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Understanding Mental Health: What Are the Issues for Black and Ethnic Minority Students at University?

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Abstract: The experiences of Black and Minority Ethnic (BME) students in academia remain problematic. Within higher education, BME students consistently face barriers in terms of accessing culturally appropriate services, including a lack of cultural understanding, communication issues, and where and how to seek help (Grey et al. 2013). In an attempt to examine the problems facing ethnic minorities with regard to accessing mental health services at university, this paper replicates and builds on the research carried out by Memon et al. (2016) to examine whether their findings also apply to higher education settings. Importantly, this paper highlights that barriers to accessing mental health support for ethnic minorities directly impact attainment outcomes and psychological well-being. This study utilizes the narratives of 32 BME university students (or recent graduates) to examine the impact of negotiating racial inequality and discrimination at university and the impact on mental health. Aspects examined considered the impact of belonging, isolation, and marginalization on mental health and how this consequently affects university participation for BME students. Utilizing a thematic analysis paradigm, the key findings presented point towards differential healthcare outcomes for ethnic minority university students experiencing mental illness. The empirical findings in this paper suggest that currently, ethnic minority service users experience overt discrimination and a lack of access to culturally appropriate services that are cognizant of the racialized plight of BME individuals. These findings inform an overarching dialogue, which suggests that mental health services need to be better codesigned with ethnic minority students. Furthermore, the findings suggest that information should be made available in appropriate language formats for ethnic minorities to support understanding about their mental health and how they can seek professional intervention and help. Conclusions and recommendations provided advocate greater diversification of mental health support systems for ethnic minority students within universities. Conclusions drawn will also consider how existing systems can function to dismantle racial inequality within the mental health profession.

Keywords: black and ethnic minority (BME); ethnic minorities; service user; healthcare provider; racism; diversification; inequality

1. Introduction

Increasing diagoneses of mental illness globally have thrust the importance of mental health into public consciousness. The emphasis on mental health has gained widespread attention as healthcare professionals attempt to find more effective ways of managing mental illness (MIND 2013). Racialized disparities in access to and experiences of mental health services have been highlighted as an area of concern within a number of reviews and policies published or commissioned by the United Kingdom (UK) Government (Grey et al. 2013). This is also reflected in the wider research base (e.g., Wallace et al.

2016), which indicates that Black and Minority Ethnic (BME)[1] communities are likely to be referred to mental health services through primary care (e.g., general practices) and more likely to be arrested by the police following a crisis (Grey et al. 2013). As Grey and colleagues highlight, the criminalization of BME communities experiencing mental health crises inevitably results in poorer health outcomes and more coercive forms of care within locked wards. Within higher education outcomes, there has become a narrative of crisis regarding ethnic minority student well-being and mental health, which has seen an increasing impact on degree attainment and retention (Equality Challenge Unit 2015; Tate and Bagguley 2017).

The importance of mental health should occupy a position of prominence within the everyday language of higher education discourse since this permeates every aspect of the student experience. For ethnic minorities navigating the racialized terrain of the academy, there is a dearth of culturally sensitive interventions within the UK that allow BME students to openly discuss their experiences of mental health without fear of further discrimination, reprisal, or judgement (Arday 2017). Consequently, this has impacted confidence among ethnic minority students in being able to present potential well-being issues and access support within universities and the wider health care system (MIND 2013). Moreover, Memon et al. (2016) point out that there are considerable variations in the prevalence of mental disorders across different BME communities, as seen in their study, where the majority of respondents had received a university education. Their findings show that South Asian women experienced higher rates of anxiety and depression (63.5% compared with 28.5% of white women) and among Afro-Caribbean men, 3.1% (compared with 0.2% of white men) encountered psychotic disorders or episodes (p. 2). However, they were less likely to be well-served by mental health support services, particularly when feelings of isolation and marginalization begin to emerge (MIND 2013). Within universities, there has been an emerging pattern regarding the utilization of mental health services among ethnic minority groups, which points towards differential and inequitable experiences and outcomes. This could be indicative of a broader pattern in which people from ethnic minorities are less likely than their white British counterparts to seek mental health support from their GP and are also less likely to be prescribed antidepressant medication or be referred to specialist services (Memon et al. 2016).

People from minority ethnic communities have historically been underrepresented in health research (Giuliano et al. 2000). Racialization has historically impacted ethnic minorities attempting to navigate a discriminatory landscape permeated by institutionally racist structures (Andrews 2016). Within ethnic minority communities, there are cultural differences regarding the way mental health is perceived, accepted, and acknowledged. Globally, there is a stigmatization that has accompanied mental illness. However, raising awareness of this context has often been situated within a dominant white and Eurocentric backdrop (Grey et al. 2013; Sewell 2012). Addressing this imbalance to ensure that people from all sections of society are represented equally is important in reflecting mental illness as a problem that affects all types of people regardless of race, class, religion, gender, sexuality, or disability (Glover and Evison, 2009; Vernon, 2011). There are two significant factors that contribute to how mental illness is framed societally.

First, there is a failure within existing mental health research to ensure that all sections of society are equally represented. Research in this area repeatedly fails to acknowledge the salient differences in

[1] Commentators suggest the use of precise descriptions regarding the ethnic background when describing research findings (Bradby 2003; McKenzie and Crowcroft 1996). For the purposes of this paper, the term Black and Minority Ethnic and the abbreviation BME will be used to refer to people who are from ethnic backgrounds other than white British (including black African, African Caribbean, Asian, Latin-American, and other minority ethnic communities) with more precise descriptions used where appropriate. There is a recognition, however, that the term BME is not universally accepted. Although, this is the term commonly used within the British vernacular. It is important to acknowledge that the term BME, despite its widespread use, has severe limitations and usually follows non-specific quantifiers such as 'most' or 'some' (Glover and Evison 2009). Typically, there has been an accepted use of the term BME, which has been illustrated in research and Government papers. Given the purpose of this paper, this term is applied purely as a descriptive term having been the preferred term for most of the participants throughout this study.

how ethnic minority groups experience mental health compared to the entire United Kingdom (UK) population (Rugkåsa and Canvin 2011). Such factors include psychological issues that are commonly found in particular racial groups and could be a consequence of continuously encountering varying forms of discrimination (Wallace et al. 2016). Invariably, potential differences in the experiences of such issues within and between population sub-groups emphasize the continual development of effective services or interventions for minority groups (Yancey et al. 2006). Secondly, a social justice element encompasses the dialogue of mental illness, which has often omitted ethnic minorities from mental health research (Yancey et al. 2006). The imbalance in representation indirectly perpetuates existing power imbalances and inequities, which does not ensure that ethnic minorities receive the same types of cognitive treatment and rehabilitation, sometimes resulting in patients being incorrectly diagnosed and heavily medicated (Benoit et al. 2005; Cooper et al. 2013).

In its most rudimentary form, mental health is the culmination of everything that comes into human awareness (Norman and Ryrie 2009). Norman and Ryrie (2009) assert that the safeguarding and promotion of good mental health is paramount for all communities within British society. Developing mental health interventions that are beneficial for ethnic minorities is essential, particularly when we consider the racial ascriptions and objectification of black people and black men in particular within Britain and global society more generally (Grey et al. 2013; Memon et al. 2016). The impact of this often affects access to opportunity, most notably in education (attainment outcomes) and employment. In the UK, black men are over-represented at the coercive end of the mental health system but under-represented in terms of seeking help voluntarily (Myrie and Gannon 2013). Statutory and non-statutory organizations within the UK have often highlighted the need to address inequalities in a mental health service provision for ethnic minorities (Care Quality Commission 2011; Department of Health 2010). Presently, there are similarities in the discriminatory experiences of Black and Minority Ethnic (BME) groups within the mental health system and higher education. BME services users have expressed dissatisfaction with mental health services given the fact that they are more likely to be subject to over-diagnoses, which often results in admissions to medium-security and high-security psychiatric wards/clinics with less emphasis placed on offering psychologically-based interventions (Jones and Berry 1986; Myrie and Gannon 2013). Similarly, within higher education, there are significant rates of dissatisfaction, particularly in relation to student experience, belonging, curriculum, and the BME degree attainment gap deficit (Arday and Mirza 2018; Equality Challenge Unit 2015). BME students often report experiences of exclusion in varying forms, particularly concerning student experiences that are not culturally accepting, sensitive, or diverse. The impact on belonging is significant since ethnic minority students will inevitably withdraw themselves from these exclusionary spaces (Alexander and Arday 2015; Arday 2017). The marginalization of ethnic minority students within the university space has historically been exacerbated by the proliferation of dominant Eurocentric curricula presented as the central body of knowledge that students must ascertain (Andrews 2016; Arday and Mirza 2018). Many of these factors affect the learning experiences of ethnic minority students who encounter adverse experiences in terms of supervision, support, assessment, and access to help, impacting degree attainment (Pilkington 2013). In considering these aspects, there is an under-appreciation within the academy that BME students encounter and experience university differently, and consequently, holistic and academic needs will differ. The lack of acknowledgment within the sector does pose a significant risk to the mental and physical well-being of ethnic minority students attempting to navigate themselves through university.

As with most forms of discrimination and inequality for ethnic minorities, racism often occupies a position of centrality in their marginalized and oppressed experiences. There is evidence that attitudes towards mental health concerning BME people are often conflated within cultural contexts that advocate "resilience" and "strength" over presenting and confronting mental health concerns (Grey et al. 2013). Stigmatization within these communities is problematic, and this is exacerbated when we consider attitudes towards psychological distress and the accessibility of resources available to ethnic minority populations (Memon et al. 2016). Traversing this discriminatory terrain can be a

precursor to BME communities being more likely to struggle and less likely to receive the psychological support required.

Mental health and educational attainment within higher education, particularly for BME learners, have become interwoven against a backdrop of institutional racism. "In many cases, BME students will have already traversed a somewhat problematic education system that has historically failed ethnic minority communities and, in particular, young, black boys" (Andrews 2016, p. 4). The terrain traversed can be traumatic and can cause mental fatigue, which can often reveal itself in the form of lower attainment, increased anxieties, and cultural pressures, particularly for young, ethnic minority women (Mirza 2017). The higher education landscape within the United Kingdom (UK) presents a very complex and somewhat contradictory discourse. Within the UK, higher education is often represented as a vehicle for inclusion, diversity, and multi-culturalism (Alexander 2017). However, the contradictory position that emerges often ignores the racial discrimination that resides within the academy, which disadvantages BME students in addition to the structures that impact aspects of attainment and engagement (Bhopal 2014). Against a backdrop of societal and sometimes cultural ideologies that tend to present mental illness as showing fear, distress, or displays of emotionality, attitudes toward mental illness concerning BME individuals can be difficult (Grey et al. 2013). For BME students undertaking university study and negotiating mental illness, many of them will already be managing overwhelming family pressure and expectation to attain good degrees in the hope that this will potentially pave the way for a successful professional career (Arday 2017). This paper examines the impact of negotiating racial inequality and discrimination at a university and the impact on mental health. The aspects examined consider the impact of belonging, isolation, and marginalization on mental health and how this consequently affects university participation for BME students. Unpacking the stigma of mental illness among BME communities requires understanding some of the cultural pressures faced by ethnic minority students upon entering and transitioning through university. Illuminating some of these factors also provides opportunities to examine the service user and healthcare provider experiences while at university.

For ethnic minorities, social factors play a significant role in facilitating patterns of racialized oppression. Isolation and marginalization are widely acknowledged to be linked with the onset of mental health problems (Vernon 2011). The oppression faced can often be a precursor to mental illness, and this becomes compounded for many individuals from BME backgrounds required to be continuously resilient in the face of enduring institutional racism. Importantly, this paper will argue that, against a backdrop of continuous inequality and discrimination, BME students endure severe consequences in attempting to successfully negotiate university. As such, it is unsurprising that ethnic minorities are at an increased risk of mental health issues (Grey et al. 2013). Cultural alienation from wider communities within universities and society undoubtedly becomes a significant contributing factor that gradually affects and de-stabilizes mental and psychological well-being amongst ethnic minorities (Ahmed 2012).

Lastly, this paper concludes by providing suggestions and recommendations for how mental health support systems can be better diversified for ethnic minority people within universities. The conclusions drawn will also consider how existing systems can function to dismantle racism. Concluding thoughts will proffer that ethnic minorities encounter continuous discrimination and institutional racism throughout varying societal structures, which leaves ethnic minorities more vulnerable to mental illness in the first place.

2. The Problem

The prevalence of student mental health issues has gleaned significant attention, with students encountering ever-increasing pressures associated with good degree attainment, debt, and gaining employment. Sadly and rather worryingly, the current plight has coincided with an increase in suicide attempts by university students. The extent of BME and white differences regarding student mental health is significant. Research undertaken by the mental health charity MIND (2013) suggests

that nearly two-thirds of ethnic minority students experiencing mental illness often experience discriminatory encounters with healthcare professionals. Furthermore, MIND (2013) states that ethnic minority students already encounter hyper-surveillance within societal spaces, which heightens feelings of sensibility and vulnerability. The prejudiced scrutiny of environmental and socialization factors has often resulted in diagnoses that advocate medication above cognitive therapies and coping strategies for ethnic minorities (MIND 2013).

Comparatively, white students are often presented with a variety of cognitive and behavioral therapies aimed at not developing a dependency on medication instead of focusing on promoting continuity and stability in managing mental illness. White university students do continue to experience mental health support differently, with MIND (2013) finding that white students often report positive experiences with mental health professionals that are situated around several self-help interventions and building confidence within patients to create autonomous individuals that become aware of the potential triggers that may affect their mental health and physical well-being.

An aspect of higher education that often underpins the BME student experience is feelings of isolation and marginalization (Arday 2017; Rollock 2016). The way in which this isolation is experienced creates a hyper-consciousness, which can be exacerbated by unwanted surveillance, often resulting in a solitary experience for BME students in predominantly white environments within the university space (Bhopal 2014). In many cases, Ahmed (2012) suggests that this isolation can become intensified when discussing culturally sensitive information, which can negatively impact aspects of well-being. Representation creates a sense of belonging, and for many BME students, the paucity of diversification is often reflected within staff and student populations, most notably at the Russell Group[2] institutions, which remain overwhelmingly white with regard to staff and student concentration (Alexander 2017; Alexander and Arday 2015). The lack of diversification has wider implications for the mental health of BME students, who may feel reluctant to disclose their issues considering the dearth of representation and relatability racially and culturally (Equality Challenge Unit 2015; Shilliam 2015). Significantly, these factors will inevitably impact attainment, particularly when considering the interactions that students often need with academic tutors to ensure their successful transition through university. Tate and Bagguley (2017) explain that many BME students find it difficult to express race-related issues to academics because there tends to be a cultural and contextual disconnect in attempting to understand the nuances of racialized experiences.

2.1. Why Does This Matter?

The plight of BME mental health within higher education and wider society points to a failing of institutional services that have a designated remittance to support the mental well-being of these individuals. Within health-related research, people from ethnic minority communities continue to be under-represented. As a direct consequence, there remains a dearth of literature that has extensively examined the effects of mental health on BME communities within professional environments. Recent offerings (Memon et al. 2016; MIND 2013; Vernon, 2011) have attempted to highlight the consequences of mental health issues and inequalities when not adequately addressed regarding equitable experiences within higher education. Wallace et al. (2016) suggest that inequitable access to mental health services for ethnic minority students creates a discerning chasm between receiving support and becoming progressively more entrenched within the perils of mental illness. Furthermore, Wallace et al. (2016) assert that ethnic minority students often do not receive the culturally sensitive help and support required from health care professionals and, as a consequence, will become

[2] 'The Russell Group is a self-selected association of 24 public research universities in the United Kingdom. The group is headquartered in London and was established in 1994 to represent its members' interests principally to Government and Parliament. Representing the UK's leading universities, the Russell Group has historically been committed to maintaining its status as research intensive in addition to having unrivaled links with business and the public sector (The Russell Group 2018).

reliant upon themselves to negotiate mental illness. This is problematic because the immediate intervention and diagnosis of mental illness are essential in arresting the early phases of symptoms associated with depression, anxiety, and psychosis. The equitable experience in higher education is further compromised for ethnic minority students who have not been given access to the type of non-judgmental mental health provision provided to white students (Fernando 2010). The lack of equitable access for BME students submerged within the debilitating stranglehold of mental illness will enviably impact attainment outcomes and equality of experience in terms of personal and professional development while navigating university life (Alexander and Arday 2015; Memon et al. 2016).

The absence of extensive networks for ethnic minority groups is a pertinent factor in the participation of such mental health research (Davies et al. 2009, Shavers et al. 2001). Attempting to glean those voices that have experienced mental illness during university becomes problematic when we consider the cycle of marginalization and isolation that many BME students face upon entering university as self-preservation strategies move from attainment to survival (Picower 2009). For many university students, the stigma of mental illness often means that individuals are reluctant to disclose any issues they may have (Wilkinson and Pickett 2010). The backdrop to this particular reoccurring narrative has tended to be situated within building trust in pastoral interventions provided by universities, which do not pre-judge or label ethnic minorities before cognitive-behavioral processes have been utilized (Vernon 2011).

The lack of trust in research or in the medical system is often mentioned by BME communities that have experienced these particular services (Giuliano et al. 2000). Shavers et al. (2001) found that often BME individuals are less willing to participate in medical research in comparison to their white counterparts. There are other practical issues that affect the participation of BME communities within this type of research. Skepticism from BME communities can impact this context significantly, particularly for BME university students who may be carrying the burden of cultural and communal expectations while attempting to assimilate into university life (Yancey et al. 2006). Other commentaries have espoused reasons for the exclusion of BME participants from mental health surveys and interventions. Williams (2005) suggested that some research institutions have established recruitment networks that do not include BME groups. Others (Grey et al. 2013, Memon et al. 2016; Myrie and Gannon 2013; Williams 2005) have frequently reported that additional barriers include language needs and the lack of recognition that healthcare services require modernizing to facilitate the diverse needs of an ever-increasing multi-cultural society. In considering structures or barriers to healthcare services, this inadvertently becomes another way of marginalizing BME communities who are in need of potential psychological or mental health support (Vernon 2011).

Unpacking this dialogue when situated within a higher education context is challenging, particularly when we consider the ways in which higher education attempts to exclude ethnic minorities (Bhopal 2014; Andrews 2016). For BME students within universities, the centrality of whiteness is continuously facilitated through aspects of curricula, poor diversification, and racial ascriptions regarding the attainment capabilities of ethnic minority students (Alexander and Arday 2015; Law 2017). Navigating the inequitable terrain for BME students can become mentally exhausting and taxing, which subsequently impacts aspects of attainment (Equality Challenge Unit 2015). Furthermore, this becomes problematic because attitudes towards mental illness within BME communities can be restrictive, with discourses often situated in developing greater resilience or establishing a greater connection with faith (religious) as the only reliable and viable intervention in arresting mental health decline (Alvarez et al. 2006; Keating and Robertson 2004). Keating and Robertson (2004) explain that culturally, we exist within a society that has historically been guilty of trivializing mental illness as mental frailty rather than as a legitimate illness that destabilizes individuals' mental facilities for short or prolonged periods of time. For BME students, these trivializations of mental illness make it increasingly difficult to disclose some of the crippling psychological symptoms of mental illness. Aspects of loneliness, marginalization, and isolation can become accelerated as ethnic minorities attempt to deal with this issue on their own, which

ultimately plunges them into further difficulties without the correct coping mechanisms (Keating 2007). Within a higher education context, ever-increasing student populations have also placed a strain on pastoral services and resources at universities as they attempt to cater for increasing student populations. Illuminating the ethnic minority voice is particularly important in challenging how we change dominant norms, which often omit how BME individuals experience mental health within society and throughout their journeys within education (Grey et al. 2013; Rugkåsa and Canvin, 2011). Gleaning this voice provides the stimulus for how we revaluate discussions regarding mental health among ethnic minorities. Wendler et al. (2006) detected very small differences in willingness to take part between ethnic groups in their review of published research that reported consent rates (in mainly quantitative surveys) by race or ethnicity. They concluded that, rather than focusing on changing the attitudes of minority groups, it is necessary to promote access to health research for all groups. However, it is safe to assert that the catalyst to changing this narrative is dictated by how we better engage ethnic minorities in disclosing experiences of mental illness (MIND 2013). Initially, Fernando (2003) suggests that the primary focus should involve providing more inclusive and accessible platforms for ethnic minorities to enable disclosures regarding mental illness. However, as alluded to earlier, this is normally dependent on specific cultural contexts or traditions. Ahmed (2012) explains that relationship building is essential in creating spaces of belonging and disclosure for BME communities that have historically felt on the periphery of some of society's major institutions. There is a consensus that advocates building relationships through community representatives regarding BME voices and their mental health (Fernando 2010). The traction gathered regarding greater calls for better representation and diversification within universities in terms of academic representation and student service representation becomes integral, particularly in terms of building synergy and cultural familiarity for ethnic minority students (Rollock 2016; Shilliam 2015).

2.2. The Causes

The heightened and relatively recent pressures attributed to navigating university within the UK have significantly impacted ethnic minority students who, in many cases, will have already traversed systemic and institutional racism in some form throughout their lives (Alexander and Arday 2015). Precipitating factors such as racial ascription, stereotyping, stigmatization, discrimination, hyper-surveillance, and a lack of access to opportunities regarding employment exacerbate mental health issues for ethnic minorities. For BME students, these factors will invariably impact their worldview; consequently, mental wellness can become disrupted or compromised. As already discerned, the academy is an exclusive rather than inclusive space that has often marginalized BME individuals through various instruments of discrimination, such as curricula, unconscious bias, and poor cultural diversification (Andrews 2016). Wallace et al. (2016) explain that, for BME students attempting to navigate university life, these factors become cumulative, and the dearth of specific and non-judgmental mental support interventions deepens issues concerning access to equitable mental health provisions for ethnic minorities within universities. Continuously encountering these discriminatory factors has contributed to the increase in mental health diagnoses among ethnic minority students (Braun and Clarke 2006; Memon et al. 2016).

While some BME students will arrive at universities with mental health difficulties, there has tended to be a paucity of pastoral interventions with an ethnic focus, which has meant that ethnic minorities, in particular, have struggled to gain the required support needed to navigate or manage their mental illness (Grey et al. 2013). Furthermore, Arday and Mirza (2018) suggest that the inequitable nature of universities for ethnic minorities can cause mental health difficulties or exacerbate them.

Traditional enrichment activities at universities in the form of clubs and societies can often ostracize BME students, especially those who are non-inclusive of other cultures. Potential cultural clashes can often emerge regarding university enrichment activities (facilitated via university Student Unions) that may conflict with cultural or religious beliefs. This leaves many BME students feeling marginalized as they struggle to assimilate into these somewhat exclusionary spaces (Ahmed 2012;

Pilkington 2013). Vernon (2011) emphasizes that such racialized experiences heighten feelings of angst, which is a tenet of mental illness. As a minority voice with no outlet to express these feelings, the university experience becomes fraught, which consequently affects attainment as many BME students will endure systemic forms of racism. This may be overt or covert among some of their peers and academic staff (Equality Challenge Unit 2015; Shilliam 2015).

Student accommodation has also proven to be a place where BME students face experiences of discrimination and exclusion, which can often result in ethnic minorities spending large periods of time on their own without avenues to converse with others who may be experiencing similar feelings of ostracism (Andrews 2016; Shilliam 2015). Vernon (2011) explains that, in new environments, belonging becomes essential in the initial integration process with regards to meeting new people where some individuals feel they are on the periphery of these environments. This can create feelings of angst, marginalization, and exclusion. Fundamentally, the emphasis on universities as micro-communities requires re-thinking, particularly when considering how certain minority groups remain on the periphery of these spaces. LGBTQ groups, religious groups, individuals with disability, and ethnic minorities are some examples of these minority groups. It is important to note that cross-cultural acquaintances can differ for men and women. A study undertaken by the University of Bristol with BME students at the university indicated that 66% of black men found it easier to assimilate themselves within the university through integration with clubs and societies. Conversely, this differed for black women, with 71% stating that they found it difficult to assimilate themselves within the university through integration with clubs and societies.

In constructing the narrative of marginalization and exclusion and the implications for mental health and attainment, it is important to acknowledge the impact of dominant Eurocentric curricula, which often omits ethnic minorities (Andrews 2016; Mirza 2017). Curricula becomes a significant catalyst for ethnic minorities developing a sense of belonging within universities, particularly if that curriculum reflects their worldview or life experience historically and presently. Unpacking diverse perspectives for many BME students can be cathartic in relieving mental health pressures, particularly when trying to navigate the university space (Grey et al. 2013).

2.3. The Barriers

The barriers faced by ethnic minority students at university often make it difficult for mental health difficulties to be confronted and addressed during the initial presentation of potential issues. The lack of access for BME students to mental health services reported (Equality Challenge Unit 2015; MIND 2013) often suggests that fear of further stigmatization or racial discrimination is a significant reason why ethnic minorities find it harder to access help and support within university spaces. Alexander and Arday (2015) explain that BME students will already be aware that they occupy a vulnerable and isolated position within a predominantly dominant white environment. Therefore, pastoral services will be difficult to access and retrieve against this particular backdrop. Andrews (2016) suggests that diversifying pastoral services within universities would positively impact the BME student experience, particularly if the support was culturally sensitive and targeted.

The well-being of BME students within universities is paramount for their attainment and general integration within these spaces as a minority. Lent (2004) situates well-being as an essential but often neglected area within psychological health when considering the initiation of ethnic minority students within universities. Furthermore, Fernando (2010) states that, within university spaces, a wide variety of factors make it difficult to distinguish the crucial elements of well-being, particularly with regard to negating the complex needs of varying minority groups. Understanding and safeguarding this well-being remains the responsibility of universities particularly in the case of BME students who continue to experience occurrences of exclusion that impact them upon successful integration into university life (Alexander 2017; Law 2017). Addressing these factors for universities is imperative because, in the United Kingdom (UK), there are higher rates of mental health problems in BME communities compared with the national average (MIND 2012). The dominant discourse, which

precedes this context, has often situated BME communities with mental health problems to be more likely than others to receive a diagnosis of severe mental illness, to experience involuntary treatment, and commonly to enter mental health services via the criminal justice system (Keating 2007; McKenzie et al. 2001; MIND 2013). The dialogue of severe mental health diagnoses is often conflated within this stereotypical context, which can mean that ethnic minorities can be subject to inaccurate and negative summative psychological assessments. This makes many individuals from BME communities reluctant to disclose any potential mental illnesses for fear of stigmatization against this dominant discourse (Keating and Robertson 2004). Unfortunately, such debates tend to be the precursor for some of the racially ascribed views held concerning the ethnic minority experience with mental illness. Fernando (2010) states that there needs to be a wider recognition that acknowledges that, when discussing issues concerning mental health with BME communities, this particular context has historically been underpinned with differential factors concerning "socio-economic hardship" and "power" between "minority" and "majority" ethnic communities. Importantly, while the issue of stigma surrounding mental health problems and disclosure might sound like a familiar one, discourses concerning mental health and psychological wellness as a taboo subject rarely consider cultural and communal factors that make disclosure far more difficult for ethnic minority students, particularly within universities (Palmer and Ward 2007; Wilkinson and Pickett 2010).

Unpacking this within the context of higher education, particularly when considering diversity, attention can often gravitate towards representation at the level of admissions, curricula, and lecturers, but it is easy to overlook that, crucially, our support structures and services—that is, our nurses, our officers, our tutors, our centers, and our counselors—form the basis for successful student progression (Shilliam 2015). Within higher education, a more renewed and penetrative focus is required to ensure that these existing services provide better outcomes for ethnic minority students (Equality Challenge Unit 2015).

2.4. The Solutions

Potential solutions require universities to advocate greater diversification within pastoral and mental healthcare provision. Memon et al. (2016) emphasize that there is a cultural cognizance and sensitivity that is are required when ethnic minority students present symptoms associated with mental health difficulties. The historic absence of this awareness has been a significant contributing factor in the difficulty experienced by ethnic minorities in utilizing these services (Wallace et al. 2016). Universities must develop interventions that advocate more culturally inclusive spaces since the paucity of these spaces exacerbates feelings of marginalization and isolation for ethnic minorities who are potentially already feeling on the periphery of an exclusionary university. Interventions must seek to understand how ethnic minorities experience mental illness differently from white individuals and the impact of cultural pressure and expectation on this phenomena (Fernando 2010; Vernon 2011).

Re-imagining and re-thinking our "safe spaces" within universities is a reoccurring theme that has gained traction throughout the sector as considerations shift towards how greater diversification within the sector can be achieved (Alexander and Arday 2015; Bhopal 2014; Equality Challenge Unit 2015). Importantly, Ahmed (2012) explains that this ideology needs to be better situated within an inclusive dialogue that is able to facilitate varying multi-ethnic groups. Safe spaces, by definition, are non-judgmental, confidential spaces where people can disclose personal thoughts, feelings, and issues that might be affecting their well-being (MIND 2013). Therapy similarly functions as a safe and confidential space. However, Keating (2007) explains that ethnic minorities are rarely well-represented within therapeutic settings, wider support structures, or psychological services, and, thus, working through experiences of mental illness becomes harder. Equally, "safe spaces" for BME individuals can become another discriminatory instrument to being further misunderstood and marginalized (Wilkinson and Pickett 2010). The onus on universities to improve mental health provisions regarding ethnic minorities is paramount at this particular juncture as the indifferent treatment of BME students

within the sector gains more traction regarding attainment outcomes, integration, decolonizing the curriculum, greater diversification, and access to pastoral services and provision (Arday 2017).

3. Materials and Methods

In this article, I take Memon et al.'s (2016) findings and test whether they also apply to higher education settings. For the purpose of this study, 14 UK based-universities were used, ranging from the Russell Group to Post-92[3] institutions. BME individuals (N = 32) aged between 18 to 34 years old were recruited from undergraduate and postgraduate degree programs. Thirty-two semi-structured, open-ended questionnaires were completed initially to capture participants' ethnic origin, gender, and age range. This was solely for monitoring purposes. The questionnaire also assisted in gleaning general information concerning experiences with mental health, either personally or with friends or family, to help inform the development of the focus group and individual interview questions. In addition, we included 2 unstructured focus group interviews and 32 40 min semi-structured individual interviews involving all 32 participants to explore lived experiences of negotiating mental illness as BME students within higher education. The foundational article from Memon and colleagues has been used here as a discussion piece/topic guide. The recruitment of participants was facilitated through recommendations from several African and Caribbean university societies with social media platforms used to enlist ethnic minority participants. Additionally, convenience sampling was used to diversify the pool of participants to ensure that the sample was as representative as possible regarding the ethnic minority demographic to be considered (Cohen et al. 2011).

The initial part of the study involved each participant being given an anonymous self-administered questionnaire to complete, which was deposited into a ballot box. The questionnaire included information on the following: gender, age (in age groups), level of education (up until degree level), ethnicity (according to the Office of National Statistics classification), marital status, and duration of time within higher education. The results reported in this paper draw primarily on excerpts from the two focus group discussions (each lasting for about 3 h), which included 32 participants from the following ethnicities: Asian/Asian British (n = 6), black/black British (n = 14), mixed-heritage (n = 9), and Latin-American (n = 3). The study was comprised of 18 females and 14 males. The overwhelming majority of participants attended a university where the majority of students were white.

The focus groups were conducted in April 2017 within the UK. The objectives of the study were explained to the participants, and informed consent was obtained. Discussions were facilitated by the researcher, who had experience in cross-cultural working and qualitative methods. All focus group sessions and interviews were audio-recorded and transcribed verbatim. In addition to the recorded discussions, written notes were taken, and flipcharts used for participants to document their thoughts. This facilitated a reflexive process, ensuring participants' views were clearly documented. Each participant was encouraged to speak and to express their own views. The nurturing and supportive environment cultivated candid conversations among participants, which enriched the disclosure process.

As with Memon and colleagues (2016), a topic/discussion guide with questions developed and led by the researcher was used to explore elements of mental health services both within the respondents' university as well as their local community. This included the type of service(s) used, issues with and experience of service use, perceived barriers to access, and how healthcare services could be improved for BME students within university spaces. Adapting the discussion guide utilized by Memon et al. (2016), broad questions included: (1) What are your perspectives on mental health? (2) How do ethnic minorities deal with mental health issues? (3) Do you think mental health and

[3] A New University, synonymous with Post-1992 University or modern university, is a former polytechnic or central institution in the United Kingdom that was given university status through the Further and Higher Education Act 1992 or an institution that has been granted university status since 1992 without receiving a royal charter (Armstrong 2008).

psychological services are made accessible to BME individuals within universities and wider society more generally? (4) Culturally, how might encounters with mental illness differ for ethnic minority men and women in comparison to white people? (5) How can the current mental health/well-being services provided be improved for BME individuals within universities and society more generally? The article by Memon and colleagues was also used as a prompt for discussion and reflexivity among focus group participants.

Similarly to Memon et al. (2016), thematic analysis was employed to identify patterns and themes around perceived barriers to accessing mental health services among ethnic minorities at universities. It is important to note that as a BME individual, the researcher acknowledges a personal interest and close association with the topic, due to which some organic bias may be inherent even though all protocols were administered to ensure objectivity was maintained and that any potential biases were minimized (Cohen et al. 2011). The researcher became familiarized with the data, reading and highlighting salient sections before reducing the data into themes by generating initial codes. In an iterative process of review and reflection, key themes and sub-themes were identified and defined (Braun and Clarke 2014). A selection of salient quotes that were considered to best convey each theme are anonymized and included in the results.

4. Mental Health Support Available at Universities

In attempting to unpack the paucity of mental health interventions available to ethnic minorities within university spaces, which is the premise for this particular study, it is important to acknowledge the services that are generally available for all students within the higher education sector. Generally, universities will be able to provide access and signpost university students to the following external services through consultations with occupational health: counseling, psychological therapies such as cognitive behavioral therapy, and access to mental health support charities such as Young Minds, The Samaritans, and MIND (MIND 2013; Wallace et al. 2016).

4.1. Exploring Mental Health for Black and Ethnic Minorities (BME) within Higher Education

Taking the two themes that Memon and colleagues (2016) identified, *personal and environmental factors* and *relationship between the service user and healthcare provider*, my own results show that experiences of ethnic minorities within higher education are very similar. The themes identified were comprised of sub-themes, which aim to illuminate some of the perceived problems for ethnic minorities attempting to access psychological support.

An important distinction to be made through the proliferation of these findings is that there was inevitably a natural crossover between university mental health provision and NHS mental provision since many of the participants experienced similar discriminatory issues during the presentation of mental health difficulties with healthcare professionals. The nature of the research method used was not intended to be invasive but rather to glean potential issues and problems for ethnic minority students when engaging with healthcare professionals regarding mental health within universities. There was an intention initially for participants to disclose more candid accounts regarding personal experiences with mental illness. However, this did not transpire. Mental health professionals advised the researcher that the detailing and explaining of mental health episodes can trigger phases of trauma and de-stabilize psychological rehabilitation. It was advised that the recollection and reliving of periods associated with psychological distress may interfere with behavioral strategies implemented and aimed at focusing on and prioritizing the present context. The researcher and healthcare professionals also acknowledged that they did not have the expertise to deal with the disclosure of particular traumatic experiences associated with mental health and psychological well-being.

4.1.1. Personal and Community Factors

Within the first theme, three sub-themes emerged as potential barriers encountered by BME students in accessing mental health services, as described below.

Cultural Identity and Fear of Stigmatization/Isolation

Fear of stigmatization and isolation emerged as a key factor in seeking help from health services. This was particularly pertinent for individuals who were fearful of stigmatization within their own communities. For instance, one woman stated that:

> "Negotiating mental illness is hard because, within black communities, you can become tarnished as being unstable so you are isolated…then you arrive at university as a minority and then you become further isolated because no one looks like you and the health professionals are all white and have no experience or knowledge of your racialized plight among other things". (Female, Black, UG1)

There was a perception that the consequences of cultural stigma attached to mental health were considered far-reaching and consequential beyond the individual. One participant explained that the residual effects of a mental health diagnosis could stigmatize an entire family, which affects networks and social capital within communities.

> "In my culture, if you hear that someone within your community/family has mental illness…you place all sorts of unfair and judgmental labels on that individual and their family". (Female, Asian, PG, 18)

The stigma often accompanying mental illness within communities meant that individuals were reluctant to openly acknowledge symptoms.

> "For me…the feeling of no one to turn to is difficult, none at university, none at home…these thoughts then follow you everywhere, making the mental illness worse…then you tell yourself I do not have a problem. You just become more stressed and isolated". (Male, Black, PG, 1)

Significant emphasis was placed on cultural identity and stigma towards mental health as barriers to accessing healthcare services at university. Several participants commented on how one's cultural background and identity defined acceptable responses to mental health problems and appropriate coping mechanisms. One participant indicated that:

> "Within African families, there is an expectation to continuously be resilient as you are reminded of the sacrifices made for you to attend university". (Female, Black, PG, 1)

For participants, discussions concerning mental health among families were often perceived as socially unacceptable:

> "If I ever told my parents that I was struggling to get mental health support at university, they would possibly disown me. This is not the kind of thing we openly discuss in my culture particularly as a black, female Muslim". (Female, Black, UG, 11)

According to some participants, experiencing ill mental health was perceived as reputationally damaging, which could impact "standing" and "status" within communities. Consequently, there was a reluctance to seek mental health support or

> "until they reach a crisis point or rock bottom and, as a black male, you are already stigmatized and you are aware that you will be further [stigmatized] upon being diagnosed with this illness, which will consequently affect your university studies". (Male, Mixed-Heritage, UG5)

Social and Community Networks

Social and community networks were considered an anchor for BME individuals who often felt isolated within university spaces. Individuals expressed that healthcare professionals within universities were:

> "Quick to make misinformed judgements such as are you from a one-parent family. . . are there gangs where you live, I know white students do not get asked this". (Male, Latin-American, UG 9)

Establishing networks of ethnic minority friends from similar cultural backgrounds within universities was considered to foster:

> "A sense of community in what was considered to be an overwhelmingly white environment". (Female, Asian, UG, 17)

Importantly, this was considered an integral factor towards providing a safe framework for the discussion of problems. It was felt that:

> "This could play a valuable role in accessing mental health services for BME individuals at university". (Female, Mixed-Heritage, PG, 2)

However, there was a perception that community networks could also be perceived as a barrier either through their absence, by demonizing health services, or by advocating alternative treatments to professional services. One participant highlighted that:

> "Feelings of isolation in universities can significantly affect your judgement as you become fixated on trying to survive with friends indicating that seeking help as a person of color demonstrates a weakness that white people may exploit, which can affect your studies or attainment". (Female, Black, PG, 6)

There was a perception that in navigating the racialized terrain of university life within the UK as an ethnic minority student:

> "The mental health services provided at universities did not always understand all of the racialized nuances involved" (Male, Mixed-Heritage, PG, 1). Further, one participant added:
>
> "we are really, really isolated in this space". (Female, Latin-American, UG, 7)

Social isolation external from university environments was also relevant for participants who lived alone or whose family structure was fractured for varying reasons.

> "Personally speaking, the family structure at home is non-existent so trying to negotiate these episodes while at university is difficult as I do not really get any support or solace at home. This is affecting my grade attainment. . . finding help can be so hard". (Female, Black, UG, 10)

Historical and generational feelings of distrust towards some mental health professionals were also evident among some families of participants. Aside from the formal mental health offerings available through their universities, other avenues of support that participants mentioned included religious and faith networks:

> "They believe in the power of prayer as the only viable intervention and this is often mapped against a relative talking about experiences of bad mental healthcare or diagnosis, re-emphasizing their need to solely place their faith or trust in religious intervention". (Female, Black, UG, 13)

Gender Differences

Many participants concurred with the narratives from Memon and colleagues' (2016) research that there was a reluctance among BME men to discuss or disclose issues aligned to mental health within university and society. Participants indicated that this reluctance was heightened when referrals to discuss issues with mental health professionals were suggested. While mentioning that it was difficult for men to open up and share personal information, one respondent said

> "I always think that, as a black man, I am judged differently and I do not want to provide anyone with the ammunition to judge me differently. . . even more than I am already judged". (Male, Mixed-Heritage, PG, 2)

In synergy with some of Memon et al.'s (2016) findings, participants in this study also expressed the view that services were not:

> "Available for men of color who have mental health issues particularly at universities like ours (Russell Group) where there are not a lot of black men". (Male, Black, UG, 12)

For some male participants, the need to appear strong was inherently linked to their masculinity and a sense of pride, despite an acknowledgment that discussing mental health issues was important.

4.2. Communication and Relationships between Service User and Healthcare Provider

The findings from the study carried out by Memon and colleagues (2016) suggest that the relationship between the service user and healthcare provider is a barrier to successful engagement. In my own study, (difficulties with) communication as a feature of the relationship were of particular importance, and the three sub-themes framing these are described below.

4.2.1. Communication: Cultural Naivety, Insensitivity, and Discrimination

Participants perceived that specialists within universities and the healthcare profession were (generally) unable to conceptualize or empathize with the realities and lived experiences of those from a BME background. In the act of having to continuously explain the burden of racism was experienced as contributing to worsening mental health:

> "having to navigate racism and remain on the outside as a minority in university and society. It is exhausting and mentally grinds you down". (Female, Black, UG, 8)

Often, participants felt that this lack of understanding by healthcare professionals got in the way of their therapeutic progress. They also felt that poor representation within the psychology profession was a direct consequence of this. One participant suggested that:

> "To be honest, it would just be nice to speak to a person that looked like you. . . who can relate to you culturally and understand what you are experiencing as a person of color". (Male, Mixed-Heritage, UG, 9)

Participants also commented on the discomfort often encountered when discussing issues of racism with healthcare professionals and how this impacts the quality of the therapeutic relationship.

> "I have also found that when you, for instance, discuss how racism impacts your daily existence. . . that actually a lot of them get uncomfortable. . . ". (Female, Mixed-Heritage, UG, 32)

Ultimately, services were considered too insensitive to the needs of BME service users, with insufficient provision for treating ethnic minorities.

> "The reality is that we receive inadequate treatment because of our skin color and that is the sad reality". (Female, Mixed-Heritage, PG, 30)

4.2.2. Power and Agency

Among the participants, power was considered an oppressive instrument for maintaining inequality and inequity at the expense of ethnic minorities. Participant experiences spoke to a lack of empowerment from mental health professionals. Interactions with clinicians were recalled as:

> "patronizing and condescending". (Male, Asian, UG, 2)

As well as negative interactions, participants experienced a lack of agency in respect to their own mental health. This included feeling unable to challenge or disagree with the opinions of professionals:

> "You are always in a situation where you cannot challenge what is said. Otherwise, you run the risk of being labeled difficult or unstable. In those situations, you really recognize your lack of autonomy and power". (Female, Black, PG, 29)

For one participant, active challenge led to withdrawal of support from the university, which in turn left them wishing they had not spoken out:

> "I challenged the opinion of an assessment made . . . and then I received a letter two weeks later stating that they were no longer able to support me. At that point, I wish I had not said anything in the first place". (Female, Black, UG, 15)

The latter point made by this participant ["I wish I had not said anything"] also speaks to another sub-theme around the silencing nature of the mental health system for BME students.

4.2.3. Language/Silencing

Connected to the theme of power and agency, participants identified silence as a response to feelings of a lack of agency and trust in services alongside institutional power.

> "My fear is receiving an inappropriate investigation into my psychological state, which could affect my studies and potential treatments. As a result, between university and my GP. . . I prefer not to say anything". (Female, Asian, UG, 4)

For some participants, language was a prominent factor with regard to accessing mental health services. BME students for whom English was an additional language felt that they would be misunderstood and therefore mistreated with respect to their mental health. The result was a lack of confidence in the service to meet their needs and a reluctance to speak about their mental health as a result.

> "As a student who is a recent immigrant, my understanding of English is improving daily. As a result, sometimes I struggle to articulate clearly and accurately what I would like to say to the healthcare professionals provided at university. For this reason, I prefer not to discuss my psychological issues as they will misjudge what I am saying". (Female, Asian, UG, 4)

Among the 32 participants, they collectively noted at their institutions that there were no visible interpretation services were available regarding mental health support. Concerns were raised by one participant who mentioned:

> "the inadequate provision of interpreters only highlights that universities do not value or respect the needs of ethnic minority students". (Female, Mixed-Heritage, PG, 20)

Safe, effective, and empowered communication and relationships between mental health professionals and service users were therefore considered to be critical to engagement with mental health services within universities and beyond.

5. Discussion

Memon et al. (2016) have provided a useful framework through which we can investigate the experiences and perceptions of mental health services among BME students. The findings presented in this paper indicate that their research can also be applied to the higher education context. A reoccurring narrative espoused among participants within both studies relates to the respondent's fear of their mental health difficulties being discovered by others. This was perceived as a barrier to seeking help, particularly for individuals whose cultures and communities stigmatized those with mental health problems. According to Memon et al. (2016), drawing from Bhui et al. (2003) and Grey et al. (2013), "previous research has demonstrated that culturally specific constructs of illness can determine how individuals perceive symptoms, the nature of help-seeking behavior and engagement with services" (p. 6). This is problematic because ethnic minorities feel that they continually remain on the periphery of these services through varying environmental, community, and societal factors.

Cultural pressures and perceptions were significant factors that affected access to mental health services. There was a perception that some cultures did not recognize symptoms associated with stress, depression, or mental illness generally. Consequently, this meant that symptoms normally associated with mental illness remained unrecognized among families, communities, and friends. There was a perception that other interventions, such as prayer and family and community mediation, were preferred over psychological interventions (Grey et al. 2013). The impact of cultural inference was extremely pertinent to the participants, especially those whose cultures were intertwined with faith and cultural expectations. Memon et al. (2016) explain that cultural frameworks can have a significant impact on how BME individuals attempt to access help within their community. This was particularly evident within the study, where participants continuously reiterated stigma as a barrier to seeking and accessing mental health services. MIND (2013) states that stigma is well recognized as a factor in determining health-seeking behavior and service usage.

Research carried out by Memon et al. (2016), as well as within this study, shows that ethnic minority men, in particular, were a hard-to-reach group because they believed that the stigmatizations they faced on the ground of race would be compounded by a mental health diagnosis, leading to further exclusion and stereotyping (Memon et al. 2016). Accordingly, as previous research (Dowrick et al. 2009; National Mental Health Development Unit 2011) has found, men were less likely than women to seek mental health support.

The role of community networks and aspects of social integration was considered pertinent. The possibility of social networks acting as a barrier or alternative to professional mental health services is supported by the qualitative studies described by Memon and colleagues (Evans-Lacko et al. 2014; Lamb et al. 2012), which suggests that individuals from a BME background are less likely to contact their GP about mental health issues (Memon et al. 2016). In part, this may be due to feelings of marginalization and exclusion within universities, especially those situated within majority white populations. Distrust for mental health services tends to encourage people from BME communities to utilize their friends and family as the first point of contact for mental health problems. As well as being described in Memon and colleagues' findings (2016), this is consistent with previous research (Burnett and Peel 2001; Weich et al. 2012) that BME individuals prefer to confide in family and friends and rely on them as a source of help for common mental health problems rather than healthcare professionals. Despite concerns about the negative reactions of their social and family groups, BME individuals appear to choose this option over approaching mental health professionals. This highlights the stark choice they face: risk stigmatization from their friends and family or approach mental health professionals in whom they have no confidence and where respondents believed that the lack of understanding of BME cultures and the racial discrimination they faced undermined the support offered. Many (particularly male) participants in the present study opted for neither, which exacerbated feelings of isolation and lack of support.

Indeed, within ethnic minority communities, conversations about mental health are often proscribed, given their association with negative or traumatic experiences (Bhui and Sashidharan

2003; Sainsbury Center for Mental Health 2002; Weich et al. 2004, as cited in Memon et al. 2016). This engenders significant emotional and behavioral responses from individuals and the community and thus leads to further discrimination and disadvantage (see Memon et al. 2016). As a consequence, Memon et al. (2016) suggest that individuals from ethnic minorities may take steps to mask symptoms, delay seeking help, or drop out of treatment, all of which can lead to an increased risk of mental health crisis. Creating greater cultural awareness requires a dismantling of dominant discourses concerning ethnic minorities within society regarding their association with mental health services (as often many ethnic minority individuals enter the healthcare service via the judicial or criminal system). This was a point emphasized by the participants, who felt that many of their experiences engaging with health services were couched within racially discriminatory occurrences (Grey et al. 2013). Memon and colleagues' original paper (2016) recognized cultural naivety and insensitivity within healthcare services as barriers to accessing services. The present study supported the findings from Memon et al. that "mental health services were often unresponsive to the specific and unique needs of ethnic minority groups, and studies suggest that individuals can perceive services to replicate the experiences of discrimination felt within wider society" (p. 7). Present participants indicated that the continuous traversing of external and environmental factors, often situated within a discriminatory or racial backdrop, was a significant determining factor in the onset of potential mental illness (Sivandan 1991). There was a general consensus that this became exacerbated, particularly when being in a university space as an ethnic minority, where it was felt that negotiating this space significantly contributes to the development of feelings associated with anxiety and stress. This aligns with the Memon et al. (2016) suggestion that mental health symptoms can be perceived and presented as somatic rather than psychiatric in origin. Individuals may find it easier to understand and express mental distress in the context of physical symptoms, which can potentially lead to a misdiagnosis. This is a common experience for BME individuals experiencing mental illness and often neglects the important emotional and psychological elements. It was perceived that this happens because of negative racialized ascriptions and stereotypes that often presented ethnic minorities as aggressive, violent, economically poorer, unemployable, and welfare-dependent (Fernando 2010).

Participants feeling silenced or misunderstood was another key barrier to meaningful access to mental health service provision. Supporting research from MIND (2013), fear of consequence combined with feelings of lack of agency and perceptions of professional and institutional power (traditionally valued over lived experience) all served to steer BME students towards silence. Another element was language; while participants in Memon et al.'s study (2016) felt that language was a barrier to communicating their needs to healthcare professionals, this study had a similar finding with BME university students for whom English was a second language, highlighting this as an important factor in their access to (or lack of) appropriate mental health care. This finding also echoes that of previous studies (Keating and Robertson 2004; Myrie and Gannon 2013; Yancey et al. 2006). In attempting to evaluate the spiral of discrimination encountered by BME individuals when disclosing episodes of mental illness, language becomes pivotal in accurate assessment and diagnosis. Memon and colleagues (2016) drew on previous research (Alvarez et al. 2006; Benoit et al. 2005; Bhui et al. 2004; Williams 2005) to suggest that language played a key role in the experiences of mental health care in adults. Not just regarding English as an additional language, participants in both the original (Memon et al. 2016) and present study mentioned difficulty in communicating mental health symptoms and concerns, which added stress to an already distressing experience. Further reinforcing harm and potential trauma, some provided overt examples of racism, where health professionals within universities misinterpreted the service user's words and language. Often, it was suggested that dialect and accents were considered to be discriminatory tools used by mental health professionals to misunderstand or to fail to objectively assess symptoms before using the catch-all excuse of "poor English" that prevented conclusive medical diagnoses. This, in turn, prolonged BME individuals' experiences with mental illness. As Memon and colleagues acknowledged, considering also earlier research from Suresh and Bhui (2006), "expression of mental health problems is often layered in culturally specific nuances and subtlety, which can be

lost within the service user and healthcare provider interaction with medical terminology" (Memon et al. 2016, p. 6), sometimes providing further obstacles to access.

In many ways, mental health services do not, unfortunately, recognize some of the deeply-entrenched systemic racism that permeates wider society. This situation is further exacerbated when BME individuals enter institutions, such as universities, where most of the student population is white and where, consequently, BME students feel that support services would not address their particular needs. Other studies (Arthur et al. 2010, Cross and Bloomer 2010, and Knifton et al. 2010) have shown that service users are aware of the centrality of this 'whiteness' and the way in which it permeates and affects institutions, including mental health services (Memon et al. 2016).

The need to have mental health professionals of diverse ethnicities was referenced by participants in this study as well as those within Memon et al. (2016). This was seen as a vital factor in successfully building service user-service provider relationships and rapport. This, in turn, would support better diagnoses and more successful treatment. Poor communication and interaction, particularly in the case of ethnic minorities' experiences as service users with health service providers, becomes pivotal in encouraging or dissuading future health-seeking behaviors (Memon et al. 2016). This is compounded by respondents' perceptions that an inherent 'whiteness' shapes support within universities and society in general (Grey et al. 2013), creating a power imbalance, which in turn exacerbates the sense that between the service user and the service provider, there is very little in terms of shared 'lived' experiences (Ahmed 2012; McIntosh 1990; Memon et al. 2016). There was also concern that in such an inequitable relationship, BME service users would struggle to challenge a professional diagnosis.

BME participants also spoke of their concern about the therapies or treatments offered within mental health settings. This is a similar finding to Memon et al. (2016), where respondents stated that "they were offered few alternatives to drug-based treatments" (p. 7). Respondents in the study presented here expressed concerns about the side effects or personality-altering effects of the medication they were offered and felt that the range of therapies available was not communicated to them or tailored to their specific needs.

The majority of BME participants within this study were currently studying at university, with a few having recently graduated within the last 14 months. They represent only a fraction of the BME community, which itself is incredibly diverse, and it is important to note the findings of this study should not be taken as generalizations. A key caveat is that this study does not explore the differences between specific ethnic minority groups or the specific barriers each of these groups may face. Nor does it explore the particular views and attitudes each such group may have toward mental health issues. That said, the study demonstrated some sensitivity towards the difference between men and women in the way they viewed and accessed healthcare. Building on Memon et al. (2016), this study focused on BME individuals who were engaged in undergraduate or postgraduate courses.

Given the sample used for this study, it is not inconceivable that the findings may be affected by selection bias, and given the subject focus, it could be suggested that the respondents' ethnicities may have increased the possibility that they may have had negative experiences of mental health care and that this would have guided their responses. Nevertheless, this study provides some insights into BME perceptions of mental health services, building on the findings of Memon et al. (2016). The findings strongly suggest that BME individuals are subject to significant barriers which, it could be argued, are situated within an institutionally racist society. In instances where BME individuals gain some level of social mobility, for instance, by attending university, they still face discrimination in these settings, leading to isolation exacerbated by their lack of success in accessing mental health support. This means that when they need it most, BME individuals may find they are consistently being on the periphery of healthcare services, which means that often, ethnic minorities will attempt to traverse mental illness alone.

The findings presented here serve to reinforce those of Memon and colleagues (2016) and suggest that the way in which current mental health services are shaped at all stages, including in their development, commissioning, and delivery, ultimately falls short of providing adequate support to

BME individuals. "The study not only identified key barriers that are relevant to the BME population, but also barriers likely to be shared with other minority or marginalized groups" (Memon et al. 2016, p. 6) within universities and society in general. Set against a backdrop of higher education institutions, this study has focused on BME students as a unified group. In doing so, it attempted to adopt Memon and colleagues' "comprehensive, practical, and systematic discussion on the subject of mental health" (2016, p. 8) and apply it to a higher education context, which is clearly an important area for further study. Much like the participants in the original paper (Memon et al. 2016), the narratives and perspectives point towards a need to reinvest inequitable structures, such as higher education institutions, thereby making them less discriminatory towards ethnic minorities. Dismantling this legacy of inequality is difficult, but the findings presented advocate and endorse penetrative and policy-driven actions for improving equity in healthcare and reducing health inequalities. Whilst highlighting a need for the academy to better serve the mental health needs of BME students, the results also support existing calls by researchers such as Memon et al. (2016) for the Department of Health and Public Health England to embark on a dialogue to develop more effective interventions, which aim to promote improved mental well-being among the BME populations which aim to promote mental health and equitable outcomes among ethnic minorities. It is hoped that the findings disseminated within this study could potentially serve as a stimulus to drive the redevelopment of mental health strategies within the UK[4].

6. Conclusions and Recommendations

In summary, my own research stands in conversation with the two areas that Memon and colleagues identified in their original research (2016). The first is the role of *personal and community factors*, and the second, *communication and relationship between service user and healthcare provider*. This qualitative inquiry into the perceptions of mental health services among BME students provides educators, healthcare professionals and mental health stakeholders, and policy-makers with an important perspective of the barriers to preventing access and uptake. The findings of the study indicate that, from a societal perspective, there must be a collective endeavor that focuses on removing barriers encountered at the interface between service users and healthcare providers (Vernon 2011). This needs to be coupled with urgent action to combat stigma and normalize conversations around mental health issues. Without this, merely raising awareness of the signs and symptoms of mental health issues will serve little purpose. Creating diversity in the mental healthcare workforce is a longer-term aim, but of immediate concern is the need for workforce training that understands the cultural perspectives of BME service users and a nuanced approach to interacting with them. This is crucial, given the highly discriminatory attitudes they face. Additional financial resources must be provided to healthcare providers to undertake compulsory continuing professional development training to enhance their understanding of the diverse needs of ethnic minority service users. Awareness-raising activities need to be introduced for students (and their families) upon entering university to support and empower them so that they know what services they can access and when and how they can do so. Together, these actions can promote health-seeking behavior and thus support early intervention (Dowrick et al. 2009).

As Memon et al. (2016) suggest, "delivering this work at a local level and raising awareness of the locally available services and the variety of pathways to accessing care is important" (p. 8). This,

[4] A pertinent aspect that was not explored throughout this study was the use of Complementary and Alternative Medicine (CAM). The use of this as a mental health intervention has gained momentum and popularity globally within the healthcare profession particularly as an effective intervention for ethnic minority groups. While this particular theme was not explored due to the extensive focus on BME individuals experiencing mental health issues within university contexts, there is scope for future research pathways considering ethnic minority psychological well-being to explore the effectiveness of this intervention. The incorporation of this into future related research could examine why this particular phenomena has proven to be particularly successful among ethnic minorities. Additionally, factors concerning accessibility for ethnic minority service users for this psychological intervention could also be considered.

in turn, needs a departure from siloed agencies to those that intersect, collaborate, and share data, ensuring that outputs reflect the diverse communities they serve and in languages that are appropriate to these demographics. Additionally, financial resources must be provided for healthcare providers to undertake compulsory continuing professional development training for further understanding of cultural issues and differences and the sensitive and diverse needs of ethnic minority service users.

Replicating findings from previous research (Memon et al. 2016), participants in the present study expressed a desire for greater representation in mental health service provision, believing that BME practitioners may be more empathetic and understanding of the plight and experiences of ethnic minorities. Improved diversification would facilitate better ethnic representation in the healthcare service, which may support linguistic factors while potentially facilitating more accurate clinical judgments, reducing racial discrimination, and ensuring culturally suited interventions. The acceleration of improved mental health outcomes for ethnic minorities requires building trust between individuals, communities, and mental health services and a mutual, reciprocal relationship between professionals and service users.

Government interventions must ensure that gaps are identified within the mental health service provision, which highlights potential new and culturally appropriate interventions for ethnic minorities experiencing mental illness. Importantly, policy-makers must consider how mental health support systems can include representation and lived experience. Within a university and societal context, we also need to consider how these systems can function to work against the racism and isolation in wider society that places ethnic minorities at risk in the first instance by considering the communities that are more likely to struggle and less likely to receive the support required (BME Network 2016).

Black students and, more widely, BME people experience mental health differently. These experiences are often situated and tinged with racist connotations. For ethnic minorities, mental health problems are deeply rooted in different systemic issues. The racial ascriptions, which stereotypically accompany BME individuals, ensure that this community is diagnosed and treated differently within mental health services with consistent experiences of poorer satisfaction and less productive outcomes (Vernon 2011). Moving forward, systemic changes are required to dismantle the landscape of institutional racism, which in its current form ensures that ethnic minorities experience a significant disadvantage when attempting to access psychiatric services they are entitled to receive.

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