Report on the Faculty-based engagements with stakeholders:

understanding "*uMgowo*"

Mental Health Working Group

FACULTY OF HEALTH SCIENCES | UNIVERSITY OF CAPE TOWN

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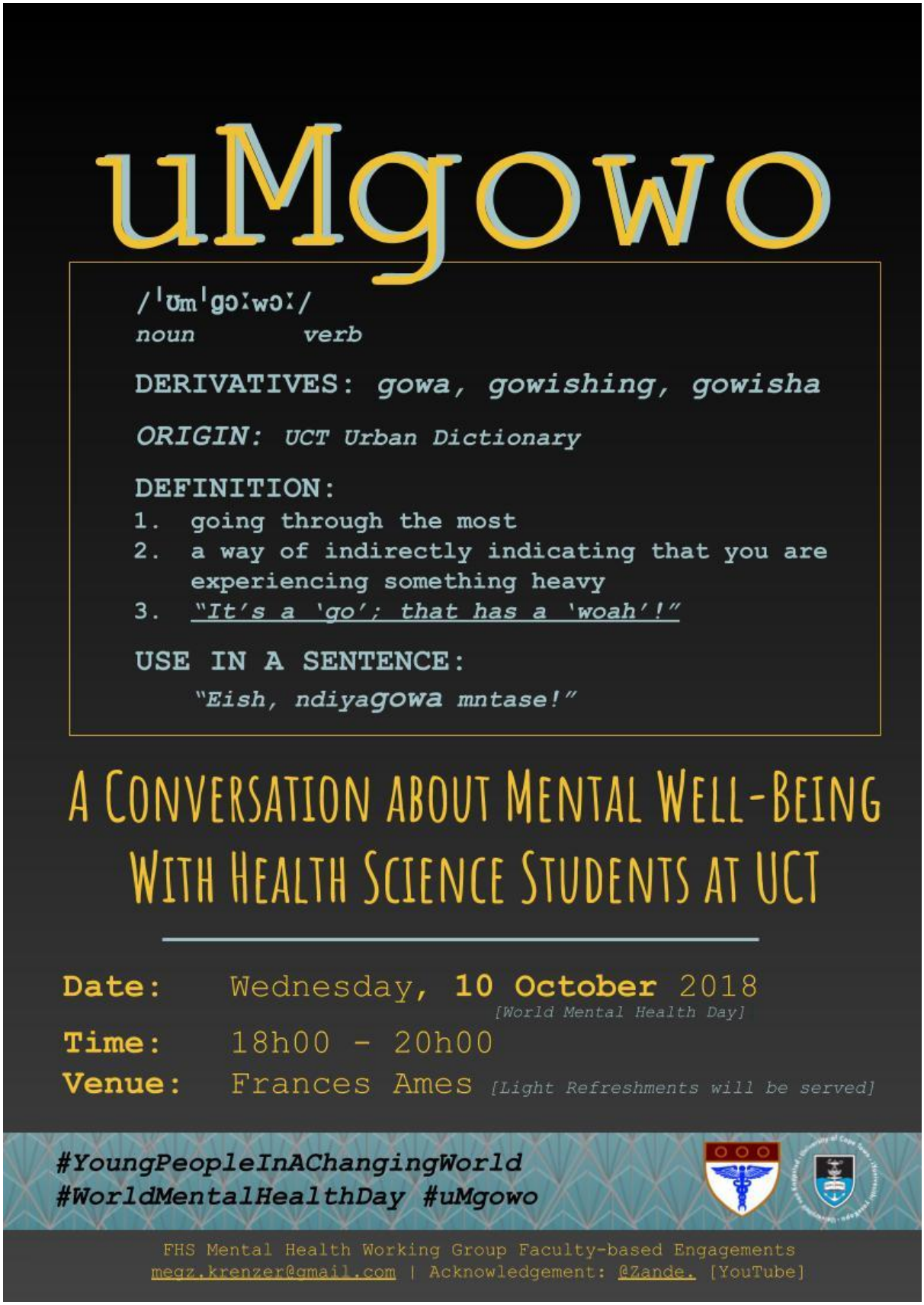
Poster from Student-led Panel | 10 October 2018



1. Key concepts: continuum of mental health

The concepts presented below reflect the continuum of mental health, drawing attention to the range of diverse needs. The definitions draw on a range of frames of reference, from a biomedical approach to health to ability and disability frames of reference. This Mental Health Working Group report adopts psychosocial perspectives informing ability and dis-ability.

	CONCEPT	DEFINITION
1	**Wellbeing**	There are various forms of *well-being,* such as mental, psychological, work-related, occupational, socioeconomic and subjective. It "*should be interpreted in the sociocultural context of the individual. It should be considered as a continuum and as operating within a spectrum, rather than a state that is present or absent. An individual, group or community can be at any given point within this spectrum."* (WHO South East Asia Regional Office, 2018). Additionally, it denotes engagement in meaningful occupations, in which human connections are developed and sustained (Galvaan & Peters, 2013).
2	**Mental Health**	*"a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community."* (World Health Organisation [WHO], 2005).
3	**Psychological Distress**	*"**Psychological distress** is a general term used to describe unpleasant feelings or emotions that impact your level of functioning. In other words, it is psychological discomfort that interferes with your activities of daily living. Psychological distress can result in negative views of the environment, others, and the self. Sadness, anxiety, distraction, and symptoms of mental illness are manifestations of psychological distress*" (Williams, 2018)
4	**Stress**	*"Stress is the **harmful** physical and [or] emotional response caused by an **imbalance** between the perceived demands and the perceived resources and abilities of individuals to cope with those demands."* (ILO, 2016:2)
5	**Burnout**	*"Burnout is a multifaceted construct characterised by various degrees of emotional exhaustion, depersonalisation (i.e. feeling detached from or callous toward [clients]) and a low sense of personal accomplishment. Burnout can undermine trainees' professional development, place [clients] at risk and contribute to a variety of personal consequences, including suicidal ideation and substance abuse."* (Dyrbye & Shanafelt, 2016:133)
6	**Acute Mental Disorder**	"*...a clinically recognised condition or illness that affects a person's thought processes, judgment or emotions, is short term (less than 12 months) in duration and causes clinically significant distress and/or impairment in social, occupational or other important areas of functioning."* (University of Cape Town [UCT] Student Mental Health Policy, 2018:3)
7	**Mental Disorder**	*"A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. "*

		(DSM V: American and Psychiatric Association [APA], 2013)
8	**Psychosocial disability**	Experience of ongoing or recurring significant mental and emotional distress which interferes in a person's ability to participate in society. People with psychosocial disabilities, *regardless of self-identification of diagnosis of a mental illness, face restrictions in the exercise of their rights and barriers to participation,* including poor access to basic services and exclusion. //www.safmh.org.za/index.php/news/item/179-what-is-psychosocial-disability-awareness-month

Environmental Factors & Responses

	CONCEPT	DEFINITION
1	**Psychosocial hazards**	*"Interactions between and among [the clinical] work, environment, job content, organizational conditions and workers' capacities, needs, culture, personal extra-job considerations that may, through perceptions and experience, influence health, work performance and job satisfaction"* (Adapted from International Labour Organisation [ILO], 1984:3)
2	**Work-related Stress**	*"Work-related stress is determined by psychosocial hazards found in: work organization; work design; working conditions, and labour relations and occurs when the* ***demands of the job do not match or exceed the capabilities, resources, or needs of the worker,*** *or when the knowledge or abilities of an individual worker or group to cope are not matched with the expectations of the organizational culture of an enterprise."* (ILO, 2016:2)
3	**Recovery**	In Anthony's seminal work (1993, p. 15), he defined recovery as: "*a deeply personal, unique process of changing one's attitude, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life even within the limitations caused by illness. Recovery involved the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness."* Recovery then is multidimensional and connected to the person's circumstances and experience of their mental health.
4	**Psychosocial rehabilitation**	*" ... a process that offers the opportunity for individuals who are impaired, disabled or handicapped by a mental disorder to reach their optimal level of independent functioning in the community. It involves both improving individual competencies and introducing environmental changes (WHO 1995). Psychosocial rehabilitation is a comprehensive process not just a technique."* (WHO, 2001:62)

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List of faculty-members involved in the Mental Health Working Group (MHWG)

Table A: List of the MHWG members

Members	Students involved in engagement-consultations
Prof. Roshan Galvaan (Chairperson) *Mrs Fadia Gamieldien* *Prof. Sharon Kleintjes* *Mrs Sarah Crawford-Browne* *Dr Rudzani Muloiwa* *Mr Langa Twala (HSSC)* *Prof. Marc Blockman* *Prof. Dan Stein* *Dr. Ayanda Gcelu* *Mrs Meghan Krenzer* *Incoming HSSC Chair*	*Mrs Buhle Maseko-MacArthur,* *Mr Nkateko Phakula,* *Ms Rivoningo Baloyi* *Ms Danél van der Westhuizen;* *Mr Wakithi Mabaso* *Mr Stefan Van Der Walt*

Table B: List of Facilitators for Generative Discussion with faculty-based groupings [co-facilitated]:

From MHWG Engagement Coordination Team:	Invited Faculty-Facilitators:
Prof. Roshan Galvaan *Mrs Fadia Gamieldien* *Prof. Sharon Kleintjes* *Mrs Sarah Crawford-Browne* *Mrs Meghan Krenzer*	*Mr Siwe Toto* *A/Prof Rudzani Muloiwa* *Mrs Ereshia Benjamin*

1 Introduction

The Faculty of Health Sciences Mental Health Working Group[1] was tasked by the Deanery to make recommendations on how the faculty might best respond to student needs with regards to mental health and well-being. The question the working group sought to answer was:

> ***"What are the barriers to promoting mental health and well-being within the Faculty of Health Sciences? And what could turn this situation around?"***

In response, the working group initiated Faculty[2]-based engagements with students and staff, both through face-to-face and online discussions. This report describes the themes that emerged through these generative Faculty-based engagements in the Faculty of Health Sciences in the last quarter of 2018.

1.1 Members

The core members of the working group consist of Faculty staff and the 2018 and 2019 chair of the Health Sciences Student Council. Five of these members embarked on the task of coordinating; facilitating the series of Faculty-based Engagements; and compiling the report. Three additional members of the Faculty, assisted in co-facilitating these engagements. Additional Faculty of Health Sciences[3] students volunteered to offer input and consult particularly around the design and coordination of these engagements.

1.2 MHWG Terms of Reference

To identify the gaps and make recommendations, where feasible, with regards to:

- University and Faculty-based mechanisms for **supported educational programmes and reasonable accommodation** for students with psychological distress and psychosocial disabilities
- **Access** to psychosocial and mental health services and care
- The organisational culture: **policies and practices** that may contribute to student distress
- **Building resilience, stress management and self-care** among students to prevent mental disabilities and to promote mental wellbeing as they pursue their studies and future careers

The working group conceded that mental health is experienced along a continuum encompassing the concepts of mental wellbeing, distress, stress, mental ill-health and psychosocial disability, as elaborated in the University of Cape Town (UCT) Student Mental Health Policy (2018).

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[1] Otherwise referred to as the *working group* or abbreviated to *MHWG*.

[2] The *Faculty* refers to the Faculty of Health Sciences of the University of Cape Town. Also abbreviated to *FHS*.

[3] Otherwise abbreviated as *FHS*

1.3 Background

FHS undergraduate students raised concerns about their mental health in 2016 and again in 2018. This, together with shifts within higher education in South Africa, particularly those related to health professionals and the training thereof, an international trend of increased mental illness and student distress[4] within tertiary institutions, prompted the formation of the MHWG.

The need to include the voices of students and invite their contribution to the way in which the MHWG generates findings and recommendations was foregrounded. A collaborative, co-constructed process began with a student-led panel, in which the students encapsulated the theme for the engagements as being a conversation about '*umgowo'*. This term is an amalgamation of the English word, 'go' with isiXhosa grammar, describing the experience of ongoing distress and yet having to get on with life. Students described this phenomena as a normative response to distress expected of FHS students.

1.3.1 Mental Health at Tertiary Educational Institutions

Common mental disorders, such as depression and anxiety, are high amongst students at universities (Auerbach*et al*, 2018), including in South Africa (Auerbach, 2018:630). Medical and health and rehabilitation students are prone to psychological distress, often in the form of depression, anxiety and burnout (Dryebye, Thomas & Shanafelt, 2005; Omigbodun, Odukogbe, Omigbodun, Yusuf, Bells & Olayemi, 2006).

Although research on medical students' distress is available (Dyrbye et al., 2005; Moir et al., 2018), little research has focused on students in the health and rehabilitation professions (Omigbodun et al., 2006; Tully, 2004). A narrative review on burnout experienced by medical students and interns, highlighted that factors within the work and learning environments were major contributors (Dyrbye, Thomas & Shanafelt, 2005; Dyrbye & Shanafelt, 2016). Furthermore, the extent of psychological distress experienced by medical students is similar to that of physicians, which is above the norms for the general population (Stallman, 2012). Given that medical students and health and rehabilitation student-professionals are exposed to the occupation of working, during practice rotations and practice learning in the health system, they may be exposed to similar stressors to health professionals working in the same health system. Factors reported as influencing student distress include personal factors (psycho-social and psychological); relational factors; the university system; the nature of the curriculum; as well as by witnessing the suffering of others (Dyrbye, Thomas & Shanafelt, 2005; Moir et al., 2018; Omigbodun et al., 2006; Tully, 2004). Similarly, causes of mental health disorders and psychological disabilities are also multifactorial (Patel et al., 2007; WHO, 2010). Studies have emphasised that personality factors and individual coping strategies play an integral role in building resilience to mental ill-health and psychological distress (Haight, Chibnall, Schindler & Slavin, 2012; Dyrbye, Thomas & Shanafelt, 2005).

[4] In this report, we refer to the term, student distress as being the psychosocial distress experienced by students of the Faculty of Health Sciences.

Intentionally adopting a critical and contextually situated approach is required in order to understand and reform practices, services and systems to become more health promoting (Walt & Gilson, 1994; Gilson, 2012; Walt, Shiffman, Schneider, Murray, Brugha & Gilson, 2008; Walt, Pavignani, Gilson & Buse, 1999).

Calls for change in the institutional culture of health professions' education have emphasised problems related to the learning environment, institutional and professional culture, identifying these as the appropriate target for intervention (Slavin, 2016). Many health sciences faculties have adopted the Learning Communities model as a response to this challenge, with the objective to build a more student-centred approach to support their engagement with the demanding curriculum; experiences of suffering and death; as well as mentorship (Osterberg, Hatem, Moynahan, Shochet, and Goldstein, 2016). Yet, in a systematic review, only a few of the hundreds of articles were empirically evaluated, and as such, the evidence for such interventions was limited (Wasson et al, 2016). Instead, recommendations emerging included 1) the value of implementing a pre-clinical pass/fail grading system to improve student wellbeing and reduce the competitive institutional culture, 2) accessible and effective mental health programmes that include the management of stigma and confidentiality, 3) the development of mindfulness-based stress-reduction training programmes, 4) the implementation of mentorship programmes using small groups and linked to the curriculum content facilitated by staff members who were not in assessment roles, 5) balancing clinical and non-clinical learning, and 6) linking these interventions to restructure the learning environment. The review suggested that these interventions were associated with improved student wellbeing, but further research was needed (Wasson et al, 2016). The Whole University Approach initiative within the United Kingdom, seeks to create enabling environments at tertiary levels, acknowledging that such spaces are prone to psychological distress. This initiative 'aspires to create a learning environment and organizational culture that enhances the health, wellbeing and sustainability of its community and enables people to achieve their full potential' (Dooris, Cawood, Doherty & Powell, 2010; Dooris & Doherty, 2016).

The contextually situated nature of psychological distress (Bantjies, Swartz & Cembi, 2017) expressed in South African students' narratives highlights why a human paradigm and an appreciation of social determinants contributing to wellbeing are needed. A human paradigm to mental health suggests that recovery from distress places value on context and meaning as being critical to understanding human distress (Grant, 2015). In so doing, a human paradigm facilitates a dialectical consideration of structural and psychosocial factors that may contribute to psychological distress. This means that approaches to understanding and addressing wellbeing and recovery should give attention to the way that the "*social, economic, and physical environments in which people live*" (WHO, 2014:8) influence their mental wellbeing (WHO, 2010; Silva et al. 2016; Fisher & Baum, 2010; WHO, 2014). A work and learning environment that supports and enables the potential of every individual member and student, cohesively promotes health and well-being (WHO Ottawa Charter, 1986; A Whole University Approach, 2016).

1.3.2 Mental Health and Wellbeing at the University of Cape Town

The FHS task team report (2016) identified that "*mental health issues relate both to the profession, our student body, but also to a curriculum*", with a range of psychosocial issues, including the institutional culture featuring as a contentious concern. A broad experience of alienation was raised by students, that suggested that they felt disconnected from the curriculum, the teaching staff, and at times each other. A strong theme of 'not being seen as an individual', not being able to 'express themselves as individuals', or connect as a person to the faculty community was frequently raised. Students challenged the idea that spaces were safe, suggesting alienation from the community and from the learning process. In 2018, Prof. Mayosi's suicide brought the urgency for a focus on mental health into sharp relief. Furthermore, the adoption of the University Student Mental Health Policy (2018) placed responsibility on each Faculty for implementation.

The shifting demographic profile of students at the university towards a community that is more representative of the country has led to a call for the culture of the university and its practices to resonate more strongly, with all its members (Cornell & Kessi, 2017). Eradicating material and symbolic exclusion (Kessi & Cornell, 2015:1) are suggested as central to building a more inclusive university culture.

2. Key findings

The following section presents a summary of the findings emerging from the generative faculty based discussions. Although the work of the Mental Health Working group focused on undergraduate students, many of the comments received, especially in the online submissions, drew attention to the need to address mental wellbeing of postgraduate students and staff. It may be that some of the issues raised in the findings may be similarly experienced by postgraduate students, but further work will be needed to address this specifically. The summary of the findings presented below is supported by quotes which were captured verbatim or transcripts from post-it notes which participants shared during the various engagements. Online qualitative written submissions as responses to open-ended questions were also captured and reflected in the findings.

Students who participated in the engagements reported on their collective awareness and experience of pervasive student distress, and in many instances, student mental ill-health. A key issue which students reported as impacting on their mental wellbeing was the existence of an institutional culture of learning and training which is individualistic, competitive and exclusionary. Students reported feeling pressure to acculturate their own familial and community ways of being with discordant normative professional knowledge, practices and ways of being within the FHS. They felt that these are pervasively reflected in dehumanising processes embedded in teaching, training, managerial and administrative practices in the faculty and and often times, in the relationships between peers, and other members within the faculty.

- ➔ ***"we must be empathic to our patients but we are not experiencing it ourselves, and between each other"***

Students felt that where these exclusionary processes have been acknowledged in the FHS, responses have not succeeded in centering students needs in service provision. To date the actions taken have been seen to be reactive "fixes" in response to instances where student-needs fall outside the norm, resulting in a sense of distancing and exclusion of the affected students.

- ➔ ***"Our first point of call is not the faculty as there is a lack of trust…the relationship has been broken"***

The recurring mode of crisis responses and approach of single-situation fixes left students and staff expressing distress and distrust in the fairness and reliability of systems and people working in the system.

- ➔ ***"I direct them to the services, but I ask myself would I access these services?***
- ➔ ***I've asked myself how I can ask people to go when I won't use it"***

This distress too was viewed as having become normalised as a part of being a student in the Faculty. Students expressed that more than individual or group based therapeutic or curative services was needed to remedy the situation. For those affected, factors within the faculty's overall institutional culture were seen by students with psychosocial disabilities as being unsupportive. Staff and students expressed that the message, even to new students entering the faculty, is one of you have arrived based on your excellent performance and that you should continue to perform this excellence. While this message may be well-intentioned, it was experienced as pressure to always be in control and being able to keep going and sort oneself out. To this end, students expressed that there was a *"culture of people not being open enough"* towards students seeking help. Feeling misinterpreted and misunderstood given the age gap between faculty and students was deemed as adding to the mistrust.

The main sub-themes which students reported as impacting on their mental wellbeing are elaborated in the next section. The sub-themes are:

2.1 Siloed ways of operating in the faculty
2.2 Space for being human in the Health Sciences
2.3 Single lens on blackness
2.4 Bullying effect of hierarchy
2.5 Tensions between staff and students
2.6 A need to re-orientate services

Selected quotes from the engagements are offered under each sub-section. For a more comprehensive list of related quotes, please see Appendix A under the same headings.

2.1 Siloed ways of operating within the Faculty

Drawing it out

- ➔ *they insist that we run like other faculties and this causes a major stress for students, because these offices – finance, accommodation, don't understand our timetable and it's been discussed over the past few years. Returning students say this is a real problem. Clinical years this is also a problem.*
- ➔ *Stand alone units within the university that are not strictly monitored by the university tend to labour lots of staff oppression, victimisation and discrimination by individual persons of (of or in?) authority*
- ➔ "not sure who to go to - whose role is what"
- ➔ Unity and the demonstration of team work especially within the mental health task team. For example, granting counsellors permanent employment contracts and effectively inducting and integrating them within the faculty structures.

The institutional culture was identified as contributing to psychological distress for students and staff with a key contributor to this being the silo-ed approach that operated across university administrative and teaching spaces. For example, curricula demands that were not supported with access to transport; the financial aid office being difficult to access because of timetable commitments and stressful choice-making when much needed mental health appointments conflict with core practice learning or clinical training obligations. This was perceived as poor integration of systems and left students feeling unsupported; thwarting efforts towards creating a system and culture that supports the learning, productivity and development of both staff and students. The logistics of navigating through administrative procedures and protocols that clash with timing and needs of the curricula were highlighted as needing to be addressed as structurally violent systems.

- ➔ *Appointments for mental health care may clash with class/academic assessment requirements*

It was noted that factors contributing to these clashes could be due to communication between departments and across levels of the university; as well as a lack of insight into the complexities of promoting and maintaining mental health and an inclusive culture. It was therefore suggested that sensitization and orientation is facilitated for all staff and students at each level, so that they can consider the need to promote mental health through each procedure, in an integrated and complementary fashion.

Moreover, offering reasonable accommodations to learning was noted as being effective only if the systems are complementary, harmonious and widespread, otherwise addressing the root of the problem would not be possible.

- ➔ *"the deferment procedure works for a person who knows how to use the system".*
- ➔ *"The fit for study panel reviews you...people… feel it is not facilitating them to be back, rather to keep them out…on paper it seems helpful but people's experience is it is not achieving the desired effect"*

Students noted that the systems put in place to ask for support were not sufficiently user-friendly or available at times that are conducive to the faculty's timetables. Students described that they needed to navigate between different offices to access support and that this caused stress as the availability of these services did not fit with the constraints of the timetable. For example, there was poor integration of systems for addressing student health and often times, students found that these protocols contradicted one another.

- ➔ *"The mission of a getting short leave of absence in itself contributes to my mental illness"*

Students noted that they were unsure which to prioritise: the curriculum or their health. Coupled by the fear that cancelled appointments may take time to reschedule and that missed academics might mean individual or group results are lowered. Moreover, DP requirements for arranging deferments may be too short and convoluted for students struggling with mental health issues. Students felt that provision was made regarding DP for other emergencies, *'but not for mental health crises '*

- ➔ *"Leave of absence is just put there for policy/ formality"*

On the other hand, staff noted that the faculty does not make it apparent to students who is responsible for what procedures and how the system works. As a result, students often opt to find support elsewhere and at their own expense. Alternatively, the stress of navigating such a complex system may be too burdensome for students already coping with the impact on mental health problems on their (inter)personal resources, resulting in the student delaying or not entering the system, compounding the impact on their ability to work and study.

- ➔ Another thing is that it always seems like there is a rush for something to be done i.e. there is so much work crammed in so little time that other parts of our lives are put on a standstill just to keep up with the workload.

In referring once again to a system that has bullying as an inherent characteristic, students reported an incongruence between the stress inducing, bullying style of some supervisors/lecturers and the content of teaching that focuses on their being empathic and emotionally attuned to their patients.

2.2 Space for being human in Health Sciences

Drawing it out

- The faculty breeds an environment whereby you are constantly being undermined; and you are forever doubting yourself - it breaks you down
- Difficult to express differing position. Call out culture and the manipulation of the concept of "Safe spaces".
- Disconnect between roles
- Some experiences are not recognized by the biomedical sciences
- Culture is punitive (i.e. bullying) and alien
- *UCT Kills that spirit of humanity*
- *Lack of support for being a human being in the world*
- *Students are far from home, no parents, friends and siblings*
- *Lack of coping skills to deal with difficulties and adversity*
- Personal issues that you don't have room to deal with:
  - Firstly, time
  - Secondly, resources
  - Often you come here and you didn't realize you have the problems you have
- Student not accustomed to failure; don't know how to ask for help
- No emotional support in dealing with cases familiar to you
- "you don't know how to put yourself out there and where to get support"

Students and staff expressed that being unwell and stressed was experienced as normalised within the faculty. The perception amongst students was that this

heightened stress was 'expected', with students often comparing the extent of "*uMgowo*" experienced. The FHS students defined "uMgowo" as going through the most, or a way of indirectly indicating that "*you are experiencing something heavy*".

Both staff and students reported a need for nurturing mental wellbeing to be mainstreamed into their learning and training experience, rather than only offering services and support for students' experiencing psychological distress or mental disorders. The factors contributing to these needs varied and are presented below.

Students reported that the emphasis on excellence, narrowly interpreted as academic excellence as concerning. They felt compelled to psychologically endure beyond their maximum threshold and to push themselves without adequately considering what is enough or too much for a person.

- ➔ *"If you say you are not coping, the question becomes, "then what are you doing here"?"*

This may be because very limited consideration is given for the contextual and situational aspects of students' lives. It also contributed to students' hesitance to seek support. This is particularly important given that many of the students were young adults and that this transition required nurturing. Little consideration is given to the fact that students are young people, adjusting to a new environment, often far from home, family and community support, or if from Cape Town, possibly light years away from familiar cultural supports and Ways of Being in the World.

They recognised that, while attention was given to being or becoming professionals, the opportunity to a build oneself as a person who could practice self compassion, was lacking. Students emphasized the need for recognising that the development of a health professional needs a holistic person-centred approach which goes beyond amassing large amounts of clinical knowledge

- ➔ *Only academic learning is prioritized , other forms neglected.*

Reflecting on possible solutions, students shared examples such as:

- ➔ a support structure regarding the impact of the realities of becoming a health professional , for e.g. illness, disability, and death needed to be taught
- ➔ a safe structure for a network of support is needed;
- ➔ skills to identify warning signs of not coping easily, so you can seek help
- ➔ more exposure and normalising of the stresses of becoming a health professional: open days regarding *psychosocial distress*, talks (with people who have had experiences, rather than as an intellectual exercise by lecturers).

2.3 Single lens on blackness

Drawing it out

- ➔ Have conversations about Racial Divide, Mental Health - no one is willing to initiate conversation. Allow on-going discussion. Build & unite student populous
- ➔ Some students feel as the problem example: making examples about blackness
- ➔ Deferral process is unkind to student
- ➔ Exclusionary culture in FHS - socio-economic; race; discipline

While identity formation may be acknowledged to be part of all students' current developmental stage, the faculty context was seen to place additional demands on black students. One of the ways in which this demand occurred was in the assumptions made and the acceptance of stereotypes related to race and class identities. Black students expressed feeling judged at times by staff and students when they seemed to be part of higher socio-economic groups (students referred to this as coming from '*monied'* backgrounds). This too led to students to feel alienated since they felt :

- ➔ '*not black enough'*

  and,

- ➔ Racial divide - lecturers speak of Black vs white, what about other races? Ignorance? Not knowledgeable? Ignorance?

Students explained this as a problem that arose when 'blackness' was reduced to the experience of current or previous financial limitations. A student summarised this as:

- ➔ Exclusionary culture in FHS - socio-economic; race; discipline

The following quotes and notes submitted on post-its capture these experiences.

- ➔ "Not seeing students as individuals and seeing their issues as unique. Treating them all the same."
- ➔ "Lived experiences of students are dismissed"

Students identified being affected by the assumptions made by and lack of understanding of staff members and fellow students about their backgrounds.

- ➔ *"Not understanding other people's background"*

This led students to feel alienated and that the challenges that they faced were misunderstood.

- ➔ "*Not being able to fit in because of how other people perceive struggle*"

Black students noted that they invested their energies into trying to fit into the faculty's institutional culture, but that this left them questioning themselves as personally.

➔ *"Identity crisis when we come to FHS, because we have to assimilate into this exclusionary culture"*

Some policies applied in residences were offered as an example of the difficulties that students faced when they took care of themselves in ways that resonated with their identities.

➔ People practice self-healing, *imphepho.* [Some self healing implementation] is prohibited

and,

➔ Some experiences are not recognized by the biomedical sciences

In response students tried to improve their situations by explaining their diverse experiences and situations with various actions. Student protest was identified as one of the ways students resorted to demonstrating their needs.

➔ *Always have to perform your trauma e.g. protest*

Students experienced having to perform their needs as burdensome, especially in relation to assessment and deferred examination processes.

➔ Process of admin is in itself triggering - filling in forms; find a health practitioner; have to justify that you are not well

Added to this, many service providers in the faculty drew attention to the hyper-criticism of some staff members towards students.

Students expressed appreciation for the MHWG engagement spaces, noting that there were few opportunities to dialogue about tensions that they navigated within teaching spaces. Students identified that the way of facilitating Equity and Diversity groups in the BSc Occupational Therapy programme was seen as a space that could be of value in promoting open dialogue. Students felt that their needs extended beyond what the accessible psychological and medical support services offered. They alluded to the need for structural and institutional level change.

➔ Holistic view: Institution should consider mental well being as an integral part of their business. They shall see this in entirety - system: made up of parts (staff, students, academic comm, external stakeholders) - deal with well-being

And,

➔ Destigmatize mental health: honesty about how UCT/FHS contributes to MI of students.

2.4 Bullying effect of hierarchy

Drawing it out

- ➔ "Type A personalities and always being in control- people perform "okayness"- so even when you're drowning academically, you won't say anything cause everyone seems okay"
- ➔ Face of excellence is exclusionary
- ➔ "The faculty breeds an environment whereby you are constantly being undermined and you are forever doubting yourself - it breaks you down"
- ➔ This becomes worse if you are non-white. Always a feeling that you were brought on to balance the books w.r.t. the number of black candidates on board.
- ➔ "No room allowed for mistakes"
- ➔ Being exhausted is seen as a job well done.
- ➔ A culture of needing and almost striving to be invulnerable could exacerbate mental illness. There is little allowance for being "not okay" and mentally/emotionally "broken". Caregivers (in particular health care professionals) are expected to give and help others, but not need (or ask for) help themselves. Of course, we know that no human being is invincible, and that care for the caregivers is crucial to maintaining standards of care for patients/clients. Despite lots of awareness and education around mental health in the past few years, there is still stigma associated with mental illness (e.g., feelings of failure and weakness), which are supposedly incompatible with the idea of a successful, competent health professional. I would imagine that the competitive culture in some health science programmes might also bring about those fears of failing and being weak.

Resonating with the HSSC 2018 Hierarchy report, students and staff commented on the hierarchical structures and practices that are reinforced within the faculty and professions. The tiered system of authority, respect and personal value based on authoritative biomedical knowledge systems was experienced by many as dehumanising and dismissive of those not centred by the system. Themes that were raised within several engagements included:

- ➔ *Hierarchical based bullying from more senior to more junior clinicians, interns and students*
- ➔ *Registrars modelling the consultants bullying behaviour with their supervisees*
- ➔ *Hierarchy between disciplines (doctors, consultants, registrars, interns, etc) [hierarchy is being taught and nurtured within the curriculum and work spaces such as ward rounds and clinical placements]*

- ➔ *Across the multidisciplinary team with different professions and disciplines*

Furthermore, the epistemological dominance of a strongly Western, biomedical, patriarchal, and heteronormative approach occurred within the faculty, leaving those with differing perspectives to be seen as disruptive. Students even expressed feeling that they are seen as a threat to the institutional system. This occurred, for example, in the way that staff and students expressed experiences of *"microaggressions"* against them**,** related to not meeting the expectations of what constitutes excellence, and what embodies excellence. These experiences were held in this collection of comments during the engagements:

- ➔ A-type personalities of culture of excellence
- ➔ "The overzealousness in the celebration of "excellence" is exclusionary and demeaning - the dean's tea/list"
- ➔ Lack of respect for staff and students and hierarchies of knowledge - some students/ courses/ disciplines / ways of knowing/ ways of researching are held in greater esteem than others and their is often epistemic aggression rather than epistemic generosity or even curiosity.
- ➔ Excessive competitiveness and continual rewarding of 'excellence' and outstanding achievement of individuals rather than a collaborative approach to health care and supporting of improvements in education - so we award only 'the best' rather than acknowledging that all students are learning and growing and that everyone has strengths and weaknesses. The constant competition puts pressure on everyone as it does not allow for a recognition of various, differing achievements or of the realities of contexts that shape 'performance'.
- ➔ Hierarchy within health sciences
    - ◆ Treated like children
    - ◆ Cycle of hierarchy
    - ◆ Not seen as people
- ➔ Treating patients badly

This categorisation continued as students distinguished between their level/year of qualifications and the imbalanced prestige attributed to various professions (For example occupational therapy as under-valued compared to MbChB) to levels of qualifications within professions. This hierarchy became evident to students as they entered into the university from secondary school, with being deemed as the "*cream of the crop"* upon selection into the HSF.

- ➔ Incongruence between the culture of being the "*Cream of the crop***"** and lived experiences of not coping **("***we are drowning but the culture is you must keep going*")
- ➔ *Struggling academically or not coping with the workload is seen as a sign of weakness. So people will tend not to vocally say when they cannot cope. Very competitive environment. All trying to outshine each other as the one who shines the most catches the eye of the HoD and principal investigators within the department.*
- ➔ Safe spaces are contradictory and in effect are not created.

- ➔ A focus on results and information over knowledge and education.
- ➔ *Course is chowing me right now"*
- ➔ *"I imagined it would be different"*
- ➔ Being exhausted is seen as a job well done
- ➔ *Dissonance : I'm not OK and that's ok*
- ➔ *Burnout within students, making it ok, normalising (Destress, depression.)*

Moreover, students expressed a fear of not knowing what will be done with information or fallibility shared to faculty members. This thwarted efforts to reach out and ask for help. Students expressed that staff can be punitive in their teaching approach, further straining their mental health. The stress of potential financial exclusion and marginalisation was another embedded social hierarchy, that students experienced as intolerance to the diversity that they brought to the faculty. The fear that additional costs may spring up during the year concerned students.

2.5 Tensions between staff and with students

Drawing it out

- ➔ *A culture where people often feel abused/ A culture where there is always a struggle for dominance and power/ A lack of communication and specifically a lack of people listening/ A focus on work and service delivery which is sometimes unrealistic*
- ➔ *Better leadership/ A place where abusive culture could be noted and reported/ A systematic response to these issues*
- ➔ *sometimes students are debriefed by the supervisor who "is the cause of the anxiety"*
- ➔ *"our first point of call is not the faculty as there is a lack of trust…the relationship has been broken"*
- ➔ *"No positive acknowledgement when we do well in classes. Only focus on when things are going bad. No motivation from lecturers*
- ➔ Barriers I think I would definitely count the culture that is ''not coping is weakness" in our fields of study whether from peers or from people who represent faculty is a barrier.
- ➔ *Service delivery that takes preference/we are focused on patient well-being more than staff wellbeing*

➔ *Style of teaching especially in pre-clinical years, it is not practical at all and it is not designed in a way that it can pick up struggling students or students who prefer other styles of teaching and learning. The style is too rigid and it is only suitable for a few.*

Staff members, in the survey and during engagements, identified their concerns about the quality of their relationships with each other.

- ➔ *"Staff relationships are not grounded on mutual trust or support, instead staff members speak about each other in front of students in an unsupportive manner"*
- ➔ *We don't model ways of being professional in the way we interact with each other*

A competitive culture where staff members were undermining of each other at times perturbed students and colleagues, but was not directly addressed. The expectation surfacing was that students and staff should cope or deal with what was there.

- ➔ "Interrogate culture around health of health professional" It's ok not to be ok.
- ➔ *"we are not a healthy community and we (staff) pass this on"*
- ➔ Own human and personal needs must be put aside in interest of hippocratic oath

These demands included the large class sizes, requiring to mentor and support, at times, hundreds of students is unrealistic, despite the willingness of some to contribute. The approach to prioritise the excessive workload and multiple demands with little consideration for human and emotional needs was viewed as a barrier to promoting wellbeing. Staff members noted that the:

- ➔ *System is inflexible, unreasonable expectations for workload, multilayers of teaching, teaching content, not emotional intelligence*

Students were reported to experience this aspect of the Faculty system similarly when their fears were sometimes confirmed when accessing support from staff members.

- ➔ *Student is asked to go somewhere, and then the person is abrupt, and the student won't bother again. Where are they supposed to go. On the first email contact the person is often abrupt or rude, and the student is left feeling bad. I was already fearful, and I was right – anyone would respond in this way.*

Lecturers questioned the boundaries of relating to students:

- ➔ *Boundaries: sometimes we are too distant, sometimes perhaps too close?*

Lecturers, on the other hand, also expressed feeling "*helpless*" and unable to "*pick up on the mental health needs of the student".*

Students acknowledged the burden on faculty members, especially for registrars, noting how such strain could blur their ability to consider the stress of undergraduates.

- ➔ *"Registrars are central in teaching but often so stressed themselves they do not recognise the undergrad stress"*

The contradictions and demands experienced left students with a dissonance between the values of the faculty and its alienating and dehumanising practices.

- ➔ *"Students feel unwelcome on the platform"*
- ➔ *"clinical block rotations feeding into anxiety and depression"*

Along with not seeing significant transformation to date, students and staff reported a mistrust that had bred within and towards the faculty as an institution and culture.

- ➔ *in particular the lack of understanding of (or indeed any interest in) emotional empathy which is the ability to feel the emotional consequences in others of what you are doing to them. I've been in the Faculty since 1969 and my impression is that those who do show emotional empathy are unlikely to make it to the top. There is just been too much toxic narcissism in leadership over the past 4 decades.*

Some staff members interpreted the mental health concerns differently:

- ➔ *To a great extent a reality check for many students and staff, and realizing that identity politics and scapegoating is not going to make this university or the medical profession a better place*

Staff noted their experiences with students who continue to challenge the system, which the staff represent

- ➔ *Students are not disciplined, very automated, you don't submit…*

- ➔ Students don't understand the relationship between faculty and support structures

Suggestions offered included:

- ➔ *"Get people who focus on humanising, not lecturer but lecturer have to put their content to use."*
- ➔ *Training in soft-skills - something only humans can do, not robots*

- ➔ *The current focus on content can be reduced to make space in the curriculum to teach students to look after themselves. Lecturers/trainers should have the necessary expertise to teach these skills.*

- ➔ *Class reps may not be the best persons to support students experiencing severe mental health problems: greater thought needed to explicate who will be the supporters on the academic side of the students reaching out for support*

    - Sensitisation of senior Dr's to prevent bullying at clinical sites
    - unpacking culture in every discipline, to pressurise change
    - Projects and Workshops on how to speak to one another, especially lecturers to students, especially those suffering with mental illnesses. How to develop empathy and understanding.

2.6 A need to re-orientate services

Drawing it out

- *Mental health days, mandatory mental health workshops for staff and students, culture of acceptance that mental illness is a serious psycho-affective disorder that can be dealt with and managed just like any other illness. There's a stigma of not talking about it. We need to talk about it openly and start the conversations, in the same way that the #MeToo movement opened up the discourse about female abuse.*
- I would have handled UCT better if I had been taught by AI, at least then i wouldn't expect a human connection [paraphrased based on a reflection student shared in the discussion]
- *Improvements needed on supporting students to get help earlier*
- Students are well defended. They see others as needing help but not themselves. Students are competitive. Staff seldom show their own vulnerability - don't discuss their own failures or mistakes.
- Lack of interest and concern extended faculty in really attending to students' needs
- I feel as if there is no consideration for one's mental health and capacity when exam schedules are being considered and planned. There were 5 exams on one week for the first year physiotherapy students in the November exams and this is not constructive for the mental wellbeing nor the academic performance of the students.
- There is support for students via the student wellness center - there would be benefit to provide a similar support for staff via a staff wellness center. May be an idea to provide relaxation non-expensive relaxation related classes - e.g. yoga, mindfulness/light meditation, pilates, or the likes - in the early am - lunch - and pm (early and end of day - then people are not stuck in traffic but can attend a class and improve time efficiency)

Students and staff indicated that there are gaps in the support system for students whose mental health issues are not responsive to the current protocol of support and basic counseling.

- ➔ *I would recommend firstly, more after hour services to be made available so that there doesn't have to be any catch-up time. In addition, it is about changing the culture of our faculty, which is a difficult thing to do. I think it could start by staff members all being on the same page about what mental illness is and what it looks like. To understand that laziness/slacking/disinterest is what may be seen but is not the complete truth. Whether this be in the form of training or reflective spaces between staff members who have experience in the mental health field to share, is flexible.*

- ➔ *Culture needs to be addressed – this includes the "microaggressions" as well as "culture of excellence". There needs to be an awareness of the emotional experience of the programme and how the programme "triggers" mental health issues.*

- ➔ *"We need lecturers who are aware and that remind us"*

In directly addressing mental health within the faculty, staff and students noted that most of the services are curative and react to students who experience mental ill-health. In addition, the poor take up of services may occur since students feel that the causes for mental illness are inadequately addressed through these current systems.

- ➔ *Rigidity of the system. Although we may try to employ more psychologists or people who are able to 'help' us, not much can be done if we don't change the system within this faculty. It seems that there is a certain way things are done and not much chances are given to changing things.*

- ➔ *"students don't have a framework to know when they are or are not coping" ….."we don't know our triggers"*

It was identified that the system currently puts the onus on the individual to assimilate into the the system, and take the necessary prescription required to do so. Students expressed confusion with the processes of accessing support or leave of absence.

- ➔ *There should be better communication of what this process involves as students go through it with little understanding of the whole process, which is very distressing.*

Additionally, students were concerned about their confidentiality when it came to opening up regarding mental health vulnerabilities or distress.It also appeared that supported education was not adequately offered, beyond allowing extra time during exams. Disability was compartmentalised with accomodations individually based, rather than integrated into mainstream curricula. This potentially marginalises persons with disabilities, both those experiencing physical impairments and mental illness. It was noted that for comprehensive support to be effective, it needs to be integrated through every practice, protocol and procedure, and not reserved as a tag-on, limited to its own policy that is in effect pushed aside.

It was indicated that there is a need for group-based, informal mental health support structures within curricula time for students on campus. Along these lines, it was expressed that if individual debriefing is required, this should be done by a third party and not the student's supervisor. Also, beyond students who have a crisis or acute

symptoms of mental illness, students who experience ongoing distress need to have opportunities within the curriculum to be adequately supported. Some students indicated that certain content within the curricula was inefficiently taught and more time could be afforded to the emotional and lifeskills required within the profession. The curricula were identified as needing to allow students to explore and express individual and diverse opinions and develop spaces that nurture one's critical thinking and expression, rather than only being fact-base with a technical approach to knowledge.

It was suggested that curricula include courses which acknowledge the humanity of students who are becoming health professionals, and teaches students coping skills to manage the stresses of becoming a health professional and the "realities of the degree", including scope of practice, post training. However at the same time, allowing the processes to see and facilitate that change to come about.

Collaborative university partnerships were suggested, seeing that collaboration can break down hierarchy and allow for support, and the nurturing of creativity and wellbeing.

- ➔ *MH Awareness for students on the signs and symptoms of normal stress becoming unhealthy stress or depression*
- ➔ *A dedicated portal for MH support as students are flooded with information and the MH info gets lost in all the emails*
- ➔ *More obvious and more reminders of where to get help. There are reminders at exam times, but there should be a focus on avoiding crises by supportive messages throughout the year, not just at exam times*
- ➔ *Class reps need orientation to what supports are available*

3. Recommendations:

In order to address and promote mental health adequately, resource allocation should extend beyond services offering mainly crisis intervention and counselling services. The environment within the faculty needs to change and this requires adequate **resource allocation** for: changes in the culture of individualised excellence; support for curriculum change; formal research; development of a co-ordinated supported education programme.

The dean's executive and deans management committee should, within 2019, deliberate and advise on how this could be accommodated within current faculty strategic and financial plans. Furthermore, all FHS committees should articulate how they will contribute to implementing necessary changes.

While the curriculum was not a focus for this workgroup, the student and staff feedback identified aspects that should be considered during curriculum change processes in the faculty, these are integrated into the sections below.

3.1 **The organisational culture:**

Address alienation and exhaustion by consciously moving from the paradigm and discourse of emphasising "excellence" as individualistic and competitive to a paradigm and focus on "people", their wellbeing, full participation and diverse contributions as central to excellence.

- ➔ Curriculum change at departmental and faculty levels should create opportunities for staff and students to dialogue about matters that affect the class and faculty
- ➔ Actively value different knowledges, professions, disciplines, and experiences
- ➔ Build an emphasis of valuing the people of the faculty, in all communications
- ➔ Have zero tolerance of hyper-criticism toward students with psychological distress
- ➔ Re-orientate engagements with staff and students to a concern about people and wellbeing, with realistic expectations and demands on staff and students
- ➔ Expect and demand attitudes of respect in all personal engagements among faculty members, staff and students
- ➔ Emphasise wellbeing, a person-centred approach, and self compassion as crucial to professionally providing health services within the curriculum. Students request talks from role models, rather than only formal teaching
- ➔ Value and build the student community by either moving the academics and teaching from the Old Main Building to the Anzio Road campus, or create a cafeteria for students based within the Groote Schuur clinical setting and Old Main Building teaching space
- ➔ Value and support student expression, creativity, and wellbeing
- ➔ Ensure that there is a staff member tasked with tracking and supporting student relationships and wellbeing within each class. This task should be part of undergraduate

- ➔ Attention should be given to the ways in which hierarchy between disciplines and professions affects administrative processes and resource allocation in the faculty.
- ➔ University curriculum change processes should be supported so that, through decolonising processes, curricula could be more inclusive.

3.2 Supported educational programmes and reasonable accommodation for students with psychological distress and psychosocial disabilities

a) Identify and develop recovery based approaches for supported education to students with psychosocial disabilities.

b) The specific challenges inherent in health science education must be included and where the university is unable to adapt, the faculty needs to advocate for change and actively bridge the gaps. These challenges include the timetabling of educational activities from 8am to 5pm frequently on a dispersed health platform that are far from the campus, with rigid transport arrangements.

c) Co-ordinated, student-centered administrative systems that are able to efficiently communicate information

d) All additional costs must be communicated at the beginning of each year, including the costs of uniforms, equipment, dissection kits etc.

e) A coordinated system of communication between external service providers and academic departments should be developed. This could include an access liaison role of a mental health advisor appointed for each student with a psychosocial disability. This could be situated in the student advocacy and liaison office.

3.3 Universal access to psychosocial and mental health services and care

Ensure universal access to all student services within the faculty, and actively bridge gaps where the central university systems are unable to provide universal accessibility. Universal design principles require that the administrative and support structures must be clearly communicated in accessible diagrams or resource books, including an outline of roles and responsibilities, office hours, locations, and lines of accountability within structures.

a) It is crucial for the faculty (and the university) to acknowledge that the student

community has moved from an arguably largely homogeneous community, to that of heterogeneous communities. The design of every student service, including those of teaching, accommodation, transport, finance, information technology, health and mental health support, curriculum and assessment administration, must be designed to meet all challenges of accessibility. This includes differences in courses, campus locations, teaching schedules, resources, health, functional ability, and knowledge generation systems.

There should be a harmonisation of the administration systems, and where necessary, distance and after hours access must be facilitated. Services need to be student-centred rather than administration-centred.

b) The roles, responsibilities, and boundaries between the student development and wellbeing staff, the teaching staff, and administrative staff must be understood, maintained, and respected by all. The roles and responsibilities needs to circulated between the three groups, with sensitization and orientation around the role of each in supporting student mental health and wellbeing. Confidentiality must be maintained within and between these systems.

c) Access to Leave of Absence, Fit to Return and Duly Performed requirements must be designed to facilitate fair and universal access and this must be ensured by clear communication and transparent feedback. The criteria for access to LoA, Fit to Return, and DP needs to acknowledge the heterogeneous needs of the student communities, where the students are experiencing multiple demands and pressures from their peer, family, community and society. Current fit to study and LoA processes require review as many students have expressed feeling traumatised by these processes. This review should evaluate the staff members tasked to make these decisions' appreciation of the students' experiences and the same staff members playing multiple roles within processes.

d) Continuous support should be integrated into curricula - such as post-block reflection sessions and group reflection sessions. This requires a re-orientation to teaching and learning within some curricula.

3.4 Building resilience, stress management and self-care

a) Students felt that there should be greater emphasis on holistic, contextual development of students as future health workers. The current focus on students rapidly mastering a large body of modularised clinical knowledge and practice within a standard framework of "excellence" is experienced as extremely stressful. Approaches which go beyond students regurgitating facts in modular blocks is needed to prepare these students to transition from student to confident and capable health professional.

b) ***Bringing new technologies for study and practice:*** Students noted that health sciences knowledge is ever evolving, and increasingly difficult for the

human mind to absorb at the modern rate of production of new knowledge. This leaves both students and lecturers exhausted by the need to constantly be on a knowledge treadmill. Students want to be skilled in how to access and utilise clinical knowledge to enhance their practice, beyond having to retain an ever-increasing load of textbook assessable knowledge. In the age of the 4th industrial revolution, the development and adaptation of local teaching methodologies, technologies and practice skills which young healthcare professional can use during training and practice may bridge the gap between knowledge generation, translation and practice.

c) ***Debunking the Cream of the Crop ideology***: The myth -and expectation- that-(student) health professionals should somehow be infallible, experts in their field is a barrier to students addressing personal and professional challenges openly with teachers, trainers and mentors. Students reported seldom encountering teachers and mentors willing themselves to role-model and share the difficulties they have encountered as practicing health professionals. Student expressed a need to engage around uncertainties embedded in health care practices without fear of this been seen as an indicator of their unsuitability for the health profession. They also identified a need to have trainers share their own struggles–and solutions- as health professionals as part of mentoring future professionals they train.

d) ***Personhood in Professionalism***: Students recommended that training should forefront the importance of personal development as part of professional development. Developing and expressing personal identity is a part of this personal development. Currently there is little room for questioning, or invitation to explore what is taught from students' novel perspectives to provide them with opportunity to build a Professional Self which is congruent with their Personal Self. It was suggested that teaching and training be designed to encourage to students to bring their diverse life experiences to their training as they move from student to health professional.

e) **Self care, stress management and coping skills:** Related to the previous recommendations, students suggested that courses be included in the curriculum or time should be allowed for students to learn the essential skills needed to cope with the stresses of training and working as health professionals. Where this is covered in the curriculum, the focus is primarily on didactic teaching on how to support patients recovery, while there is a lack of focus on stress management, health professional wellness and resilience building in the curriculum

f) Time for self care and nurturing the self should be considered in curriculum design

3.5 Advocacy and action: Pervasive mental health implications

The dissonance between working towards a qualification at the expense of one's own health, may catch up and confront individuals in time. This is evident in the expressions offered through these engagements.

a) Create student informed and student centred approach to services

b) The Faculty and Departments should undertake an advocacy and action project which builds resilience of nascent health professionals through promoting and protecting their mental health. This requires an organisational attitude and culture, with policies and practices, to be infused with this positive regard for individual and collective mental well-being.

c) Address the siloed approach to services at UCT. The onus cannot be put on a few individuals, but requires pervasive sensitisation, acknowledgement and integration in action at every level and across disciplines and departments. Integral to this should be an organisational attitude that reflects inclusion of persons with psychosocial disability.

3.6 Governance

a) The faculty should engage the university on creating a university mental health team for co-ordinated mental health support

b) Management accountability at faculty level should include co-ordination of systems and programmes to promote student wellbeing. While this should be included in the KPAs of all those in management positions in the faculty, it should be delegated to a particular deputy dean within the faculty.

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5. Appendices

Appendix A: Comprehensive lists of quotes related to each sub-section.

A.1 Siloed ways of operating within the Faculty

	➔ Rigidity of the system. Although we may try to employ more psychologists or people who are able to 'help' us, not much can be done if we don't change the system within this faculty. It seems that there is a certain way things are done and not much chances are given to changing things. More and more students have said that they started seeing psychologists because of their degree - which is expensive. Not a lot of people can afford good psychologists who will spend enough time with you to sort out your issues. ➔ *Poor infrastructures within the university - which detracts from primary work, research and teaching.* ➔ "Pathological individuality, because it isn't appropriate" ◆ Self expression is pathological eg. in upper students can wear what they want but not at FHS ◆ No space on Health Sciences to express ourselves ◆ "Not seeing students as individuals and seeing their issues as unique. Treating them all the same." ➔ "Pathological individuality, because it isn't appropriate" ➔ No compulsory activities to interact - inhibits creating own culture, no interaction between different years and disciplines ◆ "No one goes the extra mile to ensure the class dynamic is smooth and that students fit in and are not isolated with in the class" ◆ "Going to upper campus, not only med school" [*Why is it that students want to be integrated more with upper campus? What does that say about the culture of upper campus in comparison to FHS?]* ◆ "No interaction between the students from different years from our discipline and others" ➔ Enormous workloads, and very high expectations of students. Students simply do not have time or energy to prioritize mental health and well-being. ➔ UCT is known for having the longest holidays - which is seen in this faculty. Although it is nice to have a long holiday, we would appreciate if more time was given to teaching and preparing us for tests/exams than having a longer holiday.

A.2 Space for being human in Health Sciences

- ➔ Fellow students often being very defensive and offensive about unnecessary issues, often blaming mental health for many other shortcomings. Mental health should not be a scapegoat for pressing issues.
- ➔ Self expression is pathological eg. in upper students can wear what they want but not at FHS
- ➔ No space on Health Sciences to express ourselves
- ➔ "Not seeing students as individuals and seeing their issues as unique. Treating them all the same."
- ➔ "Lived experiences of students are dismissed"
- ➔ *Historical extravert depressed*
- ➔ "no one goes the extra mile to ensure the class dynamics is smooth and that students fit in and are not isolated within the class"
- ➔ *Students are not seen holistically, but are asked to see patients holistically*
- ➔ *UCT is experienced by some as "exclusionary" with a strong "Eurocentric" bias resulting in those who are "non-male and non-white" to have a "very different experience": "you are not really welcome here" "the thing you are assimilating to…is not designed to see you grow as people"*
- ➔ *"Excellence has a fixed picture, you must have a certain face"…."we all excelled at school, but are not accepted as such" (when entering UCT)*
- ➔ *"Lack of understanding of culture"*
- ➔ *" you are living outside of your means"*
- ➔ *Find it stressful to be in the class.*
- ➔ "you have to find your own community"
  - ◆ Lack of support for "being a human being in the world"
  - ◆ Students are far from home, no parents, friends and siblings
  - ◆ Feel isolated
  - ◆ culture is punitive (i.e. bullying) and alien
  - ◆ used to living in family group and find living alone very difficult
- ➔ lack of knowledge of how to enter this new community and find support within it
  - "you don't know how to put yourself out there and where to get support"
  - "having to look quite hard to find support"
- ➔ "Identity crisis when we come to FHS, because we have to assimilate into this exclusionary culture"
- ➔ *UCT Kills that spirit of humanity*
- ➔ *No empathy towards each other as health professionals in training*
- ➔ *Lack of support for being a human being in the world*
- ➔ *Students are far from home, no parents, friends and siblings*
- ➔ *Lack of coping skills to deal with difficulties and adversity*

	➔ *How do you cultivate empathy? How can lecturers be mentors? Students need mentors*. ➔ *Pressure on students to perform and no time for a balanced life.* ➔ I would have handled UCT better if I had been taught by AI, at least then i wouldn't expect a human connection [paraphrased based on a reflection student shared in the discussion] ➔ Break the stereotypical and stigma drilled into first years ➔ Focus should be on technical. Not theory ➔ The current focus on content can be reduced to make space in the curriculum to teach students to look after themselves. Lecturers/trainers should have the necessary expertise to teach these skills. ➔ No compulsory activities to interact - inhibits creating own culture, no interaction between different years and disciplines ◆ "No one goes the extra mile to ensure the class dynamic is smooth and that students fit in and are not isolated with in the class" ◆ **"**Going to upper campus, not only med school" [*Why is it that students want to be integrated more with upper campus? What does that say about the culture of upper campus in comparison to FHS?]* ◆ "No interaction between the students from different years from our discipline and others"

A.3 Single lens on blackness

	➔ Not black enough ➔ "Not being able to fit in because of how other people perceive struggle. Not understanding other people's background" ➔ "The faculty and UCT lacks knowledge and empathy of black students who do not come from monied backgrounds or families" ➔ isiXhosa prioritised as being the UCT 'black language' with little recognition for the diversity of South African languages. ➔ In the faculty there are stereotypical ideas of who a black student is and what signifies this blackness, which is alien to students' personal experience to being black. for example, having a rural impoverished background may result in some students being perceived as more black. "Black hurts black" ➔ "Acknowledge individual identities ➔ racialized identity - whiteness, blackness; patriarchy, heteronormative, religious normativity and other signifiers of hierarchy ➔ Culture is not accommodated at UCT. it caters for white, male, heterosexual, non-religious. "The student" is seen in one way (homogenisation).

A.4 Bullying effect of hierarchy

- ➔ Excessive competitiveness and continual rewarding of 'excellence' and outstanding achievement of individuals rather than a collaborative approach to health care and supporting of improvements in education - so we award only 'the best' rather than acknowledging that all students are learning and growing and that everyone has strengths and weaknesses. The constant competition puts pressure on everyone as it does not allow for a recognition of various, differing achievements or of the realities of contexts that shape 'performance'.
- ➔ A focus on results and information over knowledge and education.
- ➔ Lack of respect for staff and students and hierarchies of knowledge - some students/ courses/ disciplines / ways of knowing/ ways of researching are held in greater esteem than others and their is often epistemic aggression rather than epistemic generosity or even curiosity.
- ➔ Being exhausted is seen as a job well done
- ➔ *Tiring*
- ➔ *Badge of honour*
- ➔ *Burnout*
- ➔ *Hierarchy: Toxic - breakdown*
- ➔ *Dissonance : I'm not OK and that's ok*
- ➔ *Burnout within students, making it ok, normalising (Destress, depression.)*
- ➔ *"The faculty breeds an environment whereby you are constantly being undermined and you are forever doubting yourself- it breaks you down"*
- ➔ *"Course is chowing me right now"*
- ➔ *"Some people are not successful but they are excellent " And they are disheartened when they realise that they are lead to believe that they will be okay if they are academically excellent.*
- ➔ *"I imagined it would be different"*
- ➔ safe spaces are contradictory and in effect are not created.
- ➔ incongruence between the culture of being the "Cream of the crop" and lived experiences of not coping ("we are drowning but the culture is you must keep going")
- ➔ "Type A personalities and always being in control- people perform "okayness"- so even when you're drowning academically, you won't say anything cause everyone seems okay"
- ➔ "The faculty breeds an environment whereby you are constantly being undermined and you are forever doubting yourself- it breaks you down"
- ➔ A- type personalities of culture of excellence
- ➔ Face of excellence is exclusionary

	➔ No Is not accepted ➔ "The overzealousness in the celebration of "excellence" is exclusionary and demeaning - the dean's tea/list" ➔ "Our lecturers are excellent, but not necessarily successful. They can read off the lecture slides, but not successful at empathy." ➔ No room allowed for mistakes ➔ Perfectionist behaviour. ➔ Hierarchy within health sciences ◆ Treated like children ◆ Cycle of hierarchy ◆ Not seen as people ➔ Treating patients badly, ➔ *Systemic problem – healthy community, before we get here, intervene at school level* ➔ *Struggling academically or not coping with the work load is seen as a sign of weakness. So people will tend not to vocally say when they cannot cope. Very competitive environment. All trying to outshine each other as the one who shines the most catches the eye of the HoD and principal investigators within the department.* ➔ *This becomes worse if you are non-white. Always a feeling that you were brought on to balance the books w.r.t. the number of black candidates on board.* ➔ *Hierarchical based bullying from more senior to more junior clinicians, interns and students* ➔ *Hierarchy between disciplines (doctors, consultants, registrars, interns, etc) [hierarchy is being taught and nurtured within the curriculum and work spaces such as ward rounds and clinical placements]* ➔ *Registrars modelling the consultants bullying behaviour with their supervisees* ➔ *Across the multidisciplinary team with different professions and disciplines*

A.5 Tensions between staff and with students

	➔ *in particular the lack of understanding of (or indeed any interest in) emotional empathy which is the ability to feel the emotional consequences in others of what you are doing to them. I've been in the Faculty since 1969 and my impression is that those who do show emotional empathy are unlikely to make it to the top. There is just been too much toxic narcissism in leadership over the past 4 decades.* ➔ *sometimes students are debriefed by the supervisor who "is the cause of the anxiety"* ➔ "The lecturer says that they are a recovering racist"

- ➔ *"our first point of call is not the faculty as there is a lack of trust…the relationship has been broken"*
- ➔ *"No positive acknowledgement when we do well in classes. - Only focus on when things are going bad. No motivation from lecturers*
- ➔ *"I direct them to the services, but I ask myself, would I access these services? I've asked myself how I can ask people to go when I won't use it"*
- ➔ *"Students feel unwelcome on the platform"*
- ➔ *"clinical block rotations feeding into anxiety and depression"*
- ➔ *"we are not a healthy community and we (staff) pass this on"*
- ➔ *"Staff relationships are not grounded on mutual trust or support, instead staff members speak about each other in front of students in an unsupportive manner"*
- ➔ *System is inflexible, unreasonable expectations for workload, multilayers of teaching, teaching content, not emotional intelligence*
- ➔ *People are depressed even way we are at work, way we speak about each other, way staff are impacting students*
- ➔ *We role model toxic life for each other, dismiss each other in front of students, collude, person not heard*
- ➔ *We rescue students all the time and not consistent in our boundaries*
- ➔ *My colleagues lack of boundaries*
- ➔ *Boundaries: sometimes we are too distant, sometimes perhaps too close?*
- ➔ *We don't model ways of being professional in the way we interact with each other*
- ➔ *We mustn't steal grace from someone's reputation, however the toxic space can make it more difficult to be fully human*
- ➔ *Registrars are central in teaching but often so stressed themselves they do not recognise the undergrad stress*
- ➔ *Very high work burden due to austerity/freeze on new posts*
- ➔ *Service delivery that takes preference/we are focused on patient well-being more than staff wellbeing*
- ➔ *The academic year is quite short for the amount of teaching that happens in a year*
- ➔ *The faculty and the university at large is very busy- there are a lot of deadlines and there is a lot of pressure to succeed, this in itself can be trigger for mental illness, on top of busy lifestyles.*
- ➔ *Style of teaching especially in pre-clinical years, it is not practical at all and it is not designed in a way that it can pick up struggling students or students who prefer other styles of teaching and learning. The style is too rigid and it is only suitable for a few.*
- ➔ Workload needs more support, staff development
- ➔ Health science staff are burned out

- ➔ Workload and support
- ➔ “Whole year courses!???”
- ➔ I think we try incredibly hard to assist our students in a variety of ways beyond formal teaching. In effect, we act as social workers to many of our students. In addition, our teaching workload has increased and funds have not increased. Together, I think that the pressures on the teaching staff are simply too much. I am also worried about the deanery - it seems that they are under immense pressure and the cracks are certainly visible, yet in faculty board I am often struck by how adverserial the staff are towards the dean team. I think that we need to find ways to decentralize decisions from the deanery to the lower levels ASAP so that teaching can continue and decisions can be made.
- ➔ “ Lecturers speak of black vs white. What about other races? Ignorance?”
- ➔ “The lecturer says that they are a recovering racist”

<u>Staff noted their experiences with students who continue to challenge the system, which the staff represent</u>

- ➔ *Students are not disciplined, very automated, you don’t submit…*
- ➔ *Still focused on authority*
- ➔ Student pendulum, afraid of boundaries, allowing bad behaviour, feeds into guilt, into narrative, I am not responsible.
- ➔ Students don’t understand the relationship between faculty and support structures

A.6 A need to re-orientate services

- ➔ Class rep experience is that students are not seeking help early, they don’t recognize what they are struggling with i.e. stress and mental illness “students don’t have a framework to know when they are or are not coping” …..”we don’t know our triggers”
- ➔ Humanities subjects should be compulsory in all health science degrees and taken seriously.
- ➔ Form a panel to gain information about the black students struggles in order to form groups or projects to accommodate them in faculty / UCT.
- ➔ “Get people who focus on humanising, not lecturer but lecturer have to put their content to use.”
- ➔ Training in soft-skills - something only humans can do, not robots
- ➔ Culture needs to be addressed – this includes the “microaggressions” as well as “culture of excellence”. There needs to be an awareness of the emotional experience of the programme an how the programme “triggers” mental health issues. “We need lecturers who are aware and that remind us”
- ➔ “Interrogate culture around health of health professional” It’s ok not to be ok.

- ➔ MH Awareness for students on the signs and symptoms of normal stress becoming unhealthy stress or depression
- ➔ A dedicated portal for mh support as students are flooded with information and the mh info gets lost in all the emails
- ➔ More obvious and more reminders of where to get help. There are reminders at exam times, but there should be a focus on avoiding crises by supportive messages throughout the year, not just at exam times
- ➔ Class reps need orientation to what supports are available
- ➔ Class reps may not be the best persons to support students experiencing severe mental health problems: greater thought needed to explicate who will be the supporters on the academic side of the students reaching out for support
- ➔ Fit for study process needs review: include an evaluation of people's experience of implementation to inform review process, involve affected students in the process of review.
- ➔ There should be better communication of what this process involves as students go through it with little understanding of the whole process, which is very distressing.
- ➔ *Improvements needed on supporting students to get help earlier*
- ➔ *"We need a support group on campus where we can touch base, confidential spaces"*
- ➔ *Need for cross fertilization across campuses to expose students to new skills.*
- ➔ *Electives offers a different experience, and clues about the challenges*
- ➔ *Electives reignites a passion for medicine,*
- ➔ *A culture where people often feel abused/ A culture where there is always a struggle for dominance and power/ A lack of communication and specifically a lack of people listening/ A focus on work and service delivery which is sometimes unrealistic*
- ➔ *I would recommend firstly, more after hour services to be made available so that there doesn't have to be any catch-up time. In addition, it is about changing the culture of our faculty, which is a difficult thing to do. I think it could start by staff members all being on the same page about what mental illness is and what it looks like. To understand that laziness/slacking/disinterest is what may be seen but is not the complete truth. Whether this be in the form of training or reflective spaces between staff members who have experience in the mental health field to share, is flexible.*
- ➔ *Better leadership/ A place where abusive culture could be noted and reported/ A systematic response to these issues*
- ➔ *Better communication in the faculty, caring modelled from the top and throughout. Hierarchical and power structures should be more transparent and approachable. We need to revisit what we value.*
- ➔ *Mental health days, mandatory mental health workshops for staff and students, culture of acceptance that mental illness is a serious psychoaffective disorder that can be dealt with and managed just like any other illness. There's a stigma of not talking about it. We need to talk about it openly and start the conversations, in the same way that the #MeToo movement opened up the discourse about female abuse.*
- ➔ *Poor infrastructures within the university - which detracts from primary work, research and teaching.*
- ➔ Students reported that they have to seek help off campus, waiting lists are too long
- ➔ "Pathological individuality, because it isn't appropriate"

- Self expression is pathological eg. in upper students can wear what they want but not at FHS
- No space on Health Sciences to express ourselves
- “Not seeing students as individuals and seeing their issues as unique. Treating them all the same.”

➔ No compulsory activities to interact - inhibits creating own culture, no interaction between different years and disciplines
- “No one goes the extra mile to ensure the class dynamic is smooth and that students fit in and are not isolated with in the class”
- “Going to upper campus, not only med school” [*Why is it that students want to be integrated more with upper campus? What does that say about the culture of upper campus in comparison to FHS?]*
- “No interaction between the students from different years from our discipline and others”

➔ Clinical teaching
- “Students feel unwelcome on the platform”
- “Registrars are central in teaching but often so stressed themselves they do not recognise the undergrad stress”
- Sensitisation of senior Drs to prevent bullying at clincial sites
- unpacking culture in every discipline, to pressurise change
- clinical block rotations feeding into anxiety and depression
- “we are not a healthy community and we (staff) pass this on”
- “Staff relationships are not grounded on mutual trust or support, instead staff members speak about each other in front of students in an unsupportive manner”

➔ Projects and Workshops on how to speak to one another, especially lecturers to students, especially those suffering with mental illnesses. How to develop empathy and understanding.

➔ To a great extent a reality check for many students and staff, and realizing that identity politics and scapegoating is not going to make this university or the medical profession a better place

➔ Fellow students often being very defensive and offensive about unnecessary issues, often blaming mental health for many other shortcomings. Mental health should not be a scapegoat for pressing issues.

➔ Rigidity of the system. Although we may try to employ more psychologists or people who are able to 'help' us, not much can be done if we don't change the system within this faculty. It seems that there is a certain way things are done and not much chances are given to changing things. More and more students have said that they started seeing psychologists because of their degree - which is expensive. Not a lot of people can afford good psychologists who will spend enough time with you to sort out your issues.

➔ A culture of needing and almost striving to be invulnerable could exacerbate mental illness. There is little allowance for being "not okay" and mentally/emotionally "broken". Caregivers (in particular health care professionals) are expected to give and help others, but not need (or ask for) help themselves. Of course, we know that no human being is invincible, and that care for the caregivers is crucial to maintaining standards of care for patients/clients. Despite lots of awareness and education around mental health in the past few years, there is still stigma associated with mental illness (e.g., feelings of failure and weakness), which are supposedly incompatible with the idea of a successful, competent health professional. I would imagine that the competitive culture in some health science programmes might also bring about those fears of failing and being weak.

	➔ Enormous workloads, and very high expectations of students. Students simply do not have time or energy to prioritize mental health and well-being. ➔ Another thing is that it always seems like there is a rush for something to be done i.e. there is so much work crammed in so little time that other parts of our lives are put on a standstill just to keep up with the workload. UCT is known for having the longest holidays - which is seen in this faculty. Although it is nice to have a long holiday, we would appreciate if more time was given to teaching and preparing us for tests/exams than having a longer holiday. ➔ The courses in this faculty are very expensive as well so failure is not an option. ➔ Students are well defended. They see others as needing help but not themselves. Students are competitive. Staff seldom show their own vulnerability - don't discuss their own failures or mistakes. ➔ Lack of interest and concern extended faculty in really attending to students' needs ➔ I feel as if there is no consideration for ones mental health and capacity when exam schedules are being considered and planned. There were 5 exams on one week for the first year physiotherapy students in he November exams and this is not constructive for the mental wellbeing nor the academic performance of the students. ➔ Barriers I think I would definitely count the culture that is "not coping is weakness" in our fields of study whether from peers or from people who represent faculty is a barrier. ➔ Unity and the demonstration of team work especially within the mental health task team. For example, granting counsellors permanent employment contracts and effectively inducting and integrating them within the faculty structures. ➔ Lack of transformation and real connection with students. Culture of zero dedicated time for student activity where clinical services are protected. ➔ There is support for students via the student wellness center - there would be benefit to provide a similar support for staff via a staff wellness center. May be an idea to provide relaxation non-expensive relaxation related classes - e.g. yoga, mindfulness/light meditation, pilates, or the likes - in the early am - lunch - an pm (early and end of day - then people are not stuck in traffic but can attend a class and improve time efficiency)
	➔ "you know there is a lot of support but you're not sure what is for when" ➔ "not sure who to go to - whose role is what" ➔ *lack of knowledge of how to enter this new community and find support within it* ➔ *"you don't know how to put yourself out there and where to get support"* ➔ *"having to look quite hard to find support"* ➔ *Stand alone units within the university that are not strictly monitored by the university tend to labour lots of staff oppression, victimisation and discrimination by individual persons of authority* ➔ *"Leave of absence is just put there for policy/ formality"* ➔ *"The mission of a getting short leave of absence in itself contributes to my mental illness"* ➔ *"Rigid DP/LOA that dehumanise students e.g. demanding medical certificates for period pains"* ➔ *"Lectures being compulsory, and other excuses for missing lecturers not accepted"*

- ➔ Appointments for mental health care may clash with class/academic assessment requirements-
- ➔ *"the deferment procedure works for a person who knows how to use the system".*
- ➔ *"information is not always treated confidentially"*
- ➔ *"people are forced to take leave of absence due to mental illness"; The fit for study panel reviews you...people… feel it is not facilitating them to be back, rather to keep them out…on paper it seems helpful but people's experience is it is not achieving the desired effect"*
- ➔ *Hidden fees must be written down (there are not icl. In fees) e.g. money for dissection kits, uniforms, bones.*
- ➔ *"Lack of finances to cater for mental illness sessions/ management"*
- ➔ *I know that final year students are currently writing their final exams and their graduation is coming up soon. They have been told that they have to leave res when residences close. Some of them do not have money to pay for off-campus accommodation or transport to go back home and back while they wait for graduation day. The ones I talked with were saying now they are stressed about the fact that they may not make it to graduation day.*

A.7 General Recommendations

- ➔ *Better leadership/ A place where abusive culture could be noted and reported/ A systematic response to these issues*
- ➔ Clinical teaching
  - ◆ "Students feel unwelcome on the platform"
  - ◆ "Registrars are central in teaching but often so stressed themselves they do not recognise the undergrad stress"
  - ◆ Sensitisation of senior Dr's to prevent bullying at clinical sites
  - ◆ unpacking culture in every discipline, to pressurise change
  - ◆ clinical block rotations feeding into anxiety and depression
  - ◆ "we are not a healthy community and we (staff) pass this on"
  - ◆ "Staff relationships are not grounded on mutual trust or support, instead staff members speak about each other in front of students in an unsupportive manner"
- ➔ Projects and Workshops on how to speak to one another, especially lecturers to students, especially those suffering with mental illnesses. How to develop empathy and understanding.
- ➔ Class rep experience is that students are not seeking help early, they don't recognize what they are struggling with i.e. stress and mental illness "students don't have a framework to know when they are or are not coping" ….."we don't know our triggers"
- ➔ Humanities subjects should be compulsory in all health science degrees and taken seriously.

	➔ Form a panel to gain information about the black students struggles in order to form groups or projects to accommodate them in faculty / UCT. ➔ <u>Fit for study process needs review:</u> include an evaluation of people's experience of implementation to inform review process, involve affected students in the process of review. ➔ *I would recommend firstly, more after hour services to be made available so that there doesn't have to be any catch-up time. In addition, it is about changing the culture of our faculty, which is a difficult thing to do. I think it could start by staff members all being on the same page about what mental illness is and what it looks like. To understand that laziness/slacking/disinterest is what may be seen but is not the complete truth. Whether this be in the form of training or reflective spaces between staff members who have experience in the mental health field to share, is flexible.* ➔ There should be better communication of what this process involves as students go through it with little understanding of the whole process, which is very distressing. ➔ *Need for cross fertilization across campuses to expose students to new skills.* ➔ *Electives offers a different experience, and clues about the challenges* ➔ *Electives reignites a passion for medicine,* ➔ No compulsory activities to interact - inhibits creating own culture, no interaction between different years and disciplines ◆ "No one goes the extra mile to ensure the class dynamic is smooth and that students fit in and are not isolated with in the class" ◆ "Going to upper campus, not only med school" [*Why is it that students want to be integrated more with upper campus? What does that say about the culture of upper campus in comparison to FHS?]* ◆ "No interaction between the students from different years from our discipline and others" ➔ Enormous workloads, and very high expectations of students. Students simply do not have time or energy to prioritize mental health and well-being.