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Research Paper

Barriers to students opting-in to universities notifying emergency contacts when serious mental health concerns emerge: A UK mixed methods analysis of policy preferences

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ABSTRACT

Background: : When students experience serious mental health difficulties, universities face the dilemma of deciding whether to notify trusted others such as parents. This study investigates the key factors underpinning students' decisions not to opt-in to 'consent to contact', which would allow their university to notify an emergency contact of their choice in the event of serious mental health difficulties.
Methods: : An online survey was administered to university students in a UK institution with an active consent to contact policy. Students self-reported: (1) whether they had opted-in or opted-out of the policy, (2) socio-demographics, and (3) mental health outcomes including depression (PHQ-9) and anxiety (GAD-7). Students who recalled not opting-in were invited to explain their decision via qualitatively analysed free-text responses.
Results: : 2637 students responded, 648 (24.57%) recalled opting-in, 463 (17.56%) recalled not opting-in and 1432 (54.30%) were unsure how they opted. Students currently experiencing moderate/severe anxiety and depression demonstrated lower rates of opting-in than students not experiencing these difficulties. The most common reasons for not opting-in were 'not wanting emergency contacts to worry' and 'preferring to tell emergency contacts themselves'. These policy decisions were underpinned by four qualitative themes: 'unhelpful anticipated outcomes', 'seriousness of student difficulties experienced', 'quality of relationship with their emergency contact' and 'situational appropriateness'.
Limitations: : This study focussed on students at a single university.
Conclusions: : Students who are at greater risk of mental health difficulties may be resistant to wider support networks being contacted. Future research is required to address barriers to opting-in for students most at-risk.

1. Introduction

Internationally there is concern surrounding the levels of mental health difficulty experienced by university students (Auerbach et al., 2018). The transition into university is associated with social and psychological challenges, and for many students this transition overlaps with the transition into adulthood (Baggio et al., 2017; Barkham et al., 2019; Murray and Arnett, 2018). There is also evidence of an increase in the annual incidence of student suicides in the past two decades, in line with trends seen amongst young people in the general population (Gunnell et al., 2020; Uchida and Uchida, 2017). Further research into suicide risk amongst university students is required, however a recent cross-sectional study undertaken in 6 UK universities reported that approximately one third of surveyed students indicated significant risk for suicidal behaviour (Akram et al., 2020). In response, universities have been prompted to support students by developing innovative strategies for early intervention (Buchanan, 2012; Conley et al., 2017; Duffy et al., 2020).

Social contacts such as family have the potential to be both vital and detrimental in supporting students at university. Family members may bring an awareness of a student's past, and are uniquely positioned to offer stability and trustworthy support whilst students navigate crises and the uncertainties of university (Alsubaie et al., 2019). However, university in the UK is often related to migration away from home

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(Holdsworth, 2009), therefore family members may be less aware of the difficulties students are facing. Separately, for many students, family members may conversely be the source of difficulties, rather than a remedy (Counts and John-Henderson, 2020; Repetti et al., 2002; Wright et al., 2009).

Emergency contact procedures provide one opportunity for extending the support network available to university students experiencing mental health difficulties. Students conventionally provide their university with general emergency contact details for a trusted individual, often when registering for their academic studies (Wesley, 2019). Parents have been influential in prompting universities to consider the use of these procedures in supporting the mental health needs of university students (Department of Health, 2014). Rather than happening automatically unless students opt-out, 'opt-in' consent involves people actively indicating their preference for a policy or practice (Hunt et al., 2013). Providing students with the opportunity to opt-in to their university engaging their emergency contact if there are concerns about their mental health would enable universities to involve members of a student's support network at a time when their mental health may prevent them from making informed decisions in their best interests. Education policy experts have recommended that this contact would not necessarily have to be a parent, and that 'risk of harm' should determine when these policies are activated (Brown, 2016).

Communicating with the family or other emergency contact of a student presents legal and ethical challenges. Sharing personal Information related to a student's mental health has implications for data protection (Sladdin, 2018). In the riskiest of situations however, the duty to share personal information with trusted others can be as important as the duty to have regard for patient confidentiality (Caldicott, 2013). Although most university students are legal adults, many will still be transitioning into adult independence. This presents a dilemma for universities who need to balance their duty of care for supporting students, with their need to recognise their adulthood (Gulliver et al., 2018; Mair, 2015; McAllister et al., 2014).

Understanding the views of students is essential to ensure such a policy has high uptake, and is therefore effective at protecting students at serious risk of harm (Baik et al., 2019; Chan et al., 2016). In a survey of 14,072 undergraduate students studying across the UK, 66% indicated that they would be happy for their parents to be contacted if they were experiencing extreme difficulties, compared to 15% who would be happy in any circumstance and 18% who would never be happy for their parents to be contacted (Neves and Hillman, 2019).

There is limited academic literature on university student views towards the sharing of mental health information with emergency contacts. The aim of this study was to investigate which students may be less likely to opt-in to their university engaging a chosen emergency contact when there are serious concerns about their mental health, and explore why. This research was undertaken in one of the only UK universities with a formalised policy where students are given the opportunity to opt-in to university-initiated communication with emergency contacts. Three research questions were investigated:

1 Are there any differences in past and present mental health outcomes and demographic factors between students who have not opted-in compared to those who have?
2 What are the most frequently stated reasons for not opting-in to the consent to contact policy?
3 What are the underlying factors that inform students' decisions not to opt-in to the consent to contact policy?

2. Methods

2.1. Participants

All participants were registered students at a moderately sized UK university (with approximately 27 thousand students). The sample included undergraduates and postgraduates. All registered students were eligible to participate. We obtained ethical approval for the survey from the University of Bristol Faculty of Health Sciences ethics committee (ref: no. 49,861).

2.2. Study design and data collection

This study had a convergent mixed-methods design with a quantitative component and a dominant qualitative component (Creswell, 2014). An outline of the approach taken is presented in Fig. 1. A survey approach was selected as a way of asking closed mental health and demographic questions (quantitative) and open-ended views from free-text questions (qualitative), simultaneously. Although debate continues regarding the use of free-text data in qualitative research, the benefits of doing so are recognised when combined with quantitative methods and in new areas of study (LaDonna et al., 2018). Qualitative analyses of free-text data have been used consistently to provide insight into developing areas of study, where there is limited prior academic literature (Chevance et al., 2020; Harrop et al., 2016). Mixed method studies are well established in the investigation of mental health phenomena (Palinkas, 2014; Palinkas et al., 2011; Robins et al., 2008). As in other contexts, they provide key insight into the quantifiable differences in views and outcomes, along with an in-depth exploration of how and why those views differ.

2.3. Survey data collection

The anonymous online survey was open for completion for 3 weeks in May 2019 and students received three email reminders inviting them to participate. The survey was developed collaboratively, with the involvement of students, academic experts and university staff. We gathered sociodemographic data to characterise the sample. Age data were collected and coded as '24 and younger' or '25 and over'. Gender data were collected, coded as 'Female', 'Male' and 'Non-binary/other'. Sexuality data were collected, coded as 'Heterosexual' or 'Lesbian, Gay, Bisexual or all other sexualities'. Ethnicity data were collected, and were coded as 'Black, Asian and Minority ethnicity' or 'White'. Missing data were reported for each variable. This study was part of a wider research project examining the experiences, outcomes and views of university students.

Mental health outcomes were assessed using self-administered screening instruments. Depression severity was measured using the patient health questionnaire (PHQ-9), where scores of 10 or higher indicate moderate/severe depressive symptomology (Kroenke and Spitzer, 2002). Anxiety severity was measured using the Generalised Anxiety Disorder-7 (GAD-7), where scores of 10 or higher indicate moderate/severe anxiety symptomology (Spitzer et al., 2006). Questions on both instruments are rated on a 4-point Likert scale ranging from 0 (not at all) to 3 (nearly every day) and relate to the previous two weeks. Depression and anxiety scores were not calculated for respondents who were missing responses to PHQ-9 or GAD-7 questions.

To capture the decisions students recall making when they were given the opportunity to opt-in, we asked each student the following closed-text question: "Did you opt-in for the University to be able to contact your parents/or other nominated person in the case that we had any serious concerns about your wellbeing?", with the options 'Yes', 'No' and 'Unsure'. Any students who selected 'No' were asked a follow-up free-text question: "Is there a reason why you wouldn't want us to contact them?". This research took place approximately 6 months after students had opted-in or not whilst registering for their studies at the beginning of the academic year (September 2019).

2.4. Data analysis

2.4.1. Quantitative analysis

Responder socio-demographic characteristics, whether students

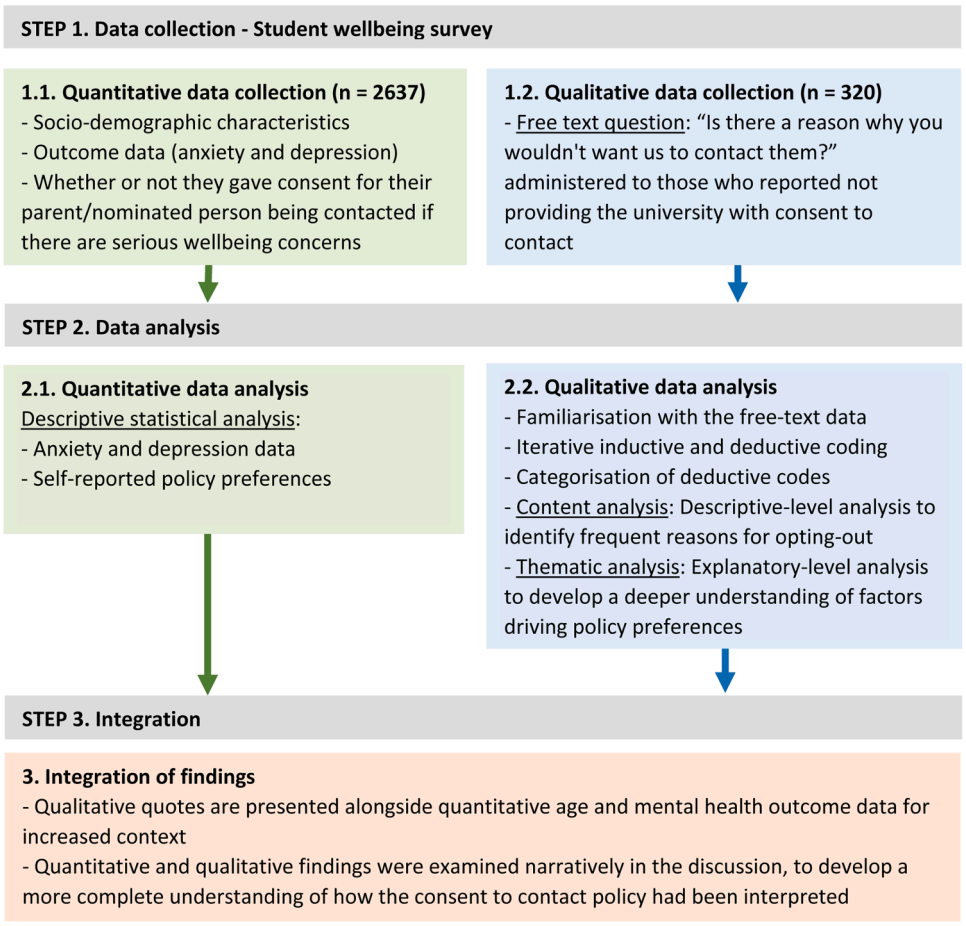

Fig. 1. Convergent mixed methods study design.

recalled opting-in or not, and mental health outcomes were all summarised descriptively using STATA 16. Missing responses are reported for each variable. Differences between students who recall opting-in and students who recall not opting-in across key variables (age, gender, ethnicity, sexuality, internationality/fee-status, history of mental health diagnosis, levels of anxiety and levels of depression) were assessed using chi-square tests.

2.4.2. *Qualitative analysis*

Free-text data were managed in Microsoft Excel. The analysis undertaken was informed by a thematic analysis approach (Braun and Clarke, 2006). First, the free-text responses were read in full, to develop familiarity with the data. Next, an initial process of highlighting and labelling responses with inductive codes was undertaken, maintaining close proximity to the data. Following this, deductive coding was undertaken, to develop a more focussed conceptual understanding of the data. These processes were undertaken iteratively, as the analysis involved frequently revisiting the raw data, codes and the emerging patterns. The development of analytical thinking was noted using qualitative memos. Deductive codes were separately analysed using a conventional content analysis approach, to summatively quantify the most frequently stated concerns amongst students who decided not to opt-in (Hsieh and Shannon, 2005). Within the thematic analysis, themes were gradually proposed, labelled, reviewed, and finally written up to describe underlying patterns. Coding was undertaken by one researcher (ML), and study team meetings involved the discussion of analytic questions raised in memo writing and provided an opportunity to review the development of themes. The content analysis provided a descriptive-level analysis to identify frequent reasons for not opting-in and the separate thematic analysis provided the explanatory-level analysis of the underlying reasons why.

2.4.3. *Integration*

Quantitative and qualitative analyses were undertaken separately. Qualitative quotes were presented alongside quantitative outcome data, to provide psychological context to the student views presented in the results section. Findings were integrated at the interpretation stage of the research within the discussion section narratively (Fetters et al., 2013). The goal of using both quantitative and qualitative methods within the same study was to provide a more comprehensive understanding of how students interact with the consent to contact policy (Creswell and Clark, 2017).

3. Results

3.1. *Quantitative analysis*

Altogether 2637 (10%) of the 26,102 registered students responded to the survey. Sample demographics for the full sample are presented in Supplementary File 1. Of the 2543 participants (3.56% missing data) who responded to consent to contact policy question, 648 (24.57%) recalled opting-in, 463 (17.56%) recalled not opting-in, and 1432 (54.30%) stated that they were unsure how they opted. Sample characteristics and differences between the students who opted-in and the students who did not opt-in are presented in Table 1.

Students aged '25 and over' were less likely to opt-in than students aged '17–24' (X^2 (1) = 18.71, p <0.001). Black, Asian and minority ethnicity students were less likely to opt-in than white students (X^2 (1) = 10.54, p = .001). International students studying in the UK were marginally less likely to opt-in than home and European Union students

Table 1
Socio-demographic and mental health outcomes for students who recall opting-in or opting-out of their emergency contact being engaged if there were serious concerns about their wellbeing, with chi-square (X^2) tests of difference.

	Opted in(n = 648)	Did not opt-in (n = 463)	X^2 (df), p value
Age [a]- *No. (row%)*			
17 – 24	557 (61.41)	350 (38.59)	18.707 (1),
≥ 25	89 (44.72)	110 (55.28)	<0.001
Gender [b]- *No. (row%)*			
Female	470 (60.49)	307 (39.51)	4.847 (2),
Male	156 (53.06)	138 (46.94)	0.089
Other genders[1]	18 (58.06)	13 (41.94)	
Ethnicity [c]- *No. (row%)*			
Black, Asian and Minority ethnicity[2]	124 (49.60)	126 (50.40)	10.537 (1), 0.001
White	523 (61.10)	333 (38.90)	
Sexuality [d]- *No. (row%)*			
Heterosexual	485 (58.86)	339 (41.14)	0.034 (1),
Lesbian, Gay, Bisexual+ [3]	131 (59.55)	89 (40.45)	0.854
Internationality (fee status) [e]- *No. (row%)*			
European Union	54 (57.45)	40 (42.55)	6.017(2),
Home (UK)	518 (59.95)	346 (40.05)	0.049
International	75 (49.34)	77 (50.66)	
Mental health diagnosis [f]- *No. (row%)*			
No previous mental health diagnosis	409 (59.19)	282 (40.81)	0.479 (1), 0.489
Previous mental health diagnosis	238 (57.07)	179 (42.93)	
Depression [g]- *No. (row%)*			
No/Mild symptoms (PHQ-9 < 10)	356 (63.91)	201 (36.09)	14.459 (1), <0.001
Moderate/severe symptoms (PHQ-9 ≥ 10)	284 (52.59)	256 (47.41)	
Anxiety [h]- *No. (row%)*			
No/Mild symptoms (GAD-7 < 10)	418 (61.65)	260 (38.35)	8.448 (1), 0.004
Moderate/severe symptoms (GAD-7 ≥ 10)	221 (52.74)	198 (47.26)	

Notes: a = 13 missing responses, b = 14 missing responses, c = 15 missing responses, d = 86 missing responses, e = 5 missing responses, f = 11 missing responses, g = 23 missing responses, and h = 22 Missing responses. 1 = Respondents self-described non-binary, prefer not to say, or another gender. 2 = Respondents self-described as Arab, Asian- Bangladeshi, Asian Chinese, Asian-Indian, Asian-other, Asian-Pakistani, Black-African, Black-Caribbean, Black-Other, Gypsy or Traveller, Prefer not to say, Other, Other mixed, Unknown, White, White and Asian, White/Black/African or White/Black/Caribbean. 3 = Respondents self-described Asexual, Aromantic, Biromantic, Demisexual, Grey Ace, Unsure, Pansexual, Panromantic, Queer or Polysexual.

(X^2 (2) = 6.02, p = 0.049). Gender and sexuality were not significantly related to policy preferences. Students with existing mental health difficulties were less likely to opt-in. 52.59% of students with moderate/severe depression recalled opting-in compared to 63.91% of students without moderate/severe depression (X^2 (1) = 14.46, <0.001). 52.74% of students with moderate/severe anxiety recalled opting-in compared to 61.65% of students without moderate/severe anxiety (X^2 (1) = 8.45, p=.004). Having a previous mental health diagnosis was not significantly associated with differences in policy preferences.

3.2. Qualitative - content analysis

Most of the students who did not opt-in provided a free-text explanation of their policy preference (68.82%, 320/463). In total, 248 (77.50%) of these students were aged 17–24 and 68 (21.25%) were aged 25–67. In terms of ethnicity, 238 (74.38%) respondents self-identified as White and 81 (25.31%) respondents self-identified as Black, Asian or minority ethnicity. 237 (74.06%) of the students identified as heterosexual, 62 identified as Lesbian, Gay, Bisexual or another sexuality (19.38%), and 21 students did not respond to this question (6.56%).

There were 98 coded reasons for not opting-in. In response to research question 2, the top 10 most frequently coded reasons were: not wanting their emergency contact to worry (n = 53), preferring to alert their emergency contact themselves (n = 28), preferring to handle the situation themselves (n = 27), not knowing opting-in was an option (n = 24), viewing themselves as an independent adult (n = 15), not want their emergency contact to know (n = 14), being a mature student (n = 14), concerns about the privacy of their personal information (n = 12), and believing this is not the university's role (n = 11).

3.3. Qualitative - thematic analysis

Addressing research question 3, four cross-cutting themes emerged from the analysis into why students recall not opting-in: unhelpful anticipated outcomes, seriousness of student difficulties experienced, quality of relationship with their emergency contact, and situational appropriateness. Each theme is described below.

3.4. Unhelpful anticipated outcomes

Quotes for this theme are presented in Table 2. Students expressed concern for the emotions they anticipated their emergency contact would feel after being contacted. One student described the emotions their parent would feel, and the knock-on effect this might have (Quote 1.1). Across examples provided, respondents often referred to mothers, while fathers were never explicitly mentioned. Students described a rich landscape of emotional reactions, including emergency contacts feeling: disappointed, guilt-ridden, negligent, anxious, concerned, freaked out, fearful, panicked, scared, stressed, upset and worried. Despite emergency contacts having some level of responsibility for students, some students clearly sought to protect their emergency contacts.

In other cases, students voiced fears about the actions emergency contacts could take once they had been engaged by the university (Quote 1.2). Other examples connected these concerns to their emergency contact not having a well-developed understanding mental health issues and communication difficulties (Quote 1.3). Responses signalled a worry that once emergency contacts had been engaged, they may unjustifiably lose control over the situation.

Students also discussed some of the ways they themselves may be

Table 2
Quotes from the 'Unhelpful anticipated outcomes' theme.

Quote #	Quote
1.1	"I don't want them to have to worry about it. My mother would become far too anxious; it would have severe negative effects on her mental health. It is necessary not to tell her to protect her from that". *(Age = 20, PHQ-9 = 20, GAD-7 = 14)*
1.2.	"Its just a mess, id rather they didnt know. Would not like to answer questions like 'why do you feel this way' etc.". *(Age = 20, PHQ-9 = 13, GAD-7 = 21)*
1.3.	"They wouldn't understand and in the past have threatened to pull me out of university if I don't seem happy enough (as being sad to them equates to being a waste of investment)". *(Age = 20, PHQ-9 score = 24, GAD-7 Score = 17)*
1.4.	"My nominated person is my scholarship provider so that would jeopardise my scholarship". *(Age = 31, PHQ-9 score = 10, GAD-7 Score = 18)*
1.5.	"Parents are tied up with trauma cause and it would be detrimental to their health and my health to have them informed at the time but I told them myself at an appropriate time". *(Age = 20, PHQ-9 score = 13, GAD-7 Score = 4)*
1.6.	"Don't want messages to get confused. Anything which would panic them would make my situation worse, and go back on progress I've made in therapy". *(Age = 22, PHQ-9 score = 16, GAD-7 Score = 8)*

Note: PHQ-9 and GAD-7 Scoring: 0–4 indicates no depressive symptoms, 5–9 mild depressive symptoms, 10–14 moderate depressive symptoms, 15–19 moderately-severe depressive symptoms, and 20–27 severe depressive symptoms.

negatively impacted. For some students, there could be negative financial consequences (Quote 1.4). Students were also explicit about the ways in which their emergency contacts were related to difficulties they experienced (Quote 1.5). On a related note, students were vocal about potential interference with professional support they are already in receipt of (Quote 1.6). These issues indicate the need for careful thought about the trade-offs involved in engaging emergency contacts.

3.5. Seriousness of student difficulties experienced

Quotes for this theme are presented in Table 3. A number of students felt they did not have any concerns at university that would warrant their emergency contacts needing to be engaged through the consent to contact policy (Quote 2.1). As described here, a strong sense of independence attained in the transition into higher education may be connected to how willing students are to disclosing difficulties experienced. Some students who had identified mental health difficulties suggested that their current circumstances were under control enough to not warrant emergency contacts being engaged (Quote 2.2). As such, if students felt able to manage the difficulties they currently faced, they did not want their preferences to self-manage being overlooked.

There were many examples given highlighting instances where students recognised in some circumstances, it would be warranted to engage emergency contacts. As one student states, the determining factor for whether contact was warranted was the severity of the situation (Quote 2.3). Crucially, engaging emergency contacts was not viewed as acceptable without also involving students. Although these respondents had not opted-in, in serious situations the importance of parental responsibilities was recognised (Quote 2.4). In such cases therefore a justifiable trade-off could be made between the self-agency of students and the necessity of emergency contact involvement.

Several students indicated that they would understand their university engaging their emergency contact if they were suicidal (Quote 2.5). A conflict was identified between the rights of students, and actions necessary for their protection and welfare. In other cases, students expressed an awareness of how their own mental health may impact the safety of others (Quote 2.6). Therefore when universities consider potential harms, this should encompass but not be limited to the student themselves. Another example of understandable engagement of emergency contacts related to students being treated for mental health difficulties in hospital or another mental health facility, without their agreement (Quote 2.7). As described elsewhere, finding oneself detained under the Mental Health Act was viewed as a situation that superseded the independence of students. Respondents recognised that families would inevitability be contacted in the most serious circumstances, regardless of their policy decision (Quote 2.8). Although in many situations there will be time to discuss with students whether widening their circle of support to include emergency contacts would be beneficial, there was an awareness for time-critical occasions where this may not be possible.

Table 3
Quotes from the 'Seriousness of student difficulties faced' theme.

Quote #	Quote
2.1	"I am an adult and can solve my problems. Secondly i dont have any". *(Age = 18, PHQ-9 = 20, GAD-7 = 20)*
2.2	"…I have had on and off eating disorder diagnosis since 13. I never am a harm to myself and am increasingly self aware… This isn't school we can't have someone butting Into our lives forever at some stage I honestly believe we have to take charge and responsibility for our health, we can ask or tell whoever but it has to be up to us". *(Age = 21, PHQ-9 = 16, GAD-7 = 19)*
2.3.	"If you had serious concerns perhaps, and i had agreed beforehand then fine". *(Age = 44, PHQ-9 score = 9, GAD-7 Score = 7)*
2.4.	"I think parents should be contacted if there are great concerns for their child ". *(Age = 26, PHQ-9 score = 7, GAD-7 Score = 1)*
2.5.	"I don't think it is anyone's right to decide what others need to know, unless I was suicidal, in that case it would be useful ". *(Age = 20, PHQ-9 score = 13, GAD-7 Score = 6)*
2.6.	"I can contact them myself if I want to. Not the university's decision, unless I was seriously suicidal or a threat to others". *(Age = 19, PHQ-9 score = 14, GAD-7 Score = 13)*
2.7	"Unless I need to be sectioned I want to handle my mental health and my parents as an adult". *(Age = 20, PHQ-9 score = 14, GAD-7 Score = 6)*
2.8	"I don't want to worry my parents. I assume if it is life threatening and I myself cannot speak to them for whatever reason, then they will be contacted either way". *(Age = 20, PHQ-9 score = 9, GAD-7 Score = 9)*

Note: PHQ-9 and GAD-7 Scoring: 0–4 indicates no depressive symptoms, 5–9 mild depressive symptoms, 10–14 moderate depressive symptoms, 15–19 moderately-severe depressive symptoms, and 20–27 severe depressive symptoms.

3.6. Quality of relationship with their emergency contacts

Quotes for this theme are presented in Table 4. At one end of the spectrum, students described an absence of available emergency contacts. These students explained how they were bereaved, estranged from their parents or otherwise had nobody to contact (Quote 3.1). Parents were directly relevant to many of the existing challenges numerous respondents were facing. Students described major conflicts with existing family members (Quote 3.2). Other students thought their parents would either not care or not believe a real issue existed (Quote 3.3). Some students found it difficult talking to their parents (Quote 3.4). Unwanted involvement of family members in university life can thus be viewed by some students as encroaching on their boundaries. Although students are able to select non-parental emergency contacts, this was not widely acknowledged.

At the opposite end of the spectrum, other students described already having good open relationships with their emergency contacts (Quote 3.5). Some students had parents who were already aware of the mental health problems students were experiencing, or they would likely be aware before the university is aware (Quote 3.6). For these students, the strength of their relationship transcends the importance of a university policy.

3.7. Situational appropriateness

Quotes for this theme are presented in Table 5. Many of the arguments students made focussed on how appropriate the policy was or was not. One of the most important topics determining whether it was

Table 4
Quotes from the 'Quality of relationship with emergency contact' theme.

Quote #	Quote
3.1.	"parents are dead and contributed to my mental health issues when they were alive". *(Age = 55, PHQ-9 = 27, GAD-7 = 21)*
3.2	"…family is abusive and my nominated person is not in a position to help much". *(Age = 26, PHQ-9 = 15, GAD-7 = 5)*
3.3.	"My parents do not believe in mental health problems, and it would generate far more familial problems for me. I do not have a good relationship with them to want them to be involved". (Age = 19, PHQ9 = 27, GAD7 = 21)
3.4.	"I don't have an especially close or easy relationship with my parents and I don't want to feel as if they are intruding into my life at university as well as at home". *(Age = 19, PHQ-9 score = 15, GAD-7 Score = 13)*
3.5.	"I have a very trusting, open, and responsible relationship with my parents. I deal with my mental health independently but I keep them in the know". *(Age = 21, PHQ-9 score = 3, GAD-7 Score = 4)*
3.6.	"I just did not realise that this was an option. However, I am very close to my parents so it would be unusual that the university knew more than they did". *(Age = 23, PHQ-9 score = 9, GAD-7 Score = 7)*

Note: PHQ-9 and GAD-7 Scoring: 0–4 indicates no depressive symptoms, 5–9 mild depressive symptoms, 10–14 moderate depressive symptoms, 15–19 moderately-severe depressive symptoms, and 20–27 severe depressive symptoms.

Table 5
Quotes from the 'Situational appropriateness' theme.

Quote #	Quote
4.1.	"The whole idea of this I find repulsive, infantilising and sinister. If you're concerned about me, talk to me." *(Age = 27, PHQ-9 = 21, GAD-7 = 19)*
4.2	"It's my life, I'd rather deal with it than have the university make that call". *(Age = 23, PHQ-9 = 8, GAD-7 = 6)*
4.3.	"As an adult I am capable of asking my parents for help all by myself". *(Age = 22, PHQ-9 score = 13, GAD-7 Score = 7)*
4.4.	"I am a mature student. So it's my responsibility to deal with it". *(Age = 29, PHQ-9 score = 19, GAD-7 Score = 14)*
4.5.	"I feel like I have a right to keep that information to myself if that is what I choose to do". *(Age = 25, PHQ-9 score = 22, GAD-7 Score = 16)*
4.6	"Because at the age of 38 I would expect to be able to deal with the matter myself or with my wife". (Age = 38, PHQ-9 = 1, GAD-7 = 0)
4.7	"I am living in the UK by myself and I don't want my parents to be worried". *(Age = 21, PHQ-9 = 5, GAD-7 = 1)*
4.8	"They don't understand English and if they know I feel bad, they will be worried about me while they can do nothing". *(Age = 18, PHQ-9 = 11, GAD-7 = 10)*
4.9.	"There is no need for my academic establishment to contact my family". *(Age = 23, PHQ-9 score = 19, GAD-7 Score = 14)*
4.10	"They would try and pull me from my studies and that the university would help them do this so I wasn't the universities problem anymore". *(Age = 20, PHQ-9 score = 12, GAD-7 Score = 9)*
4.11	"I am talking to my parents myself and would not like the university to also get involved when I am handling it privately". *(Age = 20, PHQ-9 score = 26, GAD-7 Score = 20)*

Note: PHQ-9 and GAD-7 Scoring: 0–4 indicates no depressive symptoms, 5–9 mild depressive symptoms, 10–14 moderate depressive symptoms, 15–19 moderately-severe depressive symptoms, and 20–27 severe depressive symptoms.

appropriate for universities to engage emergency contacts related to the view that students are independent adults (Quote 4.1). As adults, students described how the difficulties they experienced were their own responsibility. Across responses students expressed a desire to have their autonomy both recognised and respected (Quote 4.2). Importantly, independence did not always mean that students were against their emergency contacts (often parents) being aware of their mental health difficulties (Quote 4.3). As such, unwarranted contact with parents or other contacts was viewed as an imposition that impeded the growth and maturity of university students. Other students explicitly referenced the relevance of returning to full-time education at a later life stage (Quote 4.4). Being a mature student was also connected to the availability of support from partners/spouses (Quote 4.5), and the possibility of parents being potentially too old or unwell to provide support. Finally, students explained the importance of how their personal information was handled and shared. Students expressed a desire to maintain boundaries between university life and family life (Quote 4.6).

Culture, location and language formed another cluster of considerations around the appropriateness of contact. For example, international students will be living and studying in countries without any family. One student described a lack of local support (Quote 4.7). In these cases, distance may mean emergency contacts live too far away to be immediately helpful and could experience a greater level of distress knowing their child is experiencing a crisis in a different country. A related challenge universities will have to navigate whilst trying to engage the emergency contact of a student is attempting to convey sensitive, personal and potentially time-critical information to contacts who do not speak English (Quote 4.8). Students sensed that their emergency contacts would feel helpless not being able to understand and intervene effectively.

Questions were raised about the appropriateness of universities contacting emergency contacts directly. Universities were viewed by some as primarily providers of education (Quote 4.9). Others conversely believed that universities would only want to engage emergency contacts as an attempt to relinquish their responsibility for supporting students experiencing difficulties with their mental health or wellbeing (Quote 4.10). Related to points raised about students wanting to be viewed as independent adults, students feared being bypassed and having their university unnecessarily involved in their personal relationships (Quote 4.11). These views point to a tension between the duty universities have to safeguard the mental health of students whilst also not being overly involved in their personal lives.

4. Discussion

Most of the students who recall their policy decisions opted-in to their university notifying their emergency contact if there were serious concerns about their wellbeing. Respondents aged over 24, international students, and Black, Asian and minority ethnicity students were less likely to opt-in. Finally, students currently experiencing moderate/severe anxiety and moderate/severe depression were also less likely to opt-in.

The most frequently cited reasons for students not opting-in were 'not wanting their emergency contact to worry', 'preferring to tell their emergency contact themselves', or 'wanting to handle the situation themselves'. The thematic analysis findings indicated that relationship difficulties with family discouraged students from opting-in. Students outlined numerous situations where the policy would not be appropriate, however in the most serious situations where there is a risk to the student or someone else respondents understood that the policy would be useful. For example, students who did not opt-in understood emergency contacts would be engaged in the case of involuntary hospitalisation under the mental health act. Engaging emergency contacts requires careful thought regarding the subsequent outcomes for both students and their families. Although family members may often be selected as emergency contacts, these findings around the quality of relationships highlight how emergency contacts will vary in how supportive they are. As highlighted elsewhere in the literature, for some students family members will be associated with the mental health difficulties students are navigating (Repetti et al., 2002). Some respondents advised caution engaging family, because of past experiences of trauma and abuse. They also described dissatisfaction with the level of mental health literacy amongst emergency contacts, with several expressing that their emergency contact did not believe mental health existed at all.

4.1. Implications

This study offers numerous implications for services involved in supporting university students. University counselling departments, accommodation services, wellbeing advisors and health practitioners should be aware that students who are at greater risk of mental health difficulties may be resistant to wider support networks being contacted. Students with mental health difficulties could have been more reluctant to opt-in if their families had previously reacted poorly to their mental health difficulties, as reported by some respondents. Another explanation could be students fear that a loss of control over the situation and subsequent parental involvement would signify that they had failed to deal with life's problems (Clement et al., 2015). When students who have not opted-in encounter university support services, their policy decision might signal a need for staff to be mindful of, explore and potentially work through family difficulties the student has experienced.

There are also implications for university leaders. Despite all respondents being invited to opt-in, many did not recall this. Given these gaps in recollection, universities considering implementing similar policies should work with their students to ensure key information about these policies is visible, clear and understood appropriately. This guidance should describe situations that universities would view as serious enough to warrant the policy being activated, and examples of who can be selected as an emergency contact.

Respondents were concerned about the potential emotional

implications for emergency contacts. These anticipated emotions included: disappointment, guilt, anxiety, concern, fear, panic, stress and worry. amongst these concerns were questions raised around how parents experiencing mental health conditions themselves would cope with distressing news about a student. This finding highlights how universities need to navigate engaging emergency contacts who will vary in how equipped and capable they are to receive and respond to news about students being in need of further support. These emergency contacts are often family members, who will be navigating the strain and burden of caring for a student in distress (Van Wijngaarden et al., 2004). A practical recommendation would be for universities to scope and signpost sources of support for families navigating mental health difficulties. This would help to ease the strain on families, whilst also reassuring students that if they do opt-in, their emergency contacts will have access to their own help. Specific care should also be taken to consider the applicability of these resources for the emergency contacts of international students.

Demographic patterns in the students most and least likely to opt-in signal topics for further investigation. Within the quantitative analysis older students were less likely to opt-in, and within the qualitative analysis this decision was often found to be motivated by a belief that mature students are more likely to draw on support from partners than parents, and will be less in need of a formal policy to facilitate this. Nonetheless, it would be beneficial to better understand whether mature students navigating crises would be able to reach out for support as well as they anticipated. Our finding that Black, Asian and Ethnic Minority students in the UK were less likely to opt-in, fits with previous findings that highlight how inequalities and barriers within university mental health support systems can impede student access (Arday, 2018). Future research could build on this literature by exploring the concerns and expectations around university communication with families amongst marginalised students.

The finding that respondents experiencing moderate/severe levels of anxiety and depression were more averse to university-initiated communication with emergency contacts extends our understanding of help-seeking amongst university students. Many respondents stated that their difficulties were not serious enough (despite their symptoms), and described wanting to deal with their mental health challenges on their own, without external intervention. Related research with health sciences students highlighted how students experiencing the highest levels of distress were also less likely to seek professional help for their difficulties (Knipe et al., 2018). For students with lived experience of mental health difficulty, the decision to opt-in may relate to a real eventuality, rather than being a purely hypothetical scenario for students currently not navigating existing challenges. Therefore the potential future consequences of opting-in for students experiencing difficulties may explain lower in levels of opting-in. Protective policies like 'opt-in' are important precisely because depression, anxiety and other mental health conditions may prevent students being able to reach out for support themselves. Given links between mental health related knowledge and help-seeking behaviour (Cheng et al., 2018; Gulliver et al., 2010), students should be provided with information on anticipated benefits of opting-in to support them in making informed policy decisions.

4.2. Strengths and limitations

A key strength of this study is its use of both quantitative and qualitative data and in the process being able to provide insight on who decided not to opt-in, and why. An additional strength is the ability to link policy preferences to self-reported outcome data, allowing us to establish that the students who did not opt-in are likely to have the greatest mental health vulnerabilities. Further, the wider survey was developed with input from academics, student representatives, mental health practitioners, and university administrative staff, as part of a 'whole university' approach to understanding student mental health (Barden and Caleb, 2019; Thorley, 2017). A final strength of this research is that the majority of students who did not opt-in provided a rationale.

Despite these strengths, there are several study limitations. This survey obtained a 10% response rate, signalling that the sample studied in this research may not be representative of the wider student population in the studied institution. A second limitation is that the study relies on respondents retrospectively recalling their policy preferences from the beginning of the academic term, which might be subject to errors of memory. Further, although the qualitative work within this research examines the views of students who did not opt-in, it has not explored the views of students who were supportive of the policy and opted-in. Nevertheless, rich insights are provided into the views of those potentially facing the greatest risk.

In the future it would be beneficial to examine cases where the policy has been implemented, to examine how students, their emergency contacts and staff members experience and understand the process. This research would enrich our understanding of practical challenges encountered, examples of good practice and help to consolidate lessons learned. It would also be beneficial to establish whether there are further demographic, academic and psychological characteristics that distinguish the students who are more or less likely to opt-in to universities engaging their emergency contacts. Addressing barriers to opting-in should also explore the potential utility of non-parental emergency contacts as a source of support for students experiencing mental health difficulties.

5. Conclusion

Although most of the surveyed students were unsure whether they had opted-in or not, students who recall not opting-in had the highest levels of anxiety and depression symptomology. These findings emphasize why clear policy guidance is needed to ensure students can make informed and thoughtful choices about whether to opt-in and how to select their emergency contact. Universities should encourage students to select their emergency contact based on who is able to provide the most supportive involvement. Further research is needed to explore how the policy is understood and interpreted across stakeholder groups, including emergency contacts and university staff. Decisionmakers involved in activating the consent to contact process should assess the possible outcomes of engaging emergency contacts, to ensure decisions are considered and informed.

6. Contributors

ML conceived and designed the study. JB conducted the data collection with input from DG. ML undertook the data analysis with qualitative support from LB and JK and quantitative support from JB and DG. ML, LB, JK, JB, SP and DG contributed to the data interpretation. ML drafted the manuscript and LB, JK, JB, SP and DG helped with revisions and approval of the final paper.

Declaration of Competing Interest

No conflicts of interest to declare.

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Supplementary materials

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