Mind  
BME Blue Light Scoping

Client

Mind

Date

8 March 19

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Executive Summary

This report looks at the experience of BME personnel in three of the four Blue Light services (police, fire and ambulance) to understand their mental health needs. The report sits alongside other scoping research conducted by Mind to establish baseline understanding, experiences and stigma around mental health issues. The research will help to inform Mind’s Blue Light Programme to address mental health in the Blue Light services.

the discourse of difference

Many of the personnel did not have a strong ethnic, cultural or religious identity and, in some cases, deliberately attempted to distance themselves from the label ‘BME’. In all cases, the discourse of ethnicity and ‘difference’ (including terms like Black, Asian, BME, Mixed and minority) had followed these personnel their whole lives. Most were fed up of being perceived as different and avoided engaging in any behaviour that would further emphasise their differences. Some had even adapted their behaviour to ‘fit in’, within a predominantly white organisation. Even though the research revealed that BME personnel may have additional mental health needs and increased barriers to accessing support services, none of the personnel had any desire to be singled out, or for these differences to be highlighted.

additional Mental health needs

The most important factors in the mental health of BME personnel are largely similar to their white colleagues, namely, heavy workload, trauma and personal problems. However some BME personnel can have additional mental health pressures to their colleagues, although these pressures were not seen across the board. These additional pressures can include:

* Perceived barriers to progression in the Blue Light services, caused by intentional or unintentional discrimination, which can affect the mental state of individuals, and cause them to take on extra work to prove themselves,
* Perceived and actual racism and discrimination, which can have a cumulative or direct impact on mental health issues,
* Community and family pressures that can cause individuals to take on greater workloads to meet these expectations,
* Religious or cultural factors, such as fasting, which can make long shifts more arduous.

stigma around mental health

**Stigma around mental health in BME communities**

Some personnel believed that there was increased mental health stigma in BME communities, including reduced understanding and an increased propensity to hide mental illness and not access support. However, in general, the Blue Light personnel had a good understanding of mental health issues, and many felt that their own families would have similar levels of understanding and stigma, compared to the general UK population. This may be because few of the personnel had a strong ethnic identity. However even unconscious or slight pressures from the community may mean BME personnel would be less likely to access support and speak out about mental illness than their white colleagues.

**Stigma around mental health in the Blue Light services**

All personnel agreed that there was stigma around mental health in the Blue Light services. The term ‘mental health’ groups a spectrum of mental health issues, from the unpredictable and difficult to manage, to predictable, manageable, treatable problems. Emergency service personnel often see the extreme end of this spectrum, and therefore can develop a negative attitude to mental health issues. Most respondents mentioned Blue Light ‘banter’ around mental health, which would make it hard to ‘come out’ to team members.

Some feared that making reference to mental health ‘buzzwords’ (e.g. ‘stress’, ‘unstable’, ‘mental’) in the presence of managers or Occupational Health, would result in a black mark against their name and risk chances of promotion. This has added importance for BME personnel who often fear that they are less able to progress in the Blue Light services due to their ethnicity.

current and unmet support services

Current Blue Light support services are rarely accessed. Most personnel feared being perceived as different, and were unwilling to access internal services that could draw attention to their differences. Many were sceptical about the confidentiality of internal mental health services; in some cases personnel were required to be referred by a manager or the HR department, but were unwilling to speak to these individuals about their issues for fear of stigma.

Personnel felt internal, and particularly peer-led, services lacked expertise. Most felt managers needed more training, both in terms of understanding and recognising mental health problems, and responding empathetically to these issues. Some personnel were involved with BME associations, but never in relation to mental health issues. Other personnel were unwilling to be associated with an organisation which emphasised their differences.

recommendations

One challenge for Mind’s Blue Light programme is engaging BME personnel, who currently face mental health stigma from within the Blue Light services and, in some cases, from the wider BME community.

**Recommendations for the Blue Light programme.**

* Emphasise confidentiality, ensuring personnel don’t feel at risk of being identified or reported to managers or HR,
* Make support and training appealing by ensuring that they are as efficient and effective as possible (e.g. run by experts and relevant to the job),
* Address stigma by re-framing mental health as something that can be manageable and predictable, and avoiding using terminology that has negative connotations for individuals who are used to dealing with the ‘worst cases’,
* Engage with BME personnel as part of the general Blue Light population, rather than emphasising their differences, which may increase stigma and discrimination towards BME personnel.

Background and Methodology

about the research

Mind are embarking on a challenging and worthwhile project to develop and deliver a programme to improve the mental health of emergency service (“Blue Light”) personnel. Prior to the programme being rolled out across the emergency services Mind are undertaking a mixed method scoping exercise to develop detailed understanding of mental health attitudes and awareness among Blue Light personnel.

One feature of the Blue Light services is that they lack ethnic diversity. In 2013, for example, 5% of police officers were from a black and minority (BME) background[[1]](#footnote-1), and this lack of diversity has been reflected in the scoping surveys, focus groups and depth interviews conducted thus far. Mind has therefore identified the need to engage with emergency service personnel from BME communities, and engaged ESRO to undertake this qualitative research.

Research aims

The overarching aim of this research is to provide Mind with an understanding of the experience of BME Blue Light Service personnel in relation to mental health issues. Specifically, the research aims to answer the following questions:

* What is the level of need for BME personnel in the Blue Light Services (including an understanding of stigma and mental health support already in place)?
* Do BME personnel have different and specific mental health needs from other Blue Light service personnel?
* How does the perception and language of mental health differ for BME groups, and across the Blue Light services?
* How can Mind best engage BME groups with the Blue Light programme?

Methodology

ESRO used a qualitative research technique consisting of:

* 10 depth interviews with respondents in three of the four Blue Light services: police, fire and ambulance. These were 1-2 hours in duration.
* 6 1/2 hour phone interviews with ‘experts’, including mental health professionals, BME association representatives and other Blue Light personnel.

A multi-approach recruitment methodology was used, allowing a range of individuals to be accessed, including those who had limited understanding of or contact with the Blue Light programme. These approaches included:

* Contacting individuals who had expressed interest in becoming ‘Blue Light Champions’,
* Reaching out to Mind contacts and experts from the wider Blue Light project,
* Utilising ESRO personal contacts,
* ‘Snowballing’ from respondents.

#### DEMOGRAPHICS

**Depth interviews with personnel.**

* Broadly even distribution of emergency service personnel: 4 police, 3 fire, 3 ambulance. Search and Rescue personnel, who tend to be based in rural or coastal areas, were excluded from the research due to low prevalence and visibility of BME personnel in this service.
* One female, and the rest male, in line with predominantly male emergency workforces (e.g. 4.5% women in Fire and Rescue, 27.9% in police)[[2]](#footnote-2)
* Range of seniority and experience: three respondents had purely frontline roles, six had a range of both frontline and managerial responsibilities, and one was in an entirely desk-based, managerial role
* Four of the ten respondents had lived experience of mental illness: two had experienced depression, one PTSD and one OCD. A further three had experienced stress, for which they sought access to mental health services
* Four of the respondents were South Asian (including one mixed race) and six were of African or Caribbean descent (including two mixed race).

**Expert interviews.**

Eight ‘experts’ were spoken to across six interviews, about their professional perspectives on BME mental health needs and mental health services and support. These experts were:

* Retired firefighter, turned ‘self-help’ author
* Chief Executive, Equality and Diversity officer and Chaplain (Ambulance service)
* LINC counsellor
* Mental health nurse, part of Occupational Health in the police
* Occupational psychotherapist, with specialisms on racism and discrimination
* Representative from the National Association of Muslim Police (NAMPUK).

Pen portraits

Due to the low incidence of BME personnel in the Blue Light services, specific personal information has been anonymised, including name, age, location and job role (if uncommon or unique).

**Krish, 48, Fire.** Training position in the fire service and limited interaction with frontline staff. Member of the Asian Fire Service Association, and is the only Asian firefighter in his area. Never experienced discrimination on the basis of his ethnicity, although he admits he ‘looks white’. Lived experience of OCD, and has accessed both internal and external services. The ability to manage his own hours helps when his symptoms are severe. Although he is vocal about a genetic condition, he has told few about his OCD.

**Aisha, 22, Ambulance.** Newly qualified paramedic who identifies as a British Muslim. On her first day she was racially assaulted by a member of the public, and in the past has pressed charges. Has never experienced discrimination from her team, except for non-malicious ‘banter’, and was unaware of BME support associations. Experienced depression after the death of a family member and accessed free counselling through Mind.

**Sanjay, 35, Police.** Reactive, specialist police officer, who responds to incidents, sometimes resulting in anti-social hours. As he has become more senior, his workload has increased. Worries about telling people about his job, for fear of stigmatisation. Non-religious and doesn’t identify as ‘BME’. No personal experience of mental health problems, discrimination or racism, and has no interest in joining a BME association. Poor understanding of mental health.

**Dhanesh, 44, Ambulance.** Ambulance driver, who has worked in a similar role in patient transport for two decades. Loves his job and couldn’t imagine doing anything else. Member of National BME Ambulance Forum. Indian heritage, which he feels proud of, but has lived in the UK all his life. Married with no children. No personal experience of mental health problems or discrimination.

**Geoff, 53, Ambulance.** Paramedic with additional role in public facing training. Worked in many aspects of the ambulance service, from control rooms to harassment support. Active member of National BME Ambulance Forum. BME staff come to him, unofficially, with grievances. In the past has experienced bullying from other staff and racism from patients. Personal experience of depression after his divorce - accessed external health services.

**Ennis, 41, Fire.** Climbed up the ranks of the fire service, and now has largely managerial aspects to his job. He “tones down” his Jamaican characteristics at work so as not to stick out. Experienced stress and saw Occupational Health, who reported him to HR and management - he has a lack of trust as a result. Involved in an internal BME staff group. Feels his ethnicity has hindered promotions at work, and believes a mental health diagnosis would do the same.

**Devon, 55, Fire.** Served for almost 30 years and is now at a senior level in the fire service. Feels the work culture prevents BME staff progressing, and personally feels he has experienced discrimination and bullying from management. This resulted in stress and accessing Occupational Health. Positive about his experience of OH but believes the fire service needs more mental health provision, using a top-down approach. Member of an internal BME group, and a Union.

**Amos, 49, Police.** Senior managerial role in the police. Grew up in a white area with white friends, attributing his success in the police force to his the fact he is ‘essentially a white policeman’. He has suffered stress at work, but does not consider this a mental health problem. Believes that police officers ought to be resilient, and that those that can’t cope with the pressure should find a different job. Both his mum and brother have experienced mental health problems.

**Kenneth, 40, Police.** Sergeant who has moved around the police force over the past 18 years. His current job is predominantly managerial, with some frontline components. Feels as if his staff test and scrutinise him more than they would a white manager. Accessed occupational health for stress in the last year, but in general is disparaging about internal services, as occupational health are able to feed back to management, and feels they lack experience compared to external support services.

**Joe, 33, Police.** Joined the police when he was a teenager, and has experienced backlash from the black community. Believes he has been given more opportunities than his white colleagues for progression and training. He developed PTSD after a traumatic incident, and took time off work. He has started managing others which he finds stressful, and is frustrated by changes to his job role. In the past considered calling Samaritans but didn’t ‘want to waste their time’.Sceptical about occupational health: concerned that they have been centralised and about their expertise.

Introduction

about the findings

Each of the individuals had very different opinions on the experiences of BME personnel. Some saw no particular BME challenges, while others felt the playing field was still very uneven for BME personnel in the emergency services and varied in their views on the impact this could have on mental health. Some had personal experience of mental health, whereas others had limited or no understanding. As a result of this there are few, if any, generalisations that can be made with regard to particular ethnicities or particular emergency services. The view of the experts and respondents involved are therefore presented here as a starting point for thinking about the ways mental health may impact different BME personnel across the Blue Light services.

At some points in the report, a specific Blue Light focus has been indicated; where this isn’t specified, findings were seen across all three Blue Light services.

**Note on the report**

This BME-specific research raised eyebrows among personnel. At best the BME personnel spoken to thought the need for individualised research was unnecessary, and, at worst, they felt that the investigation into BME mental health needs would have the unintended damaging consequence of exacerbating perceptions of ‘difference’ between BME and non-BME personnel.

This report, due to the very nature of the research, has disproportionate inclusion of commentary around race. To counter this, the report should not be read in isolation. Although BME mental health needs and access of services may be somewhat different to white personnel, these should only be considered by Mind inclusively amongst other Blue-Light-wide needs and services, rather than highlighting the needs of one particular group.

report summary

**Chapter 1. Needs of BME Personnel:** Research found that BME personnel might be at greater risk of mental health problems, due to increased workload pressures and perceived or actual discrimination and racism (Section 1.2). Furthermore, greater stigma from both BME communities and the Blue Light service itself (Section 1.3), coupled with a desire to fit in (Section 1.1), may prevent access to mental health services. As a result personnel have an increased risk of mental health issues, with nowhere to turn when the pressures become unbearable.

**Chapter 2. Addressing Mental Health:** Current mental health services are rarely accessed, including BME-specific associations. When services have been accessed there were criticisms and unmet needs (Section 2.1). However, despite there being BME-specific needs and a lack of access of services, none of the respondents expressed a desire for a BME-specific response to mental health Instead this approach could exacerbate differences. Mind’s approach (Section 2.2) therefore needs to be subtle and inclusive to meet the needs of BME personnel, without emphasising their differences.

1. Needs of BME Personnel  
*1.1 Ethnicity and Identity*

*BME personnel have no desire to stick out or be perceived as different. In predominantly white professions, some have made conscious efforts to ensure they fit in.*

self-perception

“*I don’t think of myself as BME – I’m just a normal guy*.” – Sanjay, Police

“*I’d want people to think – ‘that’s a nice bloke’, rather than ‘that’s a nice black bloke.*” – Joe, Police

Although all of the group were from black or minority ethnic backgrounds, some preferred not to think about themselves in these terms. This was particularly true of younger personnel, whereas older individuals tended to have slightly a stronger sense of ethnic identity and solidarity. This solidarity was not only felt with individuals from their own ethnic or religious background but minority ethnic individuals in general. Personnel from mixed backgrounds were particularly keen not to be labelled as such, feeling that the term ‘Mixed’ didn’t adequately describe them.

identity at work

“*I look white. I really don’t think – apart from my name – most people here would have much reason to think of me as Asian.”* – Krish, Fire

One possible explanation for this lack of strong ethnic identity is that these individuals had adapted to enter a profession that was predominantly white and which, in some cases, even carried a stigma from their own ethnic community (Section 1.2, “Black backlash”). For some, a lack of strong ethnic identity may have been present before entering the emergency services, giving them more reason than others of their ethnicity to select a largely white profession. However, two individuals told us that they had consciously changed aspects of themselves when they joined the emergency services – accent, style of speech, hair cut – in order to ‘tone down’ their ethnicity and fit in.

“*I’m essentially a white policeman: I grew up in a white area, I have white friends.*” – Amos, Police

sticking out and fitting in

The discourse of ‘difference’, including generalising terms like ‘BME’, ‘Mixed’, ‘Asian or ‘Black’ had ‘followed’ these individuals their whole life. As a result, most were eager not to be classed as something distinct from white personnel and discourse around BME and ethnicity was largely disliked.

By labelling personnel as BME, this automatically distinguishes them from white colleagues who do not encounter this generalising discourse on a day-to-day basis. Most were eager to escape from discourse that accentuates their differences, and results in them ‘sticking out’ rather than ‘fitting in’. If BME personnel have different mental health needs to white personnel (which was hinted at by the research), BME personnel did not want these different needs to be categorised as such; they wanted their viewpoints and attitudes to be included as part of Mind’s Blue Light programme, without labelling these needs as separate or distinguishable from ‘white’ viewpoints and attitudes.

*1.2 Mental Health in the Workplace*

##### Some mental health pressures could be affecting BME personnel more than their white counterparts: namely, additional workload pressures and perceived or actual racism and discrimination. Personnel may prefer informal coping strategies that do not mark themselves out as ‘different’ rather than speaking with team members or management.

Challenges and Triggers

*“We’ve all probably have suffered from it at some point” – Devon, Fire*

*“I’ve seen many officers who have gone off with stress on this job, and I know three officers who have killed themselves” – Kenneth, Police*

As with white personnel, all experts and personnel (with two exceptions) recognised there was a mental health need in the emergency services. In some cases mental health problems had gone untreated and led to severe consequences, including individuals missing work, losing their jobs and, in rare instances, alcoholism and suicide.

Workload

The greatest factors affecting the mental health of BME personnel are, unsurprisingly, similar to white personnel. Respondents commonly mentioned increased workload and long hours as the greatest causes of workplace stress. These increased pressures were felt to have two sources: austerity measures, and growing public awareness about the rights of individuals, resulting in an increased need to fill out paperwork to ‘cover’ themselves.

“*In the police there are high expectations and deadlines, and some of these expectations and deadlines are beyond realistic*.” – Kenneth, Police

“*Workload is always a factor… They all tend to be very fearful of missing something, or being held accountable even years down the line*.” – Occupational Mental Health Nurse, Police

Due to the high workload, individuals are being asked to return earlier from illness. This may not give them enough recovery time from mental illness, and could exacerbate problems. In particular, management were felt to poorly understand mental illness, and had responded insensitively to those who took time off or couldn’t work due to stress, anxiety or depression. This was particularly true of the respondents in the police.

“*It’s very difficult for line managers to make human concessions for someone when they are struggling with life, because they are very concerned with having people out there, on the streets to do the job*.” – Occupational Mental Health Nurse, Police

**Increased prevalence in BME personnel.**

One respondent, **Joe**, told us about a policeman he line manages. The policeman’swife gave birth at 26 weeks, and after the newborn became very sick, the officer took some days off with stress. Joe is obliged to give a daily report to management of everyone off sick. Management weren’t happy with the policeman’s prolonged absence and told Joe to get him back to work. They said that if the officer refused, he would be called to an ‘unsatisfactory attendance meeting’, or later down the line, an employment tribunal.

Some respondents suggested that factors like heavy workload could be more prevalent in BME personnel. For example, reviews of the police[[3]](#footnote-3) and NHS[[4]](#footnote-4) revealed that managers were less likely to apply informal disciplinary strategies with BME personnel and, instead, relied on formal disciplinary procedures, out of a fear of being called out as racist if they don’t act ‘by the book’. However unintentionally, this approach has an overall negative impact on BME personnel. They may have their records black-marked, or lose their jobs, more regularly than white personnel. Some respondents echoed these findings, with a feeling that BME personnel were more likely to be penalised heavily for illnesses and absences, and in their day-to-day work, increasing overall workload pressure. Other incidences that, intentionally or unintentionally, discriminate against BME personnel are explored in “Racism and Discrimination”, below.

“*If you’re white, you’re just taken to a side room and given a slap on the wrist. If you’re BME they go down the formal route, for fear of being seen as racist.”* – Geoff, Ambulanc**e**

One paramedic, **Geoff**,told us about an ex-colleague: a black paramedic, who started experiencing problems at home and felt low all the time. One shift he refused to go out on the ambulance. His manager chose to use formal disciplinary procedures and Geoff’s colleague was fired from the ambulance service. Unemployment is having further impacts on his mental health, and he has become an alcoholic.

Other BME complications to workload pressures include fasting (relevant for Muslim and Hindu staff at different times of the year) and attempting to fit in prayer times (particularly relevant for Muslim staff) which could exacerbate the work pressures of a 12 hour shift.

“*When people are fasting, that makes the day even harder*.” - Equality & Diversity Officer, Ambulance

Different communities also have expectations of their family members to take leave at different events and times of year. For example, one expert spoke of the need in Hindu communities to visit extended family members in hospital. However, most emergency services would not perceive this leave as a necessity, potentially pressurising employees to work, rather than take time off. Although these complications were mentioned by some experts, none of the respondents spoken to made particular reference to these pressures, suggesting they could be reasonably uncommon, or have limited impact on most personnel and their workload.

**Managerial pressures.**

There could also be an interaction with managerial workload pressures. There was an expectation that work becomes harder the higher you rise within the service. Some also spoke about the challenges of managing other people and becoming involved in their personal issues. BME personnel tend to be poorly represented in senior and managerial roles[[5]](#footnote-5),[[6]](#footnote-6). This suggests that workload pressures may be slightly reduced for BME personnel, in general, although this effect could not be confirmed by the research.

“*As you get higher up, things get harder to deal with - the workload, staffing levels: people expect you to be more efficient – it can be stressful at times*” – Sanjay, Police

Trauma

As with white personnel[[7]](#footnote-7), traumatic events were important factors for BME personnel, particularly for frontline police and ambulance staff. Most could recall one or two particular events that had particularly affected them: from a violent car accident, to delivering a death message to a family. One respondent had developed PTSD as a direct consequence of his role in a specific traumatic event. None of the respondents made particular reference to the ethnicity of the victim(s) of their remembered traumatic event, suggesting that the ethnicity of the victim(s) makes little difference to whether an event is perceived as ‘tough’ or ‘traumatic’.

Racism and discrimination

**Racism: Intentional and Unintentional**

Some respondents, but not all, reported instances of racism and discrimination. Racism suggests an intentional desire to harm or exclude individuals from a different ethnicity. This was true of some incidents respondents encountered, such as public assault. However, in other cases, racist effects were felt, but were not caused intentionally, such as banter amongst team members. In these cases, the effect on respondents’ mental health was felt to be less impactful as personnel understood the racism was unintentional and non-malicious.

**Racism: Perceived and Actual**

Some instances of racism were easy to classify as ‘racist’ – such as public assaults or name-calling. In others, such as cases of internal harassment or lack of promotion, the ties to racial motivation are less clear.

However, perceived racism (from the perspective of the respondent) can be just as harmful as actual; for the member of personnel who perceives discrimination, there is a belief it is real, and this can affect, emotional wellbeing, trust of colleagues and management, and conceptions of self- importance and value. Wherever racism and discrimination is spoken about in the following report it is on the word of respondents who may have experienced actual racism, or may have perceived racism. In both instances the effect is the same on the victim, and can contribute to mental health issues.

An understanding that non-explicit racist incidents are open to different interpretations may cause an individual to think twice about speaking to a manager or supervisor. This can lead to these incidents going unreported, and exacerbating their effect on mental health.

**Here, the terms racism and discrimination will be used to describe any behaviour, whether intentional or unintentional, or perceived or actual, which could have a negative impact on BME personnel.**

Most, but not all respondents, had experienced some form of discrimination or racism, whether from the public or within the emergency services themselves. For some, this had an impact on their mental health. There were three ways that racism and discrimination were linked to mental health issues. These were:

**Creating additional workload.**

Some respondents perceived that they had experienced barriers to progression in the emergency services, caused by a bias towards promoting white personnel. Particularly the older personnel in more senior roles felt that (predominantly white[[8]](#footnote-8)) senior management preferred to promote white personnel above BME personnel, grooming individuals ‘in their own likeness’.

“*To become senior in the police, you need to behave like a white man.*” – Amos, Police

“*Some individuals are given more interesting jobs, where they can meet influential people – these jobs are given to someone who has been groomed for the role. It is not open or equal opportunity*.” – Ennis, Fire

This perceived racism has two effects. First, it has the capacity to drive ambitious BME personnel to work harder to achieve promotions, causing increased workload – a significant driver of stress and mental health issues. Second it can cause individuals to internalise feelings of inadequacy. Two experts and one respondent referenced this ‘internalised oppression’, whereby external racism, discrimination and inequality are internalised as an individual feels like they are inferior to their colleagues. Some respondents also commented on the low numbers of BME personnel in the emergency services, particularly in Fire and Rescue and in managerial positions, which does little to bolster feelings of equality or inclusion.

“*It’s the quieter and subtle kind – I think the buzz terms in organisations is unconscious bias. This creates more damage than we realise*.” - Occupational Psychotherapist

“*I’m the only Asian fire personnel I know in this area*.” – Krish, Fire

This feeling of inadequacy could lead to low mood, and other mental health problems. A few respondents also felt that a pressure to perform caused them to take on additional work - more than their white colleagues - compounding workload stresses.

“*When I worked on the frontline there was one time when I was working 15 jobs at once – some of my colleagues only had 3 or 4. I just wanted to prove myself, but it became extremely stressful*” - Kenneth, Police

**One-off serious incidents directly impacting mental health.**

Some of the respondents, particularly those in managerial roles, who can feel under constant scrutiny from senior management, had been the victim of bullying and harassment: sometimes from their peers and sometimes from those in more senior positions. One respondent found himself the subject of joke in an email sent around to management, and another was criticised and bullied on online forums. Both respondents felt that the harassment incidents had directly caused them to seek out mental health services: external services for one, and Occupational Health for the other. Although these incidents may not be tied unequivocally with racist motivations, they were perceived by their victim as such, emphasising that perceived racially motivated attacks can directly affect mental health.

**Cumulative effect of pervasive, less serious incidents.**

“*Minor incidents in the workplace can build up to such a point where an individual feels ground down. They are so ground down that their mental health is compromised.”* – Occupational Psychotherapist.

Finally, most spoke of minor incidents of public or internal racism, or discrimination. The most ubiquitous of these was ‘banter’ around ethnicity. This was felt to be non-malicious, for the most part, and any harm caused was generally unintentional. Furthermore a restriction of banter in the presence of a BME individual, when its use is so prevalent in the emergency services, could cause feelings of exclusion and isolation. However, persistent banter could have a cumulative impact.

“*You’ve got to have a thick skin to deal with it. You’ve got to be able to give as good as you get.*” – Sanjay, Police

In addition, one respondent in a managerial role, felt that he was not as well respected by his staff as white managers.

“*Some PCs try and challenge decisions I make more than they would another supervisor who was white*.” – Kenneth, Police

Some of the respondents who had worked on the frontline had experienced racism from the public, from physical assault, to refusing to let the emergency service personnel help them or do their job. For the most part, this type of racism was brushed off by personnel – the people targeting them in this way were strangers rather than colleagues, friends or family.

“*Some patients won’t want paramedics who aren’t white*.” – LINC counsellor

**“***I went to a house fire once, and the residents were from the far right. They saw me and wouldn’t let me in. I made the choice to force entry under the fire act. I had to do my job*.” – Devon, Fire

**Black backlash (Police specific)**

From the Brixton riots to the mishandling of the Stephen Lawrence case, the black community have had a strained relationship with the police for several generations, leading to deep mistrust of policemeni. This stigma has created a barrier for black people to serve in the police. The members of black police personnel we spoke to had been called names, (“Coconut”,“Malteser”), when they worked on the frontline, and sometimes by their own families, which carried additional emotional impact, and over time could cumulatively impact mental health.

“*From my immediate family – my mum, grandparents, they were really proud. But when I told my stepdad I was joining the police he said “no you don’t” and my cousin came to my mother and actually said “Is you father happy with that?””* – Joe

i Policing ethnic minority communities; B. Bowling & C. Philips; LSE research online; 2010

None of these incidents alone had been enough to trigger a mental health problem, unlike the cases of bullying, above. However, combined with other mental health factors, such as workload or personal circumstances, the cumulative impact of these incidents was felt to be a factor by the majority of personnel.

**Impact is limited in scope.**

“*I can’t personally say I’ve been mistreated because I’m BME, and I’ve never seen any others mistreated on those grounds*.” – Sanjay, Police

Racism and discrimination had only been an issue, or caused additional stress, for some of our respondents. Two of the mental health professionals spoken to, could not recall any of their BME clientele visiting them with discrimination problems. One individual actually felt he had been given more progression opportunities than his white colleagues. However, this does not mean that mental health issues resulting from racism and discrimination do not occur - it may just be that those dealing with racism use alternative services or have different coping strategies. The research therefore suggests that racism and discrimination does exist, and can impact mental health, however the incidence of this racism and its impact can differ wildly between individuals.

Coping strategies

Common strategies

**General.**

“*We drink a lot of coffee. But mainly we just get on with it.*” – Sanjay, Police

As with white personnel, the most popular coping strategies for stress and feeling mentally unwell for BME personnel were informal. The most common responses were:

* Isolating themselves, or ignoring the issue entirely
* Speaking to friends and family
* Using the gym or exercising
* Debriefing or alleviating stress over a drink with colleagues

The ambulance staff also all spoke positively about speaking to their team or colleagues about stress or mental health problems, whereas this was a less popular option for the police and fire. This could be related to the culture of the ambulance services, where the ambulance crew work exclusively with each other for an 8-12 hour shift, allowing close bonds to form between crew members. This was suggested by two of the experts, who spoke positively about the family atmosphere and high response rates for peer-to-peer volunteering opportunities in the ambulance service.

“*It’s a family - there is a real sense of camaraderie and community*.” – LINC counsellor

Furthermore, every frontline ambulance staff member will come across individuals with mental health problems on a routine basis, however this public interaction was not necessarily as common for the police or fire services. This suggests ambulance staff may have a greater understanding of mental health than colleagues in the other emergency services. However, this perceived greater understanding of health problems generally could mean that ambulance staff are more likely to self-manage mental health problems. One individual felt that because she had knowledge about stress and mental health, she ought to be able to cope with it herself. However this can lead to greater isolation and less motivation to access services and support.

“*We deal with it so much in our jobs, sometimes we’re almost too clinical, and we just think ‘oh no, it’s fine’*” – Aisha, Ambulance

**BME specific problems.**

There were hints that some BME personnel may find some of these methods of coping more challenging than white personnel, and be more likely to isolate themselves than their colleagues.

Experts, from both this study and previous studies[[9]](#footnote-9), suggest that team based bonding around alcoholic drinks, or the pub, presents a problem for Muslim staff members who do not drink. The staff therefore cannot benefit from the alleviation of stress, and team bonding opportunities that this setting offers. However the personnel spoken to as part of this research did not raise this as a barrier to coping, partly because few identified as having strong religious identities.

“*In some jobs you might go to the pub or the wine bar, but there is an issue for staff who are not able to do that.”* - Chaplain, Ambulance

A few BME individuals, particularly those in the police and fire service, did not trust or feel comfortable in the presence of their own team. Some had felt they weren’t fully included because of their ethnicity. Examples of this included teams delegating the most menial tasks to the BME personnel, or team members going too far with ‘banter’. On the other hand, one staff member felt that his white colleagues often self-moderated their language and speech around him, for fear of seeming racist. Without open, honest dialogue with colleagues, he would find it hard to share his problems or stresses with the wider team.

“*I have to be careful who I speak to – you can’t trust people. There’s no one to talk to.”*” – Ennis, Fire

Family and community stigma around mental health also prevent communication with wider friends and family, leading to greater likelihood of isolation (as discussed in Section 1.3).

**Better resilience?**

Yet there was some evidence that BME individuals might be better at coping with mental health issues than their white counterparts. Most individuals spoken to had a strong family support network, who would rally together during tough times. This was found to be particularly true of those from South Asian backgrounds. One individual also felt that BME personnel were likely to cope better than white personnel, due to an in-built resilience created through years of discrimination, and being ‘left in the cold’.

“*What we’ve been through – the misery growing up – has given us the tools to be able to deal with it. We take a lot more crap, and we are tougher for it*.” – Devon, Fire

*1.3 Experiences of Mental Health Stigma and the Stigma of ‘Difference’*

*Negative attitudes towards mental health from some BME communities, as well as stigma about mental health and being ‘different’ in the Blue Light Services, may mean BME personnel are less likely to seek out support.*

BME attitudes to Mental Health

Most respondents and experts felt that there was a stigma around mental health in BME communities. Perceptions of the extent of this stigma differed between respondents; some felt BME individuals in the UK had a similar level of stigma to the general UK population, whereas others felt BME communities had an increased level of stigma to the general UK population. In general, research suggests that there is increased stigma in BME communities compared to the UK population as whole: for example in 2013, a Time to Change survey showed that white respondents were more likely to have positive attitudes towards mental illness compared with those from the BME community[[10]](#footnote-10).

Other research suggests that around a third of African or Caribbean individuals with mental health issues experience “a moderate amount or a lot of discrimination from within their own communities”[[11]](#footnote-11). However, in general, respondents from this research felt that the black community were likely to have similar levels of stigma to the general UK population, perhaps due to many of the personnel having limited contact with the black community; some spoke of having white friends, working with white colleagues and living in white areas. However, one member of personnel felt that the ‘sunny’ attitude of the Caribbean community meant mental illnesses were likely to be dismissed.

“*Black people are good at ignoring illness. We claim everything’s find but its not*.” – Devon, Fire.

Some black or mixed respondents were aware of the statistics suggesting that black individuals with mental health issues have worse outcomes from treatment, and are less likely to be diagnosed early[[12]](#footnote-12),[[13]](#footnote-13). A few respondents felt the statistics acted as a deterrent to seeking out support at all, for fear of poorer mental health outcomes.

There was greater consensus that there was increased stigma in the South Asian community, although this wasn’t reported by all respondents. This supports Time to Change findings[[14]](#footnote-14) that a third of South Asian individuals suffering with mental health issues, experience at least moderate discrimination from within their own communities. An earlier research project[[15]](#footnote-15) found a culture of taboo and secrecy around mental health, where families tend to hide the individual with mental health issues from the wider community.

“*If I came home with mental issues, Dad would probably clip me round the ear. It’s just the way they are.”* – Sanjay, Police

“*For BME officers, it would be that much more difficult to come out and say ‘I suffer from this’ because of culturally how it’s accepted. The police service might be ready to accept it but they face the barrier from their own communities or people*” – NAMPUK representative

This in part, is driven by poor understanding of mental illness and its causes. For example, often mental illness is perceived as the work of God[[16]](#footnote-16)[[17]](#footnote-17). Negative stigma, a culture of keeping mental illness private within the family, and a belief that mental health is reliant on a higher power, could all lead to less engagement with support services.

“*In South Asian communities, mental health is sometimes seen as someone being possessed or someone having bad fortune*” - NAMPUK representative, Police

However, in most cases the respondents spoken to had reasonable understanding of mental health and were sympathetic towards those suffering from mental health problems (with a few exceptions). This may have been because a self-declared research project on mental health automatically attracts individuals with open-minded attitudes to the topic. An alternate explanation is that many of the individuals spoken to lacked a strong minority ethnic or cultural identity (see Section 1.1). This could explain why ethnicity-related stigma around mental health is less pronounced for BME emergency service personnel than it is for the general BME population.

Yet the stigma need not come from the individual, nor even the family, to have an impact. Wider community attitudes can have an impact on individual attitude towards and handling of a mental health problem, even if this impact is unconscious and subtler than family stigma.

“*Every family has its own rules and regulations, and to an extent everyone wants to please Mum and Dad. However this is on a much larger scale if it’s a macro-cultural thing.*” – LINC Counsellor

Blue light attitudes to Mental health

stigma and taboo

**M\*\*\*\*\* I\*\*\*\*\*\***

“*There has been quite a masculine sense to the service until quite recently.”* - Chaplain, Ambulance

As with white personnel[[18]](#footnote-18), most felt there was a taboo around mental illness in the emergency service. Personnel across all services, but particularly those in police and fire departments, spoke about the fact that the emergency services are predominantly male industries and that admitting to a mental health service could be seen as a sign of weakness. Nearly all respondents identified that banter can sometimes focus on mental health problems, and that the derogatory commentary on mental health sometimes bandied about, would make it hard to ‘come out’ to a team, out of fear that it would be perceived negatively.

“*The fire service is made up of men’s men – people who don’t want to be seen as weak.*” – Krish, Fire

Emergency service personnel experience enormous demands in their working life including trauma, heavy workload, and challenging, emotional and stressful situations. Given this, two respondents suggested that if someone lacks resilience or is at greater risk of suffering mental health problems, they would be better to choose a different profession. Some had examples of individuals who had mental health issues and had quickly left the profession of their own accord, or been asked to leave. These actions reinforce the view that those prone to poor mental health are unable to cope.

“*There was one guy who just disappeared and never came back. All we ever got told was he was a nutcase*.” - Sanjay, Police

There was limited understanding from those who had not experienced mental illness that resilience and mental wellbeing could be built and strengthened. Instead they saw mental resilience in black and white terms; people either have resilience, or they do not, and these categorisations cannot change.

**Heroes don’t show weakness.**

The taboo surrounding mental illness was related to a wider problem that many of the respondents felt that those who were “having a down day” or “not being on form” were unable to perform well at their job. The emergency services requires personnel to ‘be heroes’ on daily basis, as personnel risk their own safety, and go the extra mile to save lives, often in challenging and stressful situations. Most respondents were unable to reconcile this idea of ‘being a hero’ with having poor mental health.

The pressures on personnel to be consistently mentally fit and resilient, are in part due to public expectation and the culture within the Blue Light services, and these pressures are likely to be similar for white and BME personnel. However some BME spoke of additional pressures from within their own family to constantly perform and ‘be the hero’. Family pride, driven by a person succeeding ‘against the odds’ in a typically white profession, can cause additional pressure on these individuals to work through illness and hard times, to continue to impress their families.

“*BME personnel are often under pressures from their own community to go above and beyond the normal call of duty…* *I’ve seen BME people before who have been facing disciplinaries or are under enormous stress, who are more concerned with how their family are going to take it, rather than being concerned about themselves.”* – Equality and Diversity Officer, Ambulance

**Mental illness is unmanageable**

Although there are still problems and concerns around fitness to practice with a physical illness or injury (leading individuals to avoid seeking treatment in some instances), physical illness does not have the same taboo surrounding it as mental illness does. Weaknesses associated with physical illnesses are not stigmatised in the same way, and treatment for physical illness is considered normal.

“*We’re good at dealing with the physical stuff”* - Chaplain, Ambulance

“*I’m a member of a group for people with [genetic condition] on Facebook, but nothing like that for the OCD. I’m worried about how it would be seen*.” - Krish, Fire

Physical illnesses are seen differently for a few reasons. First, they are rarely clumped together as a single ‘type’ of problem in the same way as mental illnesses can be. As physical health problems are seen on a specific basic, rather than grouped with all other physical illnesses on a more general basis, most have a clear, predictable impact and outcomes. Furthermore, most of these specific physical illnesses are perceived to be manageable through treatment.

Meanwhile, the impact, outcomes and manageability of the range of conditions that sit under the label ‘mental health’ are very broad. This can lead individuals to believe that a mental health diagnosis means something unpredictable and unmanageable. However, in reality, many mental health problems are just as manageable and treatable as physical health problems, if properly identified. In order for personnel to admit to mental health issues and seek support, the misunderstanding the mental health has unclear, unpredictable outcomes and impacts needs to be addressed.

**Seeing the worst cases (Police-specific).**

“*We see the acute end of every spectrum – whether that’s domestic violence or mental health. It does shift opinions, and explains why the police see mental illness in black and white. There are mad, dangerous people, and there is everyone else.”* – Amos, Police.

Mental health was seen in quite crude terms, particularly in the police. This was felt to be because police are often only confronted with the worst cases of mental health. Furthermore, the police are not experts in mental health, and in order to respond effectively in an emergency, their immediate priority is to know whether someone is unpredictable or dangerous. Terms like ‘unstable’ and ‘dangerous’ therefore often become proxy for ‘mentally ill’. In one case, a respondent spoken to could articulate that mental health was on a spectrum, but in practice this didn’t temper or balance his crude view of mental illness, and he didn’t perceive that he would ever personally be vulnerable to mental health issues.

**Promotion difficulties (Police and fire specific).**

One impact of the stigma around mental health, reported by police and fire personnel, was that if personnel had a mental health issue, they were less likely to be promoted or given opportunities. This is due to perceptions that they are not cut out for the job. This was felt to be a particular problem for those in senior or managerial roles, or those in high-risk settings, such as firearms.

“*There is a particular problem higher up in the ranks, where mental health is seen as a weakness. There is a worry that if you complain about stress, they’ll show you the door and find someone else.”*  – Joe, Police

One respondent, **Kenneth**, spoke about a colleague who was doing firearms training, and was performing at the top of her class. However, she had set very high standards for herself. Sometime in the past she had taken time off for stress, but that issue was now resolved. One day Kenneth’s colleague hadn’t performed as well on one aspect of the training and told the supervisor – ‘I’m really angry with myself. I am stressed out over this because I really want to succeed.’ From that, management told her she couldn’t carry on – she had mentioned the buzzword: ‘stress’.

For a few respondents, a fear of lack of progression, associated with speaking out about a mental health problem, interacted with a fear of being hindered in promotion due to ethnicity. This interaction is not surprising, considering that much of the same language used by personnel around mental health was used similarly for talking about ethnicity: ‘banter’, ‘stigma’, ‘different’.

**Buzzwords**

A few respondents felt that there were specific buzzwords that if they were used by a member of personnel, had negative connotations (e.g. ‘Stress’, ‘Mental’, ‘Anxious’, ‘Depressed’, ‘Unstable, ‘Emotional’). The consequences of using one of these terms in relation to mental state, differed dependent on whether the listener was a team member or a manager/decision maker. Using these terms in the presence of team members could result in mocking, jokes and stigma.

“*If I told a colleagues I was feeling mentally ill, they wouldn’t think I was serious*” - Sanjay, Police

In the presence of a decision-maker or manager, use of these buzzwords could risk an individual their career and promotional opportunities due to perceptions that they are not up to the job. These words were felt to be synonymous with ‘trouble-maker’ or ‘incapable’, particularly in high-risk roles, where public lives are on the line. Some felt that there was even a risk of admitting to being ‘stressed’ while using Occupational Health services, as they have the capacity to restrict duties or take individuals off their shift.

“*A lot prefer to go externally for that support because of fear of highlighting issues.*” - NAMPUK representative, Police

stigma of ‘difference’

Stigma is not just associated with ethnicity or mental health. Most felt that anything that identifies you as ‘different’ would be perceived negatively in the emergency services, whether this was whistleblowing, complaining, dyslexia, gender, sexuality or a physical characteristic like abnormal height. For BME personnel, the feeling of being ‘different’ and not ‘fitting in’ had followed most around their entire lives. Some personnel were clearly sick of this feeling, with one respondent wincing at the term ‘BME’. Any divergent behaviour was felt to further compound this difference: making BME personnel stand out more, increasing stigma towards them, and reducing their ability to fit in. This could explain the underrepresentation in Mind’s research conducted thus far.

“*As a minority person, if I say anything – I’m the bad guy. So you don’t dare to speak out.*” – Ennis, Fire

Current emergency service procedures appear to be preventing BME personnel from acting independently or complaining if necessary, without fear of exacerbating their differences. Lack of feedback from this particular segment of the population could in part, be causing problematic procedures, systems and services, including ineffective mental health services, to remain unchanged.

*“I reported someone for gross misconduct once, but by exposing a problem, my name became mud.*” – Krish, Fire

2. Addressing Mental Health  
*2.1 Services and Support*

*Current support services are known about but rarely accessed, due to fears about the confidentiality and effectiveness of services. BME associations and Unions sparked mixed reactions, and were not thought to offer mental health support.*

Current

awareness

Respondents with personal experience of mental health problems tended to have good awareness of the (often limited) support services on offer. Those who had not accessed support services, in general, had much lower awareness. Levels of awareness of support services varied within emergency services.

Most mentioned Occupational Health or welfare, although some welfare departments had been cut due to funding. Some were also aware of additional counselling services, such as LINC for London Ambulance Service personnel and an Employee Assistance Programme in one police service. Ambulance personnel had experienced debriefs after traumatic incidents, and tended to find them useful opportunities to reflect with their team and de-stress. Incident debriefs had also occurred for some police and fire personnel in response to a traumatic incident, however these seemed to be less common and largely unhelpful, often involving third parties who had no awareness of the emotional impact of life on the frontline.

“*All they did was signpost services. They didn’t encourage us to use them. You felt like they didn’t care.”* – Joe, Police

Most respondents were unaware of preventative measures, such as training to improve wellbeing and resilience, and felt it was unlikely these currently occurred. The only exceptions were two fire service personnel, who mentioned workshops on specific mental illnesses. However, with such a small sample, the fire service workshops may not be indicative of greater support services in the fire service more generally, or indicative that all fire service personnel are accessing these services. It is possible that those who are aware of or experienced mental health workshops would be more likely that other personnel to self-select for an interview on mental health.

The role of BME associations and unions

**Background.**

BME associations have varied roles in the emergency services including supporting and dealing with grievances from BME personnel, campaigning to change procedures and systems that disadvantage those from BME backgrounds, raising awareness of BME issues, raising the profile of the emergency services as a career in BME communities, and building links with the wider community, both in the UK and abroad. For example, the National BME ambulance forum have a trip to India planned to raise awareness about basic first aid.

**Limited scope of influence.**

Associations did feature in the experiences of some personnel, but certainly not all; some respondents had leadership roles or positions of responsibility in the organisations, others had never heard of them. There appeared to be a slight age distinction, where older members of staff were more likely to join and be active in BME associations. Specific organisations and BME support networks mentioned and accessed by personnel were:

* Black Police Association (or regional variation)
* National Association of Muslim Police
* National BME Ambulance Forum
* Internal equality forums (Ambulance)
* UNISON Black Member’s Group
* Internal BME staff groups (Fire)
* Asian Fire Service Association

Of those who were not involved directly, awareness of the organisations and their purpose was very low. Those who did not identify as BME found it hard to find a reason for the existence of BME associations, and had no desire to join an organisation marking them out as ‘different’, suggesting the scope of their influence is limited. This was true to a lesser extent of Unions, where one respondent refused to engage in strike action for fear of being identified as a ‘trouble-maker’. Even those actively involved in the leadership of these organisations admitted they weren’t as effective as they could be, or felt they lacked purpose.

“*They look for fights where no fight exist*s” – Krish, Fire (on the Asian Fire Service Association)

“*Before I joined, I never knew it existed. It’s not publicised as it should be*.” – Dhanesh, Ambulance (on the National BME Ambulance Forum)

Lack of use of these organisations is likely to be tied up to a fear or speaking up or highlighting differences, for fear of jeopardising promotions, or far worse. Some told horror stories of colleagues who had whistleblown and later been forced out of the service, and, in one case, arrested. A common belief among the respondents was that the negative repercussions of bringing a grievance to a BME organisation often outweighed the positives gained.

“*I’ve warned people when they come to see me about a grievance – you’re embarking down a tough road.”* – Geoff, Ambulance

“*I’m not entirely sure what the benefits of talking to the Black Police Association are. Once you make an issue about something, your cards are marked*.” – Joe, Police

**Mental health provision.**

None of the respondents felt these organisations had a direct role in providing mental health support. However by tackling some of the perceived racism and discrimination factors influencing the mental health of personnel, these organisations can indirectly reduce the pressures on BME personnel. Overall, personnel were not prepared to go to these organisations to seek support for mental health issues, instead preferring the expertise of internal or external mental health services.

“*Certainly, with the few minority groups I have seen, none of them expressed the preference to get support within a specific ethnic-aimed or goaled organisation*.” – Occupational Mental Health Nurse, Police

“*When I needed them - they weren't there for me. They're good at dealing with the big issues, but when it comes to personal issues - they're in the 'find it too hard to do' box” –* Geoff, Ambulance(on UNISON)

Access

In general, BME personnel were unlikely to access more formal styles of support. This was similar to findings with white personnel[[19]](#footnote-19) who tended to access formal support as a last resort.

*“I once contemplated ringing up Samaritans, but I didn’t want to waste their time.”* – Joe, Police

*“You don’t necessarily feel that it’s ‘bad enough’ to pursue other steps.” –* Aisha, Ambulance

The majority of personnel had experienced challenges and low moments in their day-to-day lives from marital breakups to traumatic experiences on the job. Yet most personnel spoken to had not accessed formal support for these instances. In the case of on-the-job trauma, most felt incidents hadn’t been serious enough to warrant accessing further support. One ambulance personnel who had lost a parent to cancer found meeting families in similar situations particularly distressing. However, as the majority of personnel would take these scenarios in their stride, the paramedic perceived her distress as “silly” - too silly to bring to Occupational Health or external support services.

If personnel had accessed support services for personal problems (e.g. bereavement or relationship breakdown) the majority chose to access external support services, such as GPs and counselling. On top of a desire not to draw attention to themselves or their mental health issues due to stigma in the Blue Light services, personnel felt that internal support services were not likely to be well-equipped to deal with personal problems, as they specialise in workplace health issues rather than personal issues.

*“External support focus on the person more. They address personal needs rather than the organisational needs, unlike internal Occupational Health.”* - Devon, Fire

BME personnel may be less likely to access support services than their white counterparts. One mental health nurse believed that BME personnel were underrepresented in her clientele.

“*My experience is that there are very few [BME officers] in comparison to my workload. I don’t know if that is something about lack of incidents or lack of reporting*.” – Occupational Mental Health Nurse, Police

This could be related to BME-specific stigma, including mental health stigma associated with certain BME communities, but also the problems surrounding ‘speaking out’, or putting your head above the parapet, which prevents some personnel from feeling able to access support, for fear of being emphasised as ‘different’

“*There is a stigma attached to counselling within these communities; there is something very wrong with you if you go for counselling rather than it being seen as something that can assist you or support you*.” – NAMPUK representative

There were also worries that speaking to someone, even in confidence, internally, might be fed back to managers and HR and impact progression in the organisation, or put a permanent ‘black mark’ by their name.

“*You don’t want to be seen using Occupational Health*” - Amos, Police

The research suggested that not only could BME personnel be less likely to access support, but they additionally have greater risk factors such as increased workload, racism and discrimination. The coupled effect of greater susceptibility to mental health issues and less support suggests that the mental health needs of this particular group should be taken seriously in Mind’s Blue Light programme.

#### New Support Approaches

Some of the experts and respondents mentioned approaches to mental health support being trialled and introduced in various emergency services around the country.

**Peer to Peer support: face-to-face & telephone helpline (Ambulance and Police)**

Of peer-led services encountered during the research, the best established was LINC - the confidential peer support telephone helpline for London Ambulance workers. All ambulance personnel, inside and outside of London, had heard of the service and thought, in principle, that it was a good idea. However despite this, neither respondent from London had ever accessed the service, preferring to deal with problems externally or with ‘real experts’. One policemen mentioned a similar initiative at his service, which he had accessed. However he had found theindividuals on the end of the phone lacked expertise.

Telephone services were generally preferred over face-to-face peer services. The appeal of face-to-face peer-based services is likely to be limited for BME personnel who can lack trust in the organisation in general, and have no desire to give additional reasons to be perceived as ‘different’ by their peers.

**Pastoral care workers with no specific religious faith (Ambulance)**

This approach, trialled by East Midlands Ambulance Service, is training pastoral care workers to engage in spirituality more generally, rather than the traditional Christian approach.Pastoral care workers without a Christian focus undoubtedly have some benefits for BME personnel from non-Christian backgrounds, however none of the sample spoken to for this research had strong religious identities, suggesting the impact of this on BME personnel may be limited. Additionally, very few personnel had ever accessed welfare departments, including pastoral care, believing that these departments had limited specific mental health expertise, and lacked the power to make referrals or help personnel overcome personal challenges. Most expressed a preference for external experts over internal welfare departments.

**Workshops on specific mental illnesses (Ambulance and Fire)**

A small number of experts and personnel mentioned workshops on mental illness. There were two opposing viewpoints on workshops. Some felt that workshops were only ever going to attract an audience with an interest in the topic, and were unlikely to attract those who held the greatest stigma around the topic. Others felt that workshops were gradually helping to erase taboo and stigma, not just around mental illness, but around other ‘issues of difference’ such as ethnicity, sexuality and dyslexia.

“*There was a lecture on bipolar disorders which went well - we saw a lot more acceptance as a result*.” - Retired Firefighter

Given the variety of jobs and roles in the emergency services, with different personnel facing different pressures, most felt workshops needed to be structured for these different audiences to be effective and engaging.

Unmet service provision

Many of the respondents mentioned some areas lacking in current mental health service provision. Most felt there ought to be more alternatives to internal occupational health, which had some problems, such as its perceived allegiance to the organisation, and that it could not be accessed on an ad hoc or informal basis. Four ideas that were mentioned repeatedly by respondents were: training for managers, group-based approaches (ambulance-specific), confidentiality, and having an effective service that actually fixed problems.

training for managers

Many respondents commented that understanding from managers was low. Most felt their manager would struggle to recognise if they had mental health problems. One respondent had had 14 managers in 15 years, making it much easier for senior staff to turn a blind eye when things went wrong. As BME personnel could be less likely to speak out than their white peers, due to a worry about perceptions of difference, a management training course would provide another, alternative channel to allow BME personnel to access support.

However, even if managers were aware of respondents’ mental health, most were unsympathetic to mental health needs, including one respondent with managerial responsibilities.

“*You have to be resilient to be a police officer. Some people are cut out for it, others aren’t. Those that aren’t should just leave.*” – Amos, Police

“*More is being done to give line managers awareness of mental health, but some still complain “I’m not their bloody parent*”” – Joe, Police

Although one or two of the respondents had discussed mental health issues or workplace pressures with managers, most felt their managers hadn’t cared, and were only paying them lip service. This was particularly true of respondents in police and fire services. These respondents felt that a training course would not only have to teach factual information about mental health, but would have to address empathy and ‘emotional intelligence’ in management. Beliefs that managers don’t care about them, is likely to exacerbate BME personnel’s fears of discrimination and internalised oppression.

“*On paper they do care, but in reality no one gives a shit*.” – Krish, Fire

group based services (Ambulance-specific)

**Current provision**

Ambulance personnel, used to working as part of a team and coupled with a strong sense of camaraderie in the service, spoke positively about current team-based mental health provision, such as team debriefs. However this was not echoed by all individuals across different services. One fireman felt the process of debriefing had become too bureaucratic and formal by involving third parties without frontline experience.

“*It used to be that you’d come back from a traumatic situation and you’d sit down with someone you know and have a chat. Now you get a third party sitting in the room with you. It’s much worse.*” – Krish, Fire

**Team-based approaches?**

A few experts and one respondent felt that more group based training or therapy would be helpful, particularly in the ambulance service, where individuals tend to work in close teams on a daily basis. These group based services could be therapeutic, allowing those with shared experiences to come together, or act as training for a team to learn how to better support one another. Group approaches also help personnel build up trust, potentially decreasing barriers to admitting to mental health problems, and developing more open communication between teams.

“*Creating time and space for people who have dealt with something similar to come and talk to one another*.”- Aisha, Ambulance

This process, however, may be less suitable for BME personnel in police and fire departments, some of whom spoke about lacking trust for colleagues in their organisation, particularly those in positions of authority, such as managers or Occupational Health. One expert with experience of holding therapeutic workshops on stress and discrimination suggested workshops are both possible and helpful, but that, at least initially, rank-and-file service personnel and managers, ought to be given separate forums to air their positional viewpoints, to encourage open dialogue without fear of negative consequences.

However it was clear that some BME personnel would even struggle to speak openly in front of peers and their own team. This was due to a fear of highlighting their issues and differences, and being perceived negatively as a result.

confidential services

**Self-referring, ad hoc and informal.**

Another characteristic referred to by several personnel and experts was that Occupational Health cannot be accessed without getting referral from a manager. This was not true of all internal health services, but over half of the respondents spoke of difficulty accessing health services, without going through management or HR. This has particular relevance for BME personnel who often have no desire to draw additional attention to themselves as different, particularly on top of additional worries about discrimination and bias from management.

“*It has to be signed off by the line manager. People might not want their line manager to know.”* – NAMPUK representative.

Related to this, some found the current Occupational Health option too formal and wanted a service that could be accessed ad hoc, or informally, without jumping through a series of bureaucratic hoops, which are both time consuming and could potentially draw attention to them.

**“Confidential” means confidential.**

Alarmingly, one individual had signed up for what he understood to be a confidential Occupational Health counselling session, to find out that details about his meeting had been passed onto HR. Others had fears that their internal services were not confidential, and that often Occupational Health professionals would pass on details to line managers or HR. The internal mental health professionals spoken to confirmed this fear, saying that mental health provision internally can involve managers and HR. The purpose of this is to solve the problems of personnel in the most effective manner, however it is easy to see how this can discourage personnel, and particularly BME personnel, from accessing services, out of fear of job loss, discrimination or stigma.

“*If you see a mental health nurse, they’re going to get in touch with managers and give advice on what sorts of duties you should be on, whether you should be on restricted duties –whether you should even be in the service*.” – Kenneth, Police

Another related worry was that because Occupational Health are often overly connected with the organisation itself they are incapable of offering truly personal support. Instead, they are always going to be thinking about how to get that individual back into work, rather than truly supporting the needs of the individual.

“*I want a service that’s going to address my personal needs, rather than the organisational needs, which is currently the priority for Occupational Health*.” – Devon, Fire

effective services

Considering the workload pressures on personnel, and in particular on BME personnel, most respondents felt services needed to be as effective as possible, in order to minimise the drain on their time and ensure they wouldn’t be wasting time.

**Led by experts.**

A few respondents mentioned that they would be more likely to access external services than internal services, because they perceived them to have greater expertise. One respondent had used a peer-based welfare support service and found it to be ineffective and unhelpful. Since that time he has said he would always access services externally from ‘experts’.

“*Some of the advice I could have come up with myself. I was expecting a something a bit more guided or useful*.” - Kenneth, Police

**Tough talking (Police and Fire specific).**

Both the police and fire personnel who had experienced or were experiencing mental health issues spoke of a desire for someone who wouldn’t just talk around their issues, but would be tough with them and help them make progress. This may reflect the personality types of personnel in police and fire services. If progress is being made and a problem is resolved quickly, it also reduces drain on workload. Some respondents already had these services available to them, whereas others felt their mental health provision was ineffective in this respect.

*“The employee assistance programme can arrange for counselling for different circumstances. You’re given the choice of someone ‘pink and fluffy’ or someone more direct. I think most of us would choose someone direct. You need to be told how it is and how to progress, otherwise you can end up discussing to the nth degree which would take longer. All I am looking for is an issue to be resolved.” –* Kenneth, Police

“*I thought we were making progress for a while, but I was wrong. I just want someone to help me fix it.”* – Krish, Fire

*2.2 Blue Light Feedback*

*Personnel can be best engaged by addressing stigma around ‘difference’ and mental health, emphasising confidentiality, ensuring training and services are efficient and effective, and by not emphasising BME differences.*

Views on programme

As with white personnel[[20]](#footnote-20), nearly all BME personnel were positive about the idea of Mind’s Blue Light programme. The biggest need was felt to arise from training managers to recognise mental health problems and adequately support staff with mental health needs, as outlined in Section 2.1. This is particularly important for BME personnel who may be less likely to speak out about mental health than their white colleagues, due to combined mental health and ethnicity stigma. A well-informed and understanding management structure is therefore important to allow these mental health problems to be recognised and treated. This suggests that achieving BME buy-in to the programme may be helped by sharing details about manager training programmes.

In particular the research tested out three aspects of the Blue Light programme with personnel:

* Confidential **Phoneline** with email and text service
* Online **‘webinars’** covering mental health awareness, mental health in the workplace and mental health self-management
* Emergency service courses and **training** on mental wellbeing and resilience

Advantages of each of the services and recommendations by the personnel are outlined in the following table. Predictably, these thoughts and recommendations are similar to those given by white personnel[[21]](#footnote-21).

|  |  |  |
| --- | --- | --- |
|  | * POSITIVES | * RECOMMENDATIONS |
| * Phoneline | * Most popular of the three options, as it was tailored to the personal needs of the individual. * Accessible (by text or email) at any time of day. * A signposting service was particularly useful for some staff who hadn’t accessed internal services previously | * Phoneline listeners need to have expertise. Current peer-led support does not give adequate expert advice. * External, independent and confidential to prevent HR or managerial interference. * May not get the use it needs unless promoted well, and confidentiality is emphasised. * Listeners should have an understanding of typical Blue Light pressures. * Be aware that there will likely be abuse of the service, due to the ‘locker room’ mentality and ‘banter’ in the emergency services. |
| * Webinars | * Appropriate for younger members of staff. * Less of a commitment than face-to-face training, and can happen outside of work hours. | * Staff may prefer to access in private– some frontline staff won’t have access to a private computer and instead use public IT spaces. * E-learning would need to be mandatory and well-signposted to be accessed. * Need for training to be relevant to the job and career progression. * Should be adaptable for different types of emergency service staff, particularly within the police; individuals have different educational attainment and different day-to-day pressures. * Most staff cannot fit E-learning in, already. Need to ensure managers and senior managers create sufficient time for staff to complete it, otherwise it will add to workload. |
| * Resilience Training | * New concept - none of the respondents had experienced mental resilience training before. * Group environment particularly good for team-based roles, such as frontline ambulance staff. | * [Ambulance specific] Training on stress and MH has to appreciate the medical understanding of ambulance service personnel, and not patronise otherwise they will switch off. * Frontline staff process a great deal of information quickly – courses need to be complex and informative enough to sustain attention. * Should be adaptable for different types of emergency service staff, particularly within the police; individuals have different educational attainment and different day-to-day pressures. * Need for training to be relevant to the job and career progression. |

BME specific engagement

The research suggested that BME personnel could be less likely to use or access Mind’s Blue Light programme than their white counterparts for several reasons:

* Mental health professionals suggested that BME engagement with current mental health services was lower than anticipated
* Workload pressures could be higher for BME personnel and therefore they may be less likely to have the time to access training or information services
* There is a fear of not drawing negative attention to themselves - particularly important for individuals who already believe themselves to be seen as ‘different’, and perceive that they have poorer chances of progression and promotion
* There may be stigma around accessing mental health services in BME families and wider communities

The following are therefore some recommendations to maximise BME personnel engagement with the programme and ensure that Mind’s Blue Light programme reaches all members of staff, regardless of ethnicity.

addressing BME and blue light stigma

One of the biggest challenges Mind faces is actually getting BME personnel to use the services. Despite near-universal enthusiasm for the programme *for people with mental health issue*s, some strongly believed that they would never have the need to access the Blue Light programme, and that is what not aimed at people like them. Many of these individuals had even suffered from stress, but refused to admit this was a mental health problem. This could particularly be a problem for BME personnel, considering the stigma from both within BME communities and within Blue Light services. Tackling this stigma must therefore be a priority for encouraging access.

**Re-frame mental health as predictable and manageable.**

Some could not accept that ‘good’ emergency service personnel suffer mental health conditions. Admittedly this was not felt by all personnel, and particularly not for those who had lived experience of an illness. However the idea that those who lacked resilience or mental stability would be worse at their jobs prevailed. This has particular relevance for BME personnel, who feel several levels of pressure to stay mentally stable: from family pressure to go above and beyond what is expected of them, to stigma from the community if they do ‘come out’ with a mental health problem.

In part the stigma surrounding ‘coming out’ with a mental health problem is related to how mental health is perceived in the emergency services. Mental health is on a spectrum, but emergency service personnel see the most extreme cases. Particularly in the police service the word ‘dangerous’ is often used as short-hand for those with mental health problems. For this reason ‘mental health’ has negative connotations for most emergency service personnel. Some of those spoken to were quick to imagine schizophrenic or suicidal individuals.

“*I’d define [mental health] as someone who may be hearing things, imagining things, suicidal or wanting to cause harm to others.”* - Sanjay, Police

Many did not consider their own experiences of stress and low mood to be mental illness. By calling these problems ‘mental health problems’, they were associating themselves with the ‘dangerous’ people they met in public. Any service or training branded with the term ‘mental health’ also risks being associated with more serious, unpredictable instances of mental health, rather than attracting those facing entirely manageable conditions. In order to best support the majority of service personnel, whose mental health problems may be manageable in the workplace environment, a new way of framing these mental health issues needs to be utilised, which does not automatically group them together with the worst cases.

Just like physical health problems, many mental health problems are manageable and can be worked around and treated, if identified properly. There needs to be shift in the way personnel perceive mental health, from seeing mental illness as unpredictable, untreatable and dangerous, to being a manageable issue. This will decrease stigma, and encourage more personnel to seek out support and treatment.

**Don’t call it mental health.**

“*The term mental health puts people off.”* – Ennis, Fire.

One way of reframing ‘mental health’ is by not using this or associated terms. Some individuals had a problem with the term ‘mental health’, or even the term ‘stress’ if they were in high-risk positions (such as firearms or senior managerial), perceiving that these were buzzwords for ‘trouble’ or ‘incapable’ (see Section 1.3, “Buzzwords”). Therefore, to encourage access, use of these terms should be minimised.

On this, there was a lived experience distinction; those who had diagnosed mental health problems were more likely to access training, services or resources associated with mental health, perhaps due to their increased understanding. These individuals were also more likely to understand who Mind were, and saw Mind as an authoritative source of mental health knowledge.

“*Seeing that Mind were involved was the reason I signed up for the research. Mind helped me access free counselling when I was younger.*” – Aisha, Ambulance.

However among those without lived experience of mental health issues there was a lack of awareness about who Mind were and the work that they do. This suggests that training aimed at ‘all’ personnel, such as resilience training and webinars should limit use of the term ‘mental health’, and associated terms, where possible. However, services aimed at those with mental health problems, shouldn’t be afraid of emphasising their mental health expertise, possibly through the use of the Mind logo

**Selective promotion.**

Research into BME associations suggested that these organisations have limited scope and impact among BME personnel. Although around half of the respondents were involved in these organisations, many disagreed with their existence, as these were organisations that emphasised difference rather than helping BME personnel fit in. Endorsement for the Blue Light programme by BME organisations and associations may deter as many BME personnel as it attracts. Union endorsement could be a more inclusive way to attract engagement with a particular course or service, as it does not carry the same stigma as a BME specific organisation.

“*Endorsement form the union would get people on side. It’s not 100% for the BME community, but they do represent members, and they do what’s right by firefighters and their families.”* - Devon, Fire

What did come out from the individuals we spoke to, particularly those in managerial or senior roles, was that many acted as unofficial mentors and points of contact for other BME individuals. These individuals therefore held positions of influence, and could be useful nodes for information distribution and endorsement of training, as well as building up trust amongst BME personnel.

“*BME staff come to me unofficially, if they have a problem or a grievance. I’m quite visible. People know me*.”- Geoff, Ambulance.

NO-rISK Confidentiality

Confidentiality is important for white personnel, but it has particular relevance for BME personnel who can lack trust in their organisation. Some may have felt personally discriminated against or bullied by colleagues or management, while others may just be tired of being the one who is ‘different’. Most would dislike accessing a service that they either had to seek referral from a manager to access, or that there would be the possibility of the conversation being relayed to HR or management.

The need for confidentiality can also be tied up to increased stigma amongst BME personnel. Though few of the personnel spoken to appeared to have BME-specific stigma personally, some spoke about wider family and community stigma. It is possible that this can have an impact on individuals’ desire to access a service, and reinforces the necessity for these services to be accessed on a confidential basis.

Just using the term ‘confidential’ when publicising mental health initiatives may not be enough to allay suspicions about confidentiality. Some had experienced problems in the emergency services where supposedly confidential conversations, either over email or in person, had been passed on to management or HR. These individuals therefore may need further reassurance, perhaps through endorsement by influential leaders or peers, that the service truly is confidential.

“*I don’t want them whispering – that’s what really bothers me*” – Krish, Fire

Equally few respondents warmed to the idea of peer-led services. Worries that peers and colleagues tend to have negative views of mental health, lack of trust for colleagues and peers, and fears that these services may not be entirely confidential, led to most respondents claiming they were unlikely to access an internal peer-led service, particularly in the police and fire services.

**Address fears of progression in the organisation**

“We *need to break down myths that speaking out will reduce chances of promotion in the future*” – Ennis, Fire

Conversations with personnel revealed that some were fearful that ‘coming out’ about mental health would hinder their chance of progressing in the organisation or put a “black mark” against their name. This could be particularly true of BME personnel who, in some cases, perceived that they were already discriminated against in terms of progression, due to their ethnicity. Therefore, in order to encourage engagement with mental health services and training, there should be two approaches:

* Keep services confidential
* Address myths that perceived mental health issues, or engagement with a mental health programme, will hinder progression.

**Make it easy to give feedback**

Respondents believed that speaking out, and offering criticisms of people, systems and services in the emergency services had led to either themselves, or their colleagues, being bullied, harassed and pushed out of the service. There is unlikely to be much vocal negative feedback and commentary on Mind’s programme for the Blue Light services, unless the process of giving feedback, and especially negative feedback, is made as easy and as confidential as possible. This may come by addressing the problem head-on and asking specifically for negative feedback on the services and systems.

efficient and focussed

**Job-relevant.**

Some respondents spoke of wanting training and learning to be relevant to career progression. With excessive workloads, and worries about their chances of promotion and progression, respondents wanted training to be directly relevant to the work they were involved in. This is a particularly important focus to engage personnel if the training is not mandatory.

Successful examples of this trailed by LINC and NAMPUK included putting in references to the day-to-day work of the individuals, showing them how their learning could relate back to doing their job more successfully. By making the training more job-relevant, it can give individuals greater impetus to access.

*'In the past, our Islamic awareness training was very religion-heavy and people would switch off after 10-15min. So we ensured that it was relevant to their job, like ‘if you stopped a Muslim female wearing a headscarf, how would you search her’ and ‘what would you do, if you had to go into a mosque’ It kept them a lot more engaged, and it made sense for them and allowed them to apply the knowledge to their job*” – NAMPUK representative

Workload stresses can be more pronounced for BME personnel, meaning that they could be less likely to access training that white counterparts. Therefore giving training and workshops a strong career focus is likely to make it more attractive.

**Quick and ‘to the point’.**

“*These guys process information quickly - so the courses need to be challenging and informative to be engaging. The sort of training that would take a day with managers in commercial organisations, I deliver here in 2 hours.*" – LINC counsellor

Related to making the training job-relevant, individuals also spoke about wanting effective, training and services that didn’t beat around the bush. Experts who had conducted their own training sessions, told us that emergency service personnel prefer fast-paced styles of training, as they regularly process a lot of information at once on the job.

With greater work pressures, the importance of time effective training and support services is particularly important. Some felt that online training, in particular, was difficult to fit into a busy schedule. Unlike face-to-face training, where once you turn up you are there for the duration, it is easy to let phonecalls, emails and responding to incidents distract from online training. This means that online training can often take much longer than is intended.

“*With all the phonecalls, emails and staff problems I deal with in a normal day, a one hour online training session might take me the whole day. And I don’t take any of it in if I do it like that*. *It’s even worse for guys on the beat.*” - Kenneth, Police

**Led by mental health experts.**

Most respondents also expressed a desire for mental health expertise, and weren’t prepared to waste their time with individuals without the required expertise. Some had had poor experiences with peer counsellors or Occupational Health, who they felt lacked the specific mental health knowledge of an external counsellor on the NHS. Of those who had heard of Mind, most were positive about the idea of Mind becoming involved in offering services or advice, both for personal problems, and for advice on dealing with the public.

“*I think the police should have a representative of Mind or someone like that who could be available to speak to - to counsel. They’re the experts.*” - Kenneth, Police.

don’t mark out bme personnel as different

**The downsides of BME specific information or training.**

“*It’s just a leaflet – it wouldn’t make any difference what’s on the front cover.*” – Sanjay, Police

Responses to BME specific training or information were resoundingly negative. Some had fears that it would exacerbate stigma around ethnic minorities, and even believed that it could put their jobs and progression at work at risk if it singled out BME personnel as particularly prone to certain mental health issues. In line with a lack of strong ethnic identity held by many of the respondents, most felt no desire to be picked out as ‘abnormal’ and some even took issue with the labelling ‘BME’.

As a compromise, most wanted to be at least recognised by mental health training and information leaflets.

“*Perhaps if there were one or two BME people in the leaflet, rather than leaving us out*.” - Aisha, Ambulance

**Understanding BME issues.**

Despite a desire not to be seen as different, BME personnel may experience greater mental health risks and barriers to access than white personnel. Personnel who had experienced mental health challenges, such as public racism or stigma from families and communities, wanted the effects these could have on mental health to be understood, but as part of a wider discourse on mental health challenges and triggers.

One counsellor suggested that BME staff may be more likely to access a mental health support worker if that individual comes from the same ethnicity or religion, because they may have increased understanding of cultural and ethnicity issues. She, herself, had found that Muslim staff members would often choose to see her over other counsellors, because of her Muslim-sounding name. This may be true of some individuals, however, based on the respondents in the study, it seems more likely that these individuals would prioritise mental health expertise over cultural understanding. Indeed, once the counsellor’s clients understood she was not Muslim, it made no difference to their counselling relationship or engagement with the service.

Conclusion

identity

In general BME personnel do not want to be described or marked out as different. In order to fit in with a predominantly white profession, some felt they had changed aspects of themselves to appear more ‘white’. Other individuals did not feel that ethnicity was a strong part of their identity and took issue with ethnicity discourse, such as ‘BME’, which they felt made them stick out from white colleagues.

mental health pressures

Alongside similar pressures to white personnel, such as heavy workload and traumatic incidents, some personnel from minority ethnic backgrounds also seem to face additional mental health pressures. These possible factors include perceived and actual racism and discrimination, which can affect an individuals’ mental wellbeing, either directly or cumulatively, and make individuals feel the need to work harder to ‘prove themselves’. Other issues brought up include difficulties balancing religious or cultural norms with the job, such as fasting or family requirements.

Popular coping strategies for mental health issues were low-key and informal, much the same as white personnel. However there was some evidence suggesting that BME personnel may find some of these coping strategies harder to use and access than white colleagues. Some may be unwilling to share personal issues with their team, or be unable to participate in certain group activities for religious regions (e.g. debriefing at the pub). Stigma in BME communities, particularly South Asian communities, may also prevent individuals from sharing worries with family.

blue light stigma

Personnel felt that there was a strong stigma in the Blue Light services surrounding mental health. This included a propensity to associate mental health with the worst cases, as Blue Light personnel are exposed to the extremes of mental health issues. Unlike physical conditions, mental health issues are seen as unpredictable and unmanageable, preventing individuals from identifying their problems as ‘mental illnesses’ and from seeking out support.

There are also fears that admitting to a mental health problem could prevent promotion, particularly for managerial staff or those in high-risk roles. However, importantly for BME personnel, this is coupled with a fear that anything that could mark you out as different can be stigmatised. BME personnel already have fears that the service perceives them differently and a desire to fit in; therefore speaking out about a mental health problem would exacerbate worries about sticking out and drawing attention to their differences.

accessing services

Stigma in the Blue Light service and stigma from BME communities means that Blue Light personnel may be less likely to access current support services. Many had concerns about the confidentiality of current services, as well as whether the current services have the needs of the individual (rather than the needs of the organisation) at their heart. Most felt there ought to be more training for managers, who not only lack mental health understanding but can lack empathy. Ambulance personnel expressed an interest in more team-based therapy and training.

engaging BME personnel in the BLue light programme

Engagement in Mind’s programme can be encouraged by making the training as effective and focussed as possible, including job-relevant. Stigma around mental health is strong, and may be overcome by reducing use of the term ‘mental health’, and associated terms. Building up trust and reducing stigma may be helped by encouraging unofficial leaders or mentors in the services to engage with the programme, and by ensuring mental illness is perceived as manageable, in contrast to the ‘worst cases’ which emergency service personnel are regularly exposed to. In order to counteract worries around confidentiality and trust in the organisation, Mind need to emphasise that services are externally-led and that details will not be passed onto management or HR. Most importantly, Mind’s programme should not mark out one section of personnel as ‘different’; BME needs should be addressed inclusively, alongside the needs of the entire Blue Light service.

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1. www.gov.uk [↑](#footnote-ref-1)
2. [www.gov.uk](http://www.gov.uk) [↑](#footnote-ref-2)
3. Independent review of the police disciplinary system in England and Wales; C. Chapman; 2014 [↑](#footnote-ref-3)
4. The involvement of black and minority ethnic staff in NHS disciplinary proceedings; Centre for Inclusion and Diversity, University of Bradford; 2010 [↑](#footnote-ref-4)
5. The “snowy white peaks” of the NHS: a survey of discrimination in governance and leadership and the potential impact on patient care in London and England; K. Roger, Middlesex University London; 2014 [↑](#footnote-ref-5)
6. Policing ethnic minority communities; B. Bowling & C. Philips; LSE research online; 2010 [↑](#footnote-ref-6)
7. Mental health and the blue light programme: scoping focus groups report; ResearchAbility; 2014 [↑](#footnote-ref-7)
8. The “snowy white peaks” of the NHS: A survey of discrimination in governance and leadership and the potential impact on patient care in London and England; K. Roger, Middlesex University London; 2014 [↑](#footnote-ref-8)
9. Policing ethnic minority communities; B. Bowling & C. Philips; LSE research online; 2010 [↑](#footnote-ref-9)
10. Attitudes to mental illness; Time to Change; 2014; <http://www.time-to-change.org.uk/sites/default/files/121168_Attitudes_to_mental_illness_2013_report.pdf> [↑](#footnote-ref-10)
11. Mental health survey of ethnic minorities: Research report; Ethnos; 2013; https://www.time-to-change.org.uk/sites/default/files/TTC\_Final%20Report\_ETHNOS\_summary\_1.pdf [↑](#footnote-ref-11)
12. Race on the agenda 34; 2009; http://www.rota.org.uk/webfm\_send/4 [↑](#footnote-ref-12)
13. Ethnic variations in pathways to and use of specialist health services in the UK: Systematic review; K. Bhui et al.; 2003 [↑](#footnote-ref-13)
14. Mental health survey of ethnic minorities: Research report; Ethnos; 2013; https://www.time-to-change.org.uk/sites/default/files/TTC\_Final%20Report\_ETHNOS\_summary\_1.pdf [↑](#footnote-ref-14)
15. Family Matters: A report into attitudes towards mental health problems in the South Asian community in Harrow, North West London; Time to Change; 2010 [↑](#footnote-ref-15)
16. Family Matters: A report into attitudes towards mental health problems in the South Asian community in Harrow, North West London; Time to Change; 2010 [↑](#footnote-ref-16)
17. Mental health stigma in the Muslim community; A. Ciftici, N. Jones, & P.W. Corrigan; Journal of Muslim Mental Health; 2012 [↑](#footnote-ref-17)
18. Mental health and the blue light programme: scoping focus groups report; ResearchAbility; 2014 [↑](#footnote-ref-18)
19. Blue light personnel information needs scoping report; R. Donaldson, J Irwin, &, B. Williams; Fiveways & Mind; 2014 [↑](#footnote-ref-19)
20. Blue light personnel information needs scoping report; R. Donaldson, J Irwin, &, B. Williams; Fiveways & Mind; 2014 [↑](#footnote-ref-20)
21. Blue light personnel information needs scoping report; R. Donaldson, J Irwin, &, B. Williams; Fiveways & Mind; 2014 [↑](#footnote-ref-21)