An evaluation of the Sanctuary Community Conversation Programme to address mental health stigma with asylum seekers and refugees in Glasgow

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Section 1: Introduction

1.1 Background

With Scotland hosting increasing numbers of asylum seekers and refugees, the mental health needs of this population has become an important issue to address. The Sanctuary Programme was initially developed in 2007, bringing together national, regional and local partners to undertake an action research project in 2008, seeking to identify patterns of stigma and discrimination experienced by asylum seekers and refugees in Glasgow and to explore how this may be addressed through community development approaches. The research led to the development of the community conversations project; mental health awareness workshops facilitated by people with experience of seeking asylum. The programme was delivered between 2009 and 2010 and aimed to effectively engage with asylum seeker and refugee communities to increase understanding of mental health, reduce stigma, increase help seeking and promote recovery.

1.2 Purpose of report

This report aims to evaluate the impact of the community conversations project. It first sets a context for this work by providing a review of the relevant literature in this field and a background to the development of the Sanctuary programme. The major focus of the report is to present the study of the impact of the project, detailing the methodology used and presenting key findings from the study. There is then a discussion of the implications of these findings and the main conclusions and recommendations from the study are identified. It is intended that this report be of use to policy makers, planners and commissioners, health improvement practitioners, voluntary sector organisations, community groups and service user activists with an interest in developing programmes to understand and address the mental health needs of asylum seekers and refugees and in particular the stigma and discrimination they experience. The report will also be of use to researchers and academics undertaking research and evaluation in this area.
Section 2: Literature review

This literature review provides a background and context for the Sanctuary Community Conversation Programme, by discussing policies and research which focus on and affect asylum seekers and refugees in Scotland, particularly where mental health is concerned. The review begins with a general introduction to the asylum process, showing that not only is this not only an important social policy issue but raises a number of issues in terms of the control, marginalisation and social exclusion of asylum seekers. The review then goes on to discuss mental health problems and their associated stigma within the asylum seeker and refugee populations. Finally, the effectiveness of community mental health awareness workshops in reducing stigma amongst these populations will be addressed.

2.1 The Asylum Process in the UK

The Immigration and Asylum Act 1999 and the Nationality, Immigration and Asylum Act in 2002, provide the legal basis for the dispersal of asylum seekers in Scotland. There is however a relatively fluid relationship between reserved and devolved matters in Scotland, this having ramifications for refugees and asylum seekers: while entry and status issues are reserved, the provision of services is devolved; and this opens up the possibility of conflict between the Scottish and British administration over such matters (Charlaff et al. 2004).

Whilst refugee studies are a growing field of enquiry, it has been indicated that the broader theoretical framework is lacking (Black 1991; Malkki 1995) and indeed there is a dearth of research on asylum seekers and refugees in Scotland prior to the 2002 dispersal act being put in place. Many of the current issues of most concern for asylum seekers are related to the existence of and barriers to accessing rights (Mulvey 2009).

A refugee is one who has been recognised under the United Nations Convention (1951) as person who is outside of his or her country of nationality who is unable or unwilling to return because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion (Article 1A: UN 1951). As such, asylum protection is given by a country to individuals who are fleeing persecution in their own country. This requires the individual seeking asylum to provide evidence to show that they have a well-founded fear of persecution due to their race, religion, nationality, political opinion or membership of a particular social group; and that the
authorities in their country are unable to provide protection, or the individual is, owing to that fear, unwilling to avail himself of the protection of that country. In comparison to refugees whose status has been granted and recognised under the UN Convention (1951), asylum seekers are those who are awaiting judgement on their claim for asylum. One may also apply to remain in the UK on the basis that they have a claim to humanitarian protection if they do not qualify as a refugee but can show that there are substantial grounds for believing that if they were returned to their country of origin, they would face a real risk of suffering serious harm. Diagram 1 outlines the Asylum process in the UK.¹

¹ Claims for asylum must be made in person at a port of entry or at one of the UKBA’s Asylum Screening Units. After the application, a screening interview is undergone to establish identity and nationality. At this stage, all of the applicant’s official documents are surveyed and fingerprints are taken to guard against fraud and multiple applications. All claimants will be issued with an Application Registration Card (ARC), containing their personal details. Since March 2007 when the New Asylum Model (NAM) was introduced, every new asylum application is placed with a case owner, who will deal with every aspect of the application from beginning to end. As such, a case owner is responsible for interviews, making decision on the application and managing support. If the person is recognised as a refugee, he will gain the right to stay in the UK for initial period of five years. Refugee status will allow the individual to work, have access to the welfare system and apply for family reunion. If the asylum application is refused, the case owner may decide that the individual may stay in the UK for humanitarian reasons. As such, an applicant may be granted Humanitarian Protection¹ or Discretionary Leave to Remain¹. If the case owner decides that there is no reason for individual to stay in the UK, the applicant will be requested to leave the UK. In such case, applicant may apply for Voluntary Assisted Return and Reintegration. In addition, the case owner may decide to detain the applicant until he will be deported from the UK. The applicant has a right to appeal to the Tribunal Service for Immigration and Asylum and there are strict time limits for making an appeal.
In February 2005, the UK Government published a five year strategy for immigration and asylum\textsuperscript{2}, announcing the development of the New Asylum Model (NAM). This aims to conclude an increasing proportion of asylum cases within six months leading to either integration or removal. This shortage of time increases the pressure for submitting applications and means evidence to support claims must be submitted quickly. This may be particularly difficult for asylum seekers who have gone through a traumatic experience and need respite before they can provide information and details about the reason of claiming asylum. In addition, many of them are unaware of the formal requirement of claiming asylum and are overloaded by the amount of information they have to take in (Refugee Council\textsuperscript{2} Controlling our borders: Making migration work for Britain - five-year strategy for asylum and immigration www.archive2.official-documents.co.uk/document/cm64/6472/6472.pdf).

Diagram 1: Asylum process in the UK (source: COSLA Strategic Migration Partnership)
The NAM also discontinued the possibility of providing written evidence for asylum, which previously provided asylum seekers with an opportunity to express in their own words the basis of their claim. For many asylum seekers, a written statement was the only way of being able to disclose sensitive details of traumatic events. Because of the short time period in which they must submit their claim, asylum seekers may find themselves unable to access adequate advice and obtain necessary support to disclose their circumstances to support their asylum claim. Additionally, asylum seekers often spend substantial periods of time travelling to the UK, and for those experiencing physical health problems due to malnutrition, the effects of torture or other forms of violence, tight timescales may hamper their ability to obtain medical evidence to support their claim. Being unfamiliar with the UK system and culture is another reason asylum seekers may have initial difficulties in talking about their experiences (Refugee Council, 2007).

2.2 Relationship between the asylum process and social exclusion/isolation

Lack of support puts asylum seekers at risk of severe and absolute poverty. For example, the Immigration and Asylum Act, Section 55 (2002) allows the state to deny any support in the form of housing or state benefits to asylum seekers who have lodged their claim for asylum more than 72 hours after arrival. Recent research by the Refugee Council (2006) on destitution, reveals that majority of asylum seekers are destitute because they were refused asylum, or are still waiting for a final decision on their asylum claim. Destitution occurs when a person is unable to meet their own subsistence needs and when they have no assets such that they become dependant upon charity and the goodwill of others (Devereux, 2003). Inability to secure basic needs, such as access to food or a place to live is a main cause of asylum seeker destitution. The effects of destitution have further implications on material well-being and individual’s assets, and ability to make choices about one’s life (Malloch and Stanley 2005). This also has direct impact on a person’s emotional and psychological well-being (ICAR 2007).

The category of ‘refugee’ denotes those individuals who live in exile and experience forcible uprooting. Forced movement from one place to another, that is changing the point of reference for self understanding, affects the way one defines himself. Refugee displacement means not only by physical movement, but disrupted social ties and sense of belonging (Al-Rasheed, 1994). As such refugees, by being stateless persons, do not belong to any territory and do not fall under the protection of rights that are ascribed to the members of particular territory. This often results in the refugee being uprooted, dislocated and forced out
of their community. As citizenship brings certain rights, non-citizenship seems to imply a lack of rights, placing the refugee in a vulnerable position. The refugee is therefore in a position of inferiority relative to other citizens of the country which gives him shelter. On top of this, the fear of threat towards welfare and state security means that refugees may be perceived as undeserving of state protection (Sales, 2002). The notion of being undeserving has coincided with a general move to restrict and control access to welfare services. As such the asylum process, through diverse disciplinary techniques such as identification cards, detention houses and removal centres, controls asylum seekers’ behaviours and limits their agency.

Detention of asylum seekers has been one of the most controversial asylum related practices undertaken by the UK Government. The aim of detention (removal) centres is to target and expel ‘failed’ asylum seekers, however recent research on detention centres revealed the examples of detained individuals whose cases were ongoing (Welchand and Schuster 2005). Placing an asylum seeker in a detention centre causes them to exist in a limbo, characterised by restricted rights for movement, education, legal support and health services. The precarious legal status of asylum seekers due to detention limits their agency and affects their wellbeing (Palmers and Ward, 2006). As such, asylum seekers who are detained in the host country experience a further and more specific set of stressors including loss of liberty, uncertainty about the future, and social isolation, which affects their mental health status and often leads to anxiety, depression, PTSD, and self harm (Robajant 2009).

The Asylum Act of 1999 introduced ‘no-choice’ dispersal which gives legitimacy to disperse asylum-seekers on a no-choice basis to consortia regions around the country regardless of whether they had family, friends or specialist support elsewhere (Mynott, 2002). Such dispersal removes from asylum seekers the freedom to choose their place of living, and can detach them from kin and other social networks, as well as community organisations that are known to be important in the early stages of settlement (Bloch, 2000; Robinson et al., 2003). Those asylum-seekers who refused dispersal or absconded forfeit their right to accommodation. As result of dispersion, asylum seekers have been sent to areas with relatively small or non-existent ethnic communities and with little experience of receiving and integrating other ethnic groups (Boswell, 2003). Absence of established ethnic minority communities means that asylum seekers can find themselves in areas where they are obvious foreigners and the target of violence, prejudicial attacks and harassment (Schuster 2004; Scottish Executive 2003). Areas of asylum seeker dispersal have been characterised as low-demand areas which are high in deprivation, are poverty-stricken, and where community tensions and racial harassment are evident (Scottish Executive, 2003). Together,
these result in further marginalisation and isolation of the asylum seeker from society (Bloch and Schuster, 2005).

In the past few decades, public discourse in the UK has framed the concept of refugees in increasingly negative terms, perceiving the group as a threat to the security of UK residents (Zetter et al 2003). While asylum is acknowledged as both a humanitarian and human rights concern, most of the rhetoric on asylum has been influenced by notions of ‘danger’ and ‘risk’ to the social, moral and economic threat (Zetter 2007). Problematisation of the refugee category in political and public discourse introduces certain activities, attributes and characteristics that both define the refugee and are perceived as problematic for the state. For example, refugees have been portrayed as terrorists (Seidman-Zager, 2010) and illegal migrants (Malloch and Stanley 2005). That is, the dominant recent public debates have focused on the ‘undeserving’, ‘bogus’ and dangerous nature of asylum seekers causing that all asylum seekers are treated with suspicion (Morris 2002). This mean that asylum seekers are placed in situations that is damaging to their health and wellbeing.

The exclusion of asylum seekers is not only defined by their temporary immigration status but their experiences of exclusion and marginalisation. As such, asylum seeker status is regarded as a highly dynamic and multidimensional process in which various forms of exclusion appear (Steward, 2009). For example, the Asylum Act 1999 reduced support for asylum seekers to 70% of standard benefit levels; and the Asylum and Immigration Act 2004 allowed termination of basic support to families unsuccessful in their asylum application. This legislative background has increased the vulnerability and powerlessness of asylum seekers. The refugee group remains one the most unemployed groups in the UK (Bloch, 2000). This is often explained as being the result of language barriers, lack of recognition of overseas qualifications, lack of previous work experience in the UK, cultural differences and general employment discrimination (Bloch, 2000, 2004). Previous research shows the positive relationship between an individual’s unemployment, social exclusion and the downward mobility of a neighbourhood where refugees are settled (Phillimore and Goodson, 2006). Research also suggests that refugees are at a high risk of homelessness and that there is a significant level of ‘hidden homelessness’ among this group (Cole and Robinson, 2003; Bloch, 2000). Uncertainty about re-housing decisions and a lack of stable contact with the local neighbourhood due to constant displacement or racial harassment effects refugees’ overall physical and emotional well-being and ability to feel ‘at home’ in the host community (Glover et al. 2001; Deborah, 2006; Ager and Strang, 2008).
2.3 Mental health needs of asylum seekers and refugees

Loss of power and control over one’s own life, whether in regard to individual place of residency, family union or employment, impoverishes an individual's agency. The experience of disempowerment, being deprived of choice and the ability to decide about one’s own life, lowers the asylum seekers self-esteem and negative negatively on their mental wellbeing (Refugee Council, 2006). A study of destitution and experience of poverty of asylum seekers and refugees in Scotland revealed that many asylum seekers who experience destitution were suffering, or had suffered from, depression; and that there was positive correlation between length of time that an asylum seeker stayed destitute and risk of depression (Marsden et al., 2005). As such, destitution has widespread and severe mental and emotional effects such as acute anxiety and stress, feelings of extreme vulnerability and powerlessness. Not being able to secure access to food and accommodation often leaves asylum seekers in a growing sense of hopelessness. It should be emphasised that many asylum seekers who become destitute do not understand for what reason they feel strained, uncertain, powerless to change the future and lower self-esteem (Green 2006). In addition, those asylum seekers who suffer from stress or depression were less able to engage with other organisations providing support for asylum seekers and therefore they were less able to solve the problems causing by experience of poverty and destitution (Marsden et al., 2005).

The temporary nature of asylum means that asylum seekers live a life ‘in between’ their home country and their potential future life in the UK. As such, being an asylum seeker means living a suspended life based on waiting (Stewart, 2005b). There is uncertainty about one’s future and a deep sense of insecurity has implications for asylum seekers' wellbeing (Palmer and Ward, 2006). There is also uncertainty about how long an asylum seeker is going to have to wait before receiving the final decision on their claim on top of uncertainty about the outcome of the decision. The feeling that one has an unclear future has serious consequences on individual mental wellbeing (Brekke 2004).

A study of the mental health needs and mental health provision for refugees in London (Palmer and Ward, 2006) indicates that poor housing conditions and the experience of living in deprived areas leads to greater marginalisation of refugees and impacts negatively upon mental health. In addition, the common experience of racial harassment makes asylum seekers more vulnerable and puts them at risk of persecution. The trauma that asylum seekers and refugees experience in the country of resettlement through racism, violence, social isolation and hostility has further implications for their mental health. The post-
migration experience of exclusion and racial harassment also appears to have a cumulative effect with both pre-migration trauma of violence and persecution in home country, having negative implications for refugees' wellbeing. For example, a study of Iraqi refugees in London revealed a strong relationship between experiences of social isolation and marginalisation in exile and the severity both of post traumatic stress disorder (PTSD) and depression (Gorst-Unsworth and Goldenberg, 1998). As such, post-migration stress faced by asylum seekers and refugees adds to the effects of previous trauma and creates a risk of ongoing post traumatic stress disorder and depression. A study of Kosovan Albanian refugees in the UK (Turner et al., 2003) revealed that increased trauma experienced by asylum seekers due to experience of poverty, discrimination and separation from family members was associated with ongoing symptoms of PTSD, anxiety, and depression. Therefore as a result not only of past experiences but also because of their current situation in Britain, refugees may experience symptoms of anxiety, depression, guilt, and shame.

2.4 Asylum seeker and refugee access to health services

Refugees\(^3\) and asylum seekers are entitled to free primary and secondary health care (see Table 1 for details). This includes the right to be registered with an NHS general practice, free NHS dental care and sight test, and free prescriptions, under the same conditions as any other patient (Department of Health, 2009). However, some GP practices are over-subscribed and feel pressured by the programme of dispersal of asylum seekers: In some cases hundreds of asylum seekers have been moved to a surgery’s catchment area without prior notification; and if unable to find a practice to accept them, asylum seekers are likely to rely on inappropriate use of emergency hospital services (BMA 2008). Refused asylum seekers granted temporary asylum or temporary release, are entitled to primary health care, though are only entitled to free secondary health care if they are considered to be ordinarily residents\(^4\) in the UK,\(^5\) and they must produce written authorisation by an immigration officer or other UKBA official on behalf of the Secretary of State to the individual in order to register for hospital treatment.

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3 This includes individuals with Discretionary Leave to Remain or Humanitarian Protection status

4 There is no concrete definition of ‘ordinarily resident’. The definition is guided by the intent of the person to remain in the UK for a significant period of time. Generally, a person residing more than 3 years in the UK can be defined as an ordinarily resident. However, legal immigrants could already have ordinarily resident status from the day they arrive in the UK

5 Not all refused asylum seekers on temporary admission are ‘ordinarily resident’ in the UK, but in certain circumstances they may be. Hospitals and trusts must consider whether each refused asylum seeker that they treat can be considered ‘ordinarily resident’ in the UK, in the same way as they would do with any other patient, and obtain sufficient proof of ordinary residence (BMA 2008:2).
National Health Service | Primary Care | Secondary care
---|---|---
Asylum Seekers | Yes | Yes
Asylum seeker affected by Section 55 of NIA Act | Yes | Yes
Asylum seeker at any stage of appeal | Yes | Yes
Asylum seeker awaiting a judicial review | Yes | Yes
Unsuccessful asylum applicants receiving ‘hard cases’ grant | Yes | Hospital decides entitlement based on the individual's complete circumstances
Unsuccessful asylum applicants awaiting deportation | Yes | Hospital decides entitlement based on the individual's complete circumstances
Unaccompanied children and young people under 18 | Yes | Yes
People with Discretionary Leave to Remain or Humanitarian Protection status | Yes | Yes
People with Refugee Status | Yes | Yes

Table 1: Access to health services (source: Refugee Council Briefing 2003)

The recent implementation of the Race Relations (Amendment) Act 2000 and Fair for All (2002, Scottish Executive) have required all NHS Boards to meet the needs of ethnic minority communities. In addition, the Scottish Refugee Integration Forum Action Plan (2002, Scottish Executive) emphasised the need for more co-ordinated and integrated services for refugees. The recent Glasgow Centre for Population Health (GCPH) (2005) study examining the barriers facing asylum seekers and refugees in accessing health services highlighted a lack of consistency in the data available on the number of asylum seekers and refugees in Glasgow. As such, according to NASS (National Asylum Support Service) data, in January 2005 there were 5,798 asylum seekers registered in Glasgow, compared to 11,849 registered with NHS general practices. This difference may be due to the fact that the GP registration figures could be regarded as a measure of how many people have entered the system, while NASS figures could be regarded as a measure of the number of asylum seekers currently in the population.

There is growing recognition that asylum seekers and refugees have multiple health needs. The main barrier to accessing health services experienced by asylum seekers and refugees is a lack of understanding of the overall health care system (Mulvey, 2009). Research on
Bosnian refugees in Glasgow (McFarland and Walsh, 1994) shows that refugees remain confused about NHS systems, the role of GPs, and the out of hours system. Lack of understanding about the NHS system is often caused by language barriers (O’Donnell et al. 2007), which can also result in difficulties with registration and an inability to explain individual health conditions.

2.5 Need for culturally sensitive mental health services for asylum seekers and refugees

As argued by Netto et. al (2008), differences in health beliefs should be considered in order to make treatment culturally relevant. According to this, the cultural needs and background of asylum seekers and refugees must be considered in order that treatment and interventions are appropriate for their intended recipients. Netto et al. (ibid.) argue that it is only those interventions that engage with social and cultural aspects that will create change. Newbigging et al. (2008) also argue the importance of exploring mental wellbeing in difference cultural contexts, and go so far as to say that it is ‘self-evident’ that mental wellbeing is likely to be understood differently by diverse communities. Cultural knowledge has been argued as important in understanding conceptions of illness, attitudes towards health and illness, appropriate treatment for different illnesses (Hsiao et al, 2006). Considering cultural perspectives in terms of the mental health literacy of a specific cultural group allows the development of more culturally appropriate public education programmes for that group (Wong, Lam & Poon, 2010).

Despite the fact that cultural diversity, religious beliefs, and social norms have been said to play an important part in the definition and diagnosis of mental health difficulties (Kleinman, 1990), psychiatry on the whole is still based on a white Eurocentric perspective of mental health (GAMH, 1995). Previous research has highlighted areas where mental health services for asylum seekers and refugees could be improved. Misra et al (2006) found that cultural barriers reduced constructive engagement between services and asylum seekers and refugees. Language has also been argued as a barrier to engagement (Misra et al., 2006) and the need for information to be provided in various languages and access to trained interpreters (Tribe, 2006), and bilingual workers within refugee community organisations (Summer, 2005) has also been stressed.

2.6 Mental health stigma within Black and minority ethnic (BME) communities
Stigma has been defined as ‘a disgrace or discredit, which sets a person apart from others’ (Byrne, 2000, p65). Stigma is said to consist of three related problems (Thornicroft et al 2008) which are: problems of knowledge that lead to ignorance; negative attitudes which lead to prejudice; and problematic behaviours which lead to discrimination (Kassam and Thornicroft, no date). People often conceal stigmatising health conditions (Berger et al., 2005); and indeed stigma has been identified by professionals as a key issue in mental health (Bayar et al., 2009). Stigma towards mental illness has been argued to be one of the main barriers to improving care for those with mental health problems (Zalar et al., 2007), and furthermore, the success of rehabilitation of those with mental illness is said to be at risk because of stigma (Lauber, Carlos and Wulf, 2005).

Mental illness stigma is an issue within BME and asylum seeker/refugee groups. According to Byrne (2001), minority ethnic individuals with mental illness may face ‘double discrimination’ (p.282) due to the combination of their ethnic background and mental illness. For many communities, the stigma of mental illness is layered upon racism and other forms of discrimination, leaving individuals and their families in a complex, highly vulnerable and often helpless situation (Scheffer, 2003).

It has been suggested that in fact the effects of stigma may be even more detrimental for ethnoracial and ethnocultural communities, than for the general population (Scheffer, 2003). A clearer understanding of the cross-cultural elements of stigma and discrimination experienced by those with mental health difficulties has been argued as an area that should be investigated further by future research (Stuart, 2008).
Section 3: The Sanctuary Community Conversation Programme

3.1 Addressing mental health stigma within BME communities

Evidence of what works in addressing stigma with BME communities is limited. Anti-stigma activities are often one aspect of mental health projects with BME communities and are rarely evaluated systematically (Rethink 2004). National anti-stigma programmes are often culturally inappropriate (Tilbury et al 2004); omitting multi-racial images and role models from their campaigns and failing to use appropriate media channels, clear language, and translated materials (Glasgow Anti-Stigma Partnership 2006).

A major study looking at addressing stigma with BME communities is the Mosaics of Meaning Programme which was designed to explore and address stigma within BME communities in Scotland; and to use action research involving universities, public organizations and community groups to explore patterns of stigma in a local context (Glasgow Anti-Stigma Partnership, 2007). Experienced researchers trained and supported members of BME communities to design, implement and evaluate focus group research. This approach helped to build capacity within communities to understand mental health inequalities. The research was an iterative process in which the research partners continuously reviewed and drew conclusions from the findings. A key theme to emerge from the findings was that of “shame”, resulting in concealment of mental health issues due to profound concerns about its impact on marriage prospects. Issues around perceived dangerousness and concerns about low educational achievement emerged in some groups. There was also a strong belief that mental health problems are incurable. This had serious implications in terms of people being reluctant to seek help. In some cases mental health was seen as a punishment from God or caused by black magic, spirits or jinn. This might be accompanied by avoidance of individuals and families linked to notions of contagion. The findings varied in nature and extent across communities and by generation but highlighted that stigma within these communities is as significant as for the wider indigenous population.

The research also considered what could be done to address stigma. Participating communities in the research talked positively about community interventions and discussion groups to address stigma, and targeted work in community venues and with family members, clinicians and media used by BME communities. This research identified the value of community development approaches, which engage with people, and are designed
and delivered by community organisations and work within cultural understandings of mental health.

In response to this community research completed in 2007, the existing partners continued to work together to develop an intervention that used community development approaches to address stigma and discrimination, entitled ‘community conversation’. The community conversation intervention aimed to explore mental health and stigma in safe, supportive workshops. Community organisations led the design and evaluation of the workshops, to ensure the process was culturally sensitive in terms of language, process and content. A continuous process of learning and development was undertaken to inform the development of the community conversation model. The evaluation aimed to measure changes in the knowledge, attitudes and behavioural intent of the participants as well as participants’ views on the workshop. In order to evaluate impact, pre and post questionnaires were administered in conjunction with qualitative feedback. Community conversation workshops were delivered to over 250 participants from Chinese, Indian and Pakistani ethnic minority communities. The baseline results reinforced findings from the previous community research, which indicated that significant levels of stigma exist within these communities as they do in the wider population. Areas of concern include perceptions of dangerousness, social distance, capability, secrecy and shame, but there were positive findings in relation to recovery optimism.

The evaluation of change in attitudes and perceptions as a consequence of the community conversation workshops was promising. There was a significant positive impact on attitudes towards mental health problems amongst participants. In particular we see a greater recognition that mental health issues are common, alongside a willingness to tell someone that you are experiencing a mental health problem. There was possibly a reduction in secrecy and shame, accompanied by a reduction in desire for social distance, an increased willingness to talk to someone and a willingness to allow someone to marry into the family, an area of particular concern. There was also a reduction in perceived blame of the person for their condition and also greater recovery optimism. Overall, the community conversation workshops had a similar impact upon participant attitudes according to age, gender and ethnicity. However, sufficient variation between and within communities indicated that intervention models need to be developed by and not for communities, if we are to respond adequately to diversity within them (Knifton et al 2010).
3.2 The Sanctuary Programme

With Scotland hosting increasing numbers of asylum seekers and refugees, the mental health needs of this population has become an important issue to address. The Glasgow Anti-Stigma Partnership felt that following the success of the Mosaics of Meaning Programme described above, there would be value in replicating this work with asylum seekers and refugees.

The Sanctuary Programme therefore started in 2007. It brought together national, regional and local partners to undertake a similar action research project, seeking to identify patterns of stigma and discrimination experienced by asylum seekers and refugees in Glasgow and to explore how this may be addressed through community development approaches. Peer led research was undertaken with over 100 participants and identified how pre-migration trauma as well as poverty, racism and the stress of the asylum process was impacting negatively upon people’s mental health (Sherwood 2008). In addition, significant levels of stigma and discrimination towards mental health issues were found within communities, with rejection, avoidance, gossip and labelling being common across all groups. The study found that the stigma and shame associated with mental health problems resulted in a reluctance to seek help. As with the Mosaics of Meaning Programme, the idea of developing discussion groups on mental health was found to be universally popular across all the groups who took part in the research. As such it was felt by the programme partners that there was potential for the community conversation intervention to be a useful resource in addressing stigma and discrimination within asylum seeker and refugee communities in a similar way as it had done in the Mosaics Programme.

3.3 Sanctuary community conversation workshops

Within the Sanctuary Programme, community conversation workshops explored mental health and stigma in safe, supportive environments. Peer educators drawn from asylum seeker and refugee community organisations designed and delivered the workshops to ensure cultural sensitivity in terms of language, process and content.

The aims of the community conversation workshops were:

1. To promote positive mental health
2. To encourage peer support for people experiencing mental health problems
3. To encourage help-seeking
4. To reduce stigma and
5. To promote recovery

The content of the workshops included sessions on mental health, mental health problems, stigma and recovery. The workshops combined didactic presentations alongside participatory group work.

The workshops were based in a range of community venues across Glasgow. 25 workshops took place between May 2009 and May 2010 and each lasted one and a half hours. In total 324 asylum seekers and refugees residing in Glasgow took part in the community conversation workshops. Participants were recruited via asylum seeker and refugee community groups. The rationale for the session was to improve awareness of mental health issues for the whole asylum seeker and refugee community (not just those at risk of mental health problems) in order to reduce stigma, promote help seeking and peer support.
Section 4: Evaluation of the impact of community conversation workshops

Different methods were used to assess the impact of the community conversation workshops. For the first 12 sessions, pre and post questionnaires with a qualitative component were used; and in the second 13 sessions, 4 focus groups were used to gather feedback on the experience of participants.

4.1 Pre and post workshop questionnaires evaluation

4.1.1 Methodology

In the first 12 sessions, the study adopted a repeated measures design where an opportunistic sample of participants completed a self-reported attitudinal questionnaire immediately prior to and following the workshop. The independent variable was workshop status of which there were 2 levels (i.e. before the workshop and after the workshop). The dependent variables were 1) total stigma score and 2) stigma component (i.e. individual questionnaire statement) scores.

A questionnaire was developed to capture attitudes to mental health problems using questions adapted from the Scottish Public Attitudes Survey, which had previously been used in a study on the impact of community conversation workshops with settled BME communities in Scotland. This is not a standardised measuring tool re stigma and it is acknowledged that reliability and internal & external validity has not been verified. The questionnaire consisted of a set of 11 statements about individuals with mental health problems and participants were asked to indicate, using a 5-point Likert scale, the extent to which they agreed or disagreed with the statements made. The 11 questionnaire statements were as follows:

1. Mental health problems are very common.
2. I would feel unsafe around a person with a mental health problem.
3. I would find it hard to talk to someone with mental health problems.
4. People with mental health problems should have the same rights as anyone else.
5. People with mental health problems are to blame for their own condition.
6. People with mental health problems are unpredictable.
7. I would be happy for someone with a mental health problem to marry into my family.
8. People with mental health problems cannot contribute to their community.
9. The majority of people with mental health problems recover.
10. Anyone can experience a mental health problem.
11. If I had a mental health problem, I wouldn’t want to tell anyone about it.

The questionnaires that were administered immediately prior to and following the anti-stigma workshops were essentially the same (Appendix 2). However, the post workshop questionnaire contained some open-ended questions at the end. These asked participants to indicate

- what was helpful and unhelpful about the session/workshop
- 3 new things that they had learned from the workshop/session
- how the workshop had altered their views of mental health problems
- whether they would do anything differently as a result

On arrival at the training venue, participants were asked to complete the questionnaire prior to commencement of the workshop. Participants were advised that responses would be anonymous and that they should indicate what they really thought and should not confer with others regarding completion. Participants were given a total of 15 minutes to complete the questionnaire. Following delivery of the workshop, the questionnaire was re-administered to participants with identical instruction re completion.

Baseline (pre workshop) and post intervention (post workshop) stigma scores were calculated for each participant based on questionnaire quantitative responses. To prevent a response pattern developing, just over half the questions (i.e. 6) were phrased positively and just under half (i.e. 5) were phrased negatively. Prior to analysis, responses were all coded in the same direction where 1= response was not stigmatising and 5 = response was maximally stigmatising. Point 3 on the Likert scale response option was "no opinion".

Overall stigma scores were calculated by summing Likert scale responses to provide a score within the range of 11-55: the higher the score, the greater the stigmatising attitude towards individuals with mental health problems.

Questionnaire statement (component) stigma scores were calculated for each of the 11 questionnaire statements. The score for each statement ranged from 1-5: the higher the score, the greater the stigmatising attitude towards that particular element of mental (ill) health.
4.1.2 Demographic profile of participants

Of the 117 participants that took part in the anti-stigma workshops/training sessions, 114 provided information in relation to gender indicating that one third (33.3%, n= 38) of participants were male and two thirds (67.3%, n= 76) were female. 113 participants provided information in relation to age indicating that two thirds of participants (i.e. 66.4%, n = 75) were aged between 25 and 44 years; 15% of the sample (n= 17) were aged between 16-24 years whilst the remaining participants (18.6%; n = 21) were aged 45 years or above.

116 participants provided details of their ethnicity indicating that 36.2% (n = 42) of participants were of African origin; 28.4% (n = 33) were of Middle East/South East Asian origin; 9.5% (n=11) were of Kurdish origin; 4.3% (n= 5) identified themselves as White British; 1.7% (n= 2) were of mixed ethnicity whilst the remaining 19.7% (n= 23) were of `other' ethnic origin.

113 participants provided information in relation to their religious persuasion indicating that the majority of participants were followers of Islam (61.9%, n = 70); 18.6% (n = 21) identified themselves as Christian: other; 8.8% (%) indicated that they were Roman Catholics; 1.8% (n = 2) were followers of `other' religion whilst the remaining 8.8% (n = 10) preferred not to specify their religion (see Appendix 1 for a more detailed account of the demographic profile of participants). It is acknowledged that English language ability may be a confounding variable in this study. There was varying ability in the level of English proficiency amongst participants, which may distort the findings of this study.

4.1.3 Overall stigma scores

Pre and post total mean stigma scores and standard deviations were calculated to determine if attendance at the anti-stigma workshop/training reduced stigmatising attitudes towards individuals with mental health problems. Figure 1 clearly indicates that:

1. Overall, participants did not hold particularly strong stigmatising views towards individuals with MH problems at baseline (i.e. prior to the anti-stigma workshop).
2. The workshop reduced stigmatising attitudes towards individuals with mental health problems.
3. There was some variation within participants regarding the extent to which they held stigmatising views towards individuals with MH problems both prior to and following the anti-stigma workshop/training.
On average, participants total stigma score reduced by 6.84 points on the stigma scale. However, there was a high standard deviation associated with this (St. Dev. 6.07) indicating that while some participants may have altered their views considerably (in a positive sense), others views remained largely unchanged by the intervention.

### 4.1.4 Demographic differences in total mean stigma scores

As previously indicated, participants had relatively low stigmatising attitudes to mental health problems prior to commencement of the anti-stigma workshop(s) and this applied to virtually all demographic sub-groups (see table in Appendix 3 for pre and post mean total stigma scores and differential scores by demographic variables). There was considerable variation in the sample size of demographic sub-groups making any comparisons re stigmatising views problematic/inappropriate. Relatively high standard deviations associated with demographic sub group scores further confounded any meaningful comparisons between groups. However, a review of mean scores and standard deviations suggests that:

- Those aged between 25-34 years (n= 41) held slightly greater stigmatising views at baseline (34.54; St. Dev. 6.05) when compared with other age ranges. However, the greatest differential mean score was evident within this age range (8.00; St. Dev 6.59) suggesting that the workshop was particularly effective in reducing stigmatising attitudes within this age group.

![Fig. 1 Pre and post workshop total mean stigma scores and associated standard deviations.](image-url)
Those of Pakistani origin (n= 19) held slightly greater stigmatising views at baseline (37.26; St. Dev. 4.11) but had a greater differential mean score (10.63; St. Dev. 4.51) indicating that participants of Pakistani origin may have been particularly receptive to the anti-stigma messages delivered over the course of the workshop(s).

4.1.5 Questionnaire statement stigma scores
Pre and post workshop mean stigma scores (see Fig. 2) and standard deviations were calculated for responses to the 11 questionnaire statements to determine if attendance at the anti-stigma workshop reduced stigma towards individuals who have/have had mental health problems.

A review of mean questionnaire statement stigma scores indicated that at baseline, the most stigmatising views related to (respectively):

- People with mental health problems having the same rights as anyone else (4.23; St. Dev. 1.13)
- People with mental health problems being unpredictable (3.91; St. Dev. 1.31)
- Happiness regarding someone with mental health problems marrying into the family (3.59; St. Dev. 1.38).

Following the anti-stigma workshop/training, the most stigmatising views related to (respectively):
- People with mental health problems having the same rights as anyone else (4.46; St. Dev. 1.08)
- People with mental health problems being unpredictable (3.11; St. Dev. 1.28)
- Happiness regarding someone with mental health problems marrying into the family (3.02; St. Dev. 1.39).

A review of mean questionnaire statement stigma scores indicated that at baseline, the least stigmatising views related to (respectively):

- Anyone can experience a mental health problem (1.85; St. Dev. 1.00)
- Mental health problems are very common (2.03; St. Dev. 1.16)
- People with mental health problems being to blame for their own condition (2.21; St. Dev. 1.31)

Following the anti-stigma workshop/training, the least stigmatising views related to (respectively):

- Anyone can experience a mental health problem (1.32; St. Dev. 0.72)
- Mental health problems are very common (1.40; St. Dev. 0.77)
- Majority of people with mental health problems recover (1.61; 0.87)
- People with mental health problems being to blame for their own condition (1.79; St. Dev. 1.14)

These statistics suggest that the anti-stigma workshop(s)/training had very little impact on the areas/issues around which participants held stigmatising views but rather it reduced the magnitude of stigma in these areas.

The difference between pre and post workshop stigma scores (i.e. differential scores) and their associated standard deviations were calculated for responses to each of the 11 mental health problem related statements contained in the evaluation questionnaire (see table 3 for attitudes most amenable to change (respectively) as a result of the anti-stigma workshop).

Results suggest that the anti-stigma workshop/training was most effective in alleviating concerns/stigmatising attitudes in relation to:

1. Safety around people with mental health problems (differential mean = -1.01; St. Dev. 1.54)
2. Ease of social interaction i.e. talking to people with mental health problems (differential mean = -0.95; St. Dev. 1.46)

3. The potential for recovery from mental health problems (differential mean = -0.83; St. Dev. 1.37)

<table>
<thead>
<tr>
<th>Statement</th>
<th>Differential Mean Score</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Would feel unsafe around someone with MH problem</td>
<td>-1.01</td>
<td>1.54</td>
</tr>
<tr>
<td>Would find it hard to talk to someone with MH problem</td>
<td>-0.95</td>
<td>1.46</td>
</tr>
<tr>
<td>Majority of people with MH problems recover</td>
<td>-0.83</td>
<td>1.37</td>
</tr>
<tr>
<td>People with MH problems are unpredictable</td>
<td>-0.80</td>
<td>1.38</td>
</tr>
<tr>
<td>People with MH problems cannot contribute to their community</td>
<td>-0.79</td>
<td>1.68</td>
</tr>
<tr>
<td>MH problems are very common</td>
<td>-0.62</td>
<td>1.04</td>
</tr>
<tr>
<td>Would be happy re marriage into family</td>
<td>-0.57</td>
<td>1.22</td>
</tr>
<tr>
<td>Would not tell if I had MH problem</td>
<td>-0.54</td>
<td>1.32</td>
</tr>
<tr>
<td>Anyone can experience a MH problem</td>
<td>-0.53</td>
<td>1.02</td>
</tr>
<tr>
<td>People with MH problems are to blame for own condition</td>
<td>-0.43</td>
<td>1.25</td>
</tr>
<tr>
<td>People with MH problems should have same rights as anyone else</td>
<td>+0.23</td>
<td>1.17</td>
</tr>
</tbody>
</table>

Table 3 The difference between pre and post workshop responses (i.e. differential scores) to the 11 mental health related statements contained in the evaluation questionnaire and associated standard deviations

4.1.6 Demographic differences in mean questionnaire statement stigma scores

As previously indicated, participants had relatively low stigmatising attitudes to mental health problems overall prior to commencement of the community conversation workshops. However, some variation was evident within demographic sub-groups in relation to specific areas of stigma (see Appendix 4 for pre and post mean questionnaire statement stigma scores and standard deviations by demographic variables).

1. Overall, the workshops appeared effective in reducing stigmatising attitudes towards most mental health related issues for the majority of demographic sub-groups.

2. Prior to the commencement of the workshops, participants of Pakistani (n=19) and Kurdish (n=11) origin were most likely to be concerned about someone with mental health problems marrying into their family. The workshop appeared to reduce concern in some participants of Pakistani origin (baseline mean = 4.63, St. Dev. 0.76; post workshop mean = 3.58, St. Dev. 1.26) but had little effect on those of Kurdish origin (baseline mean = 4.36, St. Dev. 0.81; post workshop mean = 4.27, St. Dev. 0.90).
3. For those of Kurdish origin (n=11), the workshop appeared to cause a slight increase in concerns about telling anyone if they had a mental health problem (baseline mean = 2.73, St. Dev. 1.79; post workshop mean = 3.27, St. Dev. 1.90).

4. For those of Afghan origin (caution regarding particularly small sample size i.e. n =3), the workshop appeared to exacerbate stigma in relation to the contribution that those with mental health problems can make to their community (baseline mean = 3.67, St. Dev. 1.15; post workshop mean = 4.00, St. Dev. 1.00). However, the converse was true for those of Pakistani origin where the workshop appeared effective in reducing stigma in relation to the contribution that people with mental health problems can contribute to their community (baseline mean = 4.05, St. Dev. 0.97; post workshop mean = 2.47, St. Dev. 1.22).

5. The workshop appeared particularly effective in reducing stigma amongst those of Afghan origin (again caution regarding particularly small sample size i.e. n =3) with regards to attitudes towards recovery from mental health problems (baseline mean = 4.00, St. Dev. 1.73; post workshop mean = 1.00; St. Dev. 0.00).

6. Of all demographic subgroups, exacerbation of stigma following the workshop in relation to the rights of those with mental health problems was most evident in those of Iraqi (n= 9) origin (baseline mean = 3.00, St. Dev. 1.32; post workshop mean = 4.00, St. Dev. 1.12).

### 4.1.7 Qualitative feedback

Responses to the open ended questions were content-analysed to describe the frequency of the main themes identified. A total of 60 (50%) of the 117 participants responded to the qualitative questions.

In response to the question “what was helpful about the session” the most common themes to emerge were ‘information’ (12), ‘learning about mental health problems’ (11) and ‘discussion’ (10).

In response to the question to the question “what did you learn” the main themes to emerge were ‘how to get help’ (14), ‘that people recover’ (9) and ‘mental health problems can effect anyone’ (6).
In response to the question “has the session changed your views about mental health problems” the main themes to emerge were ‘people can recover’ (5) ‘anyone can experience mental health problems’ (5) and ‘less stigma towards people with mental health problems’ (4).

In response to the question “would you do anything differently as a result of the session” a range of issues were identified including ‘not labelling people’, ‘respect people’, ‘not being scared of people with mental health problems’ and ‘offers help and support to people with mental health problems’.

4.2 Participant focus group evaluation

4.2.1 Methodology
In the second set of 13 community conversation workshops, four focus groups were conducted qualitatively to analyse the impact of the workshops on the asylum seeker and refugees participants. The workshops all had 6-10 participants. The focus groups took place immediately after the workshops had finished with approximately 4 of the attendees. The focus group lasted between 15-30 minutes.

The first focus group was a mixed ethnicity women’s workshop; the women were of Pakistani, African, Lebanese and Iranian ethnicity. The second group was a mixed gender African workshop; 3 men and two women. The third focus group was mixed gender and mixed ethnicity workshop; 2 men and 3 women took part in the focus group they were of Pakistani, African and Somalia ethnicity. The fourth focus group was a Pakistani men’s workshop; 4 Pakistani men took part.

The participants were asked two questions
1. What did you learn about mental health as a result of attending the workshop today?
2. Have you changed the way you think about mental health and mental health problems as a result of attending the workshop today?

4.2.2 Findings
A range of findings emerged from the focus groups and these have been grouped into 7 themes.

4.2.2.1 Anyone can experience mental health problems
The majority of participants in all of the four focus groups felt that as a result of attending the workshop they learned a lot more about mental health. They learned that mental health problems is an illness like any other and can be treated:

“Now I know that mental health is like any other ordinary illness”

Participants in group commented that they had previously viewed any kind of mental health problem as a ‘sickness’. As a result of attending the workshop the participants now felt that mental health is a state of mind and people can be on a spectrum. In addition, there was a view amongst participants that anyone can experience mental health problems:

“Every person has mental health… people would think ‘oh he’s got a mental problem’ and just lock him in the room and stuff but rather that doing that we should cure them and give them hope.”

The majority of participants in all focus groups felt that people experiencing mental health problems need to be supported and they are suffering from an illness just like ‘flu or a broken leg:

“I know in my countries they used to keep them in hospitals and things because to them it is an unusual disease.”

“For examples where I come from in Africa these mental health problems are viewed they don’t exist and if they do exist we suppress them.”

4.2.2.2 Differentiating between mental health problems
Participants in all of the four focus groups commented on the fact they had changed their views with regards to mental health as a result of attending the workshop. However the extent of this varied between the four groups. The definition of mental health problems appeared to be much clearer for participants and they understood that there is both positive and negative mental health and that everyone has mental health. Previously, the group equated someone suffering from a mental health problem as being “mad” and that this had changed as a result of the workshop. The workshop helped to increase their knowledge of mental health through explaining the wider concept of mental health, not only its negative connotations and experiences.
“It’s always referred to as a problem when it’s mental health issues, sometimes it’s something positive, it’s a state of mind in that particular time.”

Furthermore the difference between different types of mental health problems was identified. Identifying differences between stress, depression, anxiety and severe mental problems was a major theme which ran through all of the four focus groups. Participants felt this was helpful in that they felt they could put their experiences and current situation into context and not feel so overwhelmed. Some of the groups had the opportunity to hear different views on mental health as a result of the workshop and they learned about concepts of isolation and stress.

“I now know the differences between the mental health problems... everything she explained very well.”

Prior to attending the workshop they associated the term mental problems with psychosis and people who are unpredictable:

“Someone who is really ‘psycho’, someone who needs to go to hospital, someone who needs kept somewhere with medication; but in reality it just that everyone can suffer from mental health either positive or negative.”

“Before when I heard mental health, I thought this man is crazy want to take him to hospital or something like that; but now I can understand the differences between mental health and mental health problems. Before I didn’t understand.”

The groups felt that people have complex emotions and can go through very stressful periods in their lives. However they also acknowledge that such periods are not permanent and that it is possible to get help.

“If you are in a bad state and it continues for a long time then you need counselling.”

4.2.2.3 Causes of mental health problems
In relation to causes, culture was brought up by most participants in all focus groups. They felt that within their culture, there is a good family structure which helps when they are feeling stressed or low. Some of the groups brought up issues within communities and how groups such as refugees and asylum seekers may be at a greater risk of mental health problems. The group felt that their mental health was being affected or had been affected
with the asylum seeking process and moving from their counties of origin. This is because they are coming from war torn countries and may not have families around or people they can talk to.

4.2.2.4 Stigma

Almost all the groups talked about feeling stigmatised and unable to talk about the mental health problems they have faced in the past or are currently going through as they fear they will be embarrassed and bring shame to themselves. Most of the groups commented on previously being unable to talk about mental health issues especially within their communities. Some groups discussed that within certain cultures, people suffering from anxiety and depression can be branded and “mental”. Some countries may be inclined to lockup a person suffering from a mental health problems and disregard them and their opinions.

The majority of participants in all groups felt that the stigma related to mental health problems is not only present in their countries of origin but also in the UK and they have experienced it first-hand here in Scotland. All groups commented that as a result of attending the workshop they had learnt more about the stigma attached to mental problems and how they themselves had some negatives views with regards to mental health.

The workshop helped to give all the groups knowledge about predictability of people suffering from mental health problems. They now feel not all people suffering from MH problems are unpredictable. However in one group some participants felt that when a person has a serious mental illness only then they might become unpredictable. The group felt that the workshop has not alleviated all their fears about people with mental health problems. They would still be scared of and avoid people with serious mental health problems.

“I haven't changed my mind on (serious mental health problems) that I'm still gonna be scared if someone is in a bad mental state, obviously some of the may be violent, maybe suicidal, hopeless maybe they don’t so anything at all.”

With regards to marriage, the groups felt that they now have more knowledge of mental health issues and would not be against someone with mental health problems marrying into their families.

“I used to think someone with mental health problems...she can't marry in my family but today I changed my opinion.”
4.2.2.5 Recovery
Recovery from mental health problems has emerged as a major theme from the workshops across all four focus groups. The all participants felt they really learned about recovery as a result of attending the workshops. They previously had little knowledge about how and if people with mental health problems can recover. However now they feel that full recovery is possible and likely for a person experiencing mental health problems:

“\textit{I learned about recovery.}”

Recovery was a major theme with all groups commenting on understanding the concept of recovery much better. They commented on recovery being possible and even likely when a person is suffering from mental health problems.

4.2.2.6 Help and support
Participants talked about recognising the importance of help and support. In one focus group the participants all felt as a result of attending the workshop they had acquired news skills. One participant used the example of if a person had a broken heart or a broken leg then he now has the skills to support them. They also learned to deal with some of these issues and how they might be resolved with help:

“(\textit{I know now}) \textit{what’s happening to the person and then what the solution.}”

Some of the participants in most of the groups felt they learned how to be patient with someone with a mental health problem. This group also felt they had learned much more about coping:

“\textit{I learnt about the symptoms and then about the healings and about coping}”

Participants felt that if they came across a person with any kind of mental health problem in the future they would be a lot more accepting and understanding of their condition. They feel they will now be able to help someone suffering from mental health problems based on their experiences and as a result of attending the workshop.

Participants felt that the workshop enabled them to talk about their stress openly and by learning each other’s issues they felt comforted that they are not alone and others have had similar experiences.
“If we come like this people from different backgrounds, we can go back and tell our different friends and spreading the knowledge and raising awareness.”

“It would have been nice to have some leaflets or some papers that we can also go and give our friends.”

In terms of sources of support for mental health, one of the groups commented on needing help with asylum, with money and practical support. They feel social events, sightseeing and excursions would also help their mental health. The group were keen to take part in any future workshop and put forward the idea that there should be discussions similar to this workshop every month. The group also stated that they would be interested in any future workshop which may provide them with more information and knowledge about mental health.

Some of the participants provided examples from their personal lives about getting help from their counties for mental health problems. The group felt they needed a counsellor present at the workshop so that they could talk about mental health issues they are facing. They needed additional help because they are asylum seekers who are facing a lot of stresses in their lives and the workshops should provide additional support and advice.

4.2.2.7 Delivery of workshops

The group commented on the content and the delivery of the workshops; the content was easy to understand and generated good communication in the group. The delivery was clear and concise and everything was explained to them very well. If they struggled with any words or ideas the workshop leader explained this to them in their own language, this was perceived as extremely helpful by the group.

Participants found the atmosphere of the workshops was friendly and focussed of giving lot of unnecessary information. The group particularly enjoyed the communication amongst one another and enjoyed the opportunity to view their thought and opinions.

The groups particularly emphasised that the workshops created dialogue and enabled them to talk very openly about their views and experiences of mental health. Also they felt that this sharing of information helped them to put their problems, stresses and mental health issues into perspective. The group felt that due to their common issues of seeking asylum they had empathy for each other and also similar stress that they had experienced:
“Listening to other people’s problems then maybe you think your problem is minor in comparisons”

“During this workshop I realised so many people are suffering (from mental health problems) so that really helped.”

All groups commented that the workshops were delivered in a way that everyone was participating and everyone had an opportunity to speak. They felt that they came together and enjoyed the sharing of information and the dialogue in the group.

This group felt that talking openly about mental health issues at the workshops was very helpful and that there is a lack of knowledge in their countries:

“Most of our cultures are not developed countries were you can talk”

Some participants from across the four focus groups felt that they still needed additional education and training in this area; expressing a need for more knowledge about mental health and mental health problems:

“I think we need more learning and training.”
Section 5: Views of peer educators, project co-ordinator and partners

In addition to assessing the impact of the workshops on asylum seekers and refugees, given the innovative nature of the process, there was a desire to capture the learning from the process of delivering these workshops, so that the model could be replicated. This was done in 3 ways: a focus group with peer educators; an interview with the project co-ordinator; and the written perspectives of 2 partners from the Sanctuary steering group.

5.1 Methods

A focus group was carried out with peer educators. The peer educators were people from refugee and asylum seeking communities; they were given training and delivered the workshops. The peer educators were from various backgrounds, this included Iran, Iraq, Kurdistan and Libya. The peer educator focus group was made up of four peer educators - 3 female and 1 male. The focus group lasted approximately 40 minutes.

The role of the project co-ordinator was to organise and facilitate each workshop. The co-ordinator was involved in overseeing all aspects of the workshop. A one to one interview was carried out with the project co-ordinator, this lasted approximately 50 minutes.

The same questions were asked within the focus group and the interview.

5.2 Findings

5.2.1 Can you describe your role in the community conversation project?

The project co-ordinator explained she often took on most of the responsibility for the planning and delivery of the workshops. She had initially assumed peer educators would have a bigger role, for example in helping to recruit participants. The co-ordinator suggested recruiting more peer educators in order to have a diverse range of individuals who may be able to play a more effective role. Also she felt it would be good to have peer educators who were more active in the community.
“I could have easily gone in and delivered awareness raising workshops. But it was really about getting the people from the communities themselves. The recruiting was the most difficult task”

Peer educators felt their role was to provide information about mental health issues on a general and basic level. They also identified that their role was to de-stigmatize mental health. They also felt their role was to raise awareness of mental health the issues in their communities.

“Change their mentality, change their concepts about mental health issues so that they can relies that it is like any other disease”

5.2.2 How well do you think the sessions were received?
The project co-ordinator explained that the success of a session was dependent on the groups that the session was being delivered to and that the response to the workshops varied. Peer educators felt that the sessions were well received however identified language as a barrier/problem and that an interpreter was needed at the workshops. Peer educators found it difficult when the participants were not from the same cultural background as them, due to not being able to translate the content of the workshops.

5.2.3 What went well?
The project co-ordinator felt that sessions were more successful when delivered to groups who were from the same community as this seemed to help sessions work better because of dialogue and cultural values being similar:

“When you’re recruiting a group and you put down a specific group like African or Iraqi that works much better than mixed groups”

Peer educators felt the sessions were compact, straightforward and to the point and didn’t assume prior knowledge. They felt that the training materials were put together well. The emphasis on recovery in the session was felt to be useful. Peer educators also felt that the simplicity of the sessions was what went particularly well. They also felt that participants were not overwhelmed with too much information and introduced the content of the workshop clearly and at a basic level
"We go for their level of understanding, we just give them this information so they can understand it."

5.2.4 What didn’t go well?
The project co-ordinator identified a number of factors that were more challenging. There was often a huge level of emotional need identified at the sessions, which she felt was impossible for her or the peer educators to meet. This often involved participants staying behind to talk and the co-ordinator often felt overwhelmed by this. As a result, she reported that she needed counselling and a means of providing the participants with additional information about the difficulties they were facing. Peer educators thought that there was a lack of visual aids and additional facilities to make participants more interested in the content of the workshops. They suggested the use of power point and DVD materials would be useful in the future. They also felt that providing participants with more information to take away would have been useful.

5.2.5 How did you find the process of recruiting peer educators for the workshops?
The co-ordinator explained that recruiting peer educators was not a difficult task because of the links she had with various community based organisations which helped her contact suitable candidates. However, due to the peer educator training involving full days, women were more reluctant to attend because of crèche facilities not being onsite. The payments made to peer educators and the value of the experience gained were identified as very good incentives for potential future peer educators.

5.2.6 How did you find the process of recruiting participants for the workshops?
The co-ordinator explained that recruiting participants was one of the most difficult aspects of her role. She worked long hours to ensure the workshops were well advertised and she was in constant contact with potential participants. She explained that the logistics involved in finding a neutral venue were very demanding. Although they were aware it was part of their role, peer educators reported they didn’t play much of a role in recruiting participants.

5.2.7 Would you make any changes to the content of the workshops?
The co-ordinator explained she would not change any of the workshop content as she felt everything was very well received and created positive discussions about mental health problems amongst the participants. She felt however that the evaluation process could be improved although was unsure how to simplify the evaluation form any further. The peer educators said they were happy with the content of the workshops and they would not make any changes to it. They felt the content was basic and easy to understand for all the
participants. However they did reiterate that the participants and the workshops would have benefited from visual aids and electronic facilities.

5.2.8 Do you think the content and material covered in the session was relevant to all the diverse ethnic groups who attended?
The co-ordinator explained that the material covered in the workshops was of a basic level and not complicated and was actually relevant to all the ethnic groups who attended the sessions. Peer educators agreed that the content of the workshops was relevant to all ethnic groups they delivered to because the content was general and of a basic level.

“We explained to them in the beginning that this material is for teaching purposes and we are not here to diagnose anyone so I think it was ok, it was relevant.”

5.2.9 Did you receive adequate training and support to undertake your role?
The co-ordinator felt that her training was adequate for her role. However due to the nature of her role she needed to use her own initiative a lot of the time due to circumstances changing and expanding constantly and this was very demanding. She felt that latterly she did receive the support needed to deal with the role adequately. Peer educators felt they received adequate training in order to undertake their role. They also indicated that they received good support from the project co-ordinator and really appreciated the opportunity to practice the workshops with her before delivering them to the participants.

5.2.10 What were the emotional demands of your role?
The project co-ordinator felt that her role was demanding in a number of ways including: exposure to others’ distress, receiving requests for support outwith the workshops and beyond the boundaries of her role and coping with the anxieties of peer educators. She felt that she protected the peer educators from the need for advice and emotional demands from participants. She found her role very stressful and very emotionally demanding at times.

“It was actually very stressful sometimes”

“You felt that you wanted to go and help them that person was in your mind all night because you know you sat and talked with them”

Peer educators on the other hand did not find their role emotionally demanding, although some of the views of the participants made them angry because they were stigmatising.
“Yes I think so some views just make you angry”

However, they were positive the majority of the time towards participants because they would see a change in their attitudes towards mental health during the workshops.

“It makes me feel proud that I am at least doing something to help them”

5.2.11 How appropriate were the venues and other practical issues like catering, use of interpreters and child care?
The co-ordinator explained that a lot more needs to go into the future recruitment of groups attending the workshops. She feels if that is in place then everything else would run smoothly. Child care facilities within the venues used were a difficulty, and the financial cost involved in child care was also an issue. Peer educators felt that having childcare facilities helped them attend the training and also helped participants attend the workshops. Peer educators discussed the idea of audio visually recording the delivery of their workshops. In order to make improvements in their delivery in the future and also to assist other peoples learning.

5.2.12 How easy or difficult was it to manage the expectations of participants?
The co-ordinator explained she was heavily involved in making participants feel welcome and comfortable attending the workshops. She feels most the participants gained a lot from the session; however some were a little disappointed with the content and wanted a lot of advice and emotional help, which it was impossible for her to meet in her role.

“I really did wrap them in cotton wool and keep them away from any issues”

5.2.13 How easy or difficult was it to manage the expectations of peer educators?
The co-ordinator felt that managing the expectations of the peer educators was not difficult because of the incentives they would gain from their roles. She feels she supported them a lot and took on many of their responsibilities. She feels she managed their expectations quite well; however she feels it would be important to place more responsibility on the peer educators in the future.

5.2.14 Were there issues identified by participants at the workshops that required follow up and how easy/difficult was it to signpost participants to the appropriate help?
The co-ordinator felt that there were an enormous amount of practical and emotional issues identified by participants at the workshops that required follow up and that is was difficult to direct participants to the appropriate help. She feels some of the issues participants raised required input that she was not adequately equipped to deal with. The task of signposting participants was very difficult. She feels the need for additional knowledge and access to some kind of directory would help with signposting. Peer educators explained that in the majority of cases participants wanted help and advice about asylum. Participants attributed their mental stress to the asylum process and claimed that their mental health was being affected by their circumstances. They did find signposting participants to sources of help difficult and they felt they were letting participants down if they could not help them.

5.3 Perspectives of partners

In addition to the views of peer educators and the project co-ordinator, the views of two partners who were members of the Sanctuary steering group were collected. This was done through asking for their written views on the process. The findings from this are detailed below.

5.3.1 Recruitment of project co-ordinator

In relation to developing the Sanctuary community conversation programme, it was recognised there was a lack of capacity within asylum seeker and refugee community organisations to deliver this work. This was a major difference from the community conversation programme carried out with settled communities within the Mosaics of Meaning Programme. The Sanctuary partners felt that due to this lack of capacity, the community conversations would be most effectively delivered through being peer led and decided to recruit asylum seekers and refugees to deliver workshops to community groups. In order to manage this process, it was agreed to recruit a co-ordinator. Given the unique nature of the community conversation model, it was agreed to recruit someone with experience of using this approach. As such, the co-ordinator was recruited from one of the BME community organisations who had delivered the original Mosaics of Meaning community conversation work.

5.3.2 Recruitment of peer educators

It was originally intended to recruit peer educators who were attached to organisations and who had links with asylum seeker and refugee communities. The project co-ordinator did outreach work with community organisations, following up existing contacts and via the
Scottish Refugee Council networks, to identify 12 people who wished to train as peer educators. At this stage all 12 identified themselves as being part of, or having links to, community organisations that support refugees and asylum seekers.

5.3.3. Training the peer educators
The Sanctuary partners initially planned 2 one-day training workshops to equip the peer educators with the knowledge and skills to deliver the workshops within their respective organisations and communities. The sessions were planned to take place a week apart. Travel expenses and subsistence costs were provided. The peer educator training was designed and delivered by the project co-ordinator with members of the Sanctuary steering group each having a role.

The first day of the peer educator training programme aimed to familiarize the peer educators with mental health and wellbeing as well as introduce concepts around stigma and recovery. The second day of the training focused on group work techniques and then designing the actual workshop sessions which the peer educators would be delivering.

Reflections and feedback from both the trainers and the peer educators from the 2 day training identified the need for further training and support in relation to 2 areas – developing the content of the training pack to be used in the workshops and developing the peer educators’ confidence in delivering material to a group. As a result, a further 2 training sessions for the peer educators were developed. These 2 sessions focused on practicing delivering sessions using role play and building up the workshop content into a useable training pack.

5.3.4 Developing the training pack
The peer educator training initially used an existing mental health awareness workshop resource developed through the Mosaics of Meaning settled BME community conversation programme. In order for the peer educators to feel confident in delivering the pack with asylum seeking and refugee communities, a number of adaptations were made. These adaptations were made in discussion with peer educators. The project co-ordinator, in partnership with the Sanctuary steering group, adapted and refined the workshop contents into a trainer’s pack which was tried and tested by the peer educators in their role play and shadow training sessions. The resulting training manual and pack was then used across phase 1 and phase 2 of the community conversation workshops by the peer educators and project co-ordinator.
5.3.5 Learning from the peer educator training and training pack

In developing the peer educator training, a number of assumptions were made by the Sanctuary partners:

- that 2 day’s training would equip peer educators to deliver this training
- that learning styles would be the same as for the settled BME peer educators who were trained before
- that the training pack could simply be replicated from that previous work
- that knowledge and confidence about delivering workshop sessions would happen quickly
- that peer educators would be highly motivated to deliver the programme.

In reality we found a different picture:

- peer educators needed more time to practice
- training the peer educators took longer than we thought
- having a flexible approach to the training meant we could adapt and strengthen the process as we went along
- the training pack benefitted from peer educator input and suggestions
- the original 12 peer educators recruited were not the peer educators who finished the training process
- peer educators gained a lot of knowledge and skills from each other through practicing and shadowing
- certificates of attendance were valued as an end in themselves
- peer educators’ ability to deliver sessions varied.

5.3.6 Peer educators’ experience of delivering the workshops

The 12 peer educators all had experience of seeking asylum and many of their individual circumstances changed during the course of the programme, with all eventually having status to remain in the UK. This may be one of the factors which contributed to the high ‘drop out’ rate as people naturally moved on to fuller employment or education; from a pool of 12 recruits, 8 were available to facilitate sessions, tailing off to 4 by the end of the programme.

As a result of the training sessions it was agreed that peer educators would be mentored by the project co-ordinator into the role of independently facilitating the workshops. In undertaking this it gradually become apparent that most peer educators did not feel confident to fully facilitate, taking the role instead of becoming part of the sessions themselves. We also found it difficult to match peer educators’ availability to that of the
workshops, meaning that 4 of the 12 sessions in phase one were delivered by the project co-ordinator alone. During phase 2 this increased to the project co-ordinator delivering 7 of 13 sessions. Where the co-ordinator didn’t facilitate alone she still mostly retained the lead role as only 3 peer educators of the original 12 felt able to lead sessions.

It was intended to employ the peer educators as consultants to the Mental Health Foundation however this proved difficult with peer educators reluctant to take up a formal position. It may be inferred that people still within the asylum system may have significant concerns about signing papers, given the precariousness of their legal situation. As such we concluded that a flexible and sensitive approach to employment and remuneration should be agreed through early dialogue between employing agencies and peer educators.

5.3.7 Recruiting participants

Engaging peer educators who were already ‘attached’ to organisations was intended to the make recruitment of participants straightforward in that recruitment would be undertaken by peer educators who knew the community and the Community Conversation hosting organisations. It was assumed that peer educators would develop relationships with community organisations to host and that community organisations would recruit for Community Conversations and support the co-ordinator in making practical arrangements such as childcare and interpreting. In reality peer educators struggled to pull groups together and the project co-ordinator had to intervene to recruit groups. Although this approach was largely very successful, with a total of 154 participants attending 12 sessions, it put strain on the project co-ordinator as she undertook a significant amount of detached work to meet people and bring them together. This included following up peer educators connections by phone, email and in person, going ‘door-to-door’ in communities, leafleting and talking to people in the street, attending a range of community events (often at evenings and weekends) as well as persuading community organisations to support the programme and asking them to let members know of when and where sessions were taking place. The project co-ordinator quickly found that community organisations were unable or unwilling to recruit for sessions and so she booked the workshop venues, childcare and catering and then recruited to fill sessions. It was concluded from this that to ensure future success, organisations need to invest in the programme to then support participation.

Frequently people attending sessions were not the people expected. This worked well for facilitating the Community Conversations but created difficulty with crèche provision, as the number and ages of children were unpredictable, interpreting, catering and payment of
expenses for participants. This approach also resulted in mixed language sessions which were well received but problematic in terms of interpreting and completing evaluation forms.

During the course of phase 1, the project co-ordinator reported back to her line manager about the processes involved in engaging participants. At this stage significant health and safety issues were addressed. It was agreed that a lone working policy be adopted immediately with procedures including booking in and out with the line manager when working away from the office or at evenings or weekends, an immediate end to outreach to unknown areas, a work mobile phone and limits to amounts of cash carried to sessions.

At the end of Phase 1, the project co-ordinator reported the difficulties and the new arrangements for lone working to the steering group and a change of approach was agreed to end the detached work to recruit groups. It was agreed that organisations would agree to recruit groups in order for conversations to take place. This meant working with those organisations that were willing and able to do this, rather than persuading disinterested organisations to take part in order to aim for fully representative geographic and cultural representation. This new approach also included single language based Community Conversations. Phase 2 sessions worked better, particularly to reduce the extensive workload of the project co-ordinator, with 174 people participating in 13 Conversations. There were however issues with a number of organisations who were keen to have sessions but who did not progress this through recruitment, thus there was still a requirement for the project co-ordinator to visit groups, drop in sessions and events in order to invite people to participate. This added to the co-ordinator’s workload as well as putting considerable pressure on her personally.

5.3.8 Participants’ support needs

It was assumed that engaging in Community Conversation workshops would elicit only general discussion about mental health. However, Community Conversations also revealed an extensive range of support needs, both for participants and for the co-ordinator, which the programme struggled to adequately meet. Frequently participants had little in the way of practical support and few outlets for discussing issues relating to their experiences. As the co-ordinator was often the first person to have ‘reached out’ to participants in this way, she was asked for help with a wide range of issues including with housing, transport and health care. The supportive and open atmosphere at each workshop naturally led to people sharing the experiences that caused them to flee their countries of origin and their experiences of racism, isolation and stress in the UK as a result of their displacement and the asylum system. This was distressing for the co-ordinator and, as Phase 1 progressed, the Sanctuary
steering group identified counselling support via one of its partner agencies. This alleviated some of the distress, allowing her to ‘off load’ but didn’t completely ameliorate the impact of this work on the co-ordinator as there was no system or organisation mobilised to allow her to ‘hand over’ the issues for meaningful follow up. At all of the Community Conversations, issues emerged that could not be adequately addressed within the sessions, resulting in a high level of ‘follow up’ work for the project co-ordinator. In response to this, the steering group collated a list of useful resources to which were printed and given out at each session, although barriers did exist to accessing some of these services. As such, the co-ordinator was sometimes left with feelings of responsibility for individuals’ needs due to the difficulty in handing over these issues to anyone else for follow up.
Section 6: Learning

This section assesses what learning can be drawn from piloting this type of work with asylum seekers and refugees.

6.1 What were the challenges around process?

The significant uptake of the Sanctuary Community Conversation programme by such large numbers of asylum seekers and refugees supports the view that community development approaches effectively make use of community knowledge and improve mental health awareness within a cultural context. However, there were a number of major challenges, which made this a much more challenging project than a similar project with settled BME communities (Knifton et al 2010). Peer educators struggled to carry out many of the functions of their role, highlighting the lack of infrastructure within asylum seeker and refugee community organisations and the need to invest in developing the skills and confidence of asylum seekers and refugees before developing another peer led initiative such as this. Whilst this capacity building element is crucial to all peer led initiatives, it seemed particularly the case in this context.

The other main challenge arising from the delivery process was how to address the significant mental health needs of participants arising from the process and the impact this had on the project co-ordinator. What this reinforces is the extent of mental health needs experienced by asylum seekers and refugees, in terms of the relationship between experiences of social isolation and marginalisation in exile and the severity both of post traumatic stress disorder (PTSD) and depression (Gorst-Unsworth and Goldenberg, 1998), as well as the negative impact of the asylum process on the mental health of asylum seekers and refugees (Palmer and Ward 2006). It also supports findings around the numerous barriers asylum seekers face in accessing services (Mulvey 2009). The experience of undertaking this project highlights the need for having an additional support available at workshop session to effectively deal with the range of emotional and practical issues presented by asylum seekers. It also suggests that future programmes would be best delivered jointly by mental health improvement specialists/peer educators in partnership with colleagues from mental health and other support services.
Given the stressful nature of what participants reported to the project co-ordinator, ensuring adequate emotional support for community development staff and peer educators, including debriefing and access to counselling support, appeared crucial to ensure the effective and safe delivery of this programme.

6.2 What do the evaluation results tell us?

6.2.1 Baseline measurements
At baseline measurement there were significant levels of stigma apparent amongst participants. Areas that attracted the most stigmatizing responses included: equal rights; unpredictability; and social distance (marrying into the family). This is broadly in line with findings from the other studies, which highlighted how mental health problems may attract shame within families and communities (Wynaden et al 2005) as well as the baseline results from the previous community conversation study (Knifton et al 2010). However, other findings in this study indicate low levels of stigma in relation to blame and a view that mental health problems are common and can develop in anyone. This suggests that some of the traditional beliefs about causation identified in the Sanctuary community research such as blame for sins and mental health problems as a punishment were not strongly held amongst these participants (NHS Greater Glasgow and Clyde NHS 2007). A potentially important finding was high levels of recovery optimism amongst participants, again similar to the Mosaics study, but contradicting some of the findings from the Scottish Public Attitudes survey (Davidson et al 2009). The finding supports the use of positive recovery based messages to challenge negative views about marriage prospects, social contact, contribution, and shame. The baseline scores within the study are valuable in understanding change within the groups receiving this intervention.

However, we must be cautious when making comparisons against population level attitudinal studies as there is evidence that some members of the community may assume that questionnaires refer to more severe mental health problems, which attract higher levels of stigma (Crisp et al 2000). In addition, questionnaires were administered in a safe setting which may have generated more honest responses, and questionnaires were translated and subtle differences in language and phrasing may skew results. The sample was therefore likely to be less self-selecting than the Scottish Public Attitudes sample.

6.2.2 Impact of workshops
There was particular success in these workshops in reducing stigma in relation to safety around people with mental health problems. This contradicts findings from the Mosaics study, which found that there was no significant improvement in perceptions of dangerousness or unpredictability and that future work needed to address this issue more, which appears to have happened here with the Sanctuary work. In our findings, there was also a desire for greater social interaction, which appears to address the issue of people with mental health problems experiencing rejection and avoidance as highlighted in the community research. In addition, the increased recovery optimism suggests that a community conversation model has the potential to promote key recovery messages and a culture of greater openness and acceptance towards mental health issues.

Attitudes worsened in relation to people with mental health problems having equal rights. The issue of rights is a particularly challenging area for asylum seekers and refugees and perhaps there is a fear that admitting to having a mental health problem will affect the asylum process, as suggested in the Sanctuary community research. The workshops had a similar impact upon participant attitudes according to age, gender and ethnicity. However, there was enough variation between and within communities to indicate that intervention models need to be developed by and not for communities, and tailored for variance within communities.

6.2.3 How do the pre and post results compare to the qualitative findings?

The qualitative focus groups provided a great deal of rich material with which to contextualise the pre and post findings. The findings of the focus groups supported the findings within the questionnaires on reduction in stigma, particularly in relation to unpredictability and marriage. The main theme to emerge in the qualitative feedback was increased knowledge and attitudinal change around recovery, again suggesting this model is particularly effective in promoting recovery. Another major issue highlighted in the focus groups was the differentiation between different types of mental health problems. It appears the workshops were particularly effective in introducing the concept of a spectrum of mental health problems. They also appear to have helped participants recognise that when talking about mental health problems we are not just talking about people with severe problems, such as psychosis, which was a major finding of the community research. The other key issue to come out of the focus groups was in relation to help and support. Participants appeared to feel more confident about supporting peers with mental health problems and if they came across a person with any kind of mental health problem in the future they would be a lot more accepting and understanding of their condition. The importance of the link between mental health support and providing help with the asylum process, money and
practical issues was stressed (as well as providing this support at such workshops themselves). This links with wider studies on the need to address the social stressors experienced by asylum seekers.

6.2.4 What are the major strengths and limitations of the evaluation approach?

The use of modified and translated questionnaires in this work has made a valuable contribution to our understanding of patterns of stigma within the BME communities, but findings must be interpreted cautiously. Scales and measures are useful in getting a sense of the elements of stigma that are affected positively and negatively by the intervention, and this specificity can often be missed in qualitative research. However, there are a number of limitations. There is the risk of the subtle meanings of questions being altered in translation, a risk that questions assume a shared view of mental health problems that is western, and that intra-group diversity such as generational differences may not be fully identified. Further issues limit the degree to which we can generalise findings, including the lack of specificity in defining mental health problems, the short-term nature of the study, and the fact it assessed behavioural intent rather than actual behaviour change. Whilst the sample used was not representative in terms of gender and age, people were recruited through community organisations and were therefore not self-selecting. We can therefore be reasonably confident that we engaged a spectrum of views.

The use of qualitative focus group research with participants, highlighted as a recommendation from the Mosaics of Meaning community conversation work, is a major strength of this evaluation. It has allowed a richness of understanding by allowing the contextualisation of meaning behind numerical data and reflection on the complexity of perceptions that exist. Issues of literacy suggest that focus groups have been more valuable than written questionnaires.

The use of focus groups with peer educators and the project co-ordinator provided useful information about the process, although failed to capture the full range of challenges within the programme. Adding the perspectives of partners helped to provide additional information surrounding the context of the programme and provided a fuller picture of the range of issues to consider when developing such a programme further in the future.
Section 7: Conclusions and recommendations

The evaluation findings suggest that the Sanctuary Community Conversation workshops effectively engaged participants, reduced reported stigma, promoted recovery and encouraged help-seeking. As such, the evaluation highlights the value of community development approaches which engage communities in a meaningful dialogue about mental health rather than only using information based campaigns with pre-determined messages. Given the variety of beliefs held about mental health by asylum seekers and refugees, this approach would seem to be of particular value in future use with these communities.

However, major challenges did exist around the delivery process, which need to be taken into account in the development of future work in this area. There needs to be more capacity building work with asylum seekers and refugees to enable peer educators to have the confidence and skills to deliver the programme. In particular, given the scale of need presented by participants, future programmes need to build in a great deal more support to meet the mental health and practical support needs of participants. Specifically, the recommendations for future programmes should involve the following:

- Counselling support for project co-ordinators and peer educators when engaging in such a programme
- Clearly identified support processes for the programme to deal with emerging issues facing participants
- Awareness raising programmes should be developed alongside and supported by services (mental health and wider) able to meet needs arising from sessions
- The provision of a support worker at sessions to deal with emotional distress and link people directly into services
- The need for partner organisations in the project to actively engage in the recruitment of both peer educators and workshop participants and the need to host these sessions in collaboration with existing community groups.

The challenges presented in delivering the programme do not suggest that the community conversation model is not workable but rather it needs to be adapted and aligned more closely with mental health and other support services. The scale of need amongst the asylum seeker and refugee community highlighted in the workshops suggests that there is an important role for a programme to improve mental health awareness and that the
community conversation model offers excellent potential to have a positive impact on the mental health and well-being of asylum seeker and refugee communities in Scotland.
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