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A mixed methods exploration of the utilisation of embedded university counselling services by ethnic minority students in London.

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PART A: Doctoral Research

Abstract

In the UK, student mental health issues have become of increasing concern over the last 20 years, a pattern that has been mirrored across the world (Auerbach et al., 2018; Holm-Hadulla & Koutsoukou-Argyraki, 2015). However, the UK does seem to face particular challenges not replicated in other countries with students presenting much later with more severe levels of distress (Broglia et al., 2018). There is very little data on ethnic minority students experiences of seeking help and accessing support for mental health difficulties whilst at university in the UK. It can be seen from the existing literature that there are three types of barrier to receiving help from embedded university counselling services: individual barriers to help seeking (stress, ethnicity, and gender), cultural barriers (including recognition of mental health distress, cultural identity, shame and stigma), and practical barriers (including time) to receiving initial help.

The aim of the study was to explore the incidence and severity mental health difficulties and the utilisation of embedded university health services by ethnic minority students. In addition to understand the barriers to initially accessing support and then attending counselling sessions. The study took a mixed methods approach using a sequential explanatory design with data collected in two phases from 203 students via an online survey and five semi structured interviews. Quantitative data was analysed using a series of ANCOVA, chi-squared tests and Fisher's exact tests. The qualitative data was analysed using reflexive thematic analysis with a combined deductive and inductive approach to enable the integration of the Health Belief Model.

Quantitative analysis suggests that contrary to expectations White students exhibit significantly higher levels of distress than ethnic minority across generalised anxiety, eating and alcohol concerns. In line with expectations ethnic minority students experienced barriers such as higher ingroup stigma, cultural values, and lack of access at higher levels than their White peers. No significant differences were found between White and ethnic minority students in terms of utilisation and dropout. Post hoc analysis of ethnic minority students found two significant predictors of help seeking. Students with higher cultural barriers displayed lower help seeking and those with higher levels of distress were more like to seek support. The findings of this study have implications for embedded counselling services and counselling practice with ethnic minority students.

Chapter 1 Introduction

1.1 Overview

In the UK, student mental health issues have become of increasing concern over the last 20 years, a pattern that has been mirrored across the world as reflected in WHO world mental health surveys, focused on university students from 21 countries across six continents spanning low to high income countries (Auerbach et al., 2018). However, the UK does seem to face particular challenges not replicated in other countries, with students presenting much later with more severe levels of distress (Broglia et al., 2018; Broglia et al., 2021b). Alongside this increase in student mental health concerns there has been a large increase in the number and diversity of students in UK universities over the last 20 years (Dufour, 2020). Numbers have increased from 33% of young people enrolled in 2000 (Lewis, 2002) to 58% in 2020 (Bolton, 2024). Alongside this, the number of students reporting a mental health condition on entry to university increased from 1.45% in 2014/15 to 4.18% in 2021/2022 (HESA, 2023). This has been reflected in the numbers seeking help for mental health challenges from university support services with 61% of services reporting an increase in demand of over 25% (Thorley, 2017). Research from anonymous surveys of students indicate that this may be an under reporting and there are much higher rates of students in distress than are presenting to university mental health services (Hubble & Bolton, 2019; Thorley, 2017).

The Covid-19 pandemic that started to impact the UK at the beginning of 2020 had a significant impact on the lives on university students. Those from ethnic minority backgrounds were disproportionality impacted compared to the White population by Covid - 19 both in terms of up to double the infection rates and 23% higher risk for Black and Asian communities of experiencing excess deaths death from the virus (Oskrochi et al., 2023). There were also found to be racial inequalities in the mental health impacts of Covid-19, with higher levels of anxiety and depression throughout lockdowns than the White population (Raghavan & Jones Nielson, 2021). In the student population, rates of wellbeing showed a significant decrease in the early stages of the pandemic, in comparisons between pre and during lock down conditions. Rates of depression also increased by 50% over this time period (Evans et al., 2021). Those students arriving at university were impacted by the uncertainty and loss of missing out on key activities that usually mark the last year at school (Demkowicz et al., 2020). Those starting university or already at university were also significantly impacted by the changes to teaching by the move to online learning and the impact of the isolation for those in university residences. Research findings on the impact on

students mental health and wellbeing from the later stages of the pandemic have been varied, seeming to show differences between different universities (Lemyre et al., 2023), belonging to an ethnic minority was also identified as a risk factor in reporting lower levels of wellbeing (Bennett et al., 2022).

In terms of the UK student population during the academic year 2021/22 27% of students were from ethnic minority backgrounds (Black 8%, Asian 12%, Mixed 4%, Other 2% and not known 1%) and 73% were White (HESA, 2021). In London the number of ethnic minority students rises to 52% (Black 15%, Asian 22%, Mixed 7%, Other 5% and not known 3%) (HESA, 2021). In the same academic year 679,970 students in the UK were international students (15.1% of undergraduates and 45.4% of postgraduates) which is 23.8% of the total student population. In the UK population as a whole, ethnic minority people report higher levels of mental health disorders than White people (Baker, 2000), they also present with a higher severity of symptoms at initial assessment (National Collaborating Centre for Mental Health, 2023). These findings have also been replicated in the UK student population (Arday et al., 2022; Broglia et al., 2021a). International students from ethnic minorities also seem to be an under researched group in the UK (Cogan et al., 2023); the limited research shows a similar pattern to domestic ethnic minority students.

Several organisations have been set up to focus on student mental health. The Mental Health in Higher Education Advisory Group and Student Minds (The UK's student mental health charity) have worked together to produce the Step Change Framework. It identified the need to work towards inclusivity, and to better understand the diversity of needs of the varied student population, including students from ethnic minority backgrounds (Universities, U.K., 2020). The issue of student mental health has been identified by other papers (Broglia et al., 2021a) and other groups including: Student Mental Health Research Network (SMaRteN), (who is calling for more research in this critical area), Student Minds and the Student Counselling Outcomes Research and Evaluation (SCORE) consortium (working towards a shared outcome database) (Dufour, 2020). In 2019 The University Mental Health Charter (Hughes & Spanner, 2019) was published which proposed a whole university and sector approach to supporting the mental health and wellbeing of all members of the university community. It was set up by Student Minds in collaboration with organisations including the Department for Education and universities were invited to sign up to the charter and work towards The University Mental Health Charter Award. In 2023/24 96 institutions were signed up to the charter and the award has now been received by 10 institutions in the UK. A key component of the charter is highlighting the need for inclusivity for those that face personal, structural or cultural inequalities including ethnic minority students.

1.1.1 Defining terminology to be used in this study for ethnic minority students.

A variety of terminologies pertaining to mental health and ethnic minority students are discussed in this study and have been widely cited in the literature. It is important to contextualise some of these terms at the beginning of this thesis.

1.1.1.1 Race

The term race is socially constructed and was originally used as a way to group populations often based on physical appearance predominantly skin colour during the 17th century colonialism (Basset, 2022; Tinsley, 2022). As a result of the tension around the use of the term race, its usage in the UK has now reduced and has been largely replaced in much official reporting (ONS) by the term ethnicity.

1.1.1.2 Whiteness

Whiteness has continued to be used in the US and UK as the default to confer normality and superiority and with that dominance over ethnic minority populations (Sue et al., 2022), although Whiteness is still largely invisible as a concept to many, especially White people.

1.1.1.3 Ethnicity

The term ethnicity has been developed in part to acknowledge that race is socially constructed to also consider an individual's language, religion, national identity (Omi & Winant, 2014). Ethnicity as defined by the APA (2023) is characterising people based on factors related to a shared history and common ancestry, which include a shared cultural heritage including values, beliefs, language food, music, dress etc.

1.1.1.4 Culture

Culture is often used to have a wider meaning and looks at any social grouping that not only looks at identities, including "socially definable group with its own set of values, behaviours and beliefs' (APA, 2023). This could relate to race and ethnicity, gender, socioeconomic group, and sexuality. The use of these terms is complex and continues to evolve. In the literature from the UK, US and elsewhere these terms are not used consistently and sometimes used interchangeably.

1.1.1.5 Intersectionality

Although this study is focused on ethnicity of participants intersectionality will inevitably be important to consider. Intersectionality is the idea that everyone does not have a single identity but multiple identities such as ethnicity, gender, sexuality each of which may confer

privilege or oppression to varying degrees (Cho et al., 2013).

1.1.1.6 Ethnic minority

Terminology used to describe racial and ethnic groups in the UK is constantly evolving. Various terms were considered which are outlined here with the decision taken to use ethnic minority within this thesis.

Aspinall, in his 2020 critical review of ethnic/racial terminology in use in the UK, found that acronyms such as Black and Minority Ethnic (BME) and Black, Asian and Minority Ethic (BAME) are widely used in the media and government despite being widely misunderstood and being against official guidance (ONS, 2024). He recommended that terms such as minority ethnic or ethnic minority are widely accepted and understood and therefore are more appropriate. Since Aspinall's review (2020) was conducted terms have continued to evolve and other terms such as minoritised communities, person/people of colour, ethnically diverse and global majority have been posited. This is not an exhaustive list. Organisations such as Race Equality Matters in the UK conduct regular polls to ascertain views from its online community via LinkedIn and its website. As a result of these polls, they transitioned from recommending the terminology ethnic minority to recommending the terminology ethnically diverse since 2022 (Race Equality Matters, 2023). As my research predated this change, and as at the time of writing the new terminology has not been widely adopted in the UK ethnically diverse has not been used in this thesis. I have, in line with the ONS recommendations and Aspinall, used the term *ethnic minority* and then used the specific ethnic group terminology as appropriate (as described by the ONS and used in the UK census in 2021). In this doctoral thesis the term ethnic minority does not include White minority groups, such as Irish travellers. Throughout the literature a variety of different terms have been used, when discussing others' research, I have used the terminology from the original paper.

1.1.1.7 Mental health

The final key term is mental health is a very commonly used term. However, it can have many meanings and can be used as an all-encompassing term to include psychological, emotional and social wellbeing. In the context of this study, and in much of the research discussed, it is used more specifically to refer to psychological health and in this case poor mental health including depression and anxiety.

1.1.3 University counselling services in the UK

Embedded university counselling services in the UK are generally found on campus or within university buildings as part of a student support and wellbeing team. Support for mental health difficulties varies between different universities but often involves three types of service within the student services department, including wellbeing services, counselling services, and disability services (Lewis & Stiebahl, 2024). The focus of this study is on counselling services. University counselling services in the UK provide a free and confidential services to all registered students. Many offer up to 6 sessions of short term therapy.

1.2 Barriers to help-seeking and accessing support.

1.2.1 Overview of literature review

Studies have found that a variety of help seeking behaviours in university students have been identified from both formal and informal sources (Bryant et al., 2022) including from their personal tutor, university mental health service, peers, off campus services, family, and online services. Those that do seek support from their university counselling service request support for a variety of concerns. In the UK there is not currently a nationwide data set of student counselling data as there is in the US (although the SCORE consortium have argued for its creation) (Broglia et al, 2021b). In the US, the Centre for Collegiate Mental Health (CCMH) has complied a nationwide annual data set since 2009. In the year 2022/23 195 institutions' data were included with 185,114 students experiences captured. As would be expected, students presented with a wide variety of presenting concerns. Many of these would be expected to be found in a general population and others are more specific to the university environment including adjustment to a new environment, academic performance, and attention/concentration difficulties. The concerns that the highest proportion of students were experiencing on entry to counselling were anxiety (65%), stress (46.9%), and depression (44.3%) (CCMH, 2023). Similar concerns have been reported by UK studies (Broglia et al., 2021a; Broglia et al., 2021b) . In addition to the challenges all students face in adapting to the shift from school to university, international students have additional challenges to contend with including adjusting to cultural differences (e.g. adapting to new foods), homesickness, language barriers, navigating differences in healthcare, transport systems (Cogan et al., 2024).

The literature search was conducted to identify existing research on embedded university counselling services. A systematic review, however, was not conducted as it was beyond the scope of this thesis.

A literature search was conducted in April 2024 using the following databases: APA Psych info, APA Psych articles and APA Psych extra. The following search terms were used (in addition to alternative spellings and synonyms): university students: counselling, and barriers. The initial search produced 87 papers that were in English and peer reviewed. In total 28 papers were retained, and a further 18 papers were found by checking references and citations of original papers.

The findings from the literature review have been grouped into three main sections; individual barriers, cultural barriers, and practical barriers. Individual barriers include stress, ethnicity, and gender, cultural barriers include recognising mental health distress, shame, stigma, cultural identity, and mistrust and finally practical barriers include lack of information about services, and ability to attend sessions.

Limited research has been conducted that focused on barriers to help-seeking and accessing support in the UK, particularly when focused on ethnic minority students. As a result, literature has also been included from the US and in some cases from non-student populations. It is important to acknowledge that findings from the US need to be viewed with a different lens from the UK research due to the different health systems in which universal free at source healthcare is present in the UK and not US. There are also differences in the university set ups including very large campus universities present in the US and also significant differences in the ethnic diversity of universities/colleges including the impact of the existence of historically Black colleges in the US.

1.2.2 Individual barriers

1.2.2.1 Stress

Racial discrimination has long been linked in the US to increased stress and lower wellbeing (Benner et al., 2018; Brown et al., 2000; Sellers et al., 2003) and recent studies in the UK have found that experiencing racial discrimination in the past 12 months was associated with greater psychological distress and poorer physical health (Hackett et al., 2020). Racism perpetrated against an individual can be both overt and covert (Nkansa-Dwamena & Ade-Serrano., 2023). In several longitudinal studies the cumulative effect of repeated occurrences of discrimination (which included over verbal and physical attacks) were found

to magnify the negative effect on mental health. In addition, fear of subsequent discrimination was expressed through feeling unsafe or avoiding situations. Suggesting that both knowledge of others experiencing discrimination, or previous personal experiences, can continue to have a negative impact on health (Maletta et al., 2024; Stopforth et al., 2022; Wallace et al., 2016). Experience of discrimination also extends to the university experience of ethnic minority students which adds to the minority stress and its impacts. Ethnic minority students often have to contend with additional stressors as university students including underrepresentation on campus (Crozier et al., 2016) or within their programme of study. Students have described the experience of racism on campus including navigating othering (Crozier et al., 2016), microaggressions (Olaniyan, 2021) and course materials reinforcing racial stereotypes (Stoll et al., 2022). It has been posited that these experiences of discrimination have impacted on increasing ethnic minority student stress and decline in mental health with UK students (Arday, 2018; Olaniyan, 2021; Stoll et al., 2022). These findings are supported by similar findings in the non-student population in the UK (Bignall et al., 2019; Memon et al., 2016). The majority of the research done in the UK has been qualitative, but the findings are echoed by quantitate work done in the US. In the US there is a significant body of evidence focused on students finding that discrimination increases number and severity of mental health symptoms (Hope et al., 2015; Jochman et al., 2019; Qeadan et al., 2022) and increase in suicidal thoughts, planning and attempts (Boyd et al., 2024). As university counselling services are embedded within the university organisation it is posited that students that have experienced discrimination within the university may be reluctant to seek support from the same organisation fearing further discrimination.

Another factor to consider is health based discrimination as a result of institutional racism that is perpetuated within healthcare and mental health services, which was highlighted during the Covid-19 pandemic (Oskrochi et al., 2023; Raghavan & Jones Nielson, 2021). These ethnic inequalities have been documented for over 50 years (Bansal et al., 2022; Bignall et al., 2019). This general distrust of mental health care has been found to be a factor in deterring students from mental health help seeking from university counselling services (Olaniyan, 2022). Several Black students described family members being detained under the Mental Health Act and this led them to be fearful about seeking help (in recent data release by the UK government Black people were almost four times more likely to be detained than White people (NHS England, 2024)).

Alongside external university experiences, on campus discrimination was also found to be a factor in discouraging students from seeking support from mental health services. With students disclosing that after previously attempting to seek support from university staff

about exclusionary behaviour by their peers, which was dismissed, they felt that they would be treated in a similar way if they contacted university mental health services (Olaniyan, 2022). In summary, ethnic minority stress as a result of wider structural racism, mental health inequalities and discrimination both off and on campus negatively leads to a distrust of services and negatively impacts on ethnic minority students willingness to seek help. This may also be acerbated by a lack of ethnic diversity in staff of university counselling services (Bansal et al., 2022).

1.2.2.2 Ethnicity

Data from university students suggests that ethnicity impacts on disclosure of a mental health condition on entry to university with differences reported between different ethnic groups. Lowest proportions were reported by Asian and Black students with 2% of Asian students, 2.8% of Black students, rising to 6% of White students and 6.3% of mixed ethnicity students reporting a mental health condition (Office For Students [OFS], 2023). The impact of ethnicity on numbers experiencing mental health difficulties seems to contrast with the ONS data with several studies reporting ethnic minority students experiencing poorer mental health than White students (Campbell et al., 2022), although the available data from students is limited. Many of the quantitative studies conducted in the UK focused on the student population have had small number of ethnic minority participant's (between 11 and 24% of the sample) and have not reported findings in relation to ethnicity (Broglia et al., 2021b; Cage, 2020) or have not reported ethnicity of participants (Broglia et al., 2021a). Data from the general population have found that the ethnic minority population have poorer mental health than the White British population (Bansal et al., 2022; NCCMH, 2023).

In the UK student population two quantitative studies have been conducted to focus on help seeking behaviours and attitudes. A study of help seeking behaviours in higher education (with 304 participants, 82% female) from a Midlands university in the UK (Bryant et al., 2022). Although the study was not explicitly focused on ethnic minority students, it was stated that participants were White and BAME but no breakdown of numbers of participants was given. It looked at preference for help seeking from informal and formal sources: personal tutor, university mental health service, peers, off campus services, family, and online services. The study reported ethnic differences and found that ethnic minority students were more likely to seek help from their tutors than White students. For university counselling services Black students were more likely to seek help than White students. In seeking help from family or off campus there were no significant differences between the different groups. Overall White students were more likely to seek help than Black or Asian students across the different sources of support. A British quantitative study was focused on

professional psychological help seeking among South Asian students (not specifically from university services, although all participants were students) (Soorkia et al., 2011). It was found that participants with higher identification with their ethnic identity reported more negative attitudes towards help seeking once gender had been controlled. In total 148 students were recruited (55% women and 45% men). All were born and raised in the UK and were from either Indian (41.9%), Pakistani (20.9%), Bangladeshi (6.8%) or other South Asian (30.4%) descent.

In the US, Miranda et al. (2015) found that minority students had sought help less often (53%) than White students (89%) in the past and, after initial assessment, had also sought less treatment (31 % vs 52%). This is a pattern echoed in many other studies in the US in terms of seeking help (Broman, 2012) and utilisation of counselling (Eisenberg et al., 2011; Hunt et al., 2015). It has been found to be consistent over time with findings from a Healthy Minds study from over 350,000 students at 373 college campuses between 2012 and 2021 (Lipson et al., 2022). Ethnic minority students had lower reported utilisation rates across all eight years that data was collected; utilisation rates also increased across all groups during this period. A variety of barriers to accessing support was identified. The most commonly perceived barrier across ethnicity was financial (61%), followed by not enough time (51%), would rather deal with problems on their own (48%), and not knowing if they needed treatment (47%). The four highest rated barriers had a similar proportion of ethnic minority and White students to overall number. However ethnic minority students perceived that lack of time (62%) was a more significant barrier than White students (32%). Overall, about 20% of students suggested that stigma either from family or friends was a factor but when looking at ethnic minority students alone this number rose to 28% as compared to White students at 9%. Miranda et al. (2015) recommended that flexible options for sessions should be offered to help overcome the lack of time to take part in counselling. It also recommended increasing the numbers of minority staff members and ensuring that any publicity materials include minority populations to help to overcome stigma.

Three other recent studies have focused specifically on mental health help seeking in Asian American students (Gee et al., 2020; Kim & Zane, 2016; Tang & Masicampo, 2018). Gee et al. (2020) compared Asian American and European American students and found no significant difference in utilisation of mental health support, however Asian American students reported greater general barriers. In contrast Kim and Zane (2016), and Tang and Masicampo (2018), found that American Asian students did display lower help seeking intentions than their European American counterparts. Different explanations were given for this difference in help seeking with intentions being attributed to perceived benefits of

seeking help (Kim & Zane., 2016), whereas Tang and Masicampo (2018) suggested an additional component of perceived burdensomeness. Thus, the more the student felt that they were a burden the less they were likely to seek help. In both the Kim and Zane (2016) and Gee et al. (2020) studies the samples all reported experiencing mental health distress, whereas Tang and Masicampo (2018) used a general sample of students of those with and without mental health distress. Although studies in the US have examined differences in barriers of ethnic minority students data from the UK is extremely limited and the main study stated that White and BAME student were included although no proportions were given (Bryant, 2022).

1.2.2.3 Gender

Gender differences are found in disclosure of mental health conditions on entry to university. In 2021-22 6.3% of women disclosed conditions compared to 2.3 % of men (OFS, 2023). Once at university rates of mental health conditions including anxiety and depression are consistently higher for women (Sheldon et al., 2021). Despite these lower disclosures and incidences of mental health conditions, in deaths by suicide of students in the UK between 2000 and 2017 66% were male and only 34% female (Gunnell et al., 2020). Differences are also found in attitudes towards seeking help. Amongst a group of British South Asian students there was found to be a significant difference in help seeking between gender groups. Women had significantly more positive attitudes than men with a very large effect size (Soorkia et al., 2011). Cage et al. (2020) found that men were more likely to intend to seek help than women, but they did not report if there were any gender difference in actual help seeking behaviour. Several studies have found gender differences in help seeking behaviours with female students much more likely to seek help for mental health concerns (Booth et al., 2019; Heath et al., 2017; Thorley, 2017). A scoping review was conducted with a focus on non-student male adults which reviewed the largely qualitative data from the UK and US focused on understanding male help seeking. A number of common factors were found to influence help seeking behaviours in men including the act of help seeking challenging masculine identity. Those that did seek help reported feelings of shame, fear and stigma (Shepherd et al., 2023). Research focused specifically on the student population in the UK is extremely limited, a qualitative study used focus groups to elicit attitudes around help seeking for mental health support at university, 62% of participants were from an ethnic minority background. Difficulty identifying when and how to seek help was identified as a key issue (Sagar-Ouriaghi et al., 2020). This can be explained by other studies that have found that men have much lower levels of mental health literacy than women (Rice et al., 2018; Shepherd et al., 2023).

1.2.5 Cultural Barriers

The role of cultural barriers in utilisation of university mental health help seeking has been outlined below including factors such as recognition of mental health distress, the therapeutic relationship and stigma with both international and home students.

1.2.5.1 Acculturation

Acculturation is a key consideration in cultural barriers to seeking mental health support. It is a term that describes the process of individuals or groups adjusting to cultural values of the host country (Berry & Sam, 2016). It has been found to have an impact on mental and physical health (Sam et al., 2016) and is associated with differences in mental health help seeking (Markova et al., 2020). In the UK participants with higher identification with adherence to Asian values, and cultural mistrust, all resulted in more negative attitudes towards help seeking once gender had been controlled (Soorkia et al., 2011).

1.2.5.2 Recognition of mental health distress

From the literature on international students, Lu et al. (2014), in their quantitative study of 144 Chinese speaking international students, found that 54% were experiencing significant mental health distress but of those only 9% had sought help. This could be partly explained by the fact that 65% of those surveyed were unaware of the symptoms of stress, anxiety and low mood. Therefore, they did not recognise that they were experiencing mental health distress for which they could seek help. This was supported in other studies that have also found differences in utilisation rates of international students (32%) compared to home students (49.8%) (Zhou et al., 2021). This was a very large national Healthy Minds study of 228,421 participants, which adds credibility to the findings. The authors did however find, in contrast to their hypothesis, that there was no clear data that international students had higher levels of mental health issues when compared to their domestic counterparts. Within this international group 151 different nationalities were recorded with huge variation of numbers from over 5,000 from China down to only 1 from St. Vincent and the Grenadines. The difficulty in recognising mental health difficulties or lack of mental health literacy has also been found to be a factor in ethnic minority home students in the UK (Arday, 2018; Sancho & Larkin, 2020) This extended to not being able to identify or acknowledge that the problem may be serious (Gee et al., 2020; Kim & Zane, 2016; Sancho & Larkin, 2020; Tang & Masicampo, 2018).

1.2.5.3 Cultural identity

Two qualitative studies were conducted in the UK using focus groups to elicit the views of ethnic minority students. Sancho and Larkin (2020) conducted five focus groups with three or four participants per group with a total of 17 Afro-Caribbean undergraduates (10 females and seven males, 65% were psychology students). They identified 15 critical incidents or

barriers students perceived would prevent them from accessing mental help support (not specifically from university mental health services). Of those related to culture all five focus groups identified the role of religion and other coping mechanisms to support mental health rather than accessing professional support. In addition, 80% of the groups identified a strong sense of pride in their Afro-Caribbean culture that lead to a strong sense of needing to appear strong and positive to both society in general and within the family. These findings were echoed by Arday (2018) who also employed focus groups with 32 ethnic minority students (six were Asian/Asian British, 14 were Black/Black British, nine mixed-heritage and three were Latin-American). The majority of those included were studying at White majority institutions. Each participant took part in an unstructured focus group which was then followed up with a semi-structured focus group. The study was focused on a broad topic of understanding mental health from the perspective of Black and ethnic minority students, of which barriers to accessing mental health support was identified as a component. Other culturally relevant barriers that were identified, related to their relationship with the therapist, were language and fear of not being able to express their feelings accurately in a second language (Arday, 2018; Lu et al., 2014). It was also noted by all participants that there were no obvious interpretation services available. Lack of diversity of staff has been highlighted as an issue (Sancho & Larkin, 2020) which may extend to additional languages spoken by therapist in addition to English. Lack of cultural competency displayed by therapists has also been highlighted, with students' perceived lack of cultural understanding by providers and reporting experiences of cultural naivety, insensitivity and discrimination (Arday, 2018). However, the authors noted that the results may be impacted by selection bias in the participants. As it was a qualitative focus group, those participants that volunteered may be keen to discuss their views after having a negative experience with help seeking. Similar views were also expressed in a qualitative study of 11 South Asian international students studying in the UK, in an unpublished thesis (Kainth, 2020). Participants felt that the presence of a cultural difference between themselves and a therapist would be a barrier to accessing support. There was also a strong belief that British therapists would be unable to understand their experiences as a result of these cultural differences.

1.2.5.4 Shame

Amongst international students in the UK the issue of shame was identified as a factor in help seeking. The number of international students in the UK make up about 24% of university students (HESA, 2023). Despite this there is very little research on this group in the UK. A recent qualitive study by Cogan et al. (2023) focused on mental health, disclosure and help seeking of international students at a Scottish university. In total 20 Asian international students were included in the study (10 men and 10 women). Ethnic origins included: China, India, Hong Kong, Indonesia, Iran, Saudi Arabia and Malaysia. Students

needed to be full time students and have been studying in the UK for a minimum of three months. Semi structured interviews were conducted using 11 open ended questions. The transcripts were then analysed using reflective thematic analysis. All participants expressed nervousness about disclosure of any mental health worries with others for a variety of reasons including bringing shame to themselves and their family, fear of judgement and fear of consequences (such as being sent home). Findings from an unpublished doctoral thesis that focused on attitudes of British BAME young people towards counselling found similar fears of bringing shame onto their families and community (Khan, 2021). This included a fear that being see to seek support would have a negative impact of the image of their community. Bringing shame onto the family has been a theme that is echoed in the literature from the US both with home students and international students (Gee et al., 2020; Kim & Zane, 2016; Tang & Masicampo, 2018). It could be posited that fear of disclosure would have a negative impact on help seeking.

1.2.5.5 Stigma (self, societal and in-group)

The main focus of research into students barriers to accessing support for mental health difficulties has been on stigma including self-stigma, societal stigma and in-group stigma to seeking help (Heath et al., 2017; Laidlaw et al., 2016; Levin et al., 2018). All of which have been identified as barriers to seeking support in qualitative studies with British ethnic minority students (Arday, 2018; Sancho & Larkin, 2020). Self-stigma or internalised stigma can be defined as negative attitudes towards oneself in relation to experiencing mental health difficulties and seeking help, and can often encompass shame (Clement et al., 2015). Societal stigma or public stigma is related to the attitudes others may have about mental health issues or help seeking (Komiya et al., 2000). In-group stigma is associated with a person's friend, family or cultural group (Shea et al., 2019). There are differences in the impact of different types of stigma. Several studies have concluded that self-stigma has a significant impact on reducing the incidence of both seeking information about mental health support (Lannin et al., 2016) and help-seeking behaviour (Cole & Ingram, 2020; Jennings et al., 2015; Morena et al., 2024), although this conclusion is not without its critics. In contrast to many other studies Marsh and Wilcoxon (2015) found that stigma was not a barrier to seeking help and in fact those with higher levels of stigma had higher levels of help seeking. They posited that stigma may be more important among those accessing mental health support than those who are not utilising those services. However, they did not differentiate between different types of stigma and only asked participants if they worried about what others would think.

The role of societal stigma is less clear, Jennings et al. (2017) did find a link between stigma from others and a lower incidence of seeking treatment, but it was not robust enough to be a

significant predictor of behaviour. It has been found that there is a link between societal stigma and self-stigma in university students, with public stigma being a strong predictor of self-stigma (looking at 448 US college students over three months) (Vogel et al., 2013). In Scotland, Laidlaw et al. (2016) found that there were differences in students studying in different departments. Medical students reported higher levels of public stigma in seeking support for mental health difficulties than those from four other undergraduate subjects. Kearns et al. (2015) found, in a study of Irish students, that those that identified strongly with their university had more stigma to seeking help from embedded mental health services. The findings were in contrast to the research teams' predictions.

In-group stigma has been identified as being a potential barrier to help seeking within the UK ethnic minority student population (from qualitative research using focus groups) (Arday, 2018; Khan, 2021; Sancho & Larkin, 2020). However, the study of the impact of in-group stigma has had little quantitative measurement (Shea et al., 2019). Initial findings from the development of a scale designed to measure in-group stigma found that there was no significant correlation to mental health help seeking in a study of US college students.

The implication of stigma on mental health help seeking behaviours have been explored and have been found to have an effect on both intentions to seek help and actual help seeking (in two recent studies in the UK) (Broglia et al., 2021a; Cage et al., 2020). Cage et al. (2020) used a small cross-sectional survey of 376 students comprising of 84% female, 77% White British and over 65% of the participants were from South East England (excluding London). Only 14% were international students and 90% were undergraduates. In terms of intentions of seeking help self-stigma was a significant barrier which was also reflected in actual help-seeking behaviour. Broglia et al. (2021a) carried out a larger mixed methods study of 1,956 students studying across five UK universities. Ethnicity of participants was not reported in the study although the author acknowledged that one of the limitations of the study was that female, undergraduate, heterosexual, and White students were overrepresented. They also found that students described both having stigmatising experiences and of self-stigma both impacting their help-seeking intentions and additionally created barriers to accessing support. Very few papers focused on ways to overcome stigma as a barrier to accessing support. In a small study of 284 US male students self-compassion was found to lead to lower levels of self-stigma (Heath et al., 2017). Levin et al. (2018) sought to determine if self-help would minimise stigma and increase rates of seeking help for mental health problems. They found that although self-help may have an impact, intentions were low.

In summary although the role of self and societal stigma has been implicated as a barrier to

help seeking, the data from the UK student population is largely qualitative or the quantitative data has very low numbers of ethnic minority participants or ethnicity is not stated. In-group stigma is an under reached topic across the US and UK.

1.2.4 Practical barriers

A limited amount of research has investigated practical barriers. The majority of papers that were retrieved did not have practical barriers as their main focus and were quantitative studies, apart from three qualitative papers from the UK (Broglia et al., 2021; Cage et al., 2021; Priestley et al., 2021). The quantitative papers were all from the US (Jennings et al., 2017; Marsh & Wilcoxon., 2015), Australia (Li et al., 2018; Lu et al., 2014) and Ireland (Walsh et al., 2020).

The main practical barriers identified in the US and Australian papers were related to cost of treatment and driving long distances to counselling services, neither of which are applicable to the UK (Li et al., 2018; Lu et al., 2014; Marsh & Wilcoxon, 2015). Cost was found to be a significant inversely proportional predictor of help seeking behaviour, the higher the concern around cost the lower the help seeking (Marsh & Wilcoxon, 2015), with 79% of participants rating this as a concern (Lu et al., 2014). Other barriers included difficulty in getting time off college for sessions, not enough time to look for treatment options, and not enough time to attend treatment (Jennings et al., 2017; Li et al., 2018; Lu et al., 2014; Marsh & Wilcoxon, 2015). Lack of time was rated highly as a concern with 65% of students in a study of Chinese speaking international students in Australia (Lu et al., 2014).

In the UK a number of qualitative papers were based on focus groups involving students (Priestley et al., 2020), or staff and students (Cage et al., 2021). They were focused on how to improve mental health support at university and identified perceived barriers to accessing support. Priestley et al. (2022) examined mental health support services at university and how they could be improved from a student perspective. Six student co-creation panels were held across the UK as part of Student Minds university mental health charter consultations. Each panel had between seven and 17 participants comprising of undergraduate and postgraduate students, and student union officers, both with and without lived experience of mental health difficulties and of seeking support. The panels identified a variety of practical barriers including lack of awareness of services (Baik et al., 2019; Broglia et al., 2021; Jennings et al., 2017; Li et al., 2018; Lu et al., 2014; Marsh & Wilcoxon, 2015; Priestley et al., 2020; Walsh et al., 2020). However, some students knowledge about services deterred them from seeking help, as they had concerns about the ability of the services to support

them. These concerns included worries that it was ‘thinly stretched’ and perceiving that waiting times would be long (Broglia et al., 2021a; Priestley et al., 2020). Walsh et al. (2020) also concluded, when considering student preferences on embedded counselling service design, that short waiting times was a key factor. The impact of the location of services on campus remains unclear as students had differing views on location of services which for some were described as being ‘hidden and daunting’ . This was in contrast to other participants who reported that waiting rooms in main areas of campus was a deterrent (Priestley et al., 2020). This highlights the complexities of meeting individual needs of students. Others highlighted the rigidity of session times and that physical opening hours matched standard office hours and were term time only.

University staff have also been involved in research alongside students and Cage et al. (2021) conducted a qualitative study that reported findings from a series of focus groups which looked at the needs of students during times of transition at university. One of the main considerations discussed was around mental health concerns and support from both staff and students’ perspectives. Student themes identified included: ensuring active promotion of support available, a joined up approach between different services, extension of opening hours (particularly to support those on placement), online services, and more inclusive support of mature, international, and part-time students with diverse needs. Staff themes related to mental health support included: need to support students in recognising what is ‘normal’ and at what point to seek support. This is a key issue, as highlighted by Broglia et al. (2018), that UK students wait until problems are severe to seek help rather than seeking support early on. It could be posited that part of the reasons for that delay is the difficulty in recognising when to seek help. The staff also identified the challenge of supporting a diverse student population such as mature students, international students, post graduate students, disabled students and those commuting from home. Staff also highlighted the need for mental health support information to be not just given in the fresher’s week but to be embedded in the first semester. Another key point was the need for better training for academics both in terms of mental health issues and what support is available within the university. Limitations of this study included generalisability due to the nature of the qualitative analysis and that the sample was recruited through Students Minds. Therefore, participants already had an interest in the area and staff from student services were overrepresented compared to academics. There was also no demographic information reported on participants in terms of gender, ethnicity and socioeconomics.

In summary, the existing evidence shows potential barriers that could impact on help seeking and utilisation but no evidence of how these potential barriers could be implicated in

utilisation in the UK. In addition, however, there was little, or no consideration given to any demographic differences in students which may impact barriers.

1.2.6 Summary of barriers

The review of the current literature has identified barriers which it is argued are responsible for the gap between mental health issues experienced and those seeking help. Barriers have been grouped into three main areas: individual, cultural, and practical. Individual barriers that impact on help seeking and utilisation include stress (Olaniyan, 2022), ethnicity (Bryant et al., 2022; Soorkia et al., 2011), and gender (Cage et al., 2020; Sagar-Ouriaghi et al., 2020; Soorkia et al., 2011). Cultural barriers included recognition of mental health distress, cultural identity, shame, and stigma (self, societal and in-group) (Jennings et al., 2017; Shea et al., 2019). Practical barriers identified included time (to research, to attend, off lectures) (Cage et al., 2021; Jennings et al., 2017; Li et al., 2018; Marsh & Wilcoxon, 2015) and lack of awareness of services (Baik et al., 2019; Broglia et al., 2021; Priestley et al., 2020; Walsh et al., 2020). Across all barriers there was a lack of quantitative research data from the UK focused on ethnic minority students.

1.3 Dropout rates

1.3.1 Overview

Once initial barriers to seeking help have been overcome there are still a proportion of students who do not continue with treatment after the initial assessment, with higher dropout rates among US ethnic minority students (De Haan et al., 2018; Kilmer et al., 2019; Kivlighan et al., 2019; Levy et al., 2005). Rates of dropout differed in different studies, in a comparison of Racial and Ethnic Minority (REM) and non-REM students, REM students were twice as likely to drop out than non-REM students (Kilmer et al., 2019). However, the data from international ethnic minority students remains unclear. Caldwell et al. (2024) conducted a large US quantitative study that looked specifically at Asian American and international Asian students and utilisation of university counselling centres. Participants were studying at 163 colleges in the US who were part of the Centre for Collegiate Mental Health (CCMH). From the complete dataset collected (which totalled 301,345 students) 5.4% (11,905) of participants identified as Asian American, or Asian and international. Both undergraduate and graduate international students were found to have statistically lower utilisation rates than the American students. Due to the nature of the data collected the study was not able to ascertain why there was a difference in utilisation. Despite this difference in number of sessions attended there was no difference in the proportion of scheduled sessions attended between the groups, which suggests no difference in dropout rates. This finding was echoed

in another US study of 65,293 students (3,970 of which were international students) that also did not find any difference in drop out between the two groups (Bartholomew, 2022). This is in contrast to another study which found that international students were more likely to drop out (Keum et al., 2021) where drop out was measured by if they did not attend the final session.

In the UK there is very limited research on drop out from university counselling services and therefore no statistics to report on percentage dropout. There is some qualitative data, but Broglia (2021a) reported that “a small group of students describe dropping out of counselling if they felt that it was no longer needed or wanted to handle problems alone” (no ethnicity reported). There has been limited research which has explored the reasons for this difference. In the US Anderson et al. (2019) conducted a national study where participants were eligible if they were over 21 years, US residents and has previously had outpatients’ therapy as an adult. Some participants were college students. Despite this broad eligibility only 475 responses were received and only 278 were accepted. Environmental obstacles were given as a key factor (36%) which is supported by the findings on utilisation discussed above with practical barriers identified as a key barrier to seeking and utilising support (Broglia et al., 2021a; Cage et al., 2021; Jennings et al., 2017; Li et al., 2018; Lu et al., 2014; Marsh & Wilcoxon, 2015; Priestley et al., 2020; Walsh et al., 2020). Further reasons were given for premature termination of therapy: dissatisfaction with therapy (30.6%); unmotivated for therapy (15.3%) and problem improvement (13.4%). As this was a quantitative study and participants were given a list of options to choose from there was no scope to understand why participants were unsatisfied or unmotivated with therapy and if their relationship with their therapist was a factor.

The role of the therapeutic relationship in dropout has been identified and explored in literature in the UK and US. In the UK Stoll et al. (2022) carried out a review and thematic synthesis of articles published on Black students at UK universities focused on mental health and mental wellbeing. Of the 12 studies that were included four were unpublished dissertations or doctoral theses. This has been included here as a result of the paucity of UK studies. Hayford, 2019 (unpublished data), in a study of six Black students, found that students who did overcome barriers to engage with services, reported that their relationship with White therapists was impacted by experiencing racialised stereotypes, suggesting that their therapists were not displaying cultural competency. However, no data was included on if this led to drop out from the service. The therapeutic relationship has been found to play a significant role in drop out. In studies that have looked at the differences in drop out between different therapists, different rates of dropout between ethnic minority and White clients have

been found (Kivlighan et al., 2019; Owen et al., 2012). In the US, De Haan et al. (2018) posited that ethnic mismatch between therapist and client could be a factor as well as the importance of culturally competent therapists. This is supported by the findings in a study of Asian America students and counsellors (Chinese, Vietnamese and Korean heritage) where it was found that matching of language and ethnicity predicted both successful completion of sessions and number of treatment sessions (Presley et al., 2018). A recent study in the UK found that the issue of ethnic matching and cultural competency was not as straight forward. Olaniyan et al. (2022) conducted a qualitative study using semi structured interviews with 48 REM students from two British universities. In total 62% were women and 67% from a Black British background and 33 % from a South Asian-British background. The work was focused on exploring REM student views of what culturally appropriate support means and approaches they felt would promote help seeking. The findings suggested a nuanced and complex picture. In terms of ethnic matching of client and therapist most thought that would be a good place to start reform of provision, but some felt that it enabled a lack of accountability of White practitioners to engage with REM students. Other students, particularly those from a South Asian background, felt that ethic matching was a negative approach as the therapist concerned may bring potential of shame and judgement from the wider community. The student views on culturally focused services are again nuanced but the capacity to engage culturally was important and to ensure that students were treated as individuals.

In summary, although data from the US has suggested that there are differences in dropout rates from university counselling between ethnic minority and White students there is no quantitative data in the UK to the author's knowledge. It also remains unclear as to the impact of ethnic matching of client and therapist.

1.4 Theoretical frameworks to explain mental health help seeking.

Rickwood and Thomas (2012) conducted a review of models used in studies focused on help seeking for mental health problems. They found that the large majority of studies (81%) did not use a conceptual framework as a basis for the study. Their findings are in line with the studies described above where the majority do not include a framework and those that do include the Health Belief Model (HBM) (Rosenstock, 1966) and several have developed their own using the Theory of Planned Behaviour (TPB) (Ajzen, 1991) as a basis. For the basis of this study frameworks have been considered that have been developed specifically with students in mind.

1.4.1 Theory of Planned Behaviour

Several studies considered in this review of the literature considered their findings in the context of TPB, but these studies were not focused explicitly on ethnic minority students (Li et al., 2018) and UK Cage et al. (2020) and Cage et al. (2021). Those that were focused on more diverse populations used TPB as a basis for the development of their own models. Shea et al. (2019) incorporated TPB to develop the Barriers to Seeking Mental Health Counselling Scale (used in this study) and Kim and Lee (2014) used the Intrapersonal-Interpersonal framework to develop the College Students' Barriers to Seeking Mental Health Counselling Scale (used in this current study).

1.4.2 Health Belief Model

The HBM was originally published in (Rosenstock, 1966) and then revised in (Rosenstock, Strecher & Becker,1988) to add in self-efficacy. See fig. 1.

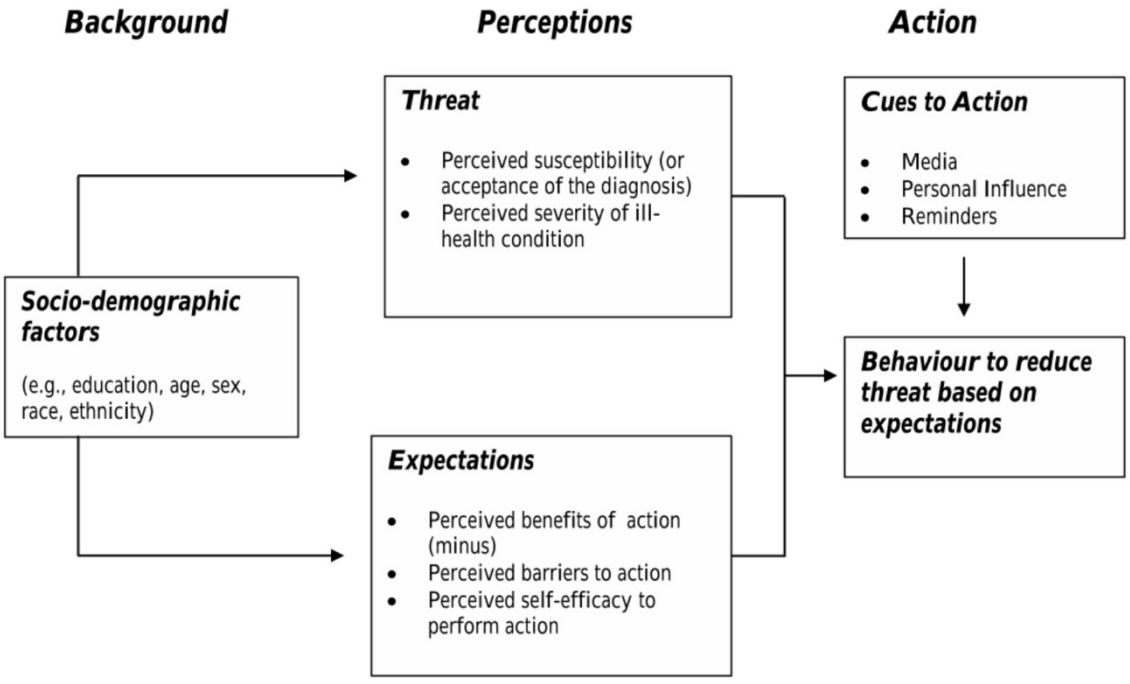

Figure 1.1 HMB from Taylor et al. (2006) adapted from Rosenstock et al. (1994).

Henshaw and Freedman-Doan (2009) applied the heath belief model as a tool for "conceptualizing mental health care utilization". Unlike the TPB the HBM explicitly considers the socio cultural factors, including ethnicity, as impacting on threat expectations and

therefore help seeking behaviours. It has been applied to several studies on the mental health of students of diverse ethnicities (Bird et al., 2020; Langley et al., 2018; Langley et al., 2021, Nobiling & Maykrantz, 2017; Panicker et al., 2023) and specifically focused on barriers to help seeking included in this review of the literature (Kim & Lee 2022; Kim & Zane, 2016; Morena et al., 2024).

The model that has been chosen for this research to focus on is the HBM, as it specifically acknowledges ethnicity as a factor in potential benefits and barriers. It has also been used specifically with ethnic minority student participants (Kim & Zane, 2016). It was the model that was most used in the literature reviewed above in studies focused on ethnic minority students.

The HBM is comprised of three main stages background, perceptions and action. Each stage will be outlined and linked to the current study. The first stage “background” encompasses any individual sociodemographic factors that pertain to the individual including education (in this case all university education individuals), age, ethnicity gender etc. These barriers were conceptualised as individual barriers in the current study and discussed in section 1.2.2.

The second stage in the model is “perceptions”, which include threat and expectations. Threat has two components: perceived susceptibility and perceived severity. Perceived susceptibility links into recognition of mental health distress discussed in section1.2.5.2. Literature suggests that international and home students from ethnic minority backgrounds had difficulty recognising symptoms of mental health distress (Arday, 2018; Lu et al., 2014; Sancho & Larkin, 2020) and also not acknowledging that that problem was serious (Gee et al., 2020; Kim & Zane, 2016; Sancho & Larkin, 2020; Tang & Mascicampo, 2018). This was a factor in not seeking support. Perceived severity of ill health condition this is related to, in this case, students understanding of the consequences of poor mental health and the related impact on ability to study and ultimately on academic achievement. This is linked to the students level of mental health literacy. The second component of perceptions is expectations which is composed of perceived benefits to action, perceived barriers to action and perceived self- efficacy. In relation to the current study perceived benefit of action relates to students perceived benefit of seeking support and receiving counselling sessions. Perceived barrier to action encompasses cultural and practical barriers as described in section 1.2.4 and section 1.2.5. Finally perceived self-efficacy the belief that students will be able to contact the service and attend sessions.

The final stage in the HBM is “action”, which is divided into two components; cues to action and behaviour to reduce threat based on expectations. In relation to seeking support from

university counselling services. Cues to action would include advertising of services on campus, personal influence from friends or family and reminders from the administration team of the service via email or text communication once signed up. The final component of the HBM is “behaviour to reduce threat based on expectations”. In the context of this study this refers to a student’s behaviour to contact and attend sessions at the university counselling service. The HBM can then be used as a framework for the literature presented to predict that ethnic minority students would have lower rates of help seeking based on the “Background”, “Perception” and “Action” factors.

1.5 Rationale for this study

1.5.1 Research summary and aims.

It can be seen from the existing literature that there are three types of barrier to receiving help from embedded university counselling services. Individual barriers to help seeking (stress, ethnicity, and gender), cultural barriers (including recognition of mental health distress, cultural identity, shame and stigma), and practical barriers (including time) to receiving initial help. If these barriers are overcome and a student has contacted the service and received an initial assessment there are then barriers to continuing to receive help which led to drop out. Limited research has been done in this area in the UK, and the studies that have been conducted have largely been quantitative where the majority of participants have been White women. Therefore, this research aims to focus on ethnic minority students in the UK (specifically London) including both home and international students. The majority of the studies cited above are from the US which are difficult to generalise to the UK setting for a number of reasons including that treatment in the US has a cost attached (unlike the UK). In addition, there are several concepts in relation to help seeking that have been understudied in the UK including ingroup stigma and dropout from services.

The aim of this research is to explore the incidence and severity of mental health difficulties and the utilisation of embedded university health services by ethnic minority students, and to understand the barriers to initially accessing support and then attending counselling sessions.

1.5.2 Research Questions

Based on the Health Belief Model it is predicted that ethnic minority students will have lower utilisation and higher dropout rates than their White peers. In the context of this research help seeking has been defined as students who have contacting university counselling services to request an initial assessment. Utilisation of counselling services has been

defined in terms of attendance at initial assessment session and subsequent sessions.

Quantitative research strand

Comprised of information from the online survey

Hypothesis 1. There will be a significant difference in severity of mental health distress between ethnic minority and White students.

Hypothesis 1.1 Ethnic minority students have higher rates of mental health difficulties than White students.

Hypothesis 2. There will be a significant difference in utilisation rates between ethnic minority and White students.

Hypothesis 2.1 Ethnic Minority students have lower rates of actual help seeking.

Hypothesis 2.2 Ethnic minority students have lower utilisation of counselling services.

Hypothesis 3. There will be significant differences in drop put rates between ethnic minority and White students.

Hypothesis 3.1 Ethnic minority students have higher dropout rates than White students after assessment.

Hypothesis 4. There will be significant differences in barriers faced by ethnic minority students to help seeking from embedded university mental health services.

Hypothesis 4.1 Ethnic minority students will face higher levels of individual and cultural barriers than White students.

Hypothesis 4.2 Ethnic minority students will face higher levels of practical barriers than White students.

Qualitative research strand

Comprised of information from open ended questions in the survey and semi-structured interviews.

The main exploratory research questions for this component are:

What factors impacted on ethnic minority students' decision to drop out from therapy after attending an initial session?

Mixed methods research question

To what extent, and in what ways, do the open ended survey questions and the qualitative

interviews help to explain the quantitative results on utilisation, barriers, and drop out.

Chapter 2 Methodology

2.1 Overview

This chapter includes a methodological outline, theoretical stance, and reflexivity, followed by a detailed description of the mixed methods approach taken and, finally, a consideration of the ethical components of the study.

2.2 Theoretical stance of researcher and methodology

All research studies are underpinned by a viewpoint that will shape the research. The starting point may be the views and questions of the researcher that will then feed into the methodological approach and the data collection and analysis. These philosophical beliefs or assumptions can also be described as the paradigm or worldview. My worldview is compatible with a pragmatic worldview (Dewey, 1920), with the idea of a problem centred, pluralistic and with a real-world practice orientation. This relates strongly to the focus of this research in that it is proposed that there is a problem that needs to be solved with students not accessing support for their mental health when it is needed. This worldview fits well with a mixed methods approach, in particular the idea of taking a pluralistic standpoint to data collection using both quantitative and qualitative data (Creswell & Plano Clark, 2018). It is able to recognise the strength of combining methods in this way. It is a commonly used approach when employing mixed methods (Tashakkori & Teddlie, 2003). The central point is the idea that helpful knowledge will be produced, which aligns with the aims of this research (Yardley & Bishop, 2017). In terms of ontology the chosen approach is critical realism, which is able to acknowledge the subjective nature of knowledge production (Willig, 2013). In the case of research, you are able to access your participants' reality that has been shaped by their environment, for example their cultural context which will shape their perception of their reality (Braun & Clarke, 2022). It proposes that rather than there being multiple realities, reality can be understood in multiple ways. This is an approach that can be, and is increasingly, used in mixed methods research (Mittapalli & Maxwell, 2010). Epistemology can be understood as the nature of knowledge and knowledge production. Positivism was dominant in the field of social science which assumed that there was a real world out there that could be measured. This approach assumes that the aim is to produce objective knowledge where a researcher can investigate a topic without having an influence on the findings (Willig, 2013). The development of this approach is post-positivism which is now the dominant approach, and the epistemological stance taken in this research. It continues to

have a goal of objective knowledge but acknowledges that the researcher's own culture, and values will influence the work to some degree (Braun & Clarke, 2022).

2.3 Rationale for choosing mixed methods approach.

Research conducted via a mixed methods approach combines quantitative and qualitative research techniques into a single study (Burke Johnson & Onwuegbuzie, 2004). Quantitative research has the ability to test hypotheses and the potential to work with large sample sizes which enables generalisability. It can be argued that it lacks the context of the participants' lived experience (Cresswell & Clark, 2018). Whereas qualitative research has the capacity to provide a richer and contextual understanding of the topic (Willig, 2013). By employing a mixed methods approach in this study and combining quantitative and qualitative approaches it is hoped to overcome the weaknesses and combine the strengths of the two approaches (Jick, 1979). In this study there are two reasons that a mixed methods approach will be beneficial as a result of providing complementarity and development (Green, Caracelli & Graham, 1989). Complementarity means that in this case the quantitative component alone will not be sufficient to understand the reasons for students to drop out after assessment. There is very little data on this in the UK and as a result a qualitative approach will be needed to enhance and explain the findings from quantitative stage. Development refers to the fact that the data from strand one will be used to inform strand two, in particular to identify areas that need further exploration. This information was then used to inform the interview schedule. Consequently, the chosen methodology is a mixed methods approach which includes a survey for the quantitative component and semi structured interview in addition to several open-ended survey questions that are included at the end of the survey, for the qualitative component.

2.4 Research design

In order to address the research hypotheses and questions outlined in chapter one, a mixed methods approach has been chosen. The study was conducted following a sequential explanatory approach with two sets of data (Johnson & Onwuegbuzie, 2004). Using a notation system for mixed methods research, the design can be summarised as QUAN (qual) → qual (Cresswell et al., 2003). Priority is indicated by upper case letters and the bracket indicate that the first qualitative component is concurrent with the quantitative component. The first and main component of the study was the quantitative strand with data being obtained via an online survey. Embedded within the survey was also the first qualitative data collection in the form of open ended questions,which were used to

allow participants to amplify views already captured by the questionnaires or to express views that were not captured by these.. The answers to the open-ended survey questions were also used to construct an interview schedule. These semi-structured interviews were conducted to generate the second qualitative data set. The purpose of the interview data was to explain the quantitative findings in more detail and to allow issues to be explored in more depth. In particular it was focused specifically on ethnic minority students' experiences of attending an assessment but not completing sessions offered. The focus was on ethnic minority students only as a result of minimal exploration of these issues in the literature. The quantitative survey captured numbers of students that dropped out but not the reasons behind that decision.

An important consideration from the outset of the study was how to integrate the data from the different strands, an aspect not always given sufficient importance in mixed methods research (Bryman et al., 2008). Figure 2.1 below shows the two different strands of the study and their respective points of integration. In common with many mixed methods studies the main point of connection and integration occurs at the data interpretation stage and discussion (Hansen et al, 2005). Figure 2.2 below shows the inclusion criteria and participation numbers for each strand of the research. A concurrent triangulation design was also considered but was discounted as that would have meant that the survey and interview would have been conducted in parallel, and it would not have allowed the survey findings to inform, and therefore help to explain, the findings.

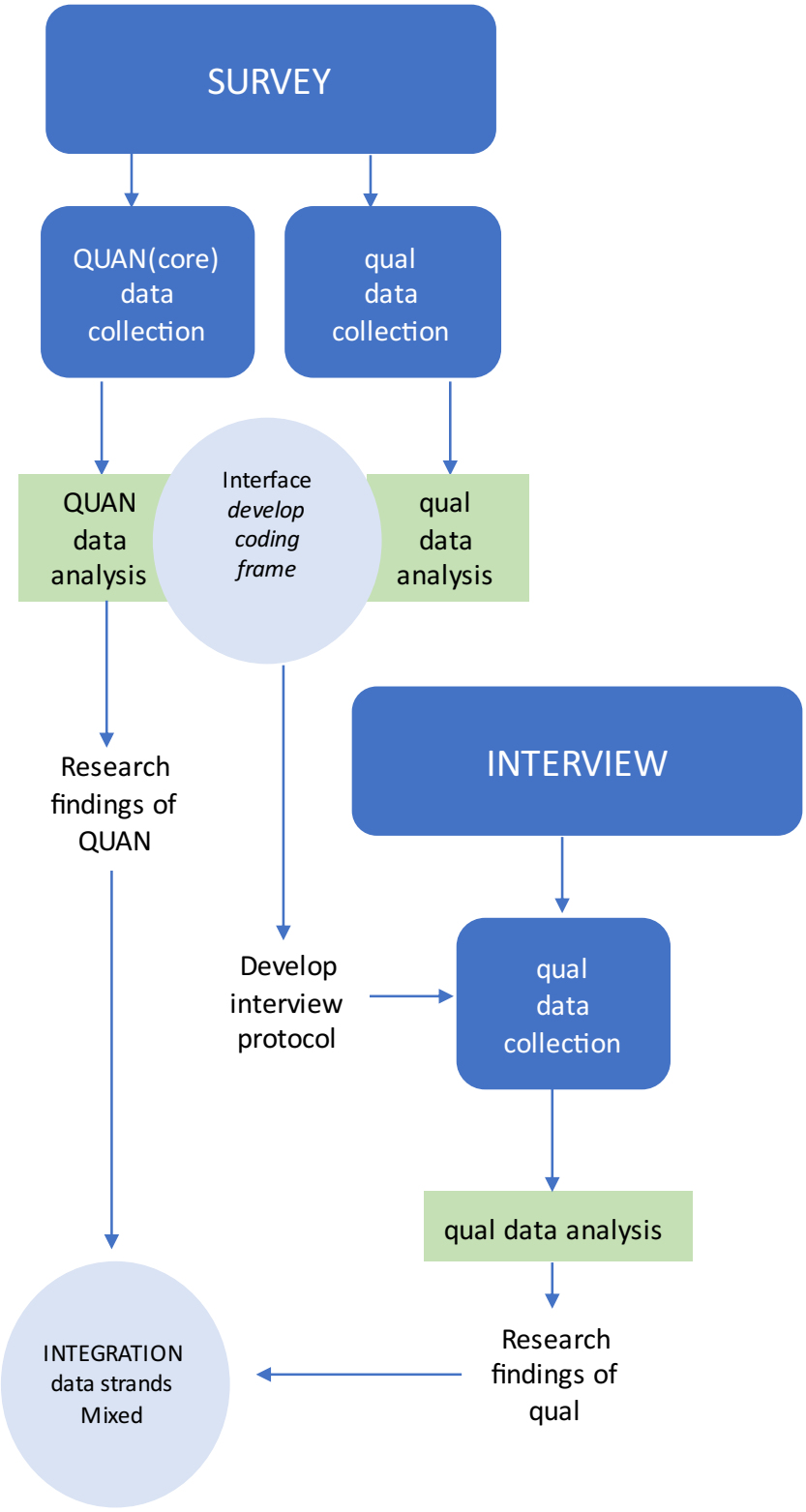

Figure 2.1 Connection of the data strands

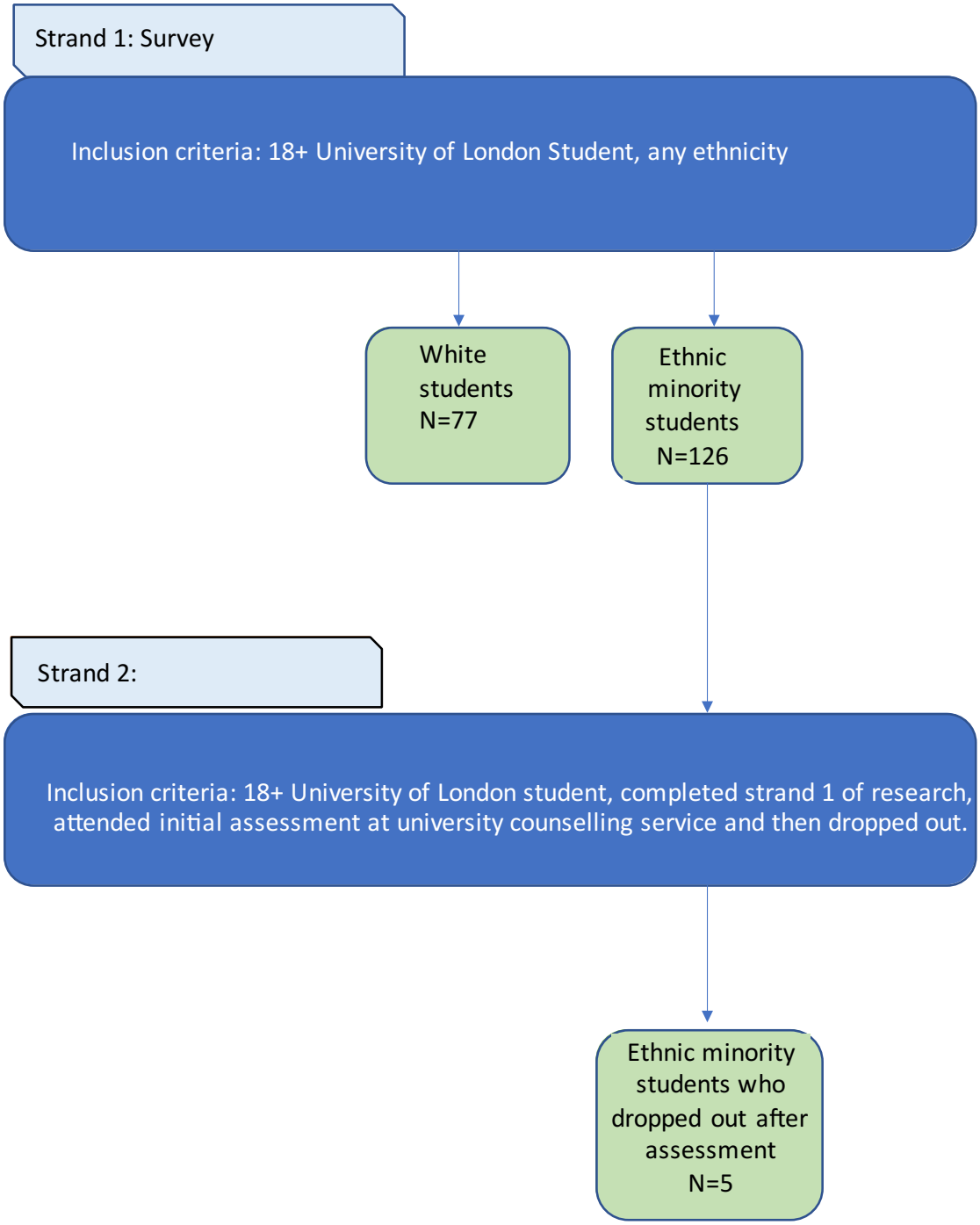

Figure 2.2 Sample Inclusion

2.5 Ethical considerations

All components of this research have met the BPS code of human research ethics (BPS, 2021) and City University ethical guidelines. Data collection only commenced once the research proposal had been approved by City University's Ethics Committee, approval number ETH2122-1642, a further two amendments were made ETH2223-1354 and

ETH2324-0346 (Appendix A). The first was to include a prize draw as an incentive for survey participants and the second to gain permission to advertise the interviews directly and to pay interview participants.

2.5.1 Informed Consent

Informed consent was gained from all quantitative participants online before the research began. They were directed to a participant information sheet (Appendix B) which included: an outline of the purpose of the study, what was involved, how their information would be used and how their data would be protected. This was followed by a consent form (Appendix C). Only after participants had read and completed the consent form could they progress to complete the survey. Participants who were recruited for the interview stage were then emailed an additional participant information sheet (Appendix D) and consent form (Appendix E) specific to the interview.

2.5.2 Participation incentives

Both a prize draw and payment for interviews have been utilised in this research. Initially a prize draw only was used. This is a common technique used in surveys with a student population and it has been found that prize draw incentives have a positive impact on recruitment and completion of online surveys (Laguilles et al., 2011). After difficulties in interview recruitment were experienced, participants were offered a guaranteed £15 amazon voucher for participation which was emailed to participants on completion of the interview. This method has been used successfully with university students (Dykema et al., 2024). The BPS code of human ethics identifies some potential issues with using such incentives, including that such a prize draw may be seen to encourage or endorse gambling (British Psychological Society, 2021), but this has been minimised by using modest prize values to minimise the risk of coercion. It also highlights that payment should be in proportion to participation. In this case the decision of the payment value was taken in conjunction with the ethics committee to ensure that the payment for participants to be in proportion to the time burden of the interview.

2.5.3 Confidentiality

Confidentiality was maintained at all times during the research. The interview was audio recorded, therefore only the researcher had knowledge of the participants identity. The recording was downloaded directly after the interview to the researchers OneDrive storage, which is password protected. All data used in the research has been anonymised, including direct quotes. This research has met the BPS ethics guidelines for internet-mediated

research (BPS, 2013). In particular it has ensured that the issue of social responsibility is taken seriously, and any information published on internet forums was appropriate. All data has been protected and stored in compliance with the General Data Protection Regulation (GDPR). The data has only been used for purposes for which consent has been obtained. No personal identifying information from the questionnaires or interviewees has been used in the study. Only the research team has access to the data and all data will be deleted after 10 years. This information was communicated to the participants via the participant information sheet.

2.5.4 Conflict of Interest

An important consideration was that during the initial recruitment stage of the research I had a dual role in one of the institutions included in the study as I was on placement as a trainee counselling psychologist in the university counselling service. There was a possibility that a student that had been a client of mine may have been eligible for the interview stage. Although this was unlikely, this was considered in advance and it was decided that it would not have been appropriate to include them in the study. This situation did not arise.

2.5.5 Emotional Distress

If participants were to become distressed after taking part in the questionnaire or the interview then a participant debrief form was provided at the end of participation (Appendix O), which included links to support for any issues that have been raised during participation in the research. Participants had the option to withdraw from the research at any stage up to data analysis. If they were to become distressed during the questionnaire they were able to stop at any stage. There were several potentially sensitive questions contained within the questionnaire. For example, in the CCAPS-34 Q 25 “I have thoughts of ending my life”. If a participant answered yes to that question then the questionnaire was set up to move immediately to a page detailing support and my contact details. They would then have the option to continue with the survey if they wished. No students answered yes to this question, and I was not contacted by anyone distressed by participation.

2.6 Strand one – Quantitative methodology

QUAN (qual)

Strand one was composed of an online survey which was completed online via Qualtrics. It was primarily quantitative with several open-ended qualitative questions. The first section of

the questionnaire was a series of demographic questions including gender, age, ethnicity, current academic level, international or home student. There was then a series of scales to assess barriers to help seeking and finally questions to assess actual help seeking from the university counselling centre and drop out. Students that had dropped out were then invited to participate in the interview stage.

2.6.1 Sampling

This study utilised volunteer sampling via a study advert disseminated via a variety of routes. All of the individual institutions of University of London were contacted via student union reps including student union societies for ethnic minority students. The project was advertised via SMaRteN social media channels and advertised via KCL research participation circular.
A poster (Appendix F) advertising the study was displayed at City, University of London and King's College London. It was also disseminated via department heads at City and through the Sona scheme. Students were incentivised to take part in the study by being offered the chance to enter a prize draw to win Amazon vouchers. There were 17 prizes in total available: one £100, two £50, four £25 and ten £15.

2.6.2 Sample size

The aim was to recruit 398 students to stage one of the research. This was calculated using a G*power 3.1 calculation assuming a small effect size of d- 0.2 and a medium effect size of 0.25 for a t-test, for hypothesis 1.1.

2.6.3 Sample inclusion and exclusion

Inclusion criteria were that participants were over 18,currently enrolled at a University of London (UoL) institution (Appendix G) and from any ethnicity. The rationale for recruiting from UoL students was grounded in the fact that the London universities have a high proportion of ethnic minority students. The proportion of ethnic minority students enrolled at UoL institutions is 52% compared to 27% across the UK in 2021/22 (HESA, 2021). Previous quantitative studies in the UK had recruited small numbers of ethnic minority students (Broglia 2021b; Cage 2020) it was hoped that by recruiting from UoL students with a higher proportion of ethnic minority students this would increase the participation. In addition, in order to maximise the number of participants the decision was taken to include students from all ethnicities.

2.6.4 Participants

Category	Subcategory	N	%
Gender	Female	172	84.7
	Male	26	12.8
	Other	5	2.5
Student status	Home	156	76.8
	International	47	23.2
Student level	Undergraduate	151	75
	Postgraduate	52	25
Ethnicity	White	77	37.9
	Ethnic minority	126	62.1
	Asian	72	35.5
	Black	14	6.9
	Mixed	17	8.4
	Other	23	11.3

Table 2.1 Demographic details

2.6.5 Study Measures

The survey was comprised of the following sections and measures.

Demographic Questionnaire

There were five questions to ascertain the demographics of each participant including gender (male, female, non-binary or other), age (open text box), ethnicity (Asian or Asian British; Black, Black British, Caribbean, or African; Mixed or multiple ethnic groups; White; or Other ethnic group), level of study (undergraduate or postgraduate), and student status (home or international) (Appendix H).

Stigma Scale for Receiving Psychological Help

The Stigma Scale for Receiving Psychological Help (SSRPH) (Komiya et al., 2000) was developed to measure public stigma to help seeking with undergraduate students in the US. This scale is composed of 5 statements which the participants rated on a scale from 0 (strongly disagree) to 3 (strongly agree), for example ‘It is a sign of personal weakness of inadequacy to see a psychologist for emotional or interpersonal problems. Scores for all items are summed with scores ranging from 0-15 and higher scores reflecting higher levels of stigma for receiving help. Internal consistency was good (0.72) with the original

participants of Komiya et al.. (Appendix I).

Self-Stigma for Seeking Help Scale

The Self-stigma for Seeking Help Scale (SSSH) (Vogel et al., 2006) was developed to measure internalised social stigmas in relation to help seeking. This scale comprises of 10 statements which are rated from 1(strongly disagree) to 5 (strongly agree), for example 'If I went to a therapist, I would feel less satisfied about myself'. Internal consistency was very good (0.83). Sum scores were used, and five items were reverse scored, scores range from 10-50, higher scores indicating higher levels of self-stigma for seeking help. It has been used with university students (Kearns et al., 2015; Jenning et al., 2017) and has been found to have validity in a cross-cultural context (Vogel et al 2013) and racial and ethnic minority students (Cheng et al., 2013) (Appendix J).

Barriers to Seeking Mental Health Counseling and Depression

The Barriers to seeking Mental Health Counseling and depression (BMHC) (Shea et al., 2019) assesses perceived help seeking barriers in university students. It is a 27-point scale in which each statement is rated on a 6 point scale from 1 (strongly disagree) to 6 (strongly agree). An example is "I perceive that most mental health counsellors would not be sensitive to issues related to my cultural identity". The six subscales are Negative Perceived Value, In-group Stigma, Discomfort with Emotions, Lack of Knowledge, Lack of Access and Cultural Barriers. Sum scores were used with possible scores between 27 and 162. It has a very good average internal consistency (0.84) across the 6 subscales, and it was developed with university students in the US based at a Latino majority college (Appendix K).

Counseling Centre Assessment of Psychological Symptoms-34

The Counseling Centre Assessment of Psychological Symptoms-34 (CCAPS 34) (Locke et al., 2012) was developed as a clinical tool in university counselling centres to measure psychological distress in the student population. This is a short version of the Counseling Centre Assessment of Psychological Symptoms-62 (CCAPS 62) (Locke et al., 2011). This is a 34-point scale that measures psychological symptoms across seven subscales each item is rated using a 5-point Likert scale (4 = extremely like me, 0 = not at all like me). The seven subscales are Depression, Eating concerns, Substance Use, Generalized Anxiety, Hostility, Social Anxiety and Academic Distress. Example items are "I feel isolated and alone", "I drink more than I should" and "I have spells of terror and panic". Scoring was done by adding (two items are reverse scored) and averaging scores for each subscale, higher scores on each subscale reflect higher severity of distress. Each subscale has 2 cut-off points that divide scale scores into low, medium and high levels of distress. This questionnaire was developed

for use with university students in the US and has also been used with UK students (Broglia et al., 2021) (Appendix L).

Beliefs Toward Mental Illness Scale

The Beliefs toward Mental Illness scale (BMI) (Hirai & Clum, 2000) was designed to measure cross-cultural differences in beliefs around mental illness. This is a 21-item scale with three subscales that focus on: dangerousness, poor social and interpersonal skills, and incurability. Each item was rated on a 6-point Likert scale from (5 = completely agree to 0 = completely disagree). Sum scoring was used with possible scores from 0-105, higher scores indicate higher levels of stigma towards mental health disorders. High internal consistency was found with both Asian (0.91) and American (0.89) students. Items include “A mentally ill person is more likely to harm others than a normal person” and “I would be embarrassed if a person in my family became mentally ill” (Appendix M).

Mental Health Experience of Support

This final section of the survey included seven closed questions to determine help seeking from university counselling services, utilisation and drop out, and an invitation to take part in strand 2 of the research (if eligible) (Appendix N). Three answers gave the option of a free text box to give participants an opportunity to explain their reasons for not attending an assessment when offered, attending sessions if offered and finally reasons for drop out before completing sessions.

2.6.6 Procedure

Once students had accessed the Qualtrics (https://www.qualtrics.com) survey via the QR code or link in the research advert they were directed to the participant information sheet (Appendix D), outlining what the study involved and the inclusion criteria. Participants then had to complete a consent form (Appendix E) to confirm that they met the inclusion criteria and consented to participation and the data conditions. Subsequently they completed the survey which took approximately 20 minutes to complete. On completion of the survey, they were directed to a debrief page (Appendix O), where they then had the opportunity to enter a voucher prize draw.

2.6.7 Data analysis procedure

The Qualtrics data collected from the surveys was exported to IBM SPSS Version 29 for Mac and all analyses were conducted using this software. The data was screened and cleaned; the initial 312 responses were reduced to 203 data sets. There were 66 incomplete data sets where participants had only completed the consent form and initial demographics

and then not completed the survey. The questions were set up with forced entry so those that completed the survey did not have any missing entries. Midway through the survey there was a test question included to ensure that participants were not clicking through the survey without reading the questions to reach the prize draw entry page. “We use this question to see if respondents are reading the questions. Please choose Moderately Agree”. Thirty-five participants did not answer this question correctly and therefore their data was removed. Data from 203 participants could be included in the analysis dataset. Initial analyses of the demographic characteristics were conducted.

2.6.8 Demographic analyses

Initial demographic analyses were conducted on the two groups, White and ethnic minority students, using t-tests and Chi-squared tests. The student status (home or international) of the two groups did not differ significantly, $\chi^2(1, n = 203) = 1.302$, $p = .254$, *phi* = .092. The level of study (undergraduate or postgraduate) was significantly different between the two groups with a higher proportion of ethnic minority students (n = 101, 80.2%) that were undergraduates than White students (n = 50, 64.9%), χ^2 (1, $n = 203$) = 5.042, $p = .025$, *phi* = -.169, with a small effect size. The group of ethnic minority students (M= 21.89, SD=5.864) were significantly younger than the group of White students (M=24.91, 8.67; t(203)=<.001, p=.008, two tailed). The effect size was medium with Cohen’s effect d=.428. The gender distribution of the two groups did not significantly differ (χ^2 (1, n=203)=8.348, p=.080, phi=.203).

2.6.9 Assessing for normality

The data from all of the scales was assessed for normality by inspecting the data using the following measures: skewness and kurtosis values, Kolmogorov-Smirnov test, histograms, detrended normal Q-Q plots, and finally a boxplot. Two outliers were identified from the box plots. One outlier was identified in the self-stigma scale for seeking help. On inspection the outlier score of 42 appeared genuine as it was within possible score (10-50) for the self-stigma scale. To assess the impact of the outlier the 5% trimmed mean was inspected, and it did not have a strong influence on the mean, removing the top and bottom 5% reduces mean from 23.53 to 23.41. There is only a difference of 0.08 therefore the data point was not changed or removed (Pallant, 2016). The second outlier was found in the barriers to seeking mental health counselling scale with a score of 123 which was well within possible scores of the barriers to seeking help score (27-162), so the score is genuine. To assess the impact of the outlier the 5% trimmed mean was inspected and showed the outlier had not had a strong influence on the mean. Removing the top and bottom 5% reduced the mean from 77.99 to

78.05, it made a very small difference of 0.06 therefore the outlier was not removed or changed. If either outlier had made a significant difference to the results then it would have been windsorized (rescored to the next lower value). All data was found to meet assumptions of normality and therefore parametric tests were used in the analysis (further details of the normality testing can be found in Appendix P).

2.6.10 Analytic tests

A series of analyses were conducted using ANCOVAs, Chi-squared tests, Fisher's exact test, Pearson correlation and Logistic regression. The details of each hypothesis with study measure and analytic test used are shown below in table 2.1. ANCOVAs were conducted to compare the two groups of participants (White and ethnic minority students) across all continuous scales. An ANCOVA was used rather than t-tests as it was able to control for any confounding factors, in this case age (Field, 2013). In addition, a chi-squared test was used to compare the categorical data. The qualitative data obtained from the mental health experience of support open-ended questions were analysed using the same procedure as the interviews and is described in detail in section 2.7.

Hypothesis	Study measure	Analytic test
1.1 Ethnic minority students have higher rates of mental health difficulties than White students.	CCAPS-34 CCAPS-34 clinical cut offs	ANCOVA Chi-squared test
2.1 Ethnic Minority students have lower rates of actual help seeking.	Mental health experience of support: contacted service, offered assessment.	Chi-squared test
2.2 Ethnic minority students have lower utilisation of counselling services.	Mental health experience of support: attended first session, attended subsequent sessions.	Chi-squared test
3 Ethnic minority students have higher dropout rates than White students after assessment.	Mental health experience of support: drop out after assessment, drop out after starting sessions and total drop out.	Chi-squared test and Fisher's exact test.
4.1 Ethnic minority students will face higher levels of individual	Stigma scale Self-stigma scale	ANCOVA

barriers than White students.	Barriers to seeking help scale (negative perceived value, ingroup stigma, discomfort with emotion, cultural values) Beliefs about mental illness scale.	
4.2 Ethnic minority students will face higher levels of practical barriers than White students.	Barriers to seeking help scale (lack of knowledge and lack of access).	ANCOVA
Post hoc analyses within ethnic minority group.	Barriers to seeking help scale (in-group stigma) and contacted service.	Pearsons correlation
	Student status (home or international), stigma scale , self-stigma scale ,barriers to seeking help scale (ingroup stigma, negative perceived values and cultural values) and CCAPS-32 (distress index).	Logistic regression

Table 2.2 Showing each hypothesis with corresponding study measures and analytic test used

Before analyses were conducted the data was assessed to check it met the assumptions required for each test. For an ANCOVA the following assumptions were tested and in all cases met; covariates should not be highly correlated, residuals should be normally distributed, and homogeneity of variance. Scatter plots for each scale are included in Appendix Q. For Chi-squared the following assumptions were checked; two categorical variables, with two or more categories, and a minimum expected frequency of five for 80% of the data. All data met the first assumption and in several cases a minimum frequency was not met and in those cases a Fisher's exact test was used instead.

The analyses were slightly underpowered as a result of only 203 participants, rather than 398 for the expected effect sizes. As a result, some effects may have failed to reach significance. In addition, low power may increase the risk for false positive (Christley, 2010).

2.7 Strand 2 – Qualitative methodology

In total 11 respondents provided qualitative data from the three open-ended survey questions in the mental health experience of support section at the end of the survey. These written responses were then followed up with five semi-structured interviews. The survey data was analysed using thematic analysis (Braun & Clarke, 2006). This analysis, in addition to data from the literature, was then used to produce an initial template for coding the data and producing initial themes. Newly emerging themes were then integrated when they arose. The qualitative interview data was analysed in the same way as the survey qualitative data. The analysis will be presented in the next chapter as a thematic map with quotes to highlight the themes and sub themes. A detailed description of the thematic analysis process will be given in section 2.7.4.

2.7.1 Rationale for thematic analysis

The reason for using reflexive thematic analysis is due to its flexibility, in this case the desire to use a combined approach of deductive and inductive to the data which is possible with thematic analysis. It also fits well with the mixed method approach. Other qualitative methods were considered such as grounded theory (Bryant & Charmaz, 2007) and interpretative phenomenological analysis (IPA) (Smith et al., 2009). Grounded theory did not fit with this research design, in particular the inability to incorporate preconceived theoretical idea into the analysis such as the Health Belief Model. IPA didn't align with the mixed methods approach with the quantitative data as the main strand, and the qualitative being used to explain the quantitative.

2.7.2 Sampling

This approach used volunteer sampling with eligible participants being recruited via the survey, the aim was to conduct between four to six interviews (Fugard & Potts, 2015), the final number conducted was five. Due to difficulties recruiting interview participants there was an additional round of recruitment that targeted only those eligible for the interviews who then completed the survey after the interview had been scheduled. Inclusion criteria were that participants needed to be over 18, from an ethnic minority background, have completed the survey, and attended an initial assessment at a university counselling service and then dropped out (either directly after the assessment or before completion of the sessions). The rationale for the qualitative inclusion criteria was aligned with stage two which was focused on gaining a more detailed understanding of ethnic minority students' reasons for dropping out from university counselling services.

	Gender	Ethnicity	Student level	International/ home
Interview 1	Female	Asian/Asian British (Sri Lankan)	Undergraduate	Home
Interview 2	Female	Asian/Asian British (Chinese)	Undergraduate	International
Interview 3	Male	Asian/Asian British (Indian)	Postgraduate	International
Interview 4	Female	Black, Black British, Caribbean, or African (Caribbean)	Undergraduate	Home
Interview 5	Female	Asian/Asian British (Filipino)	Postgraduate	International

Table 2.3 Demographics of interview participants

2.7.3 Interview recruitment

Recruitment was challenging for the interview stage of the study, initial recruitment via the survey generated interest from nine participants. Random sampling was then used to select six participants who were contacted with participant information (Appendix D) and a consent form (Appendix E). Only three responded and therefore the details were then sent to all nine respondents, four replied and booked interviews but only one interview was completed. Subsequently an amendment was approved to the ethics application for a change to recruitment and payment. Funding was secured for £15 Amazon vouchers for up to five additional participants and a second round of study advertisement and recruitment was conducted via a poster on campus and a PowerPoint slide shown in some undergraduate psychology lectures. Four expressions of interest were received via email, one interested individual responded to details and booked an interview but was ineligible to partake in the study because they had completed counselling sessions offered. The final stage of recruitment was via SONA and an email to all doctoral students at the researcher's institution, City, University of London. This resulted in eight expressions of interest and four completed interviews, all interviewees also completed the online survey prior to the interview.

2.7.4 Interviews – study measures

The interviews were semi-structured and guided by the interview schedule (Appendix R) which was developed and then amended post survey analysis. The interview schedule comprised seven main questions with some supplementary probes (Marks & Yardley, 2004).

2.7.5 Interviews – procedure

Interviews were conducted via Zoom and took an average of 24 minutes (15 – 32 minutes). Particular consideration was given to the context of the interview dynamics in terms of the

cultural and ethnic differences between interviewer and interviewee in the cross-cultural interviews (Griffin, 2022). At the start of the interview the difference was acknowledged (Sands et al., 2007) and participants were given space to discuss their feelings or any concerns around this. In addition, commonalities, such as student status were also discussed to aid rapport building (Roulston, 2010). All interviews were audio recorded.

2.7.6 Analytic Strategy

Both the qualitative data from the survey and the interview data were analysed using thematic analysis. The interviews were first transcribed using the automatically generated transcript by Zoom as a starting point and then the transcript was corrected by listening to the recording in detail and correcting the transcript. The transcripts were then analysed using a combined or hybrid approach of deductive and inductive thematic analysis (Fereday & Muir-Cochrane, 2006; Proudfoot, 2022). Deductive thematic analysis was then carried out by approaching the data using theoretical constructs from the existing literature, where inductive thematic analysis is driven by the data. The rationale for choosing this approach was that it fitted with the aims of the mixed method approach to this study, where the qualitative study component is being used to explain any differences from the hypothesized quantitative study findings. Therefore, the literature was the basis for themes, and then the qualitative data added to the initial findings/knowledge.

The analytic process was conducted using a six phases approach to reflexive thematic analysis (Braun & Clarke, 2022). This was first done with the 11 participants' comments from the survey and then was repeated using the interview data from five participants.

Phase one: Familiarisation of the data set

This was done by reading and rereading the data, and in the case of the interviews listening to the audio recording; initial notes were then made.

Phase two: Coding

This was done inductively by going through the data line by line and identifying any segments of data that were relevant to the research questions. Initial code labels were assigned to the data, this was done using a two-column table in Microsoft Word. This process was repeated several times to ensure that the data was systematically covered, and to ensure rigour. This was done at the semantic (or surface level meaning) and latent (or implicit) level. The initial codes labels were then reviewed and, in some cases, reworded.

Phase three: Generating initial themes

This stage took a combined deductive and inductive approach. The initial main themes were

derived from the Health Belief Model (see Figure 1), sub themes were then taken from the literature and survey scales. The code labels were all assigned to a sub-theme. Those that did not fit under an existing sub-theme were listed together. Once all codes had been considered, those that had not been assigned to a sub-theme were then reconsidered. At this stage several additional sub themes were inductively identified from the data.

Phase four: Developing and reviewing themes

This stage involved returning to the codes and full data set, and ensuring that the candidate themes fitted the data well. At this stage there was some reworking of the themes.

Phase five: Refining, defining and naming the themes

At this stage the final themes and sub themes were produced. This involved final reworking of the themes, writing a brief summary for each, and renaming the themes which had initially had names derived from the literature. They were renamed to reflect the words of the participants.

Phase six: Writing up

Using the familiarisation notes and reflexive notes taken during the process along with the production of a thematic map to complete the analytic process.

2.8 Fidelity and trustworthiness of the data

Qualitative research has developed different evaluation tools from quantitative research where psychometric tests such as reliability and validity can be used. Specific consideration has been given to thematic analysis and how to ensure that the criteria for trustworthiness are met (Nowell et al., 2017). The following steps were taken in order to ensure trustworthiness of the qualitative data analysis.

- A reflexive diary was kept throughout data collection and the analytic process.
- The research supervisor reviewed the initial coding of the transcripts and the development of themes.
- A prolonged engagement with the data, involving a detailed familiarisation with the data and then extended to revisiting the data throughout each stage of the phased analysis detailed above.
- Each sub theme and theme have been supported by data extracts from all participants to support the themes.
- Both the method and the analysis have been clearly outlined and then described in detail.

2.9 Reflexivity

The process of reflexivity has been central throughout this work, both personal and methodological. It has been considered at each stage of the research: pre-research, data collection and data analysis (Finlay, 2002). This section will consider the pre-research considerations. Reflective notes were taken throughout the research process and integrated in the write up.

2.9.1 Personal reflexivity

My worldview has undoubtably been influenced by my background in education and my training in mental health. My personal interest in the topic of student mental health is long standing as a result of previously working as a personal tutor with post graduate students. During the research process I was on two placements within student mental health services at City, University of London (City) and King's College London (KCL), both of which are universities that fall within the remit of the study. In addition, I am also a student at City therefore I have multiple roles; student, researcher, trainee psychologist, all within the university sector. All of these have the potential to influence my role in the research process. There were several stages during the research where my multiple roles were particularly apparent, such as during the literature review and the data collection and analysis. When writing the introduction section there were often times where my own clients' experiences in barriers to accessing support would come to mind, or my own knowledge gained as a trainee psychologist in these services. When this did occur, I would note in my research journal so that I could keep track of which thoughts were from reading the literature and which from my own experiences. My assumption from the outset was that the role of the therapist may be involved in drop out. It was therefore imperative that in my role as researcher I stayed alert to any assumptions that I may have made as a result of other experience rather than from the data, by being open and reflexive. The methodology that has been chosen for the qualitative strand, reflexive thematic analysis, fits well with this approach. It is important to note that as a White researcher focusing on exploring ethnic minority students' views that I am culturally aware and using inclusionary language and behaviours throughout. I have also ensured input from students who are culturally diverse during the piloting stages of the questionnaire. On an individual level this research has the scope to have a large influence in my role as a trainee, and then qualified Counselling Psychologist, working with ethnically diverse clients. This research has a clear relevance to both the theory and practice of Counselling Psychology. In practical terms Counselling Psychologists are employed within university counselling services and as a result it has the potential to impact directly on the work with ethnic minority students within such services. It also has the potential to have a

wider reach in terms of impacting on service design and how embedded mental health services are promoted internally to both students and staff. The findings may also be useful in the development of training materials for use with academic staff and personal tutors.

2.9.2 Methodological reflexivity

A key point to acknowledge is the potential impact my role as a White interviewer may have had on the interview process and responses of the interviewee. This was particularly relevant if having a counsellor of a different ethnicity played a role for them in not continuing in therapy (this was a factor for the majority of participants).This issue and strategies taken to address this were discussed above in more detail in section 2.7.5. There was also the additional difference of a significant age difference between myself, and the students being interviewed. I tried to manage this situation by being open at the start of each interview and discussing the difference, but also ‘reminding’ that I was also a student to acknowledge the similarities. Despite these mitigations there was a difference in length of interviews in particular one that was only 15 minutes compared to the longest at 32 minutes. It may be that these differences between myself and the participant impacted on rapport as it was challenging to elicit more detail from the participant and mistrust may have been relevant.

2.10 Summary

This chapter has given a methodological outline, a rationale for the approach taken, and an approach to reflexivity. Ethical considerations are presented, a detailed explanation of the data collection and analytical stages, and, finally, fidelity and trustworthiness of the data were considered.

Chapter 3 Results

The findings from the quantitative and qualitative strands of this study are presented in this chapter and have been reported sequentially. As discussed in the previous chapter (fig. 2.1), integration of the results from the two strands has taken place at the interpretation stage and these integrated results are presented at the end of the chapter.

3.1 Quantitative strand analyses

3.1.1 Demographics

The sample is comprised of 203 participants of which 37.9% are White and 62.1% are from an ethnic minority background, a detailed demographic breakdown of the participants is summarised in Table 3.1. This is not a reflection of the ethnic makeup of UK higher education students as a whole (72% White, 26% ethnic minority and 2% not known (HESA 2023)) or of the ethnic breakdown of University of London students the population that has been sampled in this study (63% White and 37% Ethnic minority).

Category	Subcategory	N	%
Gender	Female	172	84.7
	Male	26	12.8
	Other	5	2.5
Student status	Home	156	76.8
	International	47	23.2
Student level	Undergraduate	151	75
	Postgraduate	52	25
Ethnicity	White	77	37.9
	Ethnic minority	126	62.1
	Asian	72	35.5
	Black	14	6.9
	Mixed	17	8.4
	Other	23	11.3
		Total Mean	SD
Age in years		23.03	7.19

Table 3.1 Demographic details

3.1.2 Hypothesis 1

The first hypothesis that ethnic minority students would have higher rates of mental health difficulties than White students was investigated with an ANCOVA using the CCAPS-34.

3.1.2.1 Hypothesis 1.1. Ethnic minority students have higher rates of mental health difficulties than White students

Initial analyses were conducted between the two main groups (White and ethnic minority students) using the eight subscales. Follow up analysis was then conducted which focused on the clinically significant group differences for each of the subscales. Results showed that there were no significant differences in scores between the two ethnic groups for the majority of subscales including Distress index, Depression, Social anxiety, Academic distress and Frustration/Anger. The means and adjusted means for all groups are shown in table 3.2. There were three subscales that did show significant differences between groups which were Generalized Anxiety and Eating concerns in which White students had significantly higher scores than ethnic minority students (both with a small effect size) and alcohol distress in which White students had significantly higher scores with a large effect size. Table 3.3 shows the ANCOVA scores.

		Mean	Standard deviation	Adjusted Mean
Distress index	Ethnic minority	1.78	.78	1.76
	White	1.92	.88	1.97
Depression	Ethnic minority	1.60	.97	1.57
	White	1.76	1.09	1.80
Generalized anxiety	Ethnic minority	1.84	.96	1.81
	White	2.16	1.07	2.20
Social anxiety	Ethnic minority	2.06	.96	2.04
	White	2.16	1.01	2.20
Academic distress	Ethnic minority	2.35	.92	2.32
	White	2.03	1.15	2.09
Eating concerns	Ethnic minority	1.42	1.29	1.40
	White	1.91	1.43	1.92
Frustration/Anger	Ethnic minority	1.10	.87	1.09
	White	1.12	.88	1.13
Alcohol use	Ethnic minority	0.38	.73	0.36
	White	1.15	1.17	1.18

Table 3.2 Means and adjusted means for age, N=126 (ethnic minority students), N=77 (White students)

	F	Sig.	Partial Eta squared
Distress Index	3.09	.080	.02
Depression	2.25	.135	.01
Generalized Anxiety	6.74	**.010***	**.03***
Social Anxiety	1.15	.284	.01
Academic Distress	2.38	.125	.01
Eating Concerns	6.78	**.010***	**.03***
Frustration/Anger	.12	.735	.00
Alcohol use	36.41	**<.001***	**.15***

Table 3.3 ANCOVA Test between subject effects for White (N=77) and ethnic minority students (N=126)

3.1.2.2 Clinically significant CCAPS -34 group differences

CCAPS-34 data was then analysed considering the clinical cut off scores for each subscale. The majority of the results were not significant; the exception were Eating Concerns and Alcohol Use which were both significant with higher levels of distress for White students than ethnic minority students with a small effect size. Further details are shown in table 3.5 below.

		High – clinically significant		Low/medium		
		%	n	%	n	$\chi 2(2)$
Distress Index	Ethnic	31	39	69	87	1.92
	White	41.6	32	58.4	45	
Depression	Ethnic	41.3	52	58.7	74	1.34
	White	50.6	39	49.4	38	
Generalized Anxiety	Ethnic	40.5	51	59.5	75	2.65
	White	53.2	41	46.8	36	
Social Anxiety	Ethnic	33.3	42	66.7	84	0.72
	White	40.3	31	59.7	46	
Academic Distress	Ethnic	51.6	65	48.4	61	1.13
	White	42.9	33	57.1	44	
Eating Concerns	Ethnic	40.5	51	59.5	75	*4.68
	White	57.1	44	42.9	33	
Frustration/Anger	Ethnic	39.7	50	60.3	76	0.10
	White	36.4	28	63.6	49	
Alcohol Use	Ethnic	15.1	19	84.9	107	*12.28
	White	37.7	29	62.3	48	

Table 3.4 Group difference in clinically significant CCAPS-34 scores for all subscales, N=126 (ethnic minority students), N=77 (White students)

3.1.2.3 Hypothesis 2.1. Ethnic Minority students have lower rates of actual help seeking.

Overall, 43 (34.1%) ethnic minority students who participated in the study contacted their university counselling service for support compared to 19 (24.7%) White students, but this difference was not significant. A chi-squared test for independence indicated no significant correlation between ethnicity and contacting counselling services, χ^2 (1, *n* = 203) = 1.59, *p* = .21, *phi* = -.10. In total (84.2%) of White students that contacted counselling services were offered an assessment, higher than ethnic minority students (69.8%). A chi-squared test for independence indicated no significant correlation between ethnicity and an offer of an assessment, χ^2 (1, *n* = 62) = .780, *p* = .347, *phi* = .15.

3.1.2.4 Hypothesis 2.2 Ethnic minority students have lower utilisation of counselling services

Attended first session

In total 10 (62%) White students attended an assessment when offered compared to 24 (80%) ethnic minority students. A Fisher's exact test indicated no significant association between ethnicity and attendance at first session, (two-tailed p = .29).

Attended subsequent sessions

In total 8 (80%) of White students went to attend further sessions compared to 15 (65%) of ethnic minority students. A chi-squared test for independence indicated no significant correlation between ethnicity and those that went on to attend sessions, χ^2 (1, *n* = 46) = .35 *p* = .44, *phi* = .17.

3.1.3 Hypothesis 3. There will be significant differences in dropout rates between ethnic minority and White students.

In order to address this question data has been collected at various stages throughout the students' interactions with the counselling service.

3.1.3.1 Hypothesis 3.1 Ethnic minority students have higher dropout rates than White students after assessment.

Drop out after assessment

Drop out immediately after sessions, two (20%) White students compared to nine ethnic minority students (37.5%). A Fisher's exact test indicated no significant association between ethnicity and those that dropped out after assessment, (two-tailed p = .437).

Drop out after starting sessions.

In terms of dropout after starting sessions one (12.5%) White student dropped out compared to two (13.3%) ethnic minority students. A Fisher's exact test indicated no significant

association between ethnicity and drop out after starting sessions, (two-tailed p = 1.00).

Total drop after assessment (including immediately after assessment and during sessions).
In terms of total dropout three (30%) White students dropped out compared to 11 (45.8%) ethnic minority students. A Fisher's exact test indicated no significant correlation between ethnicity and those that dropped out after starting sessions, (two-tailed p = .47).

3.1.4 Hypothesis 4. There will be significant differences in barriers faced by ethnic minority students to help-seeking from embedded university mental health services.

3.1.4.1 Hypothesis 4.1 Ethnic minority students will face higher levels of individual barriers than White students.

There was no significant difference between the groups in terms of their Stigma scale, Self-stigma scale and beliefs about mental illness scale. The means and adjusted means are presented in table 3.7 below.

Ethnic minority students reported significantly higher levels of barriers to seeking help than White students with a medium effect size. The results of the ANCOVA test are shown in table 3.8. Within the barriers scale it was in-group stigma and cultural values that accounted for this difference. With in-group stigma reporting a moderate effect size and cultural barriers a large effect size.

		Mean	Standard Deviation	Adjusted Mean
Stigma scale	Ethnic minority	4.76	3.07	4.72
	White	4.47	3.02	4.54
Self-stigma scale	Ethnic minority	23.68	6.35	23.51
	White	23.29	7.84	23.54
Barriers to seeking help scale	Ethnic minority	81.02	13.91	80.81
	White	73.03	14.53	73.38
Negative perceived value	Ethnic minority	14.17	4.64	14.04
	White	13.86	5.21	14.07
Ingroup stigma	Ethnic minority	15.22	4.05	15.18
	White	12.86	4.15	12.92

Discomfort with emotion	Ethnic minority	18.25	4.94	18.08
	White	18.21	4.81	18.49
Cultural barriers	Ethnic minority	19.08	3.84	19.12
	White	15.08	4.62	15.01
Beliefs about mental illness scale	Ethnic minority	40.78	16.54	40.49
	White	35.87	16.70	36.34

Table 3.5 Means and adjusted means (for age), N=126 (ethnic minority students), N=77 (White students)

	F	Sig.	Partial Eta squared
Stigma scale	.169	.682	.001
Self-stigma scale	.001	.977	.000
Barriers to seeking help scale	12.66	**<.001***	**.06***
Negative perceived value	.002	.967	.000
Ingroup stigma	13.97	**<.001***	**.065***
Discomfort with emotion	.336	.563	.002
Cultural barriers	44.98	**<.001***	**.184***
Beliefs about mental illness scale	2.87	.092	.014

Table 3.6 ANCOVA test between subject effects for White (N=77) and ethnic minority students (N=126)

3.1.4.2 Hypothesis 4.2 Ethnic minority students will face higher levels of practical barriers than White students.

Lack of knowledge

There was no significant difference between the two groups in their scores for the subscale lack of knowledge. *F*(1,200)=.000, p=.988, partial eta squared=.000

	Mean	Standard Deviation	Adjusted Mean
Ethnic minority	8.96	4.32	8.90
White	8.79	4.53	8.89

Table 3.7 Lack of knowledge, N=126 (ethnic minority students), N=77 (White students

Lack of access

Ethnic minority students reported significantly higher lack of access scores then White

students, *F*(1,200)=.4.412, p=.037, partial eta squared=.022 with a small effect size.

	Mean	Standard Deviation	Adjusted Mean
Ethnic minority	14.29	4.80	14.37
White	13.03	4.65	12.90

Table 3.8 Lack of access, N=126 (ethnic minority students), N=77 (White students)

3.1.5 Post hoc analyses

Several post hoc analyses were conducted to explore relationships within the ethnic minority group.

3.1.5.1 Correlation between stigma and seeking support

The relationship between in-group stigma and seeking support from university counselling service was investigated using Pearson's correlation. A non-significant negative relationship between ingroup stigma and seeking support was found r = -.08, n = 126, p = .4

3.1.5.2 Logistic regression examining predictors that contributed to ethnic minority students seeking support from the university counselling service.

A logistic regression was conducted to assess the association between several factors (student status (home or international), stigma, self-stigma, ingroup stigma, negative perceived values, cultural values and distress index) would have on ethnic minority students seeking support from university counselling services.

The model containing 7 independent variables was statistically significant χ^2 (7, n = 126) = 19.93 p = <.05. This indicates that the model was able to distinguish between those who did and did not seek support. The model as a whole explained 14.6 % (Cox and Snell R squared) and 20.2 % (Nagelkerke R squared) of the variance of seeking support and correctly classified 66.7% of cases. Two variables provided a statistically significant contribution to the model: cultural values and distress index (as shown in Table 3.9). The strongest predictor was cultural values. The B values indicate that a higher cultural value score was related to a lower probability of a student seeking support. The OR value indicates that students who scored higher on distress were 2.15 times be more likely to seek help.

	B	S.E.	Wald	df	Sig	Odds Ratio	95% C.I. for Odds Ratio	
							Lower	Upper
Student Status [a]	.193	.468	.170	1	.680	1.213	.484	3.038
Stigma scale total score	-.018	.089	.039	1	.843	.983	.825	1.170
Self-stigma total	-.043	.042	1.039	1	.308	.958	.883	1.040
Ingroup stigma	.059	.059	1.010	1	.315	1.061	.945	1.190
Negative perceived values	-.075	.056	1.793	1	.181	.928	.831	1.035
Cultural values	-.121	.058	4.403	1	.036	.886	.792	.992
Distress index	.768	.303	6.422	1	.011	2.156	1.190	3.904
Constant	1.356	1.458	.865	1	.352	3.881		

a Home or international

3.1.5 Summary of quantitative strand results

In summary, across the three main hypotheses, only hypothesis 3.1 and 3.2 can be partially accepted. There was no significant difference in rates of mental health difficulties apart from generalised anxiety, eating concerns, and alcohol use where White students had significantly higher rates of distress. In terms of actual help seeking, utilisation of services, and dropout rates there was no difference between the two groups. Therefore, hypotheses one and two can be rejected. The third and final set of hypotheses focused on barriers to accessing support and found a more nuanced picture. It was found that it could be partially accepted that ethnic minority students will face higher levels of individual barriers than White students. Ethnic minority students were found to experience significantly higher barrier scores overall, this was as a result of higher scores for in group stigma and cultural barriers. For other individual barriers there was no significant difference. In terms of practical barriers,

this hypothesis could also be partially accepted as ethnic minority students were found to experience significantly higher levels of lack of access scores than their White peers, but for lack of knowledge scores there was no significant difference.

3.2 Qualitative results

Findings from the thematic analysis will be included in this section and are derived from the open-ended questions of the study survey and data from the five semi-structured interviews conducted with study participants. It will explore the following research question: “What factors impacted on ethnic minority students’ decision to drop out from therapy after attending an initial assessment?”

In total 11 out of 203 participants responded to the open-ended questions from the study survey. Participants were invited to provide further information to explain the reasons for drop out from counselling sessions. This information was then helped to shape the initial coding frame and then was analysed in the same way as the interview data and integrated into these qualitative results.

Five semi-structured interviews were conducted with participants who completed the study survey from the quantitative strand. The interviewed participants were four women and one man, two home and three international students. Four of the participants were from a variety of Asian/Asian British backgrounds (Sri Lankan, Chinese, India and Filipino) and one participant was from a Black, Black British, Caribbean or African background (Caribbean). In terms of student level there were three undergraduates and two were postgraduates.

A thoughtful and careful consideration of the use of pseudonyms was undertaken. Participants were not invited to choose a pseudonym that represented their identity. I felt discomfort about imposing a name on participants because of the power differential as a researcher, which at best may not capture the intersectionality of their identity and may even cause offense. This has been balanced with the potential dehumanising effect of using numbers. I have taken the decision to use interview or survey participant and number for example IP1 or SP4.

3.2.1 Thematic Overview

The themes and subthemes that were initially produced during phase three of the analysis (five themes and nine sub-themes) were, during the subsequent phases, reviewed and refined to produce the final version (Table 3.1). This involved one theme being moved into another theme as a subtheme and further subthemes being created. This allowed more detail to be added to the existing themes. The final version contains four themes and 12 subthemes. The relationship between the different themes and subthemes is illustrated in

the thematic map (Figure 3.2).

A narrative account of each theme with its corresponding subthemes is then presented with illustrative quotes from transcripts of the interviews and in some cases quotes from the survey data to support the interpretative approach of the analysis.

Themes	Sub themes
Therapeutic relationship	Not feeling understood
	Cultural misunderstanding
Privacy at the expense of connection	Don’t speak to anyone about it
	Distance
	Visibility
Not good enough	Not important enough
	Others needs greater
	Service really busy
	It won’t help me
Time is of the essence	Waiting time
	Timing
	Restriction

Table 3.9 Summary of themes and sub themes

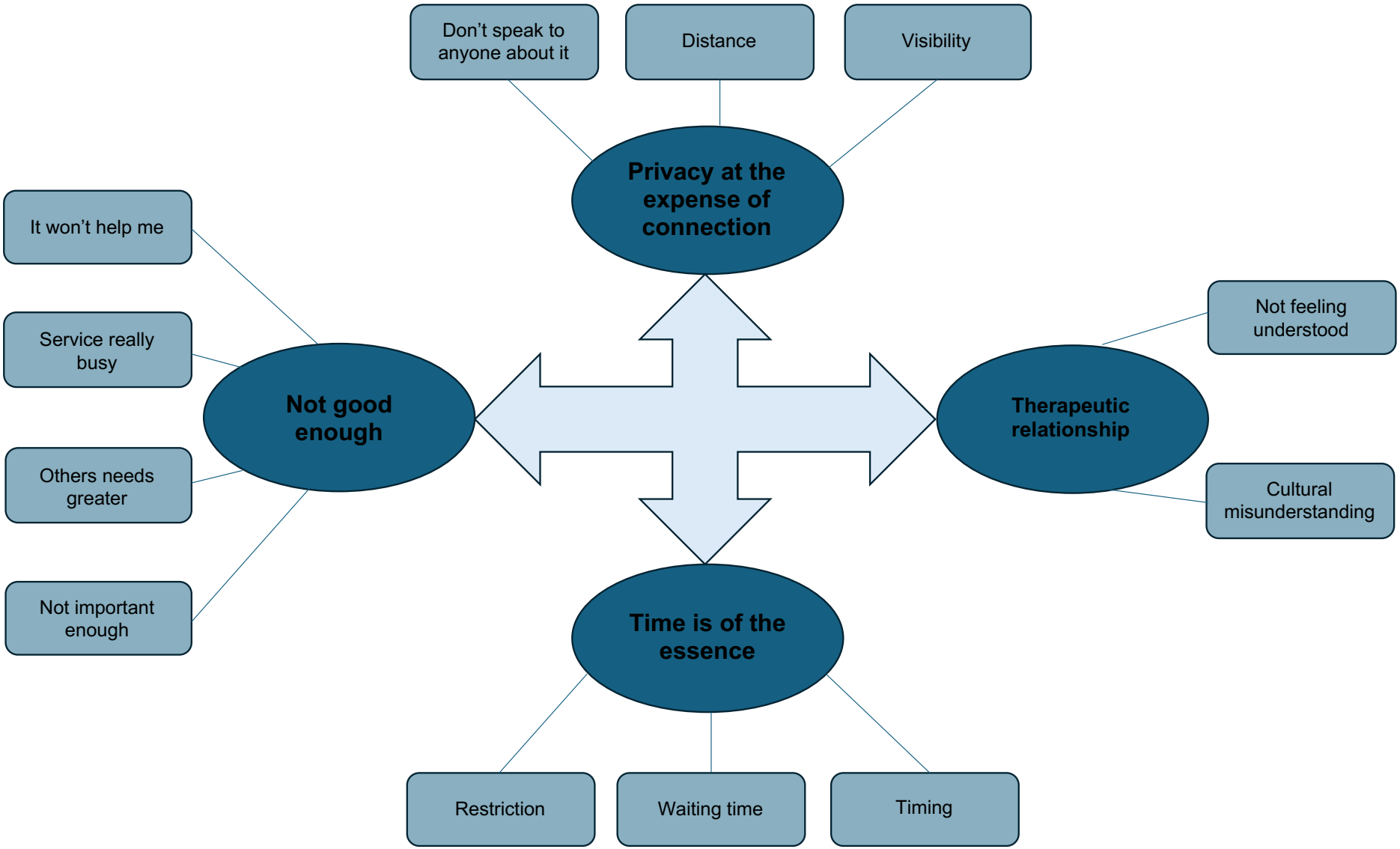

Figure 3.1 Final thematic map showing themes and subthemes

3.2.2 Theme One: Therapeutic Relationship

This theme encapsulates the value that participants had in the connection with their therapist and its importance in engaging with the counselling. Across study participants those that did mention their relationship with their therapist felt that it played a very significant role in their decision to drop out. Participants described feelings of difficulty in feeling 'connected' to their therapist which reflected feeling of being misunderstood or culturally incongruent. The feeling of cultural incongruency in this case relates to the participants perception of not fitting in within the therapeutic relationship or the counselling environment. Most of the interview participants explained that the ethnicity of the therapist was a factor in their decision to drop out of therapy. In all cases, the therapist was of a different ethnicity to the interviewee. The quotes below highlight the impact of that mismatch for the participants.

> *" My therapist was not of my ethnicity, so I didn't really feel like going to the sessions". (IP1)*

> *"It's very difficult to build a connection with the person who's trying to help you" (IP3).*

The participants relationship with their therapist was pivotal to their negative experiences in therapy and decision not to continue with sessions.

3.2.2.1 Not feeling understood

This sub-theme relates to participants' experience of not feeling understood during their encounters in therapy. Many participants described feeling misunderstood by their therapists as which they For some it was around difficulty in expressing difficulties and for others there seemed to be a disconnect between what was expressed and what was understood. Both of these seem to be underpinned by and resulting from cultural incongruence in the therapeutic relationship. There is a strong link between the feeling of being misunderstood and the sub-theme of cultural misunderstanding.

> *"I felt like the psychiatrist was unwilling to understand my current problems and unable to understand my childhood experiences". (SP12).*

> *"I do think like because of where and how I grew up I probably at the time didn't verbalise it (my difficulties) as well as maybe they were used to". (IP5).*

3.2.2.2 Cultural misunderstanding

Specific cultural misunderstanding was a consistent sub-theme both in terms of making assumptions about participants based on their ethnicity but also failing to consider that there might be cultural differences. One participant described that the therapist repeatedly suggesting that he discuss his difficulties with his parents, without any consideration to any cultural differences that may be present (in terms of his parents' attitudes towards mental health, help seeking and societal stigma around both).

> "I can't have that conversation with them. It is not that prevalent back in India so that was not an option for me. My parents are particularly insensitive to these things like they usually brush it off".(IP3).

> *"I feel like there is a massive gap between understanding of different cultural factors". (IP1).*

The experience of cultural difference was so significant, for one participant, that they emphasised it as their motivation to seek a counsellor from their ethnic background in the future.

> *"Sometimes a cultural difference is going to put me off and actually, funny enough next time I chose a counsellor of my ethnicity to make it much easier". (IP3).*

Another participant explained that their status as an international student influenced the degree to which their therapist made assumptions about their cultural values.

> *"I remember him making assumptions that because I was from overseas. That I, all my feelings like what I was going through or why I came to therapy was because of like cultural differences". (IP5).*

Cultural misunderstandings had a significant impact on the therapeutic relationship and led participants to feel a strong disconnect with their therapist. This had a profound effect on their decision to discontinue therapy. With these participants these cultural misunderstanding were all made by therapist of a different ethnicity from their own.

3.2.3 Theme Two: Privacy at the expense of connection

This theme relates to participants desire to keep their mental health difficulties and help seeking separate from their university but also in many cases their families. The theme captures how the fear of the consequences of breaches in confidentiality (including the impact on grades and stigma from family and friends) creates a sense of distrust in service and provision of care. This theme was expressed by all of the interview participants which has been divided into three sub themes: don't speak to anyone about it, separation and privacy at the expense of connection.

3.2.3.1 Don't speak to anyone about it.

Most of the participants spoke of their concerns in sharing their experience with family members, mainly parents. There was an element of secrecy around attending sessions, a theme that was mentioned by all but one of the interviewees.

The majority did not discuss access counselling with their parents, there was a sense that mental health difficulties was not something that would be understood or accepted as a result of in-group stigma.

> *"I can't have a conversation with them, that was not an option for me". (IP3).*

On the contrary, one participant had an open conversation with both of her parents about her mental health difficulties and about seeking and accessing support. In fact, it was her Mum that actually prompted her to sign up for support.

> *"It was one of my Mum's priorities….she initially gave me instructions of what to do….otherwise I wouldn't have really looked into it honestly". (IP4).*

Despite support from one parent, she felt caught in the middle as her Dad having a very different view.

> *"With my Dad…'you can deal with it yourself and don't need to speak to anyone about it'…. Maybe I do need it and then it is like nah, it's a kind of battle in my own head sometimes". (IP4).*

The participant above, and others, described the tension between those contrasting viewpoints and involving family members in their decision to access support. This subtheme of keeping quiet about accessing counselling was strongly linked to the subtheme of visibility expressed as a fear of being seen whilst waiting for a counselling session. Both factors giving the sense of a need for secrecy.

3.2.3.2 Distance

Some of the participants decided to seek help outside of the university counselling service, either through the NHS, low cost counselling services, or in some cases, privately. They sought to have a clear distinction between their university experience and their own wellbeing support.

> *"I felt like I'd rather not have my umm like mental health details associated with my university. So, I'd rather get something in the community. …It felt more anonymous". (IP2).*

This desire not to have mental health information attached to university record suggests fear of possible consequences such as breach of confidentiality or the worry that there may be an impact on grades or references at the end of the course. There was a clear sense that the participant wanted to keep academics and mental health concerns completed separate from each other.

3.2.3.3 Visibility

Most of the participants mentioned that they have had some or all of their sessions remotely. Many found this to be positive experience which possibly provided total anonymity. As a result of conducting sessions from home or a private space they would not have the possibility of being seen by other people (either peers or lecturers) entering the counselling service or wating to be seen. This links into the previous sub-theme of distance by seeing a counsellor online, despite being from the university counselling service, there is still an element of separation.

> *"I actually prefer virtual meetings, so I don't have to go anywhere". (IP2).*

This was not a uniform view, for another participant it was a major part of the decision not to continue with sessions. They found it to be a barrier connecting with their therapist and found it very awkward in comparison to seeing someone face to face. This mode of delivery then

impacting on the therapeutic relationship and links to theme one.

> *"(The assessment was online) was fine but it was harder to connect because of the setup itself (online) I didn't follow through with an appointment because it was online". (IP1).*

3.2.4 Theme Three: Not good enough

This theme encapsulates the participants' feelings of not being important enough and not wanting to be a burden, leading to prioritising others needs over their own, including the service as well as the other students in need of support. It is also led to feeling that "it doesn't help me". Theme three was expressed strongly across the data set.

3.2.4.1 Not important enough

Many of the interview participants believed they were not worth the therapist's time in sessions or that their symptoms were not severe enough.

> *"And I don't even like I don't even expect them to remember what I told them in the last session so they should be a continuity right that oh I remember what I told you last week and that doesn't particularly happen over a month". (IP3).*

> *"He could not remember what I said during the preceding session, so every 30-40 min session felt like the first one. I felt like I was wasting the therapist's time, and he couldn't wait to see me disappear for good".(SP12).*

This left participants to feel like the therapist wasn't interested in them or their problems. Maybe reinforcing their own negative feelings about themselves. Each week there were left with the feeling that they weren't important enough to the therapist to be remembered or to be given time and space for.

> *"I was sort of placed on the back burner".(SP2).*

> *"Maybe I am not ill enough". (IP5)*

3.2.4.2 Others' needs greater

Several participants mentioned their needs in relation to others accessing the service and assumed that others need was greater.

> *"I assumed other people must have much more serious issues". (SP6).*

> *"They have more immediate cases they have to prioritize". (IP2).*

This theme strongly links into the previous subtheme of not being important enough and as a result others needs must be greater.

3.2.4.3 Service really busy

The same participants also mentioned that the service may be overwhelmed, and therefore, in some cases, prioritised the service over their own needs as a result of not wanting to be a burden. As a result, they didn't proceed past the assessment.

> *"The service was in high demand". (SP6).*

> *"I also know that it's very like a lot of students reach out for help through them. And so, they might be really busy". (IP2).*

3.2.4.4 It won't help me

Several of the interview participants felt that there was no point in continuing with sessions as they did not feel they were getting any benefit from them.

> *"I just didn't see the point of you know carrying on". (IP1).*

> *"I did not feel it would help me". (SP8).*

> *"Sometimes talking about it doesn't work and I feel like I'm in the wrong service" (IP1).*

“I guess I feel like it doesn't help me necessarily and maybe I can handle it on my own and do it myself because I feel like talking about it is not gonna fix it. I may as well just get on with it and kinda carry on”. (IP4).

All of the subthemes encapsulated in theme three ‘not good enough’ highlight the way that the interview participants in either their interaction with service administrators or therapist acted as a significant barrier to accessing care after initially contacting the service.

3.2.5 Theme Four: Time is of the essence

Time as a main theme came up as an important factor across the data set and was mentioned in all five interviews and in four of the survey comments. In all cases it had a negative impact on participants’ desire to continue with sessions. It links strongly to the third theme about the participant not feeling important enough to have their needs considered by the service. The participants gave a sense that if the timing wasn’t right then the opportunity to access support was missed. The description by the participants around time came up in several different forms which has resulted in the creation of three sub themes. The whole procedure of accessing support was time consuming.

“It’s like a long process” (IP3)

3.2.5.1 Waiting time

The time between an assessment to sessions starting was key point of attrition and it highlighted for some the inability to get support when it was needed.

“The counselling session was months away after all my assessments so wouldn’t be useful at all to me”. (SP1).

For others the delay in accessing support impacted on their ability to engage with counselling and led to drop-out. It had taken them a lot to overcome barriers to make initial contact with the service and then during the delay those factors such as stigma or feeling that they are not important enough to get help have had time to impact again.

“Like a long process or whatever, but by the time I booked the next session that's already, like for me the motivation of continuing had already gone and like I already mustered up so much of my energy or so much of like this courage of trying something new out”. (IP3).

3.2.5.2 Timing

This sub-theme came up with several participants. This was in terms of inconvenient time of sessions offered, both in terms of time of day and time during the academic term. The was a lack of flexibility in the services and they didn’t seem to responsive to individual students needs, particularly those with caring responsibilities.

“Time ended up clashing with picking my child up from school, so I cancelled my appointment”. (SP5).

“The session was cancelled by the centre. The only time to reschedule was during the holidays so did not suit me”. (SP6).

In addition, students felt like there was not enough time to attend sessions.

“It's not something I prioritised right now. There are other things I need to get done. I've got uni work to do I'm living in like a new place; I'm trying to adjust. It's not like a priority where I can just take time out”. (IP4).

3.2.5.3 Restriction

The final sub-theme reflects the restriction felt by the time limit of 50-minutes for a counselling session. Two interviewees who were both international students mentioned the impact of having a fixed session time limit as very limiting and was something that they hadn’t experienced before. It seemed to have an impact on the development of the connection between the participant and therapist. This led to participants holding back and feeling like they could only divulge surface level feelings or situations.

“It felt it felt rushed I would say. I don't understand it they have like 45 minutes or whatever but then then you have to put your mind in this framework that oh this is just like a brief conversation that I have to have within the amount of time that I've been

given which felt very unnatural which like I couldn't get into a lot of depth about the problem that I was facing and felt very superficial from their side as well". (IP1).

Interviewee five made the comparison to previous counselling using a non-western model in their home country.

"My psychologist who would just see me until I would like stop talking or until their next client was there. Sometimes I was there an hour and a half, 2 hr sometimes it was short, it was kind of fluid and flexible. (Later when I went home in the holidays) I would just pop in and like catch up and tell her about university life and all of that". (IP5).

Their previous experience was that the impact of less restriction meant that they felt comfortable to disclose more.

3.2.6 Summary of qualitative strand analysis

Four themes were produced, each with subthemes: Therapeutic relationship (not feeling understood and cultural misunderstanding); Anonymity (secrecy, separation and mode of delivery); Importance (negative perceived value, prioritising service, prioritising others, not important enough) and Time (restriction, waiting time and timing). Most participants felt that aspects of the therapeutic relationship impacted their decision to drop out from therapy. There was a strong link between the two subthemes with participants often expressing difficulty feeling connected to their therapist as a result of not feeling understood, and cultural misunderstanding. Participants expressed their desire to keep their mental health seeking separate from their families and, in some cases, also university. In terms of importance, participants felt that they were not important enough and did not want to be a burden, resulting in putting others' needs above their own (including the service and their peers). The final theme of time was important across the data set in both survey and interviews and strongly linked to participants' lack of feeling important enough. With them expressing difficulties in experiencing long waiting times and feeling that their needs weren't met by a rigid session length, and inflexible timing of sessions which didn't take into consideration other commitments.

3.3 Integration of Results

This section aims to integrate the quantitative and qualitative data by addressing the mixed methods research question: To what extent, and in what ways do the open-ended survey questions and the qualitative interviews help to explain the quantitative results on utilisation, barriers and drop out?

3.3.1 Utilisation

In terms of utilisation no difference was found in utilisation between the two groups of students (ethnic minority and White). The quantitative strand indicates that high levels of ethnic minority students attended assessments when they were offered (80%). This could be explained by findings from the qualitative component. The qualitative data showed that students experienced support to seek help from a variety of sources. Several participants interviewed mentioned the positive impact of advertising in terms of posters, metal health awareness days and lecturers recommending seeking help. This is illustrated in the selected quotes below.

> *"My teachers told me that a lot of people from previous years actually found it (counselling) really helpful". (IP3)*

Campus advertising had a positive impact on reducing the effect of reducing stigma.

> *"There was this whole like mental health awareness day during fresher's week, there was like a banner, student services were there. I can actually freely ask for help or like I can go to these people without fear of being judged". (IP5)*

Several participants mentioned the ease of signing up for the initial assessment.

> *"I just walked into the counselling service filled out the forms". (IP5)*

This was not a universal experience interview participant one found the sign-up process much more challenging.

> *"The whole process in itself is also overwhelming". (IP1).*

Personal influence also played a key role in encouraging students to sign up both from friends and family.

> *"The main driving force let's say (for contacting the service) would be one of my friends accessing the same service. And they said that they had an all right time with it. So, I was like, might as well give it a try". (IP2).*

Interview participant four mentioned receiving reminders from her Mum.

> "Mum checked in reminded to follow up with service . ' Have you heard back yet, like, keep checking on it". (IP4).

With regard to expectations some perceived benefits to seeking help were also mentioned.

> *"I felt like it was really important to also have the support services alongside academic support as well".* (IP1).

There was no significant difference in mental health symptoms overall between the two groups, although this wasn't explicitly addressed in qualitative questions. Minimising symptoms as a result of self-stigma was brought up by one the participants. This may have contributed to the lower than expected distress scores.

> *"I think there was more kind of minimalising or normalising that I was doing at the time that I wasn't aware of. Because like I guess on one level there is always a part of me that's like, surely I can't be feeling this way when I have this opportunity to be in a different country. And like as a as an international student, you know, the fees are so expensive, and parents are paying it and like. You know, you have that kind of oh, not that you owe something to them, but yeah, it does add a lot of pressure".(IP5).*

3.3.2 Barriers

Barriers identified in the quantitative strand data that impacted ethnic minority students at a higher rate than White students included: in-group stigma, cultural barriers, and lack of access. All three of these barriers were expressed very clearly in the qualitative strand data. These

impacted on all stages of accessing support from making initial contact, attending an assessment and then dropout.

Several students reported not being offered sessions because their problems were too complicated.

> *"I attended online in 2022; the therapist told me my problems were too complicated for the university counselling services and they were only meant for younger students having problems around study/living away from home. I am over 50 and wanted to offload too someone on the difficulties of doing a postgrad, while being a single parent to 2 ND children and having sick parents, one with psychosis". (SP2).*

In some cases, students were offered sessions, but they were unhappy with the format.

> *"No individual sessions were offered, only group, and I did not want those" (SP7).*

> *"I was not offered adequate therapy due to the constraints of the university and the complexity of my mental health difficulties so decided to disengage". (SP10*).

Importance of choice

> *"People like to have a face to face option" (IP1)*

Once students had overcome initial barriers to contacting the service and attending an assessment, the quantitative strand found that ethnic minority students faced significantly higher barriers to access, indicated by higher lack of access scores. This was also reflected in the qualitative data from the surveys in the theme of 'time is of the essence' and sub theme of 'timing'. Participants were impacted by inflexibility of session times offered, including both the time of day and time during the academic year. The other factor that impacted access was students' view that they did not have enough time to attend sessions.

In-group stigma was a barrier that was identified in the survey and was reflected in two of the themes in the qualitative strand. The first theme was 'privacy at the expense of connection' in particular 'don't speak about it' and 'distance' sub themes. For the majority of participants

speaking to their parents about their mental health, or about seeking help, was not an option. It was also a benefit for many to have online sessions to remove the possibility of being seen by peers. Confidentiality was also seen as a concern.

Cultural barriers was the final barrier identified in the quantitative results that found a significant difference between the two groups, with ethnic minority students experiencing higher levels. This was clearly demonstrated in the theme of the therapeutic relationship in particular the sub themes of 'not feeling understood' and 'cultural misunderstanding'. All participants interviewed had a therapist of a different ethnicity to their own, and expressed that cultural misunderstanding was a key factor in drop out. However, across the remaining barriers that were surveyed (stigma, self-stigma and beliefs about mental illness, negative perceives value, discomfort with emotion and lack of knowledge) there was no significant difference between the groups (White and ethnic minority). Discomfort with emotion and beliefs about mental illness were not discussed in the interviews but negative perceived value and stigma both overall and self-stigma were expressed strongly in the qualitative data.

3.3.3 Dropout

The survey data did not find a significant difference in dropout rates between ethnic groups. The qualitative data therefore doesn't support the quantitative findings to any great extent with extensive reasons given for dropout, many of which are related to ethnicity. However, two interview participants who had gone on to successfully attend subsequent counselling sessions (after dropping out of their initial ones) described the positive impact of being able to select the ethnicity of their therapist as a significant positive and encouragement to attend sessions. As these were both students that were in the final year of their courses it could be that this reflects a change by the service to offer a list of names to choose from or an increased ethnic diversity of their staff.

> *"I actually found a person of my ethnicity among the list of names. I was really excited".* (IP1).

> *"I actively sort out a therapist who is Asian as well".* (IP5).

3.3.4 Summary of integration

Overall, the extent to which the qualitative results have explained the quantitative results varies across the hypotheses. Although the hypotheses related to utilisation were not accepted, the qualitative data goes some way to explaining this. Participants described encouragement to seeking support from the university itself (through advertising around campus and lecturers, both outlining what support was available) and also highlighting that previous student had found it helpful. All of these factors may have contributed to reducing stigma towards help seeking (both societal and self) and go some way to explaining why there was no significant difference in these types of stigma in the survey. Further barriers identified in the quantitative data (such as in-group stigma, cultural barriers and lack of access) were well supported by the qualitative data. In terms of drop out there was also no significant difference in rates between ethnic minority and White students, although the majority of the qualitative data supported the hypothesis that was not accepted. There was also some data that suggested that counselling services had started to make changes to the service (students had to option to choose their therapist and select based on ethnicity) that may have positively impacted on dropout rates.

Chapter 4 Discussion chapter

4.1 Overview

This chapter will include interpretation and discussion of the two strands of the research, quantitative and qualitative, and the integration of both in the mixed research question. Finally, it will consider research limitations and strengths, implications and recommendations from the research findings, future research and final concluding remarks.

This mixed-method study set out to explore mental health difficulties, utilisation and barriers of students from all ethnicities in strand one and explored ethnic minority students' experiences of drop out from university counselling services in strand two.

Data was collected via an online survey for strand one with 203 participants. The picture that has emerged is a mixed one in regard to the quantitative strand. The aim of the strand was to explore mental health difficulties and barriers to accessing support, and in addition measure actual help seeking, utilisation and dropout. Ethnic minority students (including Asian or Asian British; Black, Black British, Caribbean, or African; Mixed or multiple ethnic groups; and Other) did not report significantly different levels of utilisation of mental health services (including actual help seeking), drop put rates, or mental health difficulties, from the White group. When barriers to accessing and continuing with therapy were considered, ethnic minority students did experience significantly higher barriers to support particularly in respect to cultural barriers including in group stigma and practical barriers including lack of access.

Strand two analysed data from 11 survey participants collected in open ended questions in the survey, five of these participants were then interviewed. The aim of the second strand was to explore factors impacting on drop out of ethnic minority students. Four main themes were identified: 'therapeutic relationship' which encapsulates the value that participants placed in their connection with their therapist and its importance in engaging in counselling, 'privacy at the expense of connection' which highlighted the participants desire to keep their participation in counselling separate from the university and also from their families, 'not good enough' which captured participants feelings of not feeling important enough or wanting to be a burden, and the final theme of 'time is of the essence' which incorporated participants views around time including waiting times, scheduling of sessions and feeling restricted by the length of sessions.

4.2 Interpretations and discussion of quantitative results with qualitative theme integration

The quantitative strand of the study aimed to address the follow research question and hypotheses.

Research questions

Based on the Health Belief Model it is predicted that ethnic minority students will have lower utilisation and higher dropout rates than their White peers.

Hypothesis 1 There will be a significant difference in severity of mental health distress between ethnic minority and White students.

Hypothesis 1.1 Ethnic minority students have higher rates of mental health difficulties than White students.

Hypothesis 2 There will be a significant difference in utilisation rates between ethnic minority and White students.

Hypothesis 2.1. Ethnic Minority students have lower rates of actual help seeking.

Hypothesis 2.2 Ethnic minority students have lower utilisation of counselling services.

Hypothesis 3

There will be significant differences in drop put rates between ethnic minority and White students.

Hypothesis 3.1 Ethnic minority students have higher dropout rates than White students after assessment.

Hypothesis 4

There will be significant differences in barriers faced by ethnic minority students to help-seeking from embedded university mental health services.

Hypothesis 4.1 Ethnic minority students will face higher levels of individual and cultural barriers than White students.

Hypothesis 4.2 Ethnic minority students will face higher levels of practical barriers than White students.

4.2.1 Mental Health Distress

In total 203 students participated in the survey. Analyses focused on comparisons of all ethnic minority students versus the White student group (n=77, 37.9%). This was as a result of several of the ethnic groups being composed of a very small number of students (Asian or Asian British (n= 72, 35.5%); Black, Black British, Caribbean, or African (n=14, 6.9%); Mixed or multiple ethnic groups (n=17, 8.4%) and Other (n=23, 11.3%). As a result, it was not possible to conduct separate analyses and therefore the decision was taken to group all ethnic minority participants together in one group. Contrary to hypothesis 1.1 and existing literature, overall, there were no significant differences in mental health distress, as measured by CCAPS-34 overall distress index between ethnicities (Arday et al., 2022; Broglia et al., 2021; Cogan et al., 2024). However, clinically significant distress scores were present in 31% of ethnic minority students and 41.6% of White students. As a result of these findings the hypothesis is rejected. The absence of group difference in terms of mental health may be due to a sense of belonging from attending a majority institution. In this context majority institution refers to the fact that the ethnic minority group are not in a minority as they are in the wider UK. At City, University of London 65.7% of students are from an ethnic minority background which closely matched the composition in the current study with 62.1% being from an ethnic minority background. The impact of attending a majority institution has been studied in the US where a study found significant differences in sense of belonging between Black students in a White majority college and Black students at a historically Black university (Campbell-Whatley et al., 2021). Sense of belonging has been found to increase emotional adjustment and lessen anxiety (Wright et al., 2022) and to reduce depression (Gummadam et al., 2016). In line with this, a national study of 1188 Black students from 15 universities in the US showed that Black students who perceived their campus to be welcoming to minority students, reported lower levels of depression and anxiety than those that did not (Leath et al., 2023).

In the current study, analyses by sub-scale showed that White students had significantly higher scores and levels of distress on three of the subscales: generalised anxiety, alcohol use and eating concerns. Although White students had significantly higher scores overall for generalised anxiety, they did not have a higher percentage of participants with clinically significant scores on that scale (53.2% as compared to 40.5% for ethnic minority students). Eating concerns and alcohol use concerns were both found to have significantly higher percentage of clinically significant scores in White students than in the minority group. With eating concerns, 57.1% of White students reported clinically significant scores as compared to 40.5% of ethnic minority

students. In terms of alcohol use concerns15.1 % of ethnic minority students compared to 37.7 % of White students. There are several possible explanations for these findings. In respect of alcohol use it may be that the ethnic minority students may have high proportion of Muslim students who do not drink, however no data on religion was collected in this study to support this explanation (but 32% of City students identify as Muslim (City, University of London, 2024).There is some evidence to suggest that eating concerns are more prevalent in cultures that attach a premium to the 'ideal' body or thinness and eating disorders were thought to be more prevalent in western cultures (Miller & Pumariega, 2001; Makino et al., 2004) but prevalence has been increasing in non-western countries (Makino et al., 2004). However, differences have been found between different eating disorders, with bulimia nervosa considered to be a culture bound syndrome and anorexia nervosa not (Keel & Klump, 2003). Others have found that overall prevalence of eating disorders has been shown to be no difference between ethnic minority and White women (Cheng et al., 2018), in this case the authors posited that this was as a result of acculturation and the widespread pressure for thinness in western counties. Therefore, the evidence around culture and eating disorders remains unclear.

An alternative explanation, particularly in respect of other mental health subscales such as depression and anxiety, is the possibility that ethnic minority students may under report mental health distress as a result of differences in interpretation of the questions or responses to choices (Seo et al., 2014). In addition, words related to mental health do not exist in all cultures or languages (Karasz et al., 2013). For example, in Muslim culture, mental distress is considered a spiritual issue and therefore attributed to 'Jinns' (Lim et al., 2018). There may also be an impact of cultural values and ingroup stigma which may impact on feelings around disclosure (Krieger et al., 2005). This was also captured in the qualitative strand by one of the interview respondents IP5 who mentioned minimising symptoms as a result of self-stigma and captured in the sub-theme 'don't speak to anyone about it'.

4.2.2 Individual and cultural barriers

There were differences in barriers faced by students, although the picture was not uniform across all measures, which were societal stigma, self-stigma, barriers to seeking help (including the subscales; negative perceived value, ingroup stigma, discomfort with emotions and cultural barriers), and finally beliefs about mental illness. The findings from this study provide a mixed picture across the different types of barriers, resulting in hypothesis 3.1 being partially accepted.

No significant differences were found between ethnic minority students and their White peers in this study in respect of societal stigma, self-stigma and beliefs about mental illness. Low levels of societal stigma were found across all participants in the study. Although
the current study's findings in relation to societal stigma were in contrast to a systematic review of 144 studies with 90,189 participants which found ethnicity differences in the impact of stigma on help seeking, with Asian Americans showing median large negative association. This finding is supported by qualitative data in the UK suggested that stigma was found to be a barrier to help seeking (Arday, 2018; Sancho & Larkin, 2020). In respect of self-stigma many found that there was a role in help seeking (Cole & Ingram, 2020; Jennings et al., 2017; Lannin et al., 2016; Morena et al, 2024). No difference was found in connection with beliefs about mental illness scale. In previous qualitative research conducted in the UK that focused on African and Caribbean heritage students, beliefs about mental illness were a factor that impacted help seeking (Dare et al., 2023). This is an ethnic group that was underrepresented in the current study; thus, this may explain the lower-than-expected scores.

However, in terms of overall barriers to seeking help, there was a significant difference with ethnic minority students reporting higher barriers than White students with a medium effect size. The two subscales that accounted for this difference were in-group stigma (medium effect size) and cultural barriers (large effect size). In-group stigma has previously been identified as a potential barrier to accessing mental health support by ethnic minority students in the UK (Arday, 2018; Sancho & Larkin, 2020) which supports the finding in the current study. Cultural barriers have also been reflected in the existing literature as having a key role in help seeking amongst ethnic minority students (Gee et al., 2020; Kim & Zane, 2016; Soorkia et al, 2011; Tang & Mascicampo, 2018).

4.2.3 Practical barriers

In terms of practical barriers observed, differences were reported between the two practical barriers measured (lack of knowledge and lack of access). Lack of knowledge about service provision showed no difference between groups, which suggests that the universities did a good job of advertising services to students and that students knew in general what support was available and how to access it. This was in contrast to existing studies that had found that ethnic minority students' barriers to help seeking included a lack of awareness of services (Jennings et al., 2015; Li et al., 2018; Marsh & Wilcoxon, 2015). Lack of access scores confirmed findings

from the literature (Jennings et al., 2015; Li et al., 2018; Marsh & Wilcoxon, 2015) that ethnic minority students experienced significantly higher access barriers than their White peers.

4.2.4 Help-Seeking and Utilisation

In contrast to expectations and much of the existing literature (Broman, 2012; Campbell et al., 2022; Lipson et al., 2022; Miranda et al., 2015;) there was no significant difference in help seeking rates between ethnic minority students and their White peers (34.1% vs. 24.7%) in the current sample. Therefore hypothesis 1.2 was rejected. Previous research from the US had mostly found ethnic minority students showed lower rates of help seeking than their White counterparts, 53 % vs 89% (Miranda et al., 2015), 9.6% vs 25.3% (Kim & Zane, 2016). In the current study utilisation of mental health services did not significantly differ by ethnicity group, either in terms attending assessment when offered (62% of White students vs 80% of ethnic minority students) or attending subsequent sessions (80% of White students as compared to 65% of ethnic minority students). Therefore hypothesis 1.3 was rejected. This was in contrast to much of the previous research in the US (Eisenberg et al., 2011; Hunt et al., 2015; Lipson et al., 2022; Miranda et al., 2015; Kim & Zane, 2016; Tang & Masicampo, 2018) who all reported ethnic minority student utilisation to be lower than White students. The majority of the research on student utilisation of embedded services in the UK was either qualitative or did not report differences in ethnicity (Broglia 2021a). However similar findings to the current study were found in both the US and the UK where it could be posited that this was a result of the assumption that the majority of participants came from an institution where they are not a minority group. It may be then that being part of the majority meant that students felt less likely to be discriminated against and experienced less stigma. These findings are in line with those reported in the US where ethnic minority students who are in a majority in their college. The research by Gee et al. (2020) was in an environment with 56.9% Asian American versus 55.1% European American, and Glickman et al.(2021) who found no difference in utilisation in relation to ethnicity of students in a predominantly minority college. Glickman et al. (2021) suggested that this was a result of an improvement in attitudes towards mental health help seeking. However, Gee et al. (2020) posited different reasons for the findings. Acculturation was considered as a factor, as the majority of their participants were second generation Asian Americans. The assumption was made that as a result they would be more acculturated to western values than if they had been first generation or Asian international students. In addition, they suggested that university centres have worked to destigmatise mental health seeking and use of counselling services.

This would seem to be supported by the findings in this current study where they were no differences in societal stigma, self-stigma or help seeking.

4.2.5 Within ethnic minority group correlates of help seeking

Further post-hoc analysis was conducted on the 126 ethnic minority students to examine possible predictors of help-seeking. Predictors that were examined included; student status (home or international), stigma, self-stigma, ingroup stigma, negative perceived values, cultural values and distress index. However, only two factors were found to predict help seeking significantly: cultural barriers and distress levels. Students with higher cultural barrier scores had a lower probability of their seeking support from counselling services. Cultural barriers that were included in the survey all related to barriers between the students and counsellor. Including identifying with statements perceiving that a counsellor wouldn't be sensitive to issues around cultural identity or cultural values, doubt around adequate training for explore issues related to cultural identity, feeling that culture would be an obstacle to seeking help and finally cultural differences between counsellor and student would be a barrier to seeking support. This finding has been echoed in the qualitative literature in the UK with concerns about cultural competence of practitioners, staff attitudes, potential of cultural insensitivity all posited as potential barriers to seeking support (Arday, 2018; Memon et al., 2016).

Those with higher levels of distress were more likely to seek support from counselling services which is consistent with several studies of UK students (Broglia et al., 2021 a; Cage et al., 2020), although both of these studies did not give details of the ethnicity of participants. In contrast there have been other studies that have found that higher levels of depression and anxiety have been linked to lower levels of help seeking intentions (Clement & Paramova, 2024).

4.2.6 Drop Out

Very small numbers of participants in the current study reported dropping out from counselling (6.89% of total participants). Of the 34 students that attended an assessment, three White students (which was 30% of those White students that had attended an initial assessment), as compared to 11 (45.8%) of the ethnic minority, students dropped out. No significant difference was found between the two groups. Caution should be taken with the significance in the findings due to the very small sample numbers. This was not echoed in the literature from the US which found significant differences in the dropout data between different ethnicities of student (De Haan et al., 2018; Kilmer et al., 2019; Kivlighan et al., 2019; Levy et al., 2005) and a study of a

wider population in the UK including students (National Collaborating Centre for Mental Health, 2023), which showed that Black and mixed ethnicity participants were more likely to dropout. It is interesting to note that the majority of ethnic minority students dropped out immediately after the assessment (81.82%), suggesting that something about the assessment itself was impacting on their decision. That was echoed in the qualitative strand around the theme of the therapeutic relationship and is discussed more in section 4.3. The importance of a culturally responsive assessment process seems to be key to retaining students in the service. Any therapist conducting the assessment has the power to decide if a client can have treatment or not, but this power differential is expanded if the dyad is a transcultural one. It is critical that if there is a White therapist working with an ethnic minority client then the therapist has in mind the power differential in the relationship and works towards addressing this issue, both directly in therapy but also with thought as to how their own cultural identity may impact the work (Gordon, 2020). Part of the assessment should also include assessing for previous positive or negative therapeutic experiences, part of signalling that the therapist is considering any previous racial micro or macro aggressions (Graham-LoPresti et al., 2019). Including ongoing work throughout the therapy sessions rather than it is mentioned it once in the assessment and then is ticked off as being completed but being reflexive throughout and open to discussion these issues in supervision.

4.3 Interpretations and discussion of qualitative research strand

This research strand was comprised of information from open ended questions in the survey and semi-structured interviews. The main exploratory research question for this component was: “What factors impacted on ethnic minority students’ decisions to drop out from therapy after attending an initial session?”. From the 203 survey participants, all of the ethnic minority participants (n=11) who had dropped out of university counselling responded to open ended questions giving more details for their reasons for dropping out from counselling. Five of those were then interviewed.

Therapeutic relationship

This theme encapsulated the importance that participants placed on the therapeutic relationship, and the study participants who highlighted that their relationship with their therapist played a significant role in the leaving therapy. All participants disclosed that their therapist was

of a different ethnicity to their own. Two reasons for difficulty in feeling connected to therapist was represented in the two subthemes: ‘not feeling understood’, and cultural misunderstanding.

There is a significant body of work around the therapeutic relationship and its impact on the success of therapy. In terms of the ethnicity and the dyad little research has been conducted on ethnic mismatch and if it is related to drop out from therapy. In the current study participants felt that they would prefer a therapist with a similar ethnic background, and in fact several had gone on to seek that in subsequent therapy (either outside of the university setting or, in one case, in a subsequent year of the course when she explained that the counselling service sign up had changed so she was able to look at a list of names and was able to find someone that she felt matched her ethnicity). Only one of the participants felt that ethnicity was not relevant and that they would be happy with any therapist. These findings show a nuanced picture, namely that matched ethnicity between therapist and client is not seen a positive thing by all ethnic minority participants and this is reflected in the limited qualitative research that has been conducted in the UK as outlined below.

Several qualitative studies concluded that increasing diversity of mental health staff was key to encouraging help seeking by ethnic minority students (Arday, 2018; Sancho & Larkin, 2020; Stoll et al., 2022). In a study by Olaniyan & Hayes (2022), which included semi-structured interviews with 48 racial and ethnic minority students, many participants reported that matching ethnicity of client and therapist was a positive approach to encouraging help seeking. In contrast a negative view to ethnic matching was found, particularly from participants from a South Asian background who consistently felt that they would prefer a therapist from a different cultural background because it may lead to judgement or conflict from the wider South Asian community that the therapist may be part of (Olaniyan & Hayes, 2022). In two quantitative studies from the US that focused on dropout, it was found (in study of 150 Asian American client/counsellor pairs) that ethnic matching predicted completion of sessions (Presley & Day, 2019) and (in a review of ethnic minority youth) that ethnic mismatch was found to be a contributing factor to dropout (De Haan et al., 2018).

In the current study students experienced cultural misunderstandings and do not appear to have encountered culturally competent practitioners. This had a significant impact on their decision to drop out of therapy. Cultural competency is an ongoing process that includes behaviours and attitudes to support the establishment and maintenance and conclusion of a counselling

relationship with clients from a diverse cultural background (Lee, 2021). This includes becoming aware of their own biases, actively attempting to understand the worldview of their culturally diverse clients, the sociohistorical context in which that worldview develops, and finally actively developing and practicing appropriate skills and strategies when working with culturally diverse clients (Sue et al., 2022). The use of term cultural competency has begun to be challenged by both clinician's and researchers in the health care field. This was as a result of the concern that cultural competency was a list of knowledge to obtain rather than a self-reflexive ongoing process in response to individual clients and their individuality termed cultural humility (Lekas et al., 2020). In 2023 this was further developed when the term cultural attunement was coined by Myira Khan and combines cultural curiosity, cultural humility and cultural empathy. As a mental health practitioner to practice, have, and offer these three qualities to our clients. In this section I have used terminology from the original source and then reverted to culturally attuned when referring to recommendations.

It has been suggested that as part of a culturally competent assessment with a client, that cultural features of client and therapist should be taken into account (Fung & Lo, 2017). The ability to discuss ethnic and cultural differences early in the therapeutic relationship is one example of a culturally competent skill (Meyer & Zane, 2013).

None of the student participants in the current study mentioned their therapists discussing difference of ethnicity with them, which again adds to the credibility that they were not working in a culturally competent way. This is not uncommon, with low rates (18.7% with ethnic minority participants) of counsellors broaching issues related to race and ethnicity with their clients (King, 2022). Ethnic minority students can benefit from an improvement to the therapeutic alliance and credibility of the counsellor if therapists acknowledge differences between them (Zhang & Burkard, 2008). However, King (2022) noted that if discussions around ethnicity were not facilitated skilfully or woven through the work then it may not benefit ethnic minority students' overall satisfaction with the overall counselling experience.

Cultural competency also includes therapists displaying an understanding of their clients worldview. Participants in this current study describe failures in this respect with one participant disclosing that the therapist repeatedly suggesting that he discussed his difficulties with his parents despite that fact that for him that would not be possible. The in-group stigma around mental health meant that he did not feel that it was acceptable to disclose that he was having

difficulties or seeking support for his mental health. Another felt that their therapist was making assumptions because they were an international student and as a result all of their difficulties were related to cultural differences. Another participant felt that the therapist was unwilling to understand their current problems or unable to understand their childhood experiences. These experiences described in the current study are reflected in the literature where studies have found ethnic minority students who have felt that professionals have been unable to understand or empathise with the everyday lived experience of experiencing racism in all its forms (Arday, 2018) and cultural mistrust (Soorkia et al., 2011).

Privacy at the expense of connection

This theme relates to participants preference to keep their mental health difficulties, or help seeking, separate from their families and university. The impact of the method of delivery of sessions on utilisation and dropout does not appear to be straight forward. In the current study, for some student participants from ethnic minority backgrounds, online sessions appear to be a positive experience both in terms of reducing stigma and increasing privacy. This is reflected in the literature where it has been posited that online therapy acts to reduce self-stigma and to encourage help seeking (Wallin et al., 2018). However, this is not supported by other studies which found that stigma persisted even with online therapy (Hanley & Wyatt, 2021). Other research findings concurred with the current study findings that the element of anonymity which came with online therapy was an advantage (Hanley & Wyatt, 2021), but that this was not generalisable across all students. Online therapy has also been found to decrease the chance of dropout in comparison to face-to-face therapy (Hellstern & Robinson, 2023). What is clear from the current study results and the existing literature is that different students have different preferences and that choice is important (MIND, 2021). In terms of face to face sessions in the current study, again students expressed contrasting views in terms of the visibility of waiting for sessions. Some felt a secluded location made the experience more daunting, while others had the opposing view that waiting outside a more central location would put them off from attending sessions for fear of being seen entering or waiting. Therefore, peers or university staff finding out that they were seeking help for their mental health), as also found by Priestly et al. (2022. The desire to have distance between the university and mental health support, driven by a lack of trust in confidentiality of services, can be found in the literature (Cogan et al., 2023), and the fear of the consequences of a breach in confidentiality (such as for international students the fear of being sent home).

Not good enough

This theme encapsulated participants feeling that they were not deserving of support, whether that was as a result of their perceived lack of importance (that results in them prioritising the service or other service users above themselves), or that they felt that the intervention would not help them. Some elements of this have been reflected in the literature. In the US it was found that perceived lack of benefit to seeking help contributed to Asian American student dropout from therapy (Kim & Zane, 2016). The concern of students that the service is 'overwhelmed' and therefore putting the service needs before their own has been shown in other studies. Students who participated in a qualitative study reported feeling worried that their service is 'thinly stretched' (Broglia et al., 2021).The worry of being a burden to the service has come up with Asian American students (Tang & Masicampo, 2018), where the authors found that they did not only experience higher rates of burdensomeness than their White peers but also tended to report a higher likelihood of keeping counselling sessions a secret from their family.

Time is of the essence

The issue of time in all it facets was reflected in this theme including the problems of long wating times, difficulties around timings of sessions and students feeling restricted by the rigidity of the therapeutic hour (50-minute) session. There seems to be very limited research on the impact of the session length on client satisfaction or its effect on drop out. It appears that the reason for the 50 minute session prevalent in the UK is largely around practical reasons for the therapist (allowing for time to write up notes, take a break between clients, and ease of scheduling) rather than as a desire for the optimum length for therapeutic benefit. There may be a cultural explanation for this as it has been found that there are differences between cultures in respect to how time is constrained. In terms of students experiencing long waiting lists for access to university mental health services this seems to be a common phenomenon which has been reported in other studies (Broglia et al., 2018) and negatively impacts help seeking across ethnicities. The negative impact of being on a waiting list for treatment in the literature seem to match with our participants' views. Those experiencing a long wait for treatment experienced the development or re-emergence of beliefs around their negative self- worth and that they are not deserving of support (Punton et al., 2022). The practicalities around attending sessions relating to time are strongly reflected in the literature across all the components found within the theme of timing, including not having enough time to attend (Jennings et al., 2015; Marsh & Wilcoxon, 2015; Miranda et al., 2015), and the time of day sessions were offered (Priestley et al., 2022).

4.4 Interpretations and discussion of the integration of results

The integration of results aims to answer the mixed methods research question: To what extent, and in what ways, do the open-ended survey questions and the qualitative interviews help to explain the quantitative results on utilisation, barriers and drop out.

There were no significant differences in utilisation of counselling services by ethnic minority students (n=24, 80%) compared to White students (n=10, 62%) attending a session when offered. After attending an assessment, again, no significant differences were found between the two groups but the percentage of ethnic minority students utilising further sessions dropped by 15% whereas the utilisation of White students increased by 18% between assessment and further sessions. The overall numbers for attending further sessions were n=15, 65% for ethnic minority students and n= 8, 80% for White students.

The qualitative data provides some evidence to explain the unexpected high utilisation by ethnic minority students. Several interview participants mentioned the positive impact that campus advertising had both in terms of posters and specific mental health awareness days. One participant mentioned that university academic staff had a positive impact both in terms of advertising services directly to but also in effect recommending services by highlight the fact that previous students has found it helpful.

This drop of utilisation of ethnic minority students from 80% to 65%, before and after the assessment, suggests that something about the assessment session is impacting on this behaviour shift. This could be explained by findings from the qualitative data where students in sub theme ‘waiting times’ expressed concerns around long waiting times between initial assessment and counselling sessions starting, leading some students to seek support outside their university. For others the lack of flexible timings offered for sessions may be impacting on their ability to engage further with services (particularly those with caring responsibilities) as identified in the sub theme ‘timing’. Another potential explanation for dropout after the assessment identified in sub theme ‘visibility’ was a lack of choice over mode of delivery when the preference of face to face was not offered, therefore they did not return for sessions after the assessment.

A higher proportion of White students (84.2%) were offered sessions following the initial assessment session than ethnic minority students (69.8%). This was an issue that was expressed in the current study with a number of student participants reported not being offered support as they were told that their problems were too complex for the service. This finding is echoed in the UK literature on ethnic minority clients seeking help with more severe symptoms and being less likely to be offered treatment following assessment (National Collaborating Centre for Mental Health, 2023). It is also more likely that ethnic minority patients will then be diagnosed with severe and complex mental health issues which results in inpatient care (Fitzpatrick et al., 2014).

The framework of the Health Belief Model (Rosenstock et al., 1988) (see section 1.5.2.) also helps to support this higher than expected utilisation of services by ethnic minority students, that the positive impact of the cues to action (from service advertising, academic staff endorsing services) and the perceived benefits (given by academic staff and peers) have had a very significant impact of overcoming the significant barriers to action. This would help to explain the lack of a significant difference in utilisation and dropout between the two groups. This would be consistent with the proposition that universities sampled already having put some systems in place to support the culturally diverse groups of students present in these institutions. This has appeared to have helped to support the initial help seeking.

Those students who dropped out after an initial assessment (but before starting sessions) for reasons such as the timing not being convenient or because there was a long wait time can be explained using the stages of change model (Norcross et al., 2011). Many of the students that participated in the qualitative strand appear to be in the preparation stage of change (having taken the first tentative steps by contacting the service, and even taking part in an assessment) but these systemic issues around service provision (that the service is not flexible or agile enough to be able to respond to students individual needs) create a barrier. Both in terms of lack of being able to offer sessions outside of office hours (to meet the needs of those with caring responsibilities), or to be able to offer sessions quickly at the point of need, mean that these students then drop out and do not return. Dropout rates after assessment highlight the importance of the therapist working in a culturally competent way as discussed earlier in the chapter, highlighting that the importance of the client's interaction with the service from the start is critical.

4.5 Research limitations

Some limitations to the study have been identified in relation to generalisability, data collection method, and social desirability. In this study students were sampled from inner London universities and the majority from City a culturally diverse city and university. The ethnic background of these students has a different composition from the UK as a whole and the university of London, which are much less culturally diverse. The sample of this study closely matches the composition of City, with 65.7% from an ethnic minority background compared to 62.1% in this research. As a result, the ethnic minority students in this study were not in a minority in their university. As a result, the findings may not generalise to other ethnic minority students studying at other institutions in the UK. An additional limitation to consider, in relation to generalisability, is the examination of all ethnic minority groups together. This decision was taken as a result of small numbers of self-identified Black, Mixed and Other to combine with Asian students into an ethnic minority student group. This decision was taken as the small groups sizes as compared to the Asian and White groups would not have allowed for valid analyses to be conducted. As a result, it has not been able to take into consideration that students within these different groups may have had different experiences that haven't been captured. Other options may have been to conduct the analyses using three groups Asian, White and a third group to include Black, Mixed and Other ethnicities. A final factor affecting generalisability is the gender split of participants, most participants were women (84.7%). This is a common phenomenon in psychological research with more women taking part.

Furthermore, in terms of data collection, self-reported mental health surveys have been found to be impacted by social desirability bias (Latkin et al., 2017), but this has been partially mitigated by the quantitative strand survey being anonymised (Reisinger, 2022).

Finally, although the qualitative strand of the research centred on the ethnic minority students lived experience of help seeking, utilisation and drop out, the quantitative strand centred on Whiteness. It did this by comparing ethnic minority students to White students assuming the White outcome was normative. As a result of previous quantitative studies that had struggled to recruit ethnic minority students it was decided early on to include students from all ethnicities in the quantitative strand of the research. In reality, uptake was strong among ethnic minority students, in particular Asian students. At this stage an option would have been to focus the analyses only on ethnic minority students either to only include Asian students, or all ethnic

minority students, and to remove the data from White students. However, this would have been unethical to collect data and then not use it.

4.6 Research strengths

Despite the limitations discussed above this study does have a number of research strengths. A significant strength of the study is the proportion of ethnic minority students that participated, particularly students from an Asian background. In previous quantitative or mixed methods studies there has been very limited ethnic diversity. When comparing the current study to other UK quantitative studies on student mental health in the UK they had much lower rates of ethnic minority participation, with 88.9% from a White background and 11.1% from an ethnic minority background (Cage et al., 2020) or no ethnicity breakdown was given but authors reported the majority of participants were White (Broglia et al., 2021a). In particular the qualitative responses in this study have captured ethnic minority students' experience of dropping out from university counselling which have not been previously represented in the literature.

The other strength is the mixed methods approach that was taken. In this case it helped to explain the survey results and to capture the lived experience of the students, the nuances of which were not captured by the survey. In addition, the explanatory sequential design allowed the integration of the quantitative and initial qualitative results from the open-ended survey questions, to input into the design of the semi-structured interview question. This ensured that the second strand was responsive to the first and that unexpected quantitative findings could be explored. For example, higher initial utilisation than hypothesised. It also added to the qualitative analysis by inductive and deductive analysis to be undertaken.

A final strength is the clinical relevance of the study where the findings have direct relevance to university counselling services' practitioners working with students and also to service managers and policy makers within the university sector.

4.7 Implications and recommendations for culturally sensitive university counselling services.

The findings from this study have implications for both counselling services in the university setting and clinical practice with ethnic minority students.

Several positives that came out of the current study is that the universities' counselling services seem to have already taken steps to address help seeking and utilisation amongst ethnic minority students. This is through increasing awareness of services but also campaigns around mental health more generally through mental health awareness weeks. Outside of the service the impact of trusted academic staff also destigmatised use of services by discussing positive use of services by previous students which was helpful to encourage help seeking. Recommendations include, in addition to general advertising of services, active displays of cultural sensitivity through targeting messaging to ethnic minority students, to dispel any myths or stigmatisation around accessing services (particularly around confidentiality and trust of services).

Despite the positives that were highlighted in the study the student experiences of those students that dropped of counselling suggest that there are still areas that could be improved upon, particularly in relation to clinical practice.

A common factor that was highlighted by participants was the importance of choice of ethnicity of therapist. Often gender preference is offered during the initial application stage so this could be a straightforward addition (assuming you have diversity among the staffing team). On application to the service students could be given an option to specify desired ethnicity of therapist. Some students will have no preference, others would actively choose someone from the same or different cultural background.

Based on this study's findings it is important that services should reflect or represent the student body that it serves. It many cases this would lead to a need to increase ethnic diversity of counselling centre staff. In the UK in 2023 84% of registered practitioner Psychologists in the UK were White (HPCP, 2023) and in 2022/23 86.73% of British Association for Counselling and Psychotherapy members were White (BACP, 2023). There is also an issue of diversity of students coming into training across various disciplines. For example, in the discipline of clinical psychology 85% of trainees identified as White in 2022 (Jameel et al., 2022). This underlines a secondary issue which is, it is impossible to recruit a diverse workforce if they don't exist, which highlights the importance of all practitioners to be working in a culturally sensitive way. As a result, all clinical staff should be expected to undertake culturally sensitive training to help understand issues that might be presented by ethnic minority groups. It is also important that the service also provides ongoing training and reflexive spaces for staff to highlight the need for

and develop cultural attunement in addition to supervision. Things are changing for those students currently in training to bring cultural attunement into the forefront of training from the beginning, but more needs to be done to provide continuing professional development for therapists already practicing and for it to be embedded into all supervision training.

In summary, on the basis of these implications, the following recommendations for university counselling services are made: targeting adverting of mental health services to ethnic minority students, increasing diversity of counselling staff, providing choice of ethnicity of therapist (if possible), training for all staff in cultural sensitivity and competency, and improving flexibility in the service to offer sessions outside of office hours. In order for these recommendations to be taken on board the dissemination of findings from this study will be paramount. The aim of dissemination will be to ensure that information will get to service leads and practitioners so that practical changes can follow, not solely a contribution to the literature. As a result, the chosen journal for dissemination is focussed on a special issue of the Journal of Education Sciences which is specifically focused on the mental health and wellbeing in higher education.

4.8 Future research suggestions

On the basis of this study's findings future research should be focused in the following areas. To improve generalisability work could be done on wider student body outside London. In particular to look at ethnic minority students who are in a minority in their institutions (unlike in the current study). If a comparison approach was to be used it is suggested that a more appropriate comparison group to contextualise the findings rather than a comparison with White students. An example could be comparing ethnic minority students in an institution where they are a majority compared to minority. This would be taking an anti-racist approach using a strengths approach decentring Whiteness and focusing on the strengths of what has worked well (Nelson et al., 2020).

Two participants groups that were represented in very small numbers in this study were Black students and students that had dropped out from counselling. From the literature and the small number of Black students (14%) recruited to this study it appears that Black students are underrepresented in the literature. More quantitative or mixed methods research needs to be done with Black students to build on the qualitative work that has already been done. One way to increase buy in would be to use a co-created approach from the beginning.

Finally, the area of student dropout from counselling, where in this current study only 11 participants that had dropped out were included. It is also an area where very limited quantitative work has been done. It would be useful to conduct a quantitative survey with focus specifically on drop out to investigate if the findings from this study are replicated in a larger group.

4.9 Conclusion

In conclusion this study aimed to explore the utilisation of embedded university mental health services by ethnic minority students and barriers to accessing support throughout the process, including impact on dropout. The study found that there were no significant differences between ethnic minority and White students across the majority of mental health distress measures or utilisation and dropout rates. There were significant differences found in the survey data between the ethnic groups in perceived barriers to accessing support including: in-group stigma, cultural barriers and practical barriers to accessing support. Amongst ethnic minority students two significant predictors of help seeking were found. Students with higher cultural barrier displayed lower help seeking and those with higher levels of distress were more like to seek support. The utilisation, barriers and dropout findings were explained to a large extent by the findings from the qualitative component.

Recommendations for university counselling services include: targeting advertising of services to ethnic minority student groups, offering students a choice of ethnicity of therapist, increasing the ethnic diversity of the counselling service workforce to reflect the student body, and finally ongoing training on cultural competency for all counselling staff.

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Appendices

Appendix A

Dear Rachel

Reference: ETH2122-1642

Project title: A mixed methods exploration of the utilization of embedded university counselling services by ethnic minority students in London.

Start date: 24 Oct 2022

End date: 20 Jul 2024

I am writing to you to confirm that the research proposal detailed above has been granted formal approval from the Psychology committee: medium risk. The Committee's response is based on the protocol described in the application form and supporting documentation. Approval has been given for the submitted application only and the research must be conducted accordingly. You are now free to start recruitment.

Please ensure that you are familiar with City's Framework for Good Practice in Research and any appropriate Departmental/School guidelines, as well as applicable external relevant policies.

Please note the following:

Project amendments/extension

You will need to submit an amendment or request an extension if you wish to make any of the following changes to your research project:

- Change or add a new category of participants;
- Change or add researchers involved in the project, including PI and supervisor;
- Change to the sponsorship/collaboration;
- Add a new or change a territory for international projects;
- Change the procedures undertaken by participants, including any change relating to the safety or physical or mental integrity of research participants, or to the risk/benefit assessment for the project or collecting additional types of data from research participants;
- Change the design and/or methodology of the study, including changing or adding a new research method and/or research instrument;

- Change project documentation such as protocol, participant information sheets, consent forms, questionnaires, letters of invitation, information sheets for relatives or carers;
- Change to the insurance or indemnity arrangements for the project;
- Change the end date of the project.

Adverse events or untoward incidents

You will need to submit an Adverse Events or Untoward Incidents report in the event of any of the following:

a) Adverse events

b) Breaches of confidentiality

c) Safeguarding issues relating to children or vulnerable adults

d) Incidents that affect the personal safety of a participant or researcher

Issues a) and b) should be reported as soon as possible and no later than five days after the event. Issues c) and d) should be reported immediately. Where appropriate, the researcher should also report adverse events to other relevant institutions, such as the police or social services.

Should you have any further queries relating to this matter, please do not hesitate to contact me. On behalf of the Psychology committee: medium risk, I do hope that the project meets with success.

Kind regards

Tina Forster

Psychology committee: medium risk

City, University of London

Ethics ETH2122-1642: Ms Rachel Thomas (Medium risk)

Dear Rachel

Reference: ETH2223-1354

Project title: A mixed methods exploration of the utilisation of embedded university counselling services by ethnic minority students in London.

Start date: 24 Oct 2022

End date: 20 Jul 2024

I am writing to you to confirm that the research proposal detailed above has been granted formal approval from the Psychology committee: medium risk. The Committee's response is based on the protocol described in the application form and supporting documentation. Approval has been given for the submitted application only and the research must be conducted accordingly. You are now free to start recruitment.

The approval was given with the following conditions:

Adverts and participant information sheets need to be updated to reflect the latest templates, see https://www.city.ac.uk/research/support/integrity-and-ethics/guidanc... (Anna Ramberg is no longer at City).

Please ensure that you are familiar with City's Framework for Good Practice in Research and any appropriate Departmental/School guidelines, as well as applicable external relevant policies.

Please note the following:

Project amendments/extension

You will need to submit an amendment or request an extension if you wish to make any of the following changes to your research project:

- Change or add a new category of participants;
- Change or add researchers involved in the project, including PI and supervisor;
- Change to the sponsorship/collaboration;
- Add a new or change a territory for international projects;
- Change the procedures undertaken by participants, including any change relating to the safety or physical or mental integrity of research participants, or to the risk/benefit assessment for the project or collecting additional types of data from research participants;
- Change the design and/or methodology of the study, including changing or adding a new research method and/or research instrument;
- Change project documentation such as protocol, participant information sheets, consent forms, questionnaires, letters of invitation, information sheets for relatives or carers;

- Change to the insurance or indemnity arrangements for the project;
- Change the end date of the project.

Adverse events or untoward incidents

You will need to submit an Adverse Events or Untoward Incidents report in the event of any of the following:

a) Adverse events

b) Breaches of confidentiality

c) Safeguarding issues relating to children or vulnerable adults

d) Incidents that affect the personal safety of a participant or researcher

Issues a) and b) should be reported as soon as possible and no later than five days after the event. Issues c) and d) should be reported immediately. Where appropriate, the researcher should also report adverse events to other relevant institutions, such as the police or social services.

Should you have any further queries relating to this matter, please do not hesitate to contact me. On behalf of the Psychology committee: medium risk, I do hope that the project meets with success.

Kind regards

Katy Tapper

Psychology committee: medium risk

City, University of London

Ethics ETH2223-1354: Ms Rachel Thomas (Medium risk)

City, University of London

Dear Rachel

Reference: ETH2324-0346

Project title: A mixed methods exploration of the utilisation of embedded university counselling services by ethnic minority students in London.

Start date: 24 Oct 2022

End date: 20 Jul 2024

I am writing to you to confirm that the research proposal detailed above has been granted formal approval from the Psychology committee: medium risk. The Committee's response is based on the protocol described in the application form and supporting documentation. Approval has been given for the submitted application only and the research must be conducted accordingly. You are now free to start recruitment.

Please ensure that you are familiar with City's Framework for Good Practice in Research and any appropriate Departmental/School guidelines, as well as applicable external relevant policies.

Please note the following:

Project amendments/extension

You will need to submit an amendment or request an extension if you wish to make any of the following changes to your research project:

- Change or add a new category of participants;
- Change or add researchers involved in the project, including PI and supervisor;
- Change to the sponsorship/collaboration;
- Add a new or change a territory for international projects;
- Change the procedures undertaken by participants, including any change relating to the safety or physical or mental integrity of research participants, or to the risk/benefit assessment for the project or collecting additional types of data from research participants;
- Change the design and/or methodology of the study, including changing or adding a new research method and/or research instrument;
- Change project documentation such as protocol, participant information sheets, consent forms, questionnaires, letters of invitation, information sheets for relatives or carers;
- Change to the insurance or indemnity arrangements for the project;

- Change the end date of the project.

Adverse events or untoward incidents

You will need to submit an Adverse Events or Untoward Incidents report in the event of any of the following:

a) Adverse events

b) Breaches of confidentiality

c) Safeguarding issues relating to children or vulnerable adults

d) Incidents that affect the personal safety of a participant or researcher

Issues a) and b) should be reported as soon as possible and no later than five days after the event. Issues c) and d) should be reported immediately. Where appropriate, the researcher should also report adverse events to other relevant institutions, such as the police or social services.

Should you have any further queries relating to this matter, please do not hesitate to contact me. On behalf of the Psychology committee: medium risk, I do hope that the project meets with success.

Kind regards

Andreas Jarvstad

Psychology committee: medium risk

City, University of London

Ethics ETH2324-0346: Ms Rachel Thomas (Medium risk)

Appendix B

PARTICIPANT INFORMATION FOR QUESTIONNAIRE

Title of study

A mixed methods exploration into student's attitudes towards and experiences of accessing mental health support at university in London.
Name of principal researcher: Rachel Thomas

Invitation paragraph

We would like to invite you to take part in a research study. Before you decide whether you would like to take part it is important that you understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. You will be given a copy of this information sheet to keep.

What is the purpose of the study?

This study aims explore the underutilisation of university counselling services and explore both the individual and structural barriers to seeking and accessing support. It will focus on London students due to the higher ethnic diversity in the capital in comparison the UK as a whole. It will include students of all ethnicities and genders.
It will focus on the exploring the prevalence of mental health difficulties and numbers accessing support from university counselling services. It also hopes to gain an understanding of the barriers to initially accessing support and finally understanding reasons those that attend an initial assessment appointment but then drop out and do not continue with therapy.

There is a lack of research in this area in the UK and data that does exist is primarily from White women. Therefore, there is a gap in the literature from ethnic minority students to explore their experiences. The duration of the study is approximately 20 minutes.

Why have I been invited to take part?

You have been invited to take part as you are a student over the age of 18 at a university of London institution. Choosing to either take part or not take part will have no effect on assessments, marks, future studies, or access to counselling services.

Do I have to take part?
Participation in the project is voluntary, and you can choose not to participate in the project. You can withdraw at any stage of the project without being penalised or disadvantaged in any way. It is up to you to decide whether or not to take part. If you do decide to take part, you will be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time and without giving a reason. If you do not complete the survey, then your data will be deleted during the analysis stage of the research. One the survey is completed then it is not possible to withdraw.

What will happen if I take part?

You will be sent a link to complete an anonymous survey which will take approximately 20 minutes and will be completed online. Some questions will ask about your feeling around seeking and receiving support for mental health concerns. Others will ask about feelings of stress, anxiety, and depression.

What are the possible disadvantages and risks of taking part?
Some of the questions that you will be asked are of a sensitive nature and there is a chance that you may feel distressed by them. Support information will be provided during and at the end of the questionnaire if you should require support.

What are the possible benefits of taking part?
The benefits to taking part in this research include increasing knowledge in this area and potential to impact on practice. You will also have the option of entering a prize draw to win amazon vouchers- 1 £100, 2 £50, 4 £25 and 10 £15. The prize draw will be conducted once stage 1 recruitment is completed no later than 30th June 2023.

What should I do if I want to take part?
If you would like to take part. Please proceed to the consent form.

Data privacy statement
City, University of London is the sponsor, and the data controller of this study based in the United Kingdom. This means that we are responsible for looking after your information and using it properly. The legal basis under which your data will be processed is City's public task.

Your right to access, change or move your information are limited, as we need to manage your information in a specific way in order for the research to be reliable and accurate. To safeguard your rights, we will use the minimum personal-identifiable information possible (for further information please see https://ico.org.uk/for-organisations/guide-to-data-protection/guide-to-the-general-data-protection-regulation-gdpr/lawful-basis-for-processing/public-task/).

Identifying data (Name and email address) will only be collected and stored if you decide to provide it. You do not need to provide these details; the survey can be completed anonymously. You will be invited to provide an email address if you would like to be contacted will the results of the study, you would like to take part in stage 2 of the research or if you would like to be

entered into the prize draw. The only people at City who will have access to your identifiable information (name and email address) will be Rachel Thomas and supervisor. City will keep your contact information for the duration of the research expected to be 3 years.

You can find out more about how City handles data by visiting https://www.city.ac.uk/about/governance/legal. If you are concerned about how we have processed your personal data, you can contact the Information Commissioner's Office (IOC) https://ico.org.uk/.

What will happen to the results?

The results of this research will be disseminated through to university counselling centres at the University of London institutions. It is also planned to be disseminated more widely in publications such as BACP University and College Counselling journal.

If you wish to receive a copy of the research once published, you will be asked to tick a box at the end of the survey to provide your email address and consent to it being stored securely for the duration of the research expected to be 3 years.

Who has reviewed the study?

This study has been approved by City, University of London Research Ethics Committee. Ethics approval code ETH2122-1642.

What if there is a problem?
If you have any problems, concerns or questions about this study, you should ask to speak to a member of the research team. If you remain unhappy and wish to complain formally, you can do this through City's complaints procedure. To complain about the study, you need to phone 020 7040 3040. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is 'A mixed methods exploration of the utilisation of embedded university counselling services by students in London'.
You can also write to the Secretary at:
Anna Ramberg
Research Integrity Manager
City, University of London, Northampton Square
London, EC1V 0HB
Email: Anna.Ramberg.1@city.ac.uk

Further information and contact details
Rachel.thomas@city.ac.uk
Thank you for taking the time to read this information sheet.

Version 3 06/02/2023

Appendix C

Consent form for questionnaire

Name of principal investigator/researcher: Rachel Thomas
Title of study
A mixed methods exploration of the utilization of embedded university counselling services by ethnic minority students in London.

		Please tick or initial box
1	I confirm that I have read and understood the participant information dated Autumn 2022 for the above study. I have had the opportunity to consider the information and ask questions which have been answered satisfactorily.	
2.	I understand that my participation is voluntary and that I am free to withdraw without giving a reason without being penalised or disadvantaged.	
3.	I understand that I will be able to withdraw my data up to the completion of the survey.	
4.	I agree to City recording and processing this information about me. I understand that this information will be used only for the purpose(s) explained in the participant information and my consent is conditional on City complying with its duties and obligations under the General Data Protection Regulation (GDPR).	
5.	I would like to be informed of the results of this study once it has been completed and understand that my contact details will be retained for this purpose.	
6.	I agree to take part in the above study.	

Version 2 14/10/2022

Appendix D

PARTICIPANT INFORMATION FOR INTERVIEW

Title of study

A mixed methods exploration of the utilization of embedded university counselling services by ethnic minority students in London.
Name of principal researcher: Rachel Thomas

Invitation paragraph

We would like to invite you to take part in a research study. Before you decide whether you would like to take part, it is important that you understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. You will be given a copy of this information sheet to keep.

What is the purpose of the study?

This study aims explore the underutilization of university counselling services and explore both the individual and structural barriers to seeking and accessing support. It will focus on London Students due to the higher ethnic diversity in the capital in comparison the UK as a whole. This part of the study will include only students from ethnic minority backgrounds.

This is a two-stage study. This second part of the study aim to explore the experiences of those that attend an initial assessment appointment but then drop out and do not continue with therapy. There is a lack of research in this area in the UK and data that does exist is primarily from White women. Therefore, there is a gap in the literature from ethnic minority students to explore if their experiences. The duration of the study is approximately 45-60 minutes.

Why have I been invited to take part?
You have been invited to take part as you are a student over the age of 18 at a university of London institution. You must have completed stage 1 of the research and indicated that you have attended an initial assessment for counselling at an embedded mental health counselling service at a university of London institution but did not continue or complete sessions offered.

Interviews will only take place once stage 1 of the research has been completed. If more than 6 students indicate that they are interested in participating in the research, then a random number generator will be used to select participants.

Choosing to either take part or not take part will have no effect on assessments, marks, future studies, or access to counselling services.

Do I have to take part?
Participation in the project is voluntary, and you can choose not to participate in the project. You can withdraw at any stage of the project without being penalised or disadvantaged in any way. It is up to you to decide whether or not to take part. If you do decide to take part, you will be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time during the interview and without giving a reason. Once the analysis has commenced then it is not possible to withdraw.

What will happen if I take part?

The lead researcher will contact you via email to arrange a time for an online interview via zoom. The semi structured interview will take between 45-60 minutes. The focus will be on exploring your lived experience of seeking help, experience of the initial assessment and reasons for dropping out.

What are the possible disadvantages and risks of taking part?
There is a possibility that you may feel distressed during the interview. If this is the case, please let the researcher know and they can offer support. You can stop the interview at any stage if you do not wish to continue.
What are the possible benefits of taking part?
The benefits of taking part in this research include increased knowledge in this area and potential to impact on practice.

What should I do if I want to take part?
If you would like to take part. Please proceed to the consent form.

Data privacy statement
City, University of London is the sponsor, and the data controller of this study based in the United Kingdom. This means that we are responsible for looking after your information and using it properly. The legal basis under which your data will be processed is City's public task.

Your right to access, change or move your information are limited, as we need to manage your information in a specific way in order for the research to be reliable and accurate. To safeguard your rights, we will use the minimum personal-identifiable information possible (for further information please see https://ico.org.uk/for-organisations/guide-to-data-protection/guide-to-the-general-data-protection-regulation-gdpr/lawful-basis-for-processing/public-task/).

City will use your name and contact details to contact you about the research study, as necessary. The audio recording and transcript of the interview will be stored securely and separately from your name and email address. The only people at City who will have access to this identifiable information will be Rachel Thomas and supervisor. City will keep identifiable information about you from this study for 10 years after the study has finished.

You can find out more about how City handles data by visiting https://www.city.ac.uk/about/governance/legal. If you are concerned about how we have processed your personal data, you can contact the Information Commissioner's Office (IOC) https://ico.org.uk/.

Will my taking part in the study be kept confidential?

The interview will only be audio recorded as such only the main researcher will have knowledge of the participants identity. All data used in the research will be anonymized. The records will be stored in one drive. Data will be kept for 10 years and then destroyed.

What will happen to the results?

The results of this research will be disseminated through to university counselling centres at the University of London institutions. It is also planned to be disseminated more widely in publications such as BACP University and College Counselling journal.

If you wish to receive a copy of the research once published, you will be asked to tick a box at the end of the survey to provide your email address and consent to it being stored securely for the duration of the research expected to be 3 years.

Who has reviewed the study?

This study has been approved by City, University of London Research Ethics Committee.

What if there is a problem?

If you have any problems, concerns, or questions about this study, you should ask to speak to a member of the research team. If you remain unhappy and wish to complain formally, you can do this through City's complaints procedure. To complain about the study, you need to phone 020 7040 3040. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is 'A mixed methods exploration of the utilisation of embedded university counselling services by students in London.'

You can also write to the Secretary at:

Research & Enterprise Office
City, University of London, Northampton Square
London, EC1V 0HB
Email: senaterec@city.ac.uk

Further information and contact details

Rachel.thomas@city.ac.uk

Thank you for taking the time to read this information sheet.

Version 2 12/10/22

Appendix E

Informed consent form for interview
Title of study

A mixed methods exploration of the utilization of embedded university counselling services by ethnic minority students in London.

		Please tick or initial box
1	I confirm that I have read and understood the participant information dated Autumn 2022 for the above study. I have had the opportunity to consider the information and ask questions which have been answered satisfactorily.	
2.	I understand that my participation is voluntary and that I am free to withdraw without giving a reason without being penalised or disadvantaged.	
3.	I understand that I will be able to withdraw my data up to the time of transcription.	
4.	I agree to the interview being audio recorded.	
5.	I agree to the use of anonymised direct quotes	
6.	I agree to City recording and processing this information about me. I understand that this information will be used only for the purpose(s) explained in the participant information and my consent is conditional on City complying with its duties and obligations under the General Data Protection Regulation (GDPR).	
7.	I would like to be informed of the results of this study once it has been completed and understand that my contact details will be retained for this purpose.	
8.	I agree to take part in the above study.	

Name of Participant	Signature	Date
Name of Researcher	Signature	Date

When completed, 1 copy for participant; 1 copy for researcher file. version 1 27/06/22

Appendix F:

Department of *Psychology*
City, University of London

PARTICIPANTS NEEDED FOR
RESEARCH INTO *STUDENTS ATTITUDES AND EXPERIENCES OF ACCESSING MENTAL HEALTH SUPPORT AT UNIVERSITY*

We are looking for volunteers to take part in a mixed methods exploration of the utilization of embedded university counselling services by students in London.

This study has two stages a most people will only take part in stage one and then a small number will be invited to take part in stage 2.

As a participant in stage one of this study, you would be asked to take part in a computer-based survey and your participation would involve approximately 20 minutes. To thank you for your time you will have the option of entering a prize draw to win amazon vouchers – one £100, 2 £50, 4 £25 and 10 £15.

A small number of a small number of participants will be invited to take part in stage two, an online semi structured interview, which would involve approximately 45 -60 minutes.

For more information about this study, or to volunteer for this study please

Follow this link
https://cityunilondon.eu.qualtrics.com/jfe/form/SV_bIByvfAkEvHuRHo

or contact:

Rachel Thomas department of Counselling Psychology
Email: Rachel.thomas@city.ac.uk

This study has been reviewed by and received ethics clearance
through the department of psychology ethics committee, City, University of London. Ethics approval code ETH2122-1642.
If you would like to complain about any aspect of the study, please contact the Secretary to the Senate Research Ethics Committee on 020 7040 3040 or via email:
Anna.Ramberg.1@city.ac.uk

City, University of London is the data controller for the personal data collected for this research project. If you have any data protection concerns about this research project, please contact City's Information Compliance Team at dataprotection@city.ac.uk

Version 3 06/02/2023

Appendix G

University of London

- Birkbeck College
- The Institute of Cancer Research
- Central School of Speech and Drama
- City, University of London
- Courtauld Institute of Art
- Goldsmiths College
- Institute of Education
- King's College London
- London Business School
- London School of Economics and Political Science
- London School of Hygiene and Tropical Medicine
- Queen Mary University of London
- Royal Academy of Music
- Royal Holloway and Bedford New College
- The Royal Veterinary College
- St George's Hospital Medical School
- The School of Oriental and African Studies
- University College London.

Appendix H

1. Gender	Male	
	Female	
	Non-binary	
	Other	
2. Age		
3. Ethnicity	Asian or Asia British	Bangladeshi
		Chinese
		Indian
		Pakistani
		Any other Asian background (free text box to specify)
	Black, Black British, Caribbean, or African	African
		Caribbean
		Any other Black, Black British, or Caribbean background (free text box to specify)
	Mixed or multiple ethnic groups	White and Black Caribbean
		White and Black African
		White and Asian
		Any other Mixed or multiple ethnic background (free text box to specify)
	White	English, Welsh, Scottish, Northern Irish, or British
		Irish
		Gypsy or Irish Traveller
		Roma
		Any other White background (free text box to specify)
	Other ethnic group	Arab
		Any other ethnic group (free text box to specify)
4. Level of study	Undergraduate	
	Postgraduate	
	Other	
5. Student Status	Home	

	International	

Appendix I (Societal stigma)
Stigma Scale for Receiving Psychological Help
Please rate each statement on a scale from 0(strongly disagree) to 3 (strongly agree).

1. Seeing a psychologist for emotional or interpersonal problems carries social stigma.
2. It is a sign of personal weakness or inadequacy to see a psychologist for emotional or interpersonal problems.
3. People will see a person in a less favourable way if they come to know that he/she has seen a psychologist.
4. It is advisable for a person to hide from people that he/she has seen a psychologist.
5. People tend to like less those who are receiving professional psychological help.

Appendix J

Self -stigma for seeking help scale (SSSH) (Vogel et al., 2006)

INSTRUCTIONS: People at times find that they face problems that they consider seeking help for. This can bring up reactions about what seeking help would mean. Please use the 5-point scale to rate the degree to which each item describes how you might react in this situation.

1 = Strongly Disagree 2 = Disagree 3 = Agree & Disagree Equally 4 = Agree 5 = Strongly Agree

1. I would feel inadequate if I went to a therapist for psychological help.
2. My self-confidence would NOT be threatened if I sought professional help.
3. Seeking psychological help would make me feel less intelligent.
4. My self-esteem would increase if I talked to a therapist.
5. My view of myself would not change just because I made the choice to see a therapist.
6. It would make me feel inferior to ask a therapist for help.
7. I would feel okay about myself if I made the choice to seek professional help.
8. If I went to a therapist, I would be less satisfied with myself.
9. My self-confidence would remain the same if I sought professional help for a problem I could not solve.
10. I would feel worse about myself if I could not solve my own problems.

Items 2, 4, 5, 7, and 9 are reverse scored.

Appendix K

Barriers to seeking mental health counselling for depression BMHC

INSTRUCTIONS: Imagine that for the past 4 weeks, you have experienced a high level of stress due to a personal or emotional problem. You try to keep it together and keep going, but you feel tense, worried, sad, angry, distracted, or tired most of the time. Because of these experiences, you sometimes have difficulty functioning in your daily life.

We are interested in your attitudes or perceptions about seeking mental health counselling if you were to have the abovementioned experiences. By "**mental health counselling**" we refer to services provided by counsellors, psychologists, psychiatrists, or other professionals who use therapy to help individuals cope with their personal or emotional problems (e.g., stress, anxiety, depression, substance problems, interpersonal conflicts). Academic advisement, career counselling, medication treatment or tutoring are *not* considered mental health counselling.

Please read each statement carefully and rate the degree to which you agree with each statement. There are no right or wrong answers or trick questions. Please answer each question as honestly as you can.

	Strongly Disagree	Moderately Disagree	Slightly Disagree	Slightly Agree	Moderately Agree	Strongly Agree
1. I don't think talking with a mental health counsellor would be helpful.	1	2	3	4	5	6
2. I like to count on my friends or family for support rather than reach out to a mental health counsellor.	1	2	3	4	5	6
3. I think talking with a mental health counsellor would only make me dwell on the problem without necessarily resolving the issue.	1	2	3	4	5	6
4. Because I have enough social support, I would not need to seek mental health counselling for my personal problems.	1	2	3	4	5	6
5. I don't like to rely on a mental health counsellor to tell me what to do about my problems.	1	2	3	4	5	6
6. My family or significant other would judge me poorly if I disclose my problems to a mental health counsellor.	1	2	3	4	5	6
7. Most people in my cultural group would not approve of my decision to seek mental health counselling.	1	2	3	4	5	6

	Strongly Disagree	Moderately Disagree	Slightly Disagree	Slightly Agree	Moderately Agree	Strongly Agree
8. My friends would think less of me if they knew I sought mental health counselling.	1	2	3	4	5	6
9. Seeking mental health counselling would bring shame to my family.	1	2	3	4	5	6
10. My family or significant other would not see me negatively if I share my problems with a mental health counsellor.	1	2	3	4	5	6
11. I would feel embarrassed about sharing my feelings with a mental health counsellor.	1	2	3	4	5	6
12. I would feel nervous about showing the emotional side of me during the mental health counselling process.	1	2	3	4	5	6
13. I feel comfortable expressing my feelings to a mental health counsellor.	1	2	3	4	5	6
14. It would be awkward for me to talk about my feelings in mental health counselling.	1	2	3	4	5	6
15. I fear going to mental health counselling because I don't like to reveal my feelings.	1	2	3	4	5	6
16. I don't know how or where to seek mental health counselling.	1	2	3	4	5	6
17. I don't know what kind of mental health counselling services are available.	1	2	3	4	5	6
18. I don't know how mental health counselling works.	1	2	3	4	5	6
19. I don't have the time to seek or stay in mental health counselling.	1	2	3	4	5	6
20. I have no financial means (e.g., insurance, money) to afford mental health counselling services.	1	2	3	4	5	6

21. I have too many responsibilities to other people (e.g., family, friends, significant others) that would prevent me from seeking mental health counselling.	1	2	3	4	5	6
	Strongly Disagree	Moderately Disagree	Slightly Disagree	Slightly Agree	Moderately Agree	Strongly Agree
22. I have too many academic or work-related obligations that would deter me from talking to a mental health counsellor.	1	2	3	4	5	6
22b. We use this question to see if respondents are reading the questions. Please choose "Moderately Agree".	1	2	3	4	5	6

For the following items 23-27, the word "culture", "cultural values" and "cultural identity" broadly define cultural dimensions or identities related to one's race, ethnicity, gender, sexual orientation, socio-economic status, religion/spirituality, disability, immigration, acculturation, and the intersections of these dimensions.

Check the most salient cultural dimension(s) – identity/cultural background/cultural issues –as you prepare to respond to questions (23)-(27). You may check more than one dimension:

	Race
	Ethnicity
	Gender (e.g., gender-based discrimination)
	Gender Identity
	Sexual Orientation
	Socio-economic Status
	Religion/Spirituality
	Disability
	Immigration/Acculturation
	Others, Please Specify:

23. I perceive that most mental health counsellors would not be sensitive to issues related to my cultural identity.	1	2	3	4	5	6
24. I don't think that most mental health counsellors would understand my cultural values.	1	2	3	4	5	6

25. I doubt that most mental health counsellors have adequate training to explore issues related to my cultural identity.	1	2	3	4	5	6
26. I don't think culture would be an obstacle to my seeking help from a mental health counsellor.	1	2	3	4	5	6
27. I think that cultural differences between most mental health counsellors and myself would be a barrier in counselling.	1	2	3	4	5	6

Appendix L

Counseling Center Assessment of Psychological Symptoms — **CCAPS-34**

Name: **Date:** _

INSTRUCTIONS: The following statements describe thoughts, feelings, and experiences that people may well each statement describes you, **during the past two weeks**, from "not at all like me" (0) to "extremely correct number. Read each statement carefully, select only one answer per statement, and please do not sk

	Not at all like me	.....			Extremely like me
1. I am shy around others	0	1	2	3	4
2. My heart races for no good reason	0	1	2	3	4
3. I feel out of control when I eat	0	1	2	3	4
4. I don't enjoy being around people as much as I used to	0	1	2	3	4
5. I feel isolated and alone	0	1	2	3	4
6. I think about food more than I would like to	0	1	2	3	4
7. I am anxious that I might have a panic attack while in public	0	1	2	3	4
8. I feel confident that I can succeed academically	0	1	2	3	4
9. I have sleep difficulties	0	1	2	3	4
10. My thoughts are racing	0	1	2	3	4
11. I feel worthless	0	1	2	3	4
12. I feel helpless	0	1	2	3	4
13. I eat too much	0	1	2	3	4
14. I drink alcohol frequently	0	1	2	3	4
15. I have spells of terror or panic	0	1	2	3	4
16. When I drink alcohol I can't remember what happened	0	1	2	3	4
17. I feel tense	0	1	2	3	4
18. I have difficulty controlling my temper	0	1	2	3	4
19. I make friends easily	0	1	2	3	4
20. I sometimes feel like breaking or smashing things	0	1	2	3	4
21. I feel sad all the time	0	1	2	3	4
22. I am concerned that other people do not like me	0	1	2	3	4
23. I get angry easily	0	1	2	3	4
24. I feel uncomfortable around people I don't know	0	1	2	3	4
25. I have thoughts of ending my life	0	1	2	3	4
26. I feel self-conscious around others	0	1	2	3	4
27. I drink more than I should	0	1	2	3	4
28. I am not able to concentrate as well as usual	0	1	2	3	4
29. I am afraid I may lose control and act violently	0	1	2	3	4
30. It's hard to stay motivated for my classes	0	1	2	3	4

31. I have done something I have regretted because of drinking	0	1	2	3	4
32. I frequently get into arguments	0	1	2	3	4
33. I am unable to keep up with my schoolwork	0	1	2	3	4
34. I have thoughts of hurting others	0	1	2	3	4

Appendix M

Beliefs towards mental illness scale

Please rate each statement on a scale from 5 (completely agree) to 0 (completely disagree)

1. A mentally ill person is more likely to harm others than a normal person.
2. Mental disorder would require a much longer period of time to be cured than would other general disease.
3. It may be a good idea to stay away from people who have a psychological disorder because their behaviour is dangerous.
4. The term ‘Psychological disorder’ makes me feel embarrassed.
5. A person with a psychological disorder should have a job with minor responsibilities
6. Mentally ill people are more likely to be criminals
7. Psychological disorder is recurrent
8. I am afraid of what my boss, friends, and others would think if I were diagnosed as having a psychological disorder.
9. Individuals diagnosed as mentally ill will suffer from its symptoms throughout their life.
10. People who have once received psychological treatment are likely to need further treatment in the future.
11. It might be difficult for mentally ill people to follow social rules such as being punctual or keeping promises.
12. I would be embarrassed if people knew that I dated a person who once received psychological treatment.
13. I am afraid of people who are suffering from psychological disorder because they may harm me.
14. A person with psychological disorder is less likely to function well as a parent.
15. I would be embarrassed if a person in my family became mentally ill.
16. I do not believe that a psychological disorder if ever completely cured
17. Mentally ill people are unlikely to be able to live by themselves because they are unable to assume responsibilities.
18. Most people would not knowingly be friends with a mentally ill person.
19. The behaviour of people who have psychological disorders is unpredictable
20. Psychological disorder is unlikely to be cured regardless of treatment.
21. I would not trust the work of a mentally ill person assigned to my work team.

Appendix N

1. Are you currently receiving mental health support from outside your university?	Yes	
	No	
2. Have you contacted your university counselling centre for support?	Yes	
	No	
3. Have you been offered an assessment?	Yes	
	No	
4. Have you attended your university counselling centre for an assessment?	Yes	
	No	Please give more detail (free text box)
5. After attending the assessment did you attend counselling session if offered	Yes	
	No	Please give more detail (free text box)
6. Did you drop out before completing the sessions?	Yes	Please give more detail (free text box)
	No	
7. If you answered no to Q 10 or Q11, would	No	

you be willing to take part in Stage 2 of the research which would involve participating in an interview via zoom to explore in more detail your experience. This will take approximately 45-60 minutes.		
	Yes	Please leave email address to be contacted with further details.

Appendix O

A mixed methods exploration of the utilization of embedded university counselling services by ethnic minority students in London.

DEBRIEF INFORMATION

Thank you for taking part in this study. Now that it is finished, we would like to tell you a bit more about it.

This research aims to deepen understanding of barriers and lived experiences of ethnic minority students seeking counselling with the aim to address these barriers and reduce the gap between intention to seek help and actual help seeking.

If your participation in this research has raised concerns or affected your mental health, there is help available. Please see links below for support or contact your GP.
https://www.studentminds.org.uk/
https://www.samaritans.org/
https://giveusashout.org/

We hope you found the study interesting. If you have any other questions, please do not hesitate to contact us at the following:
Rachel.thomas@city.ac.uk

Ethics approval code:

Version 2 12/10/2022

Appendix P

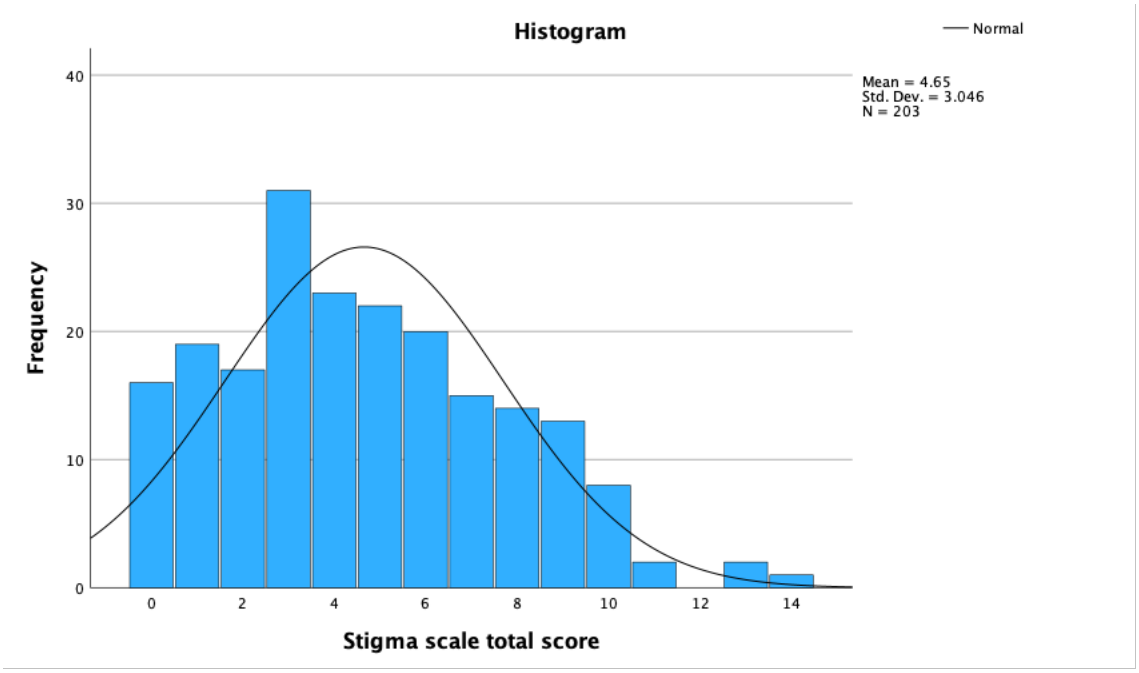
Assessing for normality

1) Stigma scale for receiving psychological help – stigma scale.

Kolmogorov-Smirnov as sample over 50.

<.001 suggests a violation of normality – quite normal in larger samples.

Histogram slight shift to left.



Q-Q plot looks normal.

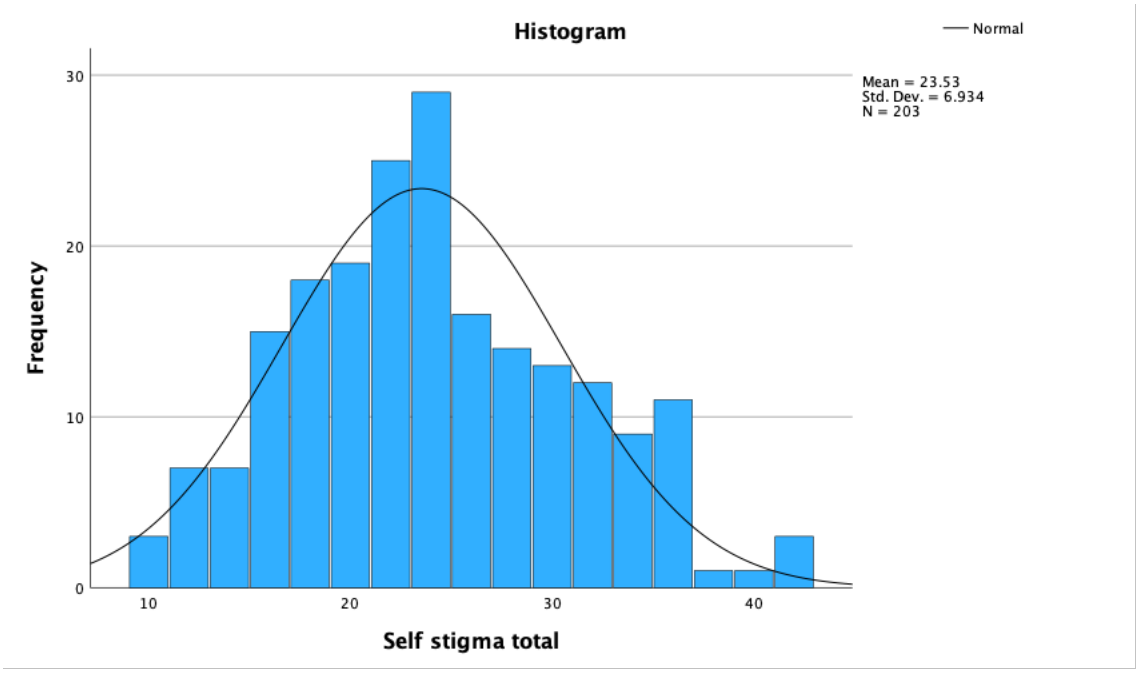
Box plot no outliers.

Reasonably normal – parametric.

2) Self-stigma scale for seeking help.

   K-S .002 suggests a violation of normality – quite normal in larger samples.

   Histogram normal.



Q-Q plot normal.

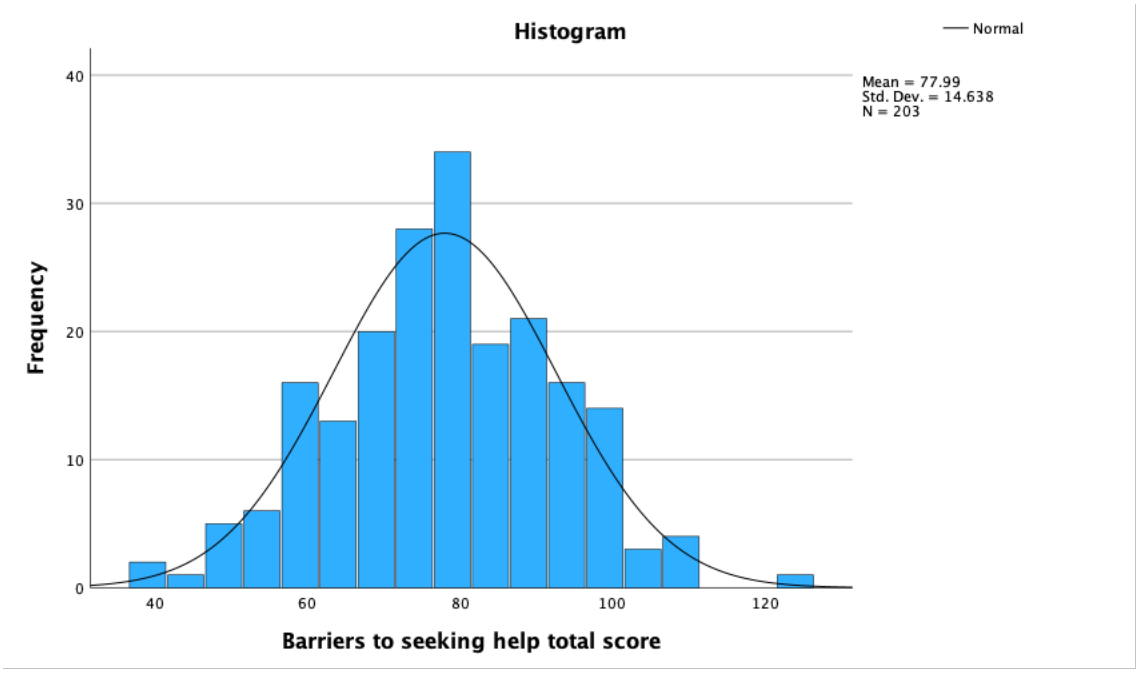
Box plot 1 outlier. On inspection the outlier score of 42 (participant 44) appears genuine and is within possible score (10-50) for the self-stigma scale. To assess the impact of the outlier the 5% trimmed mean was inspected, and it has not had a strong influence on the mean. Removing top and bottom 5% reduces mean from 23.53 to 23.41. There is only a difference of 0.08 therefore the data point will not be changed or removed. (Pallant, 2016).

Reasonably normal – parametric.

3) Barriers to seeking mental health counselling.

K-V .200 signifies normality.

Histogram normal



1 outlier on boxplot score of 123 (participant 24) is well within possible scores of the barriers to seeking help score (27-162), so the score is genuine. To assess the impact of the outlier the 5% trimmed mean was inspected and showed the outlier has not had a strong influence on the mean. As several participants at the lower 5% therefore removing top and bottom 5% reduces mean from 77.99 to 78.05 only a difference of 0.6 % therefore the outlier will not be removed or changed.

Normality of distribution – Parametric

4) CCAPS-34

- Depression.
  K-S .001 suggests a violation of normality – quite normal in larger samples

- Generalized anxiety.
- Social anxiety.

  K-V .077 Meets assumptions of normality as over .05.

- Academic distress.

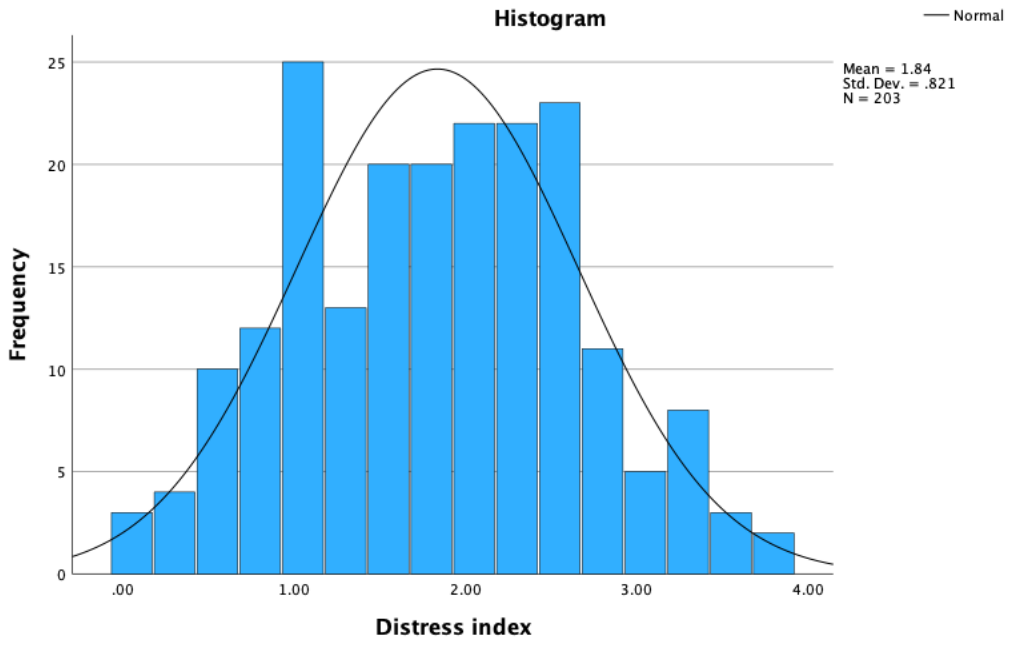
  No outliers

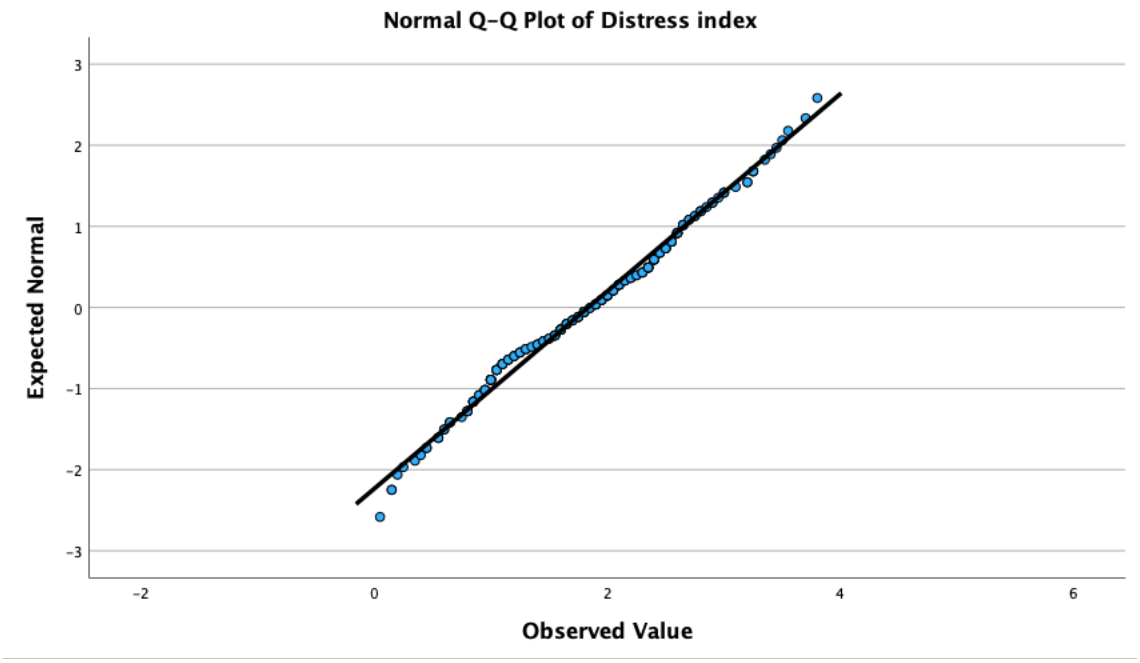
- Eating concerns.

  No outliers

- Hostility index.

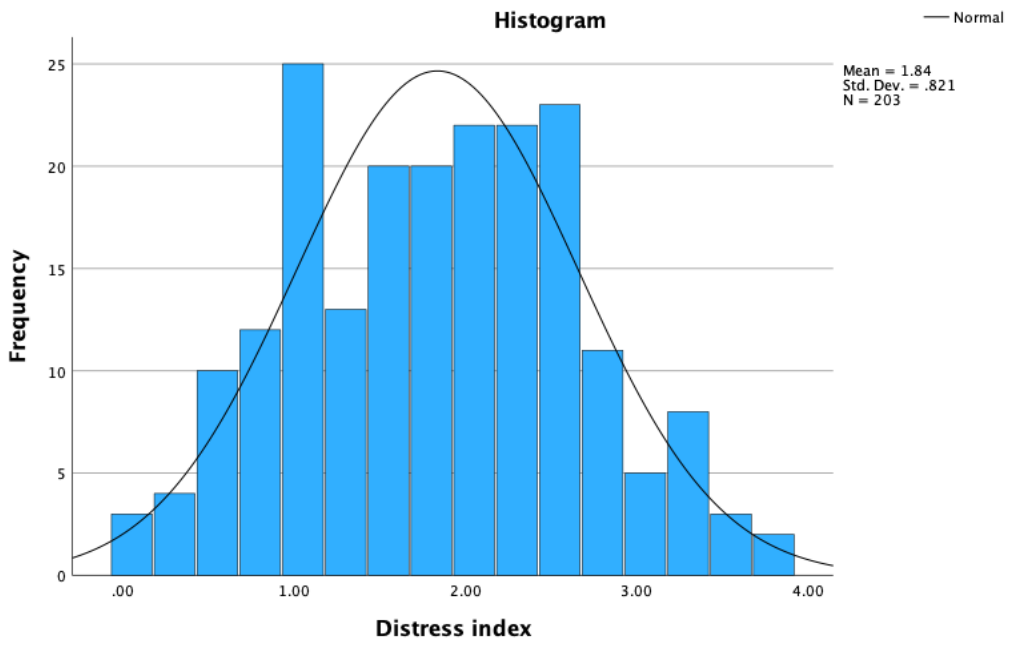
  No outliers





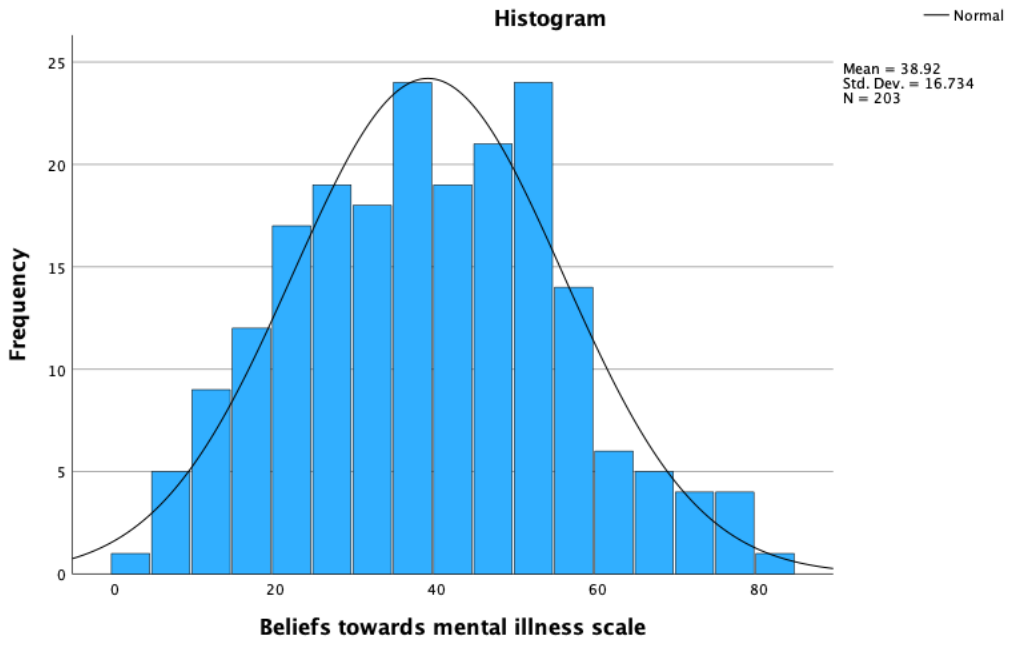
- Alcohol use index.
  Very uneven spread clusters at top and bottom of scale. Due to the nature of this scale this is to be expected.

- Distress index.
  No outliers



5) Beliefs towards mental illness scale

K-V .200 Meets assumptions of normality as over .05.



No outliers

Meets normality assumptions data is parametric.

Appendix R

Interview schedule

Explore experiences of initially seeking help and any initial barriers

1)How did you first find out about the support available and how did you make contact?
2)How long did it take to be offered an assessment?
3) How many sessions were you offered?
4) How many sessions did you complete before dropping out?
3)What was the experience like of reaching out for help and then waiting for the first session?

Explore experience of the initial assessment

4) What was your experience like of the first session?

Prompts

How did you feel about starting sessions?
How did you find the first session?
How did you feel about therapist?

Explore reasons for not returning for therapy/finishing sessions.

5) Could you tell me about your decision not to continue with sessions?

Prompts

What were your reasons for stopping sessions?

Was there anything around practicalities of the sessions that impacted you?

How did you feel about the Treatment type offered?

How did you find Therapist during session?

Any external factors outside of the counselling session?

What was support like around you for the counselling?

Were friends/ family aware that you were having counselling?

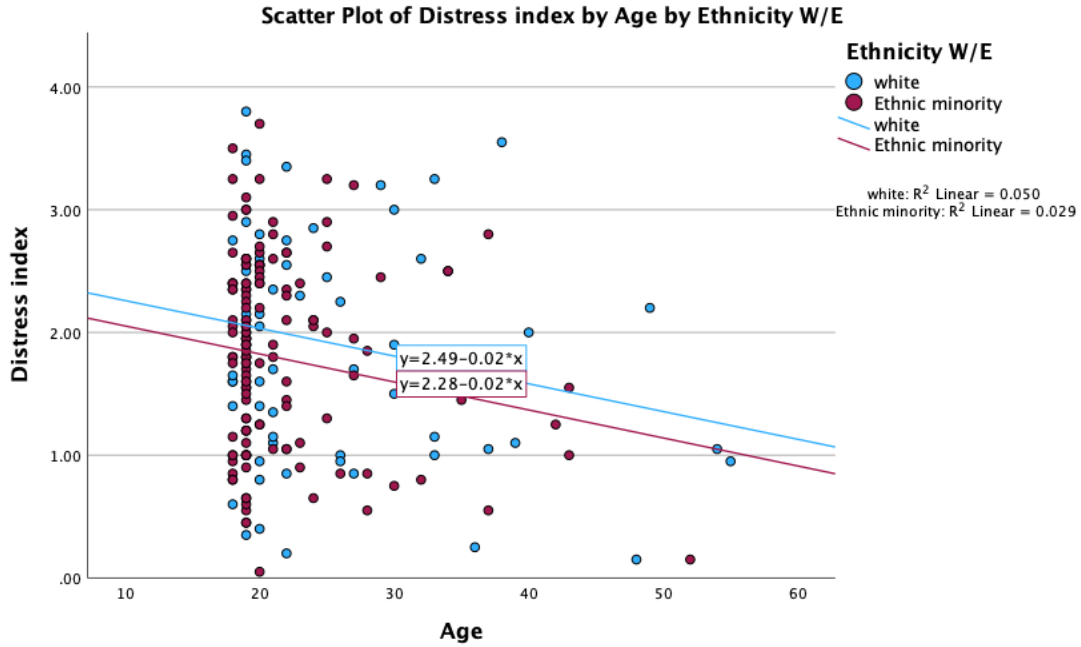
Is there anything else about your experience of stopping sessions that we haven't covered that you would like to share?

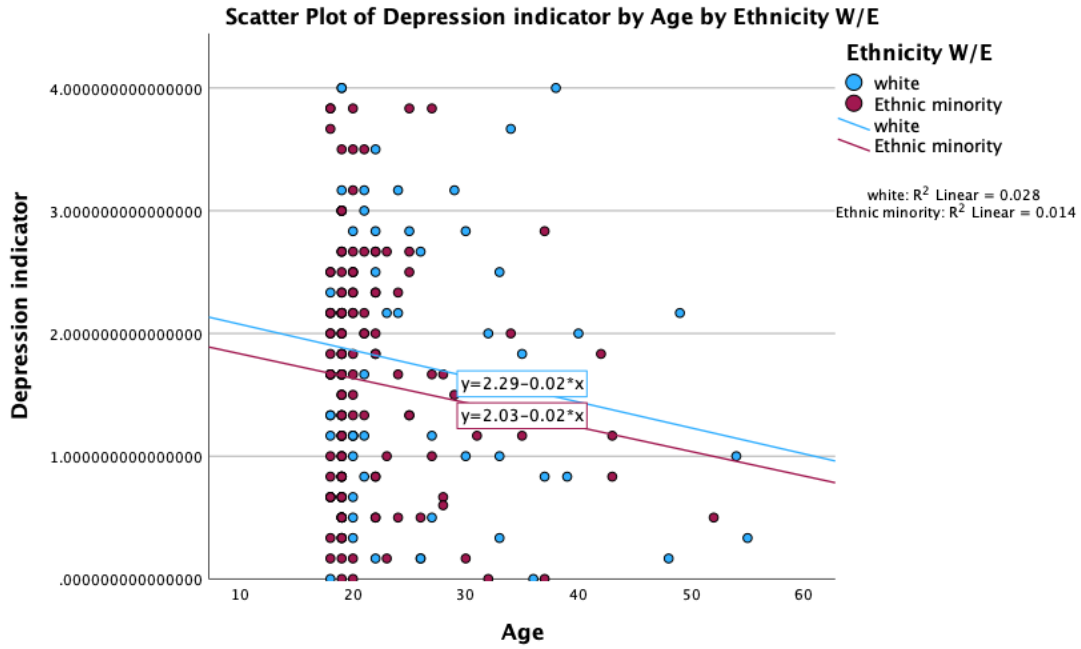
Supplementary probe question ideas

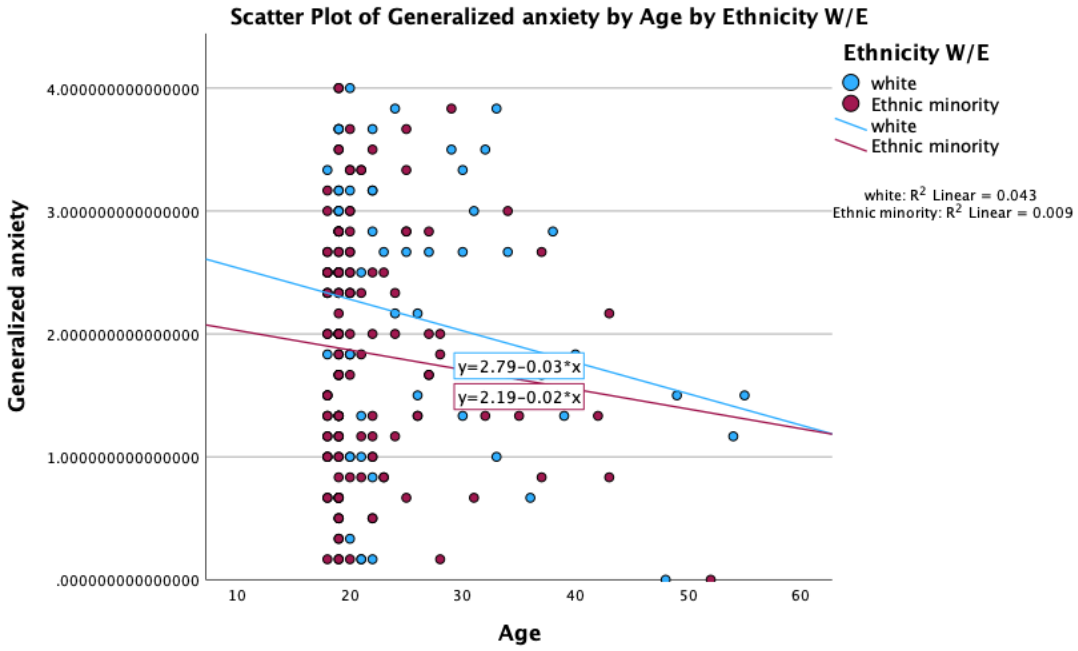
Can you tell me more about that?

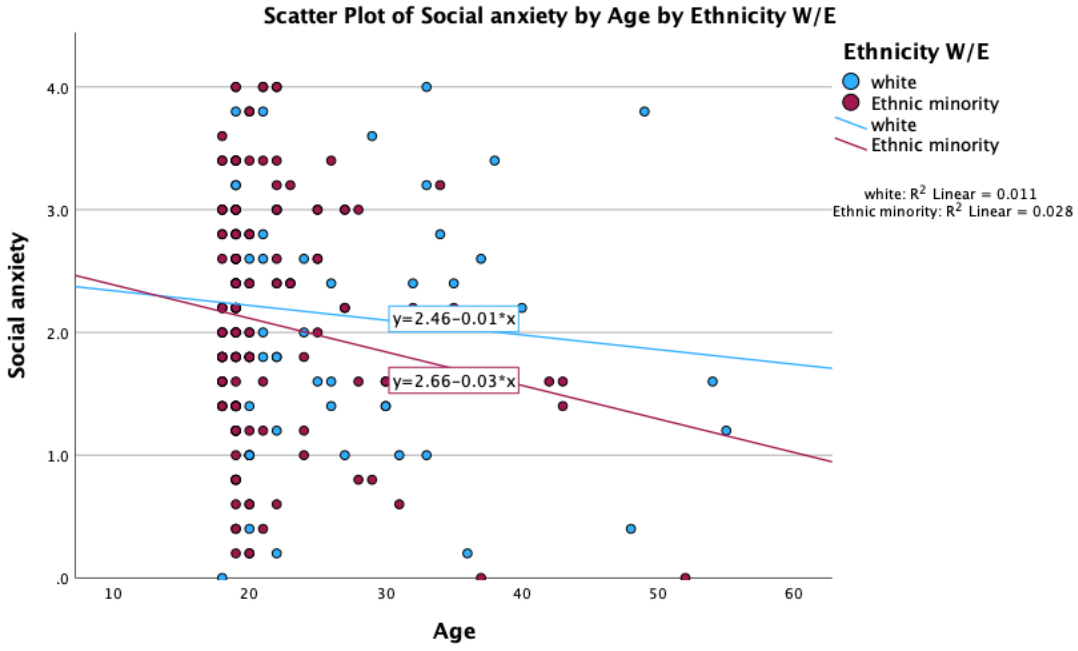
What was the experience like for you?

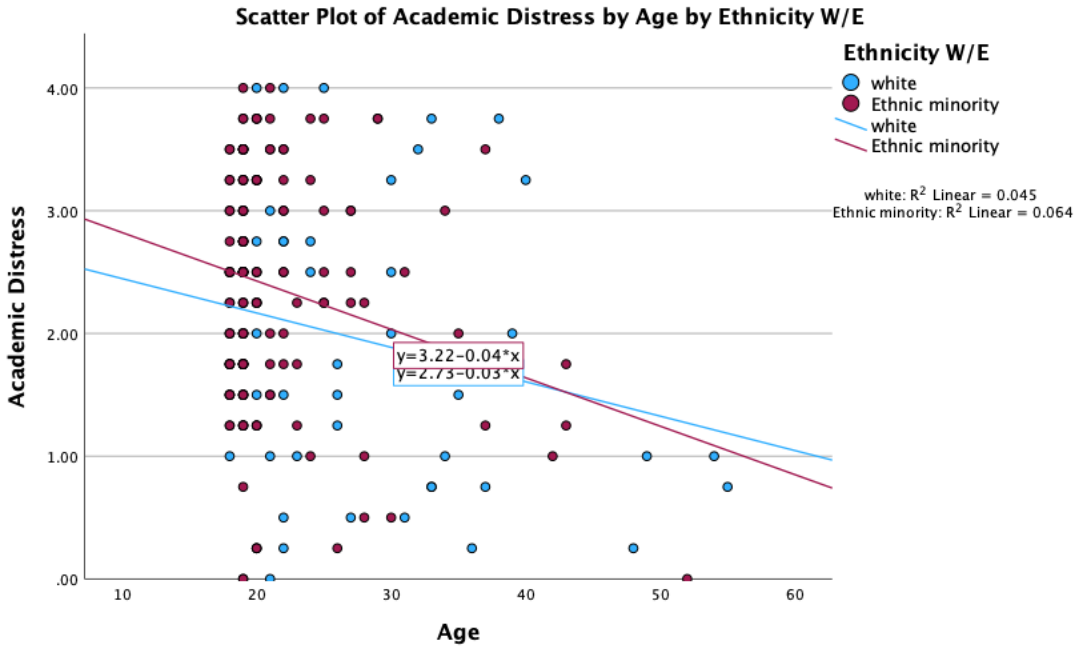
Appendix Q

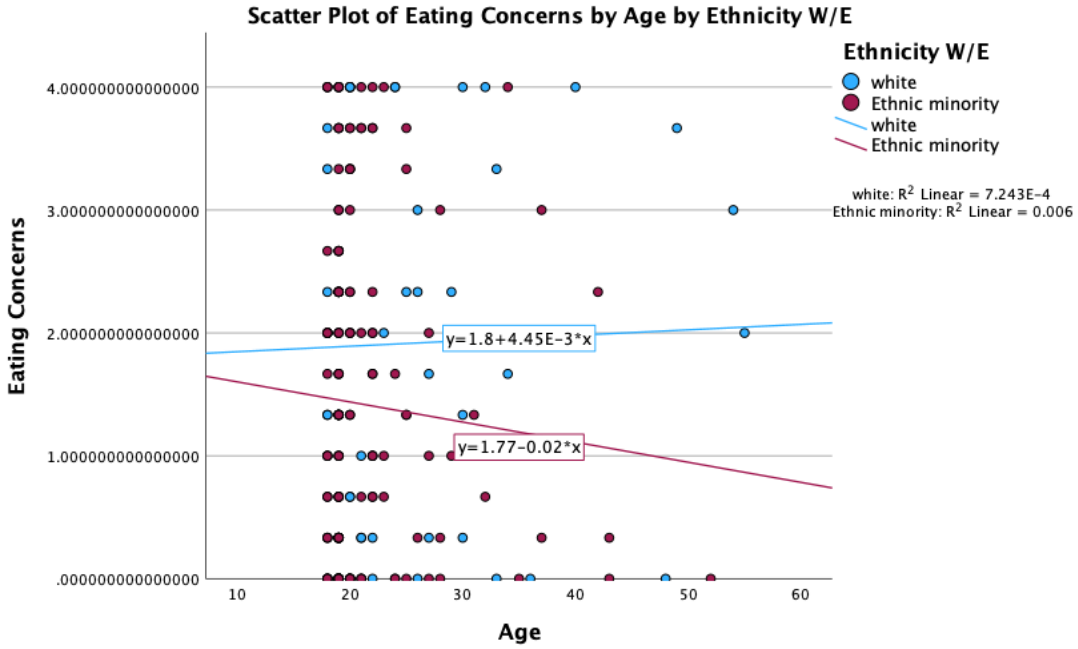

Scatter Plot of Distress index by Age by Ethnicity W/E
Ethnicity W/E
white
Ethnic minority
white
Ethnic minority
white: R² Linear = 0.050
Ethnic minority: R² Linear = 0.029
y=2.49-0.02*x
y=2.28-0.02*x
Distress index
4.00
3.00
2.00
1.00
.00
10
20
30
40
50
60
Age

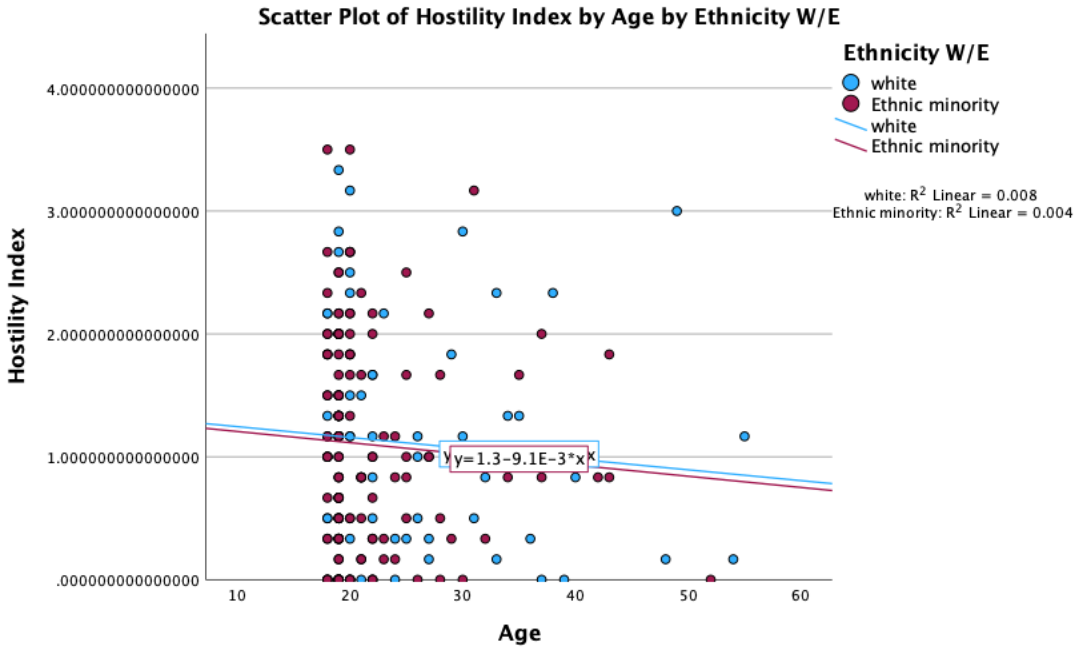

Scatter Plot of Depression indicator by Age by Ethnicity W/E
Ethnicity W/E
white
Ethnic minority
white
Ethnic minority
white: R² Linear = 0.028
Ethnic minority: R² Linear = 0.014
y=2.29-0.02*x
y=2.03-0.02*x
Depression indicator
4.000000000000000
3.000000000000000
2.000000000000000
1.000000000000000
.000000000000000
10
20
30
40
50
60
Age

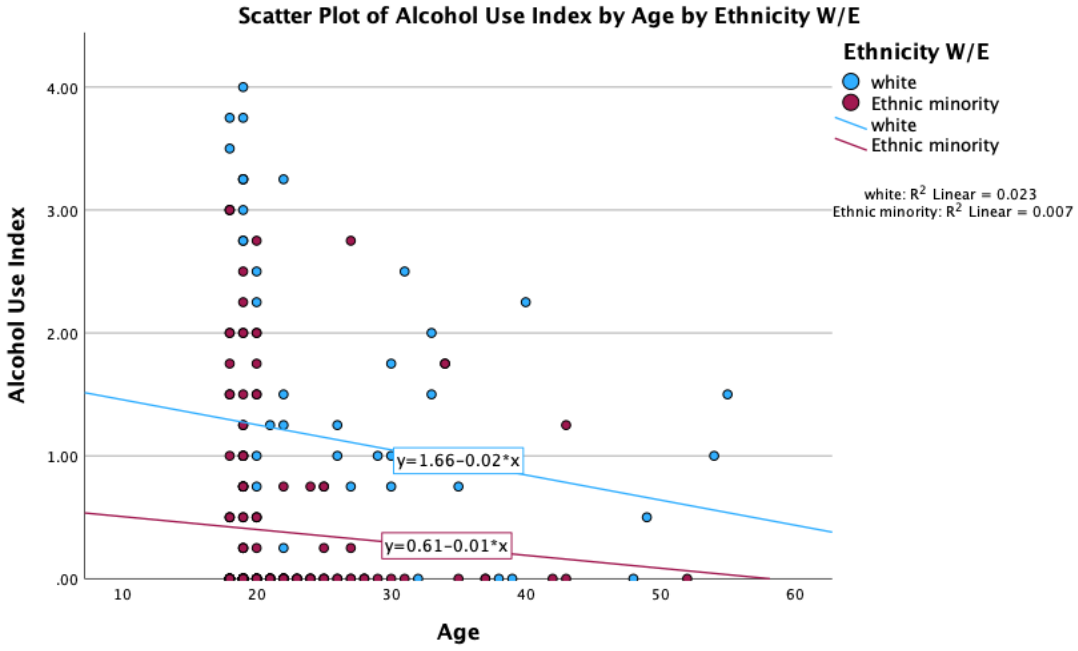

Scatter Plot of Generalized anxiety by Age by Ethnicity W/E
Ethnicity W/E
white
Ethnic minority
white
Ethnic minority
white: R² Linear = 0.043
Ethnic minority: R² Linear = 0.009
y=2.79-0.03*x
y=2.19-0.02*x
Generalized anxiety
4.000000000000000
3.000000000000000
2.000000000000000
1.000000000000000
.000000000000000
10
20
30
40
50
60
Age

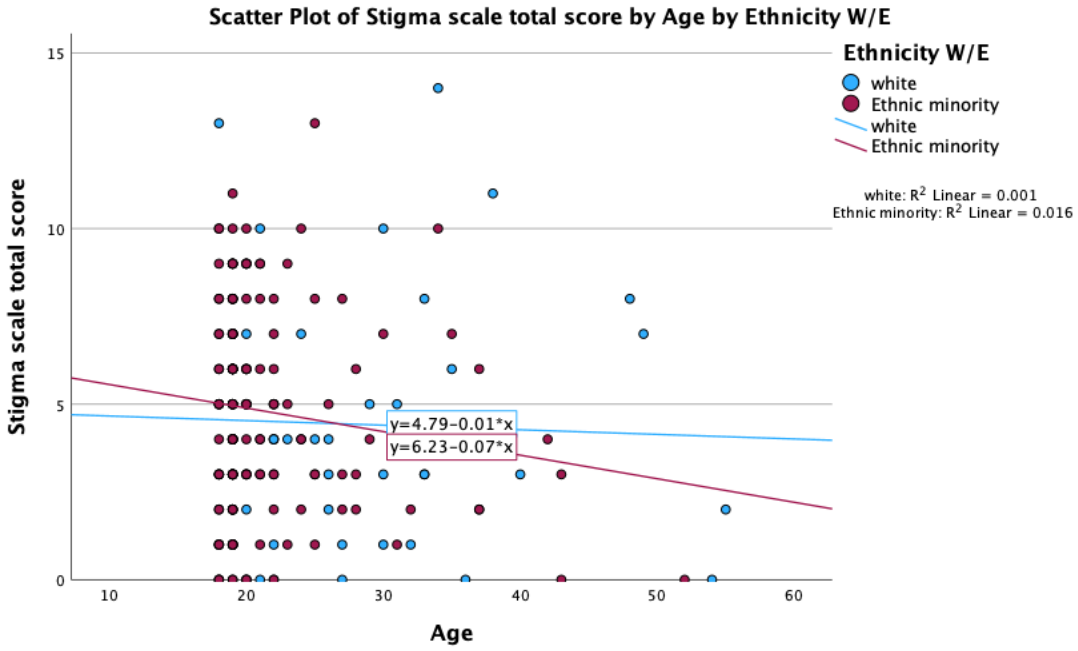

Scatter Plot of Social anxiety by Age by Ethnicity W/E
Ethnicity W/E
white
Ethnic minority
white
Ethnic minority
white: R² Linear = 0.011
Ethnic minority: R² Linear = 0.028
y=2.46-0.01*x
y=2.66-0.03*x
Social anxiety
4.0
3.0
2.0
1.0
.0
10
20
30
40
50
60
Age

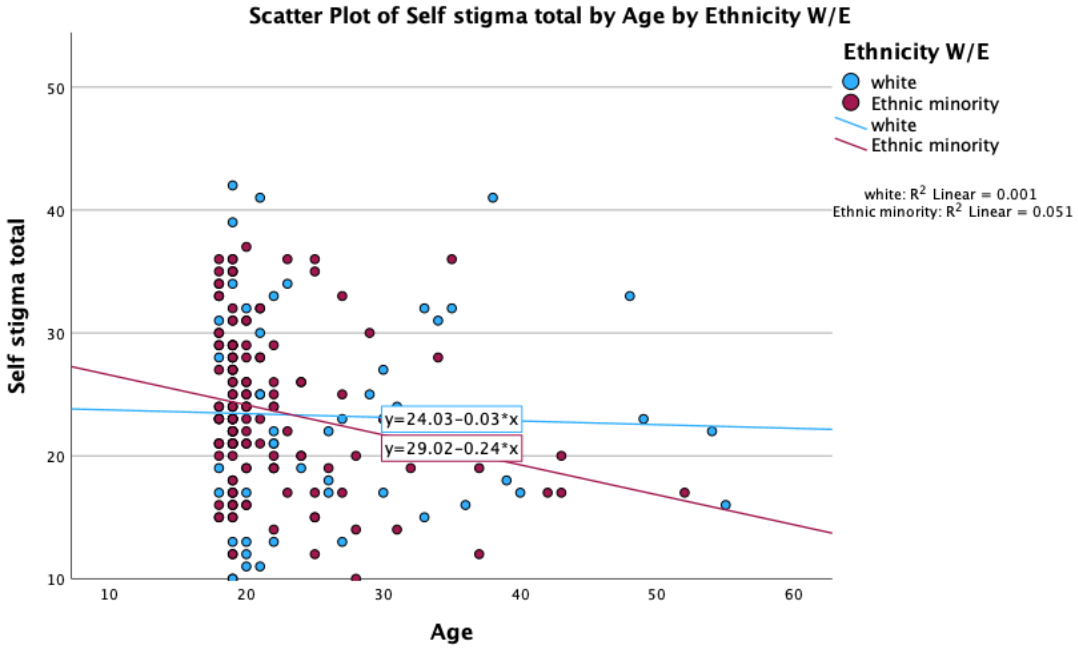

Scatter Plot of Academic Distress by Age by Ethnicity W/E
Ethnicity W/E
white
Ethnic minority
white
Ethnic minority
white: R² Linear = 0.045
Ethnic minority: R² Linear = 0.064
y=3.22-0.04*x
y=2.73-0.03*x
Academic Distress
4.00
3.00
2.00
1.00
.00
10
20
30
40
50
60
Age

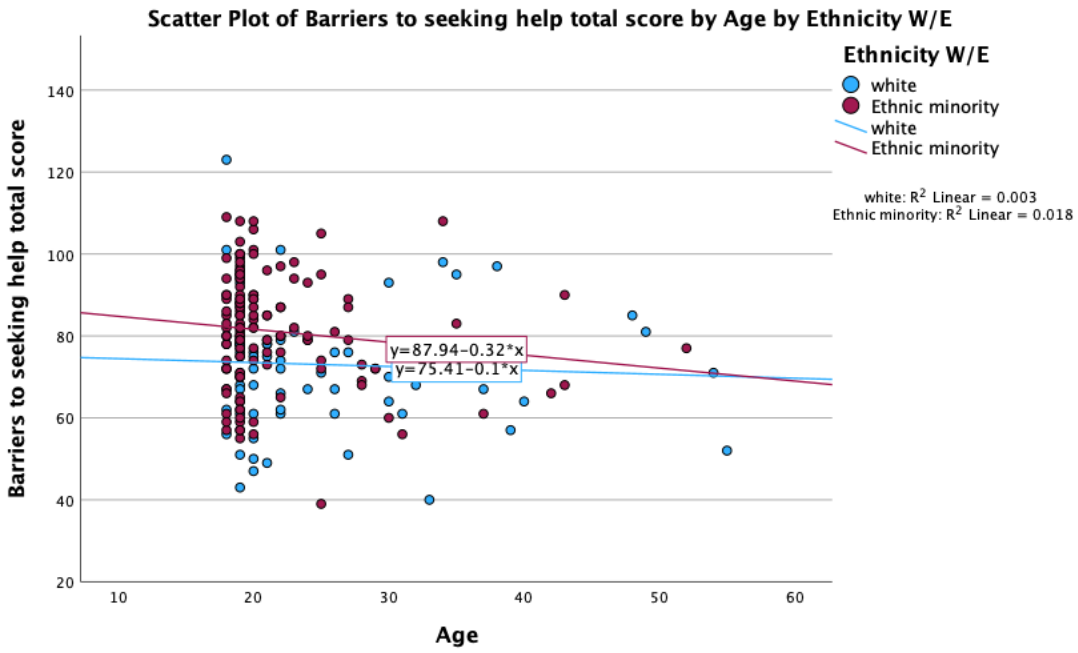

Scatter Plot of Eating Concerns by Age by Ethnicity W/E
Ethnicity W/E
white
Ethnic minority
white
Ethnic minority
white: R² Linear = 7.243E-4
Ethnic minority: R² Linear = 0.006
y=1.8+4.45E-3*x
y=1.77-0.02*x
Eating Concerns
4.000000000000000
3.000000000000000
2.000000000000000
1.000000000000000
.000000000000000
10
20
30
40
50
60
Age

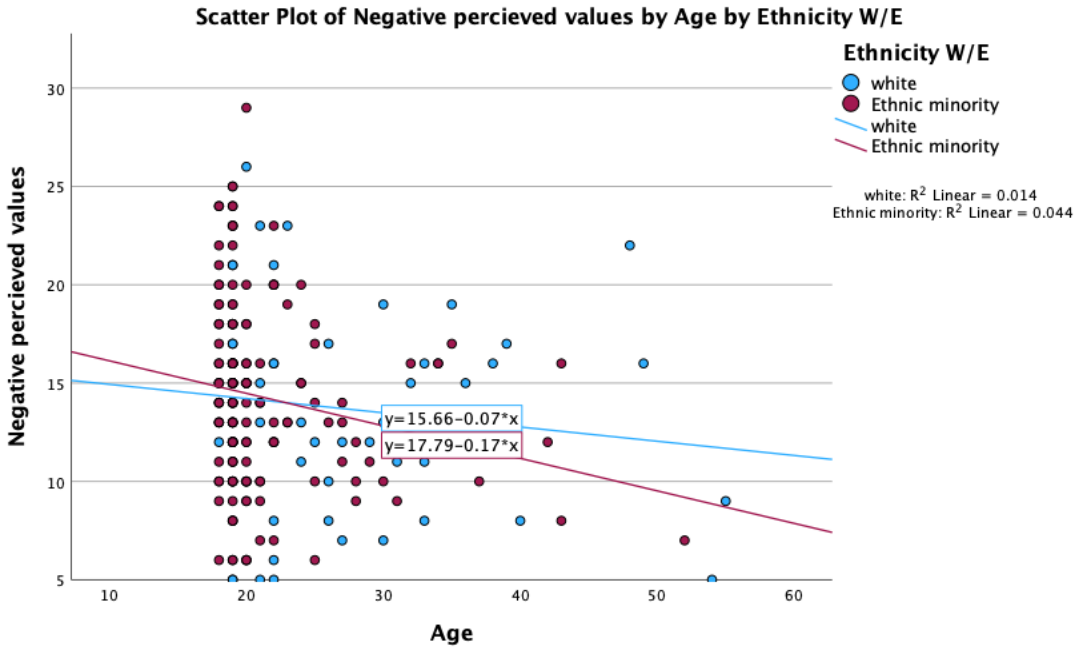

Scatter Plot of Hostility Index by Age by Ethnicity W/E
Ethnicity W/E
white
Ethnic minority
white
Ethnic minority
white: R² Linear = 0.008
Ethnic minority: R² Linear = 0.004
Hostility Index
4.000000000000000
3.000000000000000
2.000000000000000
1.000000000000000
.000000000000000
y=1.3-9.1E-3*x
10
20
30
40
50
60
Age

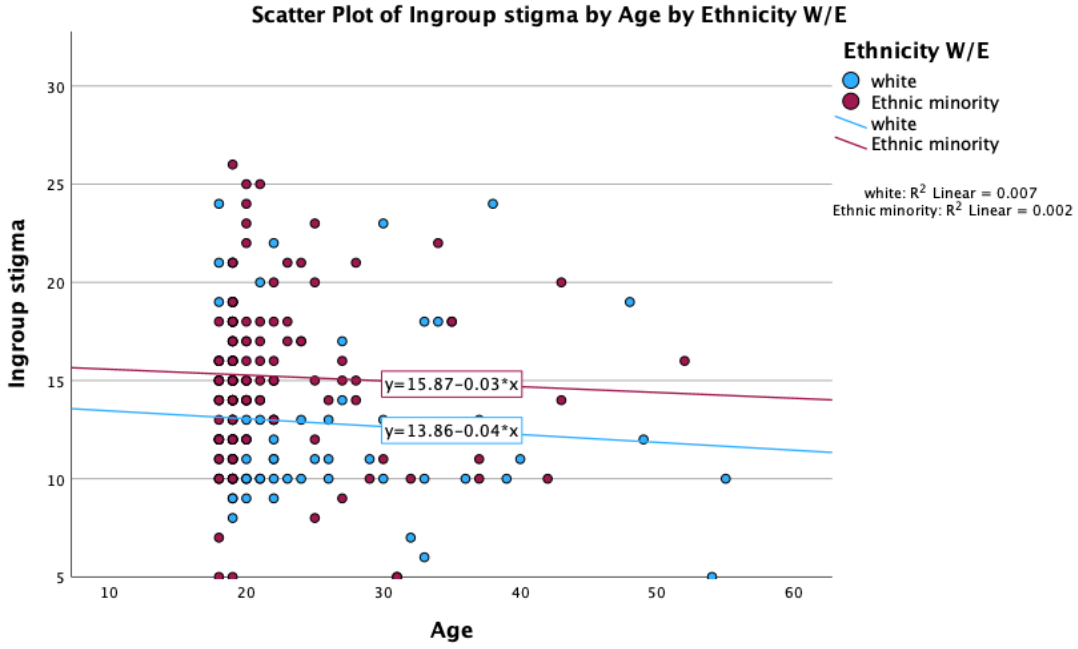

Scatter Plot of Alcohol Use Index by Age by Ethnicity W/E
Ethnicity W/E
white
Ethnic minority
white
Ethnic minority
white: R² Linear = 0.023
Ethnic minority: R² Linear = 0.007
Alcohol Use Index
4.00
3.00
2.00
1.00
.00
y=1.66-0.02*x
y=0.61-0.01*x
10
20
30
40
50
60
Age

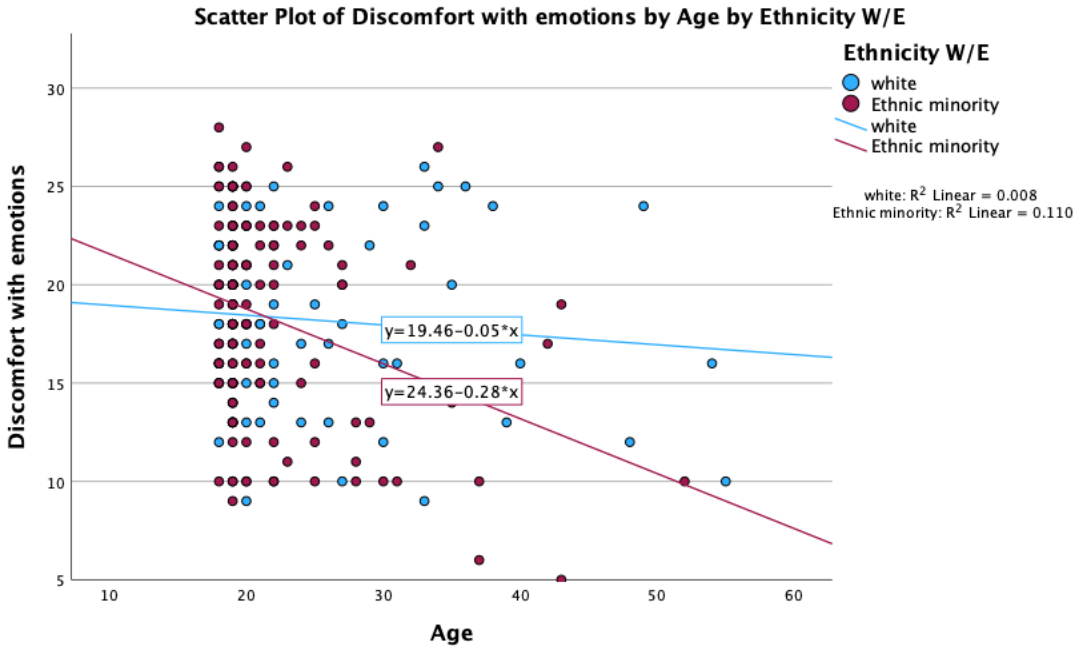

Scatter Plot of Stigma scale total score by Age by Ethnicity W/E
Stigma scale total score
Age
Ethnicity W/E
white
Ethnic minority
white
Ethnic minority
white: R2 Linear = 0.001
Ethnic minority: R2 Linear = 0.016
y=4.79-0.01*x
y=6.23-0.07*x
0
5
10
15
10
20
30
40
50
60

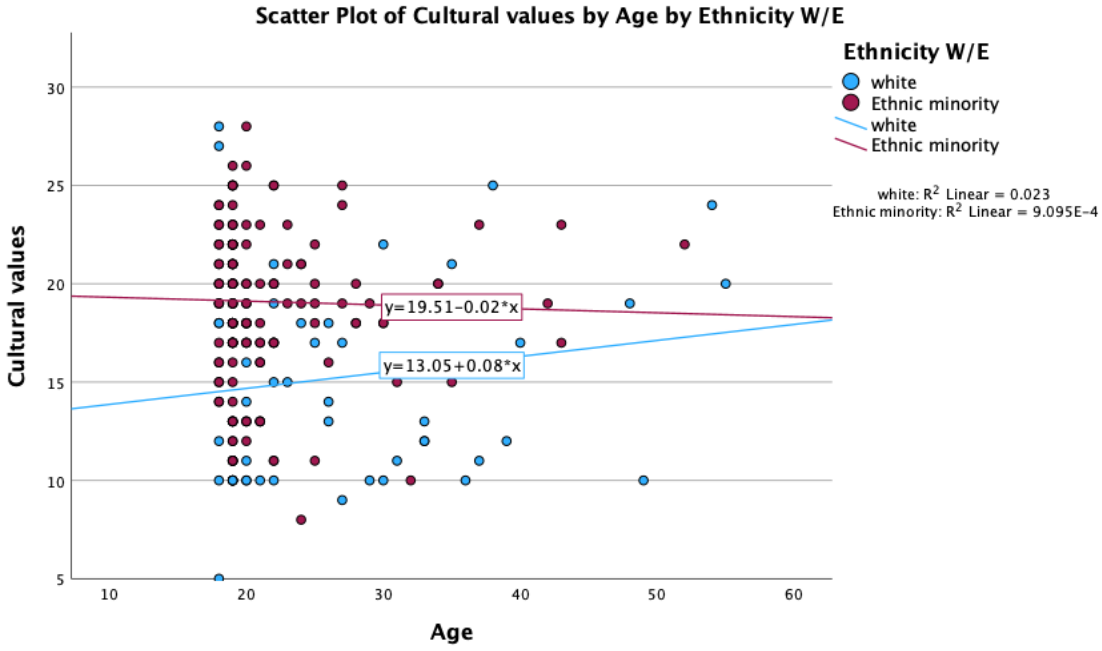

Scatter Plot of Self stigma total by Age by Ethnicity W/E
Self stigma total
Age
Ethnicity W/E
white
Ethnic minority
white
Ethnic minority
white: R2 Linear = 0.001
Ethnic minority: R2 Linear = 0.051
y=24.03-0.03*x
y=29.02-0.24*x
10
20
30
40
50
10
20
30
40
50
60

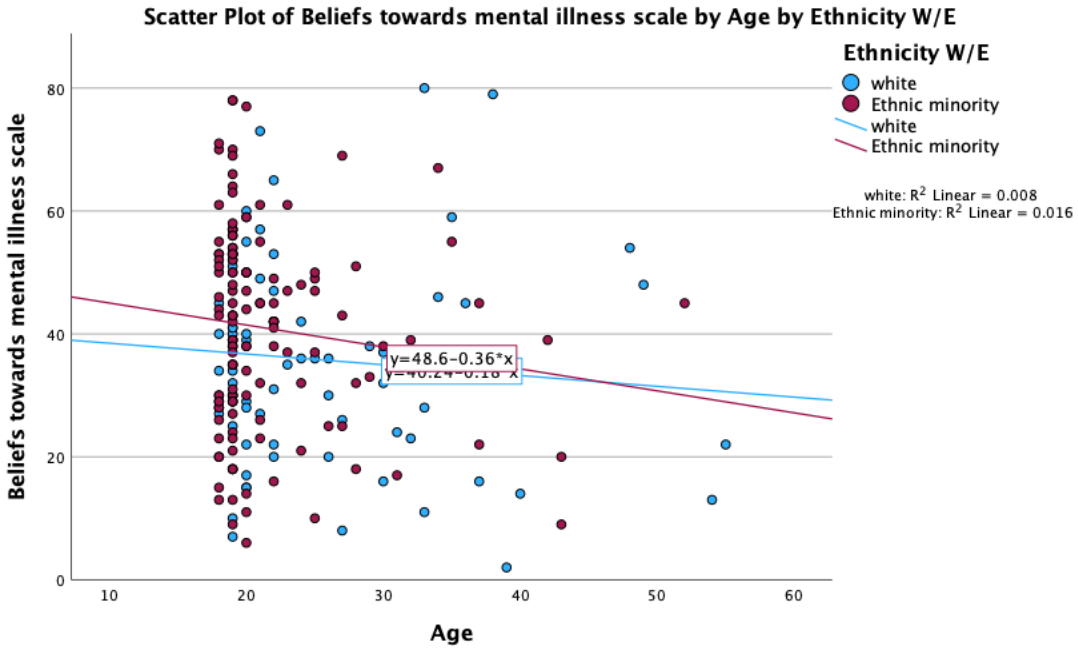

Scatter Plot of Barriers to seeking help total score by Age by Ethnicity W/E
Ethnicity W/E
white
Ethnic minority
white
Ethnic minority
white: R2 Linear = 0.003
Ethnic minority: R2 Linear = 0.018
y=87.94-0.32*x
y=75.41-0.1*x
Barriers to seeking help total score
Age
140
120
100
80
60
40
20
10
20
30
40
50
60

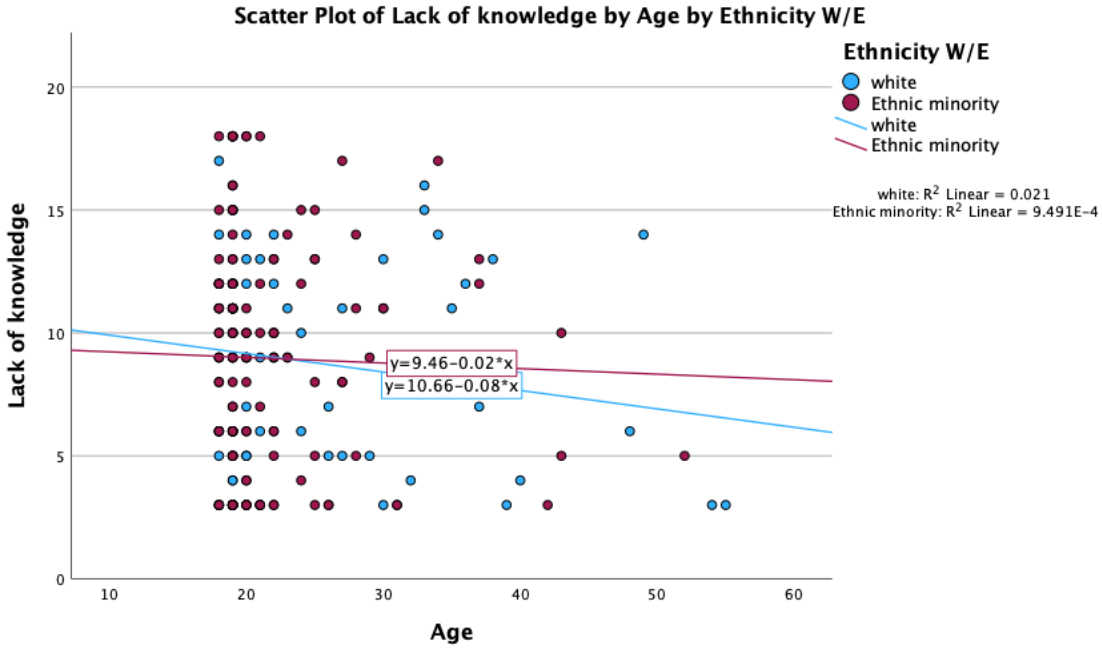

Scatter Plot of Negative percieved values by Age by Ethnicity W/E
Ethnicity W/E
white
Ethnic minority
white
Ethnic minority
white: R2 Linear = 0.014
Ethnic minority: R2 Linear = 0.044
y=15.66-0.07*x
y=17.79-0.17*x
Negative percieved values
Age
5
10
15
20
25
30
10
20
30
40
50
60

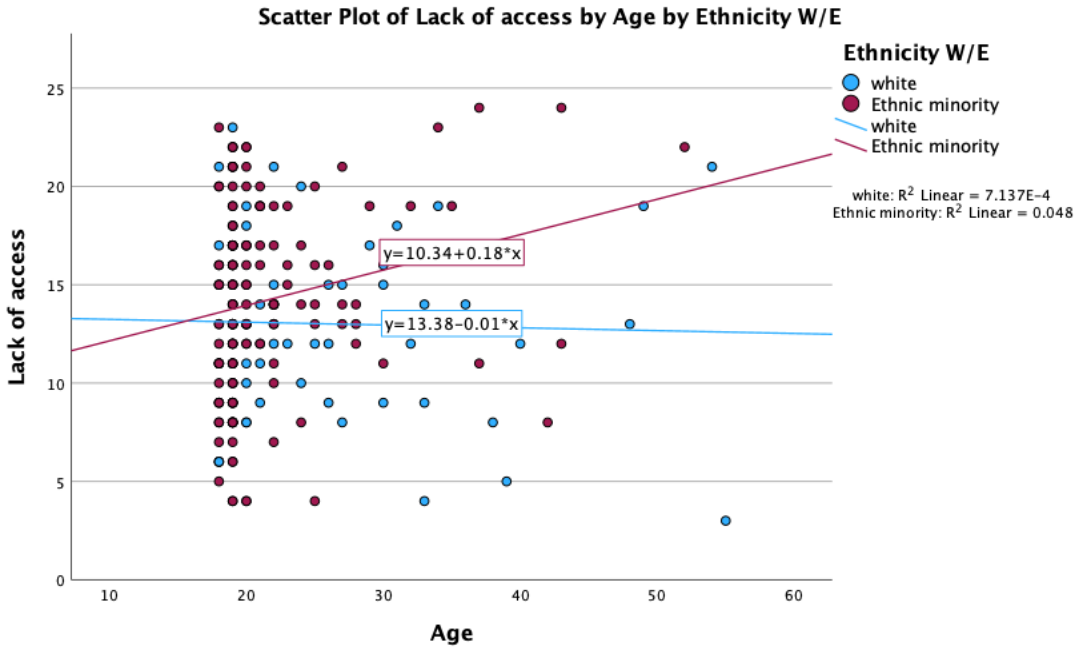

Scatter Plot of Ingroup stigma by Age by Ethnicity W/E
Ethnicity W/E
white
Ethnic minority
white
Ethnic minority
white: R2 Linear = 0.007
Ethnic minority: R2 Linear = 0.002
y=15.87-0.03*x
y=13.86-0.04*x
Ingroup stigma
Age
5
10
15
20
25
30
10
20
30
40
50
60


Scatter Plot of Discomfort with emotions by Age by Ethnicity W/E
Ethnicity W/E
white
Ethnic minority
white
Ethnic minority
white: R² Linear = 0.008
Ethnic minority: R² Linear = 0.110
y=19.46-0.05*x
y=24.36-0.28*x
Discomfort with emotions
Age
30
25
20
15
10
5
10
20
30
40
50
60


Scatter Plot of Cultural values by Age by Ethnicity W/E
Ethnicity W/E
white
Ethnic minority
white
Ethnic minority
white: R² Linear = 0.023
Ethnic minority: R² Linear = 9.095E-4
y=19.51-0.02*x
y=13.05+0.08*x
Cultural values
Age
30
25
20
15
10
5
10
20
30
40
50
60


Scatter Plot of Beliefs towards mental illness scale by Age by Ethnicity W/E
Ethnicity W/E
white
Ethnic minority
white
Ethnic minority
white: R² Linear = 0.008
Ethnic minority: R² Linear = 0.016
y=48.6-0.36*x
Beliefs towards mental illness scale
Age
0
20
40
60
80
10
20
30
40
50
60


Scatter Plot of Lack of knowledge by Age by Ethnicity W/E
Ethnicity W/E
white
Ethnic minority
white
Ethnic minority
white: R² Linear = 0.021
Ethnic minority: R² Linear = 9.491E-4
y=9.46-0.02*x
y=10.66-0.08*x
Lack of knowledge
Age
0
5
10
15
20
10
20
30
40
50
60


Scatter Plot of Lack of access by Age by Ethnicity W/E
Ethnicity W/E
white
Ethnic minority
white
Ethnic minority
white: R2 Linear = 7.137E-4
Ethnic minority: R2 Linear = 0.048
y=10.34+0.18*x
y=13.38-0.01*x
Lack of access
Age
0
5
10
15
20
25
10
20
30
40
50
60