NHS
Southwark
Clinical Commissioning Group

# Working with Black Majority Churches (BMCs) to improve the Mental Health & Wellbeing of Southwark people

## Introduction

Recent years have seen an increasing focus by commissioners and providers of mental health services to work with faith organisations to raise awareness of mental illness and tackle stigma. There have been some notable national community "events" about mental illness within the Sikh, Muslim and Black Majority Church faith organisations. Moreover, through the "Time to Change" initiative, the Church of England has also made a commitment to tackle mental health stigma. Dr Rowan Williams, the former Archbishop of Canterbury, pledged to tackle "outdated taboo" of mental health.

South London and Maudsley NHS Trust (SLaM), through its Charitable Trust has piloted a "Faith and Mental Health Training" project ('the project") with a number of Black and Minority Ethnic (BME) Churches in 4 London Boroughs including Southwark. The project has made links with both local and faith communities and increased mental health literacy as well as improved communication and understanding between mental health services and BME communities.

More and more people are attending the workshops that have been run these include: Training in Spiritual and Pastoral Care in Mental Health, Mental Health Awareness (MHA), Mental Health First Aid (MHFA), and more recently Time to Change national campaign. Through this work families are benefiting by becoming more involved and more informed about this health condition. With the right help and information they can take steps to prevent mental illness and be aware of the practical ways to access a range of services early before things get out of control and end up in crisis.

## Opportunity knocks for commissioners/providers to work with BMCs

A new report published by the University of Roehampton (Being Built Together – A Story of New Black Majority Churches in the London Borough of Southwark – Final Report - June 2013), shows that Southwark has seen a huge surge in the number of new churches, particularly BMCs, many of which are Pentecostal with a largely Caribbean or African membership. The study found that an estimated 20,000 people gather to worship in around 240 different churches across Southwark each week.

SLaM's project trained faith leaders to promote mental health awareness within community groups often described as hard to reach and to facilitate engagement with SLaM services. The initiative has proved to be far-reaching in its penetration in improving understanding, engagement and relationships between mental health services and Caribbean and African faith communities. The project began in 2010 and currently running its 6$^{th}$ cohort training course which is due to end on 18 November 2013.

The project has now trained a hundred people from a variety of faith groups predominantly from across SLAM Boroughs, Southwark, Lambeth , Lewisham and Croydon. **Appendix A** below provides a snap shot evaluation of cohort 4 which shows the shift in attitude in reducing stigma and discrimination of mental health within the BME community. Cohort 4 was hosted in Lambeth and for the first time cohort 5 was hosted in Southwark (the evaluation is still pending).

The project has concretely demonstrated the impact of taking a dual approach (spirituality and medicinal practice) to addressing mental illness within the BME community. The mental health courses on the pilot for local faith groups were oversubscribed, and the conference held to celebrate the completion of the courses and discuss the issue of spirituality and mental health attracted over 130 local people from BME communities and highlighted the need for more training in mental health issues within faith groups.

Pastors have spoken eloquently about how they have "seen the light" following the mental health awareness training. Armed with a better understanding of the causes and cures of mental illness, they have been able to provide a far better and pragmatic pastoral care for those in their congregation. The biggest change that these trained Pastors have initiated is that they no longer take the approach to mental illness as a form of demonic possession, but that members of the congregation must see a health professional, take their medication and that the church will also continue to support them spiritually. Some of the participants of the pilot have said:

"I no longer see mental illness as incurable"
" I feel better to be around people who may have mental health issues"
"My response to suffering has changed. Prayer does not always make a difference"
"I will now not treat every individual regarded to have mental health issues with suspicion".

The project has been strongly influenced by a service related project exploring perceptions of 'well-being' in BME clients accessing a service for people at risk of developing psychosis. This study involved semi structured interviews with services users to ascertain their thoughts about recovery and which factors help them on this journey. Clients reported feeling that a positive relationship with religion and spirituality were key to becoming 'well'. These results showed that there may be perceptions of wellness specific to BME groups that are distinct from the medical view of wellness promoted within services. This has recently been published by Behavioural and Cognitive Psychotherapy.

One of the other positive outcomes from the project has been the fostering of good opportunities to link with services to ensure the continued support for the church's congregation. The presentation element of the course provides an opportunity for participants to think about their role in the faith group and what they will do with this training, what difference their contribution can make and how to build capacity. In so doing, they come into contact with some of the internal challenges of their faith group and how to begin overcome them.

The graduates of this project have gone on to do voluntary work in mental health residential settings, and psychiatric inpatient wards. The Faith groups have held:

- Retreats on faith and wellbeing,
- Conferences
- Harvest service
- Put mental health on their training programme for ministry teams
- Support member of church into hospital
- Support other faith leaders with spiritual and mental health issues
- Attend local community events on health
- Invited health practitioners into church to look at the physical health and mental health

## Southwark demographics and the rise of the Black Majority Churches

Southwark's population grew from 256,700 in 2001 to 288,300 in the 2011 census – an increase of 12.3% (compared to 7.1% across England and Wales). Ethnicity is potentially significant for understanding BMCs in Southwark.

In both the 2001 and 2011 censuses, Southwark had the highest percentage and number of African residents for all London Boroughs. Southwark also has the highest percentage and number of African residents of any local authority in Britain (Office for National Statistics, 2013; Southwark Council, 2011). It is truly England's African capital with 16.40% of Southwark residents identified as African in 2011, and 16.07% in 2001 (Office for National Statistics).

Around three fifths of the African population of the Borough were born in Africa in 2001 (Southwark Analytical Hub), and this proportion was approximately the same in 2011 (Office for National Statistics, 2013). African residents are predominantly from Nigeria and other parts of West Africa (Southwark Council, 2011). The proportion of Black Caribbean residents in Southwark is somewhat different, decreasing from 8.0% in 2001 to 6.2% in 2011 (Southwark Analytical Hub).

The 2011 census also showed that Southwark is only second to Lambeth with the highest percentage of Black population (77,511). Although not quantified, the "Being Built Together" report suggests that Southwark is the African capital of the UK and probably given that the new 240 BMCs in the borough could also represent the greatest concentration of African Christianity in the world outside of Africa.

The report goes not to suggest that according to its analysis of ethnicity and culture, BMCs in Southwark are mostly African-led with a large proportion of congregants being of West African origin. Thus BMCs provide a 'home from home', a safe place for those finding their way in a new country, with attendant benefits for such communities, local authorities and London.

BMCs the report suggests serve dispersed communities across London that few other agencies can reach. They provide a 'safe haven' for migrant communities, meeting their spiritual needs alongside assisting with issues such as family, health, law and order. Consequently, BMCs are a spiritual, social and economic asset to the city and its boroughs

## Context of the Faith and Mental Health Project

- BME clients are more likely to have a distressing and convoluted pathway to care, often through the judicial system, and they are more likely to be detained under the mental health act (Morgan, Mallett & Hutchinson, 2005).
- SLaM data on people using their inpatient service shows that often black people come into contact with SLaM services in crisis and at later stage in the illness. Yet we know that that early detection, earlier access to treatment and care can reduce impact of illness, duration and length of stay on in hospital. Earlier access with support also improves patient experience reduces fear and anxiety
- SLaM has the largest number of African and Caribbean residents of all the London boroughs further highlighting a need for those providing services in this area to identify the specific needs of this population
- There is increasing recognition of the importance of spirituality in mental health as evidenced by 'Spiritual Care Matters'(NHS Scotland, 2009) and recent production of guidance on Spirituality and Mental Health by the Royal College of Psychiatry (RCP, 2010). Equally, much attention has been given to the need for enhanced understanding of the interaction between psychosis and culture.
- The NICE Schizophrenia guidelines (NICE, 2009, Update) recommend that services should address cultural differences in treatment, expectations and adherence, and clients' explanatory models of illness should be better understood.
- It is important to note the significantly negative experiences of Black African and Black Caribbean service users accessing mental health services in the UK. A glaring account of such discrepancies, detailed in Breaking the Circles of Fear (The Sainsbury Centre for Mental Health, 2002), indicates why research into mental health service provision is necessary.
- As indicated, for example, through early detection services such as OASIS (Outreach and Support In South London) which aims to intervene at the earliest point of illness, there are both social and economic gains for SLaM and the wider society (Valmaggia et al, 2009) in both supporting, providing education and helping to prevent young people making a transition to a serious mental health difficulty such as psychosis.
- There is a need for mental health commissioners/providers to recognise that the cultural and religious diversity of its inhabitants means that Western models of help seeking and explanations of illness may not be understood and may require different metaphors and language use.

- Research reports elevated rates of psychosis in the Caribbean and Black African populations in the UK ranging between two and 14 times higher than for the White British population (Cantor-Graee & Selten, 2005; Sharpley et al., 2001). This prevalence has been found to be consistent over time and it has been documented that there is an elevated risk of developing psychosis in second generation immigrants (Cantor-Graee & Pedersen, 2007). The unwavering high rates of psychotic disorders in second and third generation immigrants and the absence of raised rates in native countries (Cantor-Graee & Selten, 2005) suggests that there must be a strong environmental component involved in the development of psychosis. It has been suggested that the rates of psychotic disorders are not reflective of genuine illness but rather evidence of professionals' failure to understand and accommodate the cultural background and explanations of symptoms provided by clients (Zandi et al., 2010). This issue is still highly contentious and it is possible that further research will help to elucidate this controversy
- Many black SLaM service users are members of local faith communities and receive considerable support within the community. However, faith communities are uncertain how to deal with mental health problems in their congregations and there are often disparities between cultural and religious explanations of distress and the Western conceptualisation of mental health difficulties promoted in our service. Hence the relevance of exploring the religion and psychosis within SLaM.
- One step towards ensuring equity of access to care and facilitating engagement for our burgeoning global population may be to support faith communities in dealing with mental illness. Particularly, to help faith communities to understand more about mental illness and our services, how to keep well; and more importantly work collaboratively to validate the added value the role of faith groups in reducing stigma and discrimination, prevention, support, detection, and recovery.
- Within a strained economic climate, the capacity within the NHS to treat illness in increasingly stretched. There is a need to work closely with the faith community to build an understanding of mental health and mental health services to create better engagement with BME communities and increase the number of BME service user accessing services earlier rather than presenting in crisis. There are huge potential cost savings and economic benefits of early referrals to SLaM
- There is further a need to support the prevention and promotion of mental wellbeing with young people, and in particular with young black men.

## Why work with Black Majority Churches?

Community faith groups are a resource, which have seldom been targeted effectively by commissioners/providers. Focused and evidenced-based interventions can:

1. **Increase capacity of faith leaders to run training and events around mental health and wellbeing**

- Over the last 3 years 100 faith leaders from across the 4 boroughs have been through a 10 week community spirituality and mental health course previously developed and tested on funding by the SLaM charity.
- Building on this engagement and recruiting more faith leaders from Southwark to become mental health champions for their communities and to help facilitate future training courses. This will provide religious leaders with skills and confidence to offer basic mental health awareness training to other members of their religious community and congregation.

2. **Build Capacity of faith organisations to promote mental health and wellbeing**

- The mental health champions will cascade their learning through increasing awareness in mental health issues, enable understanding the role of religion in mental health, develop the ability to reflect on both good and bad practices within faith groups and a deepening self-knowledge and awareness
- Evaluation of two sets of 10 week workshops previously run showed significant reductions in stigmatising attitudes towards people with mental health problems after the training.
- Faith leaders are also able to run a series of local activities for faith groups to encourage inclusion of mental health on the agenda.

3. **Increase understanding of faith communities by commissioners/providers**

- Learning and feedback from the programme will inform best practice linking into key group within the CCG/Trust including Community engagement, Mental Health Promotion, Equality and Human Rights forum, Psychosis CAG, Public Relations, Social Inclusion; which will in turn benefit our service users.

- Staff interested and engaged in the role of mental health and spirituality will be encouraged and supported to feedback to their teams about how mental health is understood within different religious frameworks.
- Delivering the training will and also give faith leaders direct contact within NHS staff and more personal contacts should they need advice about how to support people to seek help.
- We hope that participation in the training will contribute to staff CPD portfolio.

## 4. Improve relationships and engagement with faith communities and mental health services

- Building an understanding of mental health and mental health services within faith communities will create better engagement with BME communities and increase the number of BME service user accessing services earlier rather than presenting in crisis
- Building capacity with faith communities to promote mental health and well-being for their congregations
- Creating a core of faith leaders who can run spirituality and mental health training courses themselves.
- Creating strong links and dialogue between faith communities and mental health services that could lead to addressing other health inequality issues.
- Production of a specialist Mental Health Awareness capacity building training Package for faith communities that can be replicated.

## Conclusions

With 20,000 attending around 240 BMC's each week in Southwark alone, SLaM's project has begun to put mental health on the agenda for faith groups across at least 4 boroughs. The positive results of the project show how education and engagement with faith communities on mental health can be positive drivers for change. Improving mental health literacy generally with a specific focus on understanding psychosis will help members of community experiencing the symptoms of early psychosis engage with services at an earlier point. This project also demonstrated that new routes into mental health services can be established which could improve how the BME community access, engagement and self-capacity built around mental health and wellbeing. Moreover, the project has embedded the culture of having mental health on the agenda of faith groups independently and established an informed working relationship with mental health services.

It requires courage to breakdown the stigma and barriers to accessing mental health services within the BME community. The SLaM project has highlighted that it is possible to develop meaningful relationships with BMCs and therefore the BME community. This, however, takes time, requires the fostering of mutual trust and addressing sensitivities.

## Recommendations

- That Southwark CCG and Southwark Council jointly consider commissioning a bespoke Pastoral mental health awareness training programme across established BMCs in Southwark adapting SLaM's faith and mental health model

- That Southwark CCG and Southwark Council jointly consider commissioning further Mental Health First Aid training specifically aimed at established BMCs across Southwark

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## Appendix A

### Spiritual and Pastoral Care in Mental Health Programme: Cohort 4

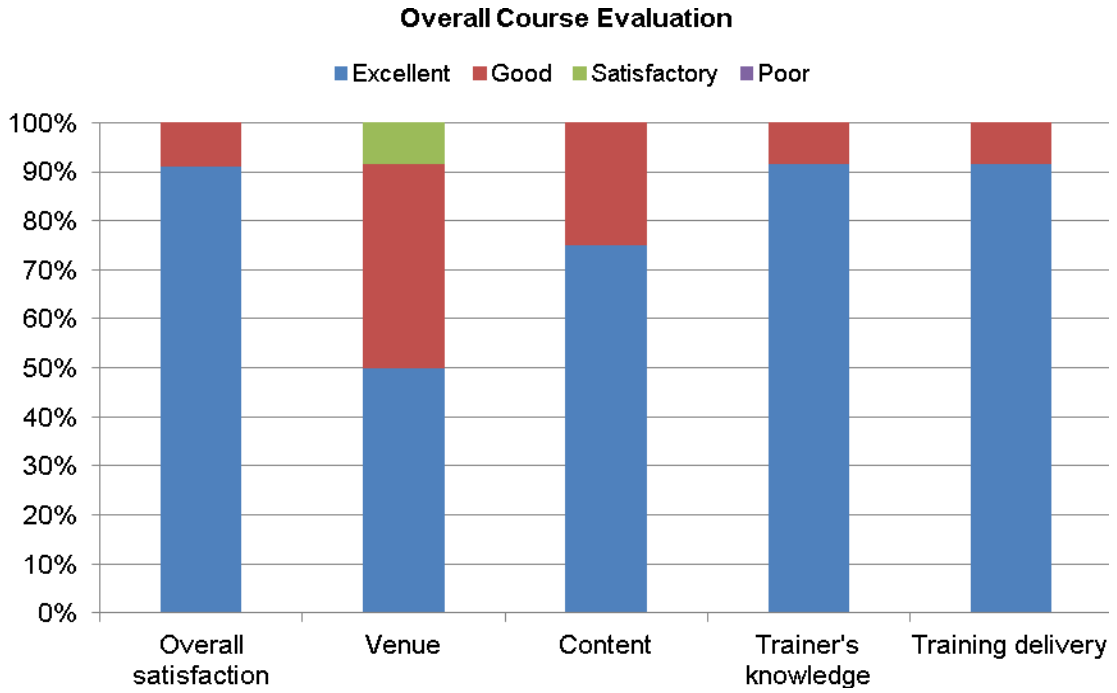
The Spiritual and Pastoral Care in Mental Health course ran weekly over a period of ten weeks. Due to feedback from previous courses, each session was extended an extra thirty minutes to two and a half hours per week.

### PARTICIPANTS

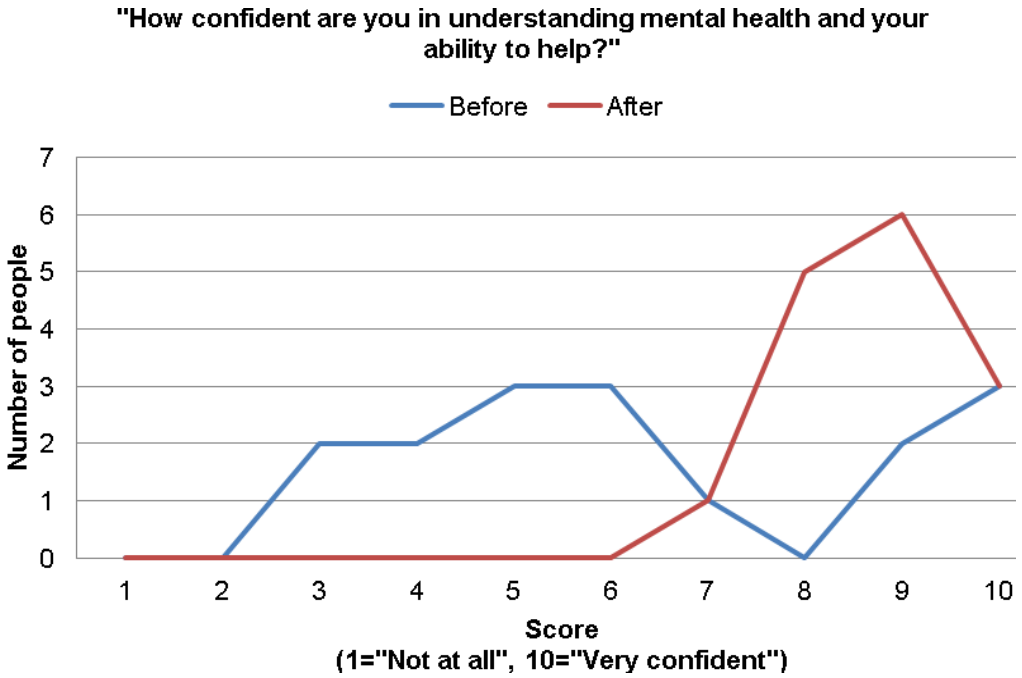
Eighteen people initially signed up to the course. Over the course of the ten weeks, three people left the course due to bereavement or sickness. Cohort four therefore comprised of fifteen participants who completed the course fully.

### GENERAL COURSE EVALUATION

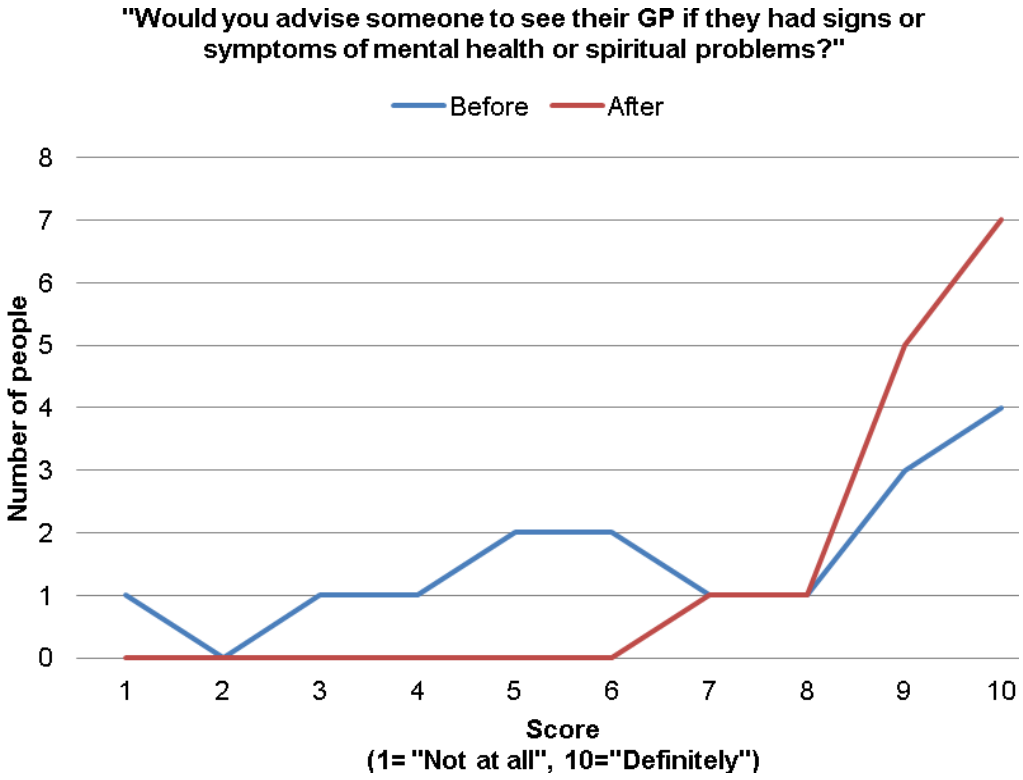
All participants rated the overall course as “excellent” or “good”. Other scores were similarly high, with the majority of or all participants giving “good” or “excellent” ratings for the venue (92%), content (100%), trainer’s knowledge (100%) and training delivery (100%).




Before and after the course, participants were asked how confident they were in their understanding of mental health and their ability to help. Before the course, participants' confidence scores ranged from 2 to 10 with an average of 6.15 (standard deviation=2.54). At the end of the course, many more participants felt confident, with scores ranging from 6 to 10 and an average of 8.73 (standard deviation=0.88).




Participants were also asked whether they would advise someone to see their GP if they had signs or symptoms of mental health or spiritual problems. At the start of the course participants scored a range of 1 to 10, with the average score being 7 (standard deviation=2.97). At the end of the course this increased to a range of 6 to 10 and an average score of 8.87 (standard deviation=1.85).




## SOCIAL DISTANCE SCALE

The Social Distance Scale[i] contains items that measure participants' willingness to have close associations with people that have mental health conditions. The scale was administered at the beginning and end of the course. Scores are rated from 0 (definitely unwilling) to 3 (definitely willing), with a minimum score of 0 and a maximum score of 21.

The table below shows the average score for each item in the scale before and after testing. Shifts in attitudes were measured by calculating the difference in scores before and after the course. The results from Cohort 4 indicated a positive change in attitudes for every item in the scale. This indicated that participants were more willing to have closer associations with people with mental health conditions at the end of the course.

**Modified Social Distance Scale Items**

| ***How would you feel about…*** | **Before** | **After** | **Difference** |
|---|---|---|---|

| *(3=definitely willing, 0=definitely unwilling)* | Course (Mean) | Course (Mean) | In scores (Mean) |
|---|---|---|---|
| **Renting a room in your home to a person with severe mental illness?** | 1.44 | 1.93 | **+0.49** |
| **Working in the same job as a person with severe mental illness?** | 2.06 | 2.60 | **+0.54** |
| **Having a person with severe mental illness as a neighbour?** | 1.94 | 2.60 | **+0.66** |
| **Having a person with severe mental illness as a carer of your children for a couple of hours?** | 0.78 | 1.60 | **+0.82** |
| **Your children marrying a person with a severe mental illness?** | 1.00 | 1.53 | **+0.53** |
| **Introducing a person with severe mental illness to a close friend of yours?** | 2.28 | 2.67 | **+0.39** |
| **Recommending a person with severe mental illness to work for your friend?** | 1.94 | 2.33 | **+0.39** |
| ***Mean Social Distance Score*** | **1.64** | **2.18** | **+0.54** |
| ***Total Social Distance Score*** | **11.93** | **15.27** | **+3.34** |

## VIEWS ON MENTAL ILLNESS SCALE

Participants were also administered the Views on Mental Illness Scale, which comprised of fifteen items taken from the Opinions About Mental Illness Scale[ii] and the Community Attitudes Toward the Mentally Ill Scale[iii]. Responses were rated from 1 (strongly agree) to 5 (strongly disagree) and some of the items were reversed, so there was no general direction for positive or negative responses.

As such, shifts in attitude were evaluated separately for each item in the scale. A positive shift in attitude was observed for thirteen of the items, indicating that the program was largely successful in improving participants' attitudes towards people with mental health conditions.

| *In general I believe...*<br><br>*(1=strongly agree, 5=strongly disagree)*<br><br>**=reversed item* | **Before Course**<br><br>**(Mean)** | **After Course**<br><br>**(Mean)** | **Difference in Scores**<br><br>**(Mean)** |
|---|---|---|---|
| People with mental health problems are able to work | 2.17 | 1.53 | **+0.64** |
| ***Psychiatric hospitals are the most appropriate settings to treat people with mental health problems** | 3.50 | 3.67 | **+0.17** |
| ***Mental health services should be kept out of residential neighbourhoods** | 3.89 | 3.27 | **-0.62** |
| People with mental health problems are far less of a danger than most people believe | 2.76 | 2.00 | **+0.76** |
| ***People with mental health problems should be forced to take medication** | 3.63 | 4.07 | **+0.44** |
| People with mental health problems are as unpredictable as the general population | 2.72 | 2.60 | **+0.12** |
| ***People with mental health problems are a burden to society** | 4.00 | 4.27 | **+0.27** |
| ***People with mental health problems are difficult to talk to** | 3.89 | 3.67 | **-0.22** |
| ***Mental health problems can never be cured** | 4.12 | 4.27 | **+0.15** |
| ***People with mental health problems are difficult to deal with** | 3.39 | 3.73 | **+0.34** |
| Most people with mental health problems can, with treatment, get well and return to lead normal lives | 2.00 | 1.50 | **+0.50** |
| ***People with mental health problems should not be given any responsibility** | 4.11 | 4.27 | **+0.16** |
| We all have mental health needs | 1.83 | 1.47 | **+0.36** |
| ***People with mental health problems are likely to** | 3.17 | 3.60 | **+0.43** |

**become violent**

## IMPACT ON UNDERSTANDING OF MENTAL HEALTH

At the end of the programme, participants were asked how the course impacted on their understanding of mental health. This was asked in terms of how participants now **think**, **feel** and **behave**.

### Thinking

Several participants stated that they felt they had *"gained a deeper understanding of mental health and wellbeing"*. This included increased knowledge, a positive shift in attitude and increased confidence, e.g.:

- *"I am more **knowledgeable** and **confident** to discuss the topic in a **non-judgmental** way, more aware of stigma and high prevalence"*
- *"I have gained a much greater **understanding** and different aspect on what mental illness is"*
- *"This course has made me more open and a lot **less fearful"***
- *"The course has immensely **broadened my concept** and understanding of mental well being and the professional response to providing help and assistance to the patient"*
- *"I have become **more open minded**, more **confident** to speak to individuals with mental health problems"*
- *"I am more **open to listen** and help others and it has helped me to be **less judgmental** in certain areas"*
- ***"**More **positive attitudes** towards mental health, increase curiosity in gaining further understanding"*

### Feeling

When asked how their feelings had changed, participants indicated that there had been a change of feelings both externally, towards people with mental health conditions and internally, concerning how they feel about themselves.
Some participants stated that they felt more positive and confident with regards to mental health conditions as well as feeling less fearful, e.g.:

- *"I feel more **positive**, assertive and more useful to be of some kind of positive confident supporter"*
- ***"Less fearful**, and now have opened me up to be able to speak"*

- ***"Confident** and proud to be part of this course"*

Several participants reported feeling more compassionate towards those with mental health conditions:

- *"The course makes me **feel more for people** with mental health problems and feeling more to contribute to their well being"*
- *"I feel that everyone should find the time to listen and care for each other and **show respect** regardless"*
- *"I feel more able in my working life/personal life to **empathy** more and feel more for others"*
- *"More **compassionate** and **sympathetic** towards the plight of people coping with mental illness"*

Some participants also reported an interest in furthering their support towards people with mental health conditions, e.g.:

- *"I feel very **optimistic** about furthering my involvement in this area"*
- *"I feel quite confident about setting up a **mental health team** in my church"*
- *"I feel I would be able to respond more appropriately to someone in my community/church with mental health issues and I could competently **refer them on"***

**Behaviour**

Many participants stated that their perceptions had improved and that they would behave in a more accommodating way towards people with mental health conditions, e.g.:

- *"The course has caused me to be more **accepting** and **open** towards mental illness"*
- *"I am now able to behave in a way, concerning mental health with a **positive outlook** to **change people's perception** towards mental health issues"*
- *"My mind has altered to **accept** what is placed before me and to deal with it with an **open mind"***
- *"I feel my behaviour towards this subject has shifted and I am more **sensitive and conscious** to some basic needs"*

This included behaving in a more compassionate and respectful way:

- *"My behaviour towards mental health patients are more of **wanting to help** and to know more about the course of their situations"*

- *"I **will behave good** towards people suffering from mental health illness. I will **find the time to listen, care and show respect** to people with mental illness"*
- *"More **respectably** in a way that helps the person realise they are loved and not alone"*

Several participants also stated that their communication skills had improved since taking part in the course:

- *"I have found myself more **careful of how I speak** to others and aware of my body language"*
- *"I will be open, and know that how I react, and that my **body language** is important"*
- *"It has improved my **listening skills**, **empathy** and be **non judgemental** now"*
- *"I am more **aware** of my behaviour when dealing with others, even close friends & family"*

Some participants felt confident in furthering mental health support within their organisations:

- *"Bold and **empowered** enough to give presentation to whole church and research into what provisions/procedures exist at my church"*
- *"I have told my church I am **willing to speak with individuals"***

**Course Content**

Participants were asked to name the three most important learning experiences for them and comment on the reasons why.

The majority of participants (73%) mentioned "**Communication**" as an important topic for them. This included general skills and techniques as well as learning the **SAGE & THYME** method, a strategy that enables people to have conversations that identify "the need" of the person with mental health conditions, especially when time is limited.

47% of participants stated that **Dr Pereira's presentation ("Understanding Illnesses of the Mind")** on chimp and human brains helped them to better understand the brain and its role in influencing emotions.

Several participants stated that having a better **general understanding** of mental health issues was very important for them, including facts about the **prevalence** of mental health conditions, applications and sections of the **Mental Health Act** and the **stigma** faced by people with mental health conditions.

Related to this, many people found it useful to know about the **resources** available to support people with mental health issues. This included signposting to **services** such as those in SLaM, GPs and IAPT.

Some found it helpful to understand **ethnic and cultural factors** that may be related to the prevalence of particular mental health conditions, access to services and how quickly someone seeks support for mental health related issues.

Similarly, a presentation on **spirituality** helped many participants to better understand the **role of faith groups** in supporting people with mental health conditions. They found the discussion of the relationship between **spirituality and mental health** helpful. Furthermore, they found it useful to understand the need to be clear about the **differences between religion and spirituality** and how to be supportive to people whilst keeping these factors into consideration. For example, it was important to consider spiritual thoughts and practice as a separate thing to religious practice and understanding. Overall, it enabled faith leaders to understand what kind of help they could offer in the context of their spirituality as well as encouraging them to be open-minded about people engaging in spiritual practices that were outside of their religion.

Finally, being clear about fundamental issues such as **roles, boundaries, confidentiality and safety** helped participants to understand how they might best support others. Participants liked discussing their role in **different settings**, such as at a church and in an inpatient setting. They also found it useful to consider how they might obtain supervision and guidance for themselves when working in this supportive role.

## CHALLENGES

Participants were asked what they found the most challenging during the course.

Some participants found it difficult to consider mental health in a holistic and systemic way. For example, many found it challenging to consider the spiritual aspect of mental health and the factors related to it. Others found it difficult to integrate their understanding of western cultures with their own value system. Furthermore, because the course was open to a range of people, some participants found it difficult to accept or understand the faith-related practices of other participants.

Some participants also mentioned the challenge of changing their mind set to integrate their new knowledge of mental health conditions, procedures and legislation. One participant stated that having greater awareness of mental health issues challenged them to become more involved in their local church. Another stated that the most challenging thing for them was to self-reflect and question themselves.

Finally, one participant said that having to give a presentation and discuss vignettes was the most challenging thing for them, as they had to apply the skills and knowledge they gained to real life settings.

## FUTURE COURSES

100% of participants felt that course met its aims and objectives. When asked if there was anything they would like to change, seven participants (47%) said they would like the course to be longer or to have a second part so they could discuss the topics further. Other participants stated that they would not change anything or that they would have liked to have studied the topics in more depth.

[i] Link, B.G., Cullen, F.T., Frank, J. & Wozniak, J.F. (1987). The Social Rejection of Former Mental Patients: Understanding Why Labels Matter. *American Journal of Sociology,* 92, 1461-1500.
[ii] Cohen, J. & Struening, E.L. (1962). Opinions about mental illness in the personnel of two large mental hospitals. *The Journal of Abnormal and Social Psychology, 64,* 349-360.
[iii] Taylor, S.M., Dear, M.J. & Hall, G.B. (1979) Attitudes toward the mentally ill and reactions to mental health facilities. *Social Science & Medicine*. *Part D: Medical Geography*, *13*, 281-290.