Mental Health Declarations for Black Students/Staff at UK HE Institution

Dr Emmanuel K Nartey, PhD, LLM, MSc, SFHEA, BA, MCMI and OLY.

Outline

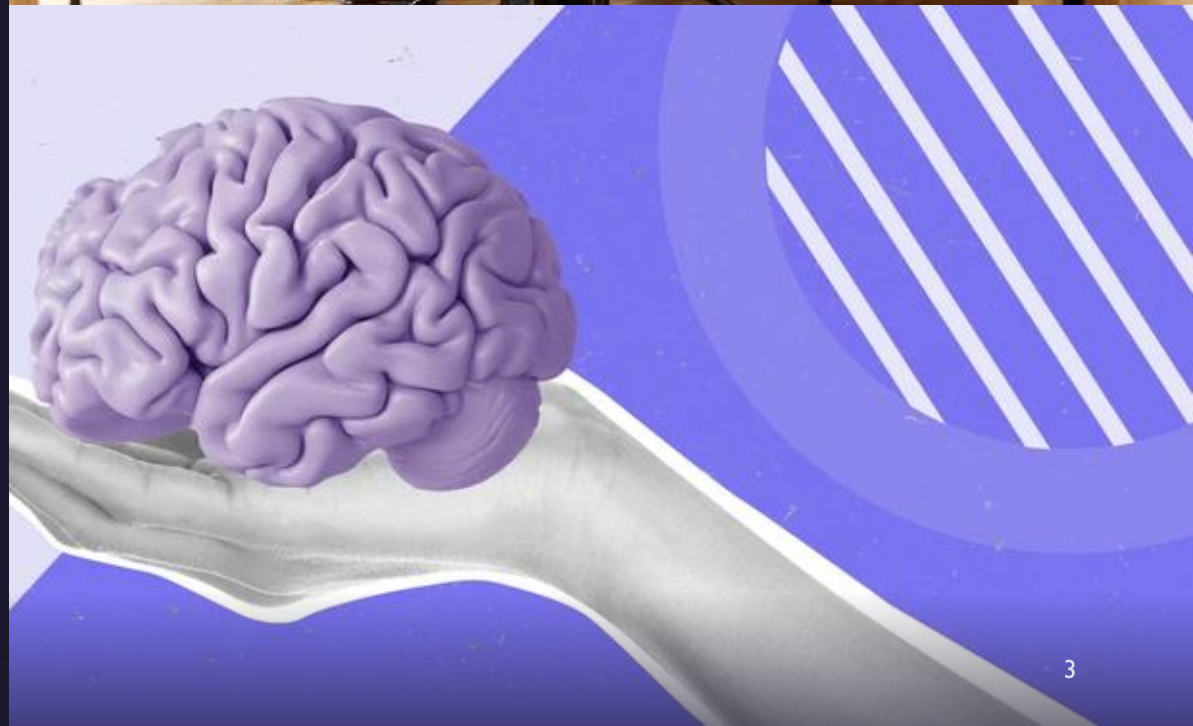
- Introduction
- Institutional Policy and Culture Impediments
- Discussion
- Declaration
- Findings - Lack of institutional understanding (internally) of
- Findings - Lack of institutional understanding (externally) of
- Suggestions to inform future support:
- Recommendations

Introduction

- The word mental health originated in 1960 to decrease the stigma that is associated with it. However, there is no widely agreed acceptance of the meaning of the term mental health and its use in the medical field and the workplace. This lack of agreed consensus led to the misunderstanding of the word mental health and illness, therefore, creating two distinctive but related issues in regard to mental health

- Health is not a medical metaphor that should be linked to the absence of illness, however, is an ideology that gives rise to an understanding of a ‘good life’. The notion of ‘good life’ is an idea whereby an individual gives sense and purpose of their life, it is also connected with the quality of relationship with others, self-respect, and the mastery of one belonging.

- If one is to adopt an inclusive approach to mental health, it is possible to say that the issue of mental health does not only lies in the realm of illness, but rather a positive lifestyle that might have a positive or negative impact on individual internal and external environments. This resonates with the World Health Organisation (WHO) definition of positive mental health.



- The positive definition of mental health is incomplete as an individual does not live in isolation and it means that the mental health of an individual is influenced by themselves, and influenced by their social and external environments. What is adequate about this statement can be seen in neurotic patterns of brain activities in mental health patients.

- This pattern of brain activities breaks the understanding of mental health as an internal and external factor that is affected by both the individual and the environment. In a rationale analysis, people give meaning to their own individual mental health and the term 'good life'. This diverse meaning leads to different sets of perceptions and treatments that are connected to individual groups and cultures.

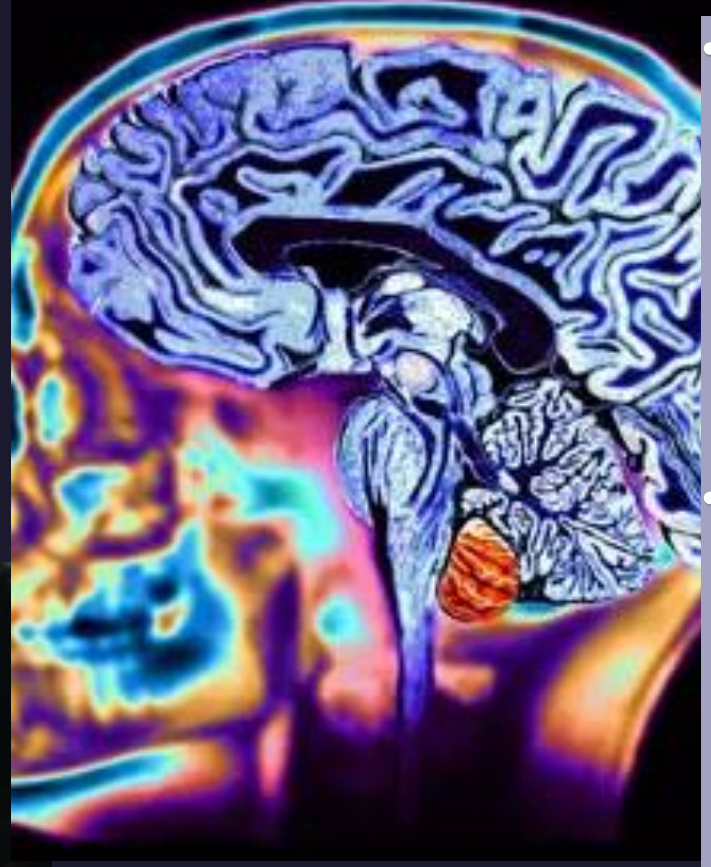
- Rowling et al (2002) define mental health as the 'capacity of individuals and groups to interact with one another and the environment in ways that promote subjective wellbeing, the optimal development and use of cognitive, affective and relational abilities, the achievement of individual and collective goals consistent with justice.' What is essentially being said here, is that distortion of the individual internal and external environment will lead to instability and mental health issues. Hence, if individuals feel a lack of belonging, value, lack of collective goals, and justice in the external environment (organisation) will result in mental health issues and distrust.

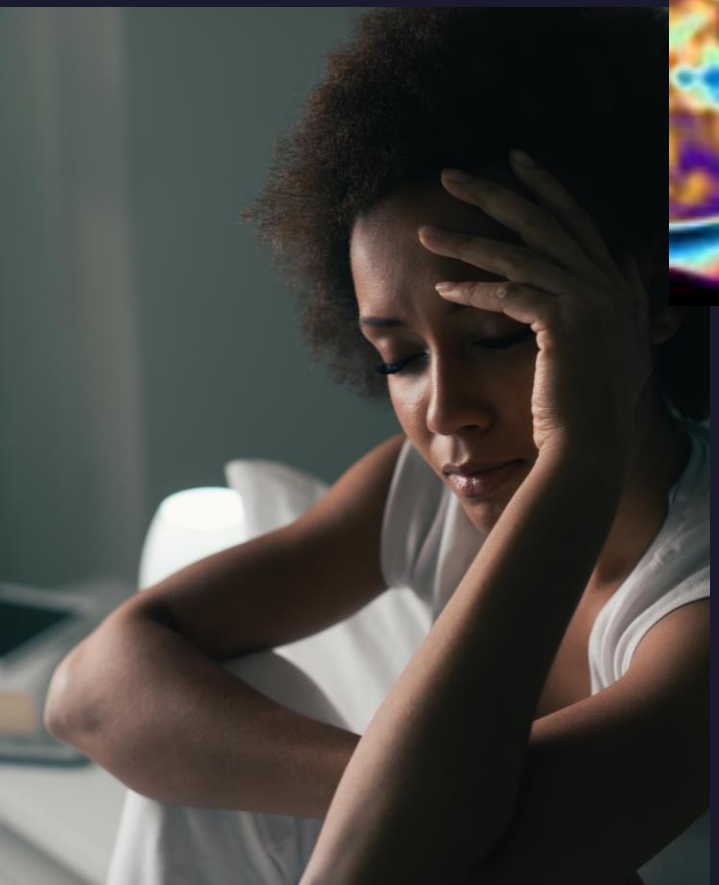
Relating this to an institutional point of view, mental health policy in an organisation should have two distinctive approaches. The individual approach is framed around appropriate cultural service and the organisation approach is framed around effective support networks and systems of services.

In these two distinctive approaches should lie the recognition of physical and mental health existing separately, however, both functioning is interdependent. Thus, the issue of mental health should be considered within the organisational culture and development context, as does the construction of mental health support and services. This is because the quality of mental health of an individual is influenced by various factors and experiences throughout a person's lifetime.

It is therefore clear that the parameter of mental health in an organisation has both intrinsic and extrinsic factors. Both factors should inform and influence policy in the promotion of quality and effective mental health services to support staff. However, this has not been the case, disparities exist in terms of Black and Minority Ethnic (BME) staff accessing mental health at universities. Institutional dogmatism shadows racial inequality and discrimination at universities.

Image credit: istockphoto.com/llhedgehogll





- This institutional approach may have created isolation, suppression, and marginalisation of mental health among BME. Therefore, the lack of understanding of these influencing factors and experience in the United Kingdom (UK) Higher Education (HE) has led to BME's refusal to access mental health in the workplace.

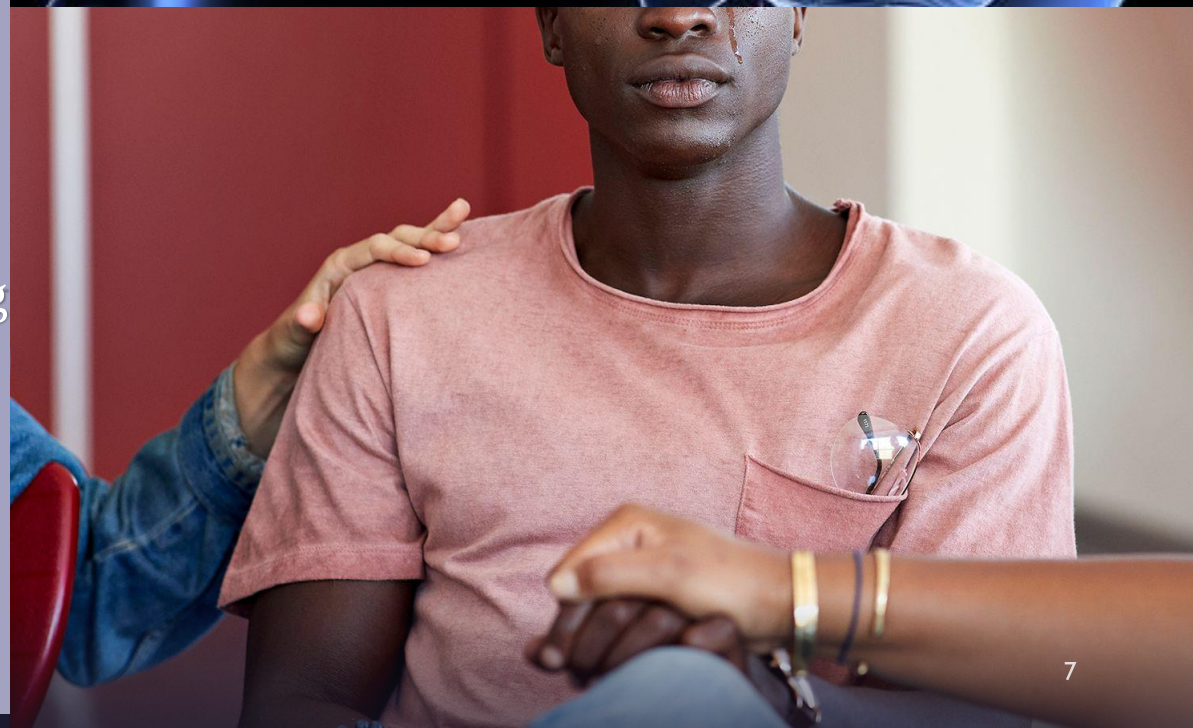
- For instance, Black and Minority Ethnic (BME) people continue to experience inequalities within the United Kingdom (UK) Higher Education (HE) system despite the major shift in government policy to promote health and wellbeing at the workplace. Access to mental health support for many BME in UK HE remains problematic and in some instances none existence among staff .

- Within HE institutional establishment BME students and staff consistently faced barriers to mental health support in terms of accessing a service that understands their cultural needs and differences. There is also a lack of cultural understanding, communication issues, what, where, and how to seek help.

- The institutional inequalities and policy deficiency in mental health continue appearing in policy documents and the UK government-commissioned report, however, this policy bears little fruit at the institutional level.

- Grey et al (2013) and Wallace et all (2016) show that many BME groups are still experiencing difficult barriers when it comes to accessing mental health care in the UK . The lack of effective action and a determinate approach to tackling BME mental health has created a support crisis in the UK HE institutions, which is gradually affecting engagement and retention in UK HE institutions.

- These findings in the literature suggest the importance of inclusivity in HE. It also stresses the importance of including mental health discussion and policy at the heart of HE operation strategy and organisational culture.



- There are also language barriers, poor communication, inequalities, poor assessment, inadequate acknowledge or response to mental health issues among BME, imbalance of power and authority between service users and providers, cultural naivety, insensitivity and discrimination toward the needs of BME service users, and lack of awareness of different services among users and provide needs to be addressed in order to develop mental health service and policy that include all components of the organisation .

- People from BME need considerable support and awareness to combat the prejudiced view of mental health. There is a need for effective communication strategies that focus on promoting awareness among BME. This strategy should include cultural sensitivity issues of care and inclusivity.

- The project was designed to contribute to the delivery of the University's Access and Participation Plan and the Access, Participation, and Success Strategy. As part of narrowing the awarding gap for black students achievement gap, there is a commitment within the APP to increase the number of black students who declare a mental health issue. The purpose of this is to ensure they can access appropriate support. The project contributes to the understanding of how organisation practice and policy have imped BME mental declaration and access to mental health services.

- **Institutional Policy and Culture Impediments**

- Memon, et al (2015) in their study ‘identified two broad inter-related themes as barriers to accessing mental health services: (1) personal and environmental factors, and (2) relationship between service user and healthcare provider. Each theme was comprised of subthemes.’ Rugkåsa and Canvin (2011) concluded that the first problem within the current mental health study is a lack of equal representation of society.

- The author went further to claim that much mental health research in the area of BME has made little progress on the issue of cultural diversity compared to research in the entire UK. Perhaps the lack of research and progress on the issue of diversity in UK universities has contributed to policy and cultural impediments.

- This policy and culture impediment might suggest that there is a lack of study and understanding of the safeguard mechanism and policy that needs to be put in place to promote mental health in UK universities.

- The lack of understanding of diversity and different cultures in UK universities also affects access to ‘education opportunity (attainment outcome) and employment.’ Without a rigour understanding of the diversity and the cultural difference that exist in higher education environments, it is therefore unlikely for the institution to explore the benefits and strength it adds to the organisational growth.

- Anjum, et al (2016) stipulated that if mental health issues and inequalities are not adequately addressed in universities, the result will be an equitable deficiency. Arday (2017) and Rollock (2016) went on to conclude that the ineffective mental health mechanism and policy at universities may often lead to BME students feeling isolated and marginalised. Ahmed (2015) further elaborated that the feeling of isolation among BME students intensifies when it comes to the discussion of culturally sensitive topics that can have a detrimental effect on them.

- In reviewing the claim made by the authors here, two distinctions can be drawn from here. The first is a lack of BME representation at universities, this may have silent BME staff and students declaring mental health and the second is BME staff and students may feel uncomfortable discussing their mental health with another racial background without the fear of stigmatisation. Such factors may have a psychological issue on the way BME students and staff address the issue of mental health and their place in the institutional workplace.

- Alexander and Arday (2015) also make a point in their study by concluding that the central whiteness of UK universities acts as a barrier to the promotion of diversities and attainment capabilities of ethnic black students.

- Perhaps, the central whiteness of UK universities may have been one of the main reasons why BME students and staff are reluctant to declare their mental health issues.

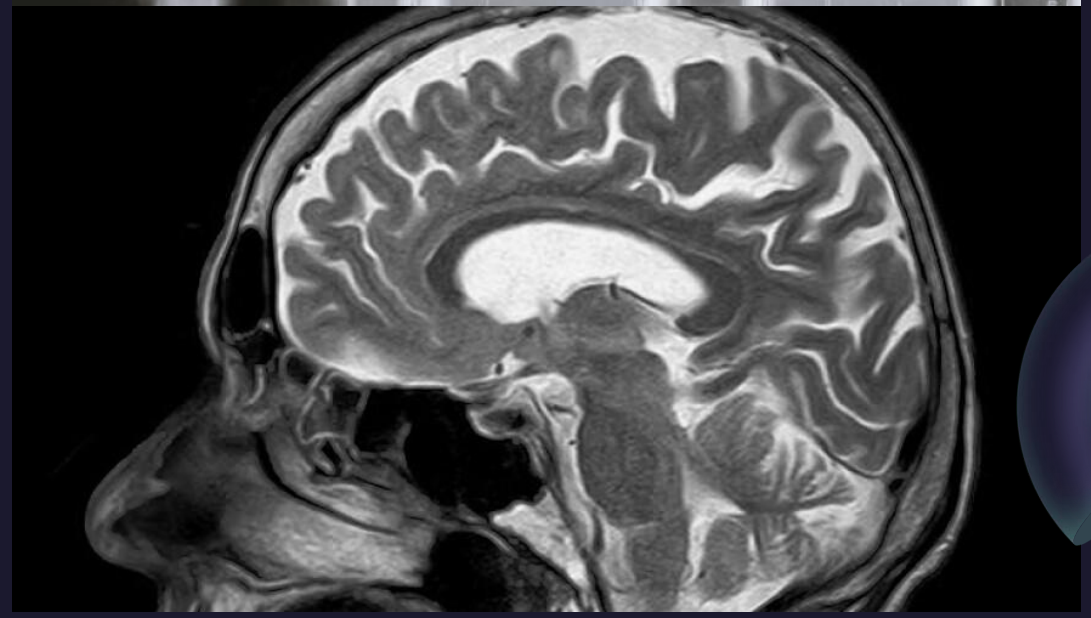
- Shillian (2015) also found that when you consider the extent and depth of mental health issues, the ‘representation, relatability racially and cultural’, the dominance of the white race at UK institutions can be problematic when it comes to BME mental health issues.

- Furthermore, the issue of central whiteness and the factors highlighted in this literature review, in the long run, may impact upon attainment, specifically when considering the engagement of students from BME backgrounds. Importantly the student whose success rest on a good relationship with their academic tutors to help their transition through university.

- Tate and Bagguley (2017) observed that BME students find it difficult to ‘express race-related problems to tutors/lecturers because the issues are connected to their culture. They also found that academics tend to be ‘contextually disconnect in attempting to understand the nuances of racialised experiences.’

- Giuliano et al (2000), asserted that the lack of trust in the medical systems and bad experience with these services is one of the reasons why BME are reluctant to access mental health services.

- In relating the author's claim to the situation in UK higher education, the challenge arises in the way the universities have attempted to exclude ethnic minorities in their policy and cultural discourse. Higher education has increased its students and staff population, this also means there is more strain on pastoral service and resources at the universities, as the universities endeavour to meet the needs of their students.



- Following the state of Arday (2018), it is possible to assert that perhaps universities are open to diversities when it comes to increasing students population but closes their doors to diversities when it comes to pastoral care service and well-being.

- The challenge though is to provide a voice for BME specifically when we seek to change the dominant culture of universities, which often excludes BME experiencing mental health within the institution, throughout their careers and education.

- Including BME in the discourse of mental health at universities may help evaluate institutional approaches and attitudes toward mental help. However, there is much less research available in the UK looking at the issue of race and mental health specifically in the context of students and staff in higher education.

Declaration

AIM

Develop and agree on appropriate **language** and terminology for use with students and staff when referring to Black Students declaring mental health conditions and presenting the findings as research/conference.

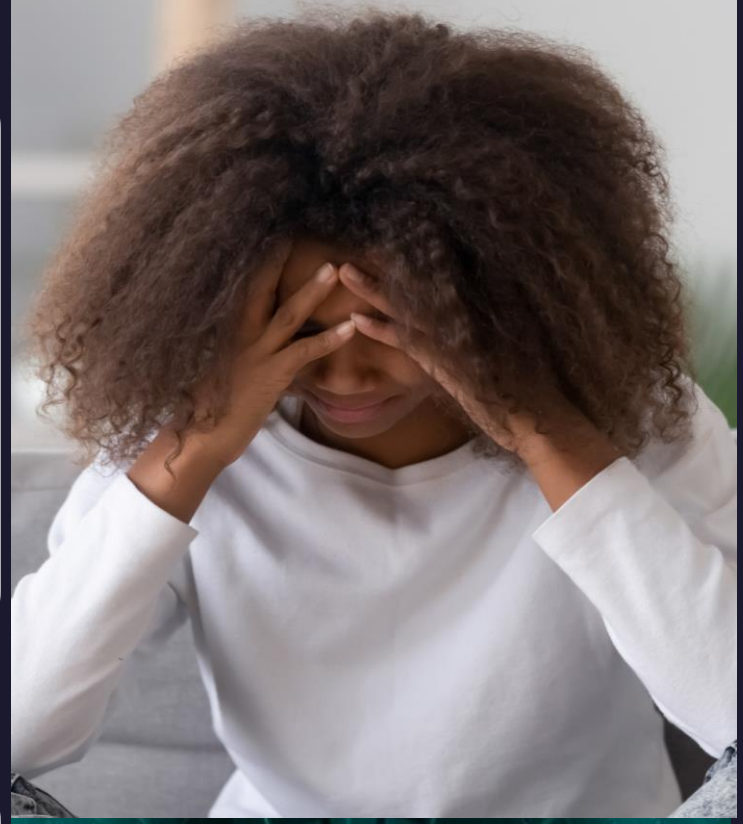
(Qualitative research methods)

Reports – Literature review and current research

Online survey – 25 participants invited, 11 responses

Interviews – Follow-up with 8 participants from the survey

Based upon previous research, a range of questions were asked from the surveys, from which interviews were later conducted with some of the participants. Five key questions about mental health declaration, service, support, and language were posed, all of which were ethically approved.



The first question asked to participants was ‘what is your understanding of mental health and wellbeing, and has the UK culture or your background shape your thinking on race and mental health? Responses to this question were quite interesting in that they presented a mixed perception of mental health and declaration. Participant A stated that ‘my parents are from Guyana and Saint Lucia so they met over here. But obviously, I was born here, so suppose I have a mixture of Caribbean, but also the UK. This respondent believes that her association with the two countries has influenced her understanding and view on mental health. However, her cultural approach from her parents has played a role when it comes to expressing mental health, but also the culture that she is surrounded by as well in respect of how she may talk about mental health issues at home as opposed to how she may discuss mental health issues outside the home with colleagues and friends may differ

- Participant B’s response to this question stated ‘I've grown up in an environment where that word was always associated with what it used to be, which was a mental or crazy person, not having sanity and there was a lot of stigma around that I can remember that even being joked about when we were younger.

- That word carries a stigma and it will carry a stigma for those in specific ethnic groups. So maybe it's being open to learning that has influenced how I think about it.’ Participant B's response seems to assert that the word mental health has a negative stigma attached, specifically for people from an ethnic minority background.

- This negative stigma is created by society and the misunderstanding of the cultural aspect of this ethnic background. Hence, the culture in the UK did not influence her view on mental, but rather her openness and her ability to learn allowed her to come to terms with the word mental health and mental support. It also became clear from Participant B`s response that discussing mental health among ethnic minority groups raised a lot of concerns and issues as they feel differently about mental health and the way they are treated.

- Participant C’s response to this question also noted environmental considerations for the use of the word mental health to address the issue among people from an ethnic minority background. Participant C’s response to this question stated, ‘I was born in the UK and I was born in the late 60s, so I went to school in the early 70s and 80s. I was one of those children that saw how Black children were treated differently compared to their white counterparts, so we tended not to talk about mental health issues or if it was, it was quite hushed because then in the UK it was deemed as another issue that we had to try and fight and overcome.’

- For Participant C`s approaching the issue of mental health is problematic since the word has been used as derogatory terms against black people. Furthermore, growing up in an area with a mental hospital and hearing the negative comments people made about the patient at the hospital give her a bad impression about the term mental health.

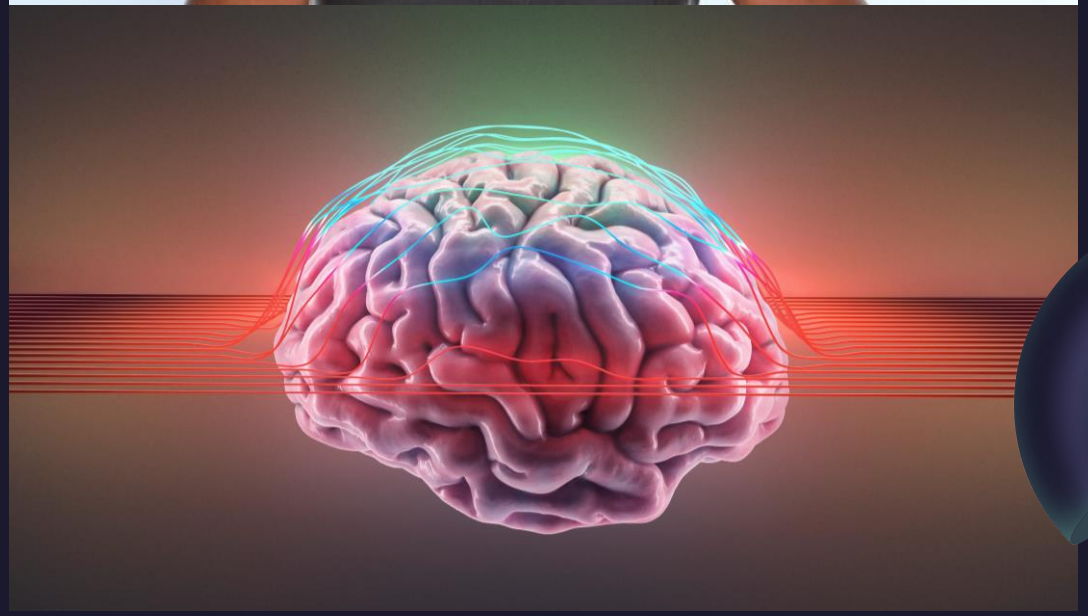
- Participant C further asserted that ‘the white establishment that was the issue because they don't understand how we communicate and the fact that you lump everybody in one part and you can't treat everybody the same because we from Caribbean origins so.’

- Participant C's response seems to highlight structure and discrimination problems in mental health declaration among people from an ethnic minority background. The first is, there is a lack of understanding of the different needs of ethnic minorities, the second is the force perception of the establishment, the third is the misunderstanding of the cultural disparities among ethnic minorities and the stigma associated with ethnic minorities declaring mental health.

- Participant D's response to this question stated 'I was born in Ghana and spent all my kind of formative years in Ghana.' However, used to visit the UK and Singapore because of family living there but fully migrated to 'the UK after my first degree.' Participant D had been in the UK for 24 years prior to the interview. When ask about influence, the response was to some extent 'my current views will be mentally shaped by cultural assimilation because I've been here for such a long time.'

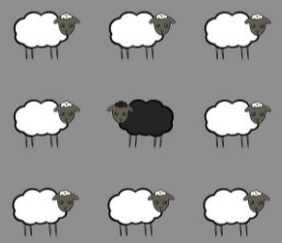
- Participant D seems to suggest that even though he did not grow up in the UK, the British culture has shaped him and influenced his understanding of mental health. Furthermore, Participant D did not have a problem discussing mental health with people of his race but was reluctant to speak about mental health with a colleague in the workplace.

- It also became apparent that workplace stigma is one of the reasons why Participant D is very reluctant to discuss mental health at the workplace. Participant D's response corresponds with the other participant on the ground of stigma and misunderstanding. It also further highlights the lack of a free and fair environment for staff from an ethnic minority background to express or discuss mental health issues.



Findings – Institutional inequalities leading to

Imbalance representation



Lack of equal representation of society (Central whiteness of UK universities)

Poor communication

Cultures of siloed working and inadequate communications to support understanding

Mental healthcare inequalities

Inadequate acknowledgment or response to mental health issues for Black, Asian and Minority Ethnicities (BAME)

Imbalance

Imbalance of power and authority between service users and providers

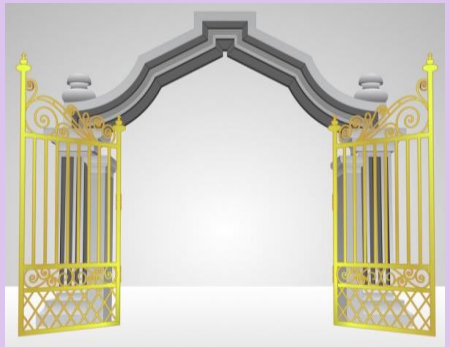
Poor assessment

Poor or limited assessment for referencing the level of inequalities

Insensitivity and discrimination

Insensitivity and discrimination toward the needs of BAME Students

Findings - Lack of institution understanding (internally) of



Encouraging students to talk

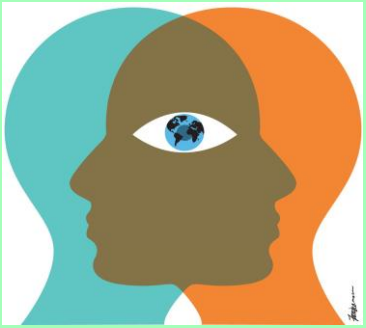
Intuitional inequalities

Black Staff and Students are already at the bottom

Language barriers

Negative words can be experienced as stigmatisation

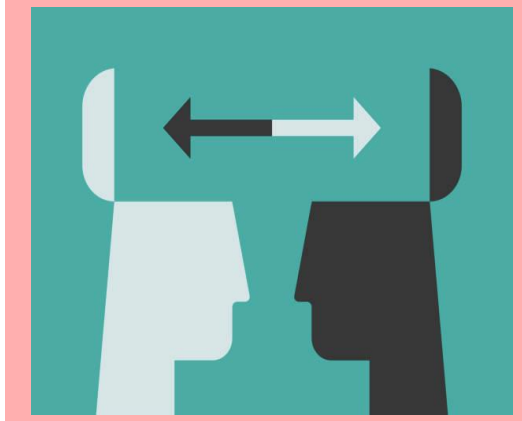
University perception



Expectation of students; sole ownership for own mental health

Findings - Lack of institution understanding (externally) of

Cultural barriers



Cultural views impact understanding and acceptance of mental health

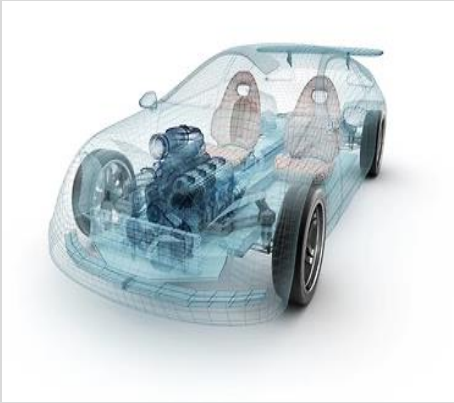
Confidentiality

Trust in information shared at any stage

Environmental context

People, culture, politics

Transparency



…is also representation!

Suggestions to inform future support:

Using ‘**People First Language (PFL)’** and **‘People Centred Language (PCL)’:**

What the INST’s Black Staff advised…

‘No one wants to admit their failings and with an individual from a BAME background this is much more difficult as they are expected to overcome everything no matter what, as no natural sympathy is afforded through their background; expectations placed upon them is high.’ (INST Staff)

‘Black Students cultural background may mean that they talk differently and express themselves differently from white students’ (INST Staff)

‘Terminology will flow naturally when an individual of an BAME background knows they are being heard and not being judged or viewed as being from a homogeneous group.’ (INST Staff)

Suggestions to inform future support:

Share good practice…
✓ Create a safe space to nurture conversation
✓ Be Patience and give them time to talk
✓ Start conversations mindfully - How are you feeling? Are you ok? (Remember, tone and manner can make a difference)
✓ Conversations should be: Direct, factual, moving from the general to the specifics
✓ Use engaging sentences to open up conversations: but try not to open with words like depression and anxiety – which are relatable terms for some but not all
✓ Lead with support: What can I do to help you? Do you feel you need some time out?
✓ Understand the context: Mental health may be talked about widely in the UK but not necessarily within Black communities.
✓ Consider that mixed race or mixed heritage students may have a different experience of discussing mental health the BAME umbrella
✓ The term mental health is viewed as derogatory and negative
✓ Avoid using words which imply negatives: angry/ anger/ manic/calm down, defensive and confrontational

Recommendations

- Diversity in mental health support advisors
- Mandatory culture and language barriers training for mental health support advisors
- Practical improvements in language *(interpreting, translating, understanding, support)*

Recommendations

- Showcasing other students' stories

  (meeting faith-related and religious needs)

- Varied approach intervention and communication

  (Increase funding to improve institutional understanding, support and resourcing)

- Increasing the ethnic diversity of staff, and action to address and reduce experiences of racism and discrimination

Thank You

Dr Emmanuel K Nartey

Email: maninartey@gmail.com