MOSAICS OF MEANING

Partnerships with black and minority ethnic communities to promote mental health:
a handbook

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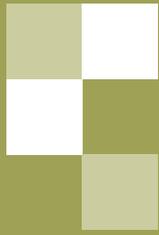
FOREWORD

Innovative. Inclusive. Engaging. Applicable. Focused on equality. Over the five years of its existence, the Mosaics of Meaning partnership has produced much-needed information about the mental health issues, particularly the stigma, faced by black and minority ethnic communities in Scotland. It has also evolved a new way of combining mental health research and health improvement work with creative community development techniques to produce measurable positive change.

Although Mosaics of Meaning has a very specific focus, its way of working has wide application. Here is a tried and tested way of engaging with hardly-reached communities that can be applied, with appropriate adjustments, with other communities and other aspects of health improvement.

This publication is intended as a resource for policymakers, service providers, health improvement and community development workers at every level, with the aim of encouraging and enabling similar community-based action throughout Scotland and beyond. All of the many partners engaged with Mosaics of Meaning are convinced of its potential for making a significant contribution to health improvement in a wide variety of settings. On their behalf I recommend this resource to you wholeheartedly; together we hope you will find it both useful and inspirational.

Dale Meller, Equalities & Planning Directorate, NHS Health Scotland

THE MOSAICS MODEL

STAGE 1: COMMUNITY RESEARCH
Enable BME community development workers to run focus groups exploring mental health and stigma in BME communities. Collate and evaluate the results together.

STAGE 2: COMMUNITY ACTION
Partner BME community development workers in delivering a five-element programme aimed at sharing information and developing understanding of mental health and stigma more widely in BME communities. The five elements are:

COMMUNITY CONVERSATION
Short mental health awareness workshops on stigma and what can be done about it.

STORYTELLING
BME users of mental health services share their experiences in personal stories.

ARTS AND FILM
Produce relevant cultural events exploring mental health issues.

FAITH LEADERS
Consult with religious leaders and convene a national conference for community, health and faith organisations.

SOCIAL MARKETING
Adapt the national stigma awareness campaign with messages for BME communities.

Evaluate all actions together. Disseminate findings locally, regionally and nationally.

BEGINNINGS

Mosaics of Meaning was launched in 2005 to research and address the stigma associated with mental health problems in partnership with Scotland's largest black and ethnic minority communities. Its unique programme of research and community action has involved training community workers in research skills and mental health issues, and using community development principles to address stigma and raise awareness at ground level. In the process, a powerful, evidence-based model of community engagement has been developed, a model which can be confidently applied in many other community settings.

In Scotland one in four people will experience a mental health problem at some point in their lives. In many cases the associated stigma, shame, exclusion and discrimination are a central part of the experience. Stigma can be as hard to deal with as illness itself; it is a barrier to seeking help, particularly when reinforced by cultural values and community-level institutions, and of course not seeking help through fear of rejection and discrimination makes recovery even harder.

A national campaign to challenge stigma, 'see me', has run in Scotland since 2002. By 2005 it was increasingly recognised that additional effort would be needed to address mental health stigma with black and minority ethnic (BME) communities. Mental health problems can be understood differently in different ethnic, cultural and religious groups, where attitudes may vary considerably. Language barriers, isolation and discrimination add to the difficulties of those experiencing mental health problems, and may make people more vulnerable in the first place.

Mosaics of Meaning was therefore launched as a joint project, led through the Glasgow Anti Stigma Partnership and chaired by NHS Greater Glasgow and Clyde, to research and then address stigma relating to mental health problems with the four largest settled BME groups in Glasgow: Pakistani, Chinese, Indian and African and Caribbean. The project has involved, and been supported by, a large grouping of national and local statutory and voluntary organisations, and is intended as a pilot for the whole of Scotland.
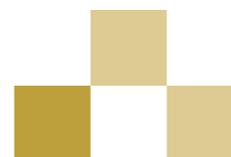
"Mosaics of Meaning has successfully raised awareness of mental health, stigma and recovery in the communities that we worked with. New networks and partnerships were formed, and knowledge and understanding have vastly increased. We learned that engaging with the needs and issues affecting different communities takes time, and that real engagement comes from a long-term perspective and shared ownership. We are committed to embed this work into future mental health services and health improvement programmes, and to disseminate the learning nationally and internationally."

Nuzhat Mirza, Equalities and Diversity Officer, NHS Greater Glasgow and Clyde

Innovation and partnership

Mosaics of Meaning is a collaborative project. It involves an alliance of statutory and voluntary organisations including NHS Greater Glasgow and Clyde, 'see me', NHS Health Scotland, the Mental Health Foundation and Glasgow Association for Mental Health, together with a large number of community-based partner organisations. Strong long-term partnerships are a key feature of the approach, and this remained a key organising principle as the project developed and grew. Some 40 organisations supported and engaged with Mosaics of Meaning between 2005 and 2010.

Other key principles informing the work were the partners' passionate beliefs that:

- project partners should help communities to address stigma, not dictate the answers
- research should be action-based, leading directly to targeted interventions
- building capacity in local organisations should be the key objective
- the key to building capacity is building relationships.

Research, then action

Stage 1 of the project was about research. We undertook action research in community settings in Glasgow, developing capacity in several BME community agencies by training local leaders and workers to enable them to use focus groups to investigate mental health and stigma in their communities. We also commissioned a literature review of published evidence on attitudes towards mental health in Pakistani, Indian, Chinese and African and Caribbean communities and cultures, both in the UK and elsewhere in the world. Both of these studies included an exploration of approaches that have been used to support BME communities to address stigma, and of what communities would like to see happen.

Stage 2 was a grassroots campaign of community action and social marketing to provide information and influence attitudes through direct contact with service users, community groups, opinion formers and mental health professionals. A range of innovative projects were developed and delivered through partnerships with local community leaders and workers, all of which have been robustly and positively evaluated, including in international journals. They include:

- community conversation workshops
- storytelling
- arts and film events
- engaging with faith leaders
- social marketing.

TALKING POINTS

- **Building capacity at local level involves forging relationships and winning trust, which takes time.**
- **The Mosaics of Meaning model is not expensive in cash terms; small amounts of funding are often sufficient to support collaborative programmes.**

PARTNERS IN RESEARCH

We supported BME community leaders and development workers in Glasgow to conduct focus groups investigating people's understanding and experience of mental health problems and stigma within their local communities. At the same time we commissioned and supported the Centre for Ethnicity and Health at the University of Central Lancashire to conduct a literature review on mental health concepts and stigma within our target communities and their countries of origin.

Greater Glasgow has the largest BME community in Scotland: 4.5% of the population in the 2001 Census, compared to 2% for Scotland overall. Almost half of the settled BME communities are from Pakistan; the other major communities are Indian, Chinese, other South Asian, and African and Caribbean.

An investigation by NHS Greater Glasgow and Clyde in 2005 into perceptions of health and social circumstances in these communities sets a context for exploring stigma. BME respondents' perceptions of their overall health were more positive than those of the general population. Pakistani, Indian and African and Caribbean communities had better perceptions of their health and of NHS services than Chinese community members. All communities had experience of racism, with higher reporting for African and Caribbean communities and for younger people generally. All groups reported more feelings of isolation from friends and family than the white community.

Literature review
Our literature review set out to investigate the knowledge, attitudes and beliefs held by our target communities towards mental health and mental illness; the language used to describe these; and the factors influencing negative attitudes towards mental health problems. The studies reviewed included those conducted in countries of origin and in other English-speaking countries such as the USA and Australia. A total of 87 papers were reviewed in detail.

"Partnership working with Mosaics' national and local partners has brought opportunities for personal professional development and enabled partners to work more creatively with BME communities. Organisationally it has enabled us to strengthen existing partnerships and form new ones, creating new projects in equality work such as the Mental Health and Ethnicity Special Interest Network and the Sanctuary project. Mosaics has provided a focused way of working with BME communities and a model to aspire to."

Tina Yu, Policy and Service Improvement Manager, Mental Health Foundation

Community research in Glasgow

Patterns of mental health stigma within BME communities are not well documented. To address this we created a staged process of research and implementation, aimed at helping communities to develop evidence-based approaches to tackling stigma. The research was overseen by a steering group drawn from national and local organisations, and used constructivist community development principles to work towards shared understandings about the issues and potential solutions. This required a real team ethos and a diverse community of practice.

Six community projects working with BME communities across Glasgow were identified; they agreed to participate in research skills training and then to recruit, host and facilitate a 90-minute focus group exploring stigma and mental health. We provided a focus group skills training workshop for the workers before starting the research, and allocated a small budget to each host organisation to cover participant and organisation expenses. We negotiated the final design of the research tool, the questions for the focus groups and written guidance for facilitators.

Ten focus groups were held during 2006. An independent researcher recorded each discussion (with interpreter support when the discussion was not in English) and worked with the facilitator to check on the emerging views and themes. A brief report was written for each of the ten groups. The data was synthesised for each of the BME groups and subsequently analysed by theme at validation sessions.

We explored the initial research findings and recommendations with all of the participating community projects at validation sessions, in which we jointly assessed the accuracy of recording and the validity of recommendations. We then held a national conference on the work in order to develop the proposed model of intervention more fully. We shared the findings with focus group participants and disseminated them widely through events, publications, partner websites and organisational meetings.

This was the first time that many of the national partners and community organisations had worked together to undertake action research into mental health. It was therefore important to reflect on the process of setting up and running the focus groups in order to be able to inform similar processes in the future. We produced a short summary of findings and recommendations for future engagements on this issue.

The findings were rich and complex. Responses and attitudes varied significantly between and within communities, most markedly between generations and socio-economic groups. However, there was a substantial consensus on the following:
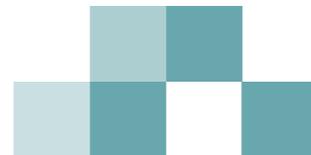
Social circumstances create mental distress

Mental health problems were seen as a consequence of stress, deprivation, isolation, cultural and value conflicts, and changes in family relationships. Migration and migrant status in a new environment were important causes of mental health problems; stresses for newer migrants include accommodation, unemployment, language barriers, racism and family responsibilities. Chinese groups talked of the 'pressures of life', whilst South Asian groups cited living conditions and concerns about violence. Racism in communities and services was commonly reported as a source of mental distress.

Causation and explanatory frameworks

Beliefs about the causes of mental health problems varied widely, but can be classified as cultural, religious, social or medical. The intensity of beliefs varied, and some people held multiple or contradictory beliefs. Summarising the discussions on these points, we can say:
- mental health is a 'contested concept'. People resisted the idea that common mental health problems are a medical issue, and tended to see them as responses to social situations or crises of faith
- the term 'mental health problems' usually referred to severe and enduring conditions. Many people did not differentiate amongst conditions, often defining the problem simply as 'madness'
- mental health problems can be seen as a punishment from God for wrongdoing, or as caused by black magic, spirits or jinn. Chinese and Hindu participants cited karma, linked to blame, as a cause.

Impact of stigma

All communities described the impact of stigma as profound. It is commonly held that mental health problems:
- make people dangerous and unpredictable
- may be a punishment from God for sins in a previous or current life
- may be contagious and inheritable through families
- negatively affect educational and employment opportunities
- damage one's prospects as a marriage partner
- may be incurable, leading to pessimism about help-seeking.

Language stigmatises people. For example, terms reported in Muslim, African and Caribbean communities were often derogatory, including 'schizo' and 'nutter'. The most common word reported by Muslim groups was 'paghu', which translates as mad or crazy.

Dual stigma is experienced by people in BME communities who face racial discrimination and social disadvantage in addition to mental health stigma. Strategies for mental health improvement therefore need to address both aspects of stigma concurrently.

Across all groups and communities, **shame** emerged as the main impact of stigma. Shame was expressed in different ways, such as 'face' in Chinese communities.

Participants from all communities described a **collective stigma**, tainting not just the person directly affected but also their family. This was frequently connected to aspects of culture and community such as strong family bonds and extended family structures, and with some of the underlying explanatory causes such as inheritability and blame.

Marriage prospects for people with mental health problems were a major concern for the Muslim, Sikh, Hindu and African and Caribbean groups. Many people suggested that this provides a strong incentive for families to keep mental health problems secret. The value placed on family reputation and marriage may lead family members to refuse support and keep the individual in isolation.

Help-seeking and treatment
BME community members frequently delay seeking medical help with mental health problems, either because they anticipate stigma and are pessimistic about recovery or because they do not see the problem as a medical issue. A common first response is to seek help from traditional healers and faith leaders, based on beliefs about the causes of the problem: for example, bad spirits for Muslims families, or divine wrath, a curse, black magic or karma of a previous life in Hindu families. Holistic approaches to mental health treatment, where body and mind are regarded as one, are common in Chinese communities.

Other barriers to seeking help were more practical: language issues for those not so confident in speaking English, and concerns about confidentiality when consulting doctors. Several groups anticipated a lack of cultural sensitivity within services and reported mistrust of psychiatrists and social workers.

Existing anti-stigma approaches
Our research indicated that the existing national anti-stigma campaign had not reached Glasgow's BME communities effectively. The concerns expressed were both practical and conceptual, and included:
• people from BME backgrounds are not seen in campaign materials or as media volunteers
• complex and subtle language is only useful if English is a first language
• no use of press, radio and television outlets popular with BME communities
• the term 'see me' is individualistic.

These findings were consistent across BME groups, although younger participants were generally more positive than older generations. Participants outlined a range of ideas and solutions, including the use of appropriate imagery, role models and media.

A new approach: where social marketing and community development meet
Out of this research has emerged a new model for engagement, grounded in community development principles and stressing dialogue, contact and community leadership. Specific ideas suggested include tackling shame and stigma through community conversation; engaging with faith leaders, community leaders and employers as a way of influencing the wider community; recognising that arts and culture are central to changing opinions and reaching large numbers of people; and promoting cultural awareness and acceptance in mental health services and mental health user groups. These ideas and principles form the basis of the interventions outlined in the following chapters.

Conclusions
Mental health initiatives targeting BME communities need to reflect the beliefs about mental health held within those communities. The plurality of beliefs held in BME communities demands a wide-ranging set of responses, all of which need to be constructed in partnership with communities and led by them.

TALKING POINTS

• **Stigma around mental illness is present in all cultures and communities in Scotland.**
• **Our research did not try to compare stigma in BME communities with stigma in white communities.**
• **Initiatives to tackle mental health stigma in target BME communities in Scotland need to be developed in partnership with communities and community organisations.**
• **Developing shared understandings about issues affecting BME communities requires a team ethos and a diverse community of practice.**

PARTNERS IN ACTION

The Mosaics of Meaning model is to work with people at community level to understand mental health and stigma; decide with them how to address stigma in their community; train and support local people and organisations in tackling the objectives they prioritise; and then evaluate the outcomes together to a high academic standard. Joint agreements were concluded with community partners in order to underline the shared ownership of projects and their outcomes. In addition to building capacity, the Mosaics of Meaning model has delivered a number of positively evaluated projects for a minimal capital outlay.

"The Mosaics model is on one level very simple. It's about supporting communities to explore issues and solutions. It's about a partnership of organisations at national, regional and local level whose contributions are equally valued and respected. And it's about outcome-focused work sustained over a long period of time. But it is also complex; it means acknowledging differing constructs of mental health and diversity within and between communities; challenging assumptions about what works; facing up to prejudice; and balancing a number of parallel programmes on the ground. Ultimately it provides a sustainable, low-cost intervention that provides insights for population-level initiatives."

Isabella Goldie, Head of Mental Health Foundation in Scotland

The findings and conclusions from our literature review and action research were explored at development sessions involving all partners. Whilst adaptations to the national 'see me' campaign were recommended, it was also recognised that a more sophisticated model for engagement is needed, based on community development principles and acknowledging both the differing explanatory frameworks that can be held in BME communities and the complex impact of racism.

Recommendations included linking key opinion-formers such as community and faith leaders with mental health services; involving community members in dialogue and workshops; addressing the lack of diversity in the mental health movement; promoting the role of the arts in addressing mental health stigma; and supporting more community-led social marketing initiatives.

Informed by existing evidence on effective community development, an initial model of intervention emerged. This model requires a range of partners to take responsibility for interventions, using different skills and tactics at individual, community and organisational levels.

Five key elements were subsequently identified and delivered:
- a Community Conversation element consisting of short mental health awareness workshops exploring ideas about mental health and stigma
- a Storytelling element which enables BME users of mental health services to share personal experiences of stigma
- an Arts and Film element which uses cultural engagement to explore mental health issues
- a Faith Leaders element involving consultations with religious leaders in Glasgow BME communities and a national conference.
- a Social Marketing programme.

TALKING POINTS
- **Community and faith leaders may themselves need information and support if they are to provide community members with a much-needed bridge to mental health services.**
- **Arts events relating to mental health stigma need not be 'stand alone' but can be linked to established cultural engagement projects at community level.**
- **A storytelling process and a mental health stigma workshop template are available to enable rapid start-up of new campaigns.**
- **All of the Mosaic of Meanings elements were delivered at low cost.**

"Working with other organisations has shown how pooling resources – cash and in-kind – can achieve objectives which would not be possible to achieve individually. Sharing of skills and resources has been the greatest strength of the Mosaics work; without this support it would not have been possible to reach so many BME groups and individuals."

Pratima Pershad, Equalities Manager, Glasgow Association for Mental Health

COMMUNITY CONVERSATION

Building on the community research programme, the Mosaics of Meaning partners continued to address mental health stigma and discrimination through an intervention based on community development principles, entitled Community Conversation. Significant changes in attitudes were noted as a result of taking part.

This project, run in two phases from 2007 to 2009, enabled BME community members to explore mental health and stigma in safe, supportive workshops run by community development workers in their own communities.

Feedback from the initial community research process was that the process of discussing mental health issues in focus groups was in itself valuable for participants – the research almost was intervention. Facilitated group discussions led by local people and conducted in people's own languages were seen by all as a positive means of exploring mental health stigma and addressing the problems associated with it. There was also clear desire at community level to continue using workshops to raise awareness with new groups of people. Some of the people who had acted as facilitators discovered that they were good at it, and they in particular wanted to do more. A key feature is that workshops allow dialogue rather than deliver didactic messages, and accommodate complexity rather than ignoring it.

Community led

As before, community organisations led the design and evaluation of the Community Conversation workshops to ensure that the process was culturally sensitive in relation to language, process and content. This amounted to a continuous process of learning and development for all, as the Mosaics of Meaning team and community organisation leaders worked together over a period of months to design and deliver the programme. Topics addressed in the workshops included frequency and range of mental health problems; understanding stigma, including fear, isolation and blame; and what can be done to reduce stigma. In all, 40 workshops were held with 400 Chinese, Indian and Pakistani community members taking part.

Evaluation and change

Pre- and post-workshop questionnaires were used to measure changes in knowledge, attitudes and behavioural intent in participants, who also gave qualitative feedback. Baseline results reinforced the findings of the 2006 research, which indicated that significant stigma attaches to mental health problems in BME communities, just as it does in the wider population. Our participants were concerned about the dangerousness of mental illness, social distance, marriage, secrecy and shame, but felt optimistic about prospects for recovery.

Post-workshop responses showed significant change in attitudes. More people suggested that mental health problems are common, and indicated a willingness to tell someone about a mental health problem that they or someone else is experiencing. Secrecy, shame and a desire for social distance (exclusion) tended to be reduced; there was greater willingness to talk to someone about problems, and to allow someone with mental health issues to marry into the family.

The tendency to blame the person for their own condition was reduced, and there was greater optimism for recovery. Deep-seated fears about danger were more resistant to change, but have been effectively challenged by adapting workshop content and delivery.

The Community Conversations experience strongly suggests that community approaches to tackling stigma are more valuable than top-down public education, and could form the basis of national initiatives.

TALKING POINTS

- A community conversation approach that effectively engages BME populations has a strong positive impact in reducing mental health stigma among participants.
- Community-led approaches that acknowledge cultural constructs of mental health were received positively by community groups.
- Variation within and between BME communities indicates that intervention models need to be develop by, and not for, communities.
- The Community Conversation model is effective, and could be adapted and used in national initiatives.

"With its creative approach to engaging with black and minority ethnic communities, Mosaics of Meaning has shown that adapting interventions to match the needs of those communities not only enables people to move forward on sensitive topics, it encourages local BME projects to work alongside mainstream organisations for greater effect. I will definitely be embedding the learning from this work in my future work with diverse communities."

Arma Sayed, Equalities & Planning Directorate, NHS Health Scotland

STORYTELLING

Launched in May 2007, the Storytelling element enabled people from BME communities to directly express their experience of living with mental health problems and stigma. Sharing their stories proved helpful and therapeutic for those taking part; by capturing their stories in book form we also created a valuable resource for community development workers, healthcare professionals, researchers and BME community members. The process we developed is a template for effective engagement with other excluded communities.

Language and cultural barriers, combined with a lack of understanding about available support and resources, are some of the reasons why BME communities take so few opportunities to engage with mental health service user groups and why their voices are often not heard. For many people in BME communities, the issues surrounding mental health problems and their care and treatment are difficult to talk about, and this makes a difficult experience worse for all those affected.

The stimulus for the storytelling project was the belief that the more open people can be about mental health problems within their own families and communities, the more confident they will become about seeking help and support. Storytelling seemed a natural way to break the silence; as a means of cultural transmission and

constructing shared meanings, storytelling is as old as human society itself, and is increasingly used as a therapeutic tool in mainstream mental health promotion and treatment. As a means of engaging with BME communities, however, storytelling took us into unfamiliar territory – and so we evolved the process for this project organically, developing and improving it as we went along.

Recovery

Some work by the Scottish Recovery Network on personal narratives of recovery from mental health problems inspired us to link with a mental health service provider in Glasgow in order to bring together a group of 10 South Asian women to share their stories of living with mental health problems. The group met for four half-day sessions over four weeks, and individual sessions with men and women from a wider spectrum of BME backgrounds followed. We engaged two storytellers from the Scottish Storytelling Centre to facilitate all these sessions and help people talk openly. Song, art and craftwork were also used as part of the creative group process.

This technique released a flood of personal stories. Stigma, shame, ignorance, exclusion and discrimination were revealed to be an almost universal experience of people with mental health problems in BME communities. A general failure of support from family members and services is a repeated theme, as is open hostility to mental health problems. But the picture is not entirely bleak: people do cope and recover, finding strength from faith, spirituality, family and friends as well as from within themselves.

All of our participants' stories were recorded, transcribed and published in a book, *Are You Really Listening?* (NHS Health Scotland, 2008). Several themes are contained within it: transition and change; isolation; family; surviving abusive relationships; community services; work and employment; support, resilience and coping; and getting help.

Evaluation

Had the storytelling been helpful to this group of participants? Their comments included:

'It was like oxygen for us, a healing process. We felt refreshed.'

'It made us feel that we now want to tell our story, as there is a purpose – to help others.'

The women taking part reported that they had been well prepared for the project, felt supported by staff and able to participate fully, and that the sessions had broadened their awareness of mental health problems, empowering them to talk about mental health more openly.

Outcomes and resources

Are You Really Listening? aims to provide anyone with a professional or general interest in mental health and/or working with BME communities with a better understanding of how stigma and discrimination affect the mental health of people from those communities. It offers powerful and often moving 'real life' insights into the family and social dynamics of mental health problems as experienced by BME community members, and has clear potential for encouraging other community members to talk about these issues more openly. It is available in a number of community languages. For health and social care workers, and for researchers, the book provides a clear picture of the additional barriers to recovery experienced by people from BME communities. It offers lessons as basic – and as important – as 'don't assume BME patients get support from their families when they go home'.

To provide a further resource for others to use when engaging with excluded groups we have documented the process developed during this work. In it we list the lessons learned, describe the storyteller's approach in detail and discuss the many practical considerations that influenced the project, from the provision of interpreters to ensuring that participants felt 'looked after'.

An independent evaluation of *Are You Really Listening?* will be published later in 2010.

TALKING POINTS

- **Involvement from BME communities in mainstream mental health service user groups is so low as to be negligible.**
- **Lack of understanding of what 'getting involved' entails is one reason why.**
- **Structural discrimination, whereby organisations fail to encourage BME individuals and communities to participate, is another.**
- **Organisations need to address the barriers to participation by BME communities.**
- **Storytelling methods empower BME people to open up about mental health problems and tackle stigma.**

ENGAGEMENT THROUGH ARTS AND FILM

TALKING POINTS:

- Arts events reach large numbers of people from BME communities from a range of backgrounds.
- The arts engage people emotionally as well as intellectually, and change perceptions.
- Co-programming with community organisations creates connections that would otherwise not happen, and allows us to reach people that general events might not.
- Narratives and voices of experience are particularly powerful.

"Creativity and the arts have been key for me, for VOX members and for all those who have been involved with our mental health and wellbeing work. Engagement with the arts can touch people from all cultures and bridge every social divide. It promotes recovery and hope, challenges stigma and, importantly, explores diverse meanings of mental health and ill health. Arts experiences have been at the core of our work with the Mosaics project, and will always be our guide to promoting positive change."

Mahmud Al-Gailani, Diversity Facilitator, Voices Of Experience

A further novel and distinctive initiative was to use arts and film as a way of engaging with BME communities. The Mosaics team supported the production and screening of two films on mental health by young people from Chinese and South Asian communities, and since 2007 has co-produced with BME communities a range of popular arts events as part of the annual Scottish Mental Health Arts and Film Festival (www.mhfestival.com). High turnout and positive evaluations demonstrate a significant impact with BME audiences.

Launched in October 2007, the Scottish Mental Health Arts and Film Festival is now the largest event of its kind in the world and a major event in Scotland's cultural calendar. Using a co-programming model, which brings together community, public and arts partners, it sets out to explore and tackle public awareness of and attitudes towards mental health using film screenings, art exhibitions and fashion, dance and music events, all available to the public free of charge or at low cost. By 2009 the festival had delivered over 300 events, attracted over 25,000 attendances and reached many more people through extensive media coverage.

The programme kicked off in 2007 with the production of short films, one involving young people engaged with the Chinese Community Development Partnership and another with local actor Atta Yaqub on mental health with young South Asian men. Screenings were followed by workshops and discussions. On the basis of strongly positive feedback from this first year of participation, the Mosaics steering group contributed to the 2008, 2009 and 2010 festivals. Among the large number of events that we have co-programmed with BME community groups are a Chinese Arts and Wellbeing day, screenings of Indian and Pakistani films portraying mental health issues, and an arts and social event for the African and Caribbean community. Venues have ranged from major attractions such as the Kelvingrove Museum to more intimate community halls.

Effective engagement

Evaluations of the festival's reach and impact have been accepted for publication in international journals and have informed further work with BME communities and arts organisations. They show that general festival events reach BME communities effectively when they are co-programmed with community groups. Events in different languages, and which draw upon traditional art forms and cross-cultural art, are particularly attractive: many of our events have been oversubscribed. Our evaluations show that arts events engage people emotionally as well as intellectually, influencing beliefs and attitudes and a creating a greater willingness to seek help and engage with people with mental health problems.

The festival is acknowledged as having opened up a wider discussion of public mental health. One effect is that community organisations not previously involved with issues of mental health and stigma are now more aware of and engaged with those issues. The 'hands on' approach adopted with local community agencies and community members is shown to be an effective way to bring mental health stigma into sharper focus with community members of all ages, and with the agencies themselves.

SUPPORTING FAITH LEADERS

"Work with faith leaders is crucial in helping to move the mental health agenda forward with black and minority ethnic communities. The priorities are appropriate training on mental health issues for faith leaders and on cultural/religious issues for mental health staff, and for faith leaders and mental health services to work together through a sustained health promotion campaign."

Ayisha Azam, South East Glasgow CHCP

TALKING POINTS
- Mental health staff need training and opportunities for engagement if they are to respond sensitively to the ways in which religion can shape people's individual responses to mental health problems.
- This work can bring together very different world views. Progress will take time, so long-term, respectful partnerships are vital.

Working with South East Glasgow Community Health and Care Partnership (CHCP) we organised meetings and a half-day conference for faith leaders to share ideas on stigma and support for people with mental health problems.

Our research indicated that a diversity of organisations and individuals are important in determining community attitudes and behaviour in relation to mental health and mental illness. Faith leaders in particular were identified as playing a key role in signposting individuals and families to sources of help, challenging stigma through their practice, and supporting awareness raising in the community generally. They are often the first person approached for help, rather than a GP.

It was therefore decided that a dialogue with faith leaders would be an essential route for engagement with the issue of stigma and for sharing views on how individuals and families experiencing mental health stigma can be supported. A development worker was employed by South East Glasgow CHCP to take this work forward and to plan a conference in 2008.

Preparatory work for this conference included meetings to discuss our research findings with faith leaders and take feedback from them on the direction of future work.

For the conference itself we accessed the large database of a Glasgow-based PR company to identify more community faith leaders, and sent out a carefully worded invitation stressing the objectives of sharing ideas and supporting communities. This resulted in a turn-out of 65 people on the day, drawn from the Hindu, Muslim, Buddhist, Christian and Jewish communities as well as from statutory and voluntary organisations. Speaker presentations and workshops were designed to challenge participants and stimulate thinking, as well as to get participants to voice their own suggestions and recommendations for faith leaders and health professionals.

Case studies
The workshops, in which two personal case studies of mental health problems drawn from Hindu and Muslim communities were discussed, were particularly well received. Having been given the essential facts of a case, participants were asked: What are the key issues going on with this person? What could you do to support them? What can faith leaders do more generally to help this individual, and what support do faith leaders need to do this?

The principal outcome of the conference was the recognition that faith leaders want training in understanding and identifying mental health issues when they arise, and that resources are needed to support faith leaders in this activity. Specific recommendations included providing faith leaders with a directory of mental health services; mental health awareness surgeries to take place in places of worship; and the allocation of designated link workers to bridge the gap between NHS service providers and faith leaders and support both groups on faith and mental health issues.

SOCIAL MARKETING

"The diversity of ideas, understandings, and experiences that form the foundations of the Mosaics of Meaning work have made this a truly fascinating programme to be involved in. The 'see me' campaign has gained valuable insight and knowledge which will have long-lasting implications for the work we do."

Johannes Parkkonen, Campaign Implementation Manager, 'see me'.

TALKING POINTS

- Our research shows how national social marketing campaigns can be made inclusive.
- The 'see me' campaign has taken positive action, and is careful not to over-generalise.
- Community development level campaigns are being planned.

One of the recommendations arising from the Mosaics action research programme was for a focused programme of social marketing to address mental health stigma with BME communities.

Two threads of social marketing activity have relevance here: using national media campaigns to raise awareness of mental health stigma with BME audiences, and developing additional resources to carry out targeted social marketing with BME communities.

An immediate response to the first requirement, and one that flowed directly from the initial research programme, was to change the visual images used in the national 'see me' campaign to make them more inclusive and more representative of Scotland's diverse population. A second response was to widen the channels used by the 'see me' national radio campaign and run these announcements on community radio stations such as Radio Awaz and Radio Ramadan. Further research and development work is needed to identify other appropriate media through which the national campaign can be delivered.

The research challenged some of the language and concepts used in the national campaign. For example, the phrase 'see me' is perceived as individualistic, and '1 in 4' (referring to incidence statistics) assumes a medical model of mental health. Interestingly, this issue has receded as the national campaign has evolved and made use of terms such as 'be there'.

Progress with social marketing work in BME communities has been carefully considered and a pilot exercise for a targeted social marketing intervention is currently being planned. In addition to that, work is in progress to build on the storytelling initiative using a specially commissioned film jointly developed by Glasgow Association for Mental Health, Voices Of Experience, 'see me' and NHS Health Scotland. Due for launch in 2010, this film covers the three main BME community groups in Glasgow and can be used to flexibly support awareness in communities and with practitioners.

New work

Further social marketing initiatives are also under consideration. One of the challenges faced is that, given the cultural differences that exist between and within BME communities, we cannot expect an approach that works with one community to be equally effective with others. In order to be effective, we need to develop a broad range of initiatives that engage meaningfully with different groups. It is important for the national campaign to work with and support local groups. By synchronising the national 'broad brush' approach with the detailed messages of small-scale interventions, we can achieve an effective and coherent programme to raise awareness and change behaviour.

"As a lawyer working with asylum-seeking and refugee communities I meet people from many different cultures, many of whom are poorly informed about issues of mental health and too ashamed to even discuss these issues. I welcomed the opportunity to train and participate as a peer educator for the Sanctuary community conversation project; participants from different communities have commended the programme as highly effective and informative."

Matthew Ndungu, Sanctuary community conversation project

THE MOSAICS MODEL: WIDER APPLICATIONS

The Mosaics of Meaning model of intervention has been successfully adopted by projects focused on the mental health needs of other minority groups, including asylum seekers and refugees, lesbian, gay and bisexual people and those in later life.

The mental health needs of the significant numbers of asylum seekers and refugees hosted in Scotland are an important concern for policymakers and service providers. To address this, the Sanctuary programme has brought together national, regional and local partners to undertake an action research project to identify patterns of stigma and discrimination experienced by asylum seekers and refugees in Glasgow, and explore how this might be addressed through a community development approach. The Mosaics model was a natural choice for this work.

Peer researchers
A team led by East Glasgow CHCP (working with the Scottish Refugee Council, The Medical Foundation for Victims of Torture and other NHS partners), recruited asylum-seekers and refugees to act as peer-researchers. Leading focus groups of other asylum-seekers and refugees, they identified that pre-migration trauma, along with poverty, racism and the stress of the asylum process itself, had a significant negative impact on people's mental health. Variations in understanding of mental health problems and its causation and treatment were also found, similar to those in the settled BME communities investigated earlier. The stigma attaching to mental health issues was once again significant; however, some very different experiences emerged in this research, particularly the impact of the asylum process on mental health and a reluctance to talk about mental health for fear of it jeopardising the process.

Peer educators
Ten people who were asylum-seekers or refugees were then recruited to lead a community conversation, using workshops delivered to groups of other refugees and asylum seekers. With input from a number of partners, a tailored programme of staff training was also devised to address the widespread knowledge gap among key service providers on the particular mental health needs of this group. In support of that programme a film has been commissioned, to capture the narratives of asylum seekers and refugees along similar lines to the storytelling work undertaken in Mosaics of Meaning. An evaluation of the project is currently under way.

Work with LGB communities

The Anti-Stigma Partnership also chose the Mosaics model as the basis of an inquiry into mental health problems and stigma experienced by lesbian, gay and bisexual (LGB) people. A programme of peer-led research was initiated in partnership with a number of mental health and LGB organisations to examine and report on beliefs and attitudes, the experience of LGB people as users of mental health services and the factors that influence the mental health of these groups. This method of working has proved effective and is welcomed by those taking part, and findings will inform future awareness-raising work with LGB people in Scotland.

The Mosaics model has also been applied in a mental health improvement project for people in later life led by NHS Greater Glasgow and Clyde and piloted in East Glasgow. With the aim of promoting positive mental health, encouraging help-seeking, addressing stigma and aiding recovery, older people in East Glasgow were recruited and trained to deliver a peer-led awareness programme on depression in later life.

"As a research and intervention model, the Mosaics approach works because it builds capacity and allows communities to decide both what and how questions should be asked. The Mosaics experience shows that people open up when talking to their peers. The model also provides encouragement as community researchers know there will be a programme of action that communities can be involved with."

Neil Quinn, Mental Health Improvement Lead, East Glasgow CHCP and chair of the Glasgow Anti-Stigma Partnership

TALKING POINTS

- **The Mosaics of Meaning model has been used in partnership with numerous communities to provide insights and create research capacity.**
- **Interventions vary, reflecting the needs of different communities.**
- **The Mosaics model links community development, social marketing and anti-discrimination activity – it can be used by your organisation to address mental health inequalities.**

PARTNERS, FURTHER INFORMATION AND CONTACT POINTS

We have produced a range of reports and resources during the lifetime of the Mosaics of Meaning project, all of which can be used and adapted freely by others. They include:

Reports

- McNeill L (2010) *'Are you really listening?' Evaluation of Process and Impact*, NHS Health Scotland.
- Shirjeel S (2010) *Sanctuary Community Conversation Evaluation*, NHS Health Scotland.
- Shirjeel S (2010) *Mosaics Community Conversation Evaluation*, NHS Health Scotland.
- Glasgow Anti-Stigma Partnership (2010) *"There's More to Me" – a report on LGB people's beliefs, attitudes and experiences in mental health*, Scottish Association for Mental Health.
- Azam A (2009) *Faith leader Conference Report*, Greater Glasgow and Clyde NHS.
- NHS Health Scotland (2008) *'Are you really listening?': Stories about stigma, discrimination and resilience towards mental health problems among black and minority ethnic communities in Scotland*.
- NHS Health Scotland (2009) *'Are you really listening?' Process Evaluation*. http://www.healthscotland.com/documents/4098.aspx
- Glasgow Anti-Stigma Partnership (2007) *Mosaics of Meaning: Exploring stigma and discrimination towards mental health problems with black and minority ethnic communities in Glasgow (Full Report)*, Greater Glasgow and Clyde NHS. http://www.healthscotland.com/uploads/documents/4621-Mosaics_meaning_full.pdf
- Glasgow Anti-Stigma Partnership (2007) *Mosaics of Meaning: Exploring stigma and discrimination towards mental health problems with black and minority ethnic communities in Glasgow (Summary Report)*, Greater Glasgow and Clyde NHS.
- Glasgow Anti-Stigma Partnership (2007) Community conversation workshop template.

Journal publications

- Quinn N, Shulman A, Knifton L and Byrne P (in press) The Impact of a National Mental Health Arts and Film Festival on Stigma and Recovery. *Acta Psychiatrica Scandinavica.*
- Knifton L, Gervais M, Newbigging K , Mirza N, Quinn N, Wilson N & Hunkins-Hutchison E (2010) Community Conversation: Addressing Mental Health Stigma with Ethnic Minority Communities, *Social Psychiatry and Psychiatric Epidemiology*, 45 (4), 497-504.
- Knifton L, Quinn N, Inglis G and Byrne P (2009) Ethical issues in a national mental health arts and film festival. *Journal of Ethics in Mental Health*, 4 (2), part 8, 1-5.
- Quinn N and Knifton L (2009) Addressing Stigma and Discrimination through community conversation. In P Bywaters, E McLeod and L Napier, *'Social Work and Global Health Inequalities: Policy and Practice developments'*. Bristol: Policy Press.

The resources listed above will be available, along with a host of other useful downloads and updates, at web-pages being developed to accompany this publication by 'see me' (www.seemescotland.org.uk) and Voices Of Experience (www.voxscotland.org.uk), These pages will be available from January 2011 to coincide with a national dissemination conference hosted by NHS Health Scotland to mark the end of the Mosaics Programme.

Links to new and related developments will also be available. These include a film being produced for 2011, a national dissemination event in December 2010, and four new anti-stigma demonstration projects with BME communities supported by NHS Health Scotland.

Partners, people and contact points

The Mosaics of Meaning initiative was conceptualised by Nuzhat Mirza and Lee Knifton of NHS Greater Glasgow and Clyde in 2005, who led the programme over a five-year period supported by the collective decision making, drive and leadership provided by the steering group partners: Dale Meller, Arma Sayed and Christopher Homfray of NHS Health Scotland; Pratima Pershad of Glasgow Association for Mental Health; Tina Yu of Mental Health Foundation; Mahmud Al-Gailani of VOX; Johannes Parkkonen of 'see me'; and Neil Quinn of East Glasgow CHCP and chair of Glasgow Anti-Stigma Partnership.

The steering group wishes to acknowledge the contribution and commitment of the many people who have contributed time and energy over and above their normal duties in research and community development roles to make the Mosaics programme a success. They include Kavita Aggarwal, Ayisha Azam, Iffat Bhatti, Florence Dioka, Dana Ho, Stephani Mok, Ravina Naroo, Karen Newbigging, Amna Qureshi, Patricia Rodger, Kuldeep Sharda, Hina Sheikh, Lesley Sherwood and Stephanie Wong.

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Finally we would like to thank all of the community members who took part in the Mosaics of Meaning research and the projects which flowed from it for sharing their thoughts and insights with us.

For further information, or to obtain additional copies of this resource, contact details of the major partners will be available on the project web pages from 2011 onwards. They will then be updated as people and organisations change.

"NHS Greater Glasgow and Clyde has played a central role in developing the Mosaics of Meaning model, which in turn has made an important contribution to understanding and addressing mental health inequalities in our region. The Mosaics model also demonstrates the power of building partnerships between communities and agencies."

Trevor Lakey, Health Improvement and Inequalities Manager, NHS Greater Glasgow and Clyde, and commissioner of the Glasgow Anti-Stigma Partnership