Sanctuary- Mosaics of Meaning: Exploring Asylum Seekers and Refugees Views on the Stigma Associated with Mental Health Problems

Final Report (January 2008)

Commissioned by **Positive Mental Attitudes**,
East Glasgow Community Health and Care Partnership

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About Positive Mental Attitudes

This research was commissioned by Positive Mental Attitudes, part of East Glasgow CHCP. Positive Mental Attitudes[1] provides mental health improvement and inequalities leadership for East Glasgow Community Health and Care Partnership (CHCP). The programme implements a wide range of targeted interventions to raise awareness about mental health and to tackle stigma and discrimination. These interventions focus upon particular groups and settings and include: developing a curriculum resource for secondary schools on mental health; workplace training on mental health awareness to front line staff; the provision of information, training and policy development to employers; the production of community arts events to raise public awareness of mental health issues. All of these approaches draw upon the personal narratives of people with mental health problems as a key element of the programme.

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[1] The website for Positive Mental Attitudes is available via www.positivementalattitudes.org.uk

Acknowledgements

The Research Steering Group wishes to thank the following people and organisations for their help and support in setting up and carrying out this research:

- Over 100 asylum seekers and refugees living in Glasgow who willingly gave their time to share their views with us during the focus groups.

- Samiha Iman and Mariegold Akomode, who set up and facilitated the 10 focus groups. Their extensive experience of working with asylum seekers and refugees and their knowledge of local networks were invaluable.

- Staff of the local venues which hosted the focus groups:
    - Helen Hughes and staff of Tron St Marys Church of Scotland, Springburn;
    - The staff of Red Road Women's Centre, Springburn;
    - Joan McManus and staff of the Rosemount Centre, Royston;
    - Leslie Grieve & staff of Cranhill Community Project in Cranhill Parish Church;
    - Jassim Johe and staff of Kingsway Court, Knightswood.

- The childcare facilitator, Harry Paterson, and staff of East End Mobile Play Team.

- The 'support people' who attended each focus group to provide support and information to focus group participants, as required:
    - Claire Scott, East Health Improvement Team, NHS Greater Glasgow & Clyde;
    - Catriona MacSween and Flutura Shala, Scottish Refugee Council;
    - Neil Quinn, Positive Mental Attitudes;
    - Nuzhat Mirza, NHS Greater Glasgow and Clyde.

- Julie Truman of the Research and Evaluation Team (NHS Greater Glasgow and Clyde) for carrying out an informal and independent ethical audit on the research proposal.

- Linda McIntosh of Positive Mental Attitudes, who ensured that each focus group had appropriate childcare facilities, catering and interpreting support.

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Sanctuary- Summary and Recommendations

Research[2] has identified mental health problems as a major health issue for asylum seekers
and refugees and highlighted that these groups face barriers in seeking help for mental health
problems. This is due, at least in part, to the stigma that exists towards people with mental
health problems. *Sanctuary* undertook to explore the stigma surrounding mental health
problems in these communities.

Data was gathered through 10 focus group discussions with pre-existing groups of asylum
seekers and refugees.

Focus groups consisted of

- o 101 asylum seekers and refugees
- o 17 different countries of origin
- o 3 groups in English, 7 in language of countries of origin
- o 85 women and 16 men, reflecting the gender of pre-existing groups

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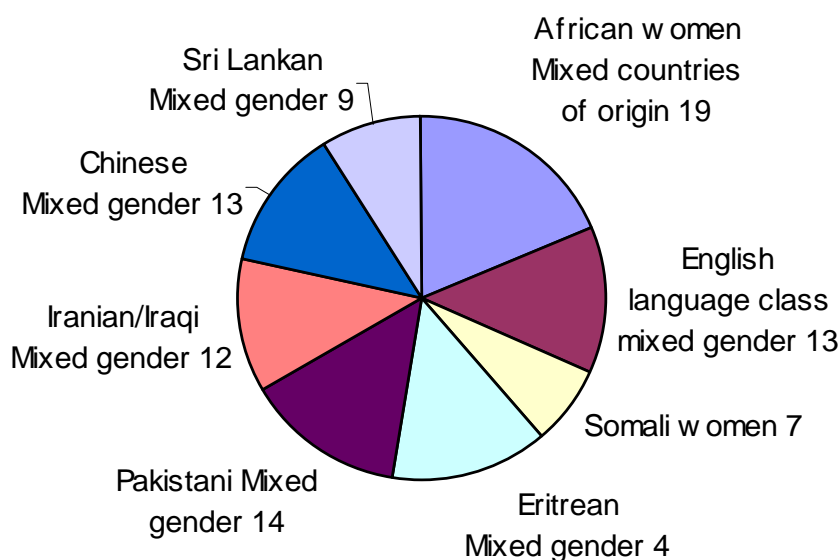
[2] Research was conducted by NHS Greater Glasgow, *'Supporting New Communities: A Qualitative Study of Health Needs Among Asylum Seekers and Refugees'*.

What did the research find out?

In general, the research findings were consistent across all the groups. However, some differences between cultural sub-groups did emerge and these are highlighted here and in the full research report, where appropriate.

Words and phrases

Focus groups began by exploring words and phrases associated with mental health problems. Most cultural sub-groups clearly associated depression, stress and worries with mental health problems but that these conditions had causes, treatment and reactions that were quite distinct to those of 'madness' and 'craziness'. Some people perceived stress and depression to be westernised forms of mental illness.

Causes of mental health problems

The main perceived causes of mental health problems were consistently reported as being worries, problems and the pressure of everyday life related to being an asylum seeker or refugee and to the negative impact of the asylum process. Many participants reported having poor mental health (a fact that has been well-established by other research studies) due to uncertainly of the future, having too much time to think, having problems sleeping, and feeling lonely and isolated. Many groups reported that their mental health had worsened since coming to the UK, compared to their country of origin. A contributory factor to this may be the reported perceived low status associated with being an asylum seeker or refugee. Many participants also referred to being subjected to racism within their communities and from local service providers.

Reactions to people with mental health problems

On exploring reactions to people with mental health problems, stigmatising behaviour, such as rejection, avoidance, gossip and labelling appear to be common across all groups, with slightly more sympathetic views being expressed by the Chinese and Iranian/Iraqi communities. Although this is in keeping with earlier research into the stigma associated with mental health within BME communities[3] one difference is clear. Asylum seekers and refugees are unfamiliar with the law in relation to mental health and propose this as a reason for avoiding helping people with mental health problems – fearing that they might attract trouble themselves. There was a strong perception that people with mental health problems in the UK are treated well and

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[3] ***Exploring Stigma Associated with Mental Health Amongst Black and Minority Ethnic Communities: A Report of Community Focus Groups Research***', NHS Greater Glasgow and Clyde, 2006.

that society here is generally more open to supporting people with mental health problems than in the various countries of origin of participants.

Religious beliefs

Religious beliefs were clearly linked to ideas about mental health across all groups. For example, being too religious, or not religious enough, were both reported as being associated with mental health problems. Also, developing mental health problems may be regarded as a 'punishment' or 'test' from God. Many groups also expressed an association between mental health problems and blackmagic, spirits and curses. These practices, however, reportedly take place in people's home countries and not here in the UK. Belief in these ideas was reported to be stronger among older generations and those with little education.

Seeking help

The stigma and shame associated with mental health problems expressed by all groups, clearly leads to reluctance to seek help for mental health problems. The type of help people sought appears to depend on the severity of the mental health problem. If it is mild, then people might approach friends and family for help, although the potential for gossip within the community was an issue for some people. Many participants said that they would be more likely to seek support from, to offer help to, someone from the same country of origin as themselves. One of the key issues is the impression that there is institutional racism in services, which is itself a barrier to seeking help.

Language

Language also seems to be a significant barrier to people in being able to access services. Lack of trust in interpreters (both in terms of confidentiality and competence) appeared to be widespread amongst participants.

Access to services

Lack of knowledge about what services are available for mental health support and how to access them appeared to be extensive and may represent a significant barrier to people in terms of getting the help they need.

Asylum seekers and refugees reported using a range of services for information and support such as the Scottish Refugee Council, YMCA and the Red Cross. These organisations have the potential to help asylum seekers and refugees access the health and social care services they require, including mental health services.

The second part of the focus group discussion enquired about people's habits regarding reading, watching TV, listening to radio, reading newspapers, using the internet and different types of face to face communication. This was to explore the potential influence of these different forms of communication on people's attitudes to mental health.

Media

In terms of challenging attitudes to mental health problems, TV was reported as potentially having an influence on beliefs and attitudes. However, unlike the settled BME communities, many asylum seekers and refugees did not have access to TV, either because they could not afford it or because of the language barrier. Radio may have significant influence on certain groups (e.g. Radio Awaz for those from Pakistan). Metro, the free newspaper, seems to be read by many asylum seekers and refugees and would present a good opportunity to influence attitudes to mental health, as may use of the internet. The use of billboards as a means of challenging attitudes to mental health problems was not clear cut and, because of cultural, language and literacy issues, would require further investigation.

Community interventions

The idea of developing discussion groups on mental health problems was proposed to each focus group. This appeared to be universally popular across all cultural sub-groups. Indeed, many had enjoyed and valued the process of having taken part in the focus group research. Holding large-scale events to raise awareness of mental health problems was also very popular.

What are the key recommendations?
In taking recommendations forward we need to work with asylum seekers and refugees to ensure that their voices shape new services and changes to existing services.

Some 25 recommendations are proposed as a result of having carried out this research. These appear in the full research report but some of the key recommendations are below.

Planning and developing services and support

Service planners and providers need to

- o Be aware of where asylum seekers and refugees are accommodated and work effectively with them and existing community resources to ensure the needs of asylum seekers and refugees are being met.

o Work with agencies to strengthen links with existing community groups, and establish new groups, to reduce social isolation. This work should be particularly focused on men, at those living in the east end and the Afghani population.

o Link with key agencies to ensure that asylum seekers and refugees have personal development opportunities including access to education, volunteering opportunities and leisure activities.

Raising awareness of mental health problems among asylum seekers and refugees
Service planners and providers need to

o Create opportunities for asylum seekers and refugees to find out about mental health problems through, for example, discussions groups, workshops and large scale events. This should include information on facts and figures, how to get help, language issues, how to offer help to a friend, mental health and the law and should include using the arts as a tool for engagement and communication.

o Target schools and colleges that have high numbers of asylum seekers and refugees to raise awareness of mental health problems

o Identify appropriate media to target asylum seekers and refugees with information about mental health issues (e.g. Radio Awaz and Metro)

o Develop a website for asylum seekers and refugees that could raise awareness of mental health issues and promote access to services.

Promote awareness amongst NHS, community and other organisations about cultural/religious issues, mental health issues and asylum issues Service planners and providers need to

o Provide awareness training for NHS staff (in particular those working in mental health services) and Community Planning staff on
- cultural /religious / spiritual influences on attitudes to mental health
- the asylum process and related issues

o Target a range of organisations that work with asylum seekers and refugees (e.g. Borders and Immigration Agency staff, accommodation providers, YMCA, Red Cross) to raise awareness of mental health issues to ensure they make appropriate referrals to other services for asylum seekers and refugees experiencing mental health problems

o Work with local organisations and communities to tackle the stigma associated with being an asylum seeker, for example, by linking to local campaigns or through use of creative arts.

And finally…..

All participants agreed that it would be very difficult to change the negative opinions associated with mental health problems and that it would take a long and sustained effort, especially with older people. Without exception, however, there was unanimous agreement that it was important to try.

'*There should be a campaign to show people that help exists and how to access it. It needs to be on an on-going basis. It should include telling people about the different types of mental illness – depression, post-natal - and who to go for to get help*'
(an African women's group).

1. Purpose of this Report

This report presents the findings from a series of 10 focus groups with asylum seekers and refugees in Glasgow. The focus for each discussion was the stigma associated with mental health problems.

The research was commissioned by Positive Mental Attitudes to inform an intervention programme with asylum seekers and refugees in Glasgow to address stigma and discrimination. The findings are supplemented by a number of proposed recommendations for future action and, as such, are intended to help guide key agencies in tackling the stigma associated with mental health problems within this population.

Investigations into the stigma associated with mental health problems have, to our knowledge, not been conducted before with asylum seekers and refugees. An important aspect of this research, therefore, was to learn from the *research process* of working with asylum seekers and refugees in Glasgow, so as to inform and guide future research and interventions within these communities.

2. Introduction and Background

Glasgow is Scotland's only city participating in the UK's dispersal programme for refugees and asylum seekers. There are estimated to be over 5000 asylum seekers and refugees in Glasgow[4]. The City's health services, as well as a wide range of other service providers, are trying to understand the complex and diverse needs of this population group, so as to be able to respond appropriately.

In 2005, NHS Greater Glasgow published a research report '***Supporting New Communities: A Qualitative Study of Health Needs Among Asylum Seekers and Refugees'***. This report identified mental health problems as a major health issue for this population group. It also highlighted that people have a problem in seeking help for mental health issues. This is due, at least in part, to the stigma that exists towards people with mental health problems.

In 2006, the NHS Greater Glasgow also published a report, '***Exploring Stigma Associated with Mental Health Amongst Black and Minority Ethnic Communities: A Report of Community Focus Groups Research***'. This research explored the different cultural and religious attitudes to mental health across different ethnic groups. It demonstrated that the main settled BME communities in Glasgow require a specially tailored approach in order to challenge the stigma related to mental ill-health and to help enable people to seek help for mental health problems. This current research project builds on the BME research to explore the particular issues relevant to asylum seekers and refugees in challenging stigma relating to mental health problems.

Furthermore, this research comes under the auspices of the Glasgow Anti-Stigma Partnership (GASP) BME programme and will inform the work of the GASP programme.

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[4] Home Office, Asylum Statistics, First Quarter 2007 (United Kingdom)

3. Aim, Objectives, Research Questions

The **aim** of this research was to:

> *'To explore patterns of stigma and discrimination in relation to mental health problems with the asylum seeker and refugee population in Glasgow and identify specific interventions to address stigma and discrimination within these communities'.*

The **objectives** were:

- to investigate the different beliefs and attitudes to mental health problems amongst the asylum seeker and refugee population, taking account of differing views between cultural sub-groups, where they exist;

- to explore different ways in which stigma and discrimination may be challenged;

- to consider the barriers to changing attitudes to mental health problems.

The main **research questions** were:

(i) How do the different cultural sub-groups within the asylum seeking and refugee population view mental health problems (i.e. beliefs and attitudes)?

(ii) What are the views of asylum seekers and refugees as to how best to change attitudes towards mental health problems?

(iii) What do the groups view as the barriers to changing attitudes towards mental health problems?

4. Method and Ethical Considerations

Asylum seekers and refugees are a very vulnerable group. Many of them have experienced extreme trauma and, even now that they are living here in the UK, their lives are dominated by insecurity, uncertainly, worry and distress. A research steering group, established to oversee the development of the research process, was very sensitive to people's potential vulnerability and took seriously their responsibility to ensure that the research participants were not adversely affected by taking part in the research. Steering Group members had extensive experience of working with the asylum seeker and refugee population and also brought expertise on mental health issues.

The main method of collecting data was through focus group research with pre-existing groups of asylum seekers and refugees, held mainly in the north and east of Glasgow. Key aspects of the research method are presented below.

4.1 Ethical Considerations

The steering group was committed to ensuring that the research process was ethically robust in order to avoid causing further distress to an already vulnerable group of people. Advice was sought from the local NHS Research Ethics Committee who confirmed that it was not necessary to obtain formal approval from them. Despite this, the steering group wanted to submit the research proposal to an informal and independent 'ethical audit'[5]. This was carried out by a member of the Research and Evaluation Team of NHS Greater Glasgow and Clyde who has extensive research experience but who was not a stakeholder in this research project. She confirmed that, in her opinion, the research proposal was ethically robust and that adequate measures to protect the research participants had been taken.

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[5] The independent ethical audit used the following guidelines: Ethical Assurance for Scottish Executive Social Research: Appendix for Ethical Scrutiny, Sally Dench and Ron Iphofen for the Scottish Executive, 2005.

4.2 Selecting Pre-existing Groups

Two sessional workers were employed to set up and facilitate 10 focus groups. They were recruited because of their experience of doing group work with asylum seekers and refugees and because of their knowledge of local networks. They used their local contacts to seek out pre-existing groups of asylum seekers and refugees and worked with the group leaders to set up the focus groups. Most of the groups were attended by the same cultural sub-groups (e.g. Somali Women's Group) but some of them, such as an English Language group, were attended by people from various countries of origin.

The main 'countries of origin' for each group was monitored at the planning stage so as to ensure most of the main nationalities of asylum seekers and refugees were represented in a way that reflected recent statistics.

4.3 Recruiting Participants & Encouraging Participation

Potential participants were invited to attend the focus group by their local contact and the sessional staff. They were given information verbally about the focus group and this was supplemented by a written information sheet (see **Appendix A**) that was translated into their own language. It was made clear that the discussion would be confidential and anonymous and that support would be available, if required. Each focus group was held at a familiar venue and at a time convenient to the majority of the participants. An interpreter[6] was provided, if required. To further encourage attendance, people were to receive a £10 voucher for a supermarket. Participants were provided with a buffet meal and childcare was provided by a local mobile crèche.

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[6] For logistical reasons, it was only possible for each focus group to work in English plus one other language, if required. Where interpreting for more than one language was required, the group was split into 2 separate groups, each with its own interpreter.

4.4 Supporting the Facilitators

Prior to the all the focus groups starting, both facilitators attended a half-day training session. This was to help ensure the generation of high quality data and a consistent approach. It was also to help to familiarise the facilitators with the questions and prompts. They were also provided with written guidance and a focus group plan (see **Appendix B**). Facilitators were also due to attend training to prepare them for managing any potential participant distress. However, this was cancelled due to unforeseen circumstances and was unable to be re-scheduled because of staffing issues.

4.5 The Focus Group Process

Following a brief introduction and agreement of groundrules, the focus group facilitator used a series of questions and prompts to stimulate the discussion . Each focus group discussion lasted no longer than 90 minutes and was split into 3 sections:

I. *Identifying issues around stigma and mental health*:

common words or phrases associated with mental health problems;

attitudes/beliefs; reactions to people with mental health problems;

the influence of religious/spiritual beliefs on attitudes to mental health.

II. *Identifying channels of communication*

TV, radio, newspapers and how much these affect attitudes and awareness of mental health issues; other opportunities for communication that shape attitudes (e.g. community groups, religious groups, school, workplace).

III. *Exploring solutions*

How easy or difficult is it to change attitudes;

main problems and opportunities; issues around seeking support.

The researcher attended each group to record the discussion in writing. All data was anonymous and it was not necessary to record the names of the research participants. Tape recording was not necessary as the pace of the discussion was slow due to the interpreting process. At the end of each focus group the researcher, facilitator and support person had a short de-brief to clarify any issues.

4.6 Post-Focus Group Information and Support

Each focus group was also attended by a 'support person'. All those who took this role had extensive experience of providing support to people with mental health problems. Their function was to help the participants deal with any difficult emotions that may have arisen during the course of the focus group discussion. This support was to be provided outwith the focus group, so as not to interrupt the flow of the focus group discussion, or after the discussion had ended.

Like the facilitators, the support people were due to attend training to prepare them for managing participant distress. However, as previously stated, this was cancelled due to unforeseen circumstances and was unable to be re-scheduled. Instead the support people were provided with the contact details of a number of organisations that could offer support to those with mental health issues, if requested. The nature of the support required at each focus group, if any, was noted.

4.7 Analysis and Reporting

The focus group data was analysed quantitatively and qualitatively using a thematic approach. It was an important aspect of this research project that the final report should contain practical recommendations for action.

4.8 Dissemination

A hard copy of the final report, or a summary report, is to be disseminated to all partner agencies, and other relevant local and national organisations. In addition, it will be available on websites of Positive Mental Attitudes[7], NHS Greater Glasgow and Clyde[8] (section of Equality and Diversity[9]) and the Scottish Refugee Council[10]. In order to give feedback on the research findings to the focus group participants, a poster will be developed (and translated, if necessary) and distributed to the community projects that 'hosted' each focus group so that participants will be able to see the findings as they come and go from their group meetings. A dissemination presentation will be arranged to which all stakeholders will be invited.

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[7] Website of Positive Mental Attitudes: www.positivementalattitudes.org.uk
[8] NHS Greater Glasgow and Clyde (NHSGG&C): www.nhsgg.org.uk/content/default.asp
[9] NHSGG&C Equality & Diversity website: www.nhsggc.org.uk/content/default.asp?page=home_equalitydiversity
[10] Scottish Refugee Council: www.scottishrefugeecouncil.org.uk

5. Research Findings

This section presents the findings of the 10 focus group discussions. The content of the discussions have been analysed thematically to draw out overall themes and issues. This section includes direct quotations from participants – these appear in '*italics*' - and the group from which the quote arose is provided in brackets. Note that discussion of the findings and any conclusions that can be drawn are reserved for the following section, Section 6.

In general, there was good consistency in people's responses across all the focus groups, however, some differences within and between cultural sub-groups were apparent, and these are highlighted where they existed.

Note that where a participant expressed a view that was not challenged by any other participant, either spontaneously or through prompting by the facilitator, this is reported as the group's overall view.

Prior to starting each focus group, the researcher checked with the interpreter that there was a readily translatable equivalent phrase for 'mental health problem' or 'mental illness'. This did not pose any problem in any of the groups. During the introduction to the discussion, the facilitator asked the participants if they were all happy with the term 'mental health problem'[11] or if they wanted to agree an alternative phrase. All groups were happy with the phrase 'mental health problem'.

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[11] Note that for the first two focus groups, we used the term 'problem that affects the mind' but this seemed unclear for some participants so the phrase was changed to 'mental health problem' for subsequent groups.

5.1 Focus Groups and Participants

A total of 10 focus groups took place, using pre-existing groups of asylum seekers and refugees. There were 101 participants in total. The groups and number of participants are shown in **Table 1** below.

TABLE 1: FOCUS GROUPS AND NUMBERS OF PARTICIPANTS

Focus Groups (using pre-existing groups)		Numbers	Language of focus group
1	African women (mixed countries of origin)	13	French
2	Somali Women	7	Somali
3	African women (mixed countries of origin)	6	French
4	Eritrean (mixed gender)	14	Tigrinya
5	English language class (mixed countries of origin) (East End)	5	English
6	English language class (mixed countries of origin) (North)	8	English
7	Pakistani (mixed gender)	14	Urdu
8	Iranian / Iraqi (mixed gender)	12	English
9	Chinese (mixed gender)	13	Mandarin
10	Sri Lankan (mixed gender)	9	Tamil
TOTAL		101	-

Three of the focus groups were conducted in English. Interpreters were required for the remainder of the groups as they were conducted in French (2 groups), Somali, Tigrinya, Tamil, Urdu, and Mandarin (see **Table 1**).

Seventeen different nationalities were represented by the focus group participants. The countries of origin represented in the focus groups are provided in **Table 2** below, alongside countries of origin, by percent, of Glasgow's asylum seeker and refugee population.

TABLE 2: COUNTRIES OF ORIGIN REPRESENTED IN THE FOCUS GROUPS BY % OF GLASGOW'S ASYLUM SEEKERS AND REFUGEES POPULATION

Countries of Origin of Asylum Seekers & Refugees in Glasgow	% of Glasgow's Asylum Seeker & Refugees population [12]	Numbers taking part in focus groups, by country of origin
Pakistan	16.6%	15
Somalia	7.8%	7
Iran	6.9%	6
Sri Lanka	6.8%	10
Afghanistan	6.71%	0
Peoples Rep. of China	5.6%	14
Democratic Rep. Congo	5.5%	10
Iraq	4.7%	7
Turkey	4.6%	0
Albania	3.7%	0
Congo	2.5%	0
Eritrea	2.2%	19
Zimbabwe	2%	0
Other (see below *)	24.4%	13
TOTAL	100%	101

* Other focus group participants were from Guinea (n=4); Ivory Coast (n=2); Angola (n=1); Burundi (n=1); Cameroon (n=1); Algeria (n=1); Sierra Leone (n=1); Sudan (n=1); Ukraine (n=1).

Effort was made to engage with a known amount of single male asylum seekers in east Glasgow. However, they did not appear to meet in pre-existing groups thus making it difficult to set up a focus group with them. At the time of the research, most asylum seekers and refugees in Glasgow were families or lone parents, mostly mothers (although numbers of single males have increased more recently[13]). This mirrored the circumstances in Glasgow at that time, that is, that most accommodation available in the city was allocated to families. The research sample is therefore reflective of the overall situation at that time [14].

The approximate age of participants was also noted. It appears that the majority of focus group

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[12] Data from Scottish Refugee Council – personal correspondence, March 07.
[13] Data through personal communication from the Scottish Refugee Council.
[14] Source – Borders Immigration Agency, previously known as the Immigration n and Nationality Directorate (of the Home Office).

participants were in their 20's and 30's, with slightly fewer people being estimated to be in their 40's, or older. Those who were of older age were mostly male. There appeared to be very few teenagers. Marital status was not reported, however, the majority of participants seemed to be here as part of a family unit – the crèche was well-used by the young children of participants.

Of the top 5 countries of origin of asylum seekers and refugees in Glasgow (Pakistan, Somalia, Iran, Sri Lanka, Afghanistan), all were proportionately represented, apart from the Afghan population. Of the remaining countries of origin, the Chinese, Congolese and Eritrean communities were rather over-represented. However these groups reflected emerging trends at the time of the research, that is that asylum seekers arriving directly in Glasgow (rather than those dispersed from other parts of the UK under Home Office policy) contained notable numbers of Chinese and Eritrean people[15].

The research set out to run focus groups in both the east and north of Glasgow. However, it was only possible to hold one of the groups in the east. Eight groups were held in the north of the city and one was in the west.

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[15] Data through personal communication with the Scottish Refugee Council.

5.2 Identifying issues around mental health and stigma

The first part of the focus group discussion explored people's beliefs and attitudes to mental health problems. It identified perceived **causes** of mental ill-health and investigated **reactions** to people with mental health problems. Finally it explored the links between **religious/spiritual** beliefs and attitudes to mental health issues.

5.2.1 First word or phrases

Participants were invited to give the first words or phrases they might think of on hearing the term, 'mental health problem'. For all groups, except one group of mixed countries of origin, the most common first response was '*mad', or 'crazy'*. In most groups, the phrases '*depression', 'stress'* and '*worries/problems'* were given high priority too. Only the Eritrean group did not mention these.

Some phrases were mentioned less consistently across the groups. There were:

- Psychological problem, needing psychiatric help, treatment, & sympathy (2 groups);
- Headache (2 groups);
- Crying (2 groups);
- Forgetful, unable to concentrate (2 groups);
- 'Mentally retarded' (1 group);
- Danger (1 group);
- Angry patient (1 group);
- Different to us (1 group).

It is worth noting that throughout some of the focus group discussions, it became clear that some people saw a distinction between 'craziness' and 'mental illness', for example, ' …*we need to use positive words to dissociate mental illness from craziness'* (an African women's group) and '*There are people who are crazy but mental illness is different'* (Chinese group). Furthermore, some participants made the distinction between words and phrases they associate with mental health problems in the UK and in their country of origin, for example, '*In Africa, people are on the street, completely out of their minds, here we don't notice them unless they tell you or they do something. You don't know about it because they are being looked after by psychiatrists. In Africa, you'll see crazy people on the streets but here you see stress and depression...it's here a lot'* (an African women's group)

5.2.2 Perceived Causes of Mental Ill-health

Participants were asked what they believe to be the main causes of mental health problems. On responding, most groups seemed to be forming a distinction between stress and depression and more severe forms of mental illness that they often referred to as 'craziness'. There was a perception that stress/depression could lead to more severe problems or 'craziness', for example, '*When you are depressed, it can make you mad (English language class)*', and '*It all starts slowly – stress, negative thoughts – then it becomes a bigger and bigger problem'* (an African women's group).

(i) Worries and Insecurity

Worries, problems and the pressure of everyday life were the most commonly reported causes of mental health problems. Although participants were not asked to give personal accounts of their mental health status, many people related these causes strongly and immediately to being an asylum seeker, in particular, waiting for a decision from the Home Office, and worry about their future, for example, *'I think it is with all of us at the moment. Because of all this stress, we have a little bit of this inside of us'* (Iran/Iraqi group). As well as the uncertainly and insecurity, several participants talked about having too much time to think, often due to being unable to work. Lack of sleep (which could be quite extreme) was commonly reported as being a side effect of having worries. Some illustrative quotes are below:

'The main problem is the government; we get benefits instead of work. We are at home thinking, thinking and it's not good. If there was work available, we'd be busy and would not have so many bad thoughts' (an African women's group).

'*You can't organise your own life because they can send you away tomorrow'* (Chinese group).

(ii) Isolation

Furthermore, many of the participants reported that their lives as asylum seekers are dominated by loneliness, isolation and feeling homesick, for example, '*We're isolated here, that is the problem'*.

(iii) Status

It was fairly common for participants to report the status of being an asylum seeker as a potential cause of mental health problems. For example, in the Sri Lankan group, someone reported, '*Asylum status'* as being a cause of mental illness - the rest of the group laughed and agreed. Other examples of asylum seekers and refugees having a sense of low status are

below:

'Because we are seeking asylum, we feel an inferiority complex' (Pakistani group)*.*

'*I am losing everything mentally. I have respect in my country, I am rich, but here I have to
clean my room. I feel like the 4th or 5th man. I have lost 5kg in a month'* (Pakistani group).

*'Everywhere people ask you if you are an asylum seeker or refugee. There is a two-tier system
and people don't refer you on' (*mixed English language group).

(iv) Racism

Experience of racism appear to be a potential source of mental health problems, '*A girl, maybe
16 or 17 years old, told me to get out the ****ing way*' (Pakistani Group). The Iran/Iraqi group
also talked about experiencing racism in their local area, as did the African women, '*In the lift,
they give you a false smile, but we know they want us out the lift. Young white people are very
rude – they can't change, it's a reality. But there is some security, the concierge, he'll call the
police but they'll take their time to come*'.

(v) Heredity

Heredity as a cause of mental health problems was only mentioned spontaneously by the
Iranian/Iraqi group. When promoted, most groups gave a mixed response. Some people said
that mental health problems, especially severe forms, can run in families, whilst others
disagreed, saying that stress and depression are not inherited but are the result of life
circumstances. The Sri Lankan group was the only one (of those that were prompted to
comment on this issue) in which there was universal agreement that mental health problems
cannot be inherited.

(vi) Other Causes

Other perceived causes of mental health problems, which were mentioned much less
consistently across the groups, were:
- 'shocks' (e.g. bereavement);
- family problems (e.g. with spouse or children or neighbours);
- punishment from God (only 2 groups mentioned this - Iran/Iraqi group and the Tamil
  people within the Sri Lankan group);
- lack of confidence (mentioned by the mixed English language class group and the
  Pakistani group);

- taking drugs and alcohol through peer pressure (reported by Iran/Iraqi and Sri Lankan groups and by younger participants in particular);

- poverty (Somali group).

Interestingly, many of the groups recognised that often the causes of mental ill-health in this country could be distinct from the causes 'back home'. Many indicted that they had swapped the stress of living in a war-torn or impoverished country with the stress of living in this country brought on by uncertainty, inactivity and isolation, for example, '*Back in Africa, we were busy. Here we do nothing. We get benefits, stay at home, watch TV and sleep'* (an African women's group). Other quotes illustrating this point are below.

'*Human beings are the same everywhere but different circumstances cause mental health problems. In Somalia, it's poverty and civil war. But it's different here – worse – because of the isolation, not being supported by many people and fear of being deported back. In this country, we can't relax. We can become sick and stressed inside with bad news from the Home Office'*

'*In Africa, soldiers might come to the house and threaten you or hit you….but we're isolated here, that is the problem'* (an African women's group).

'*In Eritrea, no-one looks after each other, they don't look at each other. Here, people expect freedom and equality and when that doesn't get fulfilled, they are disappointed, they feel hopelessness'*.

Similarly, the Chinese focus group reported that life here is more stressful than '*back home'* for example, '*If your child is sick, you cant communicate with the doctor. You worry about your child and the future and you worry about friends who don't have citizenship'*.

The Iranian/Iraqi group compared the sense of **shame** associated with mental health problems in their own countries to the perceptions of shame in the UK, '*It's very shameful in my country but it's not here, it's normal, although some families (back home) will do their best for the child'*.

5.2.3 Reactions to people with mental health problems

Focus Group participants were asked how they thought people would react to someone with a mental health problem, for example, a neighbour. Common **reactions** were:

- rejection and avoidance, e.g. '*ignore them or push them away' (*Pakistani group) and ' *They are not part of society; they are rejected'* (an African women's group);

- labelling and pointing at them (an African women's group);
- ridiculing and gossiping about people (mixed women English language), '*There is lots of gossip within our community here*' (Sri Lankan group);
- pity (only expressed by the mixed English language groups);
- trying to help, mainly through talking e.g., '*You mustn't run away from this, you must help*' (Iranian/Iraqi group) and '*People with mental health problems should not be hidden away but should be supported to be part of society'* (Chinese group).

Most groups started by saying that people's reactions would depend on the **severity of the illness**. In general, if the problem was 'severe' then most people would avoid the person because they were concerned about being on the receiving end of violent or aggressive behaviour. People would be more likely to help if the problem was 'mild', like stress or depression.

Of course, within each group there was a mix of people who would want to try to help and others who would not. Two extreme examples, both from the Pakistani group, are, '*My friend had it and everyone helped her'* and *'No-one wants to speak to a sick man'*. There is an impression that people are **more likely to help** someone with a mental health problem if:

- it is mild, rather than severe;
- they know the person, and especially if it is family member;
- they have knowledge about mental health issues, e.g. '*I know a few people with mental health problems and I want to help, honestly, but I don't know how to help'* (English language group);
- they know the law in relation to people with mental health problems. This issue was raised by 3 groups (English language Group, an African women's group and the Sri Lankan group), for example, '*If I try to help someone and they hurt themselves, I might become a suspect. We don't know the laws in this country and we are scared';*
- they feel they will be able to help e.g. *'If he doesn't know me, he might not let me help, he might be scared of me'* (Iran/Iraq group);
- people are brought up not to judge and stigmatise people (Ukrainian woman).

Most of the groups compared reactions to someone with a mental health problem here, in the UK, to how people might **react in their country of origin**. For example:

- The 2 groups of African women said that reactions to mental health problems in Africa are quite different to reactions in the UK, although there were a few exceptions to this view. In Africa, they said, people with severe mental health problems might be '*on the*

streets' i.e. they are very visible. There was reference to people with mental illness being in chains and having to wear 'identifying' clothes and that generally reactions would be much less sympathetic in Africa, e.g. '*It's very different here than in Africa. First they'd catch the person, then put them in a secure, psychiatric hospital'* and '*In Sierra Leone, people wouldn't help, they would laugh'*. There seemed to be a general impression that UK citizens are more open about mental health problems, although there was still acknowledgement that, '*Even in European society, it is hidden away';*

- The Somali women felt that reactions are the similar whether in the UK or back home;

- The Chinese Group reported that people with mental health problems in China would have to rely on families for help as there is '*No help from the government'*;

- The Sri Lankan group, in particular the Tamils, said '*Our culture tries to hide it, back home'*.

None of the group spontaneously raised issues about possible **generational differences** in people's reactions to mental health issues. Prompts were used to stimulate discussion on this issue. Quite mixed responses were received. Both the Eritrean and Pakistani group said that older people would be more likely to help someone with a mental health problem, for example, '*Young people don't have the patience and are too emotional – they might make the person more upset'*. In contrast, the Somali women felt that younger people would offer help more readily.

Most of the groups were prompted to comment on possible links between **marriage and mental health problems** i.e. whether they felt people might avoid marrying a person with mental health problems, or avoid marrying into a family in which someone had mental health problems. The Pakistani group were quite unanimous in saying, '*People with mental health problems won't get marriage* proposals', adding that this would be more of a problem for women than men. *If there is a scale of 1-100, it doesn't matter where she is, she is called 'mad', and she won't marry'*. Another participant from the Pakistani group said, '*It depends on the family – we'd hide it. We wouldn't disclose the problem until after marriage. It's our culture'*.

The Iranian/Iraqi participants had a more mixed reaction to the issue of marriage, with some saying it is genetic and marriage should be avoided, while others say it that it is '*environmental'* and '*it flows from life'*. Similarly, the Chinese group was less clear cut in views about marriage, saying that there might be a genetic component if the problem is severe or if many family members have symptoms. In either case, however, marriage would be avoided.

5.2.4 Peoples' opinions and the sort of help they might seek

Participants were asked if they think that opinions towards people with mental health problems affect the sort of help people might seek. This question seemed to be quite challenging for most of the groups, sometimes because the interpreter found the question difficult to translate. The responses can be grouped into the following themes.

Overall, there seemed to be a sense, in most groups, that people would be **reluctant to seek help** because they want to hide the problem. The Iranian/Iraqi group was the only one to mention that sometimes the person themselves does not want help and might be reluctant to talk. However, many groups said that mental health problems are an illness and that most people (sometimes with the help from family) would seek specialist treatment, for example, '*Secretly I'd take them to a doctor. Yes, I'd try to get help for them, but quietly*' (Pakistani group).

A few groups referred to having a sense of **not being trusted** by their 'host' communities and this appears to be a factor in determining help seeking behaviour. Two groups mentioned that they felt that asylum seekers are not trusted, and are not listened to, by the authorities, leading to a sense of hopelessness that may discourage asylum seekers and refugees from seeking help, for example:

'*To tell you the truth, we think no-one believes us and they think we don't tell the truth. When we seek help, they are very nice to you but once we are in the office, they ignore you*' (an African women's group).

'*People in this country don't trust asylum seekers. They think they just want benefits, even if they are in higher education*' (English language group)

'*People pretend to listen to you but they are false, even the GP is trying to get rid of you because of colour of your skin. There was a doctor who was racist, everyone know it. They got rid of him*' (an African women's group)

The issue of being able to **trust interpreters** was discussed by many groups. The Iranian/Iraqi group and the Pakistani group expressed this strongly, for example, '*Many interpreters have a big mouth*'. The need for gender-specific interpreters was highlighted too, for example, '*I can't look at a woman interpreter*' (Pakistani male). In addition to confidentiality issues, lack of trust in interpreters' competency was raised, although only in the Iranian/Iraqi group, '*I was on the*

wrong medication for a whole year because of inaccurate interpreting'. By contrast, some of the Sri Lankan participants said that, '*It shouldn't be a problem as it is a requirement of their job to keep things confidential*', however, similar numbers in this group expressed lack of trust in interpreter confidentiality.

Only the group of Somali women talked about having trust in other people from their home country who might try to help them here. They also said that they would be more likely to help another Somali person in this country.

Spiritual and religious issues were mentioned in the context of the type of treatment people might seek. One participant in the African group said, '*If people believe it's mental illness, they seek help from a psychiatrist and so they get better, but others might believe it is witchcraft, so they wont seek proper help and so the person may not get better*'. Another woman from the English language group said, '*First I would go to the doctor for medication and then I would pray because I have faith and believe that it will help*'. No other groups mentioned religious or spiritual issues in response to this question about seeking treatment for mental health problems.

5.2.5 The influence of religious and spiritual beliefs on attitudes to mental health
Participants were asked if they felt that religious or spiritual beliefs influence people's attitudes to mental health. Most participants seemed to hold some religious beliefs. Amongst the participants were Muslims, Christians, Buddhists and Hindus. Responses to this question generated some controversy within most groups.

- **Belief in God:** Many people in the Iranian/Iraqi group felt that people with religious beliefs would be mentally healthier and have fewer problems. Most groups mentioned prayer as a form of comfort in bad times, '*We would pray to God for help – use God for the answers, to show the next step*' (Pakistani Group). The Pakistani group expanded this view to say that if people are, '*too far from religion or too much into religion can get mentally ill'*. This view was supported by the Eritrean group, who said, '*Concentrating on your beliefs can be stressful*'.

- **Punishment from God:** Most groups asked if they felt that some people believe that mental health problems could be a punishment from God. Some participants in some groups (e.g. Somali women, Eritrean, Iran/Iraqi, Pakistani groups) did believe in punishments from God but that punishments typically took the form of financial loss

rather than affliction of mental illness, for instance, '*God does punish if, say, a person is acting badly, or when they become rich and forget God, they might suddenly fall down*' (Iran/Iraqi group). This view was by no means universal. The mixed nationality English language group, for instance, felt strongly that mental health problems could not be a punishment from God. Others said '*everything is a test from God'* rather than a punishment. Likewise, the Chinese group had differing views on punishments from God, depending on their religion, as did the Sri Lankan group. For example, the Singhalese (who are mostly Buddhists) believe that mental health issues are nothing to do with God, although they might pray to God for help. In contrast, the Tamils (who are mostly Hindus) were less clear cut about this issue.

- **Religion and acceptance/support:** Two groups (both African women's groups and the Chinese groups) said that religious beliefs, whatever their form, should encourage people to be accepting of everyone, including those with mental health problems, for example, '*If you have faith in God, you are taught to accept everybody*' and *'No matter what the religion is, you wont see that person differently*'. The Chinese group said that people with religious belief might be more likely to help someone with mental health problems.

- **Witchcraft, curses and spirits[16]:** Views on Blackmagic were also somewhat controversial, but at least some participants in many of the focus groups (mixed African, Eritrean, Somali, Pakistani) expressed a belief in witchcraft, '*Some people, not all, believe that enemies, or jealous people, can do this to you and it needs special treatment by 'magic' people*' (Somali group). There was reference to the fact that these things are written about in the Koran (Pakistani and Iranian/Iraqi group). There was also reference to **spirits**, for example, *'In Africa, if spirits are not happy, then they put you into that state*' and '*Some religions believe that a ghost can go into your body and cause mental illness'* (Chinese group). Furthermore, the Eritrean group referred to **curses**, for example, '*Someone in a high position might put a 'bad eye' on another*

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[16] Some 'community' definitions of blackmagic, spirits and Karma were developed for the research with settled BME communities, referred to in footnote 23. These are as follows:
Blackmagic and Curses: These are believed, by some, to be a cause of mental health problems, for example, someone might place a curse on a person (or family) if they had wronged them.
Spirits: There is a belief that mental illness can be caused by possession by spirits. The belief is that spirits of the dead are all around us, some are good, some are bad.
Karma: This belief, originating in Hinduism & Buddhism, states that a person's actions and conduct during the successive phases of their existence determine that person's destiny. In other words, a person's actions will have consequences on what happens to them in this life, and future incarnations.

person'. It is worth noting that the Sri Lankan group was the only one to strongly and unanimously state that they did not believe in Blackmagic or curses at all. It was reported, however, that many Sri Lankan people use astrology to influence their approach to dealing with mental health issues.

Although younger people believe in Blackmagic and spirits, these beliefs generally are thought to be more widely held amongst older generations. The Iranian/Iraqi group made reference to levels of education and belief in Blackmagic and spirits, for example, *'If it's a high family with open minds, then they don't believe, but others do'* as did a woman in the English language group, *'In Algeria there are two types of people – educated ones who'd go to the doctor for help and uneducated, who'd go to a witchcraft group'.* It appears that, although many people believe these things happen in their countries of origin, there is a strong sense that they do not happen here in the UK.

- **Charms:** There was brief reference (in the African and Eritrean groups) to using charms as protection against bad things, for example, '*You may need spiritual protections, such as a necklace, and if one day you don't wear it, something might go wrong* (African Group).

- **Karma:** The Chinese group was the only one to refer to karma, '*If you are bad in this life, it can be bad for you and your family in the next life*'.

- **Astrology**: This was mentioned exclusively by the Sri Lankan group and by the Singhalese people in particular. It seems that astrology can have quite a profound influence on people's lives, such as selecting a 'good' date to get married. In relation to mental health, people reported that they might use an astrologer to advise them on whether they should take medication or not, '*The astrologer might say that after a certain date, it might be fine'.*

- **Fasting**: The Tamil people within the Sri Lankan focus group were the only group to mention fasting. They said that they might use fasting, say for 30 days, to try to cure a mental health problem.

5.3 Exploring Channels of Communication

The second part of the focus group discussion enquired about people's habits regarding watching TV, listening to the radio, reading newspapers, using the internet and different types of face to face communication. This was to explore the potential influence of these different forms of communication on people's attitudes to mental health. The findings are grouped into themes and are presented below.

5.3.1 Television

Only in the Eritrean and Chinese groups, did some people mention that they could not afford a TV and/or the licence. Some Chinese people reported using a TV to watch DVDs only.

Of those who did watch TV, most participants in most of the groups watch more English TV (all channels) than anything else, even if they do not understand it. Reasons for this did not vary much amongst the different groups, unless otherwise stated:

- Some people reported not being able to afford satellite TV and therefore could not get TV channels in their own languages;
- Some of those living in YMCA accommodation reported being unable to get satellite reception or said they are not allowed it, '*They specifically choose that side of the building for asylum seekers because there is no signal'*;
- Some people like to use English-based TV to help learn the language, attitudes, culture, etc;
- Children watch children's TV programmes in English;
- Young people prefer to watch the English channels (Iranian/Iraqi group).

Both the Somali and the Iranian/Iraqi groups felt that English channels were inappropriate or '*destructive'* for children (and adults) because they were '*too sexy, people kissing'*.

A wide variety of channels were regularly viewed by those who had access to satellite TV including: French channels (TV5 and TFN), Universal (a Somali channel), TNF (Television National Français), EriTv (Eritrean channel), Sudanese channel, Arabic channels, Iranian channels, various channels in Farsi, Turkish and Kurdish, Phoenix (which is in Chinese languages), Sri Lankan TV (which is broadcast for one hour/day, Monday – Friday).

In the Pakistani group, the types of programmes that people watch are generally split by gender; women generally said they preferred to watch soap operas and dramas (using Asian channels, if possible), whereas men expressed more interest in watching news and sports. Differences in viewing patterns due to gender were not explored in other groups.

5.3.2 Radio

In general, radio appeared to be less popular than TV. Some of the reasons offered were that people found it '*boring'*, or they could not understand it or that they preferred TV. A few people seemed to be able to get radio stations in their own languages, for example, some of the Congolese people reported listening to French radio stations. A handful of participants mentioned that they listened to radio via their satellite connection (the Iranian/Iraqi group and the Sri Lankan group). It seems that if people were able to access radio stations in their own language, then radio would be more popular, *'When you're missing your home, anything in your own language really attracts you'* (Pakistani group).

There are 2 exceptions to the reported low levels of listening to radio: the Somali group, many of whom listen to BBC Somali, and many of the Pakistani group, who listen to Radio Awaz (a full-time Asian radio station in Scotland). Also, there was an indication, but only from the Somali group, that English-based radio stations may be popular with young people.

5.3.3 Newspapers and Magazines

Participants were asked if they read any newspapers or magazines relating to their country of origin and, if so, how much compared to English-language newspapers.

Responses to this question were usually brief. All groups, without exception said they read Metro more than anything else, the main reason being because it is free. A few tabloid newspapers were mentioned but not consistently. Some participants seem to use local libraries to read newspapers, both English-language papers and those from their country of origin. The internet appears to be used as a way to access news from people's home countries. The Chinese group was the only one in which all participants read a newspaper in their own language – Tsing Tao, a free Chinese newspaper.

Some people in about half the groups mentioned that they read (or for some, just look at the pictures) of celebrity magazines (e.g. OK and Hello) and a few mentioned supermarket magazines. There was one reference to the Refugee magazine published by the United Nations, to which someone had access through the local library.

5.3.4 Internet

Use of the internet, either at home, at college or at public libraries, was reported widely by most participants in all groups. In the Chinese group, 4 out of 13 participants did not have any access to the internet. Some key points in relation to internet use are as follows:

- Commonly used sites are Google, Yahoo and websites from people's country of origin so they could keep up-to-date with news and events (e.g. the Eritrean group used 'Shabia' website, the Pakistani group reported using www.manzar.pk.com);
- People also reported using BBC sites and American sites;
- Email is used as a means to keep in touch with friends and family;
- There was reference, in the Sri Lankan group, to using the internet to check asylum laws, as '*they change all the time'*.

5.3.5 Organisations as sources of general advice and support

Participants were invited give information about which local organisations they would use for general help and support. There was a great deal of consistency in the responses of all groups.

Many participants in each group, apart from one of the English language groups, said they would use the Scottish Refugee Council (SRC)[17] as the first, or one of the first, points of contact if they needed help.

The YMCA also appeared to be used regularly by many people who live in YMCA accommodation. A few negative comments were received about accommodation providers in general, for example, '*They don't listen and they don't come when they say they will'*. Three groups referred to using the Red Cross.

A number of participants across a few groups said they would use their social worker or solicitor for help and advice. An African women's group said they used the Red Road Women's Centre, the National Asylum Seekers Support Service (NASS), COMPASS, and the Medical Foundation but most of these were not mentioned by any other group.

The African and Sri Lankan groups reported that some churches are good providers of support and advice. However, religious institutions were in general only referred to in the context of getting comfort from prayer, rather than as sources of advice and support. Interestingly, the Sri Lankan community reported using the interpreter for help and advice – this is a man who is well known in the local Sri Lankan community and is knowledgeable about local networks and organisations.

A few participants said that they used their guidance worker at college for advice. Others referred to using friends and family for guidance and support.

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[17] The Scottish Refugee Council (SRC) is an independent charity dedicated to providing advice, information and assistance to asylum seekers and refugees living in Scotland. It also provides specialist services such as housing and welfare, education/employment, family reunion, women's issues, community development, the media and the arts.

The only group that took place in the East End of the city referred to quite different organisations, for example, the local Housing Officer, a Women's Group in Easterhouse and a self-defence class (which one woman said had helped to improve her confidence).

The Chinese community, as well as using SRC and social workers, use Glasgow-wide Chinese community projects for help and support e.g. San Jai and the Chinese Healthy Living Centre.

5.3.6 Influence on people opinions about mental health issues

Participants were asked if they felt that TV, radio, newspapers, internet and local organisations had an influence on people's opinions on mental health issues. This question was not discussed by 3 groups, due to time pressure. Of those groups that responded, the majority felt that TV was the most influential form of communication, for example, '*TV is the best way; it's more universal*' (English language group). The Sri Lankan group did not agree because they reported using TV mostly to watch feature films.

Metro newspaper was felt to have the potential to influence people's opinions because, '*Everybody reads Metro!*'. In fact general coverage of mental health issues in the media is regarded as being helpful, for example, '*Media gives us awareness and can change our opinions. But if it's on mental health, it needs to be in our language and then it can be a big influence*'.

5.3.7 Discussion Groups

Focus group participants were asked if they felt that group discussions were an effective way to communicate ideas about mental health.

All participants in all groups were unanimous in saying that discussion groups would be a very effective way to raise awareness about mental health issues. Some illustrative quotes are as follows:

'*It would really help as most people have the same problems*' (English Language group)

'*We would never discuss this sort of stuff in the house. It's good to come out' (*Pakistani group*)*

'*The more we talk about it, the better. It's also a chance for us to get together and do something different' (*an African women's group).

Some groups even said that they would be more likely to help someone with mental health problems as a result of having attended this focus group discussion, for example, '*Before, my perception was from my own country but now, after being to this group, it will change my reaction – I would go and help now but before I would be afraid'* (an African women's group).

Some additional ideas were proposed by participants to make discussion groups more accessible. Most of the comments were isolated to single groups unless otherwise stated.

- The Pakistani group said that discussion groups would have to split by gender, although the Eritrean and Sri Lankan groups felt that this was not necessary;
- It would not be necessary to have separate groups for young people (note: this was reported in the African group, in which the young people were very quiet and perhaps were deferring to the older women);
- An interpreter would be needed, and people would be happy to communicate through an interpreter (African, Eritrean and Chinese Groups);
- Venues would need to be local - close to where people live;
- The Mosque would not be a suitable venue for discussion although people would listen to a talk about mental health there (Pakistani group). The temple would not be suitable venue (Sri Lankan);
- Large-scale events would be popular too;
- People suffering with mental health problems should go to a separate, special group or class, and transport should be provided *(*an African women's group). The desire for a special support group for people with mental health problems was also strongly expressed by the Chinese group.

5.3.8 Other ways to communicate ideas about mental health issues

Participants were invited to suggest any additional ways in which they felt ideas about mental health problems could be communicated. Prompts were used to stimulate discussion about billboards, and targeting schools, colleges or workplaces.

The idea of using **billboards** was more popular in some groups than others. For example, the Eritrean group said '*They don't really help at all*' and the Pakistani group reported, '*Mental illness is not such a big issue that we need billboards – there are more important issues*'. Comments in favour of billboards emphasised that they should use different languages[18], that images rather than text should be used, and that they should use images from people's countries of origin in order to be more eye-catching, for example, '*Posters - people never look at them, although if there was something from my country, like a film star, then they would*' (Pakistani group).

A few groups mentioned **mass education via TV** as a useful means of communicating ideas about mental health, either as special programmes on mental health (Iranian/Iraqi groups) or integrated into popular programmes, for example, '*Start with soaps, gently and slowly. If it's everywhere you look it puts people off*' (Pakistani group).

Targeting **children and young people**, through schools and colleges, was a popular idea with 4 groups, for example, *'….so kids have an awareness from a young age of how to deal with mental health problems and also how to help others*' (Somali group). The Sri Lankan group preferred targeting colleges than school because '*They are more adult*'.

The idea of holding **large scale group events** and seminars were popular as a means of communicating ideas about mental health, especially with the African women's, Eritrean and Iranian/Iraqi groups, for example, '*It's best to communicate face to face*' (Iranian/Iraqi group).

Many asylum seekers and refugees seem to use the **internet** as a source of information and that this could be built upon, for example, '*Have a website for mental health and give basic information in different languages because people use the internet such a lot, so websites are good*' (Sri Lankan group).

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[18] The Somali group commented that the written Somali would be understood by all Somali people, even the older generation, as there are no literacy issues. Younger people read English.

5.3.9 Barriers to change and opportunities

Participants were asked if they could think of any barriers or opportunities that we might face in trying to change opinions.

For most groups, language was expressed as being the main **barrier**, for example, '*Language is the main barrier as it causes misunderstanding'*. The other barrier was conservatism and resistance to change because of strongly held attitudes (an African women's group, English language group) and the possible unpopularity of the mental health as a subject, '*Some people don't like this topic, others do'* (Sri Lankan group).

Several **opportunities** were proposed by each group. The key themes are presented below:

- Use the mass media to educate people and communicate messages – TV or leaflets, DVD's using images and different languages. This was expressed by an African women's group, Somali group, English Language group and Chinese groups. Also, use newspapers to, '*Publicise people's personal stories and give more facts'* (English language group);
- Work directly with local groups, such as drop-in centres or support groups;
- Work directly with families or people who are directly affected by mental health problems;
- Target children and young people because they have enthusiasm, more awareness and commitment (an African women's group, Somali and Sri Lankan groups);
- Provide people with general education as this '*opens the mind'* (Iranian/Iraqi group).

5.4 Exploring Solutions

The final section of each focus group discussion sought views on whether attitudes to people with mental health problems should change and, if so, what barriers and opportunities might we face.

5.4.1 Changing People's Opinions

Focus group participants were asked if they felt that anything should be done to change people's opinions of mental health issues and, if so, did they think it would be easy or difficult.

All 10 groups unanimously agreed that it was important to try to change attitudes to mental health problems. They also agreed that change would be difficult to achieve, and would require a long-term, sustained approach, especially at first and especially with older people (Somali group). The Chinese group was the exception to this view and said, '*It will be easy once*

people understand that craziness and mental health are different'. The reasons offered for potential resistance is that people's opinions are very strongly held, for example, '*People have lived with these views for a long time*' (Eritrean group) but that with time, opinions can change, for example, '*I am here 7 or 8 years now and I think as everyone else thinks. Change is difficult; the second generation will be better'* (Sri Lankan group).

Despite saying that it would be difficult to change opinions, the Iranian/Iraqi group said it would be easier here than in their home countries, for instance, '*In this society nothing is difficult, because they tell them* (people with mental health problems) *where to go. In our own country we will not do anything because it's a shame on the family. Here it is easy because there are special benefits available*'.

5.4.2 Sources of help and support for mental health problems

The final question to each focus group was about getting help for mental health problems and in particular who they, or someone they knew, would go to for help if they had a mental health problem.

For most groups, participants said that the first port of call would be trusted friends or family if the problem was mild. Being able to trust that person to keep things confidential was important, for example, 'A *good friend keeps a secret, a bad friend talks everywhere. There needs to be trust*' (Iranian/Iraqi group). Some participants said that they would prefer to seek help outside the family and community because of the potential for gossip. This issue was expressed mostly strongly in the Sri Lankan group, '*The last place you would go is your own community. It will spread very fast because of the shame'*.

However, for more severe problems, it was acknowledged across all groups that people would seek medical help first, usually from a GP, '*You need to go for help. It won't go away by itself'* (Sri Lankan group) and '*Friends and family are good for talking but may not solve the problem. You may need professional help*' (English Language class). The Chinese community would use mainstream medical services rather than Chinese medicine, '*A Chinese doctors could only assist but couldn't cure it. You'd need to go to a mental health doctor'.* Although it was not raised in other groups, the English language group expressed a need to have more awareness of services that are available for mental health problems, for example, '*Every day we get leaflets to the house. It would be good to have things telling us where to go for services, even if it's in English'.*

Other potential sources of help that were mentioned much less consistently were: a pastor (an African women's group); a counsellor (an African women's group); a teacher in college (Iranian/Iraqi); a support group, for example, '*It would be good if we could come here on a Friday to talk about problems before going to the doctor'* (Sri Lankan group); the Medical Foundation[19] (an African women's group); Homecare (an African Women's group).

Also, a couple of groups felt that the family and friends of a person suffering from mental health problems have a responsibility to make sure the person gets help. For example, one of the African women's groups said, '*If the house is untidy, friends will spot the problem'* and *'If someone is sick, they may not realise and therefore may not seek help. They need to be approached by doctors'* and *'We need to get close to them and give them advice about where to get help'.*

Some focus groups were prompted to discuss how they felt about using an interpreter to assist in their conversation with a doctor. Most would prefer not to have to use an interpreter but, for many, they would have no choice. There may be lack of trust in confidentiality and there appears to be an issue about perceived competence, '*I don't like to go to the doctor in case the translation is wrong*' (Iranian/Iraqi groups). In fact, the ideal situation may be to have bilingual medical staff. All the women in the African groups agreed, '*Trust is very, very important and it would be really good if someone could speak our own language'.*

It is worth noting that some groups compared the issues of accessing help and support here in the UK to their country of origin, for example, '*In Africa, the source of help would be hospital, and then you'd look after them at home – you wouldn't leave them alone, you'd bring them with you'.* Some other people in the mixed English language group said that there was nowhere to go for help in their countries (Pakistan, China, Eritrea, and Sierra Leone).

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19 Founded in 1985, the Medical Foundation for the Care of Victims of Torture was founded in 1985 and provides care and rehabilitation to survivors of torture and other forms of organised violence. There are specially trained staff, including medical staff, who work with people individually as well as in groups.

6. Discussion, Conclusions & Recommendations

This section discusses the findings presented in Section 5 and draws conclusions. It also proposes recommendations for future action, where appropriate.

6.1 Representativeness of the focus group participants

One hundred and one participants represented seventeen different nationalities across the ten focus groups. All the main population groups of asylum seekers and refugees were represented, fairly proportionately, apart from the Afghani people. No pre-existing group of this nationality was known to the sessional workers, members of the Research Steering Group or their contacts. However, 99% of the Afghani population are Muslim[20] and this religion was well represented by participants of other focus groups. Participants from the People's Republic of China appeared to be rather over-represented. Anecdotally, there has been a reported increase in the numbers of new arrivals in Glasgow from China recently and it was important that this population was well-represented in the research. On the whole, the Research Steering Group felt that the main countries of origin had been represented, therefore lending validity to generalisation of the research findings.

The age groups of the focus group participants are thought to reflect adequately the population of the asylum seekers and refugee population in Glasgow, the majority being young families or middle-aged. Women were rather over-represented amongst the participants, but this is perhaps inevitable given that most of the pre-established groups of asylum seekers and refugees are groups for women and their children.

The research set out to run focus groups in both the east and the north of Glasgow. However, it was only possible to hold one of the groups in the east. It seems that, despite there being substantial numbers of asylum seekers and refugees in the East End, there are not so many pre-existing groups as there are in the north[21]. Furthermore, the Research Steering Group wished to include a focus group with people from Sri Lanka, particularly because the religious and cultural backgrounds of Sri Lankan people are quite different to the Muslim-based groups whose views had already been well-represented. Attempts to locate a pre-exiting group of Sri Lankan asylum seekers and refugees in the east and north of the city proved fruitless. The only pre-existing group appeared to be in west Glasgow. Although this was outwith the geographic boundary of the Project, the Steering Group decided that this was an important

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[20] Data from www.culturalprofiles.org.uk/afghanistan/Directories/Afghanistan_Cultural_Profile/-649.html
[21] Under new accommodation contracts with National Asylum Support Service (NASS) providers have far more flexibility to place people in areas where there may not be established communities and support.

cultural sub-group from which to gather views.

RECOMMENDATIONS

Service planners and providers need to

- o Be aware of where asylum seekers and refugees are accommodated and work effectively with them and existing community resources to ensure the needs of asylum seekers and refugees are being met.

- o Work with agencies to strengthen links with existing community groups, and establish new groups, to reduce social isolation. This work should be particularly focused on men, at those living in the east end and the Afghani population.

- o Link with key agencies to ensure that asylum seekers and refugees have personal development opportunities including access to education, volunteering opportunities and leisure activities.

6.2 Definitions, causes of, and reactions to mental health problems and links to religion and spirituality

Although most groups appeared to have quite a wide range of terms with which to describe mental health problems, the predominant phrases described 'madness' or 'craziness'. Most cultural sub-groups clearly associated depression, stress and worries with mental health problems too but that these conditions had causes, treatments and reactions that were quite distinct to those of 'madness' or 'craziness'. There was an indication that some people perceived stress and depression to be westernised forms of mental illness. In some African countries, at least, mental ill-health appears to be almost exclusively associated with being 'crazy' or 'mad'. This notion was also described previously by the research participants from the settled African Caribbean community in Glasgow[22].

The main perceived **causes** of mental health problems were consistently reported across all groups as being worries, problems and the pressure of everyday life related to being an asylum seeker, and to the negative impact of the asylum process. This was invariably the point in the focus group discussions at which people started to reflect on their personal experiences of being an asylum seeker or refugee and the effect on their mental health. It seems clear from the findings that many asylum seekers and refugees are suffering from poor mental health - the fact that mental health is the single biggest health issue affecting asylum seekers and refugees is well established from other studies[23]. Many participants talked about the uncertainty of the future and the worry of waiting for a Home Office decision. There were many references across all groups to being unable to sleep because of the worry, no doubt a condition that exacerbates people's poor mental state. In addition to the insecurity, being unable to work and having '*too much time to think'* appeared to be strongly linked to people's personal experiences of mental ill-health in the UK. Loneliness, isolation and feeling homesick also featured significantly in contributing to a sense of mental ill-health. It is hardly surprising, therefore, that many groups reported that their mental health is worse in the UK than it was in their county of origin.

Possibly linked to the fact that people experience poorer mental health here than in their country of origin is the reported low status to which many asylum seekers and refugees

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[22] Mosaics of Meaning: Exploring Stigma Associated with Mental Health Amongst Black and Minority Ethnic Communities: A Report of Community Focus Group Research, NHS Greater Glasgow and Clyde, 2006.
[23] Supporting New Communities: A Qualitative Study of The Health Needs Among Asylum Seekers and Refugees Communities in Glasgow, Naasra Roshan, NHS Greater Glasgow, 2005.

referred, and to the racist comments within communities and institutional racism within services to which some people have been subjected.

The idea of inheritability of mental health problems was contested amongst participants within groups. It seems that there is less support for conditions such as stress and depression being inherited but that there may be belief in some heredity factor operating in more severe forms of mental illness. The Sri Lankan group was the only one in which there was strong and clear agreement that mental health problems cannot be inherited. The notion of inheritability of mental health problems appears to influence ideas about marriage. Those nationalities that strongly believed mental health problems could be inherited were more likely to express the view that people would avoid marrying into a family with mental health problems. These ideas were most strongly and unanimously expressed in the Pakistani community. This is consistent with the research findings amongst the settled BME communities (see footnote 23).

On exploring **reactions** to people with mental health problems, stigmatising behaviour such as rejection, avoidance, gossiping and labelling appear to be common across all groups, but with perhaps more slightly sympathetic views being expressed by the Chinese and Iranian/Iraqi communities. Such stigmatising behaviour was more likely if the mental condition was severe in nature (due to fear of violence), if the person was a stranger to them (people are more likely to help a friend or family), and if they were unfamiliar with mental health issues. These reactions are in keeping with earlier research into mental health and stigma amongst Glasgow's main settled BME communities (see footnote 23). However, one difference is clear. Asylum seekers and refugees reported being unfamiliar with the law in relation to mental health issues and this was proposed as a reason for avoiding helping people with mental health problems in this country – there is a perception that if they try to help someone, they might attract trouble themselves.

So are there any additional factors that might make asylum seekers or refugees more likely to help someone with a mental health problem? There is an indication that people might be more likely to help someone if they are from their own home country. The research with settled BME groups (see footnote 23) found, very clearly, that young people would be more likely to help someone with a mental health problem as they were more open and aware. The research with asylum seekers and refugees was much less clear cut on the generational issue. The reason for this difference may be that, in the settled community, young people may be 2nd or 3rd generation, and are more likely to have grown up with more open perceptions of mental health. Asylum seekers, on the other hand, are new (or fairly new) to the UK, irrespective of their generation, are more likely to hold the views of their own country, which may mean they are

less open to mental health issues. In fact, it might have been interesting to have monitored the length of time people had been living in the UK to see if this had a bearing on their beliefs, attitudes and reactions to people with mental health problems.

This idea also supports the strong perception, expressed by all groups participating in the research, that people with mental health problems in the UK are treated well and that UK society is generally more open to supporting people with mental health problems than in the various countries of origin of participants.

Religious beliefs were clearly linked to ideas about mental health, in some way, for all groups. The general themes were as follows:

- People with religious beliefs are generally mentally healthier;
- Being too religious or not religious enough were both associated with mental health problems;
- Prayer was commonly used for comfort and guidance in difficult times;
- People with religious beliefs are more likely to be accepting of people with mental health problems and to help them;
- Developing mental health problems may be regarded as a punishment or a 'test' from God (this belief was held mostly by the Muslim-based groups but not the Chinese or Sri Lankan groups).

Belief in links between mental health and blackmagic, curses and spirits[24] were also expressed by at least some participants in all groups, except for the Sri Lankan group. In general, not much detail about these beliefs was elicited but some views concurred with the research with the settled BME communities (see footnote 23). These were:

- Belief that blackmagic, spirits and curses take place in people's home countries but not in the UK;
- If people believe witchcraft is the cause of mental ill-health they would seek help from a special witchcraft person in preference to seeking medical treatment;
- Belief in these ideas is more common amongst less educated people;
- These beliefs are more widely held by older generations, although some younger people believe in them too.

There were 3 sets of beliefs that each were exclusive to only one country of origin or one cultural/religious sub-group. These were:

- the Singhalese people from Sri Lanka, who are mostly Buddhists, expressed belief in Astrology and the notion that this could influence people's mental health and whether or not they might seek medical treatment;

- the Tamil people from Sri Lanka, who are mostly Hindu, were the only group to mention the use of fasting, say for 30 days, to help cure a mental health problem;

- The Chinese group was the only group to refer to Karma – the belief that if you are bad in this life, you and your family might be punished in the next life. This punishment could include development of mental health problems.

RECOMMENDATIONS: **Definitions, causes of, and reactions to mental health issues and links to religion/spirituality**

Service planners and providers need to

- o Create opportunities for asylum seekers and refugees to find out about mental health problems through, for example, discussions groups, workshops and large scale events. This should include information on facts and figures, how to get help, language issues, how to offer help to a friend, mental health and the law and should include using the arts as a tool for engagement and communication.

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- Ensure there is adequate and accessible support for mental health issues targeted to asylum seekers and refugees;

- Ensure that asylum seekers and refugees have opportunities for personal development including education and being able to engage in voluntary activity;

- Tackle social isolation by working with other agencies to promote social activities and networks for asylum seekers and refugees;

- Work with local organisations and communities to tackle the stigma associated with being an asylum seeker, for example, by linking to local campaigns or through use of creative arts;

- Provide awareness training for mental health services staff to ensure they are sensitive to the cultural and religious/spiritual influences on attitudes to mental health issues;

- Provide awareness training for NHS staff and community planners on the asylum process and related issues.

6.3 Seeking Help & Treatment for Mental Health Problems

We can conclude that mental health problems have significant stigma for all of the nationalities participating in this research. All groups talked about wanting to hide the problem, to varying degrees, and this leads to reluctance to seek help.

The type of help sought by people differs according to the severity of the mental health issue. If it perceived to be mild, people might go to friends or family. If the problem is severe, then people might go to the doctor first. There was a perception, at least amongst some groups that mild mental health issues, if left untreated, could lead to more serious problems.

Seeking help from friends and family was a less popular option for some people because of the potential for gossip within their community. This appeared to be a particular issue for the Sri Lankan community. This lack of trust was also found in the research with the settled BME communities in Glasgow (see footnote 23).

Language does appear to be a significant barrier to people being able to access services and lack of trust in interpreters (both in terms of confidentiality and competence) appeared to be wide spread across all groups.

Feelings amongst asylum seekers and refugees that they are not trusted, or believed, by the host community from whom they might seek help, was another factor in preventing people from seeking help. This was only mentioned by the 2 groups of African women and so the extent to which it is an issue for other countries of origin would have to be investigated further. This issue, however, combined with comments about racism from NHS staff to which participants have clearly been subjected, indicate a need for cultural and race awareness training for health care and other staff.

It appears, although it is not clear how widespread it is, that some people would trust and seek support from other people who come from their home country. People may be more likely to offer help to someone if they were from the same country of origin.   This might be a productive and satisfying way for some asylum seekers and refugees to use their time and social skills.

This focus group research did not set out to investigate people's awareness of how to access services and support for mental health issues. This issue, however, was spontaneously raised by a few groups and indicates that this may be a significant barrier for many people. Ensuring that asylum seekers and refugees know where to go and how to access support for mental health problems should be considered.

RECOMMENDATIONS: Seeking help and treatment for mental health issues
Service planners and providers need to:
- Promote effective signposting (in people's own languages) to ensure asylum seekers and refugees know where and how to access support for mental health problems;
- Ensure that Glasgow Translating and Interpreting Service (GTIS) are aware of people's concerns about interpreting staff (regarding confidentially and competence), and agree action;
- Help ensure all asylum seekers and refugees have easy access to English language classes;
- Work to ensure that all health care and community planning staff, who have the potential to be involved with asylum seekers and refugees, receive race and cultural awareness training as well as training on specific issues relating to asylum seekers and refugees;

6.4 Channels of Communication & Challenging Attitudes to Mental Health Issues (inc Barriers & Opportunities)

There was generally good consistency on the discussions about different channels of communication and their potential to influence people's beliefs and attitudes to mental health problems.

In contrast to the research into settled BME communities (see footnote 23), the usefulness of **TV** in influencing beliefs and attitudes on mental health is not very clear cut. Although TV is used frequently as a source of information and entertainment by most groups, not all people can afford a TV or the licence (namely some of the Chinese and Eritrean participants) while other cultural sub-groups (Somali, Iranian/Iraqi) find English-based channels inappropriately 'sexy'.

Of those who do watch TV, a significant number of people seem to have access to channels from their home country, or in their native language, although they all seem to use English-based TV too. The range of potential channels used by asylum seekers and refugees is therefore huge and, for this reason, it would be very difficult to know which channels to target with any social marketing or awareness raising campaigns, without doing further research on this issue. Despite this, when asked, most groups said that TV had the potential to have the biggest influence on their beliefs and attitudes to mental health (compared to radio, newspapers and organisations), although it is difficult to see how such an intervention could be managed.

In general, **radio** seemed to be an unpopular media with most groups of asylum seekers and refugees. Although it would not be a universal approach, there may be potential to target mental health information towards two particular communities via the radio. These are:
- Radio Awaz to reach the Pakistani community;
- BBC Somalia to reach the Somali community.

Radio Awaz also seems to be used extensively by the settled Asian community in Glasgow and any planned action to target the Pakistani asylum seeker and refugee population through this radio station could be linked to a wider campaign.

The **newspaper**, Metro, appears to be read on a daily basis by many asylum seekers and refugees, mainly because it is free. Some people appear to use the library and the internet to access newspapers in their own languages, or English newspapers. However, no other newspapers or magazines were mentioned as universally as Metro. The exception to this is the free Chinese newspaper, Tao Tsing, which many of the Chinese participants appeared to read.

Although the use of the **internet** appeared to be quite widespread amongst asylum seekers and refugees (either at home, at college or the library) it is difficult to make any generalisations about how this media could best be used to raise awareness of mental health amongst the asylum seeker and refugee population. People mentioned a wide variety of sites - some from their home countries, some English or American sites. Furthermore, the internet appears to be used for a variety of reasons, from keeping up with news from home, emailing friends, checking out the latest fashions and monitoring changes in asylum laws. It was, however, suggested that the internet could be used to promote access to local services. There may be potential to develop a Glasgow- based multi-lingual site, specifically for asylum seekers and refugees, which could include a section on mental health and accessing services. This site could be promoted to people on their arrival in Glasgow.

On investigating people's use of **local organisations** as a source of help and support, a great deal of consistency was found. The Scottish Refugee Council was the first port of call for the vast majority of asylum seekers and refugees. The YMCA was also used frequently, especially by those who live in YMCA accommodation. The Red Road Women's Centre and the Red Cross, although not used as universally as the SRC, appeared to be used by some on a very regular basis. San Jai and the Chinese Healthy Living Centre were used exclusively but frequently by some of the Chinese asylum seekers and refugees. All the above organisations have the potential to reach, influence and help asylum seekers and refugees. In addition, several groups mentioned using their **social workers, solicitors** or **guidance staff** at college as sources of help and support.

We can conclude that **discussion groups**, as a means of promoting awareness of mental health issues, would be very popular across all cultural sub-groups of asylum seekers and refugees. In fact, the process of having taken part in the focus group research seemed to have

had an influence on some people's views and many people enjoyed talking about the issues and expressed gratitude for having been asked to give their views. The venues for discussion groups would have to be local and, invariably, interpreting support would need to be provided. Whether discussion groups should be split by gender and age is less clear cut and should be investigated with new groups at the planning stage.

Large scale **events**, with mental health as the focus, may be popular too. In addition, there appears to be some support for the idea of having special groups for people who are suffering from mental health problems but the actual interest in this would need further investigation.

The use of **billboards** to raise awareness of mental health issues was not universally popular. If billboards were to be used, it would be best to use images rather than text and, if text was present, different languages should be represented (which may be difficult in practice). Using images from people's countries of origin would be very popular and eye-catching, but this approach may only have appeal for one or a few nationalities at a time. Given the potential difficulties of using billboards and because of the non-specific nature of their target audience – the whole population is exposed to them – billboards may not be the best use of limited resources. These findings are entirely in line with the previous research with settled BME communities (see footnote 23).

Finally, the idea of promoting awareness of mental health issues through **schools and colleges** was popular with several groups, as children and young people may be easier to influence.

RECOMMENDATIONS: Channels of Communication & Challenging Attitudes to Mental Health Issues

Service planners and providers need to:

- Consider carefully the potential to use TV as a means to raise awareness of mental health issues and carry out further investigations before doing so;

- Assess the feasibility of using specific radio stations to target certain communities , for example through Radio Awaz and BBC Somalia;

- Approach the free newspaper, Metro, to promote mental health issues to the asylum seeker and refugee population;

- Investigate the potential to develop a website for asylum seekers and refugees in Glasgow that could promote access to services (including mental health services) as well as raising awareness of mental health issues;

- Target key organisations with information to raise awareness of mental health issues for asylum seekers and refugees and to promote access to services for them. Organisations should include the Borders and Immigration Agency, accommodation providers, the Scottish Refugee Council, YMCA, Red Cross and Red Road Women's Centre, Women's Drop-in Centres, San Jai and the Chinese Healthy Living Centre.

- Target certain solicitors, social workers and college guidance staff who are known to deal with asylum seekers and refugees with similar information;

- Liaise with local organisations that work with asylum seekers and refugees to establish the best way to set up and run discussion groups on mental health issues, taking account of language issues and considering using the creative arts as method of engagement

- Plan a large scale event for asylum seekers and refugees to promote mental health issues and access to services;

- Assess the cost effectiveness of using billboards as a means of communicating mental health messages to asylum seekers and refugees

- Target schools and colleges that have a high proportion of asylum seeker and refugee children and provide additional resources to raise awareness of mental health issues.

And finally…..

All participants agreed that it would be very difficult to change the negative opinions associated with mental health problems and that it would take a long and sustained approach, especially with older people. Without exception, however, there was unanimous agreement that it was important to try.

'*There should be a campaign to show people that help exists and how to access it. It needs to be on an on-going basis. It should include telling people about the different types of mental illness – depression, post-natal - and who to go for to get help*'
(an African women's group).

7. Lessons from the Research Process

This section describes some of the practical lessons that emerged from carrying out the research and offers some suggestions as to how similar research might be conducted in the future.

7.1 Selection of focus groups

The agreed methodology for this research was to use pre-existing groups as the basis for bringing together participants for focus groups. This worked well for most of the focus groups. Good attendance was further facilitated by the fact that most people knew the staff involved and the venues in which the focus groups were to be held.

This downside of this approach was that people who did not belong to pre-existing groups were excluded from the research, for example, 'hard to reach' individuals, such as single males. This means that the research findings and associated recommendations are skewed towards the views and needs of families, and in particular women. Soliciting the views of 'hard to reach' groups such as single males, would require extensive groundwork and may require taping into local colleges, youth groups, religious institutions, housing advice officers and other agencies. This should be considered for future research with asylum seekers and refugees in Glasgow.

7.2 Terminology of stigma and mental health

In the planning stages of the research, the steering group were concerned about how understandable and readily translatable some the mental health terminology would be, for example, 'mental illness' and 'stigma'.

It was initially agreed that the term 'a problem of the mind' would be used. However, after the first 2 groups, this was found to be confusing for interpreters and participants alike. An amendment to the focus group schedule was agreed and the term 'mental health problem' was used throughout the discussions. The researcher took time, before the start of each focus group, to check with the interpreter that they understood the term 'mental health problem' and that it was readily translatable into whichever language they were using.

7.3 Facilitators

The two focus group facilitators were recruited as sessional staff based on their previous experience of working with groups of asylum seekers and refugees. Both facilitators interacted well with participants during the focus groups. They had received half a days training on facilitation skills, which seemed to be adequate, but longer training and 'practice runs' may have strengthened skills, confidence and flexibility.

The facilitators were also employed in a 'development' capacity; their role was crucial in setting up the focus groups. They liaised with local pre-existing group leaders, visited groups at their routine meetings and then invited people to attend the focus group. They used the 'Participants Information' leaflets to reinforce their message (the leaflets had been translated into a number of appropriate languages).

The facilitators were skilled at gaining trust and in generating commitment amongst people to attend the focus groups. They spent considerable time investigating suitable venues, liaising with staff, finding out specific childcare requirements and agreeing best times to hold the focus groups. Their development role was vital to ensuring that focus groups were well-attended and it helped to build trust and rapport with participants prior to the focus group discussions. Through their development and facilitation roles, they contributed considerably to the success of the research outcomes.

7.4 Using interpreters in the research process

The quality of the service provided by the interpreters varied considerably. Some were highly professional and extremely competent in English and their other language. Others were unprofessional (e.g. having one-to-one conversations with friends during the group discussions) and were incompetent in their interpreting role (e.g. they struggled to find the right word or phrase, sometimes having to get help from participants).

The researcher tried hard to prevent any such problems by taking time to talk to each interpreter before the start of the focus groups. Issues discussed were as follows:

- Word-for-word translation was required, even if it did not make sense to them.
- An accurate account of people's views was essential and that they should ask people to clarify what they mean, if necessary.
- They should ask people to slow down or take a break in their contribution so as to allow for translation.
- It was agreed beforehand the best place for them to position themselves in terms of being able to hear everyone and to be heard.
- Interpreters were told the phrases that the facilitator was intending to use so we could check that the phrases were understandable and translatable – this never proved to be a problem.
    (NOTE: interpreters were also given a written copy of the focus group questions

although this was of no help to those interpreters who could not read English).

Despite the 'pre-focus group briefing', problems with the interpreters still arose – little can done about lack of competence in English language. The competence and professionalism of the interpreters had a considerable impact on the quality of the data that was generated.

Issues about the interpreting service were routinely recorded as were any comments about the quality of the service they provided. This information will be given to Positive Mental Attitudes, as the commissioning organisation, to provide a basis for discussions with Glasgow Translation and Interpreting Service (GTIS), should they wish to do so.

7.5 Participant vulnerability

The research steering group was very sensitive to the potential vulnerability of asylum seekers and refugees, in particular because mental health was the focus for discussion. As described earlier, each focus group was attended by a 'support person'. This was someone who was experienced in dealing with people in mental distress. Their role was to offer support to anyone who might require it during or immediately after the focus group discussions.

The researcher kept a record of the type of support and assistance required at each group. In six of the focus groups, no-one needed any support or signposting to local services. The support required at the other four groups is outlined below:

- One woman reported having depression and extreme sleeplessness. She was already linked into local health services (Compass, in particular) and had a forthcoming appointment. She was given a telephone number for the emergency mental health team.
- Another woman reported having suicidal thoughts. She was linked into the local health care system and was getting appropriate help and treatment. She said she would really like to attend a support group.
- One woman was looking for information about health services. She was advised to go into the Scottish Refugee Council to discuss her issues further;
- In another group, a few members expressed interest in knowing which websites to use to get mental health advice for themselves or others within their community. They were provided with a list of key contacts and websites.

In summary, very few people expressed the need for mental health support (only 3 out of a total of 101 participants), although others may have been too reluctant to come forward to ask for help. Many people, however, said that they would appreciate having a regular forum at which they could discuss mental health issues. This suggestion appears amongst the recommendations proposed earlier in this report.

On reflection, the researcher feels that all focus group participants should have been given contact details for mental health help and support services. The reason for this is that levels of stress and depression amongst the asylum seeker and refugee communities reported during the focus groups seemed to be much greater than the very few numbers who came to ask for help. Written 'signposting' materials might have been useful for those who were too shy to make direct contact or for those people who might have used the information to help a friend or in the future for themselves.   The option of providing written information had been considered in the planning stages of the research, however, direct contact with the 'support person' was felt to be a favoured option. In retrospect, perhaps both forms of support should have been on offer.

7.6 Incentives

The use of incentives to encourage participation was carefully considered by the Steering Group. Providing participants with a £10 supermarket voucher, given out at the end of the focus group discussion, worked well. Most people expressed gratitude for the vouchers.

Although providing catering (a substantial and tasty vegetarian buffet meal) and childcare (through a local mobile crèche) were not considered to be incentives, they did make it easier for people to attend. The crèche was very well used – most people had young families - and without it, participation for most people would have been impossible. Booking the crèche was labour intensive - exact numbers and ages of children were required about 2 weeks in advance (mainly because the crèche had to arrange to do a pre-visit for venues that it had not used before). What's more, it took sometime for parents to 'sign-in' the children before the groups could start, particularly due to language difficulties. Many of the parents needed help with this process, as they did not speak English. We quickly realised that it was necessary to have the interpreter available to help with the 'signing-in' process. The mobile crèche was rather inflexible, although staff tried to be as accommodating as possible, and we ended up turning away potential participants because the staff/child ratio of the crèche was at a maximum. Furthermore, the size of the room used for the crèche at the Tron, St Mary's (the venue for 6 of the focus groups) was small and this restricted the numbers of children that could be looked

after.

7.7 Raising Expectations and Dissemination

BME communities commonly comment on being 'over-researched' and having a sense that 'it changes nothing'. We have also heard these views recently being expressed by asylum seekers and refugees. Ensuring clear and honest communication with potential participants in the research process is an important process for setting realistic expectations.

Dissemination of the key findings (and what will happen next) to those who participated in the research is not only courteous but is a vital end point to the research process. It is important to consider language as well as literary issues when deciding both the format and process for dissemination. For instance, findings may be presented in poster format, which may be translated into appropriate languages, and can be posted at venues frequented by the asylum seekers and refugees. Dissemination events can be popular and well attended but the need for interpreting a range of different languages would need to be considered.

Appendix A: Participant Information Sheet

Exploring Stigma and Mental Health with Asylum Seekers and Refugees in North and East Glasgow

NHS
Greater Glasgow and Clyde

Information for Participants (March 2007)

1. *About the Study*

   The Positive Mental Attitudes Project (part of NHS Greater Glasgow & Clyde) is currently carrying out some research to find out what asylum seekers and refugees in Glasgow think about mental health. We would like to find out your views so we can help to address the way that society treats people with mental health problems. You do not have to have experienced mental ill-health to take part. We will **not** ask anything about your personal experience of mental illness but we would like to know about general attitudes to people with mental health problems.

   We would like to talk to you, together with some other asylum seekers and refugees, by having a group discussion. A person (a facilitator) will lead the discussion by asking the group some questions. The group discussion should last about 1 hour. Refreshments will be provided and you will receive £10 voucher.

2. *What about confidentiality?*

   If you agree to take part, anything you say will be confidential and all information will be anonymous. This means that nothing you say can be traced back to you. We do not even need to take your name.

3. *What if I want to take part?*

   It is up to you to decide whether or not to participate. If you would like to take part, please tell the person who gave you this information sheet (your group leader). They will tell you when the discussion group is due to take place. Please also tell them if you need childcare or if you would like an interpreter. If you agree to take part, you are free to change your mind at any time, without giving a reason.

4. *What support will be available?*

   If you need support about any issue arising from the group, there will be someone present to help you get appropriate support.

5. *What will happen to the information that I give?*

   A total of 10 group discussions will take place. The information from all the group discussions will be analysed by a researcher and a report will be written for The Positive Mental Attitudes Project. The Project and its partner agencies will use the information to identify things that can be done to improve the way people with mental health problems are treated by society. Once the research report has been written, a poster will be sent to your community group telling you what the research found and what action may be taken. You will also be invited to an event so we can feedback the information to you and your local community.

6. *Will taking part affect my asylum application?*

   Participating in this study will in NO WAY affect your asylum application.

7. *Before deciding, how can I find out more information?*

   If you would like more information or if you would like to talk to someone before deciding whether or not to take part, please contact your group leader in the first instance.

Many thanks!

Appendix B:

Facilitator Guidance and Focus Group Plan

GUIDANCE & FOCUS GROUP PLAN FOR FACILITATORS

ASYLUM SEEKERS AND REFUGESS: TACKLING THE STIGMA ASSOCIATED

WITH MENTAL HEALTH (MARCH 2007)

Purpose of this guidance and plan

This guidance has been prepared to support you, as a focus group facilitator, to fulfil your role in setting up and running the focus groups with asylum seekers and refugees. **You should read it carefully**.   It is intended as additional support to the training you will receive on mental health issues (run by COMPASS) and will reinforce the information you are given at the 'briefing session' with Lesley Sherwood (as you know, both of these sessions are planned for Tuesday 13th March).

This paper is in 2 parts. **Part 1** provides you with background to the research as well as a checklist of things to remember when setting up and doing the focus groups. This includes tips on facilitation skills and how to keep the discussion on track. **Part 2** provides a list of questions (with timings) which you should use to stimulate and guide the focus group discussion. There is also an **Appendix** which you can read to the participants, at the start of the focus group, to provide them with some context for the discussion on mental health and stigma.

Please do not hesitate to seek help or ask for clarification - it is really important that you are comfortable and confident in your role. If you are still unsure of anything, contact:

- Lesley Sherwood (researcher)
  Home telephone: 01360 770838
  Mobile: 07815 094050
  Email: lesley.sherwood@btinternet.com

- Ruth Donnelly (Positive Mental Attitudes)
  Work: 0141 773 4937
  Mobile: 07989 149701
  ruth.donnelly@glacomen.scot.nhs.uk

PART 1: GUIDANCE FOR ARRANGING & RUNNING FOCUS GROUPS

What's this research all about?

This research aims to explore patterns of stigma and discrimination associated with mental ill-health with the asylum seeker and refugee population in North and East Glasgow and to identify specific interventions to address stigma and discrimination within these communities'.

We will do this through a series of 10 focus groups. The information gathered will be used to
- create a better understanding of the views of these groups (and any key differences that may exist across cultural sub-groups);
- explore different ways in which the stigma of mental illness may be challenged;
- identify the best ways to deliver them (including taking account of barriers and opportunities).

Overview of your role:

Your role, as a facilitator, is to set up and run the focus groups. You will use a series of questions to stimulate and guide the group discussion thus helping us to identify the ways in which these groups understand issues of mental health and the associated stigma.

You are not expected to be an expert on mental health issues or the terminology used. This, along with the 'mental health training' and the 'briefing on arranging and facilitating the focus groups', should ensure you are confident to fulfil this role. If there is anything you are not sure of, please contact the above people.

Support on the day:

A support person will attend each focus group to help anyone who, in the course, of the discussion, seems to be becoming distressed. If you see that anyone may benefit from talking to the support person, please ask them to take the person aside to offer support in private. It is important that the flow of the group discussion is not interrupted.

Lesley Sherwood, the researcher, will be coming to each group to make notes and make sure that the key issues are recorded. She will write a report of each focus group discussion that will build towards the full research report.   Please allow around 15 to 20 minutes at the end of your session to chat with Lesley to make sure that she has captured all the main points. You are the expert on working with asylum seekers and refugees so please make sure that Lesley understands why particular points may be significant to your group and offer any cultural information that may help her write the report.

NB: the Focus Group discussion itself should last for a **maximum of 90 minutes**. You will also require time to prepare before the group, have your chat with Lesley and tidy up after the group.

Preparing for your Group:

- Liaise with the 'host' agency to arrange a **date, time** and **venue** when people will be able to attend the Focus Group. Ensure **Lesley** and a **support person** (by liaising with Ruth) are able to attend before confirming. Ideally there should be a **minimum of 5 and a maximum of 12 participants**. Make sure that the group will be able to work well using **English** and, if required**, one other language.** Ensure that you tell Ruth the **catering** and **childcare** requirements and of the need for an **interpreter** (if necessary).

- Liaise with the host organisation to ensure that participants are given clear **information** about the date, time and place and that they are provide with the '**Participant Information Leaflet**' in advance of the group.

- Ensure you are provided with a **room** with good lighting and ventilation - place the chairs round a large table / group of tables or in a circle so that everyone taking part will be able to see each other

- If appropriate, **call the participants** (or liaise with the host organisation to do so) to make sure people can come along on the day.

- Make sure that you have this **guidance and plan** with you.

- Lesley will bring flipchart, pens, bluetack, extra paper and pens for the participants, name badges, £10 vouchers and the groundrules on a flipchart page. She will also bring a copy of the information from COMPASS and a set of questions for the interpreter to use.

On the day:

Make sure you know where you are going and leave plenty of time to get there. Plan to arrive about **20-30 minutes before** the participants so that you can:

- set the **chairs** out (as above)

- Set up a **flip-chart** with paper and pens – you can write key points yourself, if you wish, but you don't have to as Lesley will keep a record of the discussion.

- put **pens and paper** on the table for anyone who may want to use them

- make sure that you will be able to see a **clock** or **watch** so you can keep an eye on timing

- Check that **tea / coffee / water / soft drinks** / **snacks** are available or due to arrive on time.

- Lesley will make a note of the **gender and (approximate) age** of each participant

- Put up groundrules

- Check with the host agency about location of the loos and fire escapes

- Give the interpreter the **focus group plan** (Lesley will bring it) and speak to them about:

  o What we require of them (2-way or 3-way translation) and where we should all sit
  o Check that there is an appropriate term for mental health and mental illness in their language. Say that you will need to check that the group understands and accepts that term and, if they do, it should be used throughout the focus group.
  o that we need an impartial interpretation of every word
  o if anything is unclear, ask for clarification

- have name badges ready to give people as they arrive (to be confirmed)

Keeping the discussion on track (facilitation tips):

The following tips should help the focus group discussion to flow well and to generate good data.

- **Participants must be willing**: People must be willing participants. They can withdraw from the focus group at any time, without the need to provide an explanation.

- **Be consistent**: Stick to the questions in the Focus Group Plan (Part 2).

- **Keep it relevant:** If people begin to wander off the point, you could say, '*That's very interesting, however, can I bring you back to the question I asked which is….. There will an opportunity at the end for you to add anything else you'd like to say, so can we keep this point to the end?'.*

- **Use prompts**: Use 'prompts' to stimulate discussion if you need to, for example:
  - rephrasing questions or say….
  - *'Does everyone agree with that view?'*
  - *'Would people from your country think that too, or would they have a different view?'*
  - *'Do you think a younger/older generation would have a different view'?*

- **Use 'probing' questions:** use probes to get to the bottom of issues, if you feel it might be important e.g. '*Can you tell us why you feel that way*?

- **Everyone participates**: it is important to try to get everyone to take part, so encourage quieter participants to speak (e.g. ask them directly, '*What do you think of that*?' or '*Does that reflect your experience?*'). If necessary, keep control of those who are more talkative, e.g. '*That's interesting, I am keen to hear what others think about that*' and lose eye contact with them!

- **Be clear**: If you are unclear about what people are saying, stop and check! For example, you could say, '*Can I just check that I understand you correctly, are you saying that…..*'

- **Checking for consensus:** try to check key things with the rest of the group, so we have a sense of whether this is only one persons view or whether it is a widely held opinion, e.g., '*What do the rest of you think about that…does anyone agree or disagree with that?*'.   For really important points, you may ask for a show of hands.

- **Encourage contributions but be impartial**: Give affirmations throughout the interview, for example, smile, nod and say, '*Thank you, that's helpful'* but don't offer opinions on what they say (your role is to get their opinions, not to influence them!).

- **Jargon**: Don't use jargon and, if anyone else does, make sure everyone understands it.

- **Timing**: Stick to the time (90 minutes) and do not go beyond that without checking it is OK.

PART 2: FOCUS GROUP PLAN

This Focus Group Plan provides a structure for the discussion with your focus group. As this Plan is to be used for a number of different focus groups, the column on the right offers a space for you to make notes or reminders to include issues specific to each group.

The Plan also has an approximate time allowance guide in the column on the left. The timings are based on NOT using an interpreter and total approximately 1 hour. If an interpreter is being used the overall timing will be 90 minutes. Once the date and time has been decided, you can make a note of the real timings (eg: 3.30pm; 3.45pm etc) to help you keep the session moving and keep track of the timing for each section.

TIME	INTRODUCTION
Approx 7 mins	**To begin the session** - Welcome everyone and thank them for attending - Introduce yourself, Lesley and the support person to the participants - Explain to the participants that Lesley will be making notes on the discussion. Also, let them know that the support person is there in case anyone feels upset and wants to talk to someone in private. - If they do not know each other already, ask the participants to introduce themselves - Explain that a 'focus group' is really just an **informal group discussion**[25], but to help it run smoothly we need to agree some **groundrules** first (refer to them and check they are all happy with that) - Say, '*The focus for today's discussion is mental health problems. In particular, we'd like to hear **what you think about the stigma and discrimination** that exist towards people with mental health problems. We **do not** need to hear your personal experiences of mental illness. And you*

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[25] **Groundrules:** Lesley will bring along a flipchart with the following groundrules written on it:
- one person speaks at a time
- don't hog the 'airtime', give everyone a chance to speak
- listen to what others have to say
- what people say should be kept confidential, don't repeat it outside
- keep to the point
- PLEASE SWITCH OFF MOBILE PHONES OR PUT THEM ON SILENT MODE.
Check that everyone *agrees* with these and ask if anyone wants to *add* anything.

	do not need to have experienced mental illness to take part in the discussion'; - Explain that that there are **no right or wrong answers** and that every opinion is important and that they should **give everyone a chance** to be heard. - Make sure everyone knows that anything that is said within the group discussion should be **confidential** and that anything people say will be **anonymous**. - Reassure them that this is **nothing to do with their asylum claim**. - Explain that the session will be divided into **three sections** and that there will be a **five minute break** between each section of the discussion, so that they can make tea / coffee; take a break to go to the toilet etc - Tell people about location of **loos** and **fire escapes**. - Make sure that everyone is settled and comfortable….then begin!

TIME	TOPIC	YOUR NOTES
approx 7 mins	**[SECTION 1: Identifying issues around mental health and stigma]** Start by saying, '*I just want to check before we start that everyone understands the terms mental health problem and stigma?*' (If any one is unsure, agree an alternative phrase with the group and use it throughout the rest of the session, for example, 'a problem that affects the mind') Q 1. What is the **first word or phrase** that you think of when you hear the words, 'mental health problem'? Prompt: what about stress, depression?	*If the interpreter has difficulty with translating the word 'stigma', suggest instead 'shame' or 'prejudice'.*
approx 15 mins	**Beliefs, attitudes and reactions:** Q 2. What do you think people believe are the <u>**causes**</u> of mental health problems? Use PROMPTS, if required Q 3 How do you think people would <u>**react**</u> if they knew that someone had a mental health problem e.g. neighbour? Use PROMPTS, if required, esp. for mild/severe. Q 4. Do you think that these beliefs and attitudes affect the kind of <u>**help**</u> that people might seek? Use PROMPTS, if required. Q 5. Do you think some people believe that **religion** or **spiritual beliefs** influence attitudes to mental health? Use PROMPTS below, if required. You could also prompt for witchcraft, spirits, curse from God.	Use **general prompts** below, if necessary.
approx 5 mins	**BREAK (if required)**	

General Prompts: can be used to get more information, if appropriate.
- Is that what people in your **country of origin** would think?

- Do you think there might be differences in beliefs across **generations**?
- Is there a difference based on whether the mental illness is **mild or severe**?

TIME	TOPIC	YOUR NOTES
approx 15 mins	**SECTION 2: Identifying channels of communication** Q 1. Do you watch any **TV** stations related to your country of origin? (If so, which ones and how much compared to mainstream English-speaking TV?) Q 2. Do you listen to any **radio** stations related to your country of origin? (If so, which ones and how much compared to mainstream English-speaking radio?) Q 3. Do you read any **newspapers** or **magazines** related to your country of origin? (If so, which ones and how much compared to mainstream English language papers? Also, prompt for library?) Q 4. Do you use the **internet**? If so, which sites? Q 5. Which **organisations** do you go to for general help and advice (e.g. Scottish Refugee Council, YMCA, religious groups)? Q 6. How much do you think that these things (TV, radio, newspapers, organisations) **influence people's attitudes** to mental health problems? …and which do you think has the **most influence** on attitudes to mental illness? Q 7. Are **discussion groups** (such as this one) an effective way of communicating ideas about mental health problems. Q 8. Do you think there are any **other ways** to communicate ideas about mental health problems? (e.g. a billboards campaign, or targeting schools, colleges, workplaces)	Use **general prompts** below, if necessary.
5 mins	**BREAK (if required)**	

General Prompts: can be used to get more information, if appropriate.

- Is that what people in your **country of origin** would think?
- Do you think there might be differences in beliefs across **generations**?
- Is there a difference based on whether the mental illness is **mild or severe**?

TIME	TOPIC	YOUR NOTES
approx 10 mins	**SECTION 3: Exploring solutions** Q 1. Do you feel that anything should be done to **change attitudes** towards people with mental health problems? (if necessary, give an example, such as: a family member might be hidden away, or people might stay away from a neighbour who had a mental health problem) If so, how **easy or difficult** do you think it will be? Q 2. Can you think of any **barriers** we might face in trying to change attitudes? What are the main **opportunities or ways** we could do this? Q 3. If you or someone you knew had a mental health problem, who, if anyone, would you or they to go for **help**? For example, family, friends or formal support through a doctor or counsellor?	Use **general prompts** below, if necessary. If people have already referred to barriers or opportunities, then acknowledge that, and ask if they think there are any **other** barriers or opportunities.
approx 5 mins	Before we finish, are there **any other comments** you would like to make about the stigma associated with mental health problems.	
2 min	Tell participants that that is the **end** of the session and **thank** them for coming along. Tell them that the **results** of the research will be displayed on a poster where the groups meets, in a few months time. Also tell them that if they would like **any information** about how to get help for mental health problems that they should speak to the (support person). Direct them to Lesley to receive their **£10 voucher**.	
	Feedback **discussion with Lesley** to make sure that all the key points have been noted and to clarify any culturally specific issues or comments. This may take an additional **15 mins** or so.	

General Prompts: can be used to get more information, if appropriate.

- Is that what people in your **country of origin** would think?
- Do you think there might be differences in beliefs across **generations**?