

*Equally Connected** Report 13

Living Life to the Full

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**Equally Connected* is an action research project using community development approaches, including the creative arts, to learn from Black and minority ethnic communities about:

- attitudes to, and experiences of, mental health
- what helps maintain well-being
- effective ways of challenging stigma and discrimination

This evidence will be used to improve understanding and help ensure that services and systems of care (such as the Integrated Care Pathway (ICP) for people with depression) are designed to meet the needs of the diverse Black and minority ethnic communities within Edinburgh and the Lothians.

Equally Connected is funded and supported by NHS Lothian and NHS Health Scotland and based at Health in Mind in Edinburgh

Evaluation Report

1 Background

Equally Connected (EC) is an action research project,¹ established in 2009, working with various Black and minority ethnic (BME) communities across Edinburgh and the Lothians on issues relating to mental health and wellbeing. Our primary aim was to challenge the three assumptions underpinning the Integrated Care Pathway (depression), namely that when experiencing low mood or depression you:

- visit your GP with depression
- discuss your concerns with him/her
- you work out an appropriate pathway together

It quickly became apparent to EC staff that many of the possible ICP interventions available to GPs, via Refhelp,² were based on self-help materials and/or Cognitive Behaviour Therapy (CBT) approaches. Using an action research approach, we were keen to pilot a CBT-based intervention with participants from BME backgrounds in order to 'test out' whether such materials and approaches are accessible to all members of our community. To our knowledge this is the first time such an approach has been tried in Scotland.

1.2 Background to LLTTF

The LLTTF course has been written by Dr Chris Williams, a psychiatrist, based at the University of Glasgow, who has many years of experience of using Cognitive Behaviour Therapy approaches.

The LLTTF website states that,

"CBT is an evidence-based and structured form of psychotherapy that aims to alter the unhelpful thinking (cognitions) and behaviour that commonly occur during times of distress. ... The Living Life to the Full course is a life skills course that aims to provide access to high quality, practical and user-friendly training in life skills..... The course content teaches key knowledge in how to tackle and respond to issues/demands which we meet in our daily lives..."³

For people with mild to moderate depression, Depression Alliance Scotland (DAS) has been running a range of LLTTF services since 2007, including a computerised CBT self-help course and in some areas of Scotland free community LLTTF courses. In each case, the courses cover modules which look at

- Understanding why we feel the way we do
- Practical problem-solving skills
- Anxiety control training
- Understanding helpful and unhelpful behaviours
- Recognizing and challenging unhelpful thoughts

DAS promotional materials recognise that whatever your reason for wanting to learn these life skills, the content will be useful in our daily lives when we feel under pressure, stressed or distressed.

¹ Funding is provided by the Scottish Government and NHS Lothian

² For more details see <http://www.refhelp.scot.nhs.uk/>

³ For further information http://www.lltff.com/index.php?section=page&page_seq=8

2. The pilot

Early discussions with DAS revealed that although they hoped their community courses were accessible to all, and were certainly popular, one trainer had noticed the courses were not well-attended by people from BME backgrounds. DAS do collect monitoring information but this does not currently include data on the ethnicity of course participants.

Around the same time, EC staff were in regular contact with Saheliya, a mental health service specifically for BME women living in Edinburgh, and observed that there seemed to be little awareness of interventions such as LLTTF. Similarly, amongst other BME specific services concern had been expressed about whether or not CBT-based courses would be suitable for use with BME community members or not. Equally Connected then asked if DAS would be willing to run the LLTTF course with a group of BME women. However, at that time DAS did not have a female trainer available and it was suggested that it may be more worthwhile to build capacity within EC and Saheliya by training female trainers to run a course with BME women. At the same time, evidence could be gathered and shared with DAS and Dr Chris Williams to improve knowledge and understanding within relevant organisations about using CBT materials with BME communities.

Over two consecutive days in June 2010, 3 Mental Health trainees from Saheliya and 2 members of staff from EC were trained to deliver the Living Life to the Full course. To run the pilot we agreed to combine the skills of two trainers from EC and one Mental Health trainee from Saheliya to co-deliver a pilot course in the late summer. In addition, to the 'training for trainers' course regular support meetings were held with staff before and during the delivery of the course.

2.1 LLTTF with BME women

Due to changes in funding and staff within Saheliya, and Ramadan in September, it was not possible to run the course until October 2010. In advertising the course we tried, as far as possible, to replicate the promotional style usually used for the DAS course.

The flyer was circulated widely to individual BME women we had worked with, as well as all the main BME organisations in Edinburgh. Participants were asked to phone/email to book a place on the course. At first there was no response from either potential participants or organisations. Follow up calls revealed that support staff, including those in health-related services, were largely unaware of interventions or courses such as LLTTF and thus not in a position to promote the course effectively with their service users. Furthermore, feedback from individuals showed that some, particularly those with limited schooling, found the description 'course' off-putting, worrying they would be unable to participate due to limited literacy skills or knowledge of the English language. DAS had informed us that the LLTTF materials are said to be pitched at those with 'a reading age of nine'.

The course was due to start on the 15th November, but only one person turned up, others had expressed interest but on the day had felt unable to motivate themselves to attend; another reason given was that the relatively new location of Saheliya was not convenient for some service users, being quite far from a regular bus route.

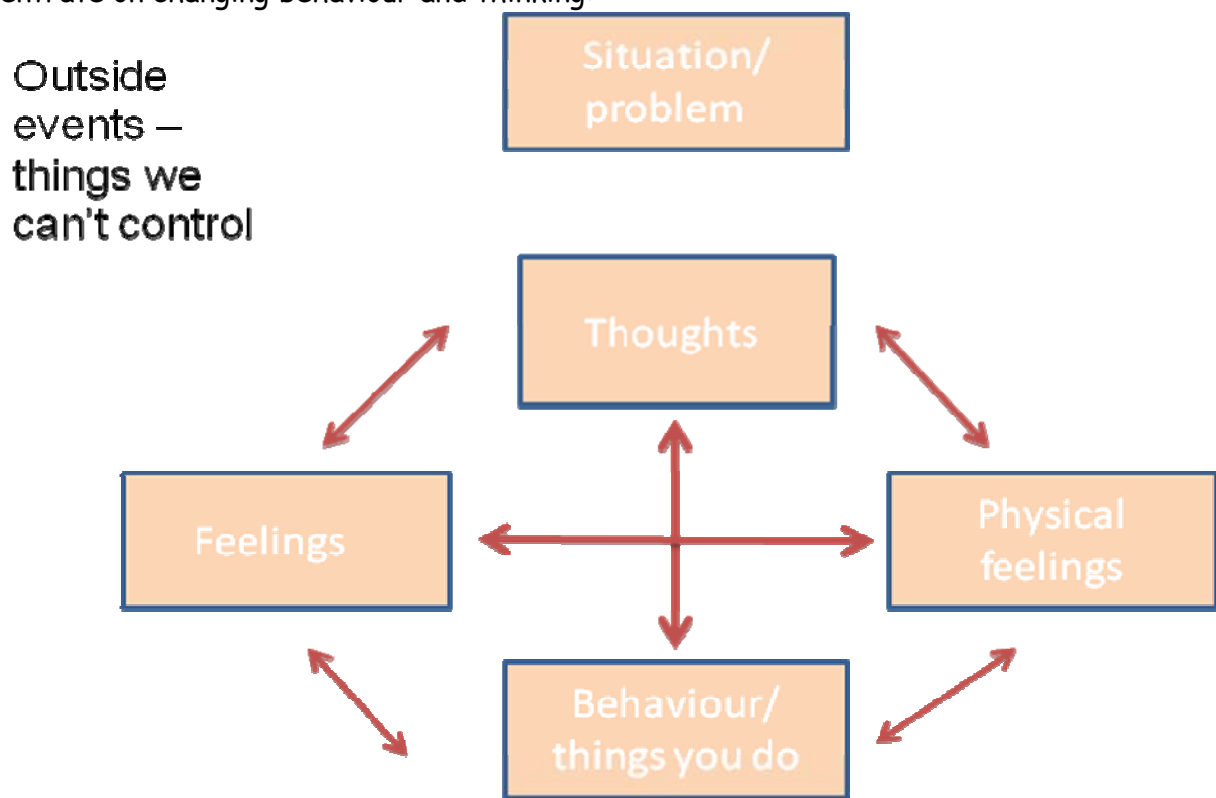
Given the low turn-out the trainers decided to postpone the course and spend more time doing outreach work to promote the course to partner organisations, in order for them to promote to their clients and

explore other venues. At this stage, Saheliya said they could only continue to support the pilot if the venue remained at their new premises and was specifically targeted at Saheliya service users. In light of this, we agreed to offer limited travel costs to women as a further incentive, as well as providing a crèche and light refreshments.

Given the general lack of awareness about Living Life to the Full, the trainers also gave short presentations about the course to colleagues and were keen to 'tag' the course onto an existing Saheliya activity rather than a standalone course. Consequently, it was decided to offer the course to Saheliya peer advocates, and other individual service users. However, by this time the winter weather had deteriorated, and with Christmas holidays approaching it was decided to re-launch the 6 week course in February. Prior to the course starting significant effort was made by the trainers to promote and remind participants about the forthcoming course.

2.2 The Materials

LLTTF course materials have been developed to be used over a six-eight week period, each week focusing on a detailed booklet giving examples and exercises to work through on your own, in pairs or in group sessions. In addition, worksheets, video and sound clips are used throughout the course to illustrate or emphasise particular points. As the next diagram shows, the sessions focus on five areas and concentrate on changing behaviour and thinking:



The course is not therapy but rather seeks to teach practical skills to help challenge unhelpful behaviours and thinking styles. The trainers are expected to act as a coach or supporter, not as a therapist. Each week the sessions are designed to be interactive and delivered in a style which encourages and promotes self-help, as well as providing information, guidance and mutual support to 'break the vicious circle'. In week 5 a short relaxation voice recording is used to illustrate 'anger control training'. During the pilot we used the regular LLTTF materials, with only minimal amendments as necessary for reasons of clarity or cultural sensitivity.

2.3 Monitoring information

Upon joining the course, each participant was asked to complete a monitoring sheet (collecting basic details about postcode, age and ethnicity) during their first session. In addition, given our interest in the ICP assumptions, we asked a few supplementary questions about previous sources of support.

2.3.1 Age

21 - 30	1
31 - 40	8
41 - 50	2
51 - 60	1
Over 60	1

2.3.2 Ethnicity - the women came from a wide range of ethnic backgrounds, some participants had lived in the UK for only a short time whereas others had lived here for many years, including one woman who was born in Scotland but had married a BME man. The self-ascribed ethnicities were Arab (2), Pakistani (2), Hindu (Punjab), African (2), Black African, Arab-African, Indian, Black African-American, White Scottish and Chinese.

2.3.3 Location - the women came from across the city of Edinburgh and were asked to list the first part of their postcode (EH16 (2), EH7, EH4 (2), EH26, EH6, EH5 (2), EH10, EH9, EH8, EH3).

2.3.4 Additional questions.

Participants were asked '*when you feel sad or stressed, where do you usually go for help?*'

Go to the Doctor	1	Check the internet
Speak to family/friends	10	Other (what?) 4 (yoga, exercise, books, Support Workers, stay at home isolated)

It is interesting to note that only one woman had visited her GP, with the majority choosing instead to speak to friends or family. Some women chose more than one option.

The women were also asked '*before attending this course, had you been to your Doctor for support when feeling sad or stressed?*' Six women said yes and suggestions from the GP had included:

- go to minority groups and find friends
- take anti-depressants and seek counselling
- medication/CPN/websites
- anxiety/bipolar/severe depression
- exercise
- medication

Seven women said they had not been to the GP.

2.4 Evaluation

DAS use Mental Health Literacy forms to evaluate changes in participants' understanding of how to manage issues which affect their mood and their confidence to do so. The Literacy forms have one part which is completed at the start and the latter part at the end of each session. In addition, a final evaluation form is issued at the end of week 6 which assesses the overall training course.

Whilst trying to be as inclusive as possible, and being aware of possible literacy and language difficulties within the group, we tried to ensure the language used on the Literacy forms was as straightforward as possible. With only minor amendments (using a sliding scale of very good, okay, bad, rather than excellent, average, poor), we used these forms at each session. Although it became clear early in the course that participants did not really 'see the point' of the forms and found it hard to detail 'what you don't know'. The trainers observed that little thought seemed to go into completion and it appeared to become a 'tick box' exercise.

At the end of the course we used the DAS evaluation form, with 3 additional questions relating to the pilot and their specific experiences as BME women, using a sliding scale of 'strongly agree to strongly disagree':

- The booklets and worksheets were relevant to my situation as a woman from a BME background
- The examples used in the booklets and worksheets were relevant to me as a woman from a BME background
- Do you have any suggestions about how the course could be improved or made more relevant?

Appendix 1 gives full details of the responses from this Evaluation form.

During the last session the trainers observed that whilst several women had been happy to share their thoughts on the relevance of materials in discussions, they did not then subsequently write these thoughts down on the final evaluation form, again following the previously observed reluctance to write some things down. With this in mind, and following the DAS practice of bringing group members together again after 2/3 weeks for support, we arranged an extra evaluation session, led by an independent facilitator, with 3 specific aims:

- To present certificates to those who had completed the course
- To verbally evaluate the course and materials
- To provide information about dealing with racism

Appendix 2 gives a full report of feedback received during the facilitated session.

The event took place two weeks after the course finished and was attended by 7 of the 8 participants who completed the full course. Furthermore, this additional event enabled us to provide a Question/Answer session for those seeking further advice about dealing with racism.⁴ This had been requested by the women following discussion of one of the many examples of racism raised during the LLTTF. As with the other weekly sessions, refreshments and a crèche were provided, and in order to promote wellbeing, two complementary therapists were available at the end of the session to offer 'taster sessions' of reflexology and back massage.

2.4.1 Participants

⁴ Kindly provided by Edinburgh and Lothians Racial Equality Council

In general, the women found the course had met their expectations and been useful. They felt the course, and materials used, were generally straightforward, teaching them new, or in some cases reinforcing existing, skills which could be utilised in their daily lives. However, there were some concerns expressed about the relevancy of some of the examples and the need to address issues linked to living with racism. The cultural appropriateness of CBT was also raised by several women.

2.4.1a Materials

There were more mixed views about the relevancy of the examples and course materials. When asked about '*the booklets and worksheets were relevant to my situation as a woman from a BME background*' four women gave a neutral response, one disagreed and 2 agreed. Similarly when asked about the relevancy of the examples used just over half the women ticked neutral or disagree, three said they agreed. However, in the facilitated session there were several specific comments about this matter, including:

- Many said the examples of alcohol were not culturally relevant and it would be better to use universal examples like bereavement
- Use examples talking about issues that we can relate to like isolation, racism, cultural differences, etc. And, include help on how to get solutions for this and help them understand the techniques better
- Took no account of cultural background

During the sessions several women became upset or emotional when sharing examples, particularly about the racism they had faced. The emotional strain experienced by some is also evident from comments made during the facilitated session and some suggestions were made for improvements:

- It would have been useful to warn people that the session would be emotional as we felt sometimes caught unaware when we explored personal examples
- It would have been better to explore issues using case studies rather than ask for own examples as this was very emotional and then it was difficult to be rational

Throughout the course, the trainers had observed a distinct reluctance by several members of the group to write things down, either in the books or on worksheets. This was noted for those who were extremely competent in using the English language as well as with those who were less confident (also see section 2.4 and summary of the Mental Health Literacy forms appendix 3)

2.4.1b Racism

When delivering the course the trainers were acutely aware when participants were asked for life events which affected their mood, for example, many of the examples given related to being a member of a minority ethnic group, either because of language, culture, religious background or racist abuse/attack. When examples of racism were shared it was often very emotional and as trainers we felt somewhat uncomfortable when returning to the course materials as if that was almost ignoring or minimizing the impact or experiences. In discussing this situation with DAS, it was suggested perhaps we could try to put 'racism' within the vicious circle but this is also inappropriate as it could imply it is the abused that should change their feelings or behaviour.

At times, it felt disrespectful or offensive to try and return to delivering the course. It was not appropriate to place 'racism' in the vicious circle because by working through the circle you would effectively be suggesting the individual should take the 'blame' for a societal problem. Consequently, at the start of session 5 (in this case somewhat unfortunately entitled 'How to fix almost anything'), we devoted the early part of the session to a specific discussion focused on the impact with racism and this in turn led to the request for a follow-up session.

As the following comments illustrate, this issue was discussed at length during the facilitated session, although was barely mentioned on the Evaluation Form:

- Felt that the additional need of the impact of racism on us not taken on board in the course, including some of the real issues we face daily (within cultural backgrounds as well as facing racism)
- Root of depression/ill health (that is racism) not addressed by course or suitable to put in vicious circle, what came up did not help with this.
- It was difficult to label the bad thought (if something like racism which is all round you) and put it in a corner

2.4.1c Cultural appropriateness

Another challenge we faced was the cultural appropriateness in using the CBT tools. Throughout the course, the majority of the women found it difficult to adapt their way of reasoning as it seemed to collide with traditions, beliefs and ways of life. Many of the women instinctively have two perceptions when looking at situations, a 'here' to refer to their lives in Scottish society, and a 'there' referring to their lives in their home countries or in their communities and when interacting with people from similar backgrounds. This was often confusing for participants as what may be expected in one ('here') was the opposite of what would be expected 'there'. For example, a participant drew a life card about 'quarrelling with a neighbour'. The participant got really confused and was not sure how to tackle the life card situation. One of the trainers noticed her confusion and tried to assist and hear her thoughts. The participant shared that in her culture a neighbour is regarded as family and is to be respected, to have a quarrel with a neighbour is very serious and it must be fixed at any cost, but at the same time she said 'here' neighbours do not have the same position and they sometimes do not even bother to greet you. So, for her, there was an inner conflict between the values she was brought up with, and the values she was aware of, in dealing with an 'imaginary neighbour', whilst living here.

Similarly, other participants in trying to use CBT approaches sometimes struggled to also accommodate their own deep rooted beliefs in 'fate', God's will, tests and punishments, and so on. At times, the way you are taught, or expected, to perceive certain situations, or overcome them, were completely different from the CBT-based suggestions.

2.4.2 Delivery style

Three trainers (two from EC and one from Saheliya) took turns to co-deliver the course, in most cases two led the session whilst the third observed, taking notes and/or supporting participants who became upset during discussions. From the trainers' point of view, this largely worked well as we were able to support each other and share the workload. We also had varied delivery styles, as well as different life experiences. Two trainers were from a BME background and this was immensely helpful in encouraging

the women to share their experiences from 'home'. The course was delivered in English with translation support provided by trainers or group members as required.

Feedback from participants, on the evaluation forms and during the facilitated session, about the trainers was very positive, with the majority of participants feeling the trainers were motivating and related well to the group. During the facilitated session one participant said "*it was easier when one person led the session. If there were more people it was sometimes difficult to understand and get lost*". Similarly, as trainers, we noted that it might have been better to lead on larger sections of each session, rather than swapping regularly.

2.4.3 Comments from Trainers

After the course a DAS trainer met with the three LLTFF pilot trainers to record their feedback and impressions. The discussion concentrated on the broad themes of: the training experience; the course materials; and the course itself.

2.4.3a Training experience

As noted earlier, the trainers felt that a strength of co-training was recognition of each other's different skills and experiences, as well as providing mutual support. However, at times it was a challenge to work together in terms of knowing how co-trainers would do their sections and a general unfamiliarity with delivering LLTFF. It was felt that any subsequent courses would be significantly easier to co-deliver with the same trainers. All the trainers said that a further challenge related to their discomfort/uncertainty about delivering the course materials as they were not convinced by the potential effectiveness of the materials themselves, particularly when issues about discrimination and racism, which could not be covered by the course, were raised in the first session. At times, it had felt like *'my hands were tied behind my back'*.

Support for the trainers from DAS was generally felt to be helpful and reassuring. The support sessions served as both a review of the previous session, and preparation and discussion about the forthcoming session. In particular it was felt that the highlighting of the essential key learning points with each session was very useful. Some support meetings were more necessary than others (due to some more challenging weeks for trainers than others), so in future once a week is unlikely to be necessary.

The two-day Practitioner training was felt to be overly intensive. Two consecutive days was perhaps too compressed a period for prospective trainers to fully absorb the information. Rather than simply going over the materials, it was suggested it may be better to include role-play elements for participants to practice delivering parts of LLTFF sessions. We understand this is now part of the DAS Practitioner training content for the two-day mode of Practitioner training.

2.4.3b Materials

In terms of promoting the course and recruiting participants there were several key learning points. For support workers and staff from other BME organisations it was noted that there was a basic lack of understanding about what LLTFF actually was. It was only when the trainers talked to individual women themselves, via outreach work, that the recruitment process progressed.

In relation to evaluation it has already been noted that the trainers noticed women were often reluctant to write things down and alternatives to writing should be considered for capturing evaluation data.

Specific comments on materials:

- Some of the women were uncomfortable with writing on the A4 handout Bad Thought Spotter, others didn't like the exercise due to bad experiences they had in the past. One woman in particular, who had had a very traumatic experience in the past, felt her particular cultural upbringing meant that she had difficulty conceptualising about thoughts as something external to her.
- One woman in particular appeared to achieve a really big change, managing to move on in her life and reported *'it changed my life'*
- The trainers had used the DVD to reinforce, or reiterate, key points but felt the DVD was not well-received, references to 'black mood' had been deemed offensive. The general point was made that the respondents in the DVD were all white and lacked ethnic diversity.
- Trainers noted that differing cultural perceptions affected how the women worked on exercises (see 2.4.1c above). It was agreed that perhaps in future courses more culturally relevant Life Card examples could be developed and courses delivered to similar BME groups could also prefix this exercise by saying, *'think about your time living here now in Edinburgh just now and work through these Life Card examples.'*
- Another culturally specific area that would need to be considered for future course delivery would be in relation to some body language (in the self-esteem session, for example). The trainers observed that some cultural norms can differ, such as the use of eye contact in social interaction.

2.4.3c The course

The trainers felt that the course would not have gone as well if it had been a mixed gender group rather than a woman-only group. The women were very open and shared a lot of sensitive information with each other from a very early stage. It is highly unlikely this would have been possible in a mixed gender group.

Due to miscommunication within Saheliya new women came along as the weeks progressed meaning that the trainers had to introduce new icebreakers each time.

The trainers also mentioned aspects of the course that they thought worked especially well:

- The chunking (although not the use of this word) and planning elements worked well
- The trainers noted that they had been pleasantly surprised when some of the women reported using the Vicious Circle at home
- The trainers received some very good feedback from the women about the course and how for some it impacted to help them change things in their life

2.5 Conclusions and recommendations

Overall participants enjoyed the course and felt it taught them several useful skills which could help them manage their low mood and anxiety. However, to be fully accessible the course materials require adaptation to ensure that the examples used are relevant to as wide an audience as possible and do not offend or present barriers to those from a BME background.

Specific recommendations from the women and trainers include:

- In some of the sessions it would have been better to use case studies to explore the issues rather than personal examples as at times this was too emotional and difficult to deal with in the training sessions.

- There was too much information for 6 weeks and maybe it could have been 8 weeks long
- Have time to reflect on the previous session before starting a new session to help link and take on new information
- Need for more cultural awareness
- Interaction in between the sessions, and after, needed to embed the learning
- Using a diverse community and images for the DVD
- Use a wider selection of examples, relevant to all sectors of the community
- Issue a 'health warning' when asking people to share personal experiences as this may be emotionally sensitive. This may also mean further support is required at the end of the course, for those affected, in a culturally sensitive way.
- The need for alternatives to writing for capturing evaluation data should be considered
- Support or enable participants to continue meeting as a group after the course has ended.
- It is not simply a case of translating the existing materials into another language as often words and concepts do not have a direct translation or meaning.
- It should be made clear at the outset that the course is not designed to deal some life situations such as racism, or the consequences of racism.

The course is designed as an individualised self-help programme but is not designed to tackle societal issues such as racism or prejudice. With this in mind, the titles of some booklets, or the approach taken in sessions, that 'everything' can be resolved is in reality untrue and potentially counter-productive. There is immense danger in trying to put such life situations into the LLTTF approach as it could end up 'blaming the victim' or implying the individual needs to change their behaviour or thinking rather than acknowledging it as a societal issue. To ensure the course is fully accessible and relevant consideration should be given to adding a specific section on this matter so that its significance is acknowledged in an appropriate way, including relevant sign-posting, which could in turn encourage and enable participants to 'self-help' as required.⁵

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May 2011

⁵ We would suggest agencies experienced in dealing with racist issues and hate crime should be consulted about the inclusion of such information.

Appendix 1

Summary of responses to DAS final session LLTTF evaluation form (completed by 7 participants)

Q1. The sessions were helpful	Strongly Agree x2 Agree x5
Q2. The trainers related to the class effectively (e.g. made you feel comfortable and understood)	Strongly Agree x5 Agree x2
Q3. The trainers were motivating (e.g. encouraging, attentive and creative)	Strongly Agree x5 Agree x1 Neutral x1
Q4. I intend to use what I have learnt in my own life	Strongly Agree x3 Agree x4
Q5. Did you get what you hoped out of the course?	Yes I did! Yes I learned a lot about thoughts and how they affect one's actions/feelings/behaviours, thank you! Yes. It has brought out all the things I have to deal with in order to come to equilibrium in my life - balanced mind. Yes the CBT based content was useful and I will try and exercise/practice techniques in my own life situations. Yes, but a reading list and contacts for BME women I wish it went more deeply.
Q6. The booklets and worksheets were relevant to my situation as a woman from a BME background	Neutral x4 Agree x2 Disagree x1
Q7. The examples used in the booklets and worksheets were relevant to me as a woman from a BME background	Agree x3 Neutral x3 Disagree x1

Q8. Do you have any suggestions about how the course could be improved or made more relevant?

More relevant examples please

I think including more things that women do to cope (within the minority populations) should be included as drinking & smoking/drug use are not always common across other backgrounds and cultures. Can prayer/meditation be included?

Discuss some BME situations which could lead to depression

Review, tailor to meet everyone's needs. Using current/relevant/diverse examples. Thanks 😊

It should be more inclusive and perhaps more sensitive to BME Women's cultural beliefs and particular difficulties.

I think the course could be more relevant if we had different case studies on which we can work and understand how to tackle problems more effectively.

Appendix 2

Participants' evaluation session

The evaluation was carried out as a graphic facilitated session where all the responses were recorded during the session with the approval of the participants. The main evaluation questions were based on reflection of the process, content and style of the course in terms of

a) What did not work and why?

- There was pressure to deliver and go through the books
- There was not enough time to reflect and discuss
- Many said examples of alcohol not culturally relevant and it would be better to use universal examples like bereavement
- A lot of forms and paperwork, sometimes difficult
- It would have been better to explore issues using case studies rather than ask for own examples as this was very emotional and then it was difficult to be rational
- Took no account of cultural background

b) What worked and why?

- The course was easy to understand and not simplistic or patronising
- It made sense and was very practical
- The vicious cycle was very good and clear
- It was easy to apply to many, but not all, everyday situations
- Group discussions helped to understand and learn from each other
- Supportive environment of similar women

c) What was missing from the course?

- Felt that the additional need of the impact of racism on us not taken on board in the course, including some of the real issues we face daily (within cultural backgrounds as well as facing racism)
- Root of depression/ill health (that is racism) not addressed by course or suitable to put in vicious circle, what came up did not help with this.
- It was difficult to label the bad thought (if something like racism which is all round you) and put it in a corner
- Use examples talking about issues that we can relate to like isolation, racism, cultural differences etc. And, include help on how to get solutions for this and help them understand the techniques better

Specific comments were also made about the materials:

The books

- There could be more relevant visual images in the books
- They looked very serious and practical.
- The colour on the cover was good
- They were not artistic
- A lot of writing and forms

- Some words not commonly used so difficult if English your second language, off-putting and confusing
- English was a second language and words do not translate well sometimes so pictures are universal, use more images

The relaxation tape

- had a male voice, female version would have been better
- the speed at which he talked was not right
- the language used was sometimes quite complicated, not easy to understand

The DVD

- The people were very Scottish and "vernacular"
- It was like being at a lecture
- Use of the word "Black" - terminology very negative and reinforced stereotypical reference to BME communities
- Referred to "black mood"

The evaluation forms

- Doing forms before and after put pressure on participants
- What was the point?
- Need time to digest and see the journey of the whole course
- Hard to do at beginning as you did not know what you did not know

Delivery style

- Would prefer the introduction to what the session was on paper and discuss this at the beginning as to the aims of the sessions and the learning outcomes
- It was easier when one person led the session. If there were more people it was sometimes difficult to understand and get lost
- It would have been useful to warn people that the session would be emotional as we felt sometimes caught unaware when we explored personal examples

Appendix 3

Mental Health Literacy forms - summary of responses

WEEK 1: WHY DO I FEEL SO BAD?

Statement	P1		P2		P3		P4		P5	
	Before	After	Before	After	Before	After	Before	After	Before	After
<i>Q1. My understanding of how life events affect my mood is:</i>	good	good	okay	good	Very good	Very good	good	Very good	Okay	Good
<i>Q2. When I have a problem, my confidence to take small steps to control of my thinking and behaviour is:</i>	good	good	okay	good	good	Good	good	Very good	okay	good
<p><i>Q3. What do you hope to get from this course/Any other comments?</i></p> <p><i>Hope it can help me change my way of thinking and over-reacting when stressed.</i></p> <p><i>Try and understand why sometimes we don't have enough confidence to think & tackle issues.</i></p> <p><i>Understand how I can deal with problems in a strong and positive way. Not allow my mood to affect my thinking.</i></p> <p><i>Need to practice at separating the (face?) sessions. Learn to live life to the full!! ☺</i></p> <p><i>Would like to learn to be less passionate about situations and be able to cope with being too overwhelmed by disappointments</i></p> <p><i>More skills, more experience, learn something new and good to my life. More people communication. I start feeling comfortable.</i></p> <p><i>Learn new life skills and hear difference experiences from other members of the group. Learnt something new about how to behave to situations and feelings</i></p>										

WEEK 2: I CAN'T BE BOTHERED DOING ANYTHING

Statement	P1		P2		P3		P4		P5		P6		P7		P8	
	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A
<i>Q1. My understanding of how my mood affects what I do/don't do is:</i>	poor	Very good	okay	good	good	good	okay	good	poor	poor	okay	good	good	good	okay	good
<i>Q2. My confidence to tackle feelings that 'I can't be bothered with' is:</i>	Very poor	Very good	okay	good	good	good	okay	good	poor	Very poor	okay	good	poor	okay	okay	Very good
<p><i>Q3. Any other comments?</i></p> <p><i>Social anxiety (phobia)</i></p> <p><i>I have understood that it is important to take one 'small' step to break the cycle.</i></p> <p><i>The lack of confidence has caused many things to come to a standstill.</i></p>																

WEEK 3: WHY DOES EVERYTHING ALWAYS GO WRONG?

Statement	P1		P2		P3		P4		P5		P6		P7		P8		P9	
	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A
<i>Q1. My understanding of what unhelpful thoughts are and how they affect me is:</i>	good	good	okay	good	okay	V. good	good	okay	okay	good	good	good	Very poor	poor	good	V. good	okay	okay
<i>Q2. My confidence to challenge negative thoughts is:</i>	poor	okay	poor	good	poor	good	okay	poor	poor	good	good	good	Very poor	V. poor	poor	okay	poor	poor

Q3. Any other comments?

Very helpful course, thank you.

Useful training!

I am going to work hard to improve my confidence.

Too long but I tried.

Very enjoyable

Assertiveness training please!!

Takes a tremendous effort to change a mindset of a lot of years of negative thoughts in my head. It will take some time to change, to start thinking good thoughts.

WEEK 4: I'M NOT GOOD ENOUGH

Statement	P1		P2		P3		P4		P5		P6		P7		P8	
	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A
Q1. My understanding of where low confidence comes from is:	poor	okay	Very good	good	poor	good	Poor	okay	good	good	good	good	Very poor	okay	poor	Very good
Q2. My confidence to start building my own confidence is:	okay	okay	okay	okay	okay	good	poor	okay	good	good	okay	okay	poor	okay	poor	good

Q3. Any other comments?

Friendly people

Where does the 'acting' confident stop? Ref page 15. How to become REAL confident.

Simple and effective message to keep with us.

Doing work activities that you are able to do fairly well makes you more confident but you need to make some effort.

Very good class. I enjoyed this session, especially the role playing to effectively show the difference between who is confident and someone who isn't 😊

WEEK 5: HOW TO FIX ALMOST ANYTHING

Statement	P1		P2		P3		P4		P5		P6		P7		P8	
	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A
Q1. My understanding of how to tackle big problems in my life is:	okay	Very good	poor	okay	poor	okay	okay	good	poor	Very good	okay	okay	okay	good	Very poor	okay
Q2. My confidence to start tackling big problems in my life is:	poor	good	poor	okay	poor	okay	good	good	poor	good	poor	okay	good	good	Very poor	okay

Q3. Any other comments?

Hope to put it into practice, Late starter, not courses fault.

Q4. Did you get what you hoped to out of the course?

Yes, Yes, Yes, and more.

WEEK 6: THE THINGS THAT DO MESS YOU UP

Statement	P1		P2		P3		P4		P5		P6		P7	
	B	A	B	A	B	A	B	A	B	A	B	A	B	A
Q1. My understanding of how things that I do are unhelpful for my mood is:	okay	Very good	Okay	okay	Okay	okay	Okay	Very good	Good	Very good	poor	okay	good	good
Q2. My confidence to start doing things that are helpful for my mood is:	okay	good	Very good	Very good	Very poor	Okay	Very good	Very good	okay	Good	poor	poor	good	good

Q3. Any other comments?

E4SP principle good to try and use

Not all course content relevant and not specific to BME community needs.

Need more practice again and again.

Why black & bad – not good to say this!