A mixed-methods evaluation of 'The Quest', a health and well-being intervention for British-based Black, Asian and Minority Ethnic gay and bisexual men

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Abstract

This article provides an evaluation of a health and well-being workshop based intervention, 'The Quest' for gay and bisexual men from British Black Asian and Minority Ethnic (BAME) communities. A quantitative component assessed reported and intended sexual risk, drugs and alcohol use alongside measures of psychological well-being with pre and post programme data collected from 26 men. Fourteen men participated in focus groups which discussed experiences of the intervention. Significant improvements were found on measures of internalised homophobia, self-esteem and self-efficacy but not for health behaviours including safer sex or substance use. Qualitative feedback was generally positive especially around enhanced psychological well-being, identity integration, and enhanced self-awareness. There were some concerns over group size and whether non-BAME gay men were appropriate as facilitators. Theoretically-informed, culturally competent interventions can demonstrate significant potential in enhancing the well-being of BAME gay and bisexual men but follow-up data are needed to show longer-term benefits.

Key Words
Black, Asian and Minority Ethnic men; Gay and bisexual men; Mental health intervention; Project evaluation; Public health, England, psychological well-being

Introduction

Gay and bisexual men from British Black, Asian and Minority Ethnic (BAME) communities face significant inequalities in relation to health and wellbeing including higher levels of HIV infection and other sexually transmitted infections, psychological distress, experience of discrimination and abuse, and problematic drugs and alcohol use (including Chemsex) than white gay and bisexual men (Bourne & Weatherburn. 2017; Jaspal *et al.*, 2018). Moreover, there is evidence that BAME gay and bisexual men often face higher levels of discrimination on the basis of their sexual, ethnic and religious identities, which can result in 'hyper-threats' to identity and, thus, poor mental health (e.g. Hickson *et al.*, 2017; Jaspal *et al.*, 2019). These cognitions and associated behaviours can increase the risk of both poor psychological well-being and sexual health. Despite the clear inequalities faced by BAME gay and bisexual men, there are limited behavioural and structural interventions for supporting and enhancing the health and well-being of men in these particular populations.

Various theoretical frameworks have been applied to understanding these difficulties including syndemics (Singer 2009), identity process theory (Jaspal, 2018) and intersectional adaptations of the minority stress model (Bostwick *et al.*, 2014; Rehman *et al.*, 2020). In a

context of structural inequalities in relation to poverty, heterosexism and widespread racism, it appears that many BAME gay and bisexual men experience high levels of shame, stigma and internalised homophobia and many find it challenging to integrate different components of their identity to form a positive, coherent sense of self (Jaspal & Williamson, 2017). Salutogenic resources (individual and community-based assets which are health-enhancing) appear to be less accessible for many BAME gay and bisexual men. Whilst community organisations providing support for the specific needs of BAME gay and bisexual men exist in the United Kingdom, they are typically funded by small organisations who have been subject to politico-economic policies around austerity measures which have significantly reduced service provision (Dalton, 2018). More recently rises in reported homophobic hate crimes and the COVID-19 pandemic has further challenged the well-being of gay and bisexual men leading to increases in psychological distress and social isolation (Donovan & Durey, 2018; Konnoth, 2020; Gonzales *et al.* 2020).

In addition, our understanding of what constitute effective interventions for gay and bisexual men from these communities remains, especially in a European context, very limited (Fish, Papaloukas, Jaspal & Williamson, 2016). Whilst strengthening salutogenic resources at individual and organisational levels has been indicated (Fish *et al.,* 2020; McDaid *et al.*,2020) few robust evaluations of interventions have been published and those that have tend to lack an adequate theoretical framework and/or rigorous research design (Maulsby *et al.* 2013). Whilst there is beginning to be a move towards a more integrated evidence base in this area, generally, there appears to be something of a schism between theorising and both policy and practice.

In recognition of the considerable systemic and psychosocial challenges facing BAME gay and bisexual men and the deficiencies within the extant research, in 2015, following consultation with numerous stakeholders, and as part of a wider LGBTQ workstream that highlighted the potentially syndemic and integrated nature of HIV and sexual health, substance use challenges and mental health difficulties, Public Health England commissioned an evaluation of several health and well-being interventions for BAME gay and bisexual men in the UK. This was funded by the MAC AIDS Foundation. These included a range of on-line, individual and group interventions aiming to support various aspects of health and well-being. The brief for the interventions was broad with stated goals "to promote positive changes on the following dimensions: sexual identity, sexual risk behaviour, mental health, wellbeing, smoking status, alcohol use, recreational drug use, employment, social isolation and use of public services." (Jaspal *et al.*, 2016 p.12). Interventions were delivered and evaluated across 2015 and 2016 and an overview of the overall scheme was published and initially disseminated at a large multi-agency conference in London in 2016. However, the scope and format of the report did not allow for the detailed description, discussion or dissemination of either qualitative or quantitative findings from any of the individual interventions. Therefore, in the present paper we describe and evaluate the approach adopted by one of the service providers, 'The Quest' whose previously established integrated workshop programme '*The Quest Awaits You'* for gay and bisexual men was amended and tailored specifically for BAME men.

Our evaluation considers three questions:

1. To what extent does participation in The Quest intervention lead to increased indicators of self-reported health and well-being?
2. How does The Quest aim to enhance participants' well-being, and how effective does this appear to be?
3. What were the views of participants about the intervention?

Method

The Quest

The Quest programme was developed in 2011 by Ade Adeniji and Darren Brady who describe it as a *'groupwork intervention*' which is '*life changing and enables significant behavioural change'* (www.thequestawaitsyou.com 2022). The underlying approach is informed by various theories from both psycho-education and coaching psychology; most predominantly, Brown's (2007) shame-resilience model.

Brown describes shame as "an intensely painful feeling or experience of believing we are flawed and therefore unworthy of acceptance and belonging" (2007, p. 44). Core to this sense of shame is a '*shame web*' which consists of feeling trapped, powerless and isolated. Associated interventions therefore focus on understanding and *speaking shame* whilst *building shame resilience* and *assembling connected communities* of empathy and support (Brown, 2007).

Participation in 'The Quest programme' includes induction, an intensive weekend workshop over two and half days, and a follow-up 'integration half-day' typically three weeks later. Participation in the programme is therefore over a month-long period although through the regular use of email, social media and community meetings (in person or on-line) participants are encouraged to remain connected to 'The Quest community' indefinitely.

In keeping with a cognitive-behavioural approach, participants are expected to engage in a daily series of structured 'homework' exercises in preparation for joining the programme, and between the workshop and integration events. The Quest programme utilises various metaphor-based narrative tasks which aim to help identify and foster individual strengths and recognise and build social capital. As well as aiming to foster peer support at group level (referred to as '*building your tribe'*) throughout the intervention, all participants are paired and asked to act as each other's '*champion*'.

In the intervention the central concept is of a '*voyage*' through the lifespan with various group activities set to '*investigate'* the past, '*explore'* and *'release'* elements of the present and '*cultivate'* both individual efficacy and social support for the future. Four key sets of cognitions are explored specifically through the intervention – *'oddly out of place'* (which considers being gay in a heterosexist society with few positive role-models), '*developing limiting beliefs'* (which explores automatic negative thoughts around low self-worth), '*survival strategies'* (which aims to identify and challenge maladaptive roles commonly undertaken in social interaction) and '*the past in our present'* (which aims to analyse past traumatic experiences such as rejection and discrimination, and to consider how these experiences may be linked to current health-impairing behaviours). It is worth noting however, whilst discussions around public health priorities such as risky sex, low affect and drugs and alcohol use typically arise in some exercises, there is no explicit focus on these within the intervention. Neither is there any specific psycho-educational focus. Rather, the programme adopts a whole-person approach to the fostering of better health and well-being and self-knowledge/acceptance. A more detailed account of the philosophy and processes of the programme is available at the website (www.thequestawaitsyou.com).

Participants

Four workshops took place across a six month period in 2015 with three being held in London and one in Manchester. The sessions were facilitated by the two co-leaders of The Quest (one from a Black African background and one white) who were supported by a group of volunteers, all of whom were from BAME communities and who had completed the programme previously. Unlike some interventions which incorporate inclusion of non-gay or bisexual identified men who have sex with men, The Quest programme is specifically targeted at men identifying as gay, bisexual or queer.

Men paid a commitment fee of £20 (unwaged) or £40 (waged) which was reimbursed on completion. The age range was 19 to 50 years. Self-reported income and levels of education were diverse. Participants were from a wide range of ethnocultural and religious backgrounds and the sample included both HIV+ and HIV- men.

Fifty-five men signed up for a workshop with 46 men completing the workshop phase (16% attrition rate) and 33 completing the follow-up integration session (40% attrition rate). Twenty-six completed measures pre and post intervention and their demographic details are included in table one below:

Table 1: Sample Details (Quantitative Component)

Participant Factors	**N**
Sexual Orientation	Gay 26
Gender Identity	Cisgender 26
HIV-Status	HIV- 19 HIV+ 5 HIV status unknown 2
Relationship Status	Single 21 In a long-term monogamous relationship 3 In a long-term non-monogamous relationship 2
Ethnicity	Black Caribbean 9 Indian 6 Pakistani 3 African 3 Chinese 2 Middle East/Arab 1 Mixed Race 1
Religion	No Religion 14 Christian 8 Muslim 2 Sikh 2
Employment Status	Employed 15 Self-employed 7 Unemployed 2 Full-time student 2
Highest Level of Education	Undergraduate Degree 14 Postgraduate Degree 11 High School Vocational Certificate 1
Utilising Mental Health Support Services at the Time of the Study	No 21 Yes 5

Evaluation Design

The evaluation consisted of a mixed-methods design incorporating the collection of both quantitative data (pre and post intervention) and qualitative data (post-intervention only). These are described below. All components of the evaluation were approved by the Faculty committee at the University where the lead author is based.

Quantitative Measures

An on-line questionnaire was compiled comprising of pre-validated measures relating to identity, community and service participation, psychological well-being and health including a range of recent and/or intended health risk behaviours such as unsafe sexual behaviours, use of alcohol and other substances and participation in 'Chemsex'. Established measures were selected because they reported good psychometric properties. Shorter versions of scales were used wherever possible to avoid participant fatigue. Measures included internalised homophobia scale (Herek & Glunt, 1995), sexual risk behaviour scale (De Hart & Birkimer, 1997), World Health Organisation WHO-5 Well-Being index (Topp *et al.*, 2015), the social inclusion scale from The European Quality of Life Study (Layte *et al.*,2010) and attitudes towards alcohol (Francalanci *et al.*, 2011). This scale was adapted to include items about other substances. Of the instruments used, Herek and Glunt's (1995) internalised homophobia scale had been robustly tested for validity with gay and bisexual men although some gay male participants were included in the development and initial validation of the sexual risk behaviour scale (De Hart & Birkimer, 1997).

Qualitative Component

Two focus groups, each lasting for around 90 minutes, took place in community spaces in London at the end of the intervention (i.e. after follow-up integration sessions had been completed). All participants had completed all elements of the intervention. Focus groups included men from all four intervention cohorts who were mixed together. This therefore meant that some men were three weeks from attending the workshop whilst others were as much as four months' later. Thirteen had attended London workshops and one had attended the Manchester workshop. All men identified as cisgender, gay men. Seven were from Black Caribbean ethnocultural heritage, three were Indian, two Pakistani and one was Black African. Nine were HIV-negative, four were HIV-positive and one had never taken a HIV-test so was unable to report his status. Four of these men were utilising other mental health support services at the time of the focus group.

A topic guide used flexibly explored both participants' views of the workshop and facilitated discussions around some of the challenges to health and well-being that they experienced as BAME gay men. Thus, it included questions around the ways in which the intervention had included the discussion around public health topics such as substance use, sexual and psychological health and psychosocial elements such as identity and interpersonal relationships. Participants were also asked about their views on The Quest, whether, how and why they felt it had been a beneficial experience, why they had chosen to take part in the programme, and whether they would recommend participation to others. They were also asked their views on the focus, nature and duration of the intervention. They were also asked their views about running groups specifically for men from a mixed Black, Asian and Minority Ethnic background.

Findings

In this section we consider quantitative and qualitative data in relation to the research questions. First, using inferential statistics we outline significant pre- and post-intervention differences on key variables of interest. Second, we provide a critical thematic commentary on the views and experiences of the participants about the workshops themselves, and using extracts from focus group transcripts provide a flavour of how they reported interacting with the intervention.

Evaluation of the Intervention using Quantitative Analyses:

Data were analysed using a series of related *t*-tests. Men completed the scales at two time points – during the induction period, when they had signed up for the programme and paid the commitment fee but before they began the weekend workshop, and shortly after the integration

session. One additional reminder was sent 14 days after the integration session. Because of restrictions in the timing and funding of the evaluation it was unfortunately not possible to collect follow-up data. As noted previously twenty-six men completed scales in full at both time points (*see table one)*. This represents 79% of participants who attended all aspects of the intervention including the integration event. Incomplete data sets (N=10) have been excluded. Findings with a significance level equal to or below 0.05 are reported. Effects sizes have been calculated using Cohen's *d.*

Statistically significant improvements with evidence of a small effect were shown on measures of self-esteem (t = 2.30, p=0.02, d=0.37), self-efficacy (t = 2.73, p=0.01, d=0.44), internalised homophobia (t = 1.75, p=0.05, d=0.36) and psychological well-being (t = 1.95, p=0.03, d=0.44) before and after the intervention. One significant result related specifically to health risk behaviours: A reduction in the intention to engage in 'Chemsex' (t = 2.23, p=0.03, d=0.27). All other analyses were non-significant.

Qualitative Commentary

Data were collected in two focus groups (each with 7 participants) and analysed with thematic analysis (Braun & Clarke, 2014). These data were collected and analysed by the first and second authors. In providing a reflective qualitative commentary we have focussed on both the psychosocial challenges that men had discussed in their sessions and their reflections on the processes addressed in the intervention as well as participants' views. Essentially here we try to elicit <u>how</u> men engaged with the intervention as well as having a sense of <u>how successful</u> they felt it had been. The commentary is divided into four broad themes; *perceived improvements to psychological well-being; recognising and resetting rituals? the benefits of an all-BAME group environment* and *reservations and recommendations.*

Perceived improvement to psychological well-being

Participants who attended the focus group discussions were generally positive about their experiences on the programme. In keeping with the significant changes noted in the quantitative analysis, most participants reported greater self-esteem and feeling more 'authentic'.

Two psychological processes appeared to be pivotal for overcoming a sense of shame and understanding how that was nuanced in different cultural contexts and recognising and addressing the ways in which participants compartmentalised aspects of identity.

The Quest, partly because of its connection to Brown's shame-resilience theory, positions *speaking* and *overcoming* shame as integral to the programme's aims and processes of the programme. Research into shame and associated constructs like self-stigma (Feinstein *et al.*, 2012) and internalised homophobia (Allen & Olsen, 1999; Williamson, 2000) has been prevalent in LGBTQ research for many years. A profound sense of shame especially when engaging in sexual acts or thinking about them was articulated by many men. Yusuf, one of the Muslim participants, described having to wash his bedsheets immediately after any sexual session:

It's so sinful I had to get rid of the sin. I have to get up and wash and clean then I'll be like okay I'm clean again (Yusuf)

Tariq described an experience he had shared in the workshop about how powerfully he has internalised a sense of shame for gay sexual desire because of his Muslim faith. For some Muslims gay sexual acts are associated with cosmic ramifications through which Allah shows

his displeasure and sinners are denied access to Jannah (the term for Paradise most commonly used in the Qur'an).

I had once someone telling me trying to get a vision of Islam to me. Around the Earth there are seven skies. And when a gay person commits a sexual act with another gay man, or when a gay sexual act occurs on Earth –and I was a kid when someone said this to me- even the seventh sky, the furthest sky from Earth of the seven skies shudders because it's such an abomination. Less skies to it when you get murder. But the furthest sky, because it's such a, such an earthquake, Earth shuddering, sort of catastrophe you have committed that it, the resonation of it is so far out that rape is less, and murder is less, child beaten is less… But, I mean. I don't even think I was a teenager and I can still recite word for word in Punjabi what the person said… I've soaked this up like. Fuck, this is what I'm going to be doing (Tariq)

Michael, who is HIV+ ,recognised how much he had internalised HIV-related stigma and because of his 'spoiled identity' and impaired seropositive sexual self-esteem (Rohleder *et al.*,2017) felt he should only seek relationships with other seropositive men:

The Quest… it has given me a bit more, it boosted my self-esteem… It did help me in my own view that because I have HIV it doesn't mean I am less of a person. Or I am not worthy of having a relationship with somebody who is, and I don't have to exclusively go for men who are HIV positive as well. So that's what it did for me. It also helped a lot with the shame and the stigma that I had myself and the blame I was putting on myself.

Accounts of risky sex included shame as both a predictor and a sequela of high-risk episodes. A number of our participants reported engaging in unprotected sessions of Chemsex – typically at least partially motivated by negative feelings about their sexuality but leading to post-session feelings of shame and for HIV- participants concerns about having been exposed to HIV:

I hit rock bottom even more last week and then when I went out and met a group of strangers five guys, and got crazy and got high in chems and a few hours of a long session but then the after effects and consequences were terrible for me. That was quite difficult. The shame. (Marc)

Researchers, such as Pollard *et al.* (2018) and Melendez-Torres and Bonnell (2017) describe Chemsex as often taking place in what they label 'littoral spaces' – escapist contexts where normal social rules and restrictions do not apply but where sex is performed in tribal and ritualistic ways. For significant numbers of our participants it appears that taking part in Chemsex sessions was motivated more by a wish to escape from negative thoughts and emotions than by the recreational pleasures of drug-enhanced sexual enjoyment (McCall *et al.*, 2015) which has been reported previously amongst men have experienced various forms of prejudice and abuse (Jaspal *et al.*, 2017).

Part of the therapeutic work of the intervention encouraged participants to work towards attaining a more coherent identity and to address the fragmentation they often reported experiencing with their families (who often did not know about their sexuality or who lacked acceptance or empathy) and on the gay scene. The terms most typically used were 'compartmentalisation' and 'splitting'. Conceptually this idea continues to attract a good deal of attention within the social sciences. For example, identity process theory posits that an adaptive identity blends a sense of distinctiveness with a coherence between differing identity elements and a narrative of self that is able to weave these together reasonably effectively (Jaspal, 2019).

For the men who participated in The Quest, perceived resolution of these challenges was important but most seemed at an early stage. However, many of the participants had reached a point of recognising that a more integrated and '*authentic*' identity was something they felt they wished to achieve and which they recognised had potential to enhance their well-being:

I still find it quite difficult to say I'm a gay Muslim in the same context in the same sentence. Now I want to get back to that because there is more in life than just been gay or just being Muslim. We've talked about boxing yourself and sacrificing yourself. And this to me was I'm not seven different people. How do I integrate all this to the same person? *It's just really nice to actually be able to talk and get stuff out and share, and talk to other people about it, rather than having it all in my head* (Yusuf)

Participation in 'The Quest' appeared to provide a safe and challenging space to interrogate these elements and to act as a catalyst to further reflection going forward:

It was about all the little bits of me and I wasn't compartmentalised. In fact, I've been encouraged not to put these little bits and edit. This Black person here, this gay person over there, this pseudo-whatever (Raymond)

Recognising and re-setting rituals?

Although the quantitative data suggested few immediate changes to health risk behavioural intentions, many participants reported becoming more 'mindful' about their behaviour especially around casual sexual interactions or drug use and how these were frequently used to '*soothe*' or '*masque*' difficulties. These behaviours generally related directly to some of the psychological issues of self-stigma or low self-worth discussed above

Roderick: *We talked about this, this numbing. It wasn't just focused on sex because people use different experiences to numb. I mean I use work to numb. We all use different, kind of things. The workshop wasn't about sex or drugs. It was about your relationship to those things and how you use those things in your life to give you an illusion of comfort*

Fazal: *Breaking it down deeper, we talked about vulnerability, about validation and what tools you use to validate yourself…When you don't get the true authentic validation I seek. it is so rare. In the meantime, I'd be like you know what I turn on porn or I turn on Grindr and someone say 'hey you, do you want a spunk release or something?' That will last an hour and then I'll be, now what? So… the whole numbing of not feeling enough or worthy, what do you use to suppress that, what do you use to… how do you validate yourself*?

Although stated behavioural change intentions were modest, most participants said that completing the programme was the start of planning for more significant changes in both their physical and psychological health. Many were aware that initially some projected goals such as better nutrition and time-management would be more easily attainable than deeper psychological changes:

Looking after myself, kind of self-worth. It's almost as if. If I had, if I had an image it's like this kid with broken toys, a kid with broken toys and start fixing them. You know? So, I can say yes to the option I want, to say no to the option I want, say yes to managing my time better and

eating better. I realised some of the dysfunctional stuff I do because of the past. I think for me this workshop has been kind of, kind of resetting things. I don't know how yet (Garry)

The benefits of an all-BAME group environment

One key aim of the programme was providing a safe environment for BAME gay men in which it was perceived as easier to connect especially when discussing the role of faith and culture in their identities. In the following extract, three men shared their views on reconnecting with a 'Black community', empathy and the dynamics of positioning in wider gay circles as a BAME individual

Desmond: *I now have an understanding because of the Quest and how to love my own community. The other thing I want to say, is there was also this thing about me being disconnected from my own community… I need more Black people in my life… I think I thrive better with my own kind…*

Aaqil: *What I found useful about having it BAME focused was… around not having to explain my background and my culture. I just got a sense of people understood and the pressures that faith brings, the pressures that one's own community brings. Being brought up in a Pakistani Muslim household. From a cultural perspective I found that the Black guys, the BAME guys in the group, just understood I didn't have to sit and explain. Being in the safe BAME environment, feeling safe really helped me*

Sebastian: *For me on the first night there was this sense of a level playing field, about walking into the room and not being the only Black person in the room. And then trying to navigate where you fit in with that and that whole white privilege and thinking, trying to find your space before you feel safe to own your own space and navigate all that. And I just felt I didn't need to do that.*

Few participants reported prior experiences of cultural diversity being accepted in what Samuel described as the *'white-esque world' of the gay scene*'. Fazal describes how he found interactions frustrating with white gay men because they commonly made '*automatic assumptions*' of his Islamic family and community:

Just because I'm a Muslim… (.) doesn't mean I have some kind of awful, Islamic oriented life. I mean my parents didn't fucking kill me because I was gay. I'm alive! … We are probably a fairly normal Pakistani family but in a white gay world you are always explaining. You are trying to justify. You are correcting.

An additional challenge reported by a number of men from African or African-Caribbean backgrounds was stereotypical sexualisation by white gay men. Terrence discussed experiences of going to gay bars in London in order to socialise and make new friends and being routinely fetishized by white men:

I'm… this chocolate fantasy. I have mistakenly taken that sometimes for people being interested in me for the person that I am rather than this new Black face in town that probably has this humongous thing between his legs, that's going to make them see all sorts of stars. That I do have a problem with and there is no denying that happens quite a bit. It's not about what role you play, what size your equipment is … I find it quite offensive at times, soul destroying. As

soon as people find out oh I am Black they are only interested in your package or the fantasy thing.

In a study with South Asian gay men from Sikh and Muslim backgrounds Jaspal (2017) found widespread experiences of widespread racism experienced in gay bars and clubs, on on-line gay communities, and dating apps. Participants in his study talked about how many white gay men had expectations of them as inevitably closeted, and psychologically distressed, similarly to those voiced by our participants. Jaspal (2017) explains the insidious nature of prejudice through three key mechanisms – the salience of intersections between ethnic and sexual identities, the hyper-sexualisation of gay spaces where direct comments about preferred sexual activities and 'types' are normalised and a lack of 'political correctness' that might otherwise inhibit offensive and hurtful talk.

However, in a support-session group made up wholly of BAME men most participants felt that they quickly were able to build trust in the group and to disclose about their difficulties:

I felt kind of connected really quickly to other members of the group and I did feel safe very, very quickly to share quite personal, intimate and seeing other people struggle, other people's journeys were quite powerful and made me to want to continue (Roderick)

You make this connection with 10-12 other guys and it was like. I feel crap but you know what I'll still check in because I promised to do it it's hard, it's hard saying that you feel crap but at least I was saying it to people who have been in the same room as me and they were like 'You know what? We get it'…Having that safe space to, to be that vulnerable was great but also to share the experiences was like, you know what you guys get it and I feel comfortable telling you ˚I feel crap˚ (Fazal)

Several participants were positive that these skills alongside a heightened sense of self-esteem would help them develop additional peer support post-programme:

I'm looking forward to building my tribe and, I've done that now and it's quite shocking to realise that I don't think I've been one hundred percent authentic. So few places where that actually happens for me. I think there is only one person I can be authentic with, completely, up until this point. And actually it's quite refreshing to know that I can make that connection with other people. I'm not dull and boring, not, not enough of anything (Roderick)

Participants' accounts provided numerous examples of finding the programme salutogenic with improved self-compassion, self-esteem and resilience, and potentially an expanded circle of social support. The intervention therefore appears to fulfil Brown's (2007) goal of facilitating shame reduction through empathetic inter-connectivity.

Reservations and recommendations:

In this final section we also consider two of the reservations voiced about the programme. Some participants disliked being limited to short time limits in group sharing sessions and a number or the participants felt that the size of their group was too large for the activities involved:

Charles: *It's not a case of I wouldn't recommend it it's just that I don't think one size fits all and any group that is over the size of seven is too big. Some people in smaller*

groups are more effective. So I would have to take into consideration the individuals' needs before I say 'you should go and do that'

Asif: *if it was 7 or smaller groups then I feel the time would be more, it would be more quality time in the room to get things out. I listened to some people's stories that I would have liked to have heard more but then the bell went and we missed it.*

There were also mixed views on whether it was appropriate for a white man to co-facilitate the programme with some participants feeling that only BAME facilitators could really understand the dynamics of the intersection of race and sexuality. For one participant this aspect potentially undermined the positive aspects of cultural connection and empathy mentioned previously.

On the tin it said it was for Black men only. It was an issue for me…we do need someone who is from the minority so hopefully they would be experienced to understand this thing we have. Because we are in a different place, the way I can explain it is that we are in a different place in this society (Henry)

Considerable academic work has looked at the roles of congruence between therapist/facilitator and client in therapeutic settings relating to race and ethnicity (Cabral & Smith, 2011) and sexuality (Lavounis & Anson, 2012) independently but rarely together. Whilst cultural competency is seen as key to effective interventions (Fish *et al.*, 2015), it is debated as to the extent this depends on the demographic characteristics of the practitioner or his/her therapeutic skills and knowledge (Chu *et al.*, 2016). Although there is evidence that senior LGBTQ facilitators who are role models from their communities are highly valued within BAME-targeted interventions (Jaspal & Williamson, 2017), findings more consistently show how appropriate cultural sensitivity of programmes can be informed by a number of factors (not least community involvement in programme design and review).

Discussion

The qualitative and quantitative components of the evaluation appeared to show similar immediate benefits of the programme for many men including improvements in psychological components such as increased self-esteem, self-efficacy and overall well-being and reduced internalised homophobia. These results are encouraging. Whilst the relationship between psychological constructs such as self-efficacy and internalised homophobia and health-risk behaviours is complex, most research suggests that internalised homophobia is predictive of a variety of health risk behaviours (Berg *et al.*, 2015; Puckett *et al.*, 2017). Changes in actual reported and intended health risk behaviours during the time of the intervention were, however, minimal. The intervention itself made little direct attempt to change actual behaviours through more established techniques such as motivational interviewing. Nonetheless, many men reported a realisation that they used alcohol, drugs and/or risky sex as a way of numbing or redirecting negative emotions and planned to address this. Through a transtheoretical framework it may be that these men had achieved a cognitive readiness to plan and enact behavioural changes that would enhance their future health and well-being (Prochaska *et al.*, 2015).

Unfortunately, because of limitations to the funding and time-frame of the project, we were unable to collect follow-up data (even at three or six months) as part of the evaluation. This means we cannot be sure whether positive changes would be sustained or whether 'slow burn' improvements might emerge as a consequence of beneficial psychological changes. There was some indication of this for men who had attended the first two workshops at the

focus group discussions. However, collecting quantitative and qualitative data in a more controlled manner and over a longer time-frame should be a priority for future evaluation work. There were some problems relating to both components of the evaluation. There is heightened risk of type-one errors with multiple analyses and this may mean that some of our findings are false positives although the consistency in which sorts of measures produced significant improvements offers partial mitigation against that concern. In addition, whilst the sample size is adequate, those men who completed the measures on both occasions may not represent all intervention participants. Participants who felt that they had benefitted from the programme may have been more likely to complete the scales. The use of an on-line questionnaire gave significant flexibility to when participants completed the scales and also ensured that they were completed in an independent setting, but it was hard to control when participants completed the measures at both pre and post-test phases. However, as the survey was date-stamped we can confirm that no questionnaires were completed more than 16 days from the integration workshop and most were completed within three days of participation. In addition most measures used, although well-established in the field and widely used in a European context, were generic with limited prior confirmatory work for their employment with BAME gay men. The qualitative component had some challenges. Both focus groups were held in London and only one participant from Manchester was able to attend giving elements of these findings a London-centric bias. Although as noted some focus group participants did make some critical comments, the content of these discussions especially when evaluating the programme itself was largely positive. Again, it may that those men who felt they had benefitted the most were likely to give additional time to agree to attend the focus groups and/or that participants wished to justify (to themselves and others) the considerable time and energy that they had invested in the programme. Attrition rates were fairly high but unfortunately, it proved impossible to re-engage men who had not completed the full workshop to offer their views in the follow up focus-groups and we were unable to capture this important component adequately. There were however some trends in the characteristics of men who did not complete the workshop and/or did not contribute to data collection at the end of the intervention with men who were less educated, on lower incomes and using other mental health support services concurrently with The Quest being more likely to drop out whilst there appeared to be no influence of faith, ethnicity or HIV-status. It is also worth noting the education level of Quest participants generally with a high majority of men enrolling into the programme being university educated. As an academic evaluation team with relatively little prior experience of service provision, we found the approach of 'The Quest' initially rather quixotic and eclectic, drawing on a variety of theoretical elements and with few anticipated measurable behavioural changes. It may have been that the use of a set of validated questionnaires of health risk behaviours (as required by the funding agency) was an inappropriate to judge the progress programme participants had made. Indeed, the programme facilitators were wary of the programme being evaluated using quantitative instruments which they felt did not fully fit the aims and focus of their programme and preferred the more open-ended inductive approach of the group discussions. Our findings are perhaps predictably in those directions – with stronger participant testimony than statistically demonstrable programme efficacy.

Our findings have also showed considerable additional evidence of some of the contextual challenges facing BAME gay men in large urban centres in the United Kingdom. BAME gay and bisexual men in smaller towns and cities arguably face additional challenges and future work needs to be committed to ensure that those voices are also heard. As several large British LGBTQ advocacy and activism organisations including Stonewall and Gay Men Fighting AIDS have argued, contemporary gay communities have much work to do to be fully inclusive and tolerant, and to design safe and welcoming spaces for those who wish to practice a faith or consume soft drinks rather than alcohol without rejection or derision. Racist abuse

and discourse need to be tackled. Without the development of these material and virtual community spaces, many BAME gay and bisexual men will be denied access to the salutogenic resources of social capital and social support that many white gay and bisexual men benefit from regularly. Our results also indicate how LGBTQ and faith organisations need to work together to support LGBTQ individuals from all religious groups and to address forms of homophobia and heterosexism that are 'justified' by some faith organisations on the one side, and the perceived anti-religious discourse of some LGBTQ organisations on the other.

Since the evaluation data were collected The Quest have continued to run their standard (i.e. open to all men identifying as gay, bisexual or queer) workshop programmes regularly. BAME men comprised 29% of participants in the eight Quest workshops delivered between 2017 and 2019. One additional BAME-focussed workshop ran in 2017 with nine participants. Because of the COVID-pandemic face to face workshops were not possible through 2020 and 2021 but the workshops are taking place once more from 2022. In response to some of the qualitative data collected in the evaluation the Quest have subsequently both diversified their provision for BAME gay and bisexual men and addressed two of the specific dissatisfactions voiced by some participants. In 2020 The 'Quest Mosaic', a multiple strand programme specifically for 'gay, bisexual and queer men for Black, Asian and other racially minoritized men' was developed. This was developed with three components which are: A monthly on-line social discussion groups; a one-to-one coaching intervention and a group coaching intervention for six men. Quest Mosaic has been funded by the Social Enterprise Support Fund and The Inclusive Recovery Fund, along with their partners, Comic Relief and the Department for Digital, Culture, Media Sport. The smaller interventions aim to offer support for men over six sessions either individually, or in significantly smaller numbers than the Quest programme. The funding achieved also allows The Quest to offer considerable subsidies to promote inclusivity. Critically, these interventions were designed to be wholly facilitated by gay men from a BAME background. As with many LGBTQ support services some elements of the delivery of the MOSAIC programme of events was affected sby the COVID pandemic. However, the regular themed on-line discussions have proved to be especially successful and as of April 2022 the on-line Quest Mosaic community has well over twelve hundred members. This paper aims makes a useful contribution to research around our understanding of challenges facing BAME gay and bisexual men in British cities and offers a detailed evaluation of one provider of specific services for this community. Indeed, it is one of very few papers to do this in a European context. In the United Kingdom funds being made available by commissioners to provide sexual and mental health services to LGBTQ communities is being strongly constrained by the austerity measures that have been imposed on services for several years (Dalton, 2018) and will likely be further affected by the long-term social and economic effects of the COVID-19 pandemic. This is especially concerning as emerging evidence shows how there has been a disproportionate effect on the mental health of LGBTQ communities as well documented by recent articles in this journal (see Drabble & Eliason, 2021)

Further collecting and reporting of a clear evidence-base is increasingly being required to justify continued investment. To develop efficacious and cost-effective interventions we need to work together as academics, activists and practitioners in order to carry out additional research and evaluation using a range of imaginative and appropriate tools to ensure that providers are delivering beneficial and culturally competent support to all members of LGBTQ communities.

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