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The Silence of Mental Health Issues Within University Environments: A Quantitative Study

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A B S T R A C T

A descriptive study was used to examine the attitudes and experiences of staff and students towards mental health problems. Staff completed the "Attitude towards mental illness survey", and students who self-identified having a mental health problem completed the "Stigma scale". Using an online collection process, data from 270 staff and 201 students showed that the "silence" surrounding mental health problems permeates the university environment and impacts on help seeking behaviors, the provision of support and on the recovery and wellbeing of affected individuals. Universities must decrease stigma and foster social inclusion to build self-esteem in people who have mental health problems.

International research into self-reported and objectively rated levels of psychological distress in university students confirms that mental health problems are common in this population (Bayram & Bilgel, 2008; Burris, Brechting, Salsman, & Carlson, 2009; Field, Diego, Pelaez, Deeds, & Delgado, 2008; Khawaja & Dempsey, 2007; Leahy et al., 2010; Stallman, 2010; Wynaden, Wichmann, & Murray, 2013; Yorgason, Linville, & Zitzman, 2008), and appear to be increasing (Hunt & Eisenberg, 2010). An Australian study identified that more than 50% of students across three universities had levels of psychological distress indicative of mental illness in the 4 weeks prior to accessing professional help. Their level of distress was greater than reported data for the general population (Stallman & Shochet, 2009) and was significantly associated with the number of days they were unable to meet their work and study commitments (Stallman, 2008). Despite the interference to their capacity, young people continue to delay or fail to seek help for their problems. Therefore, at any one time there are students trying to complete their studies while managing an existing or emerging mental illness or high levels of psychological distress that are causing them increasing concern (Wynaden et al., 2013).

In managing the distressing symptoms associated with a mental health problem, students may draw on past coping mechanisms. For example, they may use alcohol and drugs or access health care services with somatic expressions such as headaches, general malaises, and/or sleep disturbances (Ahern, 2009; Mori, 2000). However, if the underlying cause remains unresolved, it may continue to impact on the individual, interfere with social interactions with others and reduce their overall level of functioning (Raunic & Xenos, 2008). Unresolved problems may also affect students' ability to meet educational goals and lead to increased levels of stress, lowered productivity and/or increased absenteeism (Cook, 2007). Low treatment rates for mental health problems in a study of 955 tertiary students suggested that traditional models of support might not be adequate or appropriate for tertiary cohorts (Leahy et al., 2010). Furthermore, the increasing numbers of domestic and international students from Indigenous and culturally and linguistically diverse backgrounds require culturally sensitive and safe models of support.

Attitudes and stigma determine help seeking intentions (Wynaden et al., 2005) and one of the most cited reasons why people do not seek help for mental health problems is the fear of experiencing discrimination and stigma (Michaels, López, Rüsch, & Corrigan, 2012; Zartaloudi & Madianos, 2010). Mental health-related stigma can be separated into: discrimination (being treated unfairly/differently) and prejudice (stigmatizing attitudes) (Clement et al., 2013). Stigma and discrimination also reduce students' initiative to engage in help seeking behavior (Henderson, Evans-Lacko, & Thornicroft, 2013).

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It is important that universities facilitate early intervention for, and improved support to these students (Kim, Coumar, Lober, & Kim, 2011). While it is unrealistic to expect all university staff to have the level of expertise to provide effective support, university environments need to foster more supportive and accepting attitudes and improved pastoral care to reduce the impact of the unwanted consequences on students' long term level of wellbeing (Galbraith, Brown, & Clifton, 2014) and academic outcomes (Storrie, Ahern, & Tuckett, 2010).

To increase awareness of the impact of mental health problems on student educational outcomes, research was conducted at two Australian universities during mental health week in October 2013. Emails with information about the study and an invitation to participate were sent. Staff were asked to complete the "Attitude towards mental illness survey" (Health & Social Care Information Centre, 2011); and students who self-identified as having a mental health problem were asked to report their stigma experiences using the Stigma Scale developed by King et al. (2007).

METHOD

Ethics approval was obtained from the two universities, and approval to conduct the research was provided by the university management.

Staff Survey

Permission to use the "Attitude towards mental illness survey" was obtained from the National Health Service Health and Social Care Information Centre in the United Kingdom. This survey has been used annually in the United Kingdom since 2007 to measure community attitudes toward mental illness with an average of 1700 participants per annum (King et al., 2007). The survey is reviewed annually to maintain a high level of content validity (King et al., 2007). An online format was used in this current research.

The 20 question survey took approximately 10 minutes to complete and was comprised of four categories: (a) fear and exclusion of people with mental illness, (b) understanding and tolerance of mental illness, (c) integrating people with mental illness into the community, and (d) causes of mental illness. Each category included statements, and respondents were asked to rate their agreement or disagreement with each of the statements, with (1) = strongly agree to (5) = strongly disagree. Additional questions covered topics such as descriptions of people with mental illness, relationships with people with mental illness, personal experience of mental illness, and perceptions of mental health-related stigma and discrimination.

Student Survey

The Stigma Scale used qualitative data obtained from mental health service users to develop the 28 item self-report scale (King et al., 2007). The scale had a high level of internal consistency (Cronbach's alpha was 0.87) (King et al., 2007) and in the current study was 0.70 reflecting an acceptable level (George & Mallery, 2003).

The survey is in the public domain, and students who self-identified as having a mental health problem were invited to participate. The survey had a three-factor structure: 1) discrimination, 2) disclosure and 3) potential positive aspects of mental illness. The questionnaire took 10 minutes to complete and was scored on a five point rating scale, with (1) = strongly agree and (5) = strongly disagree. While the researchers were confident that students would not experience distress by completing the survey, safeguards were designed to address the possibility that some may. Contact details of the principal researcher were provided if students wanted to make contact: a) prior to starting the survey or b) regarding their experiences of completing the survey. In the event that completing the survey triggered a response to previous negative experiences, students were able to obtain professional support from counseling services at each university. Information to encourage students to seek help for the problems they were experiencing was also provided at the beginning and end of the survey.

Data Storage

Data for both studies were collected using a secure Survey Monkey Website which was password protected and only accessed by two members of the research team. When the survey closed, data were transferred to the researcher's password protected computers at the university.

Data Analysis

Data were analyzed using the Statistical Package for Social Sciences, Version 22.0 (SPSS for Windows, SPSS Inc., Chicago, IL, USA) (Statistical Package for Social Sciences, 2013). Descriptive statistics and chi square determined relationships between students with mental health problems and their experiences of discrimination and stigma. Descriptive statistics were used to identify staff attitudes toward mental illness.

RESULTS

Staff Attitudes Toward Mental Illness Survey

Staff response = 270 with 25% (n = 67) male, 67% (n = 180) female and 8% (n = 23) identifying as other; 51% (n = 138) were academic staff, 49% (n = 132) professional staff and 58% (n = 156) had been working at the university for 5 years. In line with the 2011 Survey Report from the National Health Service in the United Kingdom, the 23 attitude statements were grouped into four categories for analysis purposes.

Fear and Exclusion of People With Mental Illness

Very positive responses toward people with mental illness were recorded for all questions within this category. Staff responses ranged from 93% (n = 251) agreeing that 'people with mental illness should not be excluded from taking public office' to 86% (n = 232) disagreeing that 'locating mental health facilities in a residential area downgrades the neighbourhood'. Staff responses indicated less fear of people with mental illness with 95% (n = 256) agreeable to living next door to someone with a mental illness, and this was reflected in 96% (n = 259) disagreeing that 'signs of mental disturbance require hospitalisation'.

Understanding and Tolerance of Mental Illness

Staff responses showed 90% (n = 243) agreement that 'we have a responsibility to provide the best possible care for people with a mental illness,' and 90% (n = 243) acknowledged that 'anyone can develop a mental illness'. University rules of conduct promote tolerance, equity and social justice and increase staff awareness of diversity and discrimination reflected in the 92% (n = 248) agreed response to the question 'we need to adopt a far more tolerant attitude toward people with mental illness in our society'.

Integrating People With Mental Illness into the Community

The percentage of staff who agreed with integrating people with mental illness into the community varied across questions. The opinions ranged from 42% (n = 113) who agreed that 'mental hospitals were an outdated means of treating mental illness' to 89% (n = 240) agreeing that 'people with mental problems should have the same rights to a job as anyone else'. However only 50% (n = 135) agreed that there 'should be less emphasis placed on protecting the public from people with mental illnesses', and only 50% (n = 135) agreed 'most women who were once patients in a mental hospital could be trusted as babysitters'.