was checked for accuracy by the statistics department, and after a few minor amendments, was approved for usage. Revision training on the use of SPSS was undertaken through on-site "Generic Training for Researchers" and through reference to relevant text-books (Bryman and Cramer 1997, Field 2004 and Robson 2002). Keying the data into SPSS (Version 13) commenced in August 2006 and was completed by the end of January 2007.

A computer dataset also needs to be checked for errors made while keying in data before analysis is commenced. This involves skim-reading the dataset and checking entries against the coding scheme. This process not only highlights obvious mistakes it also performs the task of 'eye-balling' the data-set (recommended by Coolican 1993) to see what has transpired. This is in accordance with Yin (2003) who maintains case study strategies often result in quantitative data which need to be initially explored in such a way. Additionally, approximately ten per cent of the completed questionnaires were randomly chosen for a more detailed check on the accuracy of coding the data and their entry into SPSS. These measures were undertaken by an independent member of the department and the accuracy of coding and data inputting was confirmed.

Descriptive (or summary) statistics are ways of representing some important aspects of a data-set by a single number. Descriptive statistics refer to statistical techniques used to summarise and describe a data-set. They refer also to the 'measures' used in such summaries. The main descriptive statistics calculated here were the measures of central tendency, such as the arithmetic mean, the median (the central value) and the mode (the most frequently occurring value). These summary statistics have been graphically presented in graphs and tables.

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Inferential statistics assess the probability of the results of an investigation occurring by chance. The significance level (the '*p*' value) helps to rule out one validity threat to the result of a statistical test – that the result could be due to random variation in the sample, rather than to a real difference in the population. If the '*p*' value is small rather than large, it is less likely that the result is due to chance deviation rather than to a 'real' difference. In social research the significance level is usually set at 0.05 – meaning there is less than a 5 in 100 risk of this happening. Significance testing also reduces sampling bias, especially as a single sample may not be an accurate representation of the population about which generalisations are to be made, although in this case (and strictly in keeping with Yin's protocol), any generalisations made will be analytic - that is related to theories and not to populations. According to Sapsford (1999) the appropriate inferential statistics test depends on the type of data produced. The most appropriate inferential test of significance (based on all the survey question types) was the Chi-Square – a non-parametric test of inferential significance.

Parametric and non-parametric tests

Parametric tests (said to be more robust than non-parametric tests, Cooligan 1993) make assumptions about certain characteristics in the wider population, such as: is there a normal distribution curve of scores (the bell-shaped symmetry of the Gaussian curve), and are there continuous and equal intervals between test results (such as with interval/ratio data). Non-parametric tests, on the other hand, make no assumptions about the distribution of the population either as regards the parameters of the scores or with certain types of data and are, broadly speaking, the appropriate tests when working with nominal and ordinal data.

Chi-Square Test : Cross-tabulation and Statistical Testing

The chi-square value must be calculated to a significance level before any inferences can be made. This is achieved either manually (by computing the difference between the observed and expected frequencies for each cell in a contingency table and then adding all the differences, Coolican 1993), or undertaken as part of a computer package, such as SPSS. In order to relate the chi-square value to the significance level it is necessary to establish the number of degrees of freedom (expressed hereafter in parenthesis) of the table from which the chi-square value is derived. The table's degrees of freedom (df) are presented in the formula = (r-1) (c-1), that is the number of the rows in the table minus 1, multiplied by the number of columns in the table minus 1. Calculation of the chi-square value is a check on the 'critical values' of the chi-square. Critical value tables can be found

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in text books specifically for this purpose. For example, reading down the column representing the previously chosen probability of error threshold p = <.05) and across the row representing the degrees of freedom in the table - if the chi-square value is larger than the critical value in that cell there is a statistically significant relationship between the variables in the table. However, importantly, the chi-square value does not convey information about the strength of the difference between the observed variables, or where that difference has occurred.

To determine where an observed difference existed, the analysis undertaken during this quantitative phase involved a further test – the use of standardised residuals. These were used to determine where the statistically significant differences were observed. They form part of the SPSS output. Standardised residuals are said to be approximately distributed as a normal distribution with a mean of 0 and a standard deviation of 1. This enables a comparison between standardised residuals with a conventional cut off point of 2 for the standard normal distribution. Thus, standardised residuals greater than (>) 2 suggest that the cell count is significantly different from the expected count and indicate where the significant differences are likely to be. Standardised residuals have been calculated here in SPSS where statistically significant differences in the variables were observed and appropriately identified in the results of the data analysis.

The preceding commentary has documented every facet of the data collection process – in terms of providing a definition of and rationale for the method chosen, how this was executed (including issues relating to sample types, size and recruitment measures), and the steps taken to prepare the data-sets for the next stage. The next chapter presents the analyses of all three data-sets: the interviews, focus groups and survey data and aims to demonstrate the relationship between them.

CHAPTER 5

Data Analysis and Findings

The previous chapter documented the procedures executed to effect data analysis of the three data-sets. The data-sets have been treated facilitatively. This has produced a sequence of data extraction from which key areas of interest have emerged. For example, various aspects of the literature review led to the development of guide questions posed to students in the focus groups and to the MPR at the university's Medical Centre. Analysis of the focus group findings culminated in emergent issues that were specific to the UH student sample in the context of their unique experience of mental well-being in a settings based environment. These issues then evolved into defined categories of interest within which the survey findings were analysed and interpreted.

Firstly, the reporting of the data emanating from the informal interviews conducted with support service representatives provides the contextual setting for the data-set analyses that follows.

The Students' Union: As well as their role in the co-ordination and organisation of social functions, the Students' Union also plays an important role in providing a forum for the student voice. The Students' Union (SU) at this HEI conducts its own questionnaire periodically and provides the opportunity for students to become involved in annual elections for SU officers and delegates and to become student representatives. Student representatives (student reps) take part in the university's various committees on behalf of the student population's interests. The SU also runs an employment agency, a monthly newspaper and they have their own radio station. Attached to the Students' Union is the Advice and Support Centre, which provides advice on all matters – personal, social or academic. Affiliated to the Advice and Support Centre is Nightline, a confidential listening service run by students for students.

An additional objective of these meetings with Students' Union team members was to enlist their help in Phase 2 of the data collection process. Furthermore, they were a source of information and support regarding events that provided me with the opportunity of direct contact with students for the purpose of questionnaire completion. The winning raffle ticket numbers were drawn by a member of the Students' Union on two occasions, firstly with regard to the Pilot Questionnaire and secondly the Main Questionnaire.

Equality and Disability Unit:

The head of the Equality and Disability Unit was contacted due to this department's direct connection with issues relating to social capital. The intention was to learn of the aims of this department, in particular those relating to disability (and the declaration thereof) and equality matters.

Prior to this meeting, I sought out information regarding the university's policies on disabled students. In the UH Pocket Guide (2003), it stated:

> "the University is committed to enabling disabled students to study successfully and to fully enjoy University life" (. 23).

The Pocket Guide went on to define disability as being a condition which is likely to adversely affect day-to-day activities and which lasts for more than 12 months. For example, this might be sensory impairments (such as those affecting sight and hearing), physical impairments, dyslexia, and progressive medical conditions. The Pocket Guide named the member of staff designated to ensure the needs of disabled students were being met and the enforcement of policies and practices in the provision of fair and equal treatment. Within this section of the Pocket Guide undergraduates were informed about the Disabled Students' Network (involving staff and other students) and the Faculty Disabled Students Co-ordinator who provides practical advice and support to disabled students. In addition, the Disabled Support Office provides support with specialist equipment and assistive technology. Students are also fully informed about their rights with regards to receiving fair and equal treatment under the 1995 Disability Discrimination Act, as well as on matters concerning emergency evacuation procedures.

The stated aims of the Equality Unit are :

- to provide equality of opportunity in teaching and learning to enable all students to achieve their potential,
- to ensure that all students are treated equally,
- to create an ethos of fairness, courtesy and respect,
- to deal with any complaints of unfair treatment, harassment or bullying appropriately.

Furthermore, this unit is responsible for overseeing legislative matters concerning race equality and disability discrimination laws.

At the time of meeting, the head of the unit was undertaking a review of the university's policy on student mental health. In light of the university's commitment to discharging its

duties set out under the provision of the Special Educational Needs and Disability Act (2001), appraisal of the university's policies and procedures is ongoing. Part 4 of the 2001 Act superseded the 1995 Disability Discrimination Act to include education and additionally it covers admissions, enrolment, exclusions and the provision of student support services. It states it is unlawful to discriminate on grounds of disability. The policy document included definitions of disability (both physical and mental), which reinforced those of the Universities UK (2002).

Of particular interest to this work were two areas expanded on in the Equality Unit's Review Paper. These revolved around issues affecting staff and their contact with students with mental health problems and extended to the relevant support of students, both withdrawing from and returning to study after a period of recovery from a mental health problem. The Student Mental Health policy review included provision for actively encouraging students with a disability to make a declaration so that adequate arrangements could be made to support them throughout their course of study. Also covered was mention of the appropriate dissemination of information to relevant parties within the university, such as Disabled Student Co-ordinators and members of staff.

Details of the on-line publication of the university's official statement on disability further covered issues of confidentiality and the matter of disclosure. Of particular interest was the incorporation into the policy document of the university's commitment to support the training of all staff to enable them to feel competent in dealing with a mentally distressed student. Such training programmes were run by the university's Counselling Service and were an example of the liaison and inter-departmental co-operation in meeting policy guidelines.

I learned that the review took account of past experiences and changes at the university, legislative changes, contact with other HEIs and a literature review. It also invited comment from other university departments and conducted a survey of the university's disabled students through the network.

During the review process, some members of staff had commented they were concerned about advising students who would prefer not to be labelled as disabled in seeking additional help. It was also noted that some students, not actually meeting the criteria of being disabled, might nevertheless need some extra support. The Equality and Disability Unit take staff training in matters of student mental health awareness and support very

seriously and in order that the Student Mental Health policy could be implemented fully, they worked with other university support services (such as the Counselling Service and the Medical Centre) to develop a peer mentoring scheme. Noteworthy, too, was the comment that university staff were teaching more students with significant mental health needs, the number of which is anticipated to increase further.

I was also informed that the university's policies affecting students' welfare are highly race equality relevant and the review paper included a reference to the need for monitoring the impact of such on students from different ethnic groups. With this in mind, students are encouraged to complete questionnaires emanating from this university department in order to monitor its policies on equal opportunities and race relations.

As regards declaration of a disability (such as, for example, to the Universities and Colleges Admissions Service), HESA stress that students are not obliged to report a disability. Should they do so, it is on the basis of their own self-assessment. As a result some institutions are not aware of the true extent of disability amongst their student population. UH actively encourages declaration of a disability during the admission process and at enrolment. They nevertheless stress the opportunity to do so exists for the entire duration of students' period of study.

Issues relating to disability disclosure and the university's commitment to non discrimination on grounds of disability were covered through several outlets: on a website www.herts.ac.uk/equality (which also included a statement on disability declaration dissemination protocols), and in a dedicated information leaflet 'Information for Disabled Applicants'. With this statement comes an assurance that any disclosure will be treated with sensitivity and that disclosure to other members of staff would be restricted to meeting the disabled student's individual needs. This leaflet also covers learning disabilities and provides students with relevant persons of contact and contact telephone numbers.

The Counselling Service:

Information gleaned from the counselling service took place over several months and involved communication via e-mail and two informal meetings. The first meeting was conducted with a counsellor (standing in for Head of Counselling) and the second meeting took place with the Head of Counselling. My key topics of interest were: the numbers and breakdown into age and Faculty of client students, differences in attendance figures between males and females and affirmation of the declaration that mental health problems

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in young people were escalating and becoming increasingly severe. Other areas of interest were: whether overseas students use the counselling service in similar proportions to home students, and the extent of inter-departmental co-operation and referral systems. Also posed to the counsellor interviewee were questions concerning staff training opportunities, the type of appointment system in operation and measures taken to address equality and non-discrimination. Responses to these topics were covered either in written format (such as formal policies, guidelines and procedural policies) or transmitted through the discourse process.

The stated aims of this HEI's Counselling Service are:

- to provide a high quality professional clinical service to students and staff who experience emotional and psychological difficulties,
- to contribute positively to students' experience of university life by sharing an understanding of the emotional issues that affect learning and development with other members of the University,
- to contribute to the development of understanding and knowledge in the field of counselling,
- to work together with university staff and colleagues at a national level to continue raising awareness of the mental health needs of the student population.

The counselling service operates a triage system to assess students' needs at the first session which usually takes place within 24 hours of contact with the service. Subsequent sessions (lasting 50 minutes) are negotiated between student and counsellor and based on individual need.

The Head of UH Counselling is a very highly regarded and active member of several nation-wide counselling associations, committees and working parties and co-author of several influential reports emanating from with the university counselling sector. One such example was the undertaking of a survey into Medical, Psychiatric and Counselling provision in Higher Education, conducted in February 2002 on 55 universities and 10 HE colleges. Analysis of the data presented here relate to medical provision and for reasons of compatibility with this work, the responses are restricted to universities. Nearly eighty two per cent of universities responding to the HUCs (2002) survey said they had on campus medical provision and the proportions of students served by such provision were stated as being: 6.7 per cent of university medical services served just 10 per cent of the student population, 11 per cent served 11-25 per cent, 13 per cent served 26-50 per cent, 24 per cent served 51-75 per cent and 27 per cent served 76 per cent and over.

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The UH Counselling Service offers frequent training sessions to support staff in their implementation of university policy and procedures on mental health issues and are available to all university staff who have contact with students (academic, administrative and technical).

There is considerable collaborative work between the Counselling Service, Equality and Disability units and other university departments, including the Medical Centre. One such example was a Training and Research forum, initiated out of concern over whether there was adequate provision for the growing number of students with mental health difficulties. An outcome of this forum was the decision to implement a pilot mentoring scheme whereby vulnerable students, including those with mental health difficulties, are assigned to a student volunteer mentor. Such mentors, selected from second and third years of study, are given appropriate training and supervision from designated staff. They use their greater experience of university life to help the referred student access relevant practical support. It was hoped this scheme would be proactive (and therefore prevent crises from occurring) and aid student retention.

As part of the university's Professional and Academic Development Programme (and in order to raise staff awareness and increase knowledge of mental health issues), the Counselling Service regularly runs training sessions in student support for university staff for a half day over ten weeks' duration. These sessions provide advice and support to staff on how to best manage difficult situations and to consider referrals using the resources available within the university (www.hucs.org/retention.htm). The counselling service has also provided internal conference days to build inter-departmental co-operation and to clarify recent disability legislation relating to mental health issues, and its implications for both students and the university. For example, the Special Educational Needs and Disability (2001) Act requires all higher education institutes to make 'reasonable' adjustments to ensure that all students with mental health problems have the same rights and are treated as equally as other disabled students.

The counselling service produces annual reports. In their Annual Report for the academic year 2002-2003, the student client profiling demonstrated that two thirds of clients were female, one third male, and that during this period there had been a six per cent increase in 19-21 year olds (predominantly first year students) using the service. Self-referral remained the highest intake method followed by referrals from academic staff and the Medical Centre. The presenting issues were firstly relationship problems (45per cent), self-identity issues (39 per cent) and thirdly academic anxieties (35 per cent). The

breakdown of clients into faculties revealed that 27 per cent of students were from Health and Human Sciences, 16 per cent were from the Business School, 14 per cent came from Engineering and Information Sciences, 11 per cent Natural Sciences, 9 per cent Art & Design, 8 per cent Education and Humanities and Law and 7 per cent Interdisciplinary Studies. Proportionately more home students availed themselves of the counselling service than overseas students.

My visits ended with the acquisition of several leaflets produced by the counselling service, some aimed at students - which covered areas of concern to students, confidentiality issues, what to expect from counselling, information about other support groups, onward referral policies, ethical codes of practice, informed consent, equality and non-discriminatory policies, and disability access. Another booklet entitled 'Helping Distressed Students: A Guide for University Staff' aimed to provide university staff with clear, concise guidelines that directed them towards appropriate sources of help for urgent and non-urgent situations. This booklet also stressed the importance of staff mental well-being (reminding staff that the service was open to them as well), and covered confidentiality matters and informed consent. It also acknowledged that family and friends are a common source of support to many students. Leaflets about the counselling service are also printed in different languages for those whose first language is not English.

The semi-structured interview with the medical practitioner

Analysis of the formal interview undertaken with the representative of the university's Medical Centre, another of the key student service providers, further added to the study's aim of securing a more balanced overview between the micro (the student perspective) and the official macro perspective. The literature review had revealed several areas worthy of further enquiry, such as the dearth of research into young people's engagement with the medical services, a lack of knowledge about which type of service best meets the practice population's needs and the suggestion that a biomedical approach to health promotion from within general practice itself does not always effect the best outcome for 'patients'. Emergent issues from focus group analysis had also supported other issues worthy of further investigation, such as those relating to registration, confidentiality, lack of awareness concerning the role and remit of general practice, and the influence of past experiences on service uptake. Consideration of the Health Promoting University initiative, within this subject matter, also raised matters concerning inter-agency co-ordination and co-operation.

These issues were grouped according to their relevance to the topic areas under consideration and are presented below:

Registration with the University Medical Centre and the declaration of a mental health problem

In accordance with fulfilling the criteria within the quality and outcomes framework of the 2003 GP Contract, the University Medical Centre has a register for students with severe mental health problems and such cases are discussed monthly with a multi-disciplinary team within the community mental health service. When prompted about existing policies and protocol covering less severe mental health problems, the MPR replied :

> "For, you know, milder cases, such as emotional problems and that sort of thing, tend to be dealt with within primary care and, you know, the University Counselling Service" (p. 1).

Significantly, the UMC is not informed by the university registration department about students declaring a mental health problem and so they would not know about undergraduates who did have a mental health problem unless they registered with the practice. It is only on completion of the UMC's registration procedure (which allows for disclosure of a specific problem) that the practice would be aware of any pre-existing condition. The Medical Centre's policy is then to contact the student to invite them to an appointment – after a 'settling in' period.

The MPR was of the opinion there were approximately 30 – 40 per cent of students registered with the UMC, but interestingly the numbers of students on the practice list was thought to depend on the time of year. It was proposed that students often do not register until they need to and in fact some registrations do not take place until students' last term. The UMC now sends out a Medical Centre registration form with the university's acceptance pack and this, according to the MPR, has increased student registrations. It is, however, recognised that UH has a significant number of commuter students. This means there is inevitably a proportion of students who would not be able to register because they would not be residing in the Medical Centre's catchment area.

As a source of help in times of emotional distress, the MPR acknowledged that most students would probably turn to parents or friends in the first instance but, in their experience, it was felt some do turn to the Medical Centre :

> "if they've been before with a problem and they think perhaps we're not too bad, they may well come and talk to us" (p. 7).

The MPR was also of the opinion it was often a family member or a lecturer who would direct a mentally distressed student to them for help.

Confidentiality, inter-departmental/liaison/co-operation and potential areas of conflict

It was evident that the UMC had a good working relationship with other university services with regard to student well-being. There is a system in place whereby the MPR meets regularly (in varying departments) with Deans of Students to discuss 'cases of concern' and there is also frequent liaison with the University Counselling Service (UCS) about such students. The UMC refers students to the UCS and vice-versa. If counsellors or lecturers phone the UMC with a concern about a student, in most cases the student would be fitted in immediately. Only in extreme cases would students be escorted to either the UMC or UCS; this is not the preferred way. It was also stressed that a similarly strong communication system extends to other university departments and to academic staff. For example, the UMC also encourages academic tutors to contact them directly about individual cases causing concern although it was stressed students were always encouraged to make contact themselves. The MPR stressed flexibility of contact with other departments (as well as with students) was the key to a successful outcome.

It was conceded confidentiality issues can be problematic. All parties feel it is important to encourage students to access help of their own volition and the MPR stated they always ask if the student is happy for them to discuss their case with another member of another service (such as the Counselling Service). A student's permission is always needed for a meeting with another service before it can take place. Sometimes it is considered advisable to get a student's signed consent – particularly if there is likely to be on-going correspondence. The MPR said students were always reassured that nobody else would be informed unless they had given their express permission. As far as contacting parents is concerned, this is only done with the student's permission. At all times the UMC has the best interests of the patient in mind.

Implementing health promotion activities and the Medical Centre's views on and approaches to mental health promotion

When asked about whether the UMC has, or would consider, implementing health promotion activities, the MPR replied that the Medical Centre *would* be in favour of implementing health promotion activities :

> " if there's something to be gained from such" (p. 2).

On further probing to elicit the meaning of this statement, the MPR explained that it would have to be worthwhile running a specific service, over and above offering general medical services.

There had, in fact, been a few attempts to provide additional services to students on the practice list (in the form of 'special' clinics – such as an Asthma Clinic, a 'Walk-In' Clinic and the extension of an evening surgery). However, it was found that even after invitation to attend the Asthma Clinic, so few attended that the UMC concluded it was not worth running. The proposed reason for student non-attendance was attributed to the restrictive times of the clinics which were often unsuitable to students, due to their different commitments.

The UMC was of the opinion they needed to be very flexible in their approach to meeting students' needs and the provision of specifically designated clinics, run at set times on set days, was not the best way to achieve this aim. When asked directly about operating a 'mental health clinic', the MPR remarked:

> "to give you an example of the Asthma Clinic, we found that it hasn't worked. We know the reasons for this and they would be transferable across to other clinics as well" (p. 5).

In addition, stated the MPR, to be effective this type of service would need to be available every day and although working to a specific protocol would not be a problem, arranging for the whole multi-disciplinary team to be present would be. The UMC had also estimated that by providing specific clinics on specific days, up to forty per cent of those who needed to attend would not be able to so – due to other commitments. Based on past experience, the UMC had found 'Walk-In' clinics worked best, although ultimately they prefer to offer generic appointments, which overall they feel provides the best level of service.

As far as the students' needs were concerned, the MPR was of the opinion that students wanted to be seen when it suited them (not early morning or in the evening); but mostly around lunchtime. The UMC had tried staying open later in the evening to accommodate students but, again, the service was not used and was subsequently abandoned.

Notwithstanding their disappointing previous experience with running additional services, the MPR stated the UMC would consider implementing a health promotion activity - *if*

there were a demonstrable need. Indeed, the UMC did not rule out the possibility of applying (through the relevant channels) for an enhanced local service, providing the demand was there and funds were available to implement such a service.

On the matter of which of the hypothetical additional services the UMC would consider implementing to promote student mental well-being, as lead practitioner, the MPR expressed the practice's views in written format recorded on the sheet left at the time of interview and later returned completed (see Appendix 10b). The responses indicated the following:

- No comment was forthcoming about implementing a 'Walk-In' clinic. This is almost certainly due to the fact that the UMC had already run such a clinic. With regard to a nurse-led mini clinic for mental health problems, the MPR replied they would not consider this because : "We prefer to offer 'generic' appointments to be more flexible". This supports the earlier comment made during the interview.

- Neither would the UMC consider offering 'Newly Registered Undergraduate Health Checks' for the reason that: "it would be unlikely to be productive". The MPR was of the opinion: "time is better spent on those who seek help". However, of interest there was a positive response to both the proposals of a telephone-support triaging service and an e-mail support service.

As a result of this one-to-one interview I gained an understanding of some of the policies and procedures in force in dealing with student mental health issues from the perspective of a service provider. These issues included a student declaration of a mental health problem, inter-departmental co-operation, confidentiality imperatives and the UMC's views on implementing additional services, in light of the opportunity presented by the New 2003 GP Contract. It did also highlight areas of dissonance between the micro and the macro perspective, such as the provision of additional services that were not popular with the students themselves. These matters will be discussed further in Chapter 6.

Most importantly, the findings of this data-set were used facilitatively with the findings of the focus group discussions (see below) to inform the compilation of the survey questions – the analysis of which is to be found at the end of this chapter.

Focus Group Discussions: Summary and Findings

The following represents a summary of the interpretive analysis conducted on the eleven focus group discussions (consisting of 51 UH undergraduates) according to the protocol of Miles and Huberman (1994). For reference purposes, the focus group question (see Appendix 7a – 7h) has been incorporated into the themed topic summary and is represented within the text by **FGQ**. Where citations from the raw data are included, the specific focus group in which these occurred has been suffixed to the abbreviation FG.

Students' definitions of health related terminology

The focus group participants were asked for their definitions of: health, mental health, mental illness and health promotion **(FGQ1)**. Responses to this question provided valuable insight into students' perceptions of these terms for the reason that students were to be asked questions in the Student Questionnaire concerning their own mental/emotional well-being. After data analysis it was apparent (and not surprising) that the terms meant different things to different students. Health was often perceived to be associated more with physical aspects of the body and interestingly there was still a residual pre-1947 WHO biomedical definition that health was an absence of illness : "it's about not being ill" (FG2), "you're in a good state if you're not ill" (FG11).

Similarly, mental health was often defined as the absence of negative, stressful, distressing circumstances. There was also a notable association with the (internal) locus of control theory whereby several students felt mental health was associated with the individual's sense of control over "upsetting/stressful" situations and their own ability to deal with the problem and overcome it: "mental health is knowing how to cope with a situation" (FG2), "mental health is coping well with stress, disappointment or setbacks and knowing how to sort out bad feelings" (FG8). It was acknowledged that some physical conditions (such as Alzheimer's) will affect emotional well-being and are outside an individual's control. Having a strong social network (in particular friends and family) was considered to be a vital component in sustaining mental well-being. So, too, was the importance of an environment that promoted health: "If surroundings are wrong, there's a greater likelihood of mental illness developing" (FG3).

Mental illness was perceived to be either the result of not being able to cope with stressful situations (commensurate with the notion of an 'external locus of control') or as a result of unfavourable circumstances, such as: "not feeling right with your surroundings and the

situation you find yourself in, feeling different and 'wrong' with the people around you" (FG7). It was also acknowledged that mental illness can be helped by doctors and psychologists but that it carried a stigma. Reference was made to the holistic aspect of health in that mental illness can affect physical health and vice-versa.

Health promotion was seen to be first and foremost concerned with the provision of information (education) to prevent illness, in particular through nationally orchestrated campaigns (such no-smoking campaigns) and advertising through posters, leaflets and television advertisements. To other students it also meant: "life-style changes" (FG1), "preventing unhealthy things" (FG9) and for one student there was a salutogenic connection: "health promotion could be rephrased as health awareness, although it is also promoting the positive aspects of health" (FG11). The Medical Centre was cited as being an appropriate arena for health promotion. The essence of these findings were incorporated into the Student Questionnaire Briefing Sheets (see Appendix 22).

When asked their views on whether feeling emotionally/mentally well was within their own control or more to do with outside influences (**FGQ2**), students' opinions fell firmly into three camps – those believing emotional well-being was entirely within the control of the individual: "Completely in your own control. Outside situations may influence you but you can control how you feel about them" (FG4), those believing outside factors were more influential: "outside influences will have a greater impact" (FG9) and others who thought it was a combination of both internal and external factors: "depends on whether the person has a negative or positive attitude towards outside influences" (FG2). From students' responses it was evident that personality factors were deemed influential in either warding off mental health problems (resilience) or predisposing others towards developing mental illness (vulnerability): "It's more to do with personality, some people can help it, some can't" (FG7). It was also acknowledged that whether an outside factor could adversely affect emotional well-being would depend on the "goodness of fit" between internal and external influences. Furthermore, having a positive or negative approach to outside situational circumstances could not only be influenced by personality typing but also by an individual's past experiences (and the socialisation process) regarding stressful situations. It was suggested that improving self-esteem and maintaining control over potentially stressful circumstances are factors that can be learned and that some individuals would need more support than others - due to their unique predisposition towards either resilience or vulnerability: "It's a new experience which can be difficult for all students. It depends so much on the personality, some will find it hard, some won't" (FG9).

Promoting Health in the University Setting

UH is thought to promote health through the following **(FGQ3)**: the provision of a swimming pool and a gym, no-smoking areas, a Medical Centre, Nightline, the Counselling Service, Studynet (though accessing information was only achieved through a somewhat tortuous system of layers), the Students' Union (through events, advisory centre, leaflets) and healthy food options in the refectory. Induction Week was thought to be the staple medium of support service promotion at the beginning of term: "We've been very well advised and everything is explained during Induction Week. The support we get is very good" (FG11). However, several students were of the opinion there was a real need to recap on the delivery of information that took place during Induction Week as unless services were needed almost immediately after arrival, information about them was quickly forgotten among the plethora of information that had to be assimilated during a relatively short period of time. For this reason, students believed it was important to actively promote all the services over the entire campus and to periodically remind everyone by having refresher sessions as reinforcement: "They probably do give you something about the uni when you first come on the course – but who reads that?" (FG6). Leaving leaflets around and seeing the odd poster was not considered to be sufficient promotion of vital support services. Furthermore, what little promotion there was (often in the form of advertisements) was usually restricted to the proximity of the service setting, such as posters about sexual health being inside and close to the location of the Medical Centre. It was remarked that faiths (other than Christianity) should be advertised more and there was disappointment expressed concerning a lack of promotion aimed at healthy eating.

UH was thought to promote mental health through **(FGQ4)**: Nightline, the Counselling Service, the Students Support and Guidance office, the Medical Centre, lecturers, leaflets, events, activities and outings, though it was felt the latter three items were mostly aimed at overseas students rather than home students. Negative responses were that no effort was made to tackle the issue of emotional health directly. One student (expressing a salutogenic perspective) suggested there was a need to promote and maintain a mental health balance as opposed to dwelling on mental ill health. Induction Week was also thought to provide a very important socialising function which was of particular benefit to overseas students, especially with regard to alleviating homesickness and averting feelings of 'anomie' - though it was suggested not enough emphasis was placed on the cultural adaptation process. The International Students Officer and personal tutors assigned to overseas students were thought to be important agents of support and an excellent source of help and advice. Both personal tutors and lecturers were named by some focus group

participants as the first 'port of call' for those experiencing emotional problems (and sources of onward referral), although it was proposed the pastoral role of lecturers (as well as personal tutors) had not been sufficiently well promoted. Of note, the UMC was mentioned more often when students were asked to comment on how UH promoted 'health' (as opposed to how UH promotes mental health) which suggests general practice is still more readily associated with physical rather than mental health.

The Support Services

The most frequently named support services that students were aware of (FGQ5) were: Nightline, the Counselling Service, the Medical Centre, Accommodation Office, the Students' Union, Finance Office, lecturers and university staff. Those mentioned after prompting included the Careers Service, the Chaplaincy, and the Job Centre. Those services not initially regarded as support services – the security service and the university bus service – were nevertheless very highly regarded, especially with respect to safety matters. The visibility of security guards was particularly valued, as was the immediacy of contact with them (not having to leave a message on an answer-phone). Students appreciated the 24 hour cover provided by the security service, though they said they would prefer a greater and more visible presence at night. In similar vein it was thought an extended bus service to cover evenings and weekends (when there were events at the Students' Union), would alleviate much anxiety concerning safety and the fear of walking between campuses, especially as there had been reports of "incidents" of attacks and muggings. Inter-campus resentments emerged concerning the lack of representation of some of the support services on each of the campuses (especially the Medical Centre in times of illness) and particularly with respect to law students who did not benefit from the free bus service between College Lane and de Havilland

Past experiences (both good and bad, of self and others) were influential in establishing a judgement on a service and the willingness to access that service. This was especially true of the Medical Centre. Moreover, a paucity of information about the precise role and remit of the support services can lead to misconceptions and, as a consequence, result in hesitancy concerning service utilisation: "It's not been advertised, the medical centre, what is provides and how it can help us, so we're not going to use it if we don't know about it" (FG4).

Students' response to the question concerning easy access to the support services (FGQ6) was mixed, some having accessed the help they needed without too many problems, while

others encountered difficulties, largely due to: support service working hours that were incompatible with lecture times, insufficient staff to meet high demand, unhelpful staff and staff who provided conflicting advice and information. Many students, however, were very appreciative of the help and advice they had received – from a variety of outlets across the university: " it might not be one as such, but everyone I've come into contact with at the uni has been a support service to me" (FG3). Although it was acknowledged there was a strong network of support provision at the university: "….compared to German universities, the support services here are very good" (FG8), accessing help was sometimes impeded because the services were neither actively nor visibly promoted and students felt they often had to seek out the help they needed: "There is help but you have to actually go and look for it yourself. It's not being promoted" (FG4). Some services were even accessed by default (that is when students were looking for another service): "I haven't seen it walking round but you might bump into it by accident" (FG6) or learned about from other students. Generally speaking, students thought much of the support service promotion was undertaken passively rather than actively: "Not enough is done to get information across especially as there's apathy among students in bothering to find this out" (FG8). In addition, access to the support services was not easy for students from other campuses as it was recognised that most of the 'emotional support' was based on College Lane and a lack of good signposting made some of the services difficult to locate: "Most of the services are on College Lane and this poses huge problems if you're based on another campus" (FG4): "As a law student we just don't have easy access to the support services" FG4), "it would be helpful to be given orientation on all campuses so that we feel familiar with where they (the support services) are when we need them" (FG1).

The University Environment

When asked about their views on their immediate environment at UH – such as cleanliness, safety, visual attractiveness (for example: buildings and open spaces), sporting facilities, the transport system, accommodation **(FGQ7)** - students were generally satisfied with their campuses aesthetically, preferring the newness of de Havilland but appreciating the open spaces and trees on College Lane campus. St. Albans was described as consisting of concrete boxes. All campuses were considered to be as clean as could be expected and the visible presence of staff picking up litter was very much appreciated. Although some accommodation at de Havilland was thought to be small to the point of claustrophobia, it was considered to be more secure than College Lane. It was alleged there had been breaches in security and theft of personal belongings from rooms and flats on College Lane

which was apparently not so prevalent on de Havilland due to the efficacy of personalised ID cards.

Grievances were expressed about the cost of sports facilities at de Havilland, in particular from overseas students: "It's disappointing the sports facilities are not included in the fees for international students. The cost is much too high" (FG2). It was thought a considerable number of students from all campuses (both home and overseas) were missing out on the sporting opportunities due to inhibitive costs.

Safety was a huge issue for many with the biggest threat to students being posed from outside. There were access points around the campus which students would like to see better manned or surveyed by CCTV: "Safety is the biggest thing for me. At some parts of the uni security is good but there are other places where it is lax. All places where there is access to the uni from the outside should be manned" (FG3). Opinions on the use of CCTV were decidedly mixed – some seeing their use as an infringement of their privacy whereas others welcomed the protection they thought it provided: "It's good to have CCTV as long as it doesn't cross any lines with privacy and people feel their every move is being watched" (FG3). Others were cynical about whether the cameras were loaded with film but it was generally agreed CCTV helped to combat the fear of crime: "CCTV makes you *feel* more protected" (student's emphasis, FG1, female). On campus students felt relatively safe and were appreciative of the high profile and visible presence of the security guards: "the security guards are brilliant, they're usually visible, even during the night you can see them" (FG5), However, others felt their presence was not as comforting at night when they patrolled in cars or walked in pairs. There were times and places where students felt particularly vulnerable. These were late at night (especially after an event at the Font) when students felt it was too dangerous to walk home between campuses on their own: "on campus you feel reasonably safe, off campus you don't. Because buses stop early, walking from one campus to another is scary" (FG1, female). Females also felt especially vulnerable when lectures finished late.

(Cross-case analysis had revealed considerable overlap between focus groups concerning the issue of safety. On reflection it was decided passages relating to safety matters were best left in the context in which they occurred in the focus group discussions, specifically to highlight the impact this issue appeared to have on students' emotional well-being).

When asked what improvements they would like to see to the UH campus **(FGQ8)**, students replied representation of some of the support services on each campus (if only for

a day a week) would be appreciated, as well as an orientation day on all campuses to familiarise students with the whereabouts of services so that they could access them easily in times of need. More effort to reduce waiting times to be seen by most of the support services was also a consideration. More widely distributed advertising and better promotion of the support services throughout term would be helpful as well as installing cash-points and post-boxes on all campuses. A reduction in the cost of food on campus and the provision and promotion of healthy eating was an important issue to some undergraduates. Some overseas students had experienced difficulties in adapting to different cuisines and this might be borne in mind by the university, especially during Induction Week.

Other issues included the provision of more activities to suit the needs of students not interested in participating in the Pub/Club culture: "tackling the alcohol problem – it's a British phenomenon. Students are younger than in Germany and they have to be drunk by 11 because the Font closes at 12" (FG8). Several students would like to see a more vigorous approach in tackling the alcohol and drug problem that is conceded to be present in every university today.

Yet again, safety matters, above all, appeared to affect students' well-being. It was thought many students do not attend College Lane functions for fear of having to walk home after the last bus had left. Both males and females do not feel safe unless they are in a group. Some overseas students felt particularly vulnerable as there had been a few incidents of racism (off campus) though it was again conceded this could happen anywhere. It was suggested that some sort of dedicated taxi-service which operated into the early hours and over the weekend would be most welcome.

The following (extracted from the verbatim transcriptions) provides a running dialogue to illustrate the above:

FG9 : (F) For me the transport needs improving. After going to the Font we have to walk back to de Havilland.
(M) Yes, the bus stops at 11 and the Font goes on to 12-1.00 and there are no buses at the weekends between the two campuses.
(F) We are bothered walking back. It's OK if you're with friends but if you're on your own, it's not nice.
(F) My friend was walking back once and she was approached by someone and she said it was really scary. She was on her own.
(F) The CCTV cameras don't work – I can tell.
(F) We wouldn't know even if they were.
(F) One of my flat-mates got attacked but there was no-body on the CCTV.

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(M) If they had hats on they couldn't see them anyway.

(M) And if the camera was not in the right position…

FG10:

(F) I would like to change the transport system which is bad at the weekends and for de Havilland students it is particularly bad because they have to walk home after a night out. You must always walk back with a group of people.

(F) Because it's not safe without a group of people.

(F) We don't feel safe anyway. It's not safe to walk back to de Havilland. If you are a local it's OK but if you are Chinese or other people you will be beat by locals. His neighbour beat by somebody and when he came back by himself and you really noticed it.

(F) That would be the same anywhere though … I wouldn't walk round on my own at night at home.

(M) I'm English and am not really aware of the problems you've had. I get the National Express at 2.00 in the morning.

(M) If you're a foreign student then I guess you'd feel more uncomfortable.

Academic Staff

Students were asked about their experience, so far, with the academic staff at UH, particularly as regards whether they felt they were approachable and helpful **(FGQ9)**. It became apparent that not all students are allocated to a personal tutor. Some of those who did have a personal tutor seemed aware of their pastoral role: "I've got a tutor who is purely for counselling" (FG9). With regard to lecturers, responses were polarised again, with some students having found their lecturers to be helpful, kind and approachable: "I've found them very supportive" (FG10), while others had met with dismissiveness and perceived rejection: "I've had a very negative experience with a lecturer who just can't be bothered – he didn't reply to my e-mails and was dismissive when I went to see him" (FG6). The term "comfortable" was frequently used to denote a good relationship between students and lecturers: "If lecturers don't make you feel comfortable and welcome that's when you start to skip lectures" (FG4). Lecturers were also seen as being the gateway to onward referral, if they couldn't help students themselves. Furthermore, lecturers were especially valued as a source of guidance and advice with regard to the transition period from school to university: "We need adult supervision for a lot of the first year when you need someone to turn to. You can't just rely on your peers" (FG4). A good relationship with lecturers was thought to be of particular value to overseas students, though in some cases this only heightened language and cultural differences. Conversely, some home students were unable to communicate easily with their lecturers due to language problems and this was cited as being a reason to miss lectures: "On my course there are a few Chinese lecturers whose lectures I don't bother going to because I can't understand what they're saying…." (FG11). Students were also offended if lecturers did not know them by name.

Law students in particular had more positive experiences with academic staff at St.Albans and were full of praise for their lecturers. This was partially attributed to the fact that the student to lecturer ratio was considerably lower in the Faculty of Law than in other Faculties and because St. Albans campus functioned more as a community: "There's so few of us (at St. Albans). We know our lecturers well and they've always been willing to help; not just with academic work but if we're stressed as well" (FG4).

There was an acknowledgement that the work-load of academic staff can affect their pastoral role: "they're all good but they're rushed all the time – somewhere else to get to" (FG11), "Some of them are just under a lot of stress and don't deal with it very well" (FG6). Several responses highlighted the possibility that some UK students had unrealistic expectations of lecturing staff (raising the point that the transition from school to university was more difficult for some than others): "He didn't reply to my e-mails and so I thought OK, I'll just read the book myself and teach myself the subject" (FG6), whereas EU students were impressed with the level of help and support they had received: "In England a lot of the lecturers treat you as an equal and I find that very nice" (FG7).

Students' opinions on disability (physical, mental and learning)

When asked if they would have declared a physical disability **(FGQ10),** most students stated they would have declared a physical disability because the university could not be expected to make provision for them on admission if they had not been made aware of it. There was an acute awareness of what help there was available to disabled students – such as equipment, bursaries, amendments to existing provision, help with course work and during examinations and assistance in the form of visible aids such as lifts, ramps, adapted toilet facilities, microphones in lecture halls and extra work-shops for learning disabilities. There was considerable praise for UH in the provisions made – to the extent that a degree of resentment surfaced from time to time from non-disabled students concerning the attention and benefits bestowed on disabled students at UH. To some this was expressed as feeling forgotten and left out, significantly because support mechanisms for disabled students were actively promoted and highly visible throughout the university: "You want to be disabled when you come to this university because they've got so many facilities, they've got everything for them. They promote the health of disabled students but they've forgotten us while they've been doing that" (FG5). There was also an element of cynicism in that UH might be discriminating positively with regard to disabled people to reflect

admission numbers in their official reports and that this was reflected in lower entrance grades for disabled students.

It was remarked that while there is "no shame" in admitting to a physical disability, there is a stigma attached to having a learning disability and this might inhibit some from making a prior declaration.

By contrast many of the focus group participants would have been reluctant to declare a mental health disability **(FGQ11)**. Their decision to do so or not would be based on the type and severity of the condition and whether it was long-term (in which case it might have to be declared) or short-term (in which case it might not need to be declared): "If it was the sort of thing I could hide, then I wouldn't tell them because there's a stigma attached to mental disability" (FG11). The personal experience of many students with regards to others having had episodes of mental health problems, (both positive and negative), would impact considerably on their decision whether to declare it or not.

Reluctance to disclose a mental health disability was motivated by a variety of reasons – *personal:* "It's private thing so I wouldn't tell others" (FG10), the *fear of stigma and labelling:* "there's a stigma attached to it" (FG6), "you could be put into this box and it's not very nice" (FG6), *concerns about confidentiality:* "only if I was 100 per cent certain that it wouldn't get out – I'd need some assurances first" (FG7), *discrimination* "… even though they say they're anti-discriminatory, they'd probably hold it against you" (FG10), and concerns that a declaration would mean you would be treated differently.

In support of making a declaration of a mental health problem was the requirement of some professions (such as teaching and the law) to do so. Another reason was borne out of a sense of duty and responsibility to others, especially as a mental disability was not as visible as a physical disability. Notable explanations for this included preconceived notions about unpredictable and sometimes violent behaviour of people with mental illness towards others: "your disability may have an effect on other people and you could end up harming them" (FG10).

Another motivation to declare a mental health problem (if deemed absolutely necessary) was that failure to do so might result in the student's official rights being rescinded, especially with respect to university support in negotiating "time-out" to recover from a period of ill health. Some students feared this might even adversely affect their ability to complete their course.

There was again resentment expressed about the "considerable" assistance afforded to those with disclosed dyslexia - which stimulated a discussion as to whether dyslexia is actually a physical (affecting the brain) or mental (affecting the mind) disability. It was noted that dyslexics receive bursaries, computer equipment, laptops, Speak Packages, extra time in examinations and help with course-work, and that the benefits of declaring such a condition might well outweigh any disadvantages.

Factors that challenge mental well-being within the university environment

Students were asked what problems in particular could make them feel depressed/anxious/stressed while they are at university **(FGQ12)**. The most frequently mentioned, unprompted, responses fell into four main categories: academic concerns (including examination stress, course workload), relationship problems (forging new relationships and making friends, getting on with flat-mates and not being personally known to lecturers), money problems and having to work long hours off campus: "the thing that stresses me out the most is probably work, I do paid work and that takes up a lot of my time" (FG3), "I work more hours than is recommended, probably three times as many which means not doing course work properly" (FG8). Feeling homesick, missing family and friends were concerns for all undergraduates. Some overseas students' responses resonated with the description of 'anomie', such as feeling lonely and not being accepted, encountering integration problems and for some language difficulties were especially problematic: "For me with the language, with the English because I speak still I speak bad at the beginning" (FG10) and "At the beginning I was so depressed because I tried to speak and people didn't understand me…" (FG10).

Parking problems, concern about the safety of personal belongings, the drug and alcohol problem were also mentioned spontaneously, as well as there being little perceived effort made to meet diverse social needs - with the implication that the Pub/Club culture does not appeal to every student: "I think they could try harder to meet more people's interest needs" (FG4). 'Prompted' comments included: 'wanting to protect family and friends from worries', 'health problems' and 'providing emotional support to others'.

Help-seeking behaviour – on behalf of 'another'

Focus group participants were asked to respond to a scenario (see Appendix 7b) which depicted a fellow student (precise relationship not specified) exhibiting signs of depression **(FGQ13)**. Students' responses appeared to be directly related to the type of relationship they had with 'Alex', the closer the relationship the deeper the involvement. Close friends

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(and to some extent more casual friends) would not want to involve outside help, unless it was considered urgent or they felt they could not deal with it themselves. Less close friends might turn to Alex's friends, or encourage him to seek help (such as from a lecturer or counsellor; contacting the Medical Centre was not mentioned) as they thought it would be to Alex' advantage to take the initiative himself. In extreme cases his family might be contacted.

The most common reaction was first of all to talk to Alex, to try to find out what was wrong, befriend him, to take him out of the university environment, involve him in activities outside of university life, but most importantly to let him know there was someone there who cared.

Nevertheless, there was a strong sense of respect for Alex' autonomy – don't force him to talk, respect and accept he might simply want to be left alone. For almost all students ignoring Alex was not an option.

Some students expressed concern about being rejected, not by Alex but by the person from whom help was being sought: "you could tell someone else but they might turn round and say – what do you want me to do about it?" (FG8). Trust and close personal involvement were key issues in this category as was the unfolding significance and example of social capital.

Help-seeking behaviour – the influence of 'significant' others

Responding to the question about who could persuade students to seek help if they felt like 'Alex' (**FGQ14**), the most cited 'others' were family and close friends (especially mothers), rather than casual friends and peers, or university support services - due to an expressed lack of trust and fears over confidential issues. To some degree this feeling extended to lecturers. Familiarity, trust and respect are therefore important components of any support system: "I wouldn't turn to what the uni offers first. I would turn to friends because it's the person you can trust most. You don't know, if say, you have a counselling session you will have in your mind – are they going to laugh at me or talk about me..." (FG4)

However, it was also acknowledged that it can sometimes be easier to talk to someone who is not so close and familiar: "Sometimes it's easier to talk to someone who is not so involved with you" (FG3). Significant comments were made by some overseas students.

Chinese students said that due to the importance of being completely understood, it would need to be someone with the same language and understanding of their culture:

> (M) for me it would have to be other Chinese students,
> (F) this would be because of language problems,
> (M) and because of the very different culture here,
> (F) this means we usually talk to each other.

There was also the suggestion that the host nationality might not always be as welcoming and willing to try to understand as they might be: "I wouldn't turn to many English people because in case they weren't open with me" (FG10).

When asked to whom they would turn for help **(FGQ15)**, some students replied it would depend on the type of problem being experienced: "Depends what I was depressed about. Work problems I'd see someone academically, health problems I'd go to the doctor" (FG1), and the type of relationship students had with that person. Yet again family, friends (boy/girl friends) and in particular 'mum' were singled out as students' first port of call for emotional (and financial) problems. This applied to males, too, though some students of both sexes thought it would be advantageous to try to solve the problem themselves as this was part of the struggle towards independence.

Familiarity and feeling "comfortable" with that person were again most apparent and it was noted that many students did not feel sufficiently close to their lecturers or personal tutors to turn to them first in times of emotional need:

Unprompted comments from FG6 : (M) I wouldn't turn to my tutor first.
(F) Neither would I.
(M) I wouldn't either.

Prompted comments from FG7 : (F) I don't feel close enough to my personal tutor because apart from lectures I was only introduced to him once.
(F) I don't know what a personal tutor is.
(F) I do, I've got one.

Unprompted comments from FG8: (F) I'd only turn to a tutor if it was to do with the course.
(F) I wouldn't turn to a tutor with personal problems.
(F) *I only met my personal tutor once in my first year and there has been no contact since* (student's stress and intonation).

The counselling service was mentioned only twice during the unprompted discussion; the reason proposed to explain this was that the problem would need to be quite bad before

help was sought from a counsellor and the inaccessibility of the counselling service from other campuses presented a barrier to access:

Prompted comments from FG9 :   (F) It's the inconvenience of finding wherever the counselling place is.
(M) It's not important where it is.
(F) It is if you're locked away in your room and it would mean a long hike to seek out the counselling service. Not when I could talk to friends in the next room.

Breaking up the session : Exploring students' attitudes and beliefs on mental health related topics

To retain students' interest, approximately half-way through the sessions students were presented with a number of True/False Statements to discuss in pairs or small groups (see Appendix 7g). They were asked to feed-back their views to the rest of the discussion group. The idea was adapted from Bloor et al's (2002) focusing exercise technique.

With regard to only females suffering from eating disorders, self-harm and overdoses (and not males) (**StateA**), the statement was refuted as being true due to the disproportionate media exploitation of females as main sufferers of these conditions, the willingness of females to admit to the problem and the fact that females were more emotional about relationships. It was proposed that males were increasingly succumbing to these problems - due possibly to the fact that they are becoming increasingly competitive about their image amongst themselves. The proposed reluctance of some males to admit to these problems was attributed to the fact that they are less willing than females to talk openly about such issues and they tend to bottle up their emotions. However, it was also suggested that times are changing: "I don't think there's a massive difference anymore, especially with young males who seem quite happy to express their feelings" (F) (FG3). This opinion extended to the next topic – whether females (allegedly) talk more openly about mental health problems (**StateB**). Although females tend to talk more openly about mental health problems – even to casual friends – it was nevertheless conceded that males talk about it in different less direct ways and almost exclusively to close friends. It was also thought that the problem would have to be more severe before they "opened up" and there was the suggestion that males could leave it too late before seeking help.

Although it was conceded that alcohol and drugs do relieve feelings of anxiety and depression (**StateC**), it was recognised these effects were short-lived. Some thought it

could make the problem worse, actually causing anxiety and depression. Others thought there were benefits to social drinking, in that drinking with friends was preferable to sitting alone in your room. The matter of the English Pub/Club culture was raised again and with it the view that it does not suit everybody, especially when it goes against a student's culture; whether that be as an overseas student: "Some Asian students don't want to get attached to British culture, for them it means getting drunk all the time" (FG9), or as a home student.

The statement that today's males do not find it easy living up to stereotypical image of being independent, resourceful and successful (StateD) was considered to be an outdated image that does not apply to the modern male. The reality today is more about males being competitive with females in the workplace and in being successful in materialistic terms. If anything students thought there has been something of a reversal of roles (fostered by market forces and the media) which has resulted in males competing with each other in the fashion stakes. This was however thought to be essentially an attitude prevalent in the West.

Commenting on the statement: 'Depression is a weakness and carries a stigma' (StateE), students' opinions were divided about whether depression was a weakness or not. Many thought it was perceived to be, although in their opinion it was not. Others thought it might be in the sense that all illnesses are weaknesses and an illness is something that you cannot always help. Again some opinions connected with the 'locus of control theory' (Rotter 1966) in that it becomes a weakness if you can't control it. Of note, was the view that depression could result in unpredictable and possibly frightening behaviour and that this could be central to the attachment of a label which in turn could lead to difficulties with employment: "In some jobs and professions they hold depression against you. Perhaps it's because depression can come out as anger and aggressive behaviour" (FG5). It was also remarked that more should be done to reduce the stigmatising label of mental illness: "I do not view depression as a weakness but it does carry a stigma and this needs to be reduced" (FG5).

Whether admitting to a mental health problem would lead to discrimination and alienation (StateF) students deliberated that this would depend largely on the severity and type of the condition. Those with a slight problem (one that wasn't obvious) might not be treated differently by friends whereas a more serious condition could possibly result in discrimination and alienation. Based on past personal experiences, (as well as historic

age-old images of dire conditions in mental hospitals), again the fear of violent and unpredictable behaviour was a real issue: "No-one wants to admit this but there will be discrimination. For instance, if someone announces 'I'm schizophrenic, prone to violent out-bursts' you are going to discriminate because you're not going to want to stay in the same room with them" (FG4). Students proposed discrimination could only be reduced through education aimed at a greater understanding of what mental illness really was and how it could be best managed. It was commented that real, true friends would neither discriminate or alienate: "we hope the answer to this is false because true friends shouldn't be judgemental. If they are, then they're not real friends" (FG1), though regrettably it was conceded even good friends might make assumptions about expected behaviour and treat friends who had a mental health problem differently from those friends who did not: "Alienation could happen more so with peers because their reaction would be based on assumptions – because they don't really know you as friends would. They might assume that you're going to act in a certain way so they'll treat you in a certain way" (FG6) (Reminiscent of Scheff's, 1975, secondary deviance theory – see Table 2, page 30). Lack of understanding and making assumptions based on fear will also inhibit closer relationships being forged. Some believed alienation could be unintentional, for example an anorexic becomes alienated by her friends, only because she won't go out eating with them.

The majority of students, as young people, admitted they would find it difficult to ask for help with emotional problems (**StageG**), especially from an older or professional person, largely because this group of people might be dismissive or they might be rejected or not be taken seriously. Some students felt it would be a sign of weakness to admit to having a mental health problem. Other explanations were associated with aspects of adolescent psychology including the need to be regarded as independent. Due to the lack of life experience many felt they wouldn't know when to seek help. The fact that several students admitted they would not turn to anyone (if they couldn't turn to friends) was alarming, especially in light of the association between relationship problems, self-harm and parasuicide. Others disagreed with this, saying it would be easy to get help, if you're willing to take the step. Significantly, more males admitted it would be difficult for them to ask for help:

FG6   (M) It's especially difficult for males.
       (M) I agree with that.
       (M) It's especially difficult when you just arrive at uni and you haven't made friends yet.

FG11   (M) It does tend to be young males.

(M) I think it's mostly males, too.
(M) The statement is true – for males it's an even bigger problem.
(F) I think males are afraid of the answers they might get if they ask for help.
(M) In particular they're afraid of being rejected and told to go away.
(M) Males find it difficult to approach someone with a problem : 'how am I going to tell that person I've got a problem…'
(M) I'd be afraid they wouldn't take me seriously.

An interesting response was that emotional problems do not receive the high profile that they should and there was insight expressed into the dangers of a serious emotional problem being missed. Other factors affecting whether help was sought were: personality and socialisation factors, as well as the length of time and severity of the existing problem.

On balance it was felt the statement - that doctors deal with more physical than emotional problems – was true (**StateH**): "If I had an emotional problem I wouldn't think of going to the doctors, I'd deal with it myself. I'd think doctor – physical not emotional" (FG6), although it was recognised both conditions were entirely within doctors' remit. In fact, GPs were seen as being the gateway to specialist referral, such as psychologists and psychiatrists and counsellors. The most frequently cited reason for holding this view was put down to time restrictions, the ubiquitous 10 minute slot not being long enough to deal with emotional issues. Not wanting to be medicated was another reason given and older doctors (over 45) were considered to be less approachable than younger doctors, possibly due to a reduction of the stigma attached to mental health problems over the years: "I've found older doctors are not very helpful in terms of emotional problems" (FG8). Some doctors were judged to be better at dealing with and diagnosing mental health problems than others. It was suggested that dualism might persist in medicine as some doctors don't seem to pick up on the psychological element to a problem at consultation. It was alluded to that some GPs actually choose to ignore the emotional content because it is easier and quicker to prescribe medication but this view was not held by all students, many of whom were very satisfied with their doctors. Again past experiences with GPs would dictate whether or not young people would approach their doctor with an emotional problem.

The statement "Females need to constantly think about their self-image"(**StateI**) evoked some interesting responses which in many ways united male and female opinion. Whereas a positive self-image for females is considered a desirable thing (such as in the business world and for purposes of interviews), becoming obsessed with image was thought to be totally undesirable. It was the element of indoctrination and media bombardment to

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achieve "the celebrity look" that bothered most students particularly as this seems to be occurring at a younger and younger age: " This is why there's such a lot of eating disorders among females. It's partly due to media pressure to be size 8" (Female) (FG3), "the issue of young girls being obsessed with their looks is quite scary and it's getting out of hand – how can a parent let a young girl go out in the street with a short skirt – it's unbelievable" (Male) (FG11). Male students were especially vociferous in commenting on the extent to which female peers dressed up for lectures and they found that "scary". However, some female students were of the opinion that males were becoming increasingly obsessed with their looks (some even becoming "girly" in the pursuit of the right image). It was noted that Western societies were more fashion conscious than Eastern societies and that much of the pressure to conform to a specific image came from peers: "It's culture based too. Western societies are more fashion oriented and girls do it to be in the in-crowd" (Male) (FG11). It was also noted to be a very British phenomenon. An association with self-consciousness and low self-esteem was made, and first year students were seen as being particularly vulnerable as they would not forge friendships and supportive networks for several weeks.

Although there was thought to be some truth in the statement that overseas students have more difficulty in fitting in at university than home students **(StateJ),** a proportion of students thought this wasn't necessarily the case. Individual personality factors were thought to be relevant too, making it easier (or more difficult) for some students to fit in – regardless of whether they were home or overseas students.

There was resentment expressed by several home students because in many respects they felt left out and neglected. They commented on the high profile campaigns to alert overseas students to the support services and the active promotion of the orienting activities programmes at the beginning of term. They thought more of an effort was made by the university's departments to help overseas students 'fit in': "There's always something about international students – you've got to do this for them, that for them – *but what about us* (student's stress on these words). It's like we're in the process but we're being neglected" (FG4). EU students have lots of events which help them settle in better. They do some things for home students but it's easier for home students to feel left out" (FG1). Overseas students, however, were very appreciative of the concentrated help and support they received during Induction Week: "I think, if anything, it's easier for overseas students because when we first started there were posters everywhere in the uni telling overseas students not to worry…" (FG5), "It's like the whole world got us ready for the country and when the home students came we were well settled in; it wasn't a problem"

(FG7). It was pointed out that overseas students might make more of an effort to familiarise themselves with what is available to them: "Maybe international students have more societies but also probably they look out for them too when they come here" (FG5).

Several home students also felt that overseas students did not make the effort to integrate, as some nationalities tend to cluster in fairly large groups: "Overseas students have little communities on campus. Some nationalities cluster everywhere in groups" (FG1). This was seen as counter-productive to integration as it was thought to be less likely for someone from another background to feel comfortable penetrating a large group to forge acquaintances/friendships than if students went around in couples or smaller groups: "Staying in groups has it's drawbacks. You're less likely to make new friends like that because individuals are less likely to approach a group" (FG4).

On the other hand there was the suggestion that home students did not actively encourage integration either: "It's equally true English students also stick together and keep to their own culture" (FG6). Some home students admitted to having "given up" trying to talk to other students whose first language was not English due to the repeated difficulties with being understood. Other home students found benefit in making the effort to integrate: "I made the effort to interact with overseas students and it's paid off. I've made some brilliant Spanish friends" (FG4). Nevertheless, it was suggested that being with fellow compatriots, who importantly shared a language and a way of life, provided an immediate informal support system and contributed towards mental well-being, particularly during the first term and this was especially true of overseas students: "If overseas students didn't have people from their own country to share the same language and interact with them they find it very hard to fit in" (FG5).

UH was criticised for organising trips and outings for specific nationalities and for putting nationalities exclusively together in some Halls of Residence. This was thought to create an immediate divide which does not favour and encourage international integration, mutual respect and understanding: "Putting students into Halls according to their nationality is not a good idea. It does not encourage integration" (FG8). It was suggested UH should do more to encourage mixed international sporting events as sport was seen to be the leveller among different backgrounds, whatever the ethnic origin: "In a game of basket ball international students are just the same as our students; it just depends the side you're on" (FG8), "It's wrong that overseas students are put into a box according to their nationality and treated differently from home students. It creates an immediate divide which isn't fair.

People refer to Chinese students, Spanish, French and German students – *we are all just students*" (student's emphasis, FG8).

Commenting on the statement: "Young people are not supposed to feel depressed" (**StateK**), the focus group participants thought that older people tend to make comparisons with their own youth (which most believe was much tougher than today), and so they find it hard to understand that young people can feel depressed whilst at university which is often perceived to be an enviable period of hedonism.

However, these students believe university life today can be very stressful as they have to juggle more problems than any generation before them. It was recognised that substantially more young people attend higher education today than ever before. Furthermore, it was thought depression is far more acceptable in society today (notwithstanding the associated stigma that persists). Not only were older generations more reluctant to talk openly about mental health problems, they also did not have recourse to the extent of outside agencies of help available today. Certainly it was agreed that older people should not be dismissive of a young person who is depressed for whatever reason.

Students were asked whether they thought psychiatric problems were more likely to go unreported than physical ones (**StateL**). This statement was considered to be generally true, due firstly to the lack of visibility of a psychological problem which can render it more difficult to detect and diagnose and secondly because sufferers are likely to be frightened, confused and unsure of what to do and where to go for help. Several students were of the opinion some people would find it difficult to admit to having a mental health problem because of the stigma and the fear of alienation from friends and peers: "people hide it because they fear rejection if they admit to a psychiatric problem" (FG11). However, as with physical illnesses, students saw the importance of getting a psychological problem dealt with before it became more serious. The lack of social capital in society today was a possible explanation for the persistence of stigma surrounding mental health issues: "Society has become apathetic, there's no sense of bonding and people are so quick to look at the differences in our communities ...." (FG3).

Help-seeking behaviour – The Support Services

When asked which support service they would turn to (**FGQ16**), several students said this would depend largely on the type and severity of the problem: "It would depend on what the problem was as to who I'd turn to – if it's work related then I'd go to my tutor, if not

then perhaps the counselling service" (FG2). The counselling service was mentioned most frequently with the added comment that an e-mail option would be helpful in initiating contact prior to consultation. In fact a preference for non face-to-face contact " to break the ice" was a consideration for many, whereas others thought establishing a rapport with a counsellor in a face-to-face encounter would be preferable for them. Nightline was also mentioned as a popular non face-to-face means of contact because of the total anonymity it provided – that is being able to dial 141 before making the call. (It was remarked several times that confidentiality was a big issue when taking the step to access a source of help). Although a popular source of help, some students regretted that Nightline operators were not permitted to offer advice and guidance and there was some preference for the Student Support and Guidance office (affiliated to the Students' Union) because students were referred on to the most appropriate source of help (a type of triaging) and also because it was run by fellow students. The Medical Centre was mentioned less often than the Counselling Service but also in a positive way: "I think they offer a friendly open service. The service here from the doctors is a lot better than what I've experienced at home. They deal with students all the time and they know how to deal with you" (FG5). However, a number of participants admitted they would not approach any of the support services, turning instead to family and friends in the first instance: "I wouldn't use a support service, I'd turn to my family and friends" (FG11), "I wouldn't turn to any of the services unless I felt rock-bottom" (FG4).

In similar vein, students said they would prefer to turn to family and friends rather than go to the doctors when feeling depressed/unhappy/anxious (FGQ17). Reasons given for this were that doctors deal more with physical than emotional problems (these being dealt with by specialists such as counsellors), doctors are always too busy with "sick people" and you have to wait too long for an appointment especially if you're feeling acutely distressed. Yet again, ten minute appointments were also deemed to be far too short to deal adequately with an emotional problem and not only did students feel they would be wasting the doctor's time, they were also afraid they wouldn't be taken seriously. Being patronised, feeling dismissed and not wanting to take anti-depressant medication were also reasons for not going to the University Medical Centre, as was not always having the possibility of seeing a female doctor (often very important to overseas students of different religious backgrounds). Past negative experiences would prohibit some students from going to the doctors and some EU students admitted having no faith in the NHS generally, preferring to travel home with health concerns.

Due to lack of promotion, several students had no idea where the Medical Centre is situated or what services it provides: "They haven't really promoted the Medical Centre so it's like the first time I'm actually hearing about it is now. I didn't really know the university did have a medical centre" (FG4), "There's not been much advertised about the Medical Centre. What does the Medical Centre provide and how does it help you? If you know nothing about it, you're not going to use it, are you?" (FG4). Some (often overseas) students were unsure about whether they would have to pay: "If it costs a lot and you have money problems I wouldn't know how to handle that. As an overseas student I wouldn't want the bill to go to my parent's house" (FG8). There was also confusion about registration procedures, many being reluctant to register with the UMC because they thought they could never return to their home GP: "as I understand it if I'm registered with a GP outside the uni system, I cannot register with the uni GP" (FG8).

The location of the Medical Centre was important to some, but not to others. Not wanting to be labelled as a depressive, concerns about the recording of a mental health problem on medical records and confidentiality issues were also important issues to students. Confidentiality issues revolved around the fear of information being divulged to other university departments and staff but centred mostly around the fear of curtailment of career opportunities.

Students' views on 'hypothetical' additional Medical Centre services

Focus group participants were asked what specific type of service might encourage them to turn to the University Medical Centre in times of emotional distress **(FGQ18)**. Unprompted responses included an expressed interest in a "welcoming" well-person type service run by someone suitably qualified in dealing with psychological problems: "If they had a specialised clinic where they said this is just for people who are feeling depressed …. It's saying we want you to come with this problem, *not* – you'll be given a battle if you come with this problem" (FG1), "A service that would make us feel welcome and provide us with some information that would familiarise us with the people there. That would be good and I'd definitely go" (FG2). The most frequently named person to meet this need was a nurse, as not only would this mean they would not be wasting doctor's time, a nurse was also perceived to be less preoccupied with the medical side of things - someone who would be less likely to categorise and label people or over-prescribe. Nurses were also acknowledged as being quintessential health educators who would at the same time provide valuable information about matters appertaining to mental health: "Nurses deal with a lot of health education and are not as likely to categorise you" (FG2). Moreover, by

attending such a clinic, students would become familiar with the primary care staff (doctors were often viewed as strangers) and this would be a comforting factor that would facilitate beneficial monitoring and follow-up attendance.

Other unprompted suggestions included the use of telephone help-lines and e-mails. E-mailing was seen as an excellent ice-breaker – an initial step in getting help prior to a face-to-face encounter. Face-to-face meetings were still preferred by a few students who thought most problems were better dealt with in this manner. E-mailing was suggested as being good for people who preferred to write things down and because so much of students' time is spent on the computer, access would be effortless: "For some problems it's better face-to-face, for other problems you need to speak with someone – it depends on the person and the problem" (FG4). However, stated disadvantages of e-mailing were – problems with reply-efficiency, it could be too impersonal and it was emphatically not anonymous; in fact it was seen by some as a ready-made source of medical data recording. Telephone help-lines were named as another potentially popular source of help. Anonymity would be guaranteed, it would be useful to those who preferred to talk and a useful initial step. A telephone help-line, connecting directly with the Medical Centre, could make such a provision. However, any costs borne by the caller would severely prohibit its usage.

Prompted responses included the remark that it was assumed (correctly) that the UMC already operated a Walk-In Clinic: "I'd ruled out the walk-in clinic because I thought it was already in place….." (FG6). The advantages of a walk-in clinic were seen as not having to wait several days for an appointment but experience had proved it could be so busy it sometimes made students late for lectures.

Would students take up the offer of a free health check with the University Medical Centre? **(FGQ19)**. The majority of students declared they would be happy to accept such an offer because, importantly, it would suggest to students that UH really cared about their health and welfare. Some even alluded to the fact that they knew of other universities who already operated this system. Another reason for accepting the hypothetical health check was that it would be a good thing to make sure there wasn't a health problem they were unaware of and it would also provide a chance to discuss matters of concern that were thought too trivial to bother the doctor with.

However, some students added they would need further clarification about what the health check would involve before deciding whether or not they would accept the offer and also

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how the medical information would be stored. Assurances would be needed that information gained would not be shared with other university departments or personnel. Of importance, too, was that the health check would be free.

Other reasons stated for declining the offer included: not wanting to waste the doctor's time because they were healthy and there was no need: "If I didn't have any medical problems at the time, maybe I wouldn't because I'd think there's no point" (FG4), preferring to wait until there was a problem before going to the doctors, and being made to feel guilty about leading an unhealthy life-style: "I wouldn't because they might make me feel guilty about my life-style or say something about my weight. They'd tell me to do this and do that ..." (FG5).

Although many had declared they would readily accept the offer themselves, it was commented that other students might rather spend the time with their friends (drinking) than going to the doctors when they weren't even ill. The point was stressed that because there was so much to do during registration week, even with the best of intentions many would simply not turn up.

Law students commented they would be exempt from this offer because they are not permitted to register with the University Medical Centre as they fall outside of the catchment area. Some students at de Havilland said they would not travel to College Lane for this purpose: "I wouldn't bother to travel to College Lane if I wasn't ill. Too much hassle. If they did them at de Havilland I would" (FG1).

Most students said they would be prepared to complete the proposed from at registration (**FGQ20**) and were in favour of its "welcoming" approach (see Appendix 7h). They also said it would familiarise them with the whereabouts of the Medical Centre and its staff and what other services it provided. Many thought it could also encourage help-seeking behaviour, and facilitate continuity of care over the years spent as a student. Significantly, students saw this as a proactive approach: "instead of just being there, they're actually coming to you first saying 'we're inviting you, this is for your problems" (FG9). It was remarked that overseas students, in particular, might benefit through becoming familiar with the surroundings and the staff.

It was apparent that many students did not have a grasp of the purpose of health promotion – one student stating that she would have to make something up, such as a breathing problem, in order to "qualify" to be seen: "I'd want to have this done, so I'd probably have

to make something up like my breathing's irregular ...." (FG5) and there were misconceptions about what exactly would be involved and what would be achieved by undertaking the check-up.

There was much appreciated constructive criticism about the wording of the 'hypothetical proposal' (see Appendix 7h) presented to students which was thought to be too negatively focused: "The wording suggests to me that if you don't have any problems, nothing's going to happen. It's too focused on problems" (FG1), and that it could more concise - possibly better presented in bullet points. The option to say "No" however was very important to most students because they felt they would like to be left with the option of changing their minds.

Students' opinions concerning the distribution timing of such a proposition were interesting. Many were of the view this might just be one form too many to present to undergraduates at registration although others argued – what difference did one more form make amongst so many! It was suggested the 'Proposal' should be presented as an "open offer" so that students could have this done over an extended period of time and not just in the first few weeks of term. Other comments included – leave it to the UMC to contact us, or attach it to the University Acceptance form to be completed prior to registration, or simply attach it to the Medical Centre's form issued at registration: "It's not affecting your registration so why not supply your student number and they can contact you" (FG4). There was an 'unprompted' remark about the benefits of registering with the UMC at registration time, although generally there seemed to be some confusion about the role and remit of the UMC, as well as other services.

Emerging categories identified through cross-case analysis

As stated by Yin, cross-case analysis can lead to newly emerging categories as the data are processed through the sequential stages of analysis. Through the forum provided by the focus groups, this first stage in the qualitative phase of data collection and analysis identified several emergent issues (as displayed in Figure 2 below) as being important to students in sustaining their mental well-being.

Figure 2: New issues emergent from focus group analysis

Familiarity & Trust

Services:
Knowing what provision is available, (including the role, remit and location of the support service), could increase the likelihood of the service being utilised.

People:
Young people are more likely to turn to those they trust and are familiar with. Many view their doctors (and in some cases their lecturers) as strangers. Diminished pastoral care could explain why some students do not feel they know their lecturers (and in some case their personal tutors) sufficiently well to turn to them in times of emotional need.

Visibility Factors

Visibility of security guards was important in creating a sense of safety in all sub-groups of students. A clean and pleasant environment added to a sense of shared community and well-being.

Lack of visibility of : support service promotion (posters, leaflets, notices) could affect service usage.

The lack of visibility of a mental health problem can render it more difficult to detect and deal with.

Past Experiences

Past experiences were thought to be influential in establishing a judgement on a service (such as a negative or positive experience with a GP) and the willingness of the individual to access that service (for example the Medical Centre). Such pre-conceptions were linked to personality factors, including 'locus of control' and resilience/vulnerability predispositions.

Healthy Eating Issues

Difficulty was experienced by some overseas students in adapting to a foreign cuisine.

The cost of food on campus was seen as being prohibitive to healthy eating.

There was perceived to be a lack of emphasis on healthy eating in general.

Resentments & Grievances

Caused by:

Lack of representation of support services on all campuses.

Insufficient emphasis on social activities other than Pub/Club culture.

Specific groups (disabled and overseas students) are targeted for special treatment.

Integration issues left room for improvement.

Safety Issues

Personal Safety:
Visible presence of security guards was greatly valued as was the protection afforded by secure boundaries to all campuses. The use of CCTV lessened the fear of crime.

Personal belongings:
Concern was expressed about the security of personal belongings on campus and in Halls.

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Along with the findings of the semi-structured interview analysis, these emergent issues informed the next phase of the flexible design - the content of the survey, the analysis of which is covered next:

Survey data analysis

Firstly, the demographic data resulting from the survey analysis are presented below:

Sample size: The actual total sample size was 806. Unless otherwise stated, this is the total represented in the following Tables/Figures.

Age-related data: The age-range of the total student sample was from 17-47 years, the mean age being 21 years, the median age 20 years and the mode of age 19 years.

Sex of the respondents: In keeping with the quota sample, 383 males (a total percentage of 47.5%) and 423 females (52.5%) took part in the survey.

Mode of study: 96.4% of the respondents were full-time students; only 2.7% were part-time students. (Missing data = 7, n = 799).

Respondents' year of study: Clearly, as the table below indicates, most of the students were in their first year of study, a similar number were second and third year students, and very few (4.3%) were 4th year undergraduates.

Table 8: Year of study of respondents

		Frequency	Percent
Valid	1st year	346	42.9
	2nd year	232	28.8
	3rd year	188	23.3
	4th year	35	4.3
	Total	801	99.4
Missing	Other	2	.2
	Missing	3	.4
	Total	5	.6
Total		**806**	**100.0**

Faculty: The University Faculties were represented by the following percentages of respondents, 30% of whom hailed from the Faculty of Health and Human Sciences:

Table 9: Faculties of respondents

		Frequency	Percent
Valid	Business School	137	17.0
	Faculty of Creative and Cultural Industries	98	12.2
	Faculty of Engineering and Information Sciences	170	21.1
	Faculty of Health and Human Sciences	246	**30.5**
	Faculty of Humanities, Law and Education	117	14.5
	Faculty of Interdisciplinary Studies	37	4.6
	Total	**805**	99.9
Missing	Missing	1	.1
Total		**806**	**100.0**

Course of Study: The number of courses/programmes recorded for respondents totalled 95, out of a possible 170.

Location of study: According to the quota sample, 68.7% students were College Lane undergraduates, 25.1%, from de Havilland and 6.2% of students were from St. Albans campus.
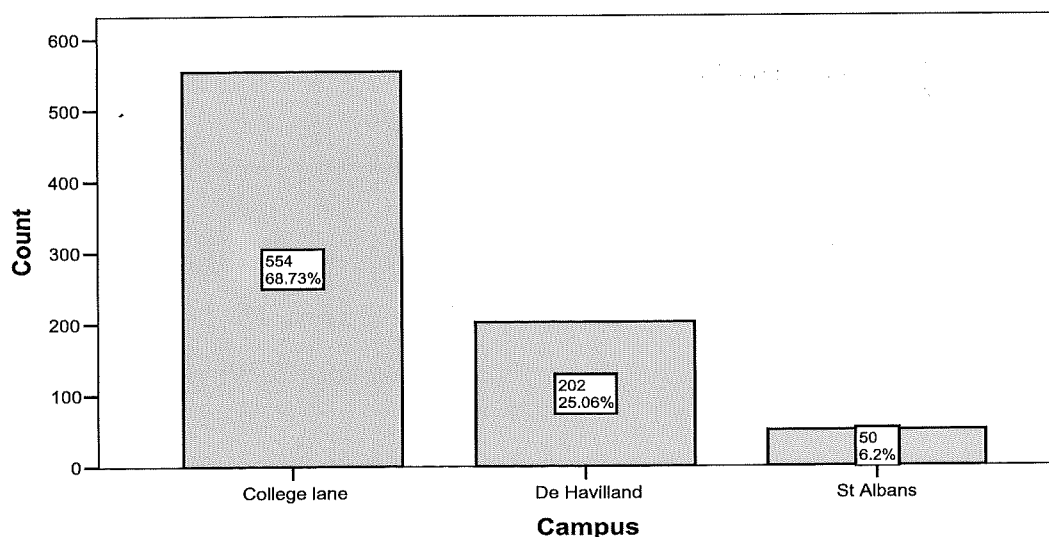
Figure 3: Students location of study

Accommodation: 37.1% of students lived on campus, 27.5% lived in rented accommodation, 17.4% lived at home, 16% lived off campus and those who ticked the 'other' option stated they were home-owners. (Missing data = 7, n= 790).

Religious affiliation: The most frequently mentioned religious affiliation was Christianity at 40.3%, closely followed by 'No Religious Affiliation' at 37.1%. Hinduism and Islam accounted for 7.7% and 6.3% of respondents' religious affiliation respectively and Buddhism, Sikhism and Judaism were reported at 2.6%, 2.4% and 0.4% respectively. Interestingly, the category of 'Other' (2.6%) was made up mostly of Catholics and Scientologists. (Missing data = 4, n= 802).

Fee Status: In keeping with the quota sample, the majority of respondents were home students (84.5%); with overseas students (including EU undergraduates) making up 15.5% of the total sample.

The ethnicity of the student sample was made up as follows, with a majority of the students being of White/Caucasian origin.

Table 10: Ethnicity of the student sample

	Frequency	Percent
Black African	40	5.0
Black Caribbean	18	2.2
Black Other	5	.6
Chinese	56	6.9
Indian	89	11.0
Pakistani	15	1.9
White	528	65.5
Other	55	6.8
Total	**806**	100.0

Declaration of a Disability: 2.4% of students in the sample declared a physical disability (97.6% did not). 1.4% declared a mental disability (98.6% did not) and 4.8% declared a learning disability (95.2% did not).

Registration with the Medical Centre: Just over half of respondents (52.6%) said they were registered with the University Medical Centre, just under half were not (47.4%). A majority of EU/overseas students (93%) were registered with the Medical Centre, compared to only 49% of home students.

Following on from the demographic data is the consideration of the survey findings as they relate to:

Students' views and experiences of the university environment:

These findings evolved into three well defined and related areas of interest and they have been broken down into the following sections:

1) Issues relating to Social Capital and 'Anomie' (Questions: 1, 2, 3, 5, 6, 12,)

2) Salutogenic Issues, presented here as a continuum ranging from issues that keep students mentally robust to anxiety provoking issues that could challenge students' mental well-being (Questions : 4, 10, 11, 13, 14,15)

3) Help-seeking behaviour
   a) Persons/Services of contact (Questions : 13, 16, 17, 18, 19)
   b) Factors affecting help-seeking behaviour (Questions:7, 8, 9, 20, 21, 22, 23)

Section 1: Social Capital and 'Anomie'

Question 1: **Issues relating to 'Anomie'**

Table 11 below shows how often students had experienced the feeling of not fitting in with those around them whilst at university. A majority of students said that they had **never**, experienced this feeling and 42,8% reported they had **only sometimes** experienced a feeling of not fitting in.

Table 11: Feeling that you don't fit in with those around you

		Frequency	Percent
Valid	Never	416	51.6
	Sometimes	345	42.8
	Often	44	5.5
	Total	805	99.9
Missing	Missing	1	.1
Total		**806**	**100.0**

Table 12 below indicates that a majority of students sometimes feel homesick and miss family and friends

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Table 12: Feeling homesick and missing your family and friends

		Frequency	Percent
Valid	Never	334	41.4
	Sometimes	411	51.0
	Often	60	7.4
	Total	805	99.9
Missing	missing	1	.1
Total		806	100.0

Table 13 demonstrates that over half of respondents stated they had never experienced difficulties adjusting to life at university

Table 13 : Difficulties adjusting to life at university

		Frequency	Percent
Valid	Never	471	58.4
	sometimes	305	37.8
	Often	28	3.5
	Total	804	99.8
Missing	Missing	2	.2
Total		806	100.0

Demographic data analysis related to the concept of 'anomie':

Each of the first three items were further analysed to see if there were any differences arising from different demographic groups.

Sex of the respondents:

With regard to the first item, "feeling you don't fit in", cross-tabulation revealed no significant differences between males and females, χ^2 (2) = 2.33, p = .31. Significant findings did however emerge for the other 2 items, with males less likely to report feeling homesick than females, χ^2 (2) = 27.06, p < .001 (see Table 14 below). Similar findings arise for the item on reporting difficulties in adjusting to university life, χ^2 (2) = 9.6, p = .008, with males again less likely (than females) to report difficulties in adjusting to life at university.

Table 14: Frequency of males and females reporting feeling homesick and missing family and friends

		Feeling homesick and missing your family and friends			Total
		Never	Sometimes	Often	
Sex	Male	194	168	20	382
	Female	140	243	40	423
Total		334	411	60	**805**

Fee status of respondents:

Significant differences arise for all 3 items in relation to fee status. Table 15 indicates that EU/Overseas students are more likely to respond "sometimes" when asked if they felt that they did not fit in with those around them, χ^2 (2) = 9.28, p = .01. Similar results emerge for the item about feeling homesick χ^2 (2) = 27.08, p < .001, again with EU/Overseas students more likely to say that they sometimes feel homesick, and for the item relating to difficulties in adjusting to life in university, χ^2 (2) = 13.91, p = .001, overseas students were again more likely to report difficulties adjusting to university life.

Table 15: Frequencies of Fee Status differences in reporting feelings of not fitting in with those around them

Count

		Feeling that you don't fit in with those around you			
		Never	Sometimes	Often	Total
Fee Status	Home Student	366	276	38	680
	EU/Overseas	50	69	6	125
Total		416	345	44	805

A sub-category cross-tabulation analysis of the three campuses revealed that de Havilland students experienced slightly more difficulty fitting in than their counterparts on the other two campuses, demonstrating higher frequencies of 'sometimes' and 'often' (de Havilland 6.9%, College Lane 5.2%, St. Albans 2%) and also feeling more homesick (de Havilland 11.4%, College Lane 6.0%, St. Albans 8.0%). A further breakdown of these data suggested a higher percentage of overseas females on de Havilland experienced the feeling of not fitting in (66.7%) and overseas males on College Lane (66.7%) with regard to missing family and friends.

Ethnicity of respondents:

With regard to ethnicity, one set of significant results stood out, and this was concerning feeling homesick and missing family and friends, χ^2 (14) = 30.03, p = .008. By examining the standardised residuals, it is clear that the significant result emerges from Chinese students being most likely to say that they 'sometimes' or 'often' feel homesick.

Table 16: Frequencies of different ethnic groups' responses to the item on feeling homesick and missing family and friends

		Feeling homesick and missing your family and friends			
		never	Sometimes	often	Total
Ethnicity	Black African	10	25	5	40
	Black Caribbean	10	7	1	18
	Black Other	4	1	0	5
	Chinese	12	35	9	56
	Indian	42	40	7	89
	Pakistani	9	4	2	15
	White	228	267	32	527
	Other	19	32	4	55
Total		334	411	60	**805**

Issues relating to Social Capital

The following findings focus on issues related to students feeling part of a supportive community within the university.

Question 2: **Feeling part of a supportive community**:

Table 17 below shows that in fact relatively few students stated that they felt a part of a supportive community all of the time. A majority of the students stated that they only felt supported some of the time, with a small but important proportion of the students saying they never felt a part of a supportive community.

Table 17: How often students stated they felt part of a supportive community

		Frequency	Percent
Valid	all of the time	187	23.2
	some of the time	503	62.4
	Never	113	14.0
	Total	803	99.6
Missing	Missing	3	.4
Total		**806**	100.0

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More College Lane students said they felt part of a supportive community all the time and over twice as many de Havilland students to St. Albans students said they never felt part of a supportive community (17.8%/8.0% respectively). A slightly higher percentage of overseas to home students reported never feeling part of a supportive community (17.7%/13.4%).

Question 3: **Issues of fairness and equality**

Students were asked whether they felt they had been treated fairly and equally with regard to a number of items which are laid out in Table 18 below. It is clear that the item for which students most often felt they were unfairly treated was to do with parking issues. On all other matters, a majority of students indicated that they have been treated fairly and equally.

Overall, College Lane students did not feel less fairly treated on any of the issues presented, whereas St. Albans students felt less fairly treated with regard to three issues: getting connected to the internet (home males), accessing the support services (home females) and not receiving free/assisted travel between campuses (home males)

Table 18: Students' statements concerning whether they have been treated fairly and equally with regard to the following issues:

	Yes I have been treated fairly	*No I have not been treated fairly*
	%	%
Getting connected to the internet	92	8
Accessing support services	88	12
Use of the sporting facilities	81	19
Parking issues	49	51
Accommodation matters	78	22
Help with financial problems	75	25
Free/assisted travel between campuses	83	17
Being included in the university's activities and events	80	20

Questions 5 and 6: **The 'Drink and Drugs' culture**

Table 19 below shows that a majority of students agree with the statement that there is a drinking culture prevalent within British universities.

Table 19: Responses to the question: 'Do you think that there is a drinking culture in British Universities today?'

		Frequency	Percent
Valid	Yes	685	85.0
	No	120	14.9
	Total	805	99.9
Missing	Missing	1	.1
Total		806	100.0

Table 20 below shows that in fact a majority of students did feel a part of this drinking culture.

Table 20: Responses to the question: 'Do you feel a part of this drinking culture?'

		Frequency	Percent
Valid	Yes	474	58.8
	No	329	40.8
	Total	803	99.6
Missing	missing	3	.4
Total		806	100.0

There were, however, statistically significant differences between overseas students and home students, between the sexes and between students of a different religion. Overseas students were more inclined not to feel part of this drinking culture (χ^2 [1] = 11.66, p = .001), as were female students (χ^2 = 7.534 [1] p = .006). Religious differences were also noted, (χ^2 [7], = 36.03, p < .001), with Buddhists and Muslims in particular not feeling a part of this culture. Only 11.8% of the total sample said they did not feel part of the Pub/Club scene because it did not appeal to their friends. A higher number (32.5%) reported it simply did not appeal to them and 13% said it went against their personal beliefs.

With regard to a 'drugs culture', Table 21 shows that the majority of students surveyed were not particularly concerned about a drug culture at UH.

Table 21: Responses to the question: How concerned are you about a drugs culture at UH?

		Frequency	Percent
Valid	very concerned	95	11.8
	a little concerned	262	32.5
	not at all concerned	400	49.6
	I'd rather not comment	49	6.1
	Total	806	100.0

However, overseas students were nearly twice as likely to be very concerned about a drugs culture, compared to home students (19.2%/10.4% respectively).

Question 12 : **Issues concerning the integration of different nationalities on campus**

Table 22 shows that a majority of students thought that different nationalities generally mixed well together some or most of the time, although only 6% thought this occurred all the time. In spite of this, as Table 23 demonstrates, a majority of students thought some groups make no effort to integrate, most or all of the time.

Table 22: Nationalities mix well

		Frequency	Percent
Valid	none of the time	101	12.5
	some of the time	422	52.4
	most of the time	235	29.2
	All of the time	48	6.0
	Total	**806**	100.0

Table 23: Do some groups of students make no effort to integrate with other nationalities?

		Frequency	Percent
Valid	None of the time	35	4.3
	Some of the time	380	47.1
	most of the time	273	33.9
	all of the time	117	14.5
	Total	**805**	99.9
Missing	Missing	1	.1
Total		**806**	**100.0**

Overall, respondents stated that they were keen to integrate - with 41% saying they strongly disagree, and a further 28% stating they disagree with the statement "I'm not keen to integrate with a group that doesn't share my language and culture". However, more males than females (14.1% to 11.1% respectively) thought different nationalities do not mix well and that some groups never make an effort to mix (males 15.4%, females 13.7%), as did more home students compared to overseas students (13.7%/6.4%). A higher percentage of overseas to home students also reported different nationalities mix well some, most and all of the time (54.4/52.0) (32.8/28.5) (6.4/5.9). With regard to Campus differences, College Lane and St. Albans students (at 30%) were more inclined to think nationalities mix well most of the time, compared to de Havilland students at 24%. At 18% of the findings, de Havilland students were also more likely to think different nationalities

never make an effort to mix, compared to 13% of College Lane students and 16% of St. Albans students.

Section 2: Salutogenic Issues

This section firstly gives an account of 'health assets' associated with emotional/mental well-being as rated in terms of importance by the students (Question 10), followed by 'health deficits' which could negatively affect students' sense of well-being (Question 4) and lastly an indication of which issues students would like to be improved at UH. The formal support service provision is then considered, together with students' views concerning their lecturers and personal tutors.

Table 24 below focuses on issues which students think are important in maintaining emotional and mental wellbeing. It is clear that all the issues raised in the questionnaire were considered important or very important by a majority of the students. Although 'having friends' was deemed to be the most important of all the stated items, safety matters and having a pleasant environment were also rated highly.

Table 24: Rating of the importance of issues which can contribute to mental and emotional wellbeing

	Not at all important	Not very important	Neither important nor unimportant	Important	Very important
	%	%	%	%	%
Having a pleasant environment	2.1	6.3	17.7	33.1	40.8
Having friends	2.4	3.5	13.9	32.4	47.8
Being able to cope with the course	1.1	4.2	13.5	41.6	39.6
Knowing you can turn to support services	3.1	8.9	28.0	34.0	25.9
Feeling safe and protected on campus	2.4	7.1	18.2	30.3	42.1
Having access to health and leisure facilities	2.0	9.6	26.8	34.2	27.4
Knowing your belongings will be secure	1.5	7.2	16.1	30.3	44.9
Knowing you can cope well with new experiences	2.5	6.6	22.5	35.6	32.9

Table 25 below indicates the issues which seem to cause most problems to undergraduates. These were firstly worries about examinations, secondly money problems, and thirdly concerns about coursework.

Table 25: Students' rating of the extent that the following issues caused them to feel depressed/unhappy/anxious whilst at university

	Not at all	Not much	Sometimes	A little	Very much so
	%	%	%	%	%
Money problems	14.8	17.9	29.5	21.2	16.6
Feeling homesick	34.1	31	23.1	7.3	4.3
Worries about coursework	8.4	16.7	30.9	29.0	14.9
Worries about exams	14.8	15.4	24.2	25.9	19.6
Personal health concerns	37.5	32.3	20.7	6.7	2.7
Feeling socially isolated	48.8	26.0	16.1	6.0	3.1
Concerns about self-image	42.8	25.9	21.3	7.6	2.5
Working long hours off campus	43.0	23.4	19.9	9.3	4.5
Wanting to protect family from worries	38.8	21.1	20.8	10.9	8.3
Not having helpful lecturers	29.7	25.1	28.5	10.9	5.7
Having to provide emotional support for others	34.2	27.8	27.0	7.7	3.4
Not knowing who to turn to in times of emotional need	41.6	21.9	22.0	9.6	5.0

Question 11 reflected students' views on what issues could be changed to improve their mental/emotional well-being whilst at university. Although nearly 15% of undergraduates *would not* want any changes to be made at UH, a majority of students indicated that several aspects of university life could be changed in order to improve their sense of well-being.

Table 26 below shows that a majority of students thought it important to increase security, and to improve bus services in particular.

Table 26: Rated importance of issues which could be improved at UH

	Not at all important	Not very important	Neither important nor unimportant	Important	Very important
	%	%	%	%	%
Improved bus service	3.8	6.5	15.7	29.7	44.3
Make security guards more visible	6.1	12.2	26.9	28.9	26.0
Increase security measures in halls and around campus	5.7	12.5	31.4	26.6	23.8
Assurance that CCTV cameras are working	6.5	10.3	27.2	27.2	28.7
Sorting out drink/drugs problem	12.2	17.7	29.3	20.0	20.8
More emphasis placed on healthy food	8.0	16.5	30.5	24.2	20.8
More help with stress management	6.1	14.9	37.2	24.4	14.9
More emphasis placed on how to keep mentally healthy	7.1	18.7	34.5	21.5	18.1
Opening times of support services extended	8.6	13.5	36.3	23.7	17.9

The questionnaire also looked at three aspects of 'formal' social support provided by the university, these being: – lecturers and tutors, the support services, and Induction Week.

Question 13 : **Personal tutors and Lecturers:**

With regard to personal tutors, 47.6% of the students surveyed said they had personal tutors, 32.8% did not. Interestingly, 19.6% were not sure whether or not they had personal tutors.

Figure 4 below breaks these data down by faculty, with a majority of students in Health and Human Sciences having personal tutors, and a majority in the Business School not having personal tutors.

Figure 4: Whether or not students have a personal tutor by Faculty
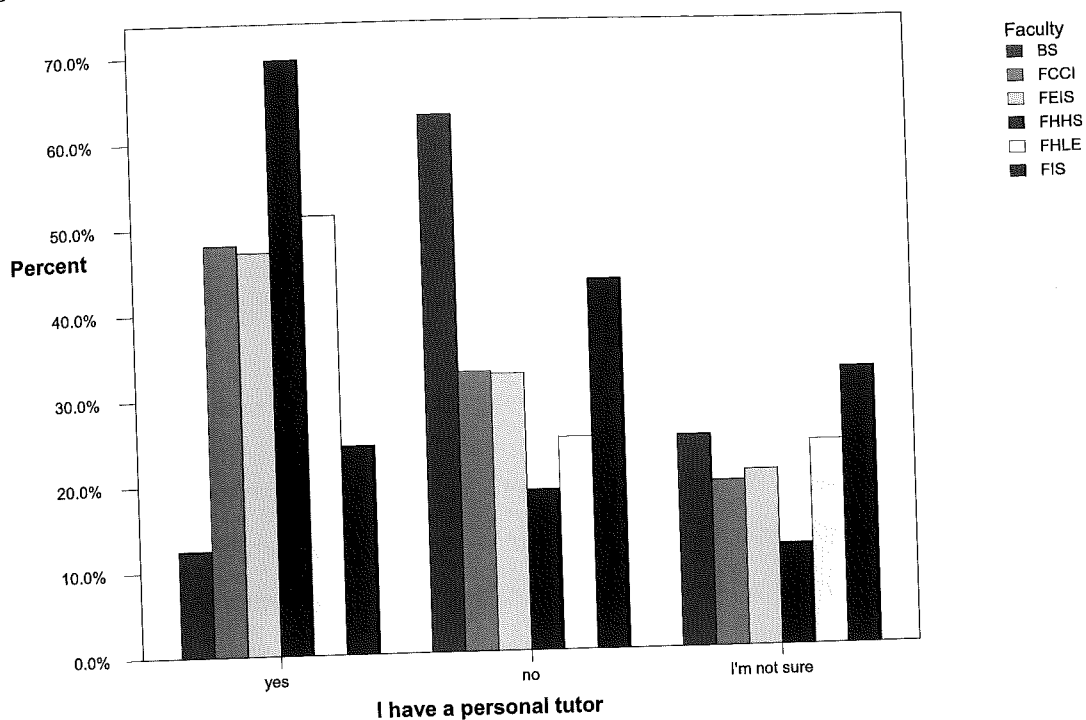
Key to Faculties: Business School (BS), Creative and Cultural Industries (FCCI), Engineering and Information Technology (FEIS), Health and Human Sciences (FHHS) Humanities, Law and Education (FHLE) Interdisciplinary studies (FIS)

Broken down into campuses, 55.6% of College Lane students stated they had a personal tutor as did 40% of St. Albans students. However, only 27.7% of de Havilland students had been allocated to a personal tutor.

For those undergraduates who did have a tutor, only 47.9% felt they could turn to their personal tutor with any problem, including emotional issues, (52.1% declaring they could not) though a majority (68.3% of the students who did have a personal tutor) said they would be confident that any information divulged to the personal tutor would be held in strictest confidence.

It is important to note however, that with regard to feelings of being in a supportive community, a significant number of students (see Table 27) who did have a personal tutor were less likely to say that they didn't feel a part of a supportive community at UH than those who did not have a personal tutor (χ^2 [4] = 13.39, p = .01)

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Table 27: Frequencies of whether or not students have a personal tutor in relation to their feeling part of a supportive community at UH.

Crosstabulation

Count

		I have a personal tutor			Total
		Yes	No	I'm not sure	
Supportive Community	all of the time	98	60	29	187
	some of the time	246	153	104	503
	Never	38	50	25	113
Total		382	263	158	**803**

With regard to lecturers, a majority of those who responded to the item (69.7%) said they did not feel that they could turn to a lecturer with any problem that may arise. In spite of this, 59% of those responding, believed their lecturers would keep a confidence and 74.2% that they would refer them on to somebody who would be able to help them.

Question 14: Awareness of the Support Services

With regard to the support services, only 16.4% of students stated they were completely aware of the role of the support services provided by the university, with 66.7% vaguely aware of them, and 17% not aware at all. Similar figures emerge for the whereabouts of the services, with 16.7% aware where the services were available, 57.6% vaguely aware, and 25.7% not at all aware of the whereabouts of the support services. Of these 58.3% of the students stated that they were only aware of the support services through hearing about them from others, while 47.7% were aware only of those they had stumbled upon themselves.

With regard to how actively promoted the different services of support were, Table 28 below indicates how well promoted the students thought these specific support services were on their campus. For all aspects, the most commonly provided answer was "neither well nor not well", indicating that none of the support services was particularly well promoted, the most notable being those relating to social activities and events and those offering help to overseas students.

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Table 28: Students' views on how well the different support services were promoted

Support services	Not very well	Not well	Neither well nor not well	Well	Very well
	%	%	%	%	%
Finance	16.2	27.6	39.2	11.9	5.1
Physical health	11.9	24.6	43.6	15.4	4.6
Mental/ emotional health	14.0	25.9	40.2	14.5	5.4
Social activities	9.6	18.5	38.4	22.3	11.3
Legal/career advice	12.4	23.8	40.7	17	6.1
Disability or equality issues	12.8	24.0	41.0	17.0	5.3
Help for overseas students	13.4	19.9	36.6	19.6	10.5
Accommodation	8.6	17.1	38.7	25.7	10.0

Question 15 : **Induction Week**

With regard to the initial Induction Week, 53% of respondents stated the Induction Week was useful in introducing them to the support services. Overseas students in particular were more likely to find Induction Week helpful (χ^2 [1] = 19.01, p <.001) than home students. Seventy one per cent of the sample stated they would have liked to have been shown around more to become familiar with the whereabouts of the Support Services. Just over 60% of students stated that the information given during Induction Week had been forgotten, and that a refresher period would be helpful.

Overseas students were also more likely to be aware of the support services than home students (14.4% to 9.8% respectively) as they were about the promotion of mental health service provision (8.9% to 4.7% respectively). When it came to a breakdown of services associated with mental health, differences emerged between campuses. Only 12.5% of College Lane students thought these services were not very well promoted, compared to 19.1% of de Havilland and 10.2% of St. Albans students.

Differences were also noted between the sexes with a higher percentage of males finding Induction Week more helpful than females (55.8% to 50.8% respectively). Females preferred to be shown round more (74.2% to males 67.5%) and females were 10% more likely to have forgotten what they had been told during Induction Week (64.8% to 55% of males).

Section 3: Help-seeking behaviour: Persons/Services of contact

Question 16 : Seeking help on behalf of another/social capital issues

Figure 5 below shows the types of responses students made with regard to how they would react if they were concerned about a fellow student showing signs of being depressed/unhappy or anxious. The majority of students would try to befriend him/her, or try and persuade them to get help. Only a small percentage of the sample stated they would ignore them, do nothing, or would not know what to do.

Figure 5: Students' responses to a fellow student showing signs of depression/unhappiness/anxiety
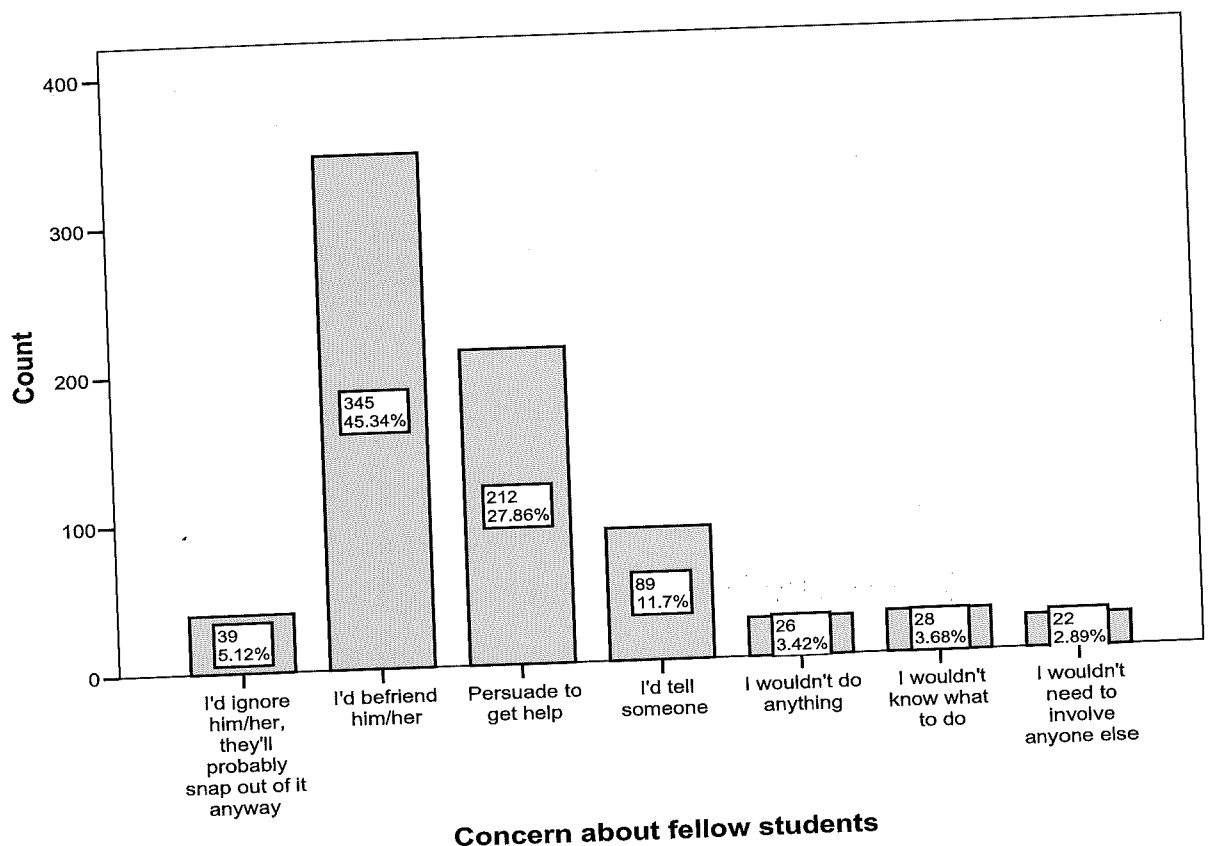
Question 17:To whom would students turn in times of depression/unhappiness/anxiety

When asked who they would be most likely to turn to in times of depression/ unhappiness/anxiety, a majority of students said they would be most likely to turn to family or close friends, with respondents being especially unlikely to turn to university officials and other support service staff (e.g. lecturer, tutor, doctor, nurse, religious official).

Table 29: Who students felt they were most likely to turn to in times of depression/unhappiness/anxiety

	Least likely	Not likely	Neither likely nor unlikely	Likely	Most likely	Missing data
	%	%	%	%	%	%
Close friends/family	3.1	5.0	8.7	16.4	66.4	0.5
Casual friends/peers	14.1	19.9	33.9	23.1	8.6	0.5
University lecturer	44.9	24.9	19.7	7.2	1.7	1.5
Personal tutor	41.3	23.6	20.2	10.5	3.1	0.1
Religious person	52.9	18.5	15.1	8.8	4	1.2
Doctor at Medical Centre	34.7	23.3	24.8	11.9	4	1.2
Counselor at the counseling service	35.9	24.9	23.9	10.9	3.2	0.9
Other university staff	49.4	25.8	16.5	6.1	1.4	0.9
Nurse at the Medical Centre	44.5	21.5	21.1	9.2	2.7	1.0
I wouldn't turn to anybody	52.9	10.3	19.7	8.6	7.2	1.4

Question 18 : Difficulties in asking for help with emotional problems:

Over half the sample in this study 51.2% (n = 411) admitted having difficulties in asking for help with emotional problems, while 48.88% (n = 393) did not. An analysis of demographic data showed no significant differences based on sex (χ^2 [1] = 1.53, p = .2), fee status (χ^2 [1] = .03, p = .86) or ethnicity (χ^2 [7] = 8.99, p = .25).

It was however noted that more de Havilland students reported having difficulty asking for help (College Lane students 49.6%, de Havilland 55.4% and St. Albans 50.2%), as did more females compared to males (53.2% to 48.8%)

For those who did admit having difficulty asking for help with emotional problems, Figure 6 displays the most common reasons cited by these students. The items chosen were: "I just do, I don't know why", and "I'd have to be really depressed" - indicating these causes were more relevant than the items relating to record-keeping and the possible effect on career pathways.
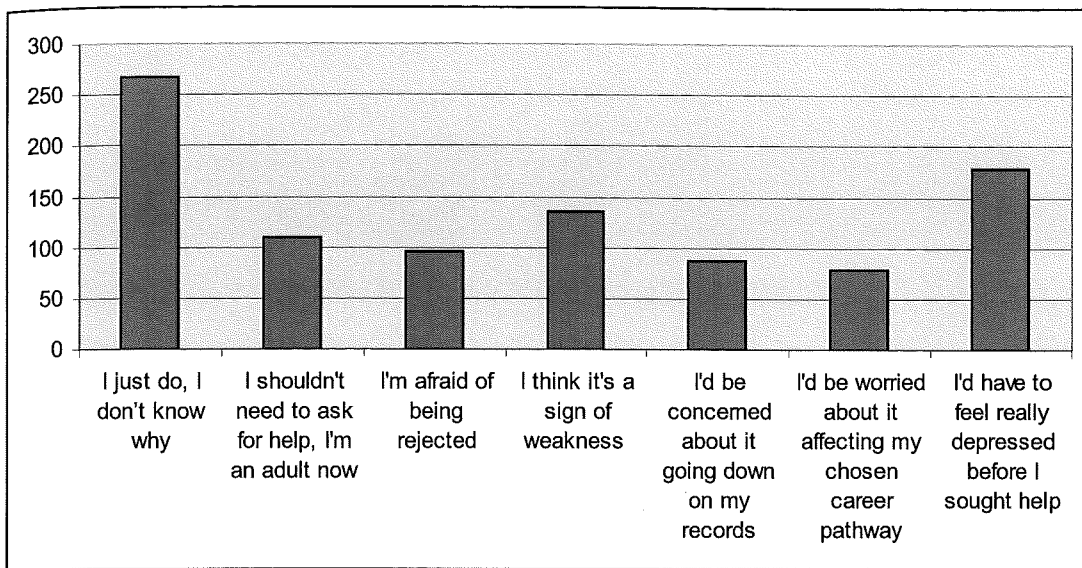
Figure 6: Frequency of agreement with reasons for having difficulty asking for help with emotional problems (N = 388)

In terms of which support service students would turn to if they felt depressed/unhappy/anxious, (Question 19), Figure 7 below shows that actually a majority of students would not turn to any of the listed university support services first (χ^2 [6] = 371.66, P < .001).

Figure 7: Which support service the student would turn to first in times of depression/unhappiness/anxiety

Which UH support services would you access first
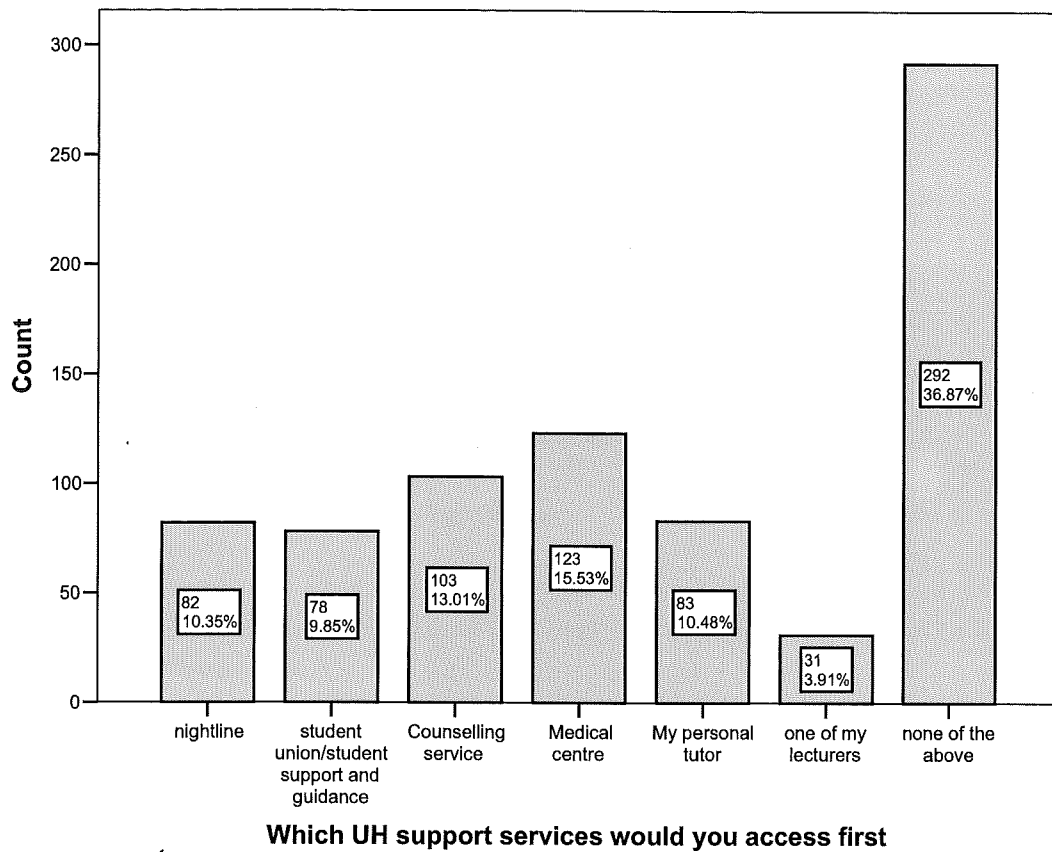
It is also interesting to note the responses of overseas students who although still not particularly likely to turn to any of the named support services, would be more likely than home students to turn to the Student Union/ Student Support and Guidance Office (χ^2 [6] = 21.73, p = .001) (Figure 8). At 16.3% of the total sample, the Medical Centre would be the next choice for home students, but only 11.5% of overseas students. The counselling service would also be a more popular choice of 13.4% of home students, compared to 10.7% of overseas students.
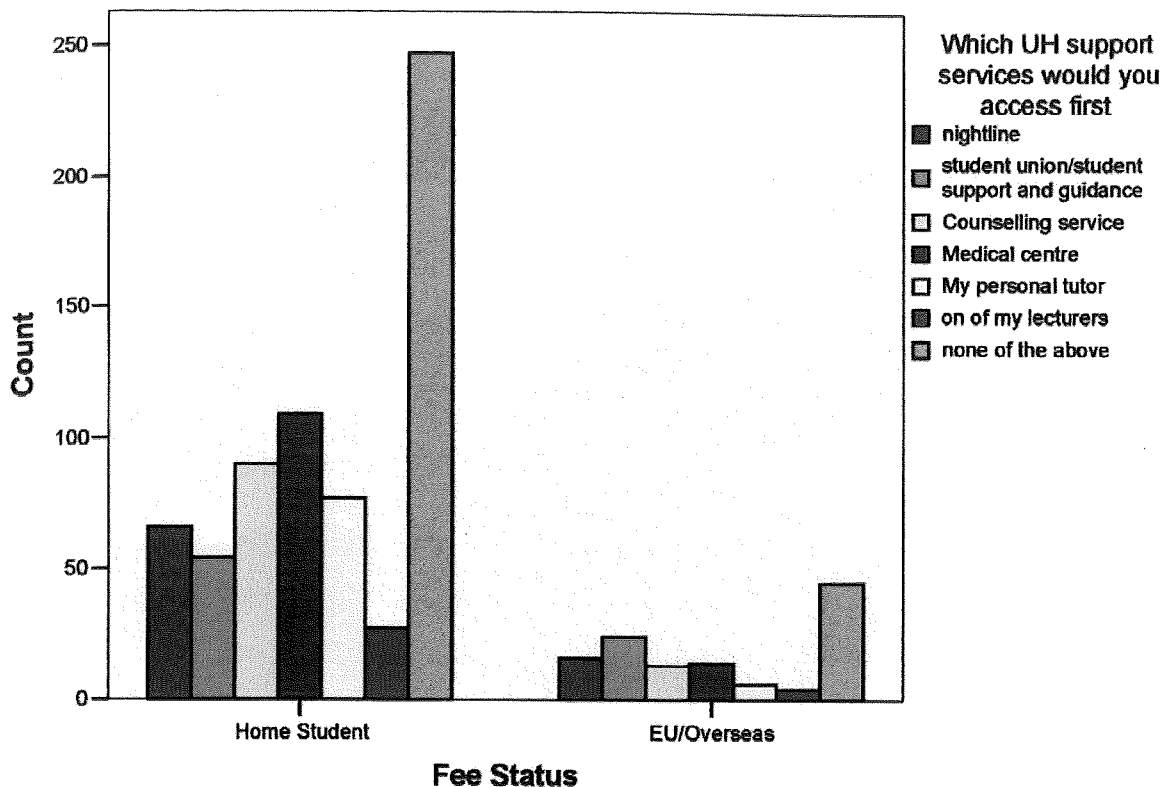
Figure 8: Differences between home and overseas students in relation to their choice of support services

Inter-campus breakdown revealed that more de Havilland students would not contact any of the named services, compared to their counterparts on the other two campuses (de Havilland 44.4%, College Lane 33.9.%, St. Albans 38.8%)

Help Seeking Behaviour: Barriers to Accessing Help

This section focuses on three different aspects of help-seeking behaviour: stigma attached to physical, mental and learning disabilities, helping others, and sources of support.

Question 7: **Physical disabilities**

Nearly thirty per cent of students stated they thought there was a stigma attached to physical disabilities. Over fifty per cent of students stated that students who do have physical disabilities should declare their disability to UH prior to registration, with 12.6% stating they should not be declared, and 35.7% saying any declaration would depend on how obvious the physical disability was. Of those students who stated that physical disabilities *should be* declared, 92.5% thought that physical disabilities are nothing to be ashamed of. Eighty seven per cent of this group also thought that UH provided exceptional help and support for those with physical disabilities, and 95.5% were of the view that it

was important for UH to know of physical disabilities in advance, in order to cater for the needs of physically disabled individuals.

Of those who *did not* think physical disabilities should be declared (12.4% of the total sample of students), a majority (57.4%) thought they should not be declared because it would make more people aware of the disability, nearly three quarters of whom (70.6%) thought declaration of a physical disability could lead to physically disabled students being treated differently.

Question 8: **Mental disabilities**

Nearly fifty per cent of students stated they thought there was a stigma attached to having a mental disability, with 33% saying there was no stigma, and 17.7% saying they would rather not comment. Fifty three per cent stated that students *should* declare a mental disability prior to starting university, with 12.3% stating they *should not* and 34.2% stating it depends on how obvious the disability was.

For those who stated that mental disabilities *should be* declared, 93.5% said this should be done because mental disability was nothing to be ashamed of, 71% thought mental disability should be declared out of concern for the safety of others and 85.5% said that a mental disability should be declared so that UH would then be able to provide exceptional support for these individuals, with 96% of these students saying that UH needs to know of these mental disabilities in advance in order to best cater for these students and their needs.

Of those who thought mental disabilities *should not* be declared (12.3%), 64% said that this was because of the stigma attached to mental disability, 64% said it would be inadvisable to declare a mental disability for fear of being labelled as having a mental health problem. Forty three per cent of respondents thought that declaring a mental disability might result in being alienated by friends and 42.5% stated a declaration might bring about discrimination.

Question 9: **Learning disabilities:**

Over thirty one per cent of students questioned thought *there was* a stigma attached to learning disabilities, with 54% stating that there wasn't a stigma attached to learning disabilities, and 14.8% of the students saying that they would rather not comment. Fifty eight per cent stated learning disabilities should be declared, with 12.6% saying they should not be declared, and 28.6% saying that it would depend on how obvious the condition was.

Of those who stated that learning disabilities *should be* declared, a majority (93.2%) stated that they should be declared because learning disabilities are nothing to be ashamed of. Nearly ninety per cent were of the view a learning disability should be declared because the university provides exceptional support for learning disabled students and 94.5% stated the university needed to know in advance in order to cater for their needs.

For those who said that learning difficulties *should not* be declared, only 42% stated that the stigma attached to this condition was a good reason for not declaring a learning disability, compared with 47.9% worrying that they would be treated differently as a result of declaring a learning disability, and 52.1% concerned that other students would resent the extra help offered to those who have registered learning disabilities.

Question 20: **Reasons for not approaching the University Medical Centre**

For those who did not think the Medical Centre was the most appropriate place to turn to, in times of depression/unhappiness/anxiety, students were given a number of options as to why they would not turn to this particular service. Table 30 below shows the different options provided, with the options cited as being the least likely reason for not accessing the University Medical Centre as: "wouldn't want to be seen going into a medical centre" and "past experiences with my GP haven't been positive". On the other hand, the reasons cited as being the most likely cause for not accessing this service were: "doctors don't deal with emotional problems", and "other services would be more appropriate", though no particular 'reasons' stood out as being more likely than another.

Table 30: Reasons students would give for not going to the medical centre for issues relating to anxiety, depression and unhappiness (n = 665)

	Least Likely	Unlikely	Neither likely nor unlikely	Likely	Most Likely
	%	%	%	%	%
Doctors don't deal with emotional problems	13.5	17.3	28.7	23.5	16.8
I might be given medication	23.9	19.9	28.5	17.7	10
Don't understand what the medical centre provides	22.8	20.1	32.1	17.5	7.5
Doctors don't have time	16.9	19.3	33.9	17.9	11.9
Wasting the doctor's time	14.8	16.5	29.7	22.9	12.7
Concerns about medical records	26.4	19.0	29.7	16.2	8.6
Concerns about confidentiality	35.1	22.6	27.8	10.0	4.6
Wouldn't want to be seen going into the Medical Centre	45.3	20.4	23.1	7.9	3.3
Past experience with GPs hasn't been positive	36.2	20.4	25.8	11.9	5.8
Other services more appropriate	21.0	15.9	33.0	16.6	13.5

Looking at possible additions to services provided by the University Medical Centre, (Question 21), the additional service most likely to be used, according to students' responses, was an e-mail based support service; the nurse led well-person clinic being the least likely to be used.

Table 31: Which additional services would be most likely to be used:

	Least likely	Unlikely	Neither likely nor unlikely	Likely	Most likely
	%	%	%	%	%
Email support	16.8	17.6	27.1	20.4	18.1
Telephone helpline	15.4	20.8	35.1	19.5	9.1
Nurse led walk-in clinic (assess need)	14.4	20.1	32.9	22.8	9.8
Nurse led well-person clinic	17.3	19.1	34.6	20.4	8.6

The next question (Question 22) focused on ascertaining students' views concerning availing themselves of the opportunity of having a free health check. A majority (nearly 70%) said they would have accepted the offer, 12.2% said they would not and 20.7% were not sure.

For those who would accept, the reason most frequently cited was 'because it would be good to know that nothing was wrong', closely followed by 'having a health check-up is a good idea'. Familiarising themselves with the Medical Centre was not as important a reason.

Table 32: Reasons for accepting the offer of a free health check (n=539)

	Yes	No
	%	%
Would be good to know nothing's wrong with me	83.5	16.5
I would become more familiar with the medical centre and staff	38.4	61.6
I think having a health check-up is a good idea	79.7	20.3

For those who declined the hypothetical offer of a free health check, the options laid out in Table 33 were provided to explain why they would not accept the offer. The most commonly given answer was "I wouldn't go if I felt well at the time".

Table 33: Reasons for declining the offer of a free health check (n=128)

	Yes	No
	%	%
Would feel guilty about life-style	25.5	74.5
Wouldn't go if well at the time	53.1	49.9
Would only go if 'at risk'	38.8	61.2
Just wouldn't want to have a health check	41.2	58.8

For those who were not sure whether they would accept a free health check, the following options were given to explain their uncertainty. A majority said that they would want to know what was involved in the health check first before accepting.

Table 34: Reasons for uncertainty on accepting a free health check (n= 167)

	Yes	No
	%	%
You'd want to know first what was involved in the health check	79.0	21.0
You'd want an assurance that results were confidential	53.9	46.1
Afraid of finding something wrong with you	44.3	55.7

The last question (Question 23) focused on why some students did not register with the University Medical Centre. Again a number of options were given. A clear majority (61.23%) stated they were already registered with doctors elsewhere (and would not want to change), followed next by the option they didn't know what was involved in registering with the Medical Centre (19.51%). Nearly 12% of students replied they would rather not say why they did not register with the Medical Centre and a small number of students (8.15%) said they would not want to register with a doctor anywhere. Cross-tabulation revealed that twice as many overseas to home student did not know what was involved in registering with the Medical Centre (35.7%, 17.6% respectively).

Despite the dominance of statistical measurement in this chapter, consideration has been afforded to Hagen's (1997) advice:

> "you should not *rely* (my emphasis) on measures of statistical significance. Providing information on the direction and size of the effect and the relationship found in a study is highly recommended" (p. 24).

Indeed, Robson (2002) also commented that the magnitude of any differences or correlations as a result of the data analysis may be of importance separately from the statistical significance, as these may give an indication of fruitful avenues for future research. Instances where this has occurred are discussed in the next chapter.

The next chapter (Chapter 6) considers the findings of all three data-sets, discussed in accordance with a complementary approach to data interpretation (Brannen 2004). This discourse brings together issues arising from the data analyses and moves us towards the development of a salutogenic model of mental health promotion within the university context.

Chapter 6

Towards a Salutogenesis of Student Mental Health

Creswell's (1994) final characteristic of the flexible design states that the findings of the research should accurately reflect the complexity of 'real life'. To this end, a complementary approach (Brannen 2004) has been adopted to the interpretation of the three data-sets. Drawing the results of all three data-sets together has led to the development of a new understanding of how mental health might be promoted in a university setting. The findings of the focus group discussions, the interviews (both semi-structured interview and unstructured) and the survey are therefore discussed here against a background of the already reviewed literature and also some new literature accessed on account of the emergent areas of interest.

As befits a flexible design, the conceptual classification of the issues posed to UH students in the focus groups and in the survey had evolved into three distinct areas and this chapter has been organised accordingly. These sections are as follows: **Social Capital and Anomie, Salutogenic Issues/Health Assets and Health Deficits** and **Help-seeking Behaviour,** both as persons/services of contact and factors affecting help-seeking behaviour. Some of these categories inevitably over-lap with another category. For example, personal tutors and lecturers are integral to the university's support system and yet equally they are connected to help-seeking behaviour issues. The demographic profiling of the study is discussed towards the end of the chapter, where limitations imposed on the conclusions drawn are also reviewed and areas of further research are identified. Where commentary is supported by reference to one of the focus group findings, the citation is suffixed by 'FG' and the number of the focus group in which the comment was made.

Section 1: 'Anomie' and social capital issues:

Fitting in, feeling homesick and experiencing difficulty adjusting to university life

The majority of undergraduates in the samples of this study were first year students (see Appendices 20 and 21). A common-sense/pragmatic approach to the three inter-connected parts of this survey question (see Question 1, Appendix 22) suggests a certain amount of homesickness and difficulty adjusting to university life for 'freshers' is to be expected. This was identified in the literature review by Wade (2002). However, there appears to be a wide range of findings concerned with the extent of this phenomenon. Fisher and Hood (1988) found 31 per cent of first year undergraduates suffered with homesickness, whereas

Adalf et al. (2001) concluded as many as 60 per cent of first-year undergraduates reported homesickness. Adalf et al (2001) further proposed these students were at a greater risk of developing mental health problems.

In the survey component of this research, just over half of the total sample (all years) said they sometimes felt homesick, just over forty per cent said they had never felt homesick and a similar number said they sometimes experienced the feeling of not fitting in. Nearly sixty per cent said they had never experienced difficulties adjusting to university life and the numbers of those admitting to often having problems with homesickness, fitting in and adjusting were all below ten per cent of the total sample. In relation to the previously mentioned studies, this begs the question – just how high a percentage of students experiencing these problems is too high and at what point would students' levels of distress affect their mental/emotional well-being? Of note, Lago (2002) argued issues of homesickness are not taken seriously enough and of particular interest, a recent study undertaken at Magdeburg University in Germany in 2007 (Born and Crackau 2007), found a link between Antonovsky's SOC and the settling-in period for 'freshers'. It was concluded that a strong SOC was a useful predictor with regard to a positive appraisal of the transition to university and problem-oriented coping. In particular, a strong SOC offers protection from appraising the new situation as threatening and harmful and this finding could be an interesting opening for future research in UK HEIs.

Certainly HEIs and in particular specific departments of the university, (such as the Students' Union and the International Students Support Unit) do a considerable amount to offset homesickness at the beginning of term with Induction Week and a plethora of special events which all aim to minimise 'anomie' and to strengthen those factors that collectively amount to higher levels of social capital. A possible recommendation to HEIs would be to undertake 'the student perspective' and monitor these levels (homesickness, not fitting in and difficulties adjusting) annually to determine whether there had been a general deterioration or improvement in students' self-reported well-being status.

Another interesting facet associated with the findings of these questions was the comparison between home students and overseas students. The survey finding revealed that a statistically significant greater number of overseas students felt more homesick, missed family and friends and had more difficulty fitting into university life than home students. A sub-group analysis of the three campuses revealed that de Havilland students felt more homesick and experienced slightly more difficulty fitting in than their counterparts on the other two campuses. A further cross-tabulation between the sexes, fee

status and campus of respondents indicated this was due to a higher percentage of overseas females on de Havilland campus with regard to experiencing the feeling of not fitting in and overseas males on College Lane with regard to missing family and friends, clearly suggesting a link between overseas students and higher levels of anomie. This finding supports the view of the Royal College of Psychiatrists (2003) that international students are more vulnerable to mental health problems; a view also upheld by some focus group participants: "for international students, it's the whole thing – moving to another country, adjusting to a different culture ..." (FG7). Nevertheless, other overseas students had had a different experience "people warned me about going to a new country – that it would be scary but it didn't affect me" (FG7).

Other researchers (Bradley 2000, Royal College of Psychiatrists 2003), have also suggested that home students, especially those from non-traditional backgrounds and from ethnic minorities, might be at greater risk of developing mental health problems, or at least experiencing these feelings in equal measure. A similar view was expressed by focus group participants: "a lot of home students have trouble fitting in – I know someone who is dropping out" (FG2), "it's equally hard to fit in – home or overseas" (FG2). Unfortunately, clarification on this matter was not possible from analysis of the survey data demographics because respondents had not been asked to expand on this item. It was, however, a very important statistically significant finding that 6.9 per cent of Chinese survey respondents were more likely than other ethnicities to 'sometimes' and 'often' feel homesick (see page 181) especially as an almost identical proportion of Chinese students (at 7 per cent of the total student count) were registered with UH for the year 2006/2007 (information gleaned from UH's Academic Registry, June 2008).

Although there was no statistically significant difference between males and females with regard to the feeling of not fitting, there was a statistically significant difference between the sexes when it came to experiencing homesickness and difficulties adjusting to university life, with females experiencing more problems than males. It could be argued (as indicated in the literature review and apparent from the focus group analysis) that females are more willing to admit to these feelings, or as proposed by The Royal College of Psychiatrists (2003) that females, (who now account for half or more of the university student population), actually exhibit increased levels of psychological disturbance during the transition to higher education. Whatever the explanation, the data alone suggest that although 'freshers' in general are more vulnerable than undergraduates in later years of

study, female 'freshers' appear to be more vulnerable than male 'freshers', as do some overseas students compared to home students.

Feeling part of a supportive community

Putnam (1995) makes reference to characteristics of a community which promote cohesion and a sense of belonging. He proposes the level of social capital within a community can be 'measured' by individuals' perception of the environment in which they exist. Over twenty years ago, Madge and Marmot (1987) had argued too little attention was paid to personal meanings and the extent to which individuals connect with their community – another reference to the benefits of taking a 'user perspective'. It was evident from the focus group findings that not all students felt part of a supportive community on campus. Survey findings revealed that although nearly a quarter of students felt part of the community all the time, nearly two thirds felt part of the community only some of the time and fourteen per cent never felt part of a supportive community at all.

A closer inspection of the data to determine whether further breakdown would reveal differences between any of the sub-groups shed light on inter-campus resentments and raised the noteworthy possibility that multi-site universities may indeed have specific problems relating to lack of social cohesion. More College Lane students than their counterparts on the other two campuses felt part of the community all the time (twice as many de Havilland students to St. Albans students said they never felt part of the community). This finding tends to reinforce several focus group participants' comments pertaining to this issue: "most of the services are on College Lane and this poses huge problems if you are based on other campuses" (FG8), "College Lane has the social side. There's nothing like that at de Havilland" (FG2). According to Wilkinson (1996) communities with high levels of social capital will have denounced exclusion and rejected any form of exclusivity. Focus group and survey data analysis indicated some students on specific campuses felt resentment because they were excluded from services on the main campus, at least from the point of view of having easy access to them, as many of the services (in particular those related to mental health) were provided exclusively on one campus.

A higher percentage of overseas students in this sample (compared to home students) experienced the feeling of never belonging to a supportive community. They also felt less part of the community all the time. This is despite considerable support targeted at

overseas students, especially immediately on their arrival at university. This finding would be contrary to the ideal of social cohesion characterised by strong bonds of cohesiveness which, according to Morgan and Ziglio (2007), minimise 'health deficits' and increase the likelihood of building desirable 'health assets'.

Fairness and Equality Issues

Feeling equally and fairly treated is integral to the concept of social capital. The impression that some students did not feel fairly and equally treated emanated entirely from cross-case analysis of Focus Groups 1, 5, 6, 7, 8 and 11. Equity and fairness is an area of university policy afforded specific consideration by the Disability and Equality Unit. Of the issues identified as causing students to feel most unfairly and unequally treated, parking issues were ranked the highest of all. Although parking problems accounted for more than half of the total number of issues expressed, (with the highest frequencies recorded across all three campuses), it was evident that the issues dividing the three campuses and causing resentment related to other issues associated with the location of the campuses and the provision of support services.

For example, St. Albans students felt more unfairly treated with regard to not receiving free/assisted travel expenses between campuses. This finding was most likely due to the distance between St. Albans campus and the other two campuses, a view upheld by comments made by some focus group participants: "it's unfair for law students as there's no free bus services between St. Albans and other campuses" (FG3) and "......If you're going to provide services at a university, we should all have the same facilities. It feels like – they're just the St. Albans lot" (FG4). It is also to be noted that Law School participants made up a disproportionate number of the focus group sample (see Appendix 20), again possibly due to their keenness to express these views in the forum provided.

De Havilland students, on the other hand, felt more unfairly treated with regard to the issues of: the use of the sporting facilities (home females), accommodation matters (home males) and not being included in the university's activities and events (overseas males). It was an unexpected finding that de Havilland students felt less fairly treated about access to sporting facilities and accommodation matters especially as de Havilland is a newly built campus with exceptional sporting facilities. This could reflect views expressed during the focus groups that the cost of the use of the sporting facilities is prohibitive. College Lane students felt the least unfairly treated on any of the other named issues.

The feeling of not being treated equally extended to different experiences between home students and overseas students, although overall fewer overseas students felt the same level of unfairness as home students. In fact, focus group comments had indicated some home students were concerned that they were not being treated equally in all aspects of university life: "It's not fair that international students have a free cable for internet use in their flats whereas we have to pay a set-up fee" (FG6).

Pub/Club Culture

Eighty five per cent of the survey respondents agreed with the statement that there is a Pub/Club culture in British universities today. This supported views expressed during focus group discussions: "tackling the alcohol problem – it's a British phenomenon" (FG8) and overall the results of this part of the question were commensurate with research undertaken by Grant (2002), Meltzer et al. (2002) and Charlton (1998).

However, based on Grant's (2002) work in particular and on current media coverage of the widespread problems of binge-drinking in young people today, it was unexpected that 41 per cent of the total student sample did not feel part of this culture. Breakdown of the survey data into sub-groups revealed that males were significantly (statistically) more likely to feel part of such a culture than females, a view that was also expressed by a focus group participant: "there is a drinking culture, especially in males" (Male, FG4). Home students were also significantly (statistically) more likely to feel part of the Pub/Club culture than overseas students (see page 183) and this finding may well have a bearing on the extent to which overseas students feel they can integrate into the host environment, especially as a statistically significant result was returned that more overseas students said the drinking culture went against their personal beliefs. This finding also added weight to some focus group comments: "I don't like drinking. If you drink you do wrong things" (FG1) and "some Asian students don't want to get attached to British culture, for them it means getting drunk all the time" (FG8). By contrast more home students said it just didn't appeal to them.

Statistically significance differences were noted between the different religious groups too, with Buddhists and Muslims in particular stating they do not feel part of the Pub/Club culture.

Focus group analysis had suggested that if home students were not inclined towards the Pub/Club culture, they felt they fared less well than overseas students with regard to the university's provision of alternative recreational outlets: "it's easier for home students to feel left out. If they don't want to get into the whole drinking culture there's not much for them, whereas with international students they go on trips and have café evenings and do all sorts of things, plus they have access to all the things home students have" (FG 7).

Notably, of those who did not feel part of the Pub/Club culture, only 11.8 per cent of the total student sample said this was because it did not appeal to their friends. This finding possibly contradicts the suggestion that peer pressure strongly influences drugs and drinking habits (Meltzer et al 2002) and is perhaps more likely to reflect the notion that individuals will tend to congregate with those who have similar values. Certainly with respect to overseas students this view was reinforced in both the focus groups and the survey analyses. It would seem prudent, therefore, to provide other alterative sources of recreation, not only for overseas students (whose background and culture might oppose such behaviour), but equally for home students who do not wish to become part of a drinking culture. This would support the recommendations made by the Royal College of Psychiatrists (2003) that HEIs should include clubs/activities associated with healthy life-styles as well as religious and cultural societies - all of which are compatible with the ethos of social capital. Jensen et al (1993) found increased 'religiosity' was associated with better mental health, as did Schweitzer et al (1995) who demonstrated evidence of increased suicidal ideation among those without religious affiliation. The Royal College of Psychiatrists (2003) urge HEIs to address these issues head-on.

Drug culture

The literature review established the considerable deleterious impact of drug abuse on young people's mental well-being (Meltzer et al 2002, The Royal College of Psychiatrists 2003). As already stated it was not intended to make any new contributions to this vast area of research, save to explore focus group findings which had suggested there might be widespread concern about a drugs culture at UH, with the implication that not enough was being done to tackle this problem: "at the start of the year it (drug taking) was a social thing to do and it was a fifty/fifty split with six people smoking and five not, but now they're smoking because they have to…" (FG5). Even though information gained from the support service personnel (see pages 61-62) had established the clear message of zero-

tolerance of drugs abuse on campus, analysis of the focus group findings had suggested there was a problem.

However, the survey findings indicated only 11.8 per cent of the total sample were very concerned about a drugs culture at UH, with nearly half the sample (49.6%) not concerned at all. Although not statistically significant, of interest was the indication that nearly twice as many overseas students were very concerned about a drugs culture, compared to home students (19.2% of overseas students, to 10.4% of home students). The Royal College of Psychiatrists (2003) suggest an ethos of salutogenesis could be advanced through psycho-educational campaigns to increase knowledge and the dissemination of information on drugs related (and alcohol abuse) problems within the student body. Certainly these topics would be amenable to health education programmes presented within the university's health education strategy.

Integration Issues

The question(s) relating to integration issues was not covered in the literature review and emanated entirely from the focus group analysis. Survey findings that 12 per cent of the total sample thought that some groups never make an effort to integrate and only just over half of those surveyed thought that different nationalities mixed well only some of the time was not totally unexpected, given the comments noted during the focus group discussions. Consideration of the results at the extreme ends of this rating scale revealed that 12.5 per cent thought different nationalities never mix well, with only 6% saying they mixed well all the time. In addition, only 4.3 per cent said some groups always make an effort to integrate with each other, whereas 14.5 per cent said some groups never make an effort.

Although analysis of the survey data revealed no statistically significant differences between the sub-groups, it is perhaps worthy of comment that College Lane and St. Albans' students were more inclined to think nationalities mix well most of the time, compared to de Havilland students. De Havilland students were also more likely to think some groups never make an effort to integrate. In fact, more College Lane students thought students of different nationalities mix well all the time and make an effort to integrate most and all of the time. The overall interpretation of these results here might suggest that College Lane students' views on matters relating to the integration of different nationalities on their own campus were more positive than that of their counterparts on the other two campuses.

Not quite half of the total sample strongly disagreed with the statement that they would not want to integrate with someone of their own language and culture and when asked whether language or culture posed the bigger barrier to integration, respondents were non-committal. It is therefore unclear as to which of these phenomena, pose the greater obstacle to integration. This question was posed in the survey because both issues had been raised during the focus group discussions: "the language barrier has a lot to do with it (lack of integration) (FG5) but also (under the direction of other focus group questions) the issue of cultural differences and the difficulties these sometimes created was cited as being another barrier to integration.

Two other issues associated with this question are noteworthy: Firstly, the indication that male students were more inclined than female students to think that different nationalities do not mix well and that different nationalities never make an effort to integrate. Secondly, the survey analysis demonstrated that more than twice as many home students, compared to overseas students, thought different nationalities do not mix well and that some groups never make an effort to integrate well on campus, with more overseas students saying they thought nationalities mix well some of the time, most and all the time. Certainly interpretation of these figures from the survey findings could suggest that home males in particular might be of the opinion that some areas of integration on campus leave room for improvement.

Indeed, interpretation of the focus group data indicated a recognition among some students that there is room for improvement with regard to integration among groups of different language and culture: "Staying in groups has its drawbacks. You're less likely to make new friends like that because individuals are less likely to approach a group" (FG4). It also transpired there was a note of resentment expressed by some home students: "One of the problems is there are certain clubs and societies just for overseas students but that's not making an effort to integrate with the rest of us" (FG4).

Another issue apparent from focus group analysis was the inference among some home students that, in their effort to welcome overseas students and facilitate integration, UH can inadvertently cause home students to feel left out: "There's always something about international students – but what about us. It's like we're in the process but we're being neglected" (FG4). It was, nevertheless, acknowledged by another focus group participant that integration is a two-way process: "Even home students tend to stick together …. partly

because it's easier to communicate with each other" (FG4). The issue of communication and in particular language competence will be discussed further on pages 238-239.

The results of both this question and Questions 1 and 2 of the survey, tend to reinforce a focus group participant's comment: "I'd say the Chinese and Indian students tend to stick together because they find it harder to fit in" (FG11). Certainly, these findings raise issues that many of the university's departments might be interested to know about, especially as they relate directly to a degree of weakness in social cohesion which, together with a sense of unfairness and inequality, could lead to lower levels of social capital and higher levels of 'anomie' overall.

Summary on issues relating to Social Capital and Anomie:

There is an indication that multi-site HEIs (compared to single-site HEIs) may have specific difficulties with regard to lower levels of social capital and higher levels of 'anomie' experienced by students on different campuses. In this instance it was noted to be on the campus with less immediate access to the support services associated with emotional well-being and where Schools/Faculties did not allocate students to a personal tutor. First year students ('freshers') probably do experience greater difficulty with homesickness and difficulty adjusting to university life than students from other years of study. It was also noted that overseas students experience more problems with homesickness and difficulty fitting into university life than home students (as do more female than male students) and in particular Chinese students.

Although the majority of students agreed with the view that there is a Pub/Culture endemic in British universities today, over forty per cent of the sample did not feel part of this culture. This was especially the case with females (compared to males) as with more overseas students than home students; in particular Buddhists and Muslims. This was stated as being because such a culture went against the personal beliefs of many overseas students, whereas the majority of home students said it simply did not appeal to them. Because it was perceived that more was provided for overseas students recreationally, home students disinclined towards a drinking culture felt more 'left out'. Perhaps more should be provided for both home and overseas students socially as an alternative to Pub/Club entertainment.

The majority of students are keen to integrate with other students of a different nationality, language and culture. However, integration issues leave room for improvement. Male students were more inclined to believe different nationalities do not always mix as well as

they might, as did home students (compared to overseas students) in general. Perhaps there should be less emphasis on placing specific nationalities together in groups (particularly with regards to housing and social events) and more effort made to advance cultural education and to finding and exploiting common ground between the different cultures. (One suggestion posed by a focus group participant was through organised multi-national sporting activities). This leads to a cautionary note about 'targeting' one group of students in particular (with respect to pastoral and/or general support matters), as this might lead to higher levels of resentment and diminishing social capital due to a lower sense of community cohesion.

Section 2: Salutogenic Issues/Health Assets and Health Deficits

The following topics for discussion: 'stress-inducing factors', 'sustaining emotional health', and 'sense of well-being', are depicted along the lines of Antonovsky's health/dis-ease concept. The first topic represents the negative end of the continuum and relates to issues that might cause undergraduates to feel 'depressed/anxious/unhappy' (Health Deficits). The second reflects the positive end of the continuum and concentrates on matters that keep students emotionally/mentally robust (Health Assets). The last topic would be situated around the middle of the continuum because it reflects on what might be changed to enhance emotional stability and minimise emotional distress. Morgan and Ziglio (2007) and Antonovsky (1987) stress the importance of the identification of those factors which keep individuals from moving towards the disease end of the health/dis-ease spectrum and which support the creation and sustainability of health.

Stress-inducing factors (as presented in the Student Questionnaire, see Appendix 22, Question 4) addressed various issues highlighted by other researchers. These have been substantially covered in the literature review, and include: money concerns (Grant 2002, Stewart-Brown et al. 2000), alcohol and drug abuse (Grant 2002 and Meltzer et al 2002). Other items arose from the focus group analysis.

Contrary to expectations (literature review) money problems were not cited as the issue causing most concern to the student sample surveyed at UH (only 17% of the total sample indicated this caused them 'very much' concern). In fact, money problems were rated as the second most likely cause of emotional distress, with concerns about examinations topping the list at nearly 20 per cent. The third most likely matter to cause distress was worries about coursework (14.9%). Stewart-Brown et al. (2000) found study problems were a major source of emotional distress, as did Hawton et al. (1995b) who demonstrated

academic concerns were the second most common source of distress after interpersonal problems. The remainder of the issues (as itemised in Question 4 of the survey) caused students little concern.

These findings will be of interest to all departments of the HEI, especially those responsible for relevant support (such as the Finance Office) and also the academic staff due to the high level of concern expressed by respondents about examinations and course-work. Possibly the most noteworthy conclusion, however, would be the execution of a policy *to ascertain* (and not assume) what issues cause students most concern. Furthermore, 'items of concern' will undoubtedly vary between universities and campuses, between the sexes and home and overseas students. Because the Students' Union conduct their own questionnaire periodically, it would be ideal for them to include items that encompass students' perspectives on the university's health promoting policies - particularly those of a salutogenic nature.

The topic of **emotional health** focused attention on the other extreme of the continuum and identified issues that were important to students in keeping them emotionally healthy. Some of the stated items in the Student Questionnaire were based upon the premise of the HPU initiative, (Dooris 1999), others based on the focus group findings.

Having friends to turn to was by far the most important issue in keeping students mentally/emotionally healthy and this supported research findings covered in the literature review (Grant 2002, Stanley and Manthorpe 2002) and also the views expressed by several focus group participants. However, this item was closely followed by safety issues (both personal safety and the safety of belongings) identified exclusively during the focus group analysis and which extended to all areas of students' lives on campus: "Access to non-residents into Halls should be tightened" (FG5), "At some parts of the university security is good but there are places where it is lax. All places where there is access to the university from outside should be manned" (FG3), "Safety is a big issue for me (FG7), "I feel safe on campus but not always in the accommodation. A lot of our equipment has been stolen" (FG10).

Also very important to the student sample (and in keeping with the HPU initiative) was their immediate environment: "It's important to feel comfortable in your environment" (FG3), "It's as clean as it can be. You always see people picking up rubbish" (FG3), "Visual attractiveness is good here – there are green open fields" (FG6), " if surroundings are wrong, there's a greater likelihood of mental illness developing" (FG3). Collectively

these comments supported the emphasis Dooris (1999) placed on the effects of the immediate environment on students' mental well-being. The survey findings indicated these issues were more important to females than males and more so to overseas students than home students. Having access to health facilities was least important to all students even though the focus group findings had suggested otherwise: "There should be some arrangements that students get a better deal with the Sports Centre" (FG4). Of interest, the availability of support services was the least important to overseas students.

A Sense of Well-being: Placed theoretically more towards the centre of the continuum, was the question posed to students about what 'health and safety' issues they would (hypothetically) change in order to improve their sense of well-being. Importantly, 14.3 per cent of the sample would not want to see any changes and were, by deduction, happy with the issues named in the question. Yet again safety features were ranked the highest in importance and represented: having the bus service extended (to cover late evenings and weekends), an assurance that the CCTV cameras were working and higher visibility of the security guards, especially at night. The impression that the drink/drugs problem caused quite considerable concern for many students (which emanated from the focus groups discussions) *was not* borne out by the survey sample.

Again, the findings relating to the last three questions reflect the need for HEIs to keep themselves informed about matters that are important to students – which in today's rapidly changing world are likely to be reflected in the problems prevalent in society at any given time. Such an undertaking would also take account of the documented changing demographic profile of students nowadays. This approach would entail the pursuit of the ethos fundamental to the HPU initiative (and in keeping with health protection measures) for HEIs to invest in a collective and unified effort towards creating a health-promoting environment in which students feel comfortable, safe and valued. Moreover, the line of enquiry (covered by these questions) is entirely commensurate with Morgan and Ziglio's (2007) Assets Model approach to health promotion which incorporates the idea of asset mapping to establish salutogenic indicators, (such as health promoting or protective factors) in order to create the necessary conditions for the maintenance of health. Morgan and Ziglio (2007) comment that all policy makers should re-conceptualise the notion of health to raise the self-esteem and resourcefulness of the individual to improve and sustain their own health and to provide mechanisms to ensure all policies and programmes take account of positive attributes already existing in the individual and the community.

Personal Tutors and Lecturers

The following findings relate specifically to areas of the support service framework within the university. Morgan and Ziglio (2007) maintain a set of strong and positive interacting networks and their positive impact on mental well-being may be seen as a 'health asset'. Collectively these reinforce the cohesiveness of a community.

A substantial part of the literature review focused on the important role played by personal tutors in the structure of the HEI's support system (Stanley et al. 2000, 2002, Grant 1999, 2002). This was recognised by focus group participants: "My personal tutor holds regular tutorials which are good for emotional problems too" (FG2). The vital function of pastoral support in today's HEIs has been documented throughout this work. For example, Apter (2001) recognised the longer period of dependency for young people nowadays. This is coupled with the higher representation in higher education of more young people coming from non-traditional backgrounds who might need extra support. However, it has also been established that pastoral care in universities is diminishing due to lack of funding and the extra demands placed on lecturers' time. Interestingly, the view that the ethos of 'in loco parentis' was outmoded was not the opinion of some of the focus group participants, one of whom said : "We need responsible adult supervision for a lot of the first year when you need someone to turn to. You can't just rely on your peers" (FG4).

However, of the total student sample, less than half said they had been allocated to a personal tutor (47.6%), nearly a third (32.8%) stated they did not have a personal tutor and nearly a fifth (19.6%) indicated they did not know whether they had a personal tutor or not. The matter of some students not being allocated to a person tutor was 'flagged up' during the focus group discussions. Of interest, of those students responding to the survey - who did have a personal tutor - less than half said they would turn to their personal tutors with an emotional problem, with just over a half indicating they could not. A possible reason for this was expressed by a focus group participant: "I don't feel close enough to my personal tutor because apart from lectures I was only introduced to him once" (FG7).

Although nearly a quarter of respondents indicated they could turn to their lecturers with any problem, a majority said they could not. Nevertheless, a clear majority of the total sample indicated they felt confident their lecturer(s) would refer them on (to another source of help) if they could not help themselves, and this was supported by focus group findings: "They've (lecturers) always directed me on to someone else that has got more

knowledge about that problem" (FG6) and "I appreciate their honesty. When they don't know something they pass you on" (FG8).

Sub-group analysis of this topic revealed that twice as many College Lane students, compared to de Havilland students were allocated to a personal tutor. As can be seen on page 188, this is most likely due to the fact that Business School undergraduates (on de Havilland campus) are less likely to be allocated to a personal tutor than undergraduates from other Faculties/Schools and this might explain why College Lane students were less likely to experience difficulty adjusting to university (and feeling homesick), that they were more inclined to feel part of a supportive community and that, overall, they felt more fairly and equally treated than undergraduates on de Havilland (and St. Albans) campuses. Furthermore, by contrast, de Havilland undergraduates were less happy than their counterparts on the other two campuses about some integration issues – indicating that some nationalities were less likely to mix well most of the time and that some groups never make an effort to integrate. Although these findings did not reach statistical significance, they nevertheless evoke considerable interest.

Most importantly, however, a statistically significant number of students who did have a personal tutor were more likely to feel part of a supportive community (see page 188-189). This finding certainly strongly suggests a positive, beneficial link between a pastoral care system and higher levels of social capital with concomitant feelings of well-being within the university environment.

Awareness of the Support Services

Fewer than a fifth (16.4%) of students surveyed said they were completely aware of the role of the support services (a slightly higher number were not aware at all), coupled with the result that only just over half (57.6%) of respondents were only vaguely familiar with the whereabouts of the support services. This tends to reinforce the argument for repeating such information after the 'settling-in' period has passed: "posters about the counselling service were around in Halls at the beginning of term, but now they've all been taken down" (FG5).

Stanley et al. (2000) stressed the importance of easy access to support services in times of need. With reference to this sample, the reported lack of awareness about which service offers what type of help and where these services were situated within the university is

perhaps a cause for some concern. Focus group participants had said: "more than just advertising, students should be made more aware (of the support services) when they arrive at uni. Only about one per cent of adverts are actually remembered and for people who feel OK at the time, they probably don't pay attention to them anyway." (FG3), and "it's hard to find the right person to contact because you have to work so hard to find them. It should be presented more on campus" (FG11). Other comments to reinforce this view included: "there is help but you have to actually go and look for it yourself. It's not being promoted" (FG4).

Stanley et al. (2000) maintain networking amongst the student population was important to students' emotional well-being. This was affirmed by a focus group participant: "Strong social networks are important for mental stability ... as is having someone to talk to .." (FG11). Indeed, the results of this question demonstrated that nearly two thirds of respondents knew about support services through their peers and friends, although nearly half of those surveyed admitted they had stumbled across information about a support service themselves: "You have to know where to look for it. I haven't seen it walking around (advertisement for counselling) but you might bump into it by accident" (FG6).

The final part of this question was concerned with how well students thought specific support services were promoted on their campus. It was generally thought the support services (listed) were neither very well promoted on the three campuses, nor very badly – with the exception of social activities and services for overseas students.

An emergent focus group category had been created for participants' expression of 'resentments'. The noted 'resentments' revolved around two issues; the assertion that the promotion of support services was not given equal standing on all campuses: " ...there's hardly any promotion at de Havilland apart from the sports centre which is just about physical health" (FG11). Secondly resentments also extended to a perception that services aimed at overseas students were afforded more importance: "There's always something about international students – but what about us. It's like we're in the process but we're being neglected" (FG4). Clearly some home students feel they are not valued as highly as their overseas counterparts: "If anything, it's easier for overseas students because when we first started there were posters everywhere in the uni telling overseas students not to worry ......" (FG5).

As has been documented throughout the literature review, overseas students (and arguably possibly some ethnicities more than others, as the survey demonstrated) are more likely to experience some aspects of 'anomie' to a greater extent than home students. Evident from the survey findings, however, was that overseas students are nearly twice as likely to be aware of the support services provided for them. Possibly overseas students exhibit a greater keenness to inform themselves about the available sources of help from the outset, (as well as the probable explanation that the international students support service is keen to promote their support to newly-arrived undergraduates from overseas), than home students who may not feel the same urgency initially. Indeed, this was alluded to by a focus group participant: "Although I don't think enough is done (to promote sources of help) ... there is a certain amount of apathy among students in terms of bothering to find out information as well; it's a bit of a double edged sword" (FG8).

A noteworthy conclusion from these findings is that support services need to continuously promote their service - not just during Induction Week - and also to do so on all campuses to raise awareness about the type of help offered and the whereabouts of the service. Monk and Mahmood (1999) observed that awareness and accessibility of student (counselling) services were key determinants in coping with emotional and psychological pressures, as this contributes to a sense of well-being by providing 'a comfort factor'. Moreover, the university needs to be aware that directing help exclusively at one section of the student population might reduce levels of social capital and increase resentment due to the perception of some groups that they are not valued as highly as another group.

Induction Week

Over half of the total sample (53%) thought induction week was helpful: "We were told during induction week about all the people who can help with problems.... The network is there if you need it" (FG11).

However, two concerns were that nearly three quarters (71%) of students said they would like to have been shown round more: "We weren't shown round, just given a map" (FG6), and nearly two thirds indicated they had forgotten some of what they had been told. In fact there seemed to be information overload during the first few weeks of term: "There's too much at the beginning, it makes you turn-off – you might not need some of these things straight away and then you forget about them" (FG6). St Albans' students in particular thought it would be a good idea to repeat aspects of Induction Week and this is most likely

to be due to the distance between campuses. There was also a difference between the sexes. A higher percentage of males found Induction Week more helpful than females, whereas females would have preferred to have been shown round more, compared to males. Females were also nearly ten per cent more likely to have forgotten what they had been told during Induction Week.

In particular, there was a statistically significant difference between the benefit derived from Induction Week between home students and overseas students (see page 190), over 70 per cent of whom thought Induction Week was helpful (though again they were of the opinion they would like to have been shown round more).

Again this topic had emerged during the focus groups discussions. The university's support services, in particular, will be interested to learn of these findings, as might a wider number of HEIs, especially those with multi-site campuses.

Summary on Salutogenic/Support services issues

Family and friends are still the most important sources of support to students. However, it is not advisable to make assumptions about what issues are important in sustaining young people's mental well-being (health assets). Factors adversely affecting their well-being (health deficits) will vary in accordance with factors external to students (such as constantly changing socio-economic variables) and to internal factors (variable traits/dispositions and coping strategies unique to the individual). Currently, safety issues are of considerable importance to the students involved in this study – both in terms of personal safety and the safety of their belongings. In fact, the *visibility* of protection was highly regarded – the security guards, CCTV, and secure boundaries to campuses. However, issues of most concern were related to examination (and course-work pressure), more so than financial worries. The university's pleasant, clean, green and welcoming environment was valued and much appreciated. Approximately fifteen per cent of all students surveyed would not want to see any changes to the university. It is wise therefore to ascertain, rather than assume, what issues are important to students in sustaining their mental well-being and by the same token to regularly update information provided by students on what causes them distress.

There is, however, insufficient promotion of the university's support services across all campuses. Lack of awareness concerning the role and remit and the location of these services was apparent. Information imparted during Induction Week (highly valued by all students but overseas students in particular) needs to be repeated at regular intervals, due to

an overload of information at the beginning of term. Unequal access to the support services and unequal targeting of some groups with regard to the promotion of social events was a cause of some inter-campus resentment, as it was between some home students and overseas students.

Of concern was the variable level of pastoral care afforded to students. Less than half of those surveyed had been allotted to a personal tutor, nearly one fifth of students surveyed did not know whether they had been allocated to a personal tutor or not. Evidence suggests there is a diminution in the pastoral role ethos as even those students allocated to a personal tutor would not always turn to their personal tutor with an emotional problem, possibly due to less personal contact with them. The majority of students surveyed regarded their lecturers (and where applicable their personal tutors) as being a source of onward referral, if lecturers did not feel they could help a distressed student themselves.

Most importantly, a statistically significant higher number of students allocated to a personal tutor were more likely to feel part of a supportive community than those students who were not allocated to a personal tutor.

Consequently, it is suggested, the undermining of the benefits of the pastoral role of the personal tutor could have repercussions for both the levels of social capital exhibited by undergraduates and their experience of 'anomie' within the university setting.

Section 3: Help-seeking behaviour – Persons and services of contact

The following section relates to the identification of aspects of students' help-seeking behaviour from the perspective of accessing help from informal sources (family and friends) and the formal support system operating within the university's institutional provision. It also discusses inhibiting factors to help-seeking behaviour which could pose a threat to students' mental well-being, in particular those concerned with stigma and accessing the university's Medical Centre.

Students' responses to a distressed fellow student

The focus group findings indicated a caring approach and high level of concern and involvement with a fellow student in emotional distress "knowing there's someone there is probably the most important thing" (FG8). Just under half of the sample (45%) said they would try to befriend the distressed peer/friend and 28 per cent said they would try to persuade him/her to get help, collectively indicating that a majority of the students

surveyed exhibited a good deal of social capital in their response to another fellow student in emotional distress. Only three per cent of the total sample said they would not do anything and this response is possibly associated with the issue of self-autonomy, as outlined both in the literature review and reinforced by some focus group participants: "He might just want to be alone and given some space" (FG7). A very low number (under 5%) said they would ignore him/her.

After indicating they would befriend the fellow student, another popular response with students would be to advise the distressed student to get help and for the befriender to seek advice from another source on the distressed student's behalf: "I'd tell someone else because maybe he can't ask for help himself" (FG2).

Focus group analysis indicated the strength of the relationship with the distressed individual would dictate the level of involvement and whether someone else would need to be involved; in fact, the closer the relationship the less likely it was the 'helper' would feel the need to seek outside help. However, it was not clear by the wording of the survey question (and therefore causing a limitation in interpretation) whether the hypothetical student was a friend or a peer and this may have been the reason why only 2.7 per cent of the survey sample respondents said they wouldn't need anybody else.

Perhaps most surprisingly, less than 4% of the sample said they would not know what to do. The 2007 study undertaken by researchers from the University of Central Lancashire and Kings College, London, between 2004 and 2006 was concerned with the identification of ways student suicides could be prevented (Stanley et al. 2007). It had identified that some students often did not know who to turn to for help when confronted with a fellow student in distress. One of the outcomes of the study was to produce leaflets aimed at students themselves (to offer guidance in recognising emotional distress in others and to signpost the avenues of help), and at university staff to help with recognition, referring on troubled students and self-help with regard to off-loading difficult cases.

The Royal College of Psychiatrists (2003) concur with Stanley and Manthorpe (2002) that peer support training may be of value in this respect. The Royal College of Psychiatrists (2003) stressed the importance of health education and anti-stigma campaigns to improve perceptions of mental health issues which should include the availability of relevant services. Such information, they stress, should be published in student handbooks, on notices and websites or transmitted through lectures, peer support programmes and also recognised as playing an important part in promoting the nurturing environment of

universities. All such services need to be provided in a format that is usable by everybody irrespective of their gender, nationality, social status, sexuality and disability and there needs to be a commitment to increasing knowledge and understanding of health through academic channels to embed health matters within the curriculum and across all faculties. Such an approach is fundamental to the Health Promoting University Initiative and it was evident from the contact with support service personnel that these considerations were paramount in the delivery of support service provision at UH.

The first person of contact (when feeling 'depressed/anxious/unhappy')

Two thirds of the total sample said they would turn firstly to close friends and family in times of emotional need. This supports all the evidence presented in the literature review. All the other listed sources of help were rated under ten per cent, of these casual friends and peers were rated at 8.6 per cent but of some concern just below this percentage, 7.2 per cent of students said they would not turn to anybody: "If I have problems with emotions and things I don't really like to talk to people because I like to keep it to myself and to resolve it within myself rather than talking to people (FG4, Male).

Furthermore, analysis of these data did not support Stanley et al's (2000) findings that students turn to university staff as a main source of support. On the contrary, this sample placed university staff, as a source of contact, at the bottom of the list at 1.4 per cent. Of interest, students indicated they would prefer to turn to their personal tutor rather than one of their lecturers (3.1% to 1.7% respectively). Of note, too, was the indication that students would prefer to contact their doctor at the Medical Centre, in preference to a counsellor at the Counselling Service, even though the question did stipulate when feeling 'depressed/anxious/unhappy'. This tends to confirm Jacobson et al's (2001) assertion (and indeed that of the UMC's MPR) that GPs are often the first port of call for young people in times of emotional distress.

In connection with help-seeking behaviour, the matters of trust and familiarity emerged as a 'new' category during focus group analysis: "It would have to be someone you could trust" (FG4), " I wouldn't turn to what the uni offers first. I would turn to friends because they're the ones you can trust" (FG4), "It must be someone I respect and who knows me well" (FG5). For this reason, overseas students indicated they would turn to each other: "For me it would have to be other Chinese students because of language problems and because of the very different culture here. This means we usually talk to each other" (FG10). In fact quite a few remarks by Chinese students during the focus groups (denoted

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by direct reference to their nationality) supported the statistically significant finding that Chinese students were the most likely of all the ethnicities to experience homesickness most keenly (see page 181).

The samples in this study had certainly not supported the findings of (Stanley and Manthorpe 1999 and Grant 1999) that the personal tutor was the second most frequently identified source of help for students with psychological problems, with only family and friends being cited more often. This could be for a host of reasons: related to the sample, to the type of HEI, whether students were allocated to a personal tutor, even to the time period in which the research was conducted. Nevertheless, what is still relevant to the findings of this study is that students need a range of support services, both formal and informal, to accommodate the varying needs demonstrated here between the sexes and between home and overseas students.

Asking for help with emotional problems

Just over half of the total sample admitted to having problems asking for help with emotional problems; the most frequently expressed causes being: they just did not know why this was and also they would have to feel really depressed before they sought help. There were no statistically significance differences between any of the sub-groups of sex, fee status or campus, although it was noted there were slightly more students admitting to having a problem on de Havilland campus, compared to the other two campuses, as there were more females compared to males. This latter finding tends to raise the issue of whether females really do have a higher incidence of mental ill health than males (Piccinelli and Wilkinson 2000) or whether as strenuously argued by many medical sociologists there are other social factors at force in this phenomenon (Goffman 1963, Scheff 1975, Porter 1997). Furthermore, more males were inclined to think asking for help with an emotional problem was a sign of weakness.

Perhaps the high number of students admitting to having a problem asking for help with emotional problems is summed up in the following focus group citations and relates directly to the higher incidence of stigma associated with mental health problems: "Admitting you're depressed is just about one of the most courageous things you can do" (FG8) and: "People hide it (an emotional problem) because they fear rejection if they admit to a psychiatric problem" (FG11).

Which of the support services would students first contact when feeling 'depressed/anxious/unhappy'

Thirty seven per cent of students would not turn to any of the listed support services in the first instance if they felt 'depressed/anxious/unhappy'. Of statistical significance was the finding that overseas students would be more likely than home students to turn to the Students' Union/Student Guidance Office, rather than the Counselling Service or the Medical Centre. At 16.3 per cent of the total sample, the Medical Centre would be the next choice for home students, but only to 11.5 per cent of overseas students. The Counselling Service would also be the more popular choice of 13.4% of home students, compared to 10.7 per cent of overseas students. This finding is commensurate with information gleaned from the Counselling Service.

Overall more College Lane students would contact their personal tutors, than their counterparts on the other two campuses (most probably because they did have a personal tutor) and more de Havilland students would not contact any of the named services.
Stanley et al. (2007) state more needs to be known about what works in making the student support services attractive and accessible to students (particularly young men). Certainly, the fact that nearly forty per cent of the survey sample would not turn to a named 'relevant' support service in times of emotional is a cause for some concern.

As discussed on pages 139-144, the Equality and Disability Service and the Counselling Service had explicitly described their role and remit, not only at interview but also through their output on line as described in the university's Prospectus and Student Handbook. It is apparent this information is not getting across to all students. This might be due to the support services not being promoted actively and equally on all of the campuses, coupled with the effects of the information over-load at the beginning of the academic year. Stanley and Manthorpe (2007) recommend that support services promote themselves again at times of transition during the academic year. This view was supported by the survey sample who indicated they would appreciate having refresher sessions throughout the year - especially as so many of the student sample admitted to having forgotten much of the information imparted to them at the beginning of term.

Help-seeking behaviour – Inhibiting factors

Disabilities (physical, mental and learning), associated stigma and the declaration thereof

This topic will be considered in three discrete sections. Firstly, the finding that there is more stigma associated with mental health disability than either physical or learning disabilities, which supports the view expounded by several writers in the literature review (Porter 1997, Stanley et al. 2000, Royal College of Psychiatrists 2003). Nearly 30 per cent of students thought there is an associated stigma with physical disability, whereas nearly 50 per cent thought an associated stigma exists with a mental disability and just over 30 per cent thought this was the case with a learning disability. There was, therefore, a 20 per cent higher association between stigma and mental disability than there was between both physical and learning disability. This finding echoed the view expressed by a focus group participant: "There's a lot of stigma attached to psychiatric problems and the fear of being seen as being more weak and vulnerable than someone who has a physical illness" (FG3).

Secondly, with regard to making a declaration of a disability to UH prior to registration, over half of the total sample (51.6%) believed students should declare a physical disability prior to registration; with 35.2 per cent saying it would depend on how obvious the disability was. Slightly more respondents (53%) thought students with a mental disability (as compared to a physical disability) should declare the condition prior to registration, whereas a slightly higher number still thought declaration should be made with a learning disability (58%).

Thirdly, for those who thought students should make a declaration of a physical disability prior to registration, the most frequently cited reason was because UH 'needed to know in advance'. This was confirmed by focus group participants: "It's important to mention it beforehand, otherwise how can they deal with it at the last minute" (FG3), and the reason most frequently expressed for not making a declaration was that physically disabled students might be treated differently: "I wouldn't want to be treated any differently, so I'd only mention it if it was going to be a major problem" (FG5).

Of those who thought a mental disability should be declared, 96 per cent of respondents thought UH needed to know in advance. However, reasons for not declaring a mental disability revealed that 64 per cent of respondents would not declare a mental disability for fear of being 'labelled', a similar number saying this would be due to the stigma associated with such a condition, and again with similar figures (43% and 42.5%) indicating it would

not be a good idea to declare a mental disability on account of being alienated by friends. It was also conceded there could be discrimination at university or in the workplace. Another notable remark emanating from the focus group discussions resonates with Scheff's (1975) and Goffman's 1963) theories on stigma: "Alienation could happen more so with peers because their reaction would be based on assumptions because they don't really know you as friends would. They might assume you're going to act in a certain way so they'll treat you in a certain way" (FG6).

Again, with regards to learning difficulties, nearly 95% of students thought UH needed to know in advance and the most frequently cited reason (at 52% of respondents) for not declaring a learning difficulty was because other students might be resentful of the extra help and financial support: "I would have declared it (a disability) because disabled people have so much help. They've got equipment and bursary money and extra time in exams" (FG3), "For someone with dyslexia they've got lots of help and computer equipment such as a whole 'speak-package', a laptop and a lot of money" (FG3).

A firm impression from the focus group discussions had been that students were very appreciative of the efforts made by UH to provide for all students with disabilities: "UH very much supports disabled students, people in wheelchairs and those with dyslexia. They have a lot of help here and facilities" (FG11), "It's comforting to see the visible signs like ramps and lifts that prove UH follows through their policies" (FG11). Such feedback would undoubtedly be of interest to the Disability and Equality team who according to their protocols and mission statements strive hard to enforce the legal requirements, and to impress upon students the university's fundamental commitment to equality of opportunity. However, although this is commendable, I would suggest this might have led to a degree of resentment from non-disabled students, borne out by focus group participants' comments (and the results of the survey): "You want to be disabled when you come to this university because disabled people have a lot going for them. They've got so many facilities and they promote the health of disabled people but they've forgotten us while they've been doing that" (FG4).

Another area of interest, emanating from the focus group discussions, was that of 'visibility' (and issues arising from the 'lack of visibility') relating to specific 'health assets' and to the declaration of a disability. Firstly, with regard to the health assets, the finding that students appreciated seeing the security guards patrolling at night, having sight of support service advertisements and being shown around the campuses to familiarise

themselves with the whereabouts of facilities was noteworthy in the enhancement of students' mental well-being. However, there was also a clear indication (from both the focus group participants and the survey sample) that if a disability was not 'obvious' students would be more inclined to conceal it than declare it: "If it was the sort of thing I could hide, then I would because there's a stigma attached to mental disability" (FG6). Stanley et al. (2000) suggested that mental health difficulties were more difficult to deal with because of their 'invisibility'. Interpreting the findings of this question certainly adds weight to Stanley and Manthorpe's assertion that the stigma attached to mental health problems inhibits early disclosure and delays accessing appropriate help.

Reasons for not approaching the medical centre when feeling 'depressed/anxious/unhappy'

The most frequently mentioned reason for not approaching the Medical Centre when feeling 'depressed/anxious/unhappy' was due to students' perception of doctors not dealing with emotional problems. This point (and all of the others listed as options within the question) had been encountered several times in the literature review and upheld by many of the focus group participants: "They're doctors, they're too busy with sick people" (FG9), "doctors are more for the physical than the emotional" (FG1), "I just wouldn't go with a mental problem because to me the Medical Centre means a broken arm" (FG8), "I'd think I'd be wasting the doctor's time" (FG3).

However, surprisingly, the second most frequently cited reason for not seeing a doctor with a mental health problem was that UH provides more appropriate services. This contradicts an earlier finding that over a third (36.2%) of students said they would not turn to any of the named support services. Furthermore, the suggestion that the location of the Medical Centre is an important issue for many (as proposed by Kai and Crossland 2001) was not at all important to the UH students surveyed. In fact, it presented as the least likely reason for students not accessing the Medical Centre, even though several focus group participants had mentioned this as a deterrent to service usage: "Everyone sees you going in and out (of the Medical Centre)" (FG6) and "Location of the Medical Centre is important to me" (FG4).

Confidentiality issues (with regard to consulting a GP) did not seem to be a problem either. Overall, reasons tended to cluster around the persisting perception that doctors only deal with physical problems, that they do not have the time to deal with a mental health problem, and a concern about being medicated; confirmed too by focus group participants

"they just medicate the problem" (FG10), "I wouldn't want to take anti-depressants" (FG1).

Students' choice of which hypothetical service they would be most likely to use for symptoms of depression/anxiety

Focus group participants had differing views about which of the additional 'hypothetical' UMC services would best suit their individual needs: "All the ideas mentioned are good. Telephone would appeal to a lot of people because it's not face-to-face and you don't have to give your name but then e-mail would be good as a first step" (FG11), "E-mail's a bit of an ice-breaker and if the response is positive and encouraging, it's a good start" (FG10). The disadvantages of this option were also noted: "Because of the recording on medical records, there would be proof of your e-mail so maybe it's better by telephone" (FG5).

Nevertheless, nearly double the number of respondents who answered this question indicated they would be more likely to use an e-mail support service than the other three named services. This was a noteworthy finding as, according to the 'Proposed Intervention' sheet returned by the MPR, the UMC would consider introducing such a service. The other proposed services were rated accordingly by the survey respondents: in second place a nurse-led walk-in clinic (9.8%), closely followed by telephone helpline (9.1%), (which the UMC indicated they would also consider), and lastly the nurse-led well-person clinic (8.6%) which also had the highest score for the least likely service to be used by students. The low response to this option was possibly not because of the 'nurse-led' component of the question because the option of having a nurse-led walk-in clinic was rated by students as their second choice. Moreover, several focus groups students had expressed a preference for seeing a nurse in such situations: "I'd prefer to talk to a nurse because they wouldn't be pre-occupied with the medical side of things and they're not prescribing all the time" (FG1).

Not only were the survey respondents particularly disinclined towards the (nurse-led) specifically designated clinics for mental health problems but so, too, was the UMC (for reasons explained on page 147. The finding that students appeared to favour the 'Walk-in' clinic (their second choice) highlighted an area of dissonance between the student response and that of the UMC. When the clinic was in operation at the university's Medical Centre, it was obviously well attended by students: "The Medical Centre used to have a Walk-in clinic but it was always so packed" (FG4). However, despite its apparent popularity, the UMC has now discontinued this service to students.

Overall, the results of this question tend to support the views expounded in the literature review (by Jacobson 2002, Harrington 2000, Shooter 2002, Walker and Townsend 1998, 1999 and Walker et al. 2002) that there is a paucity of research about what type of mental health intervention in general practice is most effective. Certainly the finding that, in this study at least, the UMC was generally opposed to 'designated' clinics contradicts Kendrick's (2000) assertion that the time 'is now ripe' for depression mini clinics in general practice.

The main question evoked here was why the UMC's initiatives had not succeeded. An explanation for the lack of student attendance could be attributed to Tudor-Hart's (1971) inverse care law or simply a form of non-compliance, such as a tension between attitude and behaviour, as described by Ajzen and Fishbein (1977). I would suggest another explanation is that such 'additional enhanced services' are sometimes implemented on the medical staff's assumption of what services are needed, rather than ascertaining exactly what the consumers' (in this case students') needs are.

Nevertheless, despite the disappointing attempts at implementing additional services, the MPR had stressed that the UMC would not rule out the possibility of applying (through the relevant channels) for an enhanced local service – *if there were a demonstrable need.* This would be a very interesting area for further research. Certainly, in light of these findings, the UMC might be interested to know that students would be in favour of an e-mail connection with the Medical Centre - which is also more compatible with their preferred generic approach to the appointment system.

The hypothetical offer of a free health check with the university medical centre

The 'Proposed Intervention' sheet returned by the MPR indicated that the UMC would not be in favour of introducing a Newly Registered Undergraduate Health Check because "it is unlikely to be productive. Time is better spent on those who seek help".

On first consideration the MPR's response is disappointing. It appears to directly oppose the ideology behind health promotion strategies and is certainly suggestive of a residual paternalistic approach to the implementation of such measures. It could also suggest that some general practitioners remain trapped in the biomedical mindset. Certainly the persistent focus on the biomedical approach to health promotion might well have distorted much of the research that has been undertaken in primary care which, according to the

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Royal College of Psychiatrists and Walker et al (2002), has also been woefully limited in its scope and reliability.

Nearly seventy per cent of students said they *would* accept the offer of a free health check with the UMC, only 12 per cent saying they would not and 21 per cent being unsure. The most frequently cited reason by those who would accept the offer was because 'it would be good to know there was nothing wrong' and secondly because 'it's a good idea to have a health check'. However, evidence documented in the literature review lends some support to the MPR's viewpoint that patient compliance with such interventions is indeed unpredictable (Waller et al. 2005). As has been previously mentioned, the UMC abandoned attempts to implement a specialist clinic due to lack of attendance. I wonder whether such non-compliance suggests a type of cognitive dissonance (Festinger 1962), in much the same way that many smokers will agree they should stop smoking because it is bad for their health but do not attend smoking cessation clinics. Moreover, the emergent category of 'familiarisation' from the focus group analysis was not upheld in the survey analysis due to this option only being cited by a quarter of the survey's sample as the reason for accepting a health-check at the Medical Centre - even though it had been remarked by focus group participants: "It's a good idea because if you go at the beginning of term you get used to the health system and you'll feel more welcome to seek help if you need it" (FG7). To another focus group student an offer of a health check transmitted a welcoming message, a point that was reaffirmed by the MPR: "If they've been here before with a problem and they think we're not too bad, they may well come and talk to us".

Another area of interest was the finding that more students choose as the reason "I wouldn't go if I felt well at the time" for not accepting an offer of a free health check, implying they would only go if they felt ill. Does this not further support the view that the ideology of health promotion - being to sustain health and not to concentrate on the identification of disease – is still generally misunderstood. For example, one focus group participant said on the subject: "I'd probably have to make something up like my breathing's irregular or something..." (FG5). On this issue, I would suggest that, despite the legislation and government directives that cite general practice as the 'logical' setting for health promotion, for many people (both users and providers) health promotional activities do not always sit well within this setting - possibly for the reasons covered in Chapter 2.

Nearly 80 per cent of students would first want to know what was involved in the health check before accepting the offer which possibly implies uncertainty about confidentiality

matters and the recording of a mental health problem on medical records. This issue had become apparent throughout the focus group discussions: "I'd be concerned about a diagnosis being recorded on my medical records because of being a teacher" (FG9), "A lot of jobs now say they want to know if you've got a mental illness…" (FG9). Certainly this finding draws attention to issues concerning confidentiality, as discussed in the literature review, to the MPR's remarks on this subject (page 146) and the matter of 'divided loyalties' as expressed by Stanley et al. (2000). In particular it has highlighted some of the difficulties which still exist with regard to the involvement of 'significant others' in the management, and the disclosure, of student mental health problems (Stanley et al 2007).

Reasons for not registering with the UMC

At interview, the MPR estimated that approximately 30-40 per cent of students were registered with the UMC. It is, of course, not possible to make any comparisons with either of the samples used in this study, as neither was a probability sample. At face value, however the MPR certainly seems to have under-estimated. Fifty nine per cent of the focus group sample stated they had registered with the UMC, as had fifty two per cent of the survey respondents (overseas students were, however, over-represented in the focus group sample).The 47 per cent of respondents who declared they were not registered with the UMC were asked why this was. Over 60 per cent said this was because they were registered elsewhere, nearly 20 per cent admitting it was because they didn't know what was involved in doing so. Coverage of this matter on page 46 points to the importance of encouraging as many students as possible to register with a medical centre on campus, if one exists. It is the undoubted policy of UH to encourage students to register with the UMC but is this getting through to students? Certainly, when this research was conducted, a considerable number of students were not aware of the registration procedure (that is that they can still see their 'home' GP as a temporary resident during the holidays), as confirmed by a focus group participant: "I'm happy with my GP at home so I wouldn't want to register here" (FG8).

During interview it had been commented by the MPR that the UMC had recently started sending out information packs about the Medical Centre with the university's official registration pack to increase the number of students registering with the practice but as cross-tabulation had indicated over twice as many overseas students, as home students, did not know what was involved in registering with the UMC. Despite this, analysis of the questionnaire demonstrated a considerably higher percentage of overseas students to home students were actually registered with the UMC.

Because more students indicated they would prefer to approach the Medical Centre (as opposed to the Counselling Service) it is important that students are informed not only about what services the Medical Centre provides (including those concerning mental health problems) but also about the registration process. This is especially important as there appears to be no transfer of information between the university's registration department and the UMC concerning a declaration of a mental health problem. This, therefore, lends weight to the argument that students should be actively encouraged to register with the UMC as soon as possible after central registration, since it is only once registration has taken place with the Medical Centre that those students most in need of monitoring and follow-up would be contacted by the practice staff.

Summary on Help-Seeking Behaviour – Persons/services of contact and barriers to seeking help

With regard to seeking help on behalf of 'another', the majority of students surveyed would involve themselves in helping another student who was exhibiting signs of depression. This finding indicated a level of concern for a fellow student that was suggestive of a high level of social capital. Very few indicated they would not know who to turn to for advice and guidance on a fellow student's behalf.

Of concern was the statistically significant finding that, after first turning to family and friends (and then peers), over a third of students would not turn to any of the university's named 'relevant' support services - if feeling 'depressed/anxious/unhappy'. This result was more evident on the campus where students were less likely to be allocated to personal tutors. There was also a statistically significant difference noted in the help-seeking behaviour between home and overseas students. Overseas students would turn to different sources of help - the Student's Union/Guidance being the most important source of help for overseas students and the Medical Centre and Counselling Service for home students.

Nearly twice as many students said they would prefer to approach their personal tutor than their lecturers (if they felt 'depressed/anxious/unhappy') and that they would prefer to see their GP rather than a counsellor. Seven per cent of respondents said they would not turn to anybody in times of emotional need. Of those students who were allocated to a personal tutor, more students said they would turn to their personal tutors than to a lecturer. Overseas students were more likely to turn to a religious person whereas more home students would not turn to anybody at all.

Trust and familiarity might be significant factors in determining from whom students seek help, as well as a shared language and culture. For this reason overseas students said they would prefer to turn to each other for support. More than half of the sample indicated they would be reluctant to ask for help with an emotional problem, with more females admitting to this than males. Males were also more inclined to think asking for help is a sign of weakness. One explanation for this is the acknowledged stigma associated with mental health problems. Students were of the opinion there was a stronger association between stigma and mental health problems than with physical or learning disabilities. Although there was an acknowledgement that UH would need to know in advance of any disability, there was also the implication that a declaration of disability should only be made if the disability was obvious and could not be concealed. Students' views with regard to not making such a declaration were stated as being due to fear of being treated differently (with a physical disability), and to avoid discrimination and alienation with a mental disability. However, with a learning disability (possibly due to the extra support received by learning disabled students - both practically and financially), it was thought there might be some resentment from other non-disabled students. Nevertheless, there was general recognition of the outstanding support afforded to all disabled students at UH.

It was confirmed that, in keeping with all the related studies reviewed, the most common reason for young people not approaching general practice with depressive symptoms is the general perception that doctors do not deal with emotional problems and also that doctors do not have the time. Students indicated they would be more inclined to use an e-mail support service as an additional service offered by the Medical Centre (specifically to address depressive symptoms), than a walk-in clinic, telephone line or well-person clinic. This highlighted an area for further research, especially with regards to ascertaining the different needs of different student groups. Potentially, opportunities to implement health promotion activities currently exist within the conditions of the New 2003 GP Contract. However, it would be prudent to ascertain 'the student perspective' first before any such undertaking is initiated to ensure provision is based on actual student need and not on the assumptions of the medical team.

Only just over half of students surveyed were registered with the UMC. Enrolment procedures and the role and remit of the Medical Centre need to be emphasised (in particular to overseas students), in order to address omnipresent misconceptions surrounding mental health problems which can represent barriers to registration and to accessing help in times of need.

Residual aspects of the biomedical model of healthcare (from both the 'provider' and the 'user' perspective) might impede the effective integration of health promotional activities within general practice, despite the 'logical' assumption of its relevance as a setting. It is, therefore, important for HEIs to compensate by placing extra emphasis on a salutogenic approach to well-being within their health protection policies and health education programmes to secure an environment for students that maximises on social capital, minimises 'anomie' and sustains and supports emotional/mental well-being.

The samples of the study: Demographic data interpretation and discussion

Demographic profiling of the two samples (focus groups and the survey) was not directly comparable, due to the fact that one was a self-selecting sample and the other a quota sample. Additionally, a more comprehensive demographic section was included in Part I of the survey (and not included in the focus group demographic profiling). These additional items were: naming the Faculty of respondents, the registration of physical, mental or learning difficulties, accommodation status, and religious affiliation.

There was, however, consonance between the age-related data of the two samples; with a similar age-range: 18-45 years for the focus groups and 17-47 years for the survey sample and with a mean age of 21 years relating to both the focus groups and the survey sample. With respect to this (latter) item, both student samples were compatible in terms of 'age in years' with the national statistics supplied by HESA for the year 2006/07, whose records showed that 15.1% of all undergraduates were 20 years old, followed by 10.4% of undergraduates who were 21 years old (see Table 1 p. 4). In both samples, too, the year of study was predominantly first year undergraduates (46% of focus group participants and 43% of survey respondents). There was a similar demonstration of status between both samples: full-time 96% to part-time 2.7% of the survey sample and 98% full-time to 2% part-time of the focus group sample. A good mix of courses was also achieved, with 95 out of a possible 170 being recorded for the survey respondents and 31 different courses (out of a total sample of 51) being recorded for the focus groups.

The fee status profiling of the survey sample was based on the calculation of the quota sample and amounted to a break-down of home students (85%) and overseas students (including EU) at 15%. The focus group sample included a higher percentage of overseas to home students as compared with the quota sample (18/33 respectively). These figures suggest that either overseas students are more willing to involve themselves with research,

or they are more strongly motivated to express their views and opinions, and possibly grievances.

In the focus groups a third of the participants were male, two thirds female whereas the in the survey sample there were 47 per cent males to 52 per cent females - again this difference being a direct result of the quota sample quotient.

Another area of comparison was with regard to registration with the Medical Centre and consideration of these figures reveal a similar picture across both samples. For example, 59 per cent of the focus group participants were registered with the Medical Centre, 41 per cent were not. Fifty three per cent of the survey respondents were registered with the Medical Centre, 47 per cent were not. The higher proportion of focus group participants registered with the Medical Centre is most likely to be due to there having been a disproportionately higher number of overseas students (more of whom were registered with the Medical Centre) participating in the focus group discussions.

The ethnicity classification used in Part I of the survey and included in the Focus Group Consent Slip was loosely based on the national classifications produced by HESA who concede there is no definitive coding structure for ethnicity throughout the UK, in particular because variations to the Census 2001 ethnicity coding were adopted in both Scotland and Northern Ireland after this date. With hindsight, the demographic profiling here would have been improved by the inclusion of the option 'mixed background', as 6.8 per cent of respondents annotated their response as 'mixed race'.

The most frequently noted Faculty for the survey sample was Health and Human Sciences at 30.5 per cent. Of note, Health and Human Science students presented to the Counselling Service in higher numbers than students from other Faculties (see page 144). The higher proportion of Health and Human Science students in the survey sample might be explained by the fact that Health and Human Science is the biggest Faculty at College Lane or because as 'healthcare' students they need more support than other undergraduates - or simply because they wanted to contribute to health related issues.

Although Christianity was the most frequently declared religious affiliation at 40 per cent, Christian students were very closely followed by 37 per cent of students stating they had no religious affiliation. As can be seen in Appendix 41, 7.7 per cent of respondents were Hindus, 6.3 per cent Muslims, 2.6 per cent Buddhists, 2.4 per cent Sikhs, and there were

only a very few Jewish students. Of interest, many of the 2.6 per cent who had ticked the 'other' category were Catholics who, apparently, did not consider themselves Christians.

Two per cent of survey respondents declared a physical disability, 1.4 per cent a mental disability and 4.8 per cent a learning disability. It was possible only to make a direct comparison with national data for the category of mental health difficulties (HESA 2007/2008 Student Returns, personal communication May 2008). This was because the national figures for physical and learning disabilities are broken down into a range of very specific problems (such as sight or hearing impairment, medical conditions and dyslexia). HESA's figure for mental health difficulties was reported as 0.4%. The one per cent difference between the findings of this survey and the nationally recorded data by HESA was not deemed to be a noteworthy discrepancy.

In the survey sample 17 per cent of students stated they lived at home, with nearly 2 per cent being home owners. This finding might well reflect a current trend as documented by the Open University (www.open.ac.uk, accessed June 2005), that many young people are now deciding to stay at home and attend their local university or engage with distance learning. In fact, the Open University's enrolment numbers have doubled in the last decade with one in twelve students being under the age of 24. Indeed, commuter students were mentioned by the MPR as a reason for many undergraduates not registering with the University Medical Centre, especially as they would then fall outside the practice's catchment area.

See Appendices 20 and 21 for verification of the above.

Meeting the Criteria of Scientific Rigor: An Evaluation

This study has met the criteria specified in Table 4 on page 78, with the exception of one aspect of construct validity: having key informants review the draft. It was not possible to achieve this objective due to the anonymity afforded to all participants. Also, it was felt to be inappropriate to include the university personnel (who contributed to the study) in reviewing the draft, as this might have led to some contamination of the data due to their 'official' position on the issues under review being at variance with the research purpose/aims. However, to enhance construct validity (and diminish researcher bias) the reporting on these informal interviews was combined with information drawn from other official sources, such as the Student Hand Book (2003-2004) and information gleaned

from the university's web-sites (retrieved January 2004), which have collectively contributed to the data-base of the study.

In order to uphold reliability, all procedures undertaken here have been rigorously documented so that external reviewers can follow the data collection procedures and form their own opinions regarding the accuracy of the study. With respect to external validity, this chapter has discussed the extent to which the findings of this work could be generalised to other broader theories, that is to say whether the conclusions drawn here would add to the knowledge base of other salutogenic approaches to mental health promotion in higher education, such as the incorporation of the student perspective into aspects of Dooris' (1999, 2001) HPU initiative, and Morgan and Ziglio's (2007) Assets Model (see the next chapter).

Identification of areas for further research

At this stage of the interpretive process, reflective practitioners (Schon 1983) reprise and reflect on specific areas highlighted in the literature review in relation to the research findings. This undertaking often reveals areas worthy of further research. The areas that transpired in this instance involve links between factors internal and external to the individual student, as well as aspects of health seeking behaviour and attitudes towards health promotion. The first area relates to Born and Crackau's (2007) finding that 'freshers' at a German university who had a strong SOC appeared to appraise the stressful period of transition more positively than 'freshers' with a weak SOC. Would such a finding transfer to students in UK HEIs? Would Antonovsky's (1987) SOC questionnaire reveal a greater likelihood of vulnerability to mental health difficulties in 'freshers' with a weak SOC in their first term(s)? Certainly 'freshers' in this study (especially females and overseas students) were more likely to report homesickness and symptoms of 'anomie' than undergraduates from other years of study. In their 1999 study, Cowley and Billings also made a connection between the development of an individual's personal capacity for resourcefulness and Antonovsky's generalised resistance resources:

> "The processes involved in gaining this sense of personal ownership and control over necessary and needful resources for health show clear links with Antonovosky's (1987) sense of coherence and the concepts of meaningfulness, comprehensibility and manageability" (p.998 and 1000).

Moreover, Hobbs (2002) found that students in higher education had lower rates of suicide compared to their counterparts in the general population. Does this not suggest undergraduates are afforded some sort of protection? It could, for example, indicate that external factors (that is environmental factors) are equally as important in maintaining mental health as an individual's internal personality/dispositional traits (such as a strong or weak SOC, internal or external locus of control, resilience or vulnerability); all resonant with the theories put forward in Appendix 2. Moreover, is this phenomenon more associated with the availability of, and access to, a fortified system of well-integrated support services, or more to do with a different expression of young people's help-seeking behaviour within the university environment? This latter area of interest links thirdly to the paucity of research concerning young people and their help-seeking behaviour towards GPs, and the type of interventions that would appeal to both service users and service providers in the provision of health promotion within general practice. A tension appears to persist between the ideology of health promotion and the practicalities of preventing disease. More research is therefore needed to identify what type of service to promote (mental) health would be acceptable and workable to both parties - an area of research, according to Walker and Townsend (1998, 1999), worthy of further consideration.

The Limitations of the Study

According to Marshall and Rossman (1999) there is no such thing as a perfectly designed study; every study has its limitations. They state an examination of any limitations imposed on the conclusions drawn demonstrates that the researcher understands this reality and this view is fundamental to my own pragmatic approach to this work.

The limitations imposed on the conclusions drawn from the findings of this investigation, revolve around identifiable aspects of the three samples and those imposed on the focus group data interpretation due to difficulty understanding what some overseas students were saying.

Due to the very low figures of overseas students on the St. Albans campus (amounting to only 4 males and 4 females, in accordance with the quota sample calculation), results expressed in this category would have had very limited value. They have, therefore, only been taken into account for total sample findings and have not been included in any cross-tabulation calculations. There was also a disproportionately higher number of law students participating in the focus groups (see Appendix 20). The reason proposed to account for

this is two-fold. Either law students had more grievances to air, or their participation was due to the extra payment of £5 they received for their contribution to the research. (It is to be remembered the extra payment was a condition set by the Ethics Committee to compensate law students for their higher travel expenses).

Another area of consideration concerns the UMC. As has been documented, it was only possible to interview one member of the practice team. This was proposed to me as being due to the fact that the lead medical practitioner (with whom the interview was conducted) was spokes-person for the entire practice and represented all the policies and procedures executed by each and every member of the practice team – doctors and nurses. It is a valid point that general practice works to guidelines and imperatives laid down nationally and locally through PCTs. Indeed the questions posed to the lead practitioner were concerned with the role and remit of the practice (as a unit of analysis) and were not concerned with individual team member's views on the topics under review. Moreover, this aspect of enquiry fulfilled the already expressed purpose of providing an interface between the 'macro' and the 'micro' levels of the investigation.

There was also an over-representation in the focus groups of Chinese students in the category of overseas students. Again this could be due to the opportunity presented by the focus groups to express their views. What must be conceded however is that the over-representation of both Chinese students and law students in the focus group sample might well have influenced the content of some of the questions posed in the Student Questionnaire, (especially with regards to grievances) as the focus group data findings were used facilitatively (although not exclusively) to inform the questionnaire. However, the findings of the survey have upheld many of these issues as being important to students' well-being - such as the value placed by students on safety matters which became evident as a result of discourse on other topics. Moreover, the richness of other findings relating to students' sense of well-being may well have mitigated this limitation, such as those newly emergent issues represented in Figure 2. Another limitation was the issue of language difficulties experienced by some focus group overseas students.

With regard to language difficulties, some of the focus group overseas students' responses were unintelligible due to a poor command of spoken English or very heavily accented English which made transcription very difficult. This was particularly the case with some Chinese students who, as can be seen in the demographic profiling (see Appendix 20) made up the largest proportion of international student involvement in the focus groups. This meant that some overseas students' comments were so open to interpretation it might

have called into question the internal validity of the study. Therefore comments such as those provided below were not included in the data analysis. This observation suggests the written command of English of some overseas students exceeds their command of spoken English. It certainly reinforces the decision to present focus group students with a copy of the Focus Group Questions. Overall, however, it also indicates that language difficulties could accentuate some issues already identified in this study : those of overseas students having slightly greater problems fitting in, with the formation of new relationships – outside of the student's own ethnic background - and possible difficulties with their programme of study. Furthermore, despite the opportunities provided by UH for overseas students to improve their command of English through on site tuition, the effect of language problems could impact on help-seeking behaviour, as well as contributing to a reduction in mental well-being. With hindsight, it might have been preferable to have interviewed overseas students on a one-to-one basis in order to have minimised potential limitations to fully understanding their views on the issues under consideration.

Examples of ambiguous comments made by some of the overseas focus group participants are as follows:

- "If I faced this style programme, if I really got this help from them, I think I would concerned what help the university would provide to me" (FG4)
- "I think to people it is that there is always difficult to make sure that you here is some, here being on mental difficult (FG6)
- "You've got to describe your condition to the nurse who is, either way, it is so terrible. I think it is always we can't go there and ask them to come and help us" (FG10).

Within this chapter I have identified, discussed and acknowledged the limitations of this research project. Avenues of further research as a result of the findings produced here have also been identified. I am of the view the complementary approach taken to the interpretation of the findings of the three data-sets produced by this multi-method study has provided a richness and depth of understanding that a single method study might not have achieved. The flexible design has also provided an opportunity to engage with both the 'micro' and 'macro' to produce an overview of the research topic from different perspectives. As a pragmatist, however, I concede other approaches might well have reached conclusions worthy of acceptance and acclaim.

Above all, interpretation of all three data-sets has resulted in the development of a model upon which universities might construct a salutogenic approach to mental health promotion within their institutions. This model is presented in the next chapter.

Chapter 7

Conclusions and Implications

This case-study has been looking at mental health promotion within a university setting through the perspective of the student body. The three data-sets were analysed and used facilitatively and interpreted in a complementary fashion, according to the paradigm from which they arose. Conclusions have been drawn from the consideration of these findings within the component parts of the health promotion model in order to develop a salutogenic model of mental health within the HEI setting. This model moves us on from Dooris' Health Promoting University initiative and Antonovsky's concept of salutogenesis to an operational model that could be used for further research and for practice.

Figure 9: A generalised salutogenic model of student mental health promotion
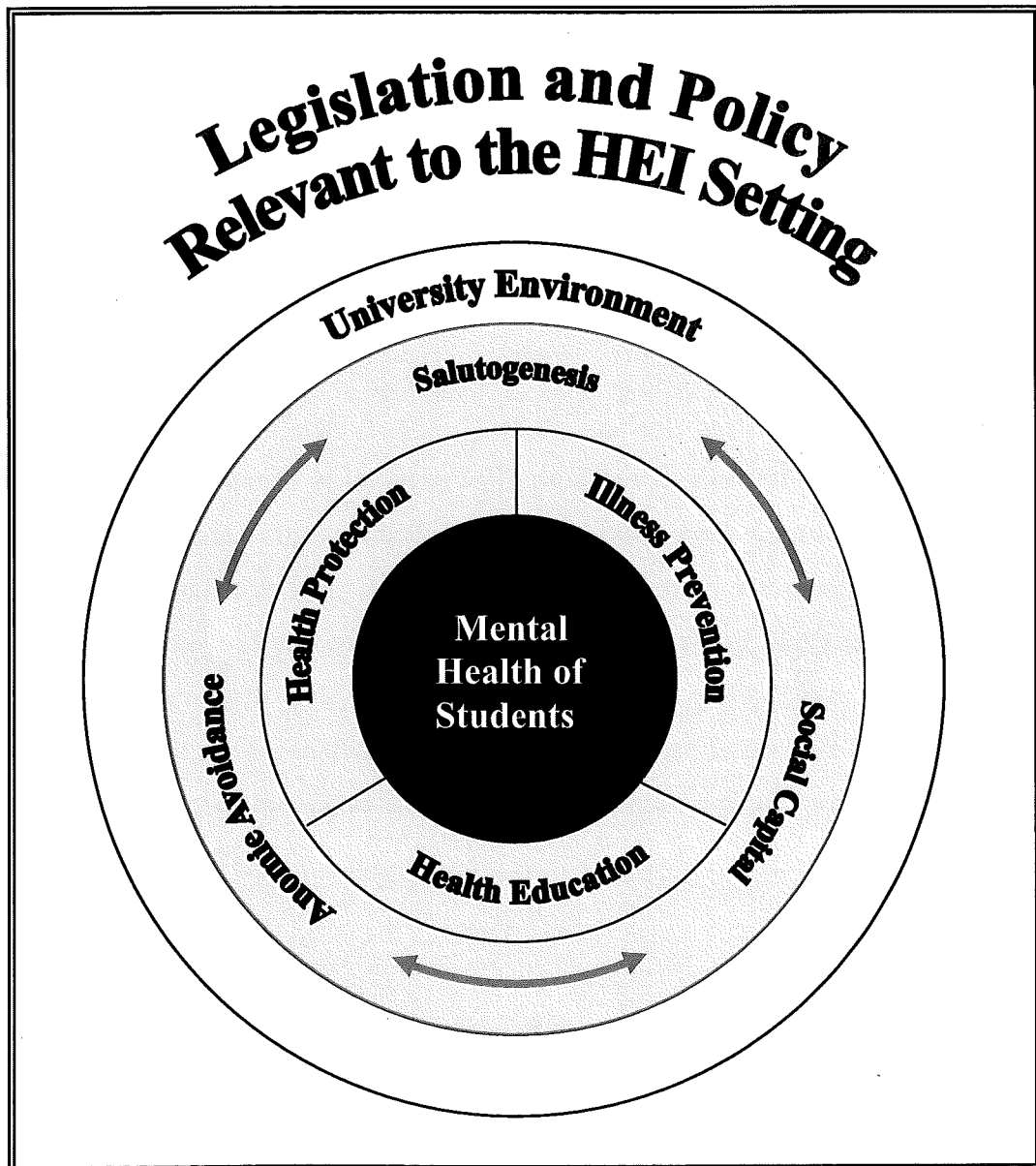
The inner core of this model is discussed below within a theoretical framework of three of the areas identified (and discussed) in the preceding chapters, these being: social capital, salutogenesis and anomie avoidance. The underlying assumption of the model is that the inner circle cannot operate effectively outside of this theoretical framework. It therefore has a dynamic relationship both with the external influences and constraints of legislation and policy imperatives and the way in which health is promoted within the HE setting.

What has this research contributed to the knowledge base?

A finding of this study suggested that multi-site HEIs could experience different problems from single-site HEIs in relation to the promotion of students' mental well-being, in particular because an unequal spread and representation of support services across different campuses can lead to grievances and resentments. The recommendation is that HEIs do not 'target' specific student groups but rather make adequate, equal provision to the support services across campuses. Allocation of students to a personal tutor might also minimise symptoms of 'anomie' and increase levels of social capital. To this end – in their pursuit of a salutogenic environment - HEIs need an understanding of the concerns of students and their help-seeking behaviour (acquired through the 'student perspective') in order to define 'health assets' and minimise 'health deficits'.

Operationalising the Model

Firstly, it is important to state that many of the students participating in this study were very satisfied with aspects of university life provided by the University of Hertfordshire. These aspects include a commendable level of provision made for disabled students, clean, pleasant surroundings and the dedication of many staff to the emotional well-being of students, as well as to their academic development. However, there are a few areas that might be of interest to UH, gleaned from the student perspective, that could further enhance the creation of a salutogenic environment. These issues will be considered prior to the points advanced below towards the development of a generalised operational model of mental health promotion.

Health Protection

It is a significant feature of this subject area that many aspects of the student environment are beyond the control of the individuals who make up that community. In other words, policies and procedures are decided upon, instigated and managed by the collective, that is by the HEI's committees and boards of governors. It is into this highly structured setting

that individual students will bring their own disposition towards mental vulnerability or mental resilience. These traits/dispositional characteristics will predispose or protect undergraduates from stressors experienced through the late adolescent/early adulthood developmental period and the transition to higher education. Arguably some students (on account of their disposition towards resilience or vulnerability) will need more help and support than others. The University of Magdeburg's (Born and Crackau 2007) study supports the view that an individual's personality characteristics *will* impact on their mental health status. It is for this reason (if for no other) that HEIs should make every effort to provide a health-promoting salutogenic environment for their student body, although it is conceded delivery of every aspect of this 'ideal' might sometimes be difficult to achieve. The following citation from a focus group participant summed this up rather pragmatically: "Responsibility for safety and well-being rests with every student, too. UH can only do so much" (FG9).

A health promoting university should be founded on principles that create and sustain an environment that empowers and supports those within its jurisdiction. Ideally the HEI's mission statement should incorporate policies that promote holism, participation, equity, sustainability, co-operation and social justice (as proposed in the World Health Organisation's documents 1978, 1986, 1998 and Dooris 1998, 1999, 2001). It is proposed this is better achieved through a generalised model of mental health promotion than through a prescriptive model, for two reasons. Firstly, due to differing values and principles upon which different HEIs build the structure of their institution, and secondly due to the diversity of the demographic composition of student populations within these diverse settings.

The University of Hertfordshire should be aware of the following:

- **an unequal spread of access to support services can invoke grievances amongst students**
- **students allocated to a personal tutor may have higher levels of social capital and lower levels of anomie**
- **targeting specific groups can cause resentment among other groups**
- **seek out the student voice on matters appertaining to their emotional well-being – currently concerned with safety issues.**

There will, nevertheless, be several 'constants' across all HEIs and these form the basis of the generalised salutogenic model of mental health promotion:

- The provision of a healthy workplace and a total environment that is conducive to physical and mental health, both in its physical presentation and in its collective approach to the denouncement of inequality, stigma and discrimination at all levels.

- The creation of a salutogenic environment attainable through inter-departmental co-operation and co-ordination and within the framework of legislative imperatives and a formal support system.

- Periodical review of the mission statement to ensure the up-dating of policies and procedures, in line with current legislative imperatives and to ensure the present situation 'fits' with the structure upon which the strategy was built. Recent demographic changes necessitate a review of the mental health policies presently applied in HEIs as new models of practice might need to be developed.

- Factor personal tutors into the pastoral care equation. Lack of a personal tutor could lead to lower levels of social capital and higher levels of 'anomie', in particular in 'freshers' and overseas students.

- Ascertain (and not assume) the student perspective on a regular basis regarding issues relating to their mental well-being in order to monitor and evaluate changes in self-reported assessments. This should include:

  - the identification of 'health assets' and 'health deficits' specific to the current student population,

  - an awareness of students' help-seeking behaviour, both formal and informal,

  - provision of recreational activities, other than the pub/club culture to suit the needs of those not predisposed to alcohol consumption.

Health Education

Health education strategies within the university provide individual students with the opportunity to enhance their knowledge and understanding of issues that affect their health status and allow them to make informed decisions and choices about their health behaviours. This relates to corporate policies that build self-esteem and activities that include campaigns/lectures on health matters (smoking, drugs/alcohol abuse, sexual health), as well as the provision of services to support both physical and mental well-being.

The Royal College of Psychiatrists (2003)[2] advocate educating students about the causes, identification and management of mental health problems in particular to demystify mental illness and to encourage higher levels of declaration. They recommend that information about mental health issues (including available services), should be published in student handbooks, on notices and websites or transmitted through lectures. Peer support programmes are also recognised as having an important place in promoting the nurturing environment of universities. It is to be noted that all such services should be provided in a format that is usable by everybody irrespective of their gender, nationality, social status, sexuality and disability and there needs to be a commitment to increasing knowledge and understanding of health through academic channels to embed health matters within the curriculum and across all faculties. Consequently, adequate and easy access to support and guidance services and information imparted about the role and remit of such services is a 'given' – including that of the Medical Centre, if there is one on site. Registration with the university's Medical Centre should be actively encouraged and misconceptions about the registration process itself dispelled. It is to be remembered young people mostly turn to those most familiar to them in times of emotional distress.

It was in these health promotional aspects that UH was found to be most lacking. This provided a template upon which to advance this aspect of the following recommendations, since despite strongly enforced health protection measures, the message was simply not always getting across to all students. There appeared to be insufficient promotion of the support services equally across all campuses and, based on these findings, too little emphasis placed on cultural education that might encourage greater integration between different ethnicities. Stanley and Manthorpe (2002) recommend *mental health awareness*

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[2] The Royal College is currently updating its 2003 report. Personal communication (via telephone) with the Scientific Editor confirmed that the awaited 2006 Review of their 2003 publication was under-way and that the estimated date of publication was late 2008.

should be built into the university's 'Health and Safety' requirements to become a fundamental part of the HEI's policy against discrimination and stigma.

The University of Hertfordshire might like to:

- **ensure that information regarding the role, remit and whereabouts of all support services is getting across to all students**
- **repeat aspects of induction week periodically**
- **promote all services equally and improve accessibility**
- **place greater emphasis on promoting integration and cultural awareness.**

A generalised salutogenic mental health model of health promotion would include:

- Provision of information regarding the role, remit and whereabouts of the support services so that the appropriate support service could be accessed if/when the need arises.

- Increased knowledge and dissemination of information relating to health through lecturers, handbooks, leaflets and posters and university websites.

- Provision of training for academic and support staff on recognition of mental health problems in students and the processes of onward referral – if appropriate.

- Programmes to de-stigmatise and de-mystify mental health problems.

- Promotion of self-esteem and well-being/training for emotional literacy.

- Provision of support clubs and associations associated with health and the organisation of social activities where alcohol is not consumed, as well as international sporting events to promote social and cultural integration.

- Supply advance information to encourage those with pre-existing disabilities to disclose the disability prior to admission so that adequate provision can be made. Signpost further information sources, support and advice agencies.

Illness Prevention

In terms of the illness prevention component of health promotion in the university setting, this work has looked into the role and remit of the Medical Centre (in this case the general practice on site) and has endeavoured to form an opinion concerning the integration of health promotional measures within this framework. To this end it has provided an interface between the 'user' and the 'provider' perspectives in terms of service provision. Another objective was to 'revisit' the definition of health promotion.

Based on issues raised in Chapters 1 and 2, it was also concerned with the theoretical positioning of general practice along Antonovsky's (1987) health continuum. Interpretation of the findings in this aspect has suggested general practice still resides at the dis/ease end of the continuum with its emphasis on the identification of disease and screening procedures and that, despite all the plaudits to the contrary, health promotional activities do not always sit comfortably and 'naturally' within general practice. It is proposed this is partly due to the enduring misconceptions surrounding the definition of health as, contrary to the message delivered by the plethora of White Papers, legislation and the numerous WHO charters (all of which promote the social model of health), it would appear 'health' is still perceived as relating predominantly to physical rather than mental health. It is argued this arises from both the 'user' and the 'provider' perspective. Moreover, successive governments have persistently concentrated public health legislation on physical aspects of health: BSE, pollution, GM foods, and most recently the banning of smoking in public places (DoH 2006).

It is acknowledged, however, that these conclusions have been based on the policies of just one general practice and cannot, therefore, be generalised to other general practices (although experiential knowledge would suggest this is not an isolated case by any means). The UMC in this study was not in favour of designated health promotion clinics, preferring to see students only when they are in need of help, although there was some common ground with the finding that both the UMC and a majority of student respondents would consider implementing/using an e-mail support system as a 'hypothetical' additional service.

Certainly in this instance, the medical team's assumptions about what students would want in terms of additional services (over and above general medical services), did not appear to meet the needs of students, as several of the piloted services were abandoned for lack of

interest/attendance. Indeed there are grounds to reflect on the notion that health promotion activities have not generally been embraced by general practice and it is therefore reasonable to conclude that, in some instances at least, rhetoric still reigns over reality. This finding also suggests that a paternalistic approach to service provision from within general practice itself is likely to result in the implementation of additional services that the medical team thinks the practice population wants, rather than what the 'user' (in this instance the student) actually wants/needs. Significantly, this conclusion supports the proposal of establishing the student perspective on matters that relate to their health needs before any new initiative is undertaken. It also begs the question - and I believe opens another avenue for research - how best to promote the mental health of young people in general practice. The view that young people and primary care would benefit from more research and evaluation has therefore been upheld. This is especially pertinent in light of the new opportunities afforded by the New 2003 GP Contract and in keeping with the Royal College of Psychiatrists' (2003) recommendation that key partners within the HEI *such as primary care* should develop integrated strategies for mental health promotion.

Consequently, due to a possible residual biomedical approach to healthcare and health promotion, HEIs would be wise to concentrate their efforts on enhancing health protection and health education policies within their (mental) health promotion directives, as they may have limited influence over what can be provided through the illness prevention arm of the health promotion model - that is through Medical Centres where they exist on their campuses.

The University of Hertfordshire might like to:

- **work with the UMC to investigate possibilities raised by this research and pilot other services to encourage health promotion activities.**
- **proactively encourage registration with the UMC.**
- **maximise on health protection (and health education) measures within mental health provision to counter-balance a possible residual biomedical approach towards health promotion from within the medical centre.**

This aspect of a generalised model would, therefore, urge HEIs to:

- Encourage early registration with the University Medical Centre (if there is one on site). Otherwise supply information regarding local general practices and registration procedures.
- Provide comprehensive information on the role, remit and whereabouts of the medical centre on site.
- Include in a periodical student survey questions concerning the help-seeking behaviour of students towards their GP for communication to the university's Medical Centre.
- Liaise with Medical Centre staff on matters appertaining to student mental health, in keeping with the whole institutional approach to mental well-being of the student population.
- Wherever possible (in line with national guidelines) involve the University Medical Centre in policy making in the development of a mental health promotion strategy to encourage inter-departmental co-operation and to establish an integral component of the working imperative.

Finally, a pragmatic researcher would acknowledge that the conclusions drawn here will need to be tried and tested before any assessments and evaluations can realistically be made as to the potential benefits derived from the proposed model's implementation. Nevertheless, representation of the model in its component parts might initially assist HEIs in promoting the mental health of their student body through the identification of 'health assets' and 'health deficits' to further support the creation of a salutogenic environment in which students can sustain mental well-being and achieve their full academic *and* emotional potential.

REFERENCES

Adalf, E., Glicksman, L. & Demers, A. (2001). The prevalence of elevated psychological distress among Canadian undergraduates: finding from the 1998 Canadian campus survey (editorial). *Journal of American College Health, 50 :* 67-72.

Ajzen, I. & Fishbein, M. (1977). Attitude-behaviour relations: a theoretical analysis and review of empirical research. *Psychological Bulletin, 84,* 888-918.

AMOSSHE. (2001). Good Practice Guide – Responding to Student Mental Health Issues: 'Duty of Care' Responsibilities for Student Services in Higher Education. Winchester: Association of Managers of Student Services in Higher Education.

Antonovsky, A. (1979). *Health, stress and coping.* San Francisco: Josey Bass.

Antonovsky, A. (1987). *Unravelling the mystery of health. How people manage stress and stay well.* San Francisco: Josey Bass.

Antonovsky, A. (1996). The salutogenic model as theory to guide health promotions. *Health Promotion International, 11* (1), 11-18.

Appleby, L., Shaw, J. & Amos, T. (1999). Suicide within 12 months of contact with mental health services: National clinical survey. *British Medical Journal, 318* 8.

Appleby, L. (2001). Preventing suicides must remain a priority. *British Medical Journal, 323,* 808.

Apter, T. (2001). *The myth of maturity. What teenagers need from parents to become adults.* New York: WW Norton.

Armstrong, D. (1993b). Mental health promotion. In A. Dines, & A. Cribb, (Eds.). *Health promotion: Concept and practice.* London: Blackwell Scientific Publications.

Arthur, H., Crisp, M., Gelder, S., Howard, I. & Meltzer, H. (2000). Stigmatisation of people with mental illness. *British Journal of Psychiatry, 177,* 4-7.

Atkinson, P. & Hammersley, M. (1998). Ethnography and participant observation. In Denzin, N. & Lincoln,Y. (Eds.), *Strategies of qualitative inquiry.* London: Sage.

AUCC Association of University and College Counsellors. (1999). *The impact of increasing levels of psychological disturbance amongst students in higher education*. London: BACP.

AUCC Association for University and College Counselling. (2001). *Annual survey of counselling in further and higher education*. Rugby: BACP.

AUCC Association for University and College Counselling. (2002). *Annual survey of counselling in further and higher education*. Rugby: BACP.

Bandura, A. (1977). S*ocial learning theory*. Englewood Cliffs NJ: Prentice Hall.

Bauer, G., Davies, J. K. & Pelakin, J. (2006). The EUHDID health development model for the classification of public health indicators. *Health Promotion International, 21* (2), 153-159.

Bauman, Z. (1993). *Postmodern Ethics*. Oxford: Blackwell.

Beck, A. & Ward, C. (1961). An inventory for measuring depression. *Archives of General Psychology, 4,* 561-571.

Beck, A. (1976). *Cognitive therapy and emotional disorders*. NY: International University Press.

Becker, M. (1974). The health belief model and personal health behaviour. *Health Education Monographs, 2,* 324-508.

Becker, M. H. & Maiman, L. A. (1975). Socio-behavioural determinants of compliance with health and medical care recommendations. *Medical Care, 13,*(10).

Berry, H. L. & Rickwood, D. J. (2000). Measuring social capital at the individual level; personal social capital, values and psychological distress. *International Journal of Mental Health Promotion, 2* (3), 35-44.

Bhaskar, R. (1978). *A realist theory of science.* (2nd ed.). Brighton: Harvester.

Biddle, L., Brock, A., Brookes, S. & Gunnell, D. (2008). Suicide rates in young men in England and Wales in the 21st century : time trend study. *British Medical Journal, 336,* 8 March, 539-542.

Bloor, M., Frankland, J., Thomas, M. & Robson, K. (2002). *Focus groups in social research*. London: Sage.

Bond, T. (1997). *Standards and ethics for counselling in action*. London: Sage.

Born, A. & Crackau, B. (2007). *How to improve freshmen's well being: sense of coherence as a resource in the transition to university life*. Otto-von-Gericke, University Magdeburg: Germany.

Bourdieu, P. (1986). The forms of capital. In J. Richardson, (Ed.). *Handbook of theory and research for sociology of education.* New York: Macmillan.

Bradley, G. (2000). Responding effectively to the mental health needs of international students. *Higher Education, 39,* 417-433.

Brannen, J. (1992). *Mixing methods : qualitative and quantitative research.* London: Gower.

Brannen, J. (2004). Working qualitatively and quantitatively. In C. Seale, G. Gobo, J. Gubrium, & D. Silverman, *Qualitative research practice* 312-326. London: Sage.

British Medical Association/National Health Service Confederation (2003). *Investing in general practice: The new general medical service contract.* London: BMA/NHS Confederation.

Brown, G. W. & Harris, T.O. (1979). *Social origins of depression: A study of psychiatric disorder in women.* London: Tavistock.

Bunn, F., Byrne, G., Kendall, S. (2005). The effects of telephone consultation and triage on patient satisfaction: a systematic review. *The British Journal of General Practice.* 55 (521): 956-961.

Bunton, R., Nettleton, S. & Burrows, R. (1995). *The sociology of health promotion.* London: Routledge.

Bryman, A. & Cramer, D. (1997). *Quantitative data analysis with SPSS for windows: A guide for social scientists.* London: Routledge.

Chaplin, R. (2000). Psychiatrists can cause stigma too. *British Journal of Psychiatry, 177,* (5), 467.

Charlton, J., Kelly, S., Dunnell, K., Evans, B. & Jenkins, R. (1993). *Suicide deaths in England and Wales: Trends in factors associated with suicide deaths.* Population Trends. 71, 34-42. London: HMSO.

Charlton, J. (1998). *Suicide Deaths in England and Wales : Trends in factors associated with suicide deaths. Population trends.* Population Trends. London: HMSO.

Cherryholmes, C.C. (1992). Notes on pragmatism and scientific realism. *Educational Research, 21,* Part 43 13-17.

Clothier, C. (1994). The Allitt Inquiry: Independent inquiry relating to the deaths and injuries on the children's ward at Grantham and Kesteven General Hospital during the period February to April 1991. London: HMSO.

Cohen, S. & Wills, T. A. (1985). Stress, social support and the buffering hypothesis. *Psychological Bulletin, 98,* 310-57.

Cohen, S. (1988). Psychosocial models of the role of social support in the aetiology of physical disease. *Health Psychology, 7,* 269-97.

Coleman, J, S. (1988). Social capital in the creation of human capital. *American Journal of Sociology, 94* Supplement 95-120.

Coleman, J. & Hendry, L. (1990). *The nature of adolescence.* London: Routledge.

Collins, I. P. & Paykel, E.S. (2000). Suicide amongst Cambridge University students. 1970-1996. *Social Psychiatry and Epidemiology, 35* 128-132.

Coolican, H. (1993). *Research methods and statistics in psychology.* London: Hodder and Stoughton.

Committee of Vice-Chancellors and Principals of the Universities of the United Kingdom (CVCP) (1995). The growth in student numbers in British higher education Briefing Note. London: CVCP.

Committee of Vice-Chancellors and Principals of the Universities of the United Kingdom (2000) Guidelines on student mental health policies and procedures for higher education. London: CVCP.

Cooper, H., Arber, S., Fee, L. & Ginn, J. (1999). Social Capital for Health: The Influence of Social Support and Social Capital on Health. A review of British data. Health Education Authority: London.

Cowley, S (1995). Health promotion in the general practice setting. *Health Visitor, 68,* (5) 199-201 5 May.

Cowley, S. & Billings, J. R. (1999). Resources revisited : Salutogenesis from a lay perspective. *Journal of Advanced Nursing, 29* (4), 994-1004.

Creswell, J. (1994). *Research design : qualitative and quantitative approaches.* London: Sage.

Dearing, R. (1997). *Higher education in the learning society: Report of the national inquiry into higher education.* London: HMSO.

Denzin, N. & Lincoln, Y. (2000). *Handbook of qualitative research.* (2nd Ed.). California USA: Thousand Oaks.

Department for Education and Skills (2003). Student support: Statistics of student loans for higher education in the United Kingdom SRF 32/2003. London: DfES.

Department of Health (1987*). Promoting Better Health: The Government's programme for improving Primary Health Care (Command Paper).* London: HMSO.

Department of Health (1989) *General Practice in the National Health Service. The 1990 Contract.* London: HMSO.

Department of Health (1992). *The Health of the Nation.* London: HMSO.

Department of Health (1997). *The New NHS : Modern, Dependent.* London: HMSO.

Department of Health (1998). *Our Healthier Nation: A Contract for Health.* London: HMSO.

Department of Health (1998c). *Primary Care Groups : Delivering the Agenda.* London: HMSO.

Department of Health (1999). *Saving Lives: Our Healthier Nation.* London : HMSO.

Department of Health (2000). *The National Service Framework for Mental Health.* London: HMSO.

Department of Health (2001). *Making it Happen : A Guide to Delivering Mental Health Promotion.* London: HMSO.

Department of Health (2002). *National Suicide Prevention Strategy for England. Consultation Document.* London: HMSO.

Department of Health (2003). *MINDOUT for Mental Health: Stop the Stigma.* London: HMSO.

Department of Health (2004). *National Service Framework for Children, Young People and Maternity Services: The Mental Health and Psychological Well-Being of Children and Young People.* London: HMSO.

Department of Health (2006). *Our Health, Our Care, Our Say: A New Direction for Community Services.* London: HMSO.

de Ponte, P. (2000). Pull yourself together. A survey of the stigma and discrimination faced by people who experience mental distress. The Mental Health Foundation: London.

Dewey, J. (1960). *The quest for certainty.* New York: Putnam.

Dickert, B. & Grady, C. (1999). What's the price of a research subject? Approaches to payment for research participation. *The New England Journal of Medicine, 341*(3), 198.

Dooris, M. (1998). The university as a setting for sustainable health: University of central Lancashire. In A. D. Tsouros, G. Dowding J. Thompson, & M. Dooris, (eds.). *Health promoting universities. Concepts,experience and a framework for action.* Copenhagen. Regional Office for Europe: World Health Organisation.

Dooris, M. (1999). The health promoting university as a framework for promoting mental health policies and procedures for higher education. *International Journal of Mental Health Promotion, 1*(4), 34-39.

Dooris, M . (2001). The health promoting university: A critical exploration of theory and practice. *Health Education, 101*(2), 51-60.

Downie, R., Tannahill, A. & Tannahill, C. (1996). *Health promotion : Models and values.* Oxford: Oxford University Press.

Durkheim, E. (1952). *Suicide.* New York: Macmillan.

Erikson, M. (1980*). Identity and the life cycle.* New York: W.W Norton.

Ewles, L. & Simnett, I. (1999). *Promoting health : A practical guide.* (4th Ed.). London: Bailliere Tindall.

Eysenck, H. & Eysenck, S. (1963). *The Eysenck personality inventory.* London: University of London Press.

Eysenck, H. (1995). Self-regulation and mortality from cancer. London: Institute of Psychiatry.

Festinger, L. (1962). *A theory of cognitive of dissonance.* London: Tavistock.

Fetterman, D. M. (1989). *Ethnography step by step.* London: Sage.

Field, A. (2004). *Discovering statistics using SPSS for windows.* London: Sage.

Fisher, S. & Hood, B. (1988). The stress of transition to university, a longitudinal study of psychological disturbance, absent-mindedness and vulnerability to homesickness. *British Journal of Psychology, 78,* 425-441.

Foucault, M. (1973). *The birth of the clinic.* London: Tavistock.

Fox, C. & Hawton, K. (2004). *Deliberate self-harm in adolescence* London: Jessica Kingsley.

Fowler, F. (1993). *Survey research methods* (2nd ed.). London: Sage.

Freidson, E. (1970). *The profession of medicine.* New York: Aldine Publishing Company.

Furnham, A. (1997). The experience of being on overseas student. In D. McNamara, & K. Harris, (eds.). *Overseas student in higher education.* London: Routledge.

Geddes, J. (1999). Suicide and homicide by people with mental illness. *British Medical Journal, 318,* 8 May 1225.

General Medical Services Committee Survey (1992) *Your choices for the future: GP Survey.* London: British Medical Association.

Giddens, A. (1990). *The consequence of modernity.* Cambridge: Polity Press.

Gilmartin, C. (1994). *The masculine self.* New York: MacMillan.

Glaser, B. & Strauss, A. (1967). *The discovery of grounded theory : Strategies for qualitative research.* New York: Aldine de Gryter.

Goffman, E. (1961). *Asylums.* Harmondsworth: Penguin Books.

Goffman, E. (1964). *Stigma: notes on the management of a spoiled identity.* Englewood Cliffs New Jersey: Prentice Hall.

Goldberg, D., Bridges, K., Duncan-Jones, P. & Grayson, D. (1998). Detecting anxiety and depression in general medical settings. Br*itish Medical Journal, 297,* 897-899. October.

Grant, A. (1999). *Helping students in difficulties: :a guide for personal tutors and other staff.* Leicester: University of Leicester.

Grant, A (2002). Identifying students' concerns: taking a whole institutional approach. In N. Stanley, & J. Manthorpe, (2002) *(*eds.). *Students mental health needs: problems and responses.* London: Jessica Kingsley.

Greenhalgh, T. & Taylor, R. (1997). Papers that go beyond numbers – qualitative research. *British Medical Journal, 315* 740. 20 September.

Guthrie, E., Kapur, N., Mackway-Jones, K. & Mendel, E. (2001). Randomised controlled trial of brief psychological intervention after deliberate self-poisoning. *British Medical Journal, 323,* 135. 21 July.

Hagan, R. L. (1997). In praise of the null hypothesis statistical test. A*merican Psychologist, 52,(402),* 15-24.

Hammersley, M. (1996). The relationship between qualitative and quantitative research : paradigm loyalty versus methodological eclecticism. In J.T.E Richardson (ed.), *Handbook of research methods for psychology and the social services. (*pp.159-79) Leicester: BPS Books.

Harrington, R. (2000). Suicide and deliberate self-harm in childhood and adolescence. *Teenage Health, 2,* 542. November.

Harvey, M. (2002). When our children kill themselves: Parental perspectives following suicide. In N. Stanley, & J. Manthorpe, (2002). *Students' mental health needs: problems and responses.* London: Jessica Kingsley.

Hawton, K. (1992). By their own hand. *British Medical Journal,304.* 1000.

Hawton, K., Fagg, J., Platt, S. & Hawkins, M. (1993). Factors associated with suicide after parasuicide in young people. *British Medical Journal, 306,* 1641-4.

Hawton, K., Simkin, S. & Fagg, J. (1995a). Suicide in Oxford University students 1976-1990. *British Journal Psychiatry, 166,* 44-50.

Hawton, K., Haigh, R. & Simkin, S. (1995b). Attempted suicide in Oxford University students 1976-1990. *Psychological medicine, 25,* 179-188.

Hawton, K,, Arensman, E. & Wasserman, D. (1998). The relationship between attempted suicide and suicide rates among young people in Europe. *Journal of Epidemiology and Community Health, 52,* 191-194.

Hawton, K., Houston, K. & Sheppard, R. (1999). Suicide in young people. Study of 174 cases, aged under 25 years based on coroners' and medical records. *British Journal of Psychiatry,* 175: 271-6.

Hawton, K. Rodham, K., Evans, E. & Weatherall, R. (2002). Deliberate self-harm in adolescents: self-report survey in schools in England. *British Medical Journal*: 1207-1211 23 November.

Heads of University Counselling Services Working Group (HUCS) (1999). The impact of increasing levels of psychological disturbance amongst students in higher education. Final Report of the heads of University Counselling Services Working Group. Rugby: British Association of Counselling.

Heads of University Counselling Services (HUCS) 2002. The Impact of Counselling Services on Student Retention. Rugby: British Association of Counselling.

Hickey, L., Hawton, K., Faggs, J. & Weitzel, H. (2001). Deliberate self-harm patients who leave the accident and emergency department without a psychiatric assessment: a neglected population at risk of suicide. *Journal of Psychosomatic Research,* February 50(2), 87-93.

Higher Education Statistics Agency/HESA (2000). *Students in higher education institutions.* 1998/1999. Cheltenham.

Higher Education Statistics Agency/HESA (2005). *Students in higher education institutions.* 2003/2004. Cheltenham.

Higher Education Statistics Agency/HESA (2007). *Students in higher education institutions.* 2005/2006. Cheltenham.

Higher Education Funding Council for England (1996). *Special initiative to encourage high quality provision for students with learning difficulties and disabilities.* London: HEFCE.

Higher Education Funding Council for England (1999). Guidance on base-line provision for disabled students in higher education institutes. London: HEFCE.

Higher Education Funding Council for England (2003). Revisiting the benefits of higher education. London: HEFCE.

Hobbs, M. (2002). Psychiatry and university counselling at Heads of Universities Counselling Services Conference. *"Beautiful minds? Students, mental health and the university"*. London: Universities UK. 9 December.

Hodgson, C., S. & Simoni, J. M. (1995). Graduate student academic and psychological functioning. *Journal of College Student Development, 36,* 244-253.

Houston, K., Haw, C., Townsend, E. & Hawton, K. (2003). General practitioner contacts with patients before and after deliberate self-harm. *British Journal of General Practice,* 53, 490, 365-370 May.

Humphrey, J. P. (1984). *Human rights and the united nations: A great adventure.* New York: Transnational Publishers.

Hunter, D. (1999). Saving lives or sustaining the public's health? *British Medical Journal,* 319, 17 July, 139-140.

Husserl, E. & Heidegger, M. (1964). *The phenomenology of internal time consciousness.* Bloomington and London: University Press.

Illich, I. (1975). *Limits to medicine.* London: Marion Boyars.

Jacobson, L., Richardson, G., Parry-Langdon, N. & Donovan, C. (2001). How do teenagers and primary healthcare providers view each other? An overview of key themes. *British Journal of General Practice.* 811. October.

Jacobson, L. (2002). Identifying Students' Mental Health Needs. In N. Stanley, & J. Manthorpe, (eds.). *Students' mental health needs: problems and responses.* London: Jessica Kingsley.

Jensen, J. Jensen, L. C & Wiederhold, T. (1993). Religiosity, denomination and mental health among men and women. *Psychological reports, 72* : 1157-1158.

Jewson, N. (1974). Medical knowledge and the patronage system in eighteenth century England. *Sociology, 8,* 369-85.

Jobes, D., Arron, M. & Jacoby, P. (1997). Assessment and treatment of suicidal clients in a university counselling centre. *Journal of Counselling Psychology ,*44,(4), 368-377.

Johnson, T. (1972). *Professions and power.* London: Macmillan.

Jones, L. (1994). *The social context of health and health work.* Basingstoke: Macmillan Press.

Jorm, A. (2000). Mental health literacy : public knowledge and beliefs about mental disorder. *British Journal of Psychiatry, 177*: 396-401.

Kai, J. & Crosland, A. (2001). Perspectives of people with enduring mental ill health from a community-based qualitative study. *British Journal of General Practice.* (730) September.

Kane, B. & Sands, D.Z. (1998). Guidelines for the clinical use of electronic mail with patients. *Journal American Medicine Informatics Association, 5,* (1) 1-14.

Katz, A. Buchan, A. & McCoy, A. (1999). *Young men speak out.* London : Samaritans.

Kelly, M. (1992). Health promotion in primary care : taking account of the patient's point of view. *Journal of Advanced Nursing ,17,* 1291-6.

Kendrick, M. (2006). Breast cancer screening: Is it pointless? *Pulse Clinical,* 24 August.

Kendrick, T., Tylee, A. & Freeling, P. (1996). *The prevention of mental illness in primary care.* Cambridge: Cambridge University Press.

Kendrick, T. (2000). Depression management clinics in general practice? *British Medical Journal, 320,* 26 February, 527.

Kendrick, T., Johnston,O., Kumar, S., Peveler, R. (2007) Qualitative study of depression management in primary care: patient goals and the value of listening. *British Journal of General Practice* 57 (544) 1-14.

Kings Fund (2000). Regeneration and Mental Health: Briefing 3.

Kobasa, S., Maddi, S. & Kahn, S. (1982). Hardiness and health. *Journal of Personality and Social Psychology,* 42, 168-177.

Kramer, T., Illiffe, S., Murray, E. & Waterman, S. (1997). Which adolescents attend the GP? *British Journal of General Practice, 47,* 327.

Kuhn, T. (1970). *The structure of scientific revolution.* Chicago: Chicago University Press.

Lago, C. (2002). The University and the Wider Community. In N. Stanley, J. Manthorpe, (Eds.). *Students' mental health needs: problems and responses.* London: Jessica Kingsley.

Laing, R. (1970). *Sanity,madness, and the family.* Harmondsworth: Penguin.

Lazarus, R. 1975). *Patterns of adjustment.* (3rd ed.). New York: McGraw Hill.

Lazurus, R. & Folkman, A. (1984). *Stress appraisal and coping.* New York: Springer.

Le Grand, J. (1980). *The strategy of equality.* London: Allen and Unwin.

Lincoln, Y. & Guba, E. (1985). *Naturalistic inquiry.* California: Sage.

Lindsay, R. O. & Paton-Saltzbury, R. (1993). *The effects of paid employment on academic performance of full-time students in higher education.* Oxford: Oxford Brookes University.

MacKenna, K. (2001). *Triage and its application to NHS Direct and walk-in centres. The new GP:changing roles and the modern NHS.* Oxford: Radcliffe Medical Press.

MacNaughten, P. & Myers, G. (2004). Focus Groups. In C. Seale, G. Gobo, J. Gubrium, & D. Silverman, (eds.). *Qualitative research practice* pp. (65-75). London: Sage.

MacPherson, A., Macfarlane, A. & Allen, J. (1996). What do young people want from their GP? *British Journal of General Practice,* 46, 627.

Madge, N. & Marmot, M. (1987). Psychosocial factors and health. *Journal of Social Affairs, 5* : 81-134.

Madge, P. & Harvey, S. (1999). Suicide among the young: the size of the problem. *Journal of Adolescence, 22,* 145-165.

Marshall, S. & Rossman, G. B. (1999). (3rd ed.). *Designing qualitative research.* London: Sage.

Meltzer, H. (2000). *Mental Health of Children and Adolescents in Great Britain.* Office for National Statistics. London: HMSO.

Meltzer, H., Lader, D., Corbin, T. & Singleton, N. (2002). *Non-fatal suicidal behaviour among adults aged 16-74 in Great Britain.* Office for National Statistics London: HMSO.

Mental Health Foundation (1997). *Suicide and deliberate self-harm.* London: Mental Health Foundation.

Mental Health Foundation (1999). *The big picture.* London: Mental Health Foundation.

Mental Health Foundation (1999a). *The fundamental facts: all the latest facts. All the latest facts and figures on mental illness.* London: Mental Health Foundation.

Mental Health Foundation (2001). *Promoting students mental health. Mental health foundation updates.*2 (11) online at : www.mentalhealth.org.uk

Mental Health Foundation (2003). *Suicide and deliberate self-harm. The fundamental facts.* London. Mental Health Foundation.

Merton, R. & Kendall, P. (1964). The focused interview. *American Journal of Sociology, 51,* 541-557.

Miles, M. & Huberman, A. (1994). *Qualitative data analysis* : *an expanded source book.* London: Sage.

Milner, P. (1974). *Counselling in education.* Hertfordshire: Aldine Press.

Monk, E. & Mahmood, M. (1999). Student mental health: a pilot study. *Counselling Psychology Quarterley, 12* (2), 199-210.

Morgan, M., Calnan, M. & Manning, N. (1993). *Sociological approaches to health and medicine.* London: Routledge.

Morgan, A. & Ziglio, E. (2007). Revitalising the evidence for public health: an assets model IUHPE – *Promotion and Educational Supplement, 2,* 17-22.

Morgan, A., Hunt, R. & Taylor, M. (1999). *Reviewing the Social Capital Literature : A lot of talk not much empiricism.* Unpublished report. Health Education Authority.

Morrow, G. (1999). Conceptualising social capital in relation to the well-being of children and young people. A critical review. *The Sociological Review, 44*: 744-765.

Morse, J. (1992). *Qualitative health research.* London: Sage.

Morse, J. (1994). *Critical issues in qualitative research methods.* London: Sage.

Morse, J. (2004). Preparing and Evaluating Qualitative Research proposals. In Seale,C, G, Gobo, J, Gubrium, & D Silverman, (2004). *Qualitative Research Practice. Qualitative research practices.* 493-503. London: Sage.

Moyer, C.A., Stern, D.T. & Dobias K,S. (2002). Bridging the electronic divide: patient and provide perspectives on e-mail communication in primary care. *American Journal of Management Care, 8* : 427-33.

Munro, J., Nicholl, J., O'Cathain, A. & Knowles, E. (2000). *Evaluation of NHS Direct first waves sites : Second interim report to the Department of Health.* Sheffield Medical Care Research Unit: University of Sheffield.

Murphy, J. P. (1990). *Pragmatism : From Peirce to Davidson.* Boulder Co: Westview Press.

Naidoo, J. & Wills, J. (1994). *Health promotion: foundation for practice.* London: Bailliere Tindall.

National Union of Students (1994). *Values for money: NUS survey of student finance and attitudes to money management.* London: NUS.

Naylor, R. A. & Smith, J. P (2001). *Schooling effects on subsequent university performance: evidence for the UK university population.* In Warwick Economic Research Papers. Warwick: University of Warwick.

Nelson-Jones, R. (1997). *Practical counselling and helping skills.* London: Cassell.

Niven, N. (1994). *Health psychology.* London: Longman.

Office for National Statistics (1998a). *Trends in suicide in England and Wales: population trends.* London: HMSO.

Office for National Statistics (1998b). *Drug-related mortality: methods and trends* London: HMSO.

Office for National Statistics (2000). *Suicide data for England and Wales.* London: HMSO.

Office for National Statistics (2001). *Statistics on young people and drug misuse in England* : Update on 1988. London: HMSO.

Okorocha, E. (1998a). Cultural Issues in working with International Students. A private collection of papers and extracts from research findings. In G, Bradley, (2000) Responding effectively to the mental health needs of international students. *Higher Education* 39, 417-433.

Okorocha, E. (1998b). Counselling International Students. A summary of the findings of a research survey on counselling international students in UK HE In G, Bradley, (2000) Responding effectively to the mental health needs of international students. *Higher Education* 39, 417-433.

Oliver, M. (1996). Defining impairment and disability : issues at stake. In C. Barnes, G. Mercer, (Eds.). *Exploring the divide: Illness and Disability.* Leeds: The Disability Press.

Oppenheim, A. N. (1992). *Questionnaire design, interviewing and attitude and attitude measurement.* London: Printer Publishers.

Oppenheim, A. N. (1996). *Questionnaire design and attitude measurement.* London: Heinemann.

Osgood, C.E., Suci, G.S. & Tannenbaum, P. H. (1957). *The measurement of meaning.* Urbana: University of Illinois.

Paykel, E. S. & Priest, R. (1992). Recognition and management of depression in general practice : consensus statement. *British Medical Journal, 305*: 1198-1202.

Paykel, E. S., Tylee, A. & Wright, A. (1997). The defeat depression campaign : psychiatry in the public arena. *American Journal of Psychiatry, 154*(supple.6) 59-65.

Payne, F. (2003). Is NHS Direct meeting the needs of mental health callers? *Journal of Mental Health.* 12 (1) 19-27.

Phippen, M. (1995). The 1993/4 survey of counselling services in further and higher education. *Newsletter, Association for Student Counselling.* November, 25-36.

Piaget, J. (1972). Intellectual evolution from adolescence to adulthood. *Human Development, 15* 1-12.

Piccinelli, M. & Wilkinson, G. (2000). Gender differences in depression. *The British Journal of Psychiatry, 177.* : 486-492.

Pilgrim, D. & Rogers, A. (1993). *A sociology of mental health and illness.* Oxford: Oxford University Press.

Pope, C. & Mays, N. (1995). Reaching the parts other methods cannot reach: an introduction to qualitative methods in health and health services research. *British Medical Journal, 311, July, 42.*

Pope, C., Ziebland, S. & Mays, N. (2000). *Analysing qualitative data.* London : British Medical Journal Book.

Pope, C. & Mays, N. (2000). *Qualitative research in healthcare.* London: British Medical Journal Publishing Group.

Porter, R. (1997). *A medical history of humanity from antiquity to the present.* London: Fontana Press.

Prior, I. (1993). *The social organisation of mental illness.* London: Sage.

Putnam, R. (1993). The prosperous community: social capital and public life. *The American Prospect, 13* : 1-8.

Putnam, R. (1995). Bowling alone : America's declining social capital. *Journal of Democracy, 6,* 65-78.

Quality Assurance Agency. (1999). *Code of practice for assurance of academic quality and standards in higher education : students with disabilities.* Gloucestershire: Quality Assurance Agency.

Rana, R., Smith, E. & Walkling, J. (1999). *Degrees of disturbance: The new agenda.* Rugby: British Association of Counselling.

Read, J. & Baker, S. (1996). *Not just sticks and stones. A survey of stigma, taboos and discrimination experienced by people with mental health problems.* London: MIND Publications.

Rickinson, B. & Rutherford, D. (1995). Increasing undergraduate student retention rates. *British Journal of Guidance and Counselling, 2 (2),* 161-172.

Rickinson, B. & Rutherford, D. (1996). Systematic monitoring of the adjustment to university of undergraduates: A strategy for reducing withdrawal rates. *British Journal of Guidance and Counselling , 24,(2),* 23-225.

Rickinson, B. & Turner, (2002) A model for supportive services in higher education In N, Stanley, & J, Manthorpe, J. (eds.). (2002). *Students' mental health needs; problems and responses.* London: Jessica Kingsley.

Roberts, R., Golding, J., Towell, T. & Weinreb, I. (1999). The effects of students' economic circumstances on British students' mental health. *Journal of American College Heath, 48* (3), 1039. 9 November.

Roberts, R. & Zelenyansk, C. (2002). Degrees of debt. In N. Stanley & J. Manthorpe, *Students mental health needs: problems and responses.* London: Jessica Kingsley.

Robson, C (1997) *Real World Research: A resource for social scientists and practitioner researchers.* London: Blackwell.

Robson, C. (2002). *Real world research: a resource for social scientists and practitioner researchers.* (2nd Ed.). Oxford: Blackwell.

Rogers, C. (1961). *On becoming a person.* Boston MA: Houghton-Mifflin.

Rosenstock, I. (1966). Why people use health services. *Millbank Memorial Fund Quarterley, 44,* 54-127.

Rotter, J. B. (1954). *Social learning and clinical psychology.* New York: Prentice-Hall.

Rotter, J. B. (1966). Generalised expectancies for internal versus external control of reinforcement. *Psychological Monographs, 23 :* 213-221.

Royal College of Psychiatrists. (2001). *People with mental illnesses : stigmatisation and discriminations within the medical profession.* London: RCP.

Royal College of Psychiatrists. (2003). *The mental health of students in higher education.* Council Report CR112. London: RCP January.

Rutter, M. (1985). Resilience in the face of adversity: protective factors and resistance to psychiatric disorder. *British Journal of Psychiatry, 147 :* 598-611.

Rutter, M. (1994). *Stress, risk and resilience in children and adolescents: processes mechanisms and interventions.* Cambridge: Cambridge University Press.

Ryen, A. (2004). Ethical issues. In C. Seale, G. Gobo, J. Gubrium, & D. Silverman, *Qualitative research practice.* pp. 230-247 London: Sage.

Sapsford, R. (1999). *Survey research.* London: Sage.

Salisbury, C., Chalder, M., Scott, T. & Pope, C. (2002a). What is the role of walk-in centres in the NHS? *British Medical Journal,324:* 16 February.

Salisbury, C., Manku-Scott, T., Moore, L. & Chalder, M. (2002b). Questionnaire survey of users of NHS walk-in centres : observational study. *British Journal of General Practice.* July 554.

Samaritans (2001). *Annual report key facts: Young people and suicide.* London : Samaritans.

Sarafino, E. (1994). *Health psychology: biopsychosocial interaction.* New York: Wiley.

Scheff, T. (1966). *Being mentally ill: a sociological theory.* London: Weidenfield & Nicolson.

Scheff, T. (1975). *Labelling madness.* New Jersey: Prentice Hall.

Schon, D. (1983). *The reflective practitioner. How professional think in action.* London: Temple Smith.

Schweitzer, R., Klayich, M., & McClean, J. (1995). Suicide ideation and behaviours among students in Australia. *Australian & New Zealand Journal of Psychiatry, 29,* 473-479.

Seale, C., Gobo, G., Gubrium, J. & Silverman, D. (2004). *Qualitative Research Practice.* London: Sage.

Seligman (1975). *Helplessness.* San Francisco : Freeman.

Selye, H. (1976). *The stress of life.* New York : McGraw-Hill.

Shooter, D. (2002). *Department of health suicide prevention strategy for England: College response.* Royal College of Psychiatrists: London.

Silverman, D. (1993). *Interpreting qualitative data: methods of analysis, talk, text and interaction.* London : Sage.

Silverman, D. (2000). *A practical doing qualitative research handbook.* London: Sage.

Silverman, M., Sloane, P. & Raffel, F. (1997). The big ten student suicide studies: a ten year study of suicide on midwestern university campus. *Suicide and Life Threatening Behaviour 27* : 285-303.

Skinner, B. F. (1974). *About behaviourism.* Harmondsworth: Penguin.

Smith, D. & Cowie, H. (1992). *Understanding children's development.* Cambridge Massachusetts : Blackwell Publications.

Stake, R. (1995). *The Art of Case Study.* London: Sage.

Stanley, N., Manthorpe, J. & Bradley, G. (1999). *Responding effectively to students' mental health needs* : A short report. Hull: University of Hull.

Stanley, N., Manthorpe, J. & Bradley, G. (2000). *Responding Effectively to Student Problems: Project Report.* Hull: University of Hull.

Stanley, N. & Manthorpe, J (2001). *Making use of hindsight. A report of a survey of parents whose children had taken their own lives.* The University of Hull: Hull.

Stanley, N. & Manthorpe, J. (eds.). (2002). *Students' mental health needs; problems and responses.* London: Jessica Kingsley.

Stanley, N, Mallon, S, Bell, J, Hilton, S Manthorpe, J et al (2007) *Responses and prevention in student suicide: The RaPSS Study.* Preston: University of Central Lancashire.

Stewart-Brown, S. (1998). Emotional well-being and its relation to health. *British Medical Journal, 317,* 1608-1609.

Stewart-Brown, S. (1999). *Disease prevention does not promote health.* Health Services Research Unit Oxford : Oxford University.

Stewart-Brown, S., Evans, J., Patterson, J., Peterson, S., Doll, H., Balding, J. & Regis, D. (2000). The health of students in institutions of higher education: an important and neglected public health problem? *Journal of Public Health Medicine, 22,* (4), 492-499.

Street, C. (2000). *Whose crisis? A young minds study.* London: Young Minds.

Szasz, T. (1962). *The Myth of Mental illness.* St. Albin : Paladin.

Tannahill, C. (1985). What is health promotion? *Health Educational Journal,44,(4)*

Tinklin, T., Riddell, S. & Wilson, A. (2005). Support for students with mental health difficulties in higher education: the students' perspective. *British Journal of Guidance and Counselling, 33,* 4 November 495-512.

Tones, K. & Davison, L. (1979). Health education in the National Health Service. In D. Anderson, (ed.). *Health education in practice.* London: Croom Helm.

Tsouros, A, Dowding, G, Thompson, J, Dooris, M. (1998) Health Promoting Universities, Copenhagen. WHO Regional Office for Europe.

Tudor-Hart, J. (1971). The inverse care law. *Lancet,1* 405-408.

Tylee, A. (Ed.). (2004). Can suicide in young men be prevented by improving access and delivery among primary care services? *British Journal of General Practice, 242-243.*

UK Department of Health. (1996). *Primary Care Act 1996.* London: HMSO.

UK Department for Work and Pensions (1995). *Disability Discrimination Act 1995.* London: HMSO.

UK Department for Education and Employment. (2001). *Special Educational Needs and Disability Act 2001.* London: HMSO.

Unite/MORI. (2004). *Student living report.* Bristol:Unite.

United Nations. (1992). *Earth summit : Agenda 21.* New York: United Nations.

Universities UK. (2000) *Handbook.* London: UUK.

Universities UK. (2000). *Guidelines on students' mental health policies and procedures for higher education.* London : UUK.

Universities UK. (2002). *Reducing the risk of student suicide: issues and responses for higher education institutions.* London: UUK.

Wade, J. (2002). Students' Perspectives. In N. Stanley, & J. Manthorpe,. (Eds.). *Students' mental health needs: problems and response.* London: Jessica Kingsley.

Walker, Z. & Townsend, J. (1998). Promoting adolescent mental health in primary care : a review of the literature. *Journal of Adolescence,* October 21 (5) : 621-34.

Walker, Z. & Townsend, J. (1999). The role of general practice in promoting teenage health : a review of the literature. *Family Practice,16,* (2), 164-172 Oxford University Press.

Walker, Z., Townsend, J., Oakley, L., Donovan, C., Smith., H., Hurst, Z., Bell, J. & Marshall, S. (2002). Health promotion for adolescents in primary care: randomised controlled trials. *British Medical Journal.* 7 September, 325:524.

Waller, D., Agass, M., Mant, D., Coulter, A., Fuller, A., Jones, L. (1990) Health checks in general practice: another example of inverse care? *British Medical Journal.* 28 April, 1115-1118.

Waller, R., Mahmood, T., Delves. S., Gandi, R., Humphreys, N et al. (2005) Student mental health: how can psychiatrists better support the work of university medical centres and university counselling services *British Journal of Guidance and Counselling* 33 (1) 118-127 February.

Wallston, B. S., Wallston, K. A. & Devellis, R. (1978). Development of the multidimensional health locus of control. *Health Education Monograph, 6,* 161-170.

Walters, P. & Tylee, A. (2003). Managing depression clinical review. *GP Clinical, 43,* 15 December.

Watson, J, B. (1920). Conditioned emotional reactions. *Journal of Experimental Psychology, 3,* 1-14.

Wertheimer, A. (1997). *Image of possibility.* Leicester: NIACE.

Westman, A. & Garralda, M. (1996). Mental health promotion for young adolescents in primary care: a feasibility study. *British Journal of General Practice, 46* 317.

Wilkinson, R. G. (1996). *Unhealthy societies: the afflictions of inequality.* London: Routledge.

World Health Organisation. (1948). *Constitution.* WHO: Geneva (definition of disability).

World Health Organisation. (1978). *Health for all by the year 2000 The Alma Ata declaration.* Geneva: WHO.

World Health Organisation. (1984). *Health promotion : A discussion document on concepts and principles.* Geneva: WHO.

World Health Organisation. (1985). *Targets for health for all.* Geneva: WHO.

World Health Organisation. (1986). *Ottawa charter for health promotion.* Ottawa: World Health Organisation and Canadian Public Health Association.

World Health Organisation. (1998). *The Jakarta Declaration on leading health promotion into the 21st century. Fourth International Conference on Health Promotion*: Geneva, 21-25 July.

Yin, R. (1994). *Case study research : design and methods.(2nd Ed.).* California USA : Thousand Oaks.

Yin, R. (2003). *Case study research : design and methods.* (3rd Ed.). London: Sage.

Yorke, M. (1999). *Leaving early. Undergraduates non-completion in higher education.* London: Falmer Press.

Yorke, M. & Thomas, L. (2003). Improving the retention of students from lower socio-economic groups. *Journal of Higher Education Policy and Management, 25,* (1), 63-74.

Zelenyanski, C. (1999). *Problem drinking in students.* London: University of Westminster.

Zola, I. (1973). Pathways to the doctor: from person to patient. *Social Science and Medicine, 7,* 677-89.

Definitions of Terms: Health, Mental Health and Mental Illness

Definition of health:

Due to the dominance of biomedicine and the medical model of health and illness, until relatively recently health was defined as freedom from the signs and symptoms of illness (Morgan et al.1993). Medical sociologists (Freidson 1970, Illich 1975, Jewson 1974 and Johnson 1972) argued this was because modern societies have a residual conception of health, due to the fact that the medical profession has been primarily concerned with illness. In 1945 the World Health Organisation acknowledged the restrictiveness of the biomedical definition of health and redefined it as a complete state of physical, mental and social well-being and not merely the absence of illness. Although this statement has been criticised for being overly simplistic, it was nevertheless hailed as a welcome reinforcement of the emerging social/biosocial model of health, the ideology of which has been incorporated into the development of strategies to promote positive well-being (DoH 1998). Most importantly, it represented a holistic approach to physical and mental disorders which rejected Cartesian dualism and took social and environmental factors into account.

Definition of mental health:

According to Prior (1993), the lack of a clear, unambiguous definition of mental health has resulted in the marginalisation of mental health issues for several decades. More recently however, and in keeping with the WHO definition which includes a positive dimension of physical health, it is now acknowledged that mental health should represent a state of psychological well-being rather than just the absence of mental illness. Such a positive perspective is encapsulated in the White Paper 'A Guide to Delivering Mental Health Promotion: Making it Happen' (DoH 2001) which describes mental health as an emotional and spiritual resilience that enables us to enjoy life and to survive pain, disappointment and sadness. This document also stresses that a positive sense of well-being will influence how we feel and think and how we interpret events and that the mentally healthy person is able to cope with the anxieties of everyday life without disintegration or lasting incapacity. Armstrong (1993b), too, stressed the coping aspect of mental health, saying: "mental health is having the ability to deal with all the vicissitudes of life without becoming ill and it needs to encompass the concepts of coping" (p.101).

As with descriptions of physical health, mental well-being will inevitably be influenced by individual experiences and expectations, as well as cultural and religious beliefs. Opinions and views concerning mental health are also most likely to be age-related, as research has shown young people have some of the most dismissive attitudes on this subject although they appear to be well aware of the stigma surrounding mental illness (Jacobson 2002). To help break this cycle of fear, stigma and discrimination, The MINDOUT for Mental Health campaign (DoH 2003) targeted young people specifically to raise awareness of mental health and the issues surrounding it.

Importantly, according to Stewart-Brown (1998) lay people are more comfortable with the terms psychological and emotional well-being than with the term mental health which they associate with mental illness.

Definition of mental illness:

Prior (1993) contends the lay person's perception of mental illness may well be so distorted by fear, prejudice and stigma that achieving an adequate single definition remains exceptionally difficult. He also believes a distinction needs to be made between organic and functional mental disorders. Because mental illness is in itself a polymorphic phenomenon, a variety of terms are used (possibly euphemistically) to describe it; these being: mental health difficulties, mental health problems and mental disorders, to name but a few. Clearly, mental illness is not simply one disorder.

Definitions of mental illness have been further clouded by influential theories emanating from both within and outside the medical profession itself (Pilgrim and Rogers, 1993). Central to this is the view held by many medical sociologists that mental illness has become medicalised as a result of the progressive move towards the medicalisation of deviant behaviour, whereby eccentric, disrupting or incomprehensible behaviour may be labelled as mental illness. From within the medical profession, the anti-psychiatry movement of the 1960s and 1970s (Szasz 1962, Laing 1970 and Foucault 1973 in particular) vociferously opposed the practice of involuntarily incarcerating patients in mental hospitals and asylums. They argued this was not in the interests of the individual or even society as a whole but rather effected a form of social control. Szazs (1962), who famously wrote about 'the myth of mental illness', proposed that while medical diagnoses are the names of genuine diseases, psychiatric diagnoses are stigmatising labels, phrased to resemble diagnoses and applied to persons whose behaviour annoys or offends others.

Other, broader definitions, include: the MIND OUT campaign fact-sheet (DoH 2003) which stated the term 'mental ill health problems' covers a wide range of experiences from grief, stress, or sadness resulting from everyday life to serious long-term depression or conditions where people lose touch with everyday reality. In Standard 9 of the National Service Framework for Children, Young People and Maternity Services: The Mental Health and Psychological Well-being of Children and Young People (DoH 2004), it is stated that a mental health problem can refer to any problem that disrupts the way we think and feel, either on a temporary basis or on a more severe and enduring basis. The document further states that mental health problems may be reflected in difficulties and/or disabilities in the realm of personal relationships, psychological development, the capacity for play and learning and in distress and maladaptive behaviour. Only when these problems are persistent, severe or affect functioning on a day-to-day basis, are they defined as mental health disorders. In a small proportion of mental disorders, the term mental or psychiatric illness is used to describe very severe cases, for example of depressive illness, psychotic disorders and anorexia nervosa.

In the Universities UK (2000) Handbook it states: "true mental disorder affects a relatively small number of the population, compared to the notion that mental health difficulties can beset anyone at any time and mental well-being affects everyone all the time" (p.7).

The Nature versus Nurture Debate :
Mental Health Problems and Coping Strategies

Theorist	Theory
Durkheim (1952)	Durkheim suggested over-rapid transition from one set of traditional social norms to a new set of values and norms can lead to the state of 'normlessness' or 'anomie'. In this state, the individual feels socially adrift, uprooted and lonely; life becomes aimless and the risk of mental ill health increases as old standards become of little use due to the rapidly changing circumstances. Such a feeling, argued Durkheim, is a potent factor in the aetiology of depression. (Durkheim was nevertheless criticised for not taking personality factors into account)
Watson (1920) Skinner (1974)	The Behaviourists placed more focus on learned behaviour than on personality factors. They developed the operant conditioning theory and the notion of positive and negative reinforcement as an agent of mental stability.
Seligman (1975)	Seligman associated learned 'helplessness' and a lack of negative reinforcement with depression/mental health problems. Essentially, argued Seligman, the individual feels no control or influence over events.
Selye (1976)	Selye postulated the view that coping with stress is an integral part of life (and often unavoidable) and can actually strengthen our coping mechanisms.
Beck (1961),(1976)	Beck suggested it was the perception of the individual's control over events that was important. He devised a Depression Inventory to identify the extent of depression and connected negative thought processes with maladaptive behaviour, leading to the invention of the cognitive behavioural intervention therapies.
Bandura (1977)	Bandura developed the concept of self-efficacy which he believed mediated the development or prevention of mental illness. He proposed individuals with a high sense of self-efficacy can successfully execute the appropriate behaviour to produce the desired outcome.
Lazarus (1975), Lazarus and Folkman (1984)	Lazurus produced the Transactional Model of Stress which emphasised the importance of an individual's assessment of the stressor and their own appraisal of successfully dealing with it. He also identified the importance of buffering (support) systems which can modify stressors.
Rutter (1985), (1994)	Rutter suggested even with the most severe stressors some individuals do not succumb to mental illness. He proposed the notion of vulnerability/resilience factors, especially individual cognition sets (self-esteem, self-efficacy). Rutter also proposed personality traits were not fixed entities but changed with altered circumstances. He identified specific social and environmental factors which act as buffers to stressors: attachment to significant others, a supportive family and social network.
Eysenck (1963), (1995)	Eysenck developed a personality inventory and proposed an individual's response to stress is inextricably linked to personality typing – what is stressful to one person might be a welcome motivator to another and quite neutral to a third.
Kobassa et al. (1982)	Kobassa proposed that 'hardy' individuals have the component of control and are less likely to succumb to mental illness. Hardy individuals reject the notion that luck or chance determine one's fate. They optimistically believe they can shape and turn negative events into a positive outcome which provides an opportunity for personal growth. Notions of 'hardiness' are rooted in Rotter's locus of control theory.
Rotter (1954), (1966)	Rotter developed the 'Locus of Control' theory. He expounded the view that individuals with an internal locus of control believe they control their own destiny and their own experiences are controlled by their own skill. Those with an external locus of control tend to attribute their experience to external factors/forces, to chance, fate or others. Rotter's concept was depicted as an internal/external personality trait continuum.
Wallston et al. (1978)	Based on the 'Locus of Control' theory, Wallston et al. developed a health specific multi-dimensional locus of control scales.
Brown & Harris (1979)	Brown and Harris identified social ties as a protective force in coping and as a mechanism of building self-esteem

Examples of Sociological Theories of Help-Seeking Behaviour

Theorist and Theory	Integral components of the theory
The Health Belief Model (HBM) (Derived from Rosenstock's 1966 psychological learning theory and subsequently developed by Becker in 1974, 1975)	Individuals take preventive action on the basis of their assessment of the threat of a health problem. Concept of vulnerability is central to its theme: being susceptible to some condition, the seriousness of the condition, the pros and cons of taking action. Used to predict health behaviour, such as screening or vaccination uptake and compliance with medical advice. Other significant factors include: age of the individual, accessibility of the regime, satisfaction with doctor/patient relationship, and prior experience with medical practitioners.
The Health Action Model of Tones 1979	Individuals form an intention to act based on an interplay of normative, motivational and belief systems and the accessibility of the programme but only if any barriers to action can be overcome, such as cultural barriers.
Tudor-Hart's (1971) Inverse Care Law	Proposed that those with the greatest need often receive the poorest services and those with the least need receive the best services. Tudor-Hart established that those who had the greatest need of the preventive services did not avail themselves of the opportunity and those who had less need actually make the most use of preventive service provision.
Zola 1973	Maintained the effects of cultural differences affect the willingness of individuals in seeking help. Different ethnic and social class groups make less use of the prevention services.
Le Grand 1980	Le Grand suggested it is predominantly the middle class who avail themselves of the preventative healthcare services.
Freidson 1970	Identified the influence of 'significant' others in determining help-seeking behaviour as well as the social distance between lay and professional cultures which could act as a barrier to accessing help.

(Template of the 'Posters and flyers' to recruit focus group participants)

NO SUCH THING AS A FREE LUNCH?
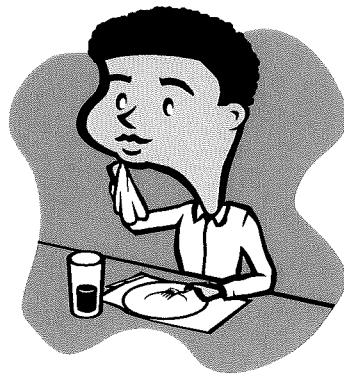
OH YES THERE IS!

(Well, sort of...in exchange for an hour of your time!)

Here's the deal...I'm a PhD student here at UH looking for volunteer *undergraduates* to take part in a Focus-Group discussion on Student Support Services and whether they meet your emotional needs and well-being.

Yours views and opinions will be of enormous value to the study and your anonymity will be guaranteed.

LUNCH WILL BE PROVIDED

All those interested in helping and for further information, please e-mail me at : r.e.rebholz@herts.ac.uk.

(Studynet entry to recruit participants for Focus Groups)

Earn £10

in exchange for an hour of your time

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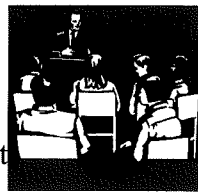
and contribute to research concerning your health and emotional well-being.

" I'm a PhD student in the Centre for Research in Primary and Community Care (CRIPACC) here at UH looking for volunteer undergraduates to take part in a **Focus-Group discussion** "

Your views and opinions regarding aspects of the Student Support Services will be strictly confidential and your anonymity will be guaranteed.

All those interested in helping and for further information, please e-mail me at : r.e.rebholz@herts.ac.uk

(Focus group participation recruitment)

BRIEFING SHEET (e-mailed to interested students)

Dear Student

PROMOTING UNDERGRADUATES' EMOTIONAL HEALTH AND WELLBEING

The purpose of this study is to find out how you, as students, feel about some very specific aspects of your life whilst at university – such as who you would turn to in times of emotional distress, what type of support service you would prefer to use, how you feel about the university environment, what you like about it and what you don't. I'm also interested to know about your views on issues such as health/mental health and health promotion.

The part of the research in which you have indicated you might like to take part will involve a focus group discussion with a few other UH undergraduates, lasting approximately one hour.

It is important from the outset that you have a clear understanding that you are under no obligation to attend the session and that by doing so you are participating on a voluntary basis. If at any time you would like to withdraw from the session, you are entirely free to do so, without giving a reason why.

Learning about how you feel on matters relating to your health and well-being will play an important part in helping us to understand the type of environment and support you would like to have and your assistance in this way is very much appreciated.

No identifiable personal details will be asked for by the researcher prior to, or during, the Focus-Group discussions and this will guarantee your anonymity in the completed written study. However the sessions' tape-recordings will be listened to by the researcher for purposes of data collection and also by the researcher's supervisors and examiners to ensure that this part of the study is being conducted according to strict research governance criteria. This will also entail keeping the tapes in a secure environment at all times until they are destroyed.

Whilst no identifying personal details are required of you, I would be grateful if you would complete the section under the Consent Slip (attached) headed "About You" as this will supply us with demographic data that will be of use to the study. Please complete this sheet and bring it with you to the discussion group.

Most importantly, there are no right or wrong answers to the questions posed to you. I am concerned only with your views and how you feel, so please express yourself freely.

The Focus-Group discussions will take place on Wednesday afternoons – the 4th and 11th May. The venue will be somewhere on the College Lane Campus. If you would still like to participate (for which you will receive a cash-payment of £10), please e-mail me by return, indicating your Faculty, and you will then be allocated to one of the groups on a first-come, first-served basis. Shortly after this, you will be advised by e-mail of the time, date and venue of your Focus-Group. Undergraduates from the Law School will be reimbursed for their travelling expenses, in addition to being recompensed for their time.

Looking forward to meeting you then.

FOCUS GROUP DISCUSSIONS TOPIC GUIDE

Abbreviation used – UH : University of Hertfordshire

1) How would you define the following : health, mental health, mental illness and health promotion?

2) Do you believe feeling emotionally/mentally well is within your own control or more to do with outside influences?

3) In what ways do you think UH promotes your health?

4) In what ways do you think UH promotes your mental/emotional health?

5) How many UH support services are you aware of?

6) Do you think you have easy access to the support services?

7) What are your views on the immediate environment here at UH – such as cleanliness, safety, visual attractiveness (eg: buildings and open spaces), sporting facilities, the transport system, accommodation?

8) What improvements would you like to see to the UH campus, if any?

9) In your experience so far, are the academic staff at UH approachable and helpful. Do they listen to you, advise you, especially as regards who you could turn to for help with problems?

"The UH operates an anti-discriminatory policy with regard to students with disabilities and you were asked to disclose a disability prior to attendance at UH so that provision could be made for you on arrival"

10) If you had a physical disability would you have declared it? If not, why not?

11) If you had a mental disability would you have declared it? If not, why not?

Question 12 "Life at university is not all fun. Situations can arise that are stressful and I'd like you to tell me what problems in particular could make you feel depressed while you're at university".

CASE SCENARIO

When Alex first started at uni, he was fun to be with. He participated in lectures and got good grades, was keen on sports and joined in all the usual social events. Over the last few weeks, however, Alex has become withdrawn; he's not fun to be with anymore and he seems to have lost interest in everything he used to enjoy doing. In fact, we don't see much of him anymore; he skips lectures and stays mostly in his room. He's probably just moody, he'll get over it …

Question 13 ⦂ What you do think you might do in this situation?

Question 14 : Do you think you could be persuaded by others to seek help if you were behaving like Alex? If so, by whom?

Question 15 : **WHO** would you turn to for help?

Question 16 : What student support service would you turn to **first** if you felt depressed/anxious/distressed?

Question 17 : Why wouldn't you turn to the University Medical Centre in the first instance?

Question 18 : What specific type of service would encourage you to turn to the University Medical Service for help, if you were feeling depressed?

Question 19 : If, after registration, you were offered the chance of a health check with the University Medical Centre, would you take it? If not, why not?

Question 20 : In order to promote your physical and mental health, would you be prepared to complete something like the attached at registration? If not, why not?

Prompt Sheet to Question 12 (as presented on Flip-Chart)

Are any of the following applicable to your response ?

- Money problems

- Academic/coursework concerns (being continuously assessed)

- Relationship problems (involving family, friends, peers)

- Health concerns

- Feeling homesick

- Lack of social integration (feeling socially isolated)

- Concerns about your self-image

- Worries about your own (or others') behaviour (such as excessive drinking, risk-taking sexual behaviour)

- Working long hours off the university campus

- Pressure placed on you to achieve good grades

- Wanting to protect your family from your worries

Prompt Sheet to Question 13 (as presented on the Flip-Chart)

Are any of the following applicable to your response :

- Ignore him, he'll snap out of it

- Encourage him to talk about what appears to be bothering him

- Tell someone else you're concerned

- Encourage Alex to get help from someone else

....

Prompt Sheet to Question 15 (as presented on the Flip-Chart)

Are any of the following applicable to your response :

- Family member

- Friends (s)

- UH peer (s)

- Person connected with your religion

- University Counselling Service

- Personal Tutor

- Course Tutor

- Another member of the university staff

- University Medical Centre

- Nobody

Prompt Sheet for Question 17 (as presented on the Flip-Chart)

Would any of the following applicable to your response?

- Concern that a diagnosis of depression or a mental health problem would be recorded on your medical records.

- Location of the University Medical Centre – I wouldn't want to be seen going in.

- Concerns about confidentiality – whether information would be passed to family or university staff.

- I wouldn't want to be labelled as having a mental health problem.

- Concern that the GP or other practice staff would be dismissive, patronising or judgemental.

- I might have to take medication and I don't want to take anti-depressants.

- Because I can never get an appointment to suit me and when I need it.

………………………………………………………………………………………..

Prompt Sheet to Question 18 (as presented on the Flip-Chart)

Would any of the following be applicable to your response?

- A Walk-In Clinic – no need for an appointment. At set times, for example 12.00 – 2.00. Run by nurses to assess need (operating a type of triaging system).

- A Well-Person Clinic, run by nurses specifically dealing with emotional problems at specified times, in the same way as asthma or diabetic check clinics are organised.

- Telephone helpline system, speaking directly to a specialist nurse at the University Medical Centre (during surgery times)

- E-mail contact with a specialist nurse at the University Medical Centre.

Prompt Sheet to Question 19 (as presented on the Flip-Chart)

Would any of the following be applicable to your response?

- I might be made to feel guilty about my life-style and blamed for not doing what I was advised to do, such as being told to stop smoking

- I wouldn't follow the doctor's/nurse's advice anyway

- I wouldn't go if I felt well at the time

- I would only take the opportunity of a health check if I felt unwell

- It's not something my family has ever encouraged me to do. We would only go to the doctor when we need to.

- I would probably only go to a health promotion clinic if I thought I was 'at risk' of developing a particular illness, such as a smoking related disease.

> Please read the following statements. Working in pairs briefly discuss whether, in your opinion, you think these statements are **true or false** and feed back to the group.

A) Only females suffer from eating disorders, self-harm and overdoses; males don't do that sort of thing.

B) Females talk more openly about mental health problems, males maintain a "stiff upper lip" and don't ask for help.

C) Alcohol and drugs can relieve feelings of depression and anxiety.

D) Today's males do not find it easy to live up to the stereotypical male image of being independent, resourceful and successful.

E) Depression is a weakness and carries a stigma.

F) Admitting you have a mental health problem will result in discrimination and alienation from friends and peers.

G) Young people often find it difficult to ask for help with emotional matters.

H) Doctors deal with physical problems, not emotional ones.

I) Nowadays females need to constantly think about their self-image; how they look and how they project themselves.

J) 'Overseas' students have more difficulty fitting in at university than 'home' students.

K) Young people are not supposed to feel depressed, therefore older people just don't understand how they feel.

L) Psychiatric problems are more likely to go unreported than physical ones.

(Attachment *to Question 20)*

PROPOSAL ONLY

(As an attachment to the Registration Form)

FREE HEALTH CHECK OFFER

"We welcome you to the University of Hertfordshire. Our aim is to provide you with a health promoting environment in which to study, learn and develop as an individual. To this end we would encourage you to register with our University Medical Centre so that you receive the best possible co-ordinated healthcare throughout the duration of your course.

Below is a slip which when completed should be lodged with the University Medical Centre. This will entitle you to a mini health-check with the practice nurse sometime in the near future to discuss any current problems you might have and to establish continuity of care if you are already receiving treatment from your present doctor.

There is absolutely no requirement that you complete this slip if you do not wish to do so. It will not affect your registration in any way. It is merely intended to provide you, as a valued member of the University of Hertfordshire student community, with the very best health and welfare support we can provide".

....

No ☐ I would not like to have a health check with the Practice Nurse

Yes ☐   I would like to have a health check with the Practice Nurse

Please let me know by e-mail when this will be ....

My student number is : ....

Examples of:
STUDENT SUPPORT SERVICES
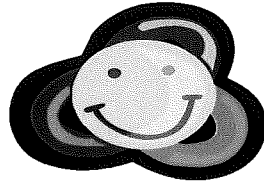
(extracted from the Undergraduate Prospectus and the Student Handbook)

Finance Centre (financial advice)

Disabled Students' Officer

Chaplaincy/Religious Worship (representing all Christian denominations, plus multi-faith centre)

Legal Advisory Centre

Careers Service

Childcare Service

Counselling Service

Universitybus

Residential (Accommodation) Service

International Students Support Service

Medical Centre

Learning Resource Centre

Security Service

Students' Union : Cultural and social events, theatre, music, students band and orchestra, live shows, gigs, summer ball, shop, insurance and travel service, welfare service, employment agency, radio station, monthly newspaper, Advice and Support Centre (nightline run for students by students), Students representatives.

Sports Village and Sporting events at the de Havilland campus : 25 metre, 8 lane swimming pool, fitness centre, squash court, cricket club, rugby and archery, and many more.

Art gallery, stationery and bookshop

Students' Charter

UH also operates equal opportunities and environmental strategies (Community Outreach)

FOCUS GROUP TOPICS GUIDE RATIONALE

Themes/Areas of Interest	Link to Literature Review	Purpose of the question
Defining the terms: Health, mental health, mental illness and health promotion from students' perspectives. **(Question 1)**	Definition of terms.	Preconceptions relating to definitions of health and illness can strongly influence behaviour patterns, compliance with treatment regimes and help-seeking behaviour.
Students' views on whether feeling emotionally well was within their own control or more to do with outside influences. **(Question 2)**	Personality/dispositional factors related to mental health status - (vulnerability/resilience, locus of control, SOC)	To gauge students' awareness of their own individual personality traits that could influence their mental health status (micro level) and the importance of providing a variety of support service outlets at the macro level to serve a variety of needs.
In what ways did students think the university promoted their health and emotional well-being. What was the extent of their awareness of the support systems and their accessibility in times of need. **(Questions 3-6)**	The Role and Remit of HEIs in promoting their students wellbeing. Links to the HPU initiative	To elicit the level of students' recognition and awareness concerning the delivery of a variety of support services within the university's support systems to meet their needs.
Identifying specific issues associated with the university environment that could affect students' mental health status. Were these issues conducive to the promotion of salutogenesis? **(Questions 7-8)**	HPU/Salutogenesis 'Assets Model'	To ascertain students' views on their immediate environment through their lived experience and establishing what is important to them to sustain emotional well-being in the university setting. Mapping of 'health assets'

What were students' experiences of pastoral care whilst at university, especially concerning their personal tutors, (and lecturers) **(Question 9)**	Pastoral care in the university setting	To ascertain students' perceived levels of support through the pastoral care system.
What were students' views on the associated issue of stigma and disabilities and the declaration of such a disability **(Question 10 and 11)**	Stigma and associated issues Declaration of a disability	To learn students' opinions on stigma associated with physical and mental disabilities and their views concerning the declaration of such disabilities to the university prior to registration.
What issues, in particular, could provoke a stress reaction in students within the university environment **(Question 12)**	Stress inducing factors relating to the student status	Were the documented stress-provoking issues common to all students, or did these vary according to different student populations.
Students' reactions to a scenario that would indicate their response to a fellow student in psychological distress; the influence of others on their own help-seeking behaviour and the most important persons of contact in times of need **(Question 13 -15)**	Help-seeking behaviour "on behalf of another" The influence of 'significant others' Issues relating to Social Capital	To elicit from students how they would react to this scenario – would they know what to do or who to turn to. What was their own help-seeking behaviour in terms of who would influence them and who would they turn to. To provide an indication of the level of social cohesion present among these students.
Presentation of **False/True Statements** which dealt with common misconceptions surrounding topics under review.	"Information Sheet" handed to students for their retention following this discussion.	To elicit opinions and elucidate preconceptions especially with regard to differences between the sexes and between 'home' and 'overseas' students.

Which of the support services would be students' first choice of contact in times of need **(Question 16)**	Help-seeking behaviour related specifically to accessing help in times of need.	To ascertain which of the support services were most important to these students, compared to the findings of other studies on the same issue.
What were the perceived barriers to accessing the University Medical Centre in times of emotional need. **(Question 17)**	Legislative imperatives placing general practice at the forefront of mental health promotion Perceived barriers emanating from other studies	To elicit, from those students who would not access the UMC in the first instance, their expressed reasons for not so doing
Which of the named additional (hypothetical) services might encourage students to attend the UMC for health promotional purposes. **(Question 18)**	Proposed initiatives to promote mental health within general practice	To identify which of the named hypothetical services would most encourage students to attend a health promotion activity within general practice.
Would students be willing to accept the offer of a free health check with the UMC. **(Question 19)**	Uptake of health promotion activities in general practice.	To ascertain the level of student interest in the offer of a hypothetical free health check with the UMC.
Presentation of a hypothetical offer to attend the UMC for a free health check **(Question 20)**	Importance of encouraging registration with the UMC	To evaluate whether students would complete another form at registration entitling them to a free health check at the UMC.

Semi-structured interview with a representative of the

UNIVERSITY of HERTFORSHIRE MEDICAL CENTRE

TOPIC GUIDE

"I understand from the Student Prospectus and Handbook that students are encouraged to register at the University Medical Centre following registration and those with a disability, physical or mental, are asked to declare their disability".

Question 1 : For those who declare a mental health disability what procedures and protocols does the University Medical Centre follow, if any?

"It is also stated that the University Medical Centre runs diet clinics and sexual health programmes".

Question 2 : Would you say your practice would be in favour of implementing other such health promotion activities?

Question 3 : Under the Quality and Outcomes Framework of the new 2003 GP Contract, would you consider implementing a service specifically to encompass the mental health needs of the student population?

Question 4: Do you think the Medical Centre has a good working relationship with other university departments with regard to students' emotional well-being?

Question 5 : Apart from referrals from the University Counselling Service, do you get referrals from other university staff, such as course lecturers – how does this usually work?

Question 6 : By the same token do you also refer students for counselling?

Question 7 : Would you say students turn to the University Medical Centre first with mental health problems, before any other of the UH support services. If not, why do you think this is?

Question 8 : Has the Medical Centre ever worked with a mental health facilitator? Would you consider doing so?

Question 9 : Do you think confidentiality issues are problematic in securing the best holistic care for your patients, for example liaising with family or academic staff?

Question 10: Do you have an idea of what percentage of the UH student population is registered with the UMC?

FOR COMPLETION BY THE UNIVERSITY MEDICAL CENTRE

Proposed Intervention	Features of that Intervention	University Medical Centre Comments
Walk-In Clinic	Along similar lines to the national Walk-In Centre ideology – with triaging to assess immediate need and onward referral.	Yes, this would be a possibility No, we would not consider this because :
Nurse-led mini clinic for mental health problems	On similar lines to asthma and diabetic monitoring clinics.	Yes, this would be a possibility No, we would not consider this because :
Newly Registered Undergraduate Health Check	Along the same lines as the 1990 Contract: To assess undergraduates' general health status and the identification of any mental health needs.	Yes, this would be a possibility No, we would not consider this because :
Telephone-support/ triaging service	To assess undergraduates' mental health needs, to provide support and to refer on, if necessary.	Yes, this would be a possibility No, we would not consider this because :

Rationale to Questions posed to the Lead Medical Practitioner

(Abbreviations used : UMC – University Medical Centre
MPR – Medical Practitioner Representative)

Themes/Areas of Interest	Link to Literature Review	Purpose of Question: Ascertaining MPR's views :
What, if any, were the procedures and protocols in place at the UMC for students making a declaration to the university of a mental health problem. (Question 1)	Declaration of a disability/mental health problem	To ascertain what measures were in place to facilitate continuity of care, monitoring and follow-up of students making a declaration of an existing mental health problem.
Was the UMC generally in favour of health promotion clinics (having advertised an existing sexual health clinic). (Question 2)	Promoting health in general practice	To ascertain the views of the UMC on matters appertaining to health promotion within general practice.
Would the UMC consider taking-up potential opportunities posed by the New 2003 GP Contract to implement mental health promotion. (Question 3)	The New 2003 GP Contract (extracts from)	To gauge whether the UMC would seize the opportunity provided in the New 2003 GP Contract to survey the needs of their practice population and consideration of the potential to introduce new measures to promote mental health.
Did the UMC have a good working relationship with other support services, in particular the counselling service and academic staff. (Questions 4-6)	The Health Promoting University Initiative	To elicit the extent of the cohesive forces in the care of students experiencing mental health problems.
Was the MPR aware of students' help-seeking behaviour, in particular to whom they would turn in the first instance and might the medical centre be considered a source of help. (Question 7)	Help-seeking behaviour, young people and accessing the health services.	To elicit the awareness of the MPR on issues relating to students' help-seeking behaviour in times of need and whether the MPR was familiar with factors inhibiting accessing the UMC

What were the MPR's views on appointing a mental health co-ordinator. **(Question 8)**	**This question was not posed to the MPR**	In light of the emphasis placed on general practice as being the 'logical' setting for mental health promotion, how interested would the UMC be in engaging with a specialist practitioner.
Did the MPR think confidentiality issues were problematic in securing the best holistic care for students with mental health problems. **(Question 9)**	Confidentiality Issues	To gauge the extent of the barriers posed by confidentiality issues as potential inhibitors of total patient care.
Was the UMC aware of the percentage of UH students registering with them? **(Question 10)**	Student Registration with the UMC	To assess the awareness of the UMC in maximising its patient list with the benefits (financial, medical) ensuing from having as many students as possible register with them

FOCUS GROUP ANALYSIS STAGE 1: INITIAL CODING SCHEMA

Focus group questions were ascribed the following codes :

Defterm (Q1 : How would you define the following : health, mental health, mental illness and health promotion)

Res/Vul (Q2 : Do you believe feeling emotionally/mentally well is within your own control or more to do with outside influences)

UHHP (Q3: In what ways to you think UH promotes your health)

UHMHP (Q4: In what ways do you think UH promotes your mental health)

UHSS (Q5: How many UH support services are you aware of)

ACCUHSS (Q6: Do you think you have easy access to the support services)

UHEnvir (Q7: What are your views on the immediate environment here at UH – such as cleanliness, safety, visual attractiveness (eg: buildings and open spaces , sporting facilities, the transport system, accommodation)

ImpUHE (Q8: What improvements would you like to see to the UH campus, if any)

UHacstaf (Q9: In your experience so far, are the academic staff at UH approachable and helpful. Do they listen to you, advise you, especially as regards who you could turn to for help with problems)

Physdis (Q10: If you had a physical disability would you have declared it. If not, why not)

Mentdis (Q11: If you had a mental disability would you have declared it. If not, why not)

Stressit (Q12: … what problems in particular could make you feel depressed while you're at university)

Resdepfr (Q13: ..response to case scenario)

Sigoth (Q14: Who could persuade you to seek help)

Helpsour (Q15: Who would you turn to for help)

StateA (Only females suffer from eating disorders, self-harm and overdoses; males don't do that)

StateB (Females talk more openly about mental health problems/males don't ask for help)

StateC (Alcohol and drugs can relieve feelings of depression and anxiety)

StateD (Today's males do not find it easy living up to stereotypical image)

StateE (Depression is a weakness and carries a stigma

StateF (Admitting you have a mental health problem will result in discrimination and alienation)

StateG (Young people often find it difficult to ask for help with emotional problems)

StateH (Doctors deal with physical problems, not emotional ones)

StateI (Females need to constantly think about their self-image)

StateJ (Overseas students have more difficulty fitting in at university than home students)

StateK (Young people are not supposed to feel depressed)

State L (Psychiatric problems are more likely to go unreported than physical ones)

HelpUHSS (Q16: What UH support service would you turn to first, feeling depressed, anxious)

UHUMC (Q17: Why wouldn't you turn to the University Medical Centre)

UMCSS (Q18: What specific type of service would encourage you to turn to the University Medical Centre)

UMCHC (Q19: Would you take up the offer of a health check with the University Medical Centre)

RegUMC (Q20: Would you complete a form at registration to entitle you to a health check with the University Medical Centre)

FOCUS GROUP DATA ANALYSIS: Stage 2 Verbatim Responses (Example page)

Question 1 – How would you define the following : health, mental health, mental illness and health promotion?

FG1

M: I think that health has more to do with your physical health, with your body and stuff like that, how your arm and stuff is working and mental health is more to do with your mind, your own mind.

F: I think mental health is more your emotional well-being, how you feel in yourself.

F : With a mental illness you would not be very well in your mind.

F: I guess (health promotion) is providing information to people about issues, health issues.

M: Yes, something like healthy lifestyles, things that you do, don't smoke and stuff like that.

F: Maybe health promotion you need it and it's information when someone helps you to improve your health.

....

FG2

F: I think health is to have a good fit body, you can do exercise and you can do what you want to do and mental health is, you know, how to face pressure and know how to be happy in your life and mental illness is maybe you don't know how to face stress or pressures, then maybe sometimes you're easily upset by these things. Health promotion is maybe in some part about how to maintain your body whilst maintaining your mental health.

F: I think mental health is if somebody has a mental illness they should know how to cope with their situation and what they want to do, somebody who knows that is healthier about the mental health. (Not included in Stage 3, due to ambiguity of meaning)

F: Somebody who has a mental illness might not only get upset but they might get like… their abilities mentally might be destroyed. It's like I know a lot of people who have mental illness and they can't like do exams or something because they get stressed out and stuff like that and that's what I think of when I think of mental illness.

M: I think health promotion is about education and it does not only include people's body, maybe some damage in people's body and maybe some health difficulties but also includes something such as mental illness. So if you have some problems, maybe you will go to some different people to help you. Doctors are very important for your difficulties and others such as psychologists help you with your mental illness.

FOCUS GROUP ANALYSIS: Stage 3 Thematic Conceptually Clustered Matrix

Focus Group	Statement J: Overseas Students have more difficulty fitting in at university than home students. CODE: StateJ	Memoing
FG1	(M) It's true	
	(F) I don't know because overseas students have little communities on campus. Some nationalities cluster everywhere in groups. The EU students have lots of events which helps them settle in better. They do do some things for home students but it's easier for home students to feel left out. If they don't want to get into the whole drinking culture, there's not much for them, whereas with international students they go on day-trips and have café evenings and do all sorts of different things, plus they have access to all the other things that home students have. I think more of an effort is made to make overseas students fit in.	*Lack of integration* *Pub-Club culture (Grant)* *Resentment*
FG2	(M) True	
	(F) True	
	(F) True	
FG3	(F) True	
	(F) True	
	(F) Some do feel very out of it	
	(F) Not really because overseas students will have other difficulties compared to home students but home students will have difficulties too.	*Bradley AND Grant*
FG4	(F) I agree	
	(F) I don't think they try to fit in, They tend to hang around with their own.	*Student's stress*
	(F) Even the home students tend to stick together with their own partly because it's easier to communicate because with Chinese students you have to repeat the sentence about ten times before they understand.	*Reason for lack of integration: language problems*
	(F) Some students from other countries feel because they've paid more to come here, they're a bit special.	
	(M) One of the problems is there are certain clubs and societies just for overseas students but that's not making an effort to integrate with the rest of us.	*Lack of integration/resentment*
	(F) *"There's always something about international students – you've got to do this for them, that for them – but what about us. It's like we're in the process but we're being neglected"*	*Student's stress – verbatim quote*
	(F) Staying in groups has its draw-backs. You're less likely to make new friends like that because	

	individuals are less likely to approach a group.	
	(F) I don't think English and Chinese students integrate as they should do. International students go to the international students' night. So did I. I went with the Chinese group because as we are all international students we can make the others feel better.	Lack of integration ? conflicting statement
FG5	(F) The language barrier has a lot to do with it.	Language barrier
	(F) If international students didn't have people from their own country to share the same language and interact with each other they would find it very hard to fit in.	
	(F) Maybe international students have more societies available to them but also probably they look out for them too when they come here.	Social support system
	(F) Overseas students are lonely because they're further from home.	In support of Grant
	(F) I made the effort to interact with overseas students and it's paid off. I've made some brilliant Spanish friends.	
	(F) I don't think the statement is true at all.	
	(F) I think if anything it's easier for overseas students because when we first started there were posters everywhere in the uni telling overseas students not to worry ….	in support of Bradley
	(F) It's true, they've got trips to this and trips to that and I'm not allowed to go because it's for overseas students – I hope I get the same when I go to uni abroad.	Resentment
FG6	(F) I agree with it	
	(F) I agree with that very much	
	(M) It's equally hard to fit in – home or overseas students. English students also stick together and keep to their own culture.	Opposing view
	(F) Overseas students have more difficulty fitting in because everything in this country is new to them and they have to adapt.	in support of Grant
	(M) I think they have a rough time; it's difficult to fit in	In support of Grant
	(M) It must be a challenge with the different culture and language.	in support of Grant
FG7	(F) It's false because the whole first week was induction "like the whole world got us ready for the country and when the home students came we were well settled in; it wasn't a problem".	in support of Bradley
	(F) Having the activities and no classes for the first week helped.	
FG8	(F) A lot of home students have trouble fitting in. I know someone who is dropping out because she doesn't get on with her flat-mates.	
	(F) It depends on the person, too.	Personality trait

	(F) It's wrong that overseas students are put into a box according to their nationality and treated differently from home students. It creates an immediate divide which isn't fair. People refer to Chinese students, Spanish, French or German students – we are all just students.	*Good point!*
	(F) Putting students into halls according to their nationality is not a good idea. It does not encourage integration	
	(F) It's true they had a number of Halls designated to Chinese students which is good because they can relate to and help each other but how are they meant to socialise and integrate if they are segregated from the start. I don't think the uni should do that.	*Social support network*
	(F) Some of the Asian students don't want to get attached to British culture which for them means getting drunk all the time.	*Pub-Club culture (Grant)*
FG9	(M) It has a lot to do with personality. I've got a good friend who's from overseas.	*Personality trait*
	(F) It's really tough at the beginning	
	(F) Home students won't have a problem with the culture though	
	(M) Home students have got their families not too far away.	
	(F) It's the new experience that can be difficult for all students... it depends so much on the personality – some will find it hard, some won't.	*Personality trait*
FG10	(F) I know lots of foreign students who find the transition very difficult	
FG11	(F) As an overseas student I think it's false	*in support of Bradley*
	(F) We're very well advised and everything is explained during induction week. The support we get is very good.	*Appreciation of Induction Week*
	(F) I disagree. In our flat we find French students stick together and their English hasn't improved so they don't communicate with us.	*Language problems*
	(M) It can be one-sided.	
	(M) I'd say the Chinese and the Indian students tend to stick together because they find it harder to fit in.	*'Anomie'*
	(M) They rely on each other a lot and they're good at looking out for each other.	*Social support*
	(M) With basket-ball the international students are just the same as our students.	*What a brilliant idea!*

FOCUS GROUP DATA ANALYSIS: Stage 4   Extended Memoing Sheet

Question 8 : What improvements would you like to se to the UH campus, if any.
CODE : impHEn

Cross-case analysis identified:

Linked Categories:	ACCUHSS : FG1/2/5
	UHHP : FG 8/10
	UHSS: FG 1/5
	UHEvir: FG1/3/5/6/7/8/9/10/11
	StateJ : FG 7/10
Emerging Categories:	Safety issues : FG 1/3/5/6/7/8/9/10/11
	Inter-campus Resentment : FG 1/4/8/9
	Health Food/Eating : FG 2/9
	Bus Service Provision : FG 6/8/9/10
	Racial Tension : FG 4/10
Review of Literature:	Not applicable

The proposed improvements mentioned were as follows:

A representative of the support services on each campus (even if only one day a week).

Orientation on all campuses at the start of term to familiarise students with whereabouts of services as accessing them when in need can be stressful.

More advertising of what support services are available and to reduce waiting times to see support service staff.

To improve provision of fresh food in the shop and to reduce the cost of food generally.

To supply cash points and post-boxes on all campuses.

To provide more activities and sports facilities that are affordable by all students (there are no reduced rates for students at weekends).

To tackle the alcohol and drug problem on campus.

Due to the number of times it was mentioned throughout this topic guide, and in the context of other issues under discussion, the matter of safety/security appeared to be of paramount concern to students. With reference to notes made during and after the focus group discussions and on repeated listening to the tape-recordings it was apparent students would appreciate: increasing the visibility of security guards late at night as many de Havilland students do not go to College Lane functions and events for fear of having to walk home after the last bus has left. Some females are frightened to walk between campuses on their own. Both males and females do not feel safe unless they are in a group. Of note overseas students feel more vulnerable than home students as there have been some incidents of racism (occurring off campus). It was however conceded that such incidents could happen anywhere. With safety in mind some sort of transport service (even a dedicated taxi-service) which operated into the early hours and over the weekend would constitute a welcome improvement due to the relatively early bus service cessation times.

FOCUS GROUP DATA ANALYSIS – STAGE 5 SUMMARY SHEETS (Example page)

Question 17 : Why wouldn't you turn to the University Medical Centre in the first instance? Code: UHUMC

During the unprompted part of the discussion on this question, several students commented that they would rather turn to friends for help than go to their doctor. Several reasons were put forward to account for this and included: Doctors deal with physical problems, not emotional ones (these are dealt with by specialists such as counsellors), doctors are always too busy ("with sick people") and you have to wait too long for an appointment. Ten minute appointments were also deemed to be too short to deal adequately with an emotional problem. Moreover, emotional problems were not thought to be sufficiently serious for doctors to deal with. Not only did some students think they would be wasting the doctor's time but that they wouldn't be taken seriously. Being patronised, feeling dismissed and not wanting to take anti-depressant medication were also reasons for not going to the university's Medical Service, as was not always being able to see a female doctor (especially important to overseas females).

Past bad experiences would prohibit some students from accessing medical care and several EU students admitted they have no faith in the NHS, preferring to travel home with a medical problem. Some students said they would prefer to talk to someone familiar with an emotional problem (although others thought it might be easier talking to a stranger). The fact that a GP is viewed as a stranger is concerning and raises issues appertaining to the doctor-patient relationship of young people.

Another area of concern was that the Medical Centre is not sufficiently well promoted. Several students not only had no idea where the Medical centre was situated but perhaps more importantly they had no idea about the services it provides: "The only sort of notices and leaflets and stuff like that I've seen are just around where the Medical Centre is. All they advertise is like pregnancy testing and free contraceptives – they don't say you can come for this, or come for that" (FG4).

Lack of awareness about the registration process was also noted. Law students were however aware that they could not register with the University Medical Centre because they were out of the catchment area and this was a source of resentment for some: ".. being at St. Albans you seem to have more down-falls than up-falls!. I think you should all have the same facilities" (FG4). Other comments demonstrated confusion over the registration process: "I think there's a problem if you register with the Medical Centre here, you have to transfer from whoever was your doctor and I think the process of changing and then changing back is a problem" (FG10). Students happy with their home doctor expressed a reluctance to register with the UMC.

Prompted comments included many of the issues dealt with above, plus some other matters mainly involving confidentiality, not wanting to be labelled as a depressive and the recording of a mental health problem on medical records. Mainly concerns centred around curtailment of career opportunities: "Because of being a teaching, if that got recorded then I'd have to put it down on my records and I don't know whether this would make a difference when I go to teaching practice, so I'd rather not risk it" (FG9). Another view was that it was sensible and important to update medical records for future purposes.

The location of the Medical Centre was important to some (because other students could see them going in and coming out), though this did not matter at all to others.

SURVEY QUESTIONS RATIONALE

(Statements compiled as a result of the Focus Group Findings Summary to inform the Questionnaire):

Part II (Students' feelings and attitudes towards emotional well-being, their views on their immediate environment and life at UH)

Symptoms of 'anomie' do not occur exclusively in overseas students who, due to their having to cope with a foreign language as well having to adjust to a different culture, are thought to be at greater risk of developing homesickness, or experiencing feelings of isolation or alienation. Home students experience similar feelings and it is felt that more effort is made by the university to avert/lessen symptoms of anomie in overseas students **(Question 1)**.

An environment that is conducive to supporting and not challenging the personal characteristics of the individual builds on social capital and is important to that individual's mental well-being **(Question 2)**. Several factors are associated with a salutogenic health promoting university. In keeping with the Locus of Control theory and Resilience/Vulnerability factors, students will react differently to perceived stressful situations and to different types of problems. Such perceptions of potentially stressful situations could ultimately affect a student's mental well-being. Students expressed specific issues that were potentially stress-inducing to them whilst at university **(Question 4)**.

Students are not as aware as they might be of all the services available to them, where they are situated and what they provide **(Question 14)**. The support services are not actively promoted and not equally so on all campuses. Support service hours of opening are not compatible with lecture times. Health Promotion: Physical health is promoted more actively (mostly by way of the Sports Centres) than mental health. Students would like to see more emphasis on healthy eating and mental health awareness.

Promotion of health on all campuses (in particular that of mental health) is not sufficiently visible to have engaged students' attention with the exception of sexual health posters which are displayed inside or close to the location of the Medical Centre. The other exception with regard to the promotion of support services is that of Nightline which is especially proactive at the beginning of the academic year in recruiting for the training of peer support operators.

There is a greater stigma attached to mental disability than physical disability. It was thought there were advantages to declaring a physical disability at UH due to the considerable help afforded to physically disabled students. By contrast, declaration of a mental disability was considered to be inadvisable on account of the associated stigma which could lead to discrimination at university or in the workplace, alienation from friends and confidentiality issues which could have long-term career implications. Another consideration for declaration of a mental disability would be out of concern for the safety of others **(Questions 7, 8, 9)**.

Grievances and Resentments: Students do not feel enough is being done to meet their individual social needs. There is a paucity of social events and activities for those who do not favour the Pub/Club culture - possibly for cultural reasons **(Question 5)**. Outings and events aimed at orienting students are not equally available to all students, some home students feeling that EU and overseas students are favoured in the welcoming process while they are undervalued. International students get free access to internet connection in their flats whereas home students have to pay to be connected or use the LRC. Accommodation is deemed to be more secure, and better maintained, on one campus than another. Help and support is not

equally accessible to all due to the majority of services being situated on one campus. This causes difficulty for Law Students in particular who are not afforded parity with students from the other two campuses with regard to inter-campus travel. Accommodation is more expensive for students at the St. Albans campus where there are no Halls of Residence. Also, the cost of using the sports facilities (sited mainly on de Havilland) is more expensive at weekends when students would benefit more from its usage. Moreover international students think the cost of the sports facilities should be included in their higher fees. Parking is a considerable source of irritation to students due to time and cost issues (**Question 3**).

Integration between different nationalities on campus is not what it might be. Some nationalities in particular "stick together". This is because it is easier to mix with someone who speaks the same language and is from a similar culture. Some Home Students do not make enough effort to befriend International Students possibly because some Overseas students tend to congregate in large groups which can be intimidating for others to penetrate. UH could do more to encourage integration by mixing nationalities in Halls of Residence accommodation as opposed to allocating groups of one nationality to specific Halls. There is an element of conflict between EU/Home students and overseas students over some cultural differences (**Question 12**).

Induction week provides information about vital support services and aims to familiarise students with what is available. Too much information is provided at one time (much is forgotten because it's not always needed immediately). Even after Induction week, some students remain unaware of how to access these sources of help and where they are situated. Information imparted during Induction Week needs to be repeated. Students would appreciate being shown round and meeting some key support services personnel, others would appreciate having seminars on cultural issues during this programme of events (**Question 15**).

Concerns centre around personal safety on campus and travelling between campuses especially at night. Several points of entry onto campus (College Lane) need to have tighter security and this would make students feel safer on campus. Students can feel vulnerable (especially females and Overseas Students) walking between campuses in the dark in particular because the bus service stops at 11.00 pm (Students Union events do not finish until 1.00 am) and it is regretted there is only an infrequent bus service over the weekends. Students would like to have assurance that the CCTV cameras actually work. The high visibility of the Security Service on campus during the day adds to students' sense of personal safety. The immediacy of contact with them is greatly valued. However, during the evening and at night the guards are far less visible (because they patrol in pairs) and this reduces students' feeling of well-being (**Questions 10,11**). Alcohol and drug problems on campus can cause considerable problems for those who do not engage in recreational drugs and alcohol abuse (**Question 6**).

Lecturers : Some lecturers are thought to be helpful, approachable and supportive and a source of help in times of emotional distress. Other students do not see their lecturers in the pastoral role and would only approach them with academic/course-work problems. Students were not sure about confidentiality aspects of the student-tutor relationship. For example, whether lecturers are bound by ethical codes of conduct not to divulge information to other parties, or whether they might even be obliged to disclose certain information to the university. Not all students are allocated to a personal tutor. Lecturers will refer students on for help if they cannot help themselves. Their role as a vital support service is not given a high enough profile (**Question 13**).

Part III
(Help-seeking behaviour – on behalf of others, oneself and the identification of barriers in accessing help)

Familiarisation with service providers is important in securing service usage and with regard to the self-referral process. Students are more likely to listen to and take advice from someone familiar or close to them, and in particular someone who shares the same language and culture, as opposed to someone unfamiliar to them. This includes a person they trust and respect. However family and friends represent the most "significant" others as direct sources of help in times of emotional need and students would turn to family and friends first before seeking help from other sources (**Question 17**).

Help-seeking behaviour on behalf of another: Students exhibited a considerable degree of social capital in their concern for the mental well-being of another student who appeared to be depressed. Such a level of concern raises the issue of whether sufficient information is available to those who would want to seek help on behalf of someone else. Close personal relationships could avert the need to involve others in dealing with a friend's depression. Respect for another student's autonomy could prevent students becoming involved with a depressed fellow student (**Question 16**).

Young people often find it difficult to seek help with emotional problems for a variety of reasons, many of which are closely associated with age-specific behaviours of late adolescence and early adulthood. This is particularly the case with males. Worries about being rejected, wasting the person's time, being made to feel emotional problems are a sign of weakness and concerns about confidentiality could all be factors affecting or prohibiting help-seeking behaviour (**Question 18**). These factors could present a barrier to consultation with personal tutors/lecturers, other university support staff, the Medical Centre and even the Counselling Service as for some seeing a counsellor is a "big-deal" (**Question 19**).

The University Medical Centre (UMC) is not the first port of call for many students with mental health problems so which support service are students most likely to turn to? Barriers to seeking help from the UMC include: the perception that doctors deal with physical and not emotional problems (mostly due to time restraints), being unfamiliar with the location and the precise role and remit of the UMC, as well as a lack of awareness about aspects of the registration process. Past and negative experiences with a previous GP, uncertainty regarding confidentiality issues (such as the disclosure of health information to the university and/or family) and not wanting a mental health problem to be recorded on medical records were additional areas of concern (Question 20). Students would prefer to see a nurse with an emotional problem because as quintessential health educators they are deemed to be more approachable, have more time and are not prone to over-prescribing. The hypothetical additional services to improve students' mental well-being (a Walk-in clinic, Well-person clinic, Telephone helpline and an E-mail support service) were all well received with advantages and disadvantages to each being noted. (**Question 21**). Being made to feel guilty because of an unhealthy life-style and only going to the Medical Centre when ill, were reasons expressed for not wanting to have a health check. By contrast, other students would take up the offer of a health check with the UMC for reasons that include: confirmation that there is nothing wrong with them, to become familiar with the Medical Centre and their staff and they would have no objection to completing a health-check proposal form at registration, providing certain criteria were met, such as having the option to change their minds (**Question 22**). It was however noted that not all students were registered with the UMC and there was also evident confusion about registration procedures, especially among overseas students (**Question 23**).

Questionnaire Data Coding Schema (example page)

6) DRUGS	Drugs	1	Were very concerned about the drugs culture at UH
	Drugs	2	Were a little concerned about the drugs culture at UH
	Drugs	3	Were not at all concerned about the drugs culture at UH
	Drugs	4	Didn't want to comment about the drugs culture at UH
7)PHYDIS	Phystig	1	Thought there is a stigma attached to physical disabilities
	Phystig	2	Thought there is not a stigma attached to physical disabilities
	Phystig	3	Preferred not to comment about stigma attached to physical disability
	Phydec	1	Thought sts with Phydis should declare disability to UH prior to reg
	Phydec	2	Thought sts with Physdis shouldn't declare dis to UH prior to reg
	Phydec	3	Thought it would depend on how obvious the disability was
	Phyash	1/88	Thought physical disability was nothing to be ashamed of
	Phyash	2/88	Thought physical disability was something to be ashamed of
	Physupp	1/88	Thought UH provides exceptional help and support with Phydis
	Physupp	2/88	Thought UH did not provide exceptional help and support with Phydis
	Phyadv	1/88	Thought UH needed to know about Phydis in advance
	Phyadv	2/88	Did not think UH needed to know about Phydis in advance
	Phydst	1/88	Should not declare Phydis due to stigma
	Phydst	2/88	Should not declare Phydis but not because of stigma
	Phyaw	1/88	Thought declaration would make more people aware of Phydis
	Phyaw	2/88	Did not think declaration would make more people aware of Phydis
	Phydif	1/88	Thought declaration would lead to Phydis students treated differently
	Phydif	2/88	Did not think declaration would lead to sts treated differently
8)MENTDIS	Menstig	1	Thought there is a stigma attached to mendis
	Menstig	2	Did not think there was a stigma attached to Mendis
	Menstig	3	Preferred not to comment on whether there was a stigma att to Mendis
	Mendec	1	Thought sts with Mendis should declare to UH prior to reg
	Mendec	2	Thought sts with Mendis shouldn't declare to UH prior to reg
	Mendec	3	Thought it would depend on how obvious mendis was

Code 88 = inappropriate/or unnecessary response
77 = incorrect data
99 = missing data

Matrix to represent the responses of the Medical Practitioner Representative (MPR) (Example page) …

Interviewer's Question	Medical Practitioner's Response
"For those who declare a mental health disability what procedures and protocols does the UMC follow, if any?" **(Question 1)**	The University Medical Centre has a register for students with severe mental health problems and such cases are discussed monthly with a multi-disciplinary team within the community mental health service: "For milder cases, you know such as emotional problems and those that sort of thing tend to be dealt with within primary care and, you know, the University Counselling Service" (page 1). The UMC is not informed by the university registration department about students declaring a mental health problem. The UMC would not therefore know about students who had a mental health problem until they registered with the practice. On completion of the UMC's registration procedure (which allows for disclosure of a specific problem) the practice would contact the student to invite them to an appointment – after a 'settling in' period.
"Would you say your practice would be in favour of implementing (other such) health promotion activities?" **(Question 2)**	The UMC would emphatically be in favour of implementing health promotion activities if "there's something to be gained from such" (page 2) (After probing) : it would have to be worthwhile running a specific service, over and above offering general medical services. The UMC would consider implementing a health promotion activity if there were a demonstrable need. For a mental health clinic to work it would need to be available every day. Working to a specific protocol would not be a problem but arranging for the whole multi-disciplinary team to be present would be (page 5) The UMC have found Walk-In clinics work best as opposed to specified set clinics.

DEMOGRAPHIC PROFILE OF FOCUS-GROUP PARTICIPANTS

Focus-Groups conducted in total = 11

Total number of participants   = 51

(Mean of between 4-5 participants at each Focus-Group)

Numbers in brackets indicate the number of students represented in that category

Variable	Response
Sex of Respondents	Males (38) Females (13)
Student Status	Full-time (50) Part-time (1)
Home or Overseas Student	Home (33) Overseas (18)
Age in years	18 years (9) 19 years (11) 20 years (7) 21 years (5) 22 years (6) 23 years (5) 24 years (3) 27 years (2) 28 years (2) 45 years (1)
Year of study	1st year (23) 2nd year (12) 3rd year (13) 4th (3)
Course undertaken by student	Law (7) Computing Science (5) Humanities (3) Foundation programme (3) Multimedia Technology (2) Radiography (2) Business Studies (2) Marketing (2) Business Administration (2) Interdisciplinary Studies (2) Engineering (2) Human Resources Management Business Economics Human Resources with French

	International Business
	Psychology
	Business and Computing
	Combined Modular
	Mathematics
	Accounts and Finance
	Management Science
	Nursing
	Primary Education
	Physiotherapy
	Electrical Engineering
	Computer Network Technology
	Biotechnology
	Graphic Design/Illustration
	Environmental Science
	Business and Tourism
	Tourism
Registered with University Medical Centre	Yes (30) No (21)
Ethnicity of students	White (29) Chinese (9) Pakistani (4) Indian (3) Black African (2) Sri Lankan (1) Iranian (1) Black Caribbean (1) African Arabian (1)

Demographic Profile of the Survey Respondents

Variable	Frequencies / Percentages
Sex of Respondents N = 806	Males : 47.5% (383) Females : 52.5% (423)
Status of Respondents N = 799	96.4% Full-time 2.7% Part-time
Fee Status N = 806	84.5% Home Students 15.5% Overseas Students (inc. EU)
Age of Respondents N = 804	Age-range : 17-47 years Mean Age : 21.01 years Median Age : 20 years Mode of Age: 19 years
Year of Study N = 801	Range : Year 1 – Year 4 42.9% Year 1 28.8% Year 2 23.3% Year 3 4.3% Year 4
Faculty of Respondents N = 806	Range of 6 Faculties and percentage of student respondents from each Faculty: Business School (17%) Faculty of Creative and Cultural Industries (12.2%) Faculty of Engineering and Inform. Sciences (21.1%) Faculty of Health & Human Sciences (30.5%) Faculty of Humanities, Law and Education (14.5%) Faculty of Interdisciplinary Studies (4.6%)
Course of study N = 806	95 named courses (out of a possible 170)
Campus N = 806	68.7% College Lane campus 25.1% de Havilland campus 6.2% St. Albans campus
Registration with University medical Centre N = 806	52.6% registered with College Lane *University Medical Centre (47.4% not registered with UMC)
Registration of Physical Disability to UH N = 804	2.1 % declared a physical disability (97.6% did not declare a physical disability)
Registration of Mental Disability to UH N = 802	1.4 % declared a mental disability (98.1 % did not declare a mental disability)
Registration of Learning Disability to UH N= 806	4.8% declared a learning disability (95.2% did not)

Accommodation status	37.1%	on campus
	27.5%	rented
	17.4%	at home
	16.0%	off campus
n = 805	1.9%	other (home-ownership)

Ethnicity of Respondents	65.5%	White
	11.0%	Indian
	6.9%	Chinese
	6.8%	Other (stated as mixed race)
	5.0%	Black African
	2.2%	Black Caribbean
	1.9%	Pakistani
N = 806	0.6%	Black other

Religious Affiliation	40.3 %	Christianity
	37.1%	No religious affiliation
	7.7%	Hinduism
	6.3%	Islam
	2.6%	Buddhism
	2.6%	Other (Catholicism, Scientology)
	2.4%	Sikhism
	0.4%	Judaism
N = 801		

U H University of
Hertfordshire

Student Well-Being Questionnaire

Please turn over and complete the questionnaire as instructed >

(ripacc

Centre for Research in
Primary and Community Care

Student Questionnaire Briefing Sheet
(attached to the front of the Student Questionnaire – first attempt at recruitment)

Thank you very much for agreeing to complete the attached survey, the purpose of which is to understand a little more about issues relating to your emotional/mental well-being whilst you are here as an undergraduate at the University of Hertfordshire (UH). Several questions on the attached questionnaire make reference to your emotional/mental well-being. Many of the terms relating to health and illness, including "health promotion", "mental health", and "mental illness" mean different things to different people and even official definitions of these terms are often confusing and open to debate. However, for the purposes of this study, I would like you to consider your own emotional/mental health as relating to a positive feeling of happiness or contentment, and conversely feeling emotionally/mentally distressed could be described or defined as any of the following: feeling depressed, unhappy, anxious or stressed (referred to hereafter as depressed/unhappy/anxious)

UH provides a network of support services to help you in times of need and the study is also concerned with your views, opinions and experiences with regard to these services. For your guidance I attach a sheet entitled "Student Support services" which I compiled and used with my focus groups. I would stress this is not an official or definitive list of the services provided by UH but merely an indication of some of the areas of support that you might benefit from during your time here as an undergraduate. This research has the support and backing of many of these services and has been approved by the University of Hertfordshire's Research Board and Ethics Committee.

I'd like to stress that you are under no obligation whatsoever to complete this questionnaire. However, if you are willing to participate in this research I would like to assure you that your responses will be treated confidentially and, in accordance with research governance criteria, the questionnaires will be kept in a locked and secure place until they are destroyed in 7 years' time. We have asked you for a few demographic details in order to perform cross-analysis between groups, that is to say to detect any differences in responses between the sexes, between different faculties, age-groups etc.

However no personal details are asked of you and therefore you cannot be identified.

To thank you for your co-operation and for participating in this study, I am entering everyone who completes and returns this questionnaire to me into a Student Questionnaire Draw, the prizes of which are as follows :

A first prize of £100, 2 prizes of £50 and 5 prizes of £20.

To this end you will find a duplicate raffle ticket stapled to the right-hand corner of the questionnaire. Please detach the unstapled raffle ticket and keep it safely, as this is your proof to claim a prize. If you are completing the questionnaire by e-mail, I will send you by return your raffle ticket number. It is anticipated approximately 700 Student Draw numbers will be entered into the raffle. To ensure absolute impartiality, a representative from the Students Union will undertake the draw. The winning numbers will be announced in the Students Union magazine before the end of the Spring term (before Easter).

I really appreciate your participation in this research. However, my over-riding concern is for your welfare and well-being and so I have made an arrangement with the University Counselling Service, just in case you are affected by anything arising from the questionnaire. Should you wish to talk to them, they would be more than happy to see you. For an appointment please ring 01707 284000 (ext 4453) or visit their website: www.herts.ac.uk/services/counselling. On contacting them you will need to mention you have taken part in the Student Questionnaire on emotional well-being and the Support Services. **GOOD LUCK WITH THE DRAW !**

STUDENT
QUESTIONNAIRE

(Abbreviation used throughout this questionnaire - University of Hertfordshire : UH)

e confirm here that you are an UNDERGRADUATE at UH ☐

Male	☐	Female	☐		
Full-time	☐	Part-time	☐		
Home Student	☐	Overseas Student	☐	EU Student ☐	

ears ....

tudy ....

ulty/School are you in ....

rse are you studying ....

mpus are you based on: College Lane   ☐   de Havilland   ☐   St. Albans ☐

egistered with the University Medical Centre (College Lane)?   Yes ☐   No ☐

leclare a physical disability to UH prior to registration?   Yes ☐   No ☐

leclare a mental health problem to UH prior to registration?   Yes ☐   No ☐

eclare a learning difficulty to UH prior to registration?   Yes ☐   No ☐

of accommodation do you live in: Student accommodation on campus ☐   Student accommodation off campus ☐

ommodation in Hertfordshire ☐   At home with family ☐   Other ....

you describe your ethnic origin:

an ☐   Black Caribbean ☐   Black Other ☐   Chinese ☐   Indian ☐   Pakistani ☐   White ☐

se state) ....

you describe your religious affiliation:

☐   Christianity ☐   Hinduism ☐   Islam ☐

☐   Sikhism ☐   None ☐   Other *(please state)* ....

PART II

The questions in this section are to find out about your feelings and attitudes towards emotional well-being and your views on your immediate environment here at UH.

Since you've been at UH have you experienced any of the following? *(Please tick **ONE** box for each option)*

Feeling that you don't fit in with those around you	Never ☐	Sometimes ☐	Often ☐
Feeling homesick and missing your family and friends	Never ☐	Sometimes ☐	Often ☐
Difficulties adjusting to life at university	Never ☐	Sometimes ☐	Often ☐

"As a student here at UH, I feel as though I am part of a supportive community" *(Please tick **ONE** box only)*

All of the time ☐   Some of the time ☐   Never ☐

UH is concerned with fairness and equality. Do you feel you have been treated equally and fairly with regard to the following? *(Please tick **ONE** box for each option)*

Getting connected to the internet	Yes ☐	No ☐
Accessing Support Services, including the Medical and Counselling Services	Yes ☐	No ☐
Use of the sporting facilities	Yes ☐	No ☐
Parking issues	Yes ☐	No ☐
Accommodation matters (relating to quality, maintenance or security issues)	Yes ☐	No ☐
Help with financial problems	Yes ☐	No ☐
Free/Assisted travel expenses between campuses	Yes ☐	No ☐
Being included in the university's activities and events	Yes ☐	No ☐

To what extent have the following problems or issues caused you to feel depressed/unhappy/anxious whilst here at UH?
(Please rate your response to each option on a scale of 1-5 with 1 representing "not at all" depressed/unhappy/anxious and 5 representing "very much so")

	Not at all			Very much so	
Money problems	1	2	3	4	5
Feeling homesick	1	2	3	4	5
Worries about coursework	1	2	3	4	5
Worries about exams	1	2	3	4	5
Personal health concerns	1	2	3	4	5
Feeling socially isolated	1	2	3	4	5
Concerns about your self image	1	2	3	4	5
Working long hours off the university campus	1	2	3	4	5
Wanting to protect your family from your worries	1	2	3	4	5
Not having approachable and helpful lecturers	1	2	3	4	5
Having to provide emotional help and support to others	1	2	3	4	5
Not knowing who to turn to in times of emotional need	1	2	3	4	5

5) It is argued there is a "drinking/Pub-Club culture" in British universities today.

A) Do you agree with this statement   Yes ☐   No ☐

B) Do you feel part of this so called Pub/Club culture?   Yes ☐   No ☐

If **No**, is this because :*(Please tick as **MANY** of the boxes as apply to you)*

it goes against your personal beliefs   ☐

it just doesn't appeal to you   ☐

it doesn't appeal to most of your friends   ☐

6) It is argued there is a growing student 'drugs culture' in British universities. How concerned are you about a drugs culture here at UH? *(Please tick **ONE** option only)*

Very concerned ☐   A little concerned ☐   Not at all concerned ☐   I'd rather not comment ☐

7) **A) Do you think there is a stigma attached to physical disabilities*?**   Yes ☐   No ☐   I'd rather not comment ☐

B) Do you think students with physical disabilities should declare that disability to UH prior to registration? *(Please tick **ONE** of the boxes below)*

Yes ☐   No ☐   Depends on how obvious the disability was ☐

If **"Yes"**, is this because you think: *(Please tick **ONE** box for each option)*

Physical disability is nothing to be ashamed of	Yes ☐	No ☐
UH provides exceptional help and support to students with physical disabilities	Yes ☐	No ☐
To provide help and support UH needs to know about the disability in advance	Yes ☐	No ☐

If **"No"**, is this because you think: *(Please tick **ONE** box for each option)*

There is a stigma attached to physical disability	Yes ☐	No ☐
It would make more people aware of the disability	Yes ☐	No ☐
It would lead to physically disabled students being treated differently	Yes ☐	No ☐

* *The Disability Discrimination Act (1995) defines a disabled person as someone who has a physical or mental impairment that has a substantial and long-term adverse effect on his/her ability to carry out day-to-day activities*

8) A) Do you think there is a stigma attached to mental disability?**   Yes ☐   No ☐   I'd rather not comment ☐

B) Do you think students with a mental disability should declare that disability to UH prior to registration? *(Please tick **ONE** of the boxes below)*

Yes ☐   No ☐   Depends on how obvious the disability was ☐

If **"Yes"**, is this because you think: *(Please tick **ONE** box for each option)*

Mental health problems are nothing to be ashamed of	Yes ☐	No ☐
They should do so out of concern for the safety of others	Yes ☐	No ☐
UH provides exceptional help and support to students with mental health problems	Yes ☐	No ☐
To provide help and support UH needs to know about the disability in advance	Yes ☐	No ☐

If **"No"**, is this because you think: *(Please tick **ONE** box for each option)*

There is a stigma attached to mental disability	Yes ☐	No ☐
They would be labelled as having a mental health problem	Yes ☐	No ☐
They would be alienated by friends	Yes ☐	No ☐
They would be discriminated against at university or in the workplace	Yes ☐	No ☐

** *The Higher Education Statistics Agency (HESA) defines mental disability as: mental health difficulties/problems. This does not include learning difficulties.*

9) A) Do you think there is a stigma attached to learning disabilities (including dyslexia) ?   Yes ☐   No ☐   I'd rather not comment ☐

B) Do you think students with learning disabilities (including dyslexia) should declare that disability to UH prior to registration?
(Please tick ONE box for each option)

Yes ☐   No ☐   Depends on how obvious the disability was ☐

If "Yes", is this because you think: *(Please tick ONE box for each option)*

A learning disability is nothing to be ashamed of	Yes ☐	No ☐
UH provides exceptional help and support to students with learning disabilities	Yes ☐	No ☐
To provide help and support UH needs to know about the disability in advance	Yes ☐	No ☐

If "No", is this because you think: *(Please tick ONE box for each option)*

There is a stigma attached to learning disabilities	Yes ☐	No ☐
They would be treated differently from other students	Yes ☐	No ☐
Other students might resent the extra help they receive	Yes ☐	No ☐

10) How important are the following issues in keeping you emotionally/mentally healthy whilst here at UH?
(On a scale of 1-5 please express the importance you attach to each of the following options, with 1 representing "not at all important" and 5 representing "very important")

	Not at all important			Very important	
Having a pleasant, clean and attractive environment to live in	1	2	3	4	5
Having friends you can turn to in times of distress	1	2	3	4	5
Being able to cope with the course	1	2	3	4	5
Knowing you can turn to the support services whenever you need help	1	2	3	4	5
Feeling safe and protected whilst on campus	1	2	3	4	5
Having access to health and leisure facilities	1	2	3	4	5
Knowing your belongings will be secure	1	2	3	4	5
Knowing you can cope well with new experiences	1	2	3	4	5

11) What changes (if any) would you like to see to improve health and safety issues at UH?
(If you don't tick A, please express your opinion on a scale of 1-5 according to the importance that option holds for you, with 1 representing "not at all important" and 5 representing "very important")

A : I wouldn't want to see any changes ☐

	Not at all important			Very important	
To have the bus service extended to cover late evenings and weekends	1	2	3	4	5
To make the security guards more "visible" at night	1	2	3	4	5
To have increased security measures in Halls and around the campus	1	2	3	4	5
To be given assurance that the CCTV cameras are working	1	2	3	4	5
To have the drink/drugs problem sorted out	1	2	3	4	5
To have more emphasis placed on healthy food and healthy eating	1	2	3	4	5
To have more help on stress management	1	2	3	4	5
To have more emphasis placed on how to keep mentally healthy	1	2	3	4	5
To see the opening times of the support services extended	1	2	3	4	5

12) To what extent do you agree with the following statements? *(Please tick ONE box for each option)*

A) I think all nationalities mix well on campus and help and support each other

None of the time ☐   Some of the time ☐   Most of the time ☐   All of the time ☐

Some groups of students make no effort to integrate with other nationalities and "stick together"

None of the time ☐   Some of the time ☐   Most of the time ☐   All of the time ☐

B) Please rate your responses to the following options on a scale of 1-5 with 1 representing "strong disagreement" and 5 representing "strong agreement"

	Strongly disagree				Strongly agree
I'm not keen to integrate with a group that doesn't share my language and culture	1	2	3	4	5
I think language difficulties can be the biggest barrier to integration between nationalities	1	2	3	4	5
I think cultural differences can be the biggest barrier to integration between nationalities	1	2	3	4	5

13) Lecturers and Personal Tutors

Personal tutors have a specific interest in their students' pastoral care whereas lecturers are mainly involved with the teaching elements of the course.

(Please tick ONE box for each option)

A) I have a personal tutor   **Yes** ☐   **No** ☐   **I'm not sure** ☐

If **YES**, please tick **ONE** box for each of the following options:

I feel I could turn to my *personal tutor* with any problem, including emotional ones   Yes ☐   No ☐

I'm confident what I tell my *personal tutor* will be kept in the strictest confidence   Yes ☐   No ☐

(Please tick ONE box for each option)

B) I feel I could turn to my *lecturer* with any problem, including emotional ones   Yes ☐   No ☐

I'm confident what I tell my *lecturer* will be kept in the strictest confidence   Yes ☐   No ☐

If my *lecturer* cannot help me, he/she will suggest someone who can   Yes ☐   No ☐

The Support Services:

14) How aware are you of the support services? *(You may wish to refer to the Support Services leaflet attached to this questionnaire when answering this question) Please tick ONE box for each option in A and B)*

A) I am familiar with the role of all the Support Services   Completely ☐   Vaguely ☐   Not at all ☐

I am familiar with the whereabouts of all the Support Services   Completely ☐   Vaguely ☐   Not at all ☐

B) I'm only familiar with the Support Services that I've heard about from others   Agree ☐   Disagree ☐

I'm only familiar with the Support Services that I've stumbled across myself   Agree ☐   Disagree ☐

C) How well do you think the Support Services are **actively promoted** on your campus:
(Please rate your response on a scale of 1-5 with 1 representing "not very well" and 5 representing "very well")

	Not very well			Very well	
Those helping with finance	1	2	3	4	5
Those associated with physical health	1	2	3	4	5
Those associated with mental/emotional health	1	2	3	4	5
Those concerned with social activities	1	2	3	4	5
Those involving legal/career advice	1	2	3	4	5
Those concerned with disability or equality issues	1	2	3	4	5
Those offering help to Overseas Students	1	2	3	4	5
Those to do with accommodation	1	2	3	4	5

Induction Week ... and Introduction to the Support Services *(please tick **ONE** box only for each option)*

Induction Week was very helpful in introducing me to the Support Services.   Agree ☐   Disagree ☐

During Induction Week I would like to have been shown around more to become   Agree ☐   Disagree ☐
familiar with the whereabouts of the Support Services

I've forgotten most of what I was told about the Support Services during Induction   Agree ☐   Disagree ☐
Week and I'd like to have it repeated

PART III

This section is about your help-seeking behaviour - who would you seek help from (on behalf of others as well as yourself) and the identification of barriers in accessing help in times of emotional need.

If you were becoming increasingly concerned about another student (with whom you have regular contact) and who appeared to be depressed/unhappy/anxious, what would your *FIRST* response be? *(Please tick **ONE** option only)*

I'd ignore him/her, they'll probably snap out of it anyway   ☐

I'd befriend him/her and encourage them to talk about what's bothering them   ☐

I'd try to persuade him/her to get help   ☐

I'd tell someone else that I'm concerned   ☐

I wouldn't do anything, they have a right to be left alone   ☐

I wouldn't know what to do   ☐

I wouldn't need to involve anyone else, I'd be able to help   ☐

Who would you be most likely to turn to if you felt depressed/unhappy/anxious whilst at UH?
Please rate your responses on a scale of 1-5 with 1 representing the "least likely" person of contact and 5 representing the "most likely" person of contact)

	Least likely			Most likely	
Close friends/family	1	2	3	4	5
Casual friends/peers	1	2	3	4	5
University lecturer	1	2	3	4	5
Personal tutor	1	2	3	4	5
Religious person	1	2	3	4	5
Doctor at the Medical Centre	1	2	3	4	5
Counsellor at the Counselling Service	1	2	3	4	5
Other university staff or support staff	1	2	3	4	5
Nurse at the Medical Centre	1	2	3	4	5
I wouldn't turn to anybody	1	2	3	4	5

Do you find it difficult to ask for help with emotional problems?   Yes ☐   No ☐

If Yes, please indicate why by ticking as *MANY* options as apply to you:

I just do, I don't know why   ☐

I shouldn't need to ask for help, I'm adult now   ☐

I'm afraid of being rejected   ☐

I think it's a sign of weakness to ask for help with emotional problems   ☐

I'd be concerned about it going down on my records   ☐

I'd be worried about it affecting my chosen career pathway   ☐

I'd have to feel really depressed/unhappy/anxious before I sought help   ☐

Which of the following UH Support Services would you be most likely to access *FIRST* if you felt depressed/unhappy/anxious? *(Please tick ONE option only)*

Nightline ☐

Student Union//Student Support & Guidance ☐

Counselling Service ☐

Medical Centre ☐

My personal tutor ☐

One of my lecturers ☐

None of the above ☐

If you DID NOT tick "Medical Centre" as an option for QUESTION 19, which of the following options provide the most likely explanation for NOT attending the Medical Centre if you felt depressed/unhappy/anxious. *(Please rate each of the options on a scale of 1-5 with 1 representing the "least likely" explanation and 5 representing the "most likely" explanation)*

	Least likely				Most likely
Doctors mostly deal with physical problems, not emotional problems	1	2	3	4	5
I might be given medication and I wouldn't want that	1	2	3	4	5
I don't fully understand what the Medical Centre provides	1	2	3	4	5
Doctors don't usually have the time to deal with emotional problems	1	2	3	4	5
I'd be worried I'd be wasting the doctor's time	1	2	3	4	5
Concerns that a mental health problem would be recorded on my medical records	1	2	3	4	5
Concerns about confidentiality: if information would be passed to family or UH staff	1	2	3	4	5
I wouldn't want to be seen going into the Medical Centre	1	2	3	4	5
My past experience with GPs hasn't been that positive	1	2	3	4	5
Because other UH support services seem to be more appropriate	1	2	3	4	5

If the Medical Centre were to provide the following services, specifically to deal with symptoms of depression/anxiety, how likely would you be to use them? *(Please rate each of the services mentioned below on a scale of 1-5 with 1 representing "not very likely" and 5 representing "very likely")*

	Not very likely				Very likely
An e-mail support service with a direct link to the Medical Centre	1	2	3	4	5
A telephone helpline system linked directly with the Medical Centre, during surgery times	1	2	3	4	5
A Nurse-led Walk-In Clinic - to assess need (triaging system)	1	2	3	4	5
A Nurse-led Well-Person Clinic, to promote mental health, and to provide advice and information	1	2	3	4	5

the Medical Centre had offered you the option of a free health check, would you have accepted the offer?

❏   No ❏   I'm not sure ❏

'Yes", please tick as *MANY* options as apply to you

ause it would be good to know there's nothing wrong with me   ❏

ause I would become familiar with the Medical Centre and the staff   ❏

ause I think having a health check-up is a good idea.   ❏

'No", for what reason(s) might you not want to attend the Medical Centre for a free health check?   *(Please tick as MANY options as apply to you)*

ight be made to feel guilty about leading an unhealthy life-style   ❏

ouldn't go if I felt well at the time   ❏

ould probably only go if I thought I was "at risk" of developing a particular illness ❏

st wouldn't want to have a health check   ❏

ou **"weren't sure"**, is this because   *(Please tick as MANY options as apply to you)*

'd want to know first what was involved in the health check   ❏

'd want an assurance the health check results would be confidential   ❏

'd be afraid of finding out there was something wrong with you   ❏

in Part I, you have stated that you are not registered with the University Medical Centre, is this because: *(Please tick ONE option only)*

re registered elsewhere and you don't want to change your doctor   ❏

don't want to register with a doctor anywhere   ❏

don't know what is entailed in registering with a GPs' surgery   ❏

d rather not say   ❏

Thank you so much for completing this Questionnaire

your information it is hoped the results of this survey (which will, of course, remain anonymous)
will be published in the Students' Union magazine within the next 12 months or so.

"GOOD LUCK WITH THE DRAW!"