

Connect and Include

An exploratory study of community development and mental health

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2008



Published in Great Britain in 2008 by the
National Social Inclusion Programme
National Institute for Mental Health In England
Part of Care Services Improvement Partnership
11-13 Cavendish Square
London W1G 0AN
In association with
Community Development Foundation
Unit 5, Angel Gate
320-326 City Road
London EC1V 2PT
Registered Charity number 306130

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ISBN 978-1-901974-89-8

Cover and typesetting

Printed in Great Britain by on paper sourced
from sustainable managed forests

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Acknowledgements

Our thanks must go first to the people who were interviewed for this project. They were, without exception, very busy people who gave up their time to share their experiences and learning. This report is the first but not the last way in which we will try to do justice to their contribution. We would also like to thank those who responded to the preliminary survey. This helped to set the parameters and direction of the research.

The Advisory Group gave us valuable feedback and support during the project. They were: Sasha Bhat, Allyson McCollam, Simon Newitt and Frances Singer. David Morris, Programme Director of the National Social Inclusion Programme, Naomi Hankinson and support staff from the Programme and colleagues at the Community Development Foundation also helped us on our way.

Finally we would like to thank the National Social Inclusion Programme for commissioning and funding the project.

What this report is about

This exploratory study was commissioned and funded by the National Social Inclusion Programme (NSIP) at the Care Services Improvement Partnership and managed by the Community Development Foundation.

The study comprised a brief review of literature relating to relevant policy and practice, a survey and 39 interviews including community development practitioners, people with experience of mental ill-health, and staff from mental health services.

The report is concerned with the individual and the community. It explores how community development can contribute to an individual's 'recovery' from mental ill-health and also how it can promote 'community well-being' within a locality or community of interest. The findings suggest that by bringing people together to address their own concerns, facilitated by community development practitioners and supported through partnerships, it is possible to reduce stigma, create new community led resources and develop new connections between individuals, groups and organisations.

Part One begins with the concept of 'recovery' from mental ill-health before outlining the response of health providers in policy and practice. It describes the community development approach and the different models adopted by funding bodies. A review of the literature suggests some opportunities and tensions when mental health and community development practice come together.

In Part Two, we describe the aims, methods and participants of the study, before reporting on the findings in Part Three. These demonstrate the many ways in which community development has a beneficial impact on mental health. We also identify factors which promote or inhibit its success.

In Part Four, we discuss the findings before making recommendations to commissioners, policy makers, employers and community development agencies on how they might promote recovery and well-being, by maximising the contribution of community development for the benefit of individuals, groups and organisations.

EXECUTIVE SUMMARY

This is an exploratory study managed by the Community Development Foundation and funded by the National Social Inclusion Programme at the Care Services Improvement Partnership. The study comprised a brief review of literature relating to relevant policy and practice, a survey and 39 interviews with workers and community participants.

Background

The report begins by describing the concept of 'recovery' familiar in mental health discourse today. This does not refer to an absence of ill-health, but denotes a process of change as an individual regains hope, acquires a new sense of self and purpose, takes control of their life and makes decisions about what to do and what help to call upon should this be needed. There is an emphasis on gaining control, good relationships and personal fulfilment which have relevance for the wider community, many of whom feel oppressed by the economic, social and emotional pressures in their daily lives.

'Community well-being' is described as a situation where communities are thriving, with many connections between individuals, groups, institutions and services, creating a sense of belonging. Well-being for the individual and community are seen to be interdependent.

Health and social care policies align well with these concepts, with their focus on patient choice, individual and community empowerment, social inclusion, citizenship and equality. The literature describes community development practice as a process which can help to bring about these policy goals, as it brings people together to share their concerns and to work together in inclusive ways. It is recognised as an intervention which can reduce race inequality in mental health. It supports community organisations, which help to promote recovery and well-being.

Despite these apparent similarities of interest, the literature reveals a recurring theme of tension between community development and mental health practice. This report is intended as a contribution towards establishing a shared evidence base which recognises that although perspective, status and style of the two occupations differ, they also have objectives in common. While healthcare services have to be accountable and in control, community development is an unpredictable and dynamic process.

Aims and methods

The aim of this study was to explore the contribution of community development practice to mental health. It has focused on:

- exploring the community development practices, community groups and activities which improve mental health and reduce stigma
- identifying the outcomes of these practices and community initiatives.

The study began with a preliminary survey to scope the interest and activity of community development practitioners in mental health, and this was followed by interviews with a selected sample of respondents and their local partners. In total, there were 39 interviews including community development practitioners, people with experience of mental ill-health, and statutory sector staff. By the term 'community development practitioner' we refer to people who adopt the values and practices of the community development occupation, including community development workers and others working in health, housing, leisure, and research.

The study does not provide a representative picture across the community development field, as the interviews are drawn from a self-selected sample of interested practitioners. Instead it provides a snapshot of what can be achieved in mental health by those with an interest in this issue.

Findings

The findings begin by describing the trusting, friendly and respectful nature of the relationship between the community development practitioner and the people in their locality. This took time to establish, especially where there was a remit for mental health, but once trust was there, workers brought people together and sustained their involvement in community groups, as they identified talent, encouraged involvement and inspired confidence. The relationship between community development practitioners and other workers was found to be similar, when successful, in its informality and reciprocity. Occasionally, working relationships were marred by bureaucracy or disinterest.

Community development practitioners in this study drew on their values, professional remit and, above all, the views of local people to identify their goals and priorities. Policy directives, such as Delivering Race Equality (DH, 2005) were deemed supportive where they offered guidance with flexibility, but funders did not always appreciate the community based, community led approach which interviewees preferred.

The activities of community development practitioners included:

- opening up ways of talking about mental health to increase understanding and reduce stigma;
- making links between local people and their public services;
- improving public services; and
- developing new opportunities and activities including community led resources.

Conversations about mental health took place where there were good relationships and safe, informal settings. Community development practitioners helped to create these connections between local people, health practitioners and local resources, improving understanding on both sides and increasing access to a wide range of support services and other opportunities, including leisure, volunteering, learning and the arts.

Community development practitioners helped mental health staff to improve their services for diverse communities and worked to improve mental health awareness within generic services. They developed structures, processes and skills for public participation, sometimes in creative, innovative ways. The appreciation of commissioners and participants demonstrated the impact of their achievement.

The stories of how community development practitioners fostered the growth of community led activities illustrate the considerable skills involved in this process. With the benefit of light-touch facilitation and shared learning, local people developed and owned these resources which complemented statutory services but could never be replicated by them. Examples included a self help group for women with post-natal depression, a peer group providing activities and support outside working hours for people with long term mental ill-health, and the agricultural resource and support service for traditional hill farmers. It was in these resources that the most dramatic impact on mental health and community well-being could be found, but only after several (or better still, many) years of continued funding.

Short term funding, lack of management understanding and limited opportunities for professional development reduced the scope of community development. In some areas, workers struggled to gain recognition from their managers or mental health services for their approach, although community participants were always highly appreciative.

Discussion and conclusions

Overall, the findings confirm the potential of community development practice to make a valuable contribution in the field of mental health. The interviewees do not suggest there are substantial differences in the nature of community development practice when it has a focus on mental health, although basic training in mental health and a critical perspective on psychiatry are important. The activities of community development in the mental health field can be framed broadly as follows:

- establishing trusting relationships;
- facilitating social and economic inclusion;
- promoting participatory democracy;
- promoting mental health and well-being;
- facilitating self-determination, self help, peer support and mutual aid;
- increasing learning; and
- promoting equality and social justice.

Much of this work is done through making connections between individuals, groups and organisations. Much of it shows that people who are often excluded can be included as both participant and leader. The changes described suggest a growth in local skills and trust, together with the bonding, bridging and linking dimensions of social capital.

Overall, the study shows that there are commissioners, practitioners and local people who know, from their own experience, how a community development approach can contribute to individual recovery and community well-being. Many have a vision that it can succeed on a broader scale, by helping to create the healthy, empowered and cohesive communities that government and local people want. We hope that this vision can be shared more widely by gathering the evidence, reducing the fear of giving local people (including those with mental health problems) more control, and resourcing the skills and continuity of the community development practitioners.

PART ONE: THE BACKGROUND

1. Recovery and well-being

The concept of recovery

People outside the field of mental health may not be familiar with the passion and debate associated with the concept of recovery from mental health difficulties. When people recover from their physical ill-health, generally they are cured and their illness has gone. Bio-medical psychiatrists describe mental health problems and recovery within the same clinical framework.

In contrast, many community development (CD) practitioners favour a social model of mental health which acknowledges that our emotional well-being is affected by social and economic aspects of daily life and the social barriers or exclusions which exacerbate ill-health.

The definition of recovery adopted here fits within this social model and is provided by people who describe themselves as ‘survivors’ or ‘service users’ of the mental health system (Box 1). Recovery, as they define it, does not necessarily imply an absence of ill-health. It acknowledges the long term nature of many mental health problems, but denotes a process of change as an individual regains hope, acquires a new sense of self and purpose, takes control of their life and makes decisions about what to do and what help to call upon should this be needed. An important aspect of recovery for them is overcoming the isolation and sense of worthlessness associated with mental ill-health. Gaining good relationships and work are important milestones for many, but each individual seeks and finds recovery in his or her own way, so each person’s journey will be different. It is a continuing journey of personal growth, and there is no specific goal or endpoint (*Repper and Perkins, 2003*).

Box 1 Recovery

- Recovery is not the same as cure.
- Recovery is about growth.
- Recovery can and does occur without professional intervention.
- Recovery is about taking control back over one’s life.
- Everyone’s recovery journey is different and deeply personal.

(Repper and Perkins, 2003)

Having people around you who believe in you; and seeing and hearing other people in recovery inspires hope. Involvement in activities such as volunteering, education or work and feeling you are contributing creates a sense of worth.

(Scottish Recovery Network, Narratives of Recovery 2007)

The promotion of recovery, as defined above, is now a key principle in the re-focusing of mental health services. As a concept that is primarily about empowerment, its promotion within statutory services has led to significant discussion of its interpretation, but the policy is broadly welcomed as a step in the right direction.

Recovery and community well-being

The emphasis on gaining control, good relationships and personal fulfilment makes the concept of recovery highly relevant to people who experience common mental health problems such as anxiety and depression, and to those whose daily lives are oppressed by economic, social and emotional pressures. Many people are isolated, lacking the hope, resources or connections needed to make the changes they would like (Inverarity, 2003).

Recovery is something that concerns individuals, but Wallcraft (2005) speaks of needing to address the breakdown of community life, the harmful interactions between certain groups of people, and the pressures imposed by rigid cultural expectations and values which we may not choose or be able to satisfy (Box 2). The quality of community life must improve if we are to flourish.

Box 2 Recovery and community well-being

Recovery is not specific to people with mental health problems.
(Repper and Perkins, 2003)

Ultimately, we all need to recover,, from an era in which the abuse of women and children was kept hidden behind closed doors, from a past riven with class discrimination and racist oppression, from a work ethic that has made it hard for many people to have any quality of life. We need to heal communities where members feel lonely and isolated, where children, young people and older people are cut off from each other. We need to halt the disintegration of supportive communities. (Wallcraft, 2005)

The well-being of individuals and the well-being of communities are interdependent. It is not enough that basic services and amenities exist; they must also be responsive to the people who use them and must treat them with respect.Action to promote well-being must recognise wider structural factors as well as the development of individual coping resources. (SDCMH, 2003)

The notion of community well-being is an increasingly familiar topic for debate. A report from the Scottish Executive describes it as communities 'thriving, not just surviving', being hopeful, healthy and sustainable (SDCMH, 2003). In a recent survey, projects found to promote community well-being demonstrated a shared sense of purpose 'to bring about connectedness' within and between individuals, communities, institutions and services, creating a sense of belonging. (SDCMH and CHEX, 2006).

Social exclusion

The experience of mental health ill-health can leave people lacking any sense of belonging, as people may be systematically denied access to work or a satisfactory social life. They often lack the help they need to overcome the obstacles to a valued role within society and personal fulfilment (Social Exclusion Unit, 2004). The stigma of mental ill-health is known to last longer and be more disabling than the ill-health itself (Social Exclusion Unit, 2004).

There is now a broad movement aiming to promote social inclusion and tackle stigma both within the statutory and independent sector. Examples include The National Social Inclusion Programme at the Care Services Improvement Partnership (CSIP), SHIFT, funded by the Department of Health (DH), and Moving People, largely funded by the Big Lottery. There is evidence that anti-stigma efforts in Scotland have made a positive impact on attitudes (Scottish Executive, 2004), but there is also evidence that prejudice in some areas, towards some groups, is increasing (Rethink, 2007). A positive direction of travel has been set but there is still far to go.

Choice, empowerment and social inclusion

Part of this direction of travel is the emphasis on new ways of working within statutory services to promote social inclusion (DH, 2007a). Mental health practitioners are required to promote recovery for their service users by offering individually tailored support, recognising them as expert in identifying their own needs and offering choice in their healthcare (DH, 2004). Many practitioners can now offer access to sports, arts, spiritual help and employment support.

New posts in the NHS workforce aim to break down the barriers between the professionalism and mystique of mental health services and their locality, including Support, Time and Recovery (STR) workers and Graduate Primary Care Mental Health Workers.

These changes are underpinned by broader government policy (DH, 2006a; DH, 2007a) in which there is an emphasis on choice and empowerment in both health and social care. Greater service user and carer involvement in commissioning and delivery of services is encouraged within a wider policy context of promoting active citizenship.

A shift in funding from secondary (specialist) mental health services to primary care at the GP or family practice has begun, reflecting the increasing importance attached to preventing ill-health and promoting well-being. Mental health resources are to become more integrated within the strategies for public health and sustainable, cohesive communities (Box 3).

Box 3 Commissioning for health

Commissioning for health and well-being means involving the local community to provide services that meet their needs, beyond just treating them when they are ill, but also keeping them healthy and independent..... We need to ...promote well-being, which includes social care, work, housing and all the other elements that build a sustainable community.

(Commissioning Framework for Health and Well-Being, DH, 2007a)

Addressing race inequality

There is a concern for equality throughout healthcare policy, and a specific focus on addressing race inequality within mental health. Ministers have accepted that services can be discriminatory to an unacceptable and possibly illegal degree (Blofeld, 2003; Winterton, 2006), failing in their response to Black and minority ethnic (BME) communities.

To address this problem, an action plan, *Delivering Race Equality* (DRE) (DH, 2005), introduced a range of measures including the recruitment of 500 community development workers (CDWs). This was not the first time that community development (CD) has been used in the health and social care field, but there was some uncertainty about how the role should function in this context.

It was suggested that CDWs should seek out the strengths and capabilities within Black and minority ethnic communities, so that they became better equipped to deal with mental health issues within their own communities (NIMHE, 2003). Statutory mental health services are founded on a western understanding of mental ill-health, which is broadly medical and focused on the individual patient, an understanding not shared by many non-western cultures (Fernando, 2003). It was intended therefore that CDWs could support the development of locally driven, locally owned, culturally relevant resources as part of the solution to improved mental healthcare.

While many people retain this aspiration for a community led approach, the final Department of Health guidance to the DRE CDWs emphasises their strategic role to support service improvement and service user involvement (DH, 2006b). While progress towards the appointment of CDWs was initially slow and there have been challenges in relation to the impact and sustainability of the DRE programme (e.g. Jackson, 2007), ministerial commitment to the recruitment of CDWs has helped to bring about greater local project innovation in the BME field than would have been possible without them.

The slow pace of institutional change

These policies of choice, empowerment and equality have changed the language within healthcare, and there are many examples of innovative services promoting recovery from mental ill-health. However, policy implementation has far to go before becoming a reality across the UK and some suggest practitioners use new language to describe old ways of working (McGonagle, 2007). A reliance on medication continues due to the dominance of the medical model in this field,

although other ways of working have been shown to work (Mosher *et al*, 1995). Change in large institutions can be very slow.

The institutional nature of the NHS can still limit the capacity of mental health practitioners to promote some aspects of recovery and inclusion. It may be hard for them to facilitate social networks or enable individuals to take control of their lives where this might involve unsupervised risks of their choice in the community. Yet self determination, social networks and collective action are core dimensions of CD. With its emphasis on social justice, mutual respect and active participation in society, CD can respond well to the aspirations of people who use mental health services. Chapter 2 looks at how CD practice might help to promote recovery for people with mental health problems, increase their participation in the planning and delivery of services and reduce the stigma of mental ill-health.

2. The community development approach

Who does community development?

In this study we use the terms CD 'practice' and 'practitioner' to embrace both community development workers (CDWs) and other workers or unpaid citizens who share the same values and approach.

“There is a CD profession, defined by national occupational standards and a body of theory and experience going back the best part of a century. There are [also] active citizens who use CD techniques on a voluntary basis, and ... other professions and agencies which use a CD approach or some aspects of it.” (*Communities and Local Government, 2006*)

The communities with whom they work may be geographical, locality-based, or communities of interest, which bring people together because of a shared identity or concern, such as their faith, ethnicity or disability. Communities are not fixed entities but rather a shifting population coming together through networks and relationships of different intensity, giving the CDW a diverse and dynamic arena in which to work (Gilchrist, 2004). There is a broad, but misleading generalisation that CDWs only work with groups. Much of their time is spent encouraging and supporting individuals, enabling them to take part in community activities (Henderson and Thomas, 2002).

What is community development?

The distinctive feature of CD is that it is a progressive intervention that helps people to identify common concerns and then work together to address them, all in ways which promotes equality, inclusiveness and participation (Box 4). When aligned to the occupational standards, this process is both led and owned by the people at its heart through their collective action, with the CDW having an enabling role (Appendix 2). It is characterised by the way in which it increases the influence of people at a grassroots level in the matters that affect them.

Box 4 The community development process and activities

- Help people see that they have common concerns and could benefit from working together.
- Help people to work together on these issues, often forming an independent group.
- Support and develop groups within an ethical framework, increasing networking.
- Promote values of equity, inclusiveness, participation and cooperation.
- Empower people and their organisations to influence public services.
- Advise and inform public authorities on community perspectives, assist them to strengthen communities and work in genuine partnership with them.

(*Communities and Local Government, 2006*)

Other community practitioners may focus on one or two aspects of this process to achieve a more targeted impact. Specialist funding for CDWs defines the issues on which they work, for instance targeting housing or mental health issues. There is a consequent reduction in scope for local people to set their own agenda, but within the given objectives, their effective voice and influence can be facilitated.

Models of community development

Not all CD practitioners have the skills, time or professional freedom to give local people a lead role in the process of change. Much of their time may be spent speaking on behalf of others with whom they have limited contact, and it is said that this approach is less likely to produce sustainable or fundamental change (Henderson, 2005).

This more limited 'consensus' model is likely to be found where the funding body hopes for incremental, rather than fundamental change. Services may be delivered within the community, but they will not be essentially different from statutory provision. There is little or no exchange of power or resources. The focus is likely to be on self-help, the delivery of welfare to marginalised groups, and supporting service user involvement in consultation exercises (Twelvetrees, 2001).

In contrast, a 'radical' CD approach seeks fundamental change in the form of a redistribution of power and resources in the planning, design and delivery of services. In the mental health field, this is likely to be found where commissioners feel that more is to be gained by enabling local communities to develop their own solutions to mental ill-health, based on their own cultural beliefs and traditions. They provide an alternative choice, rather than an extension of established provision. In practice, many CDWs may adopt a combination of these approaches (Gilchrist, 2004).

Participation and empowerment

To different degrees according to the approach adopted, the CDW role includes enabling people to participate in local activities and to share in decision making. They may develop structures and processes to increase the influence of local people in matters that concern them. They are often involved in supporting people to set up and develop mutual aid and peer support groups. For the CDW, review of their progress, together with others, is an integral part of their role (Box 5).

Box 5 The seven 'E's of community development

- Enabling people to become involved by removing practical barriers.
- Encouraging individuals to contribute to activities and decision making.
- Empowering them by increasing confidence and the ability to influence decisions.
- Educating people by helping them to reflect, learn from others and discuss.
- Equalising situations so people have equal access to opportunities and resources.
- Evaluating the impact of these interventions.
- Engaging with groups and organisations to increase community involvement.

(Gilchrist, 2004)

Strong skills, low profile

To be successful, CD practitioners need strong personal and professional skills to equip them for their roles as 'enabler' and 'facilitator' in complex, often politically charged social settings. Ultimately, they aim to establish sustainable connections and collaboration where previously there were none, and with their own presence either no longer needed or firmly in the background. They retain a great 'database' of knowledge of the key players in their locality, their relationships and wider networks (Henderson and Thomas, 2002).

These skills are used creatively but critically, shaped by a strong value base promoting social justice (Box 6) and by the National Occupational Standards (Appendix 2).

Box 6 Professional values of community development

Fairness, equality, accountability, opportunity, choice, participation, mutuality, reciprocity and continuous learning. Educating, enabling and empowering are at the core of community development.

(Federation of Community Development Learning)

3. Community development and mental health

A broader vision for mental healthcare

For over fifty years there has been an interest in improving health by drawing on a community intervention (e.g. Stallibrass, 1989). Community development in a community care context offers a valued alternative to specialised and compartmentalised support (Barr *et al*, 2001). Community development practitioners and interagency partnerships enable people with long term mental health problems to participate in community activities (SCMH, 2000; Pozner *et al*, 2000). Here they are not set apart from others: they can gain the respect, friendship and self-fulfilment essential for their recovery. By facilitating this participation, community development offers the help and opportunities that statutory services struggle to provide (SCMH, 2000; CDF/SCMH 2003).

Box 7 The potential contribution of community development practice

There is potential for the statutory sector to unlock a new dimension for support and engagement with a range of people including those who are difficult to engage in mental health services. Both specialist and mainstream services need to broaden out their vision.
(SCMH, 2000)

There have been some useful initiatives but this vision for a community development approach has not taken root in mainstream mental healthcare. This may be because of the mismatch between the service interest in the individual and the community development focus on the collective, exacerbated by a lack of interest from policy makers and community development organisations (Henderson, 2007). There are signs that this is beginning to change.

Developing social capital

A substantial body of literature on the benefits of social networks and activities has developed, and although the measurement of mental health in this context is contentious, there is evidence that we benefit by participating actively in community life (Argyll, 1989) and our communities are more healthy places to live when people are 'well-connected' (Gilchrist, 2004).

There has been much interest in the concept of social capital and its relationship with mental health (e.g. McKenzie and Harpham, 2006). Where there is substantial networking, activities and groups in a community, these demonstrate skills, resources and good relations among the local people that denote positive social capital, which is itself associated with good mental health (McKenzie, *et al*, 2002).

Community development can provide opportunities for close 'bonding' relationships, 'bridging' between different groups, and links which enable people to have influence and create partnerships across different levels, all characteristics of a community with positive social capital (Putnam, 2000). With their value base of

equality and social justice, CDWs aim to ensure marginalised groups are included as social capital grows.

Reducing stigma

Tight networks and rigid attitudes cause exclusion, negative social capital and poor health. To tackle this, CDWs create opportunities to mix and think more freely.

A demonstration of this took place in Scotland, with a three year community development programme to promote recovery from mental ill-health and address stigma (Quinn and Knifton, 2005). Mental health service users took a lead role in the planning and delivery of the project, together with a partnership of youth workers, mental health practitioners, economic and arts development organisations. Anti-stigma activities took place in schools, workplaces and community venues. Service users gained in skills and confidence as they came to see stigma as having a social rather than a personal cause. A range of evaluation methods suggested that attitudes and behaviour among the local participants improved, both in the short term and up to one year later, partly explained by the prominent role of service users in the project.

Promoting self determination

Community development activities which focus on increasing self determination and empowerment have been shown to benefit mental health.

A neighbourhood study in Norway (Sorensen *et al*, 2004) described how, in an area of economic and service decline, people were mobilised around the care of their elderly residents. The shared leisure and campaigning activities helped to create a more integrated, supportive community, suggesting increased community well-being.

A community development and mental health promotion programme became a process of empowerment within a farming community in Canada (Gerrard, 2000). Local people were engaged in the assessment of their needs, combined with social action and educational activities. They came to see their problems within the social and economic context of their agricultural industry, reducing feelings of personal blame.

Peer support and mutual aid

In a smaller but important way, CDWs can shift power from the professional to local people by fostering the growth of peer support and mutual aid groups. When these are set up by mental health practitioners, professional control may be retained through the facilitation process. Where groups are initiated by people with direct experience of mental health issues or by CDWs, it can be easier to locate control and decision-making firmly within the group.

The opportunity to share experiences, learn from each other and to be the giver as well as the recipient of support enables people to see themselves in a different light and has a positive impact on mental health. They can replace feelings of guilt or inadequacy with an understanding of how external factors help to explain their situation and inform ways of improving it, as found in the projects described above

(Borkmann *et al*, 2005). Research has shown that peer groups in a mental health CDW context helped to turn around the lives of people from Black and minority ethnic communities (Seebohm *et al*, 2005).

Promoting race equality

There have been few in-depth studies of the CDW role in promoting race equality in mental health services. A participatory study in Bradford asked people from Black and minority ethnic groups what kind of support they wanted to address their mental health needs, and it questioned the capacity of community development to help statutory services understand and respond to these views (Thomas *et al*, 2006).

The research found that people wanted a range of non-medical options, shaped and developed by their communities. The researchers argued that the capacity of community development to support statutory services to respond appropriately was said to depend on whether a radical or consensus model was adopted (see above, Chapter 2). This Bradford project and its Primary Care Trust adopted a radical approach with significant benefits for those who used it. Commissioners and senior managers felt the project, Sharing Voices Bradford, had credibility and value.

An evaluation of a DRE post within a children's mental health service found that services for Black and minority ethnic communities improved in terms of access and outcome as a result of community development and outreach work (Cornwall Business School, 2007).

Professional tensions

Much of the literature which spans community development and mental health describes successful partnership working, but also reveals a recurring theme of tension between community development and mental health practice.

One source of tension was associated with different perspectives on mental health. For instance, a community development process driven by service users took a Canadian voluntary sector project from a medical to a social model of mental health over many years (Pomeroy *et al*, 2002), involving the staff in a long and difficult journey. At Sharing Voices, the Bradford project mentioned above, CDWs adopted non-western perspectives which caused misunderstandings with front line practitioners. To overcome this, they drew on personal narratives about the people with whom they worked to create a common language with mental health practitioners, demonstrating their shared objectives (Seebohm *et al*, 2005).

The value base of the CDW profession leads workers to challenge structural and social inequalities, which are themselves causes of mental ill-health (Wilkinson, 2005). This can be perceived as questioning the skills and commitment of individual public sector workers unless CDWs have the creative and diplomatic skills to demonstrate shared objectives with service providers.

There are differences in status and style which can leave the CDW undervalued. The high status associated with medical expertise contrasts with the deliberately

low, almost invisible, profile of the CDW. Clinicians tend to be 'doing for' their clients, but CDWs have a 'doing with' style (Henderson, 2001). The subtle, facilitative skills in CD may not be obvious to other professionals.

Measuring success within a dynamic process

Medical interventions are generally time-limited, delivered on a one to one basis, and well-evidenced, in contrast to the 'more nebulous activities' of CD (Gilbert and Russell, 2006). Medically trained professionals can find the lack of timeframes, control and uncertain outcome difficult to manage and explain to their colleagues, even when they are personally committed to a CD approach (Gerrard, 2000).

The unpredictable and dynamic nature of CD is hard to fit within NHS target driven monitoring frameworks. Outcome focussed planning and outcome measurement is increasingly important in the NHS, but in CD there can be intangible and unexpected outcomes sometimes emerging years after a specific intervention has finished.

Researchers are becoming more creative in their efforts to measure progress. Participatory approaches such as 'Achieving Better Community Development' ABCD model (Barr and Hashagen, 2000) incorporate community development processes well. Academic literature recognises the affinity between community development and participatory action research (e.g. Freire, 1972; Stringer, 1996). However, the dynamic process and grassroots led nature of CD do not fit easily within the ethical framework for NHS research which emphasises academic responsibility and control.

Potential and constraints

This brief review of CD and mental health suggests there are areas of mutual interest for CD and mental health practitioner. CDWs aim to bring people together, including those who are isolated and powerless, and give them a greater say in things that matter to them. Mental health commissioners and practitioners want people with mental health difficulties to make choices and feel empowered in their recovery journey. Both want supportive social networks and inclusive activities within the locality.

Yet the very characteristics of community development which enable it to complement statutory mental health services can also make it a challenging partner. The most sustainable and effective form of CD is a creative approach led by local people with broad aims but unpredictable outputs. In contrast, mental health services are accountable for the care they provide and their management of risk. CD is strengthened by long term funding, but its current lack of a robust or coherent evidence base and performance management framework does not endear it to statutory bodies which have to be financially accountable and in control.

This study seeks to explore if and how the potential of community development can be maximised, despite these constraints, for the benefit of people with mental health problems, those who support them and the wider communities in which they live.

PART TWO: THE STUDY

4. Aims and methods

Aims and objectives

The aim of the study was to explore the contribution of CD practice to mental health. To achieve this, the following objectives were pursued:

- to describe the workplace contexts, funding and job role in which CD practitioners are working to address mental health issues;
- to gain an understanding of the CD practices, community groups and activities which promote mental health and reduce stigma;
- to explore the outcomes of these CD practices and community initiatives, in particular the opportunities they offer to:
 - be involved in community life;
 - access or shape local services;
 - gain paid or unpaid work;
 - take part in education or training;
- to disseminate the findings and lessons learned.

Stage one

The project began in May 2007 with a brief review of literature, focusing on a search of academic databases for peer reviewed articles published since 2000. Only thirteen articles were found to contain both the terms 'community development' and 'mental health', and most of these were written from a mental health perspective. Relevant articles are mentioned in Part One, above. A successful application was made for approval from Hertfordshire NHS Research Ethics Committee to carry out the study.

Stage two

The second stage was a questionnaire survey, by e-mail, telephone and post to scope the interest and activity of CD practitioners in mental health. People were advised of the work through 11 networks and personal contact. Thirty one questionnaires were returned, mostly (over 75%) from the Yorkshire and Humber Strategic Health Authority region.

A preliminary analysis of the literature review and questionnaire survey identified six strands to CD practice in the mental health field. CD sought to promote one or more of the following:

- participatory democracy
- social and economic inclusion
- mental health awareness
- self determination, collective action, mutual aid
- learning
- equality, social justice, trusting relationships.

As this was an exploratory study, which looked broadly at the contribution of CD in the mental health field, it was decided to examine all of these strands in more depth in the next stage.

Stage three

A sample for the third, fieldwork stage was selected from the returned questionnaires, on the following basis:

- to cover each of the six strands identified earlier;
- to cover as wide a geographical spread as possible;
- to interview at least ten CDWs, five mental health practitioners or commissioners and fifteen people involved in CD activities (ten with mental health problems and five carers).

To meet this criteria, it was decided to visit eight sites for face to face interviews with CD practitioners and service users or carers and, where possible, statutory sector staff. To cover all the six strands of CD activity, it was necessary to carry out supplementary interviews with additional CD practitioners by telephone or face to face.

In total, interviews took place with nineteen CD practitioners, fourteen people who had experienced varied levels of mental health difficulties, one carer, and five statutory sector staff including two in a commissioning role, one manager with responsibility for social inclusion and two frontline mental health practitioners.

There were five semi-structured interview schedules for (i) CD practitioners, (ii) people with mental health problems, (iii) carers, (iv) mental health practitioners and (v) commissioners. Interview schedules for CD practitioners explored the workplace context, CD practice associated with mental health issues, what helped and hindered in this work, the outputs and outcomes of the work. Other interviewees were asked about their perspective of the CD practice, and again what did or did not help them to benefit from it. Interviewees were invited to complete a short demographic questionnaire.

Interviews took from 15 to 90 minutes, but most were about one hour. They were taped, transcribed, and checked back with the interviewee. In three cases, notes replaced tapes. Unwaged participants were paid £10 for their contribution. The data was managed by NVIVO software to support a thematic analysis.

Limitations

The study was limited by the time constraints (for example, there was less than a week for the literature review).

The questionnaire survey attracted a low number of respondents (31) who were all enthusiastic and successful in their work and therefore the study shows what CD practice can achieve, and does not claim to be a representative sample of CD as a whole. Access to DRE networks was not available except in the Yorkshire and Humber region, which partly explains the disproportionate number of respondents

from the north. Survey respondents may have included a disproportionate number of older, white, female CD practitioners.

The limitations of the survey and time constraints adversely affected the sampling process, although the total number of participants for the interviews (39) is good for a qualitative study. There was only one carer, and the sample of five interviewees from statutory services provided a limited snapshot of this perspective. Again, the impact is to showcase good practice and what can be achieved, rather than provide a representative cross section of community development in the mental health field.

5. The participants

The community development practitioners

About two thirds (12) of the 19 CD practitioners interviewed were female. Their ages spanned from the early 20's to the 60's, with about half (10) under 50 and the rest over 50. About two thirds (12) described themselves as White British, and the rest were Australian (one), European (one) Pakistani (three), Caribbean (one) and African (one).

Job titles varied, including nine CD workers, officers, or coordinators, an Outreach Development Officer, Project Officer, Project Manager, Neighbourhood Partnership Manager, researcher, Housing Development Officer, Youth Worker, (Enterprise) Manager, Senior Community Learning Worker and Training and Development Worker.

Six CD practitioners had a mental health remit under DRE. One CDW had a mental health remit for the wider community. The Community Learning Worker had a mental health remit within mental health services. One CDW had a health promotion remit, but was currently seconded to neighbourhood work. Another had a remit to focus on faith communities, and one was based within the Sports Development Service. One had set up an independent social enterprise. Two disclosed personal experience of mental ill-health.

Two CD practitioners were based in a PCT, one in a mental health trust, 11 in the voluntary sector, and six in a local authority, including one in supported housing services.

The mental health survivors, activists, service users and carers

Fourteen people who had used mental health services and one carer were interviewed about their role as beneficiaries of the CD practice or, in the case of three people, in their role as activists who were themselves both doing and benefiting from aspects of CD practice. The age range was from 20s to 50s, with half (seven) being under 50 and the rest (eight) aged 50 or over. Similarly, half (seven) were male and the rest (eight) female. Nearly two thirds described themselves as White British, and the others were Caribbean, African, Turkish, African Asian, Pakistani, and Black Other (Nubian).

Mental health commissioners, managers and staff

The five employees of statutory services interviewed included two commissioners, one senior manager, one Carers Education Worker, and one Support, Time and Recovery (STR) worker. Four were female and one male. Other demographic data was not made available.

PART THREE: THE FINDINGS



6. Introduction

Varied roles and experience

CD practitioners in the study had widely varied working roles, from survivor activist to Social Inclusion Manager, with many CDWs. Their knowledge of mental health came from personal or professional sources or both. Several had a lifetime of experience in the field and a few were in their early 20s, but all wanted to share their learning. They sought to promote CD practice as a uniquely effective but not widely valued approach to improving mental health for individuals and across communities.

Shared values, shared approach

Despite differences in training, workplace and age, the practitioners shared the values and practices of CD. The findings below show how they sought to establish trusting relationships within communities so that they could intervene on mental health issues. They broke down stigma and improved well-being by creating connections within and across groups, between communities and public services and between services. They encouraged and enabled others to develop their skills, gain influence, and pursue shared goals. This enabling, facilitative approach was welcomed for its mutually respectful, informal relationship between equals and its beneficial impact was frequently confirmed.

“This programme has definitely, 100%, given me the strength and empowered me... What I liked about [it] is it was about making changes in mental health in our community.” (*Community participant*)

Outline of the findings

Part Three of the report continues by looking next at the nature of the relationship between the CD practitioner and people in local communities and how this can bring people together in sustainable groups (Chapter 7). It shows that the nature of the relationship with other workers is in many ways very similar (Chapter 8).

It then describes how the CD practitioners in this study draw on their values, professional remit and the views of local people to identify their goals and priorities (Chapter 9). These included:

- opening up ways of talking about mental health to increase understanding and reduce stigma (Chapter 10)
- making links between local people and their public services (Chapter 11),
- improving public services, (Chapter 12) and
- developing new opportunities and activities including community led resources (Chapter 13).

The final chapters look at the positive changes in mental health that are created by the CD activities (Chapter 14) and how this change process may be sustained (Chapter 15).

7. Establishing relationships

Taking time to establish trust

Often the CD practitioners had come to work within communities where they were largely unknown, with a remit to explore mental health issues, a topic which was either unacknowledged or taboo, out of the realms of public discourse. This was the case for CD practitioners funded under DRE, but they were not alone. Mental health problems seemed to be similarly acute and hidden in a traditional hill farming community, while in a deprived area of Bradford the mental distress was different but still deeply stigmatized.

“We knew if we went straight in to talk about mental illness and mental health they would not talk to us.” (CDW, DRE)

A range of strategies were involved, beginning with just becoming a familiar figure in the landscape who could be helpful and good company, often not even mentioning mental health issues at this early stage. The CD practitioner might be “tested” by local people, to determine if he or she had credibility and could be relied upon. They might attend local events and offer practical help. A shared heritage, shared language, shared interest or skills, and a good sense of humour eased the process of building relationships. Trust had to be established, and this was easier if CD practitioners were invited in or could join up with others who were already accepted within the community.

“You have to be very careful, you can’t walk into something like that. The community has to accept me, and I was tested almost like an animal, literally at the mart, where the farmers would go. I would go to the bar, I went to the farms, so everybody was really familiar with me before I started.” (CD practitioner)

“They need to know who you are and where you are coming from. They need to know what your values are. Also they want to know, who the hell are you, to talk to our youth? So it is quite difficult, but by doing things very slowly, that can help.” (CDW, DRE)

Informality, warmth, encouragement and respect

Over time, most CD practitioners developed relationships with individuals that were described as warm and informal. Some CD practitioners became regarded as friends, and sometimes the distinction between paid practitioner and community activist, volunteer or local person became a little blurred. Several people contrasted this with the relationship between service user and their mental health practitioner, who is professionally obliged to help.

“Oh, these [Mental Health Guides] are like ordinary people who just live next door, they are ready to listen. My social worker *has* to listen to me. These seem like ordinary people’. That’s how I felt they perceived us.” (CDW)

CDWs encouraged people, gave them hope, spotted their talents, and found opportunities for them. Although the work was primarily around groups and communities, this was underpinned by strong, supportive relationships with the individuals within them.

“One day [the CDW] phones me and says, ‘I liked your input from last week, would you be interested in joining the steering group?’ I said, ‘Oh!’ She said, ‘I liked your ideas and I think you have a lot to offer.’ That said a lot to me, it made me realise that [the CDW] is a person that picks up on your points and she encourages you to do something with it.”
(*Community participant*)

CD practitioners spoke about encouraging and enabling the people around them to take on roles within the community which both challenged and interested them and this was echoed by the participants themselves. CD practitioners were said to be respectful and non-judgemental. Even when training, one CD practitioner said that she did not aim to be like a teacher, but rather aimed to bring out and develop the skills already there. In different ways, people suggested that CD practitioners, volunteers, and local people were on a level, part of a team, rather than being set apart, divided by a professional role.

“I never felt judged by her. She never ever judged. She just knew what support was needed.” (*Community participant*)

“I would say we all worked as a team. It wasn’t easy, there were times when we were going to kill each other! We all had different opinions, but I think at the end we were satisfied that we took each other’s opinions with respect and were able to incorporate that. At the end of the day, we all wanted the same thing, and that was what it was all about.”
(*Community participant*)

Connecting individuals within groups

The trusting rapport established between CD practitioners, volunteers and group members enabled the CD to take place. The quality of the relationships was especially important when the activities involved people who lacked confidence or had mental health difficulties because they might need support to mix socially. CD practitioners took the time to listen and talk to individuals and helped them get to know others. This attention to individuals and relationships within the group was said to be critical.

“Just chat with somebody to give them the confidence, to show interest. [And] I introduce them to others....so that they know someone they can walk with, on their own. I am a kind of middle person.” (*CDW*)

Sustaining their involvement

By giving time to individuals as well as the group, many CD practitioners were able to sustain involvement. One CD practitioner in the Open Up programme ensured his mutual support group of survivor activists became “quite sticky for people”. Describing himself as the glue, he made contact between meetings or when

someone did not turn up, sending useful information or messages of support to strengthen the group connection.

“It’s really about making them feel that, in between meetings, they’ve not been forgotten about. They are still part of that little community.”
(*CD practitioner*)

A group of 15 residents from different ‘client need’ groups (including mental health) took part in six weekly meetings to shape Supporting People in Torbay. They received a high level of one to one and group support from the staff team, who adopted CD values and skills. The relationship was described by one community participant as friendly, informal, supportive and respectful. Both staff and the community participant felt that the staff approach, combined with the residents’ shared interest in housing, explained the group’s commitment to their involvement and their cohesion.

“They have all shared the experience of needing support with their housing, so they come with that shared need... We have people who have used drug and alcohol services, young people, old people, I thought it would be chaos but it’s not. They get on well.” (*CD practitioner*)

Another group who were less diverse did not have contact with their CDW or each other outside their intermittent activities, and they came to feel out of touch and deflated.

Sometimes relationships within community groups would become tense. Examples included a falling out between members, rules being broken (bringing a dog), anti-social behaviour (poor personal hygiene), and the ending of an emotional attachment. Group members said that, if necessary, they sought mediation from the CD practitioner to resolve these problems.

Reciprocal relationships

Community participants valued the CD practitioners’ deep personal commitment, both to the cause for which they are working and to the people with whom they worked.

“She is incredible, she works so hard, nothing is too much trouble. I think she is passionate about her job.” (*Community participant*)

When the CD practitioners were asked what was important to them, they said that while the broader impact of their work was important, they were personally sustained by seeing individuals benefit from their work and by their warmth.

“Some of the friendships and relationships.....they will last till you die. This is not a community that accepts people readily.” (*CD practitioner*)

“One of my groups gave me a plaque for the community work I did for them.... Sometimes people just phoning up and saying, ‘I was just sat here and was a bit upset so I thought of phoning you because you’ll cheer me up’.” (*CDW, DRE*)

8. Connecting with workers

Collaborative relationships

Most of the CD activity in this study was sparked or facilitated by relationships with other workers which share the informal, friendly style we have seen above. There was a strong element of co-operation and reciprocity. Sometimes the CDW approached another worker, and sometimes they were themselves approached, but either way, they helped each other and shared ideas in a mutually beneficial collaboration.

“I go to lots of meetings with different agencies, you find out about things and people say ‘I can help you with that’.” (CDW)

“I think that is the biggest thing, communication. The willingness to talk to everybody, Mind workers, housing workers, try to get everyone involved.” (CDW)

There were many examples. A CDW based in an East Riding leisure centre described how a Support, Time and Recovery (STR) worker contacted her: “we met in a café and had a chat about ideas”. The CDW had felt “completely ignorant” about how to widen access to the leisure centre for people with mental health problems, or how to make contact with NHS mental health services. As a result of the contact, she was able to broaden the range of people accessing the centre, and the mental health practitioners were able to offer mainstream leisure opportunities to their service users.

“It has to be a two way thing between staff in mental health services and CDWs to work out what is available and what can be done to provide access to different services.” (Mental health practitioner)

In Leeds, a CDW asked a community centre worker if the South Asian women attending her groups would like mental health sessions. They had had several sessions on diabetes, but none on mental health, and they welcomed the opportunity. The CDW brought in an NHS Worker to help deliver the sessions, benefiting all involved.

“My role was to provide interpreters and speakers. [The CDW's] role was to set up the sessions. On that basis we kind of latched together. It's very simple and works very well. We seemed to be in tune.” (Mental health practitioner)

In South Tyneside, the CDW for refugees and asylum seekers met up with the ESOL teacher and an outreach worker from the Tyne and Wear Museum service to devise an innovative project which improved language skills, promoted mental well-being and increased access to the museums, contributing to the targets for each of the three workers.

There were several examples of useful collaboration between CDWs, workers at Mind and local vicars or priests, resulting in low cost, tolerant venues, peripheral support and joint initiatives. One CDW helped people from faith organisations and groups to develop their own initiatives.

Obstacles to working together

CD practitioners were therefore working in different circles in informal and collaborative ways. Trusting relationships within the community could not always be achieved and could never be taken for granted. Faith could divide as well as bring people together. It was said that the repercussions of the September 11th and London bombings made communication with people at the mosques particularly hard. Some CD practitioners felt their one or two year funding limited the number and depth of their relationships, while others who had worked in their area for longer had many good relationships built up over time. Some had been frustrated by obstructive individuals or officials who stuck to the detail of their bureaucratic rules rather than to their social purpose.

“We have got stuff that we want to speak to the police about and ask questions about. It is going to be really hard to get them to listen, there is no forum to go to for the police and speak to them about mental health.”
(CDW)

“I feel certain people ... they don't want to rock the boat.” (*Community participant*)

Some reported particular difficulties when working with mental health managers or practitioners. One CDW compared the style of a medical practitioner who is trained to know the answers, with the CDW who has been taught to ask questions. This contributed to the misunderstanding, scepticism and confusion about CD, which left CD practitioners undermined or undervalued.

“My manager gave a presentation about community development and the top psychiatrist just shouted out ‘How can you develop a community!’ and left the meeting. I thought that was shocking. [Also] at my first meeting with the Director of Mental Health Services, she said ‘Didn't we try that in the 70s?’” (CDW)

Whatever the cause, CD practitioners sought to find other ways to pursue their goals.

“It is not like how it used to be. [People at the mosques] are very, very suspicious: ‘who are you, what do you want, why do you want to know’? So what I am doing is, I know a gentleman who works at one of the mosques just further up from here. They trust him and that helps me as well.” (CDW, DRE)

9. Identifying goals and priorities

Local people lead

Most CD practitioners gave a clear message that the direction of their work had to be determined by people in the community, even if this had to be contained within a mental health agenda. In fact, this approach was said to be especially important in the mental health field, because if the solutions to mental ill-health are not acceptable to local people, they would not use them, as many were not using existing provision.

The CD process usually began by asking members of the community what was needed, using a mapping or research exercise or informally through a network of contacts in the communities. Some CD practitioners spoke of enabling the communities to develop their own solutions.

“Community development workers have to get involved in their communities, understand them, listen to them, and together they can find a solution. There is no project that can be successful if you don’t involve the community themselves.” *(CDW, DRE)*

“As CDWs we need to be led by the communities that we purport to serve or empower.... We need to be ‘bigging up’ their ideas.”
(CDW, DRE)

The solutions sometimes took the form of mutual aid groups. CDWs did what was necessary to facilitate and sustain the group, from minding a baby to giving information, but control was held within the group.

“I make the assumption that they want to be in control, and it becomes contagious so they realise they are in the driving seat.”
(CD practitioner)

“We turned [the CDW’s] ideas on its head. She saw it as a women’s group, but everyone at that meeting said it is not just about women. Then she started to believe it and wanted to do that for the group.”
(Community participant)

Community groups often began with a small number of individuals passionately wanting to pursue an idea, and gradually their enthusiasm and conviction would draw others on board. In Upper Teesdale, a small number of local people came together to address the stress and suicide in their farming community, and over about ten years increasing numbers of people from the community have continued to shape their initiative through the steering group, staff team and membership of approximately 1200 people. It has extended to young people and provides support through recurring periods of agricultural crisis. It was said self determination runs through this initiative ‘like the lettering in Brighton Rock.’ There were several other, smaller mutual aid groups equally determined to do things their own way.

“It was an issue raised by local people, on behalf of local people, local people were involved in controlling it... This is the practical result and it is held by the community.” (*CD practitioner*)

“They are very, very keen on being a standalone, community led, community driven group that wants to provide some things for people who have experienced similar stuff to what they have.” (*CDW*)

Occasionally the influence of local people was limited by the ethos, structure and funding of the CDWs’ employing organisation, both within the statutory and third sector. There was not the same focus on transferring control to group members and the rhetoric was misleading.

Working to policy directives

Policy requirements of the funding bodies were described as useful but also a constraint. Where policies could be given a broad interpretation, there was scope for some flexibility. One experienced CD practitioner always started by finding out what people in the communities wanted to do, and then translated this to fit current policy requirements. A CDW with a DRE remit responded to the requests of a new community, even if this did not fit his mental health agenda. By offering some limited help, he could start to build a relationship and then, in time, open up the issue of mental health with them. This flexibility helped to engage local people.

“I can’t really do that for you, because that’s not [my role]. But I will do what I can for you, and then keep that relationship going.”
(*CDW, DRE*)

At the same time, some CDWs spoke of the need to draw parameters around their job, and most of the CDWs with a DRE remit felt the policy helped to guide and evaluate their work. However, some concern was expressed about the final DRE guidance for CDWs, issued in 2006, which tightened the focus on service development. The CDWs were supportive of statutory services, but they were concerned to deliver this support from a position of credibility at grassroots level.

“We need to build up a base of understanding and knowledge and trust, so that when we are talking with our statutory partners about what the issues are, we’ve got some legitimacy for what we are saying.”
(*CDW, DRE*)

There was tension when their PCT understood the role differently. Managers and commissioners did not always agree. Within a few sites, the PCT management sought greater CDW involvement at a strategic level (although it was not clear what was meant by this) or a greater focus on service improvement with less involvement at a community level. In other sites, commissioners and managers fully supported the community based approach.

Addressing injustice and inequality

The professional values of CD, including social justice and equality, underpinned the work of all those interviewed and featured prominently in the way they explained and justified their work: 'It underpins everything I am about' (CD practitioner). They were sensitive to injustice and always sought to ensure their work promoted social justice and challenged inequality.

Stigma was a central issue in work around mental health; many CD practitioners promoted training within public services and encouraged staff and groups to be inclusive and accepting. Two spoke about the 'asset-based' approach to CD, which recognises people for the potential contribution they can make, rather than the label they may have been given.

"We need to adopt that approach or people are pathologised, imprisoned within the perception of them which doesn't see the potential."
(CDW)

Gender issues were found in work with asylum seekers, minority ethnic communities and the traditional farming community where CD practitioners helped to provide support, training and work opportunities for local women.

Some CD practitioners spoke of the power imbalance within mental health services between professional and patient, exacerbated for Black and minority ethnic communities by discriminatory attitudes stemming from Britain's colonial history. It was felt that the expertise of these communities was less likely to be valued. CDWs sought to address the imbalance by developing confidence and skills on both sides.

When working with community groups, CDWs helped members develop participatory practices within their groups, which could be difficult when they had no previous experience of committee work. Some did not adhere to western notions of democracy. CDWs had to be pragmatic but challenging, keeping a fine balance between intervening too little and too much.

"Sometimes [the CDW's] influence is overbearing. You have to get the balance." (Community participant)

"There are a couple of groups I have had dealings with, and although I have stressed equality, when it gets down to the work there is a big get-out. I have been trying for some months now to find a way around this. I'm not here to be confrontational, I'm here to engage the community."
(CDW, DRE)

10. Talking about mental health

Sharing experiences

Focused work on mental health issues began when trusting relationships were established and the CD practitioner was able to create opportunities to talk about mental health. They generally began by talking about reducing stress or achieving well-being, for instance through diet, exercise and leisure. This led into talking about emotional well-being and opportunities to focus on mental health.

“We will talk more generally about health and leisure, then we use that as a springboardpeople start talking about themselves or about their emotional well-being and that is our lead in.” (CDW, DRE)

The time it took to reach this starting point depended at least partly on the depth and complexity of the work, so two CD practitioners found a couple of months was sufficient before introducing sessions on mental health promotion, but it was six months before farmers were invited to talk about stress, suicide and bereavement.

Over time CD practitioners became able to talk to people on deeply personal matters. A CDW in South Tyneside PCT brought young refugees together to play football. Their time together led to discussions about racism, work and what would make a difference to their mental wellbeing. Friendliness, informality and shared pursuits opened up private thoughts.

“Everything revolves around that smile, cup of tea and welcome. The information that comes on the back of that is far more fruitful and useful than inviting people to come in for information. Often what they want comes in a roundabout way.” (CD practitioner)

CD practitioners spoke of encouraging local people to share their difficulties in a safe environment, so that they could learn from each other, realise that they were not alone and find out about sources of help and coping strategies. The realisation that others shared similar experiences was said to give great relief. CD practitioners felt that talking about stress and mental health problems had increased and became more acceptable within their communities as a result of their work, with a reduction of fear and stigma.

“Out there you don't know who to trust and who will talk. I can talk here and I go away knowing that my load has been lightened.”
(Community participant)

Bridging perspectives

CD practitioners worked to increase understanding and communication between statutory services and local communities, divided not only by their community languages but also by different understandings of mental ill-health. They described how many communities, particularly from South Asia, do not share the concept of mental illness and may believe it to be deeply shameful, caused by the possession by evil spirits like the Djinn.

CD practitioners working with the indigenous population also spoke of shame and secrecy associated with mental ill-health, because of a traditional culture where people are expected to be able to cope with whatever life throws at them. People did not seek or find the help they wanted. Those who were desperate because of debt or hardship might 'self-medicate' with drugs or alcohol, or even take their own lives rather than get help.

The use of clinical labels in describing mental ill-health failed to resonate with many indigenous people who did not see themselves as mentally ill. Neither do they have meaning in community languages and could not be adequately translated because of the 'cultural baggage', the western world-view upon which they depend. One team of CDWs used words like 'happy' and 'sad' which made sense to most people and did not stigmatise.

"It is about getting information across to people in a way that they are able to absorb it, and there needs to be a lot of flexibility."
(Mental health practitioner)

CDWs helped mental health practitioners to talk to people with different perspectives, creating a new connection between the NHS and community. Some helped practitioners to see that each individual benefits from developing their own understanding of their ill-health and the solutions to it, based on their culture and perspective.

"[The CDWs] explained that doing it along strict NHS lines looking at mental illness from a medical model wouldn't work."
(Mental health practitioner)

"It is about choosing a story that makes sense to you, because you will choose your own route to recovery and that road to recovery has got to fit with your understanding of what is happening." *(CDW, DRE)*

11. Linking services and communities

Linking people to help

Much of what the CD practitioners did can be explained in terms of making connections and at the most simple level this consisted of 'signposting'. A regular task was giving out information about available services, such as help with jobs, training, counselling, self help, mum and toddler groups, health promotion and setting up or running groups.

"I signposted them to South Tyneside CVS, and they told [CVS] what their aims and objectives were, and CVS set up a constitution for them."
(*CDW, DRE*)

Sometimes, to enable people to access the help they needed, it was necessary to break down the fear and stigma attached to mental distress and mental health services. CD practitioners enabled people to understand more about distress, the services available, and how to use them effectively. Examples of this work included a 'Health Literacy' course in South Tyneside for up to 30 refugees and asylum seekers, and events, drama and information sessions at Roshni Ghar, Bradford for South Asian women.

Some CD practitioners helped to bring services together to provide holistic solutions. The Upper Teesdale Agricultural Support Service (UTASS) had connections with a wide range of agencies which could be called upon for the community as a whole or for individuals. In South Tyneside a multi-agency forum involving health, housing, benefits, police and others joined community spokespeople to address community problems.

"We got DEFRA involved, Trading Standards, police, and we all looked at what role we could play to help her. Each agency thought what they could do to help." (*CD practitioner*)

"When I came, I established the South Tyneside BME Well-Being Group so that we can get professionals and BME communities together, to sort out the issues that affect their people, the communities."
(*CDW, DRE*)

Extending the reach of the NHS

CD practitioners used a combination of support, practical assistance, and education to bring NHS, support staff and people from the communities together for mutual benefit.

UTASS invited a range of advice and support agencies to deliver regular sessions in the community resource building so they could be accessed easily and without stigma. The project had a 24 hour hotline to the GP surgery and supported people in crisis to get help. It provided training and volunteering in a friendly environment so GPs both took referrals and referred back in a mutually beneficial partnership.

The youth project liaised with school nurses and sexual health clinics to get help for the young people.

Touchstone in Leeds joined up with the NHS Carers Education Worker to organise three sessions for South Asian women on what it feels like to be depressed, on hearing voices and medication. Their guidance enabled the worker to present the information appropriately, and the sessions were attended by 17 to 28 women. The NHS worker said she would have found it difficult, even frightening, to do this without CDW support.

In a similar venture, Roshni Ghar, Bradford, held sessions on physical and mental health delivered to South Asian women by Asian and white British men from the local Trust. After an uncertain start when the women all sat at the back of the room, it proved popular and further sessions, focused entirely on mental health, are being planned.

It was said that some groups are hard to reach or hidden, but one CDW argued that it is more the case that people in statutory services find it hard to go out to find them. By gaining the trust of the communities, CDWs can open up a supportive space to meet.

“An awful lot of people who work in services are deeply institutionalised and are afraid of the communities, and so it is a question of trying to support them in going out there. Sometimes we can open doors.”
(*CDW, DRE*)

“[The CDW] provides the oil. To me it is like a car engine and she provides the oil and that lubricates everything.”
(*Mental Health practitioner*)

Enabling service users to access community opportunities

All CDWs worked to make groups more inclusive and sought to increase access of people with mental health problems to community activities. Some had a specific remit for this work, such as a CD practitioner at an East Riding leisure centre who acted as a link with STR workers, housing support workers and mental health services on one side and the mainstream sports activities on the other. She described herself as a link who shows people using mental health services what is available and acts as a familiar and friendly face in the large, bustling environment of the leisure centre. She has developed a Professional Carers' Pass giving free entry for people accompanying their clients, and another Carers' pass for informal carers of people on disability benefits.

One community based CDW from Roshni Ghar provided 'in-reach' support to South Asian women in hospital, with the aim of linking them in to community resources after discharge. She gained the confidence of the women, uncovered issues of which staff were unaware, contributed to their care planning and met up with them after discharge.

A lack of mutuality

CDWs worked with people who experienced all kinds of mental ill-health issues, from those who use mental health services to the many who experience debilitating poverty or hardship in their daily lives. In different ways they made local communities and services more inclusive. However, several felt their work did not receive the recognition or funding that it deserved, with government attention focused on the relatively few people accessing specialist care.

Some CDWs acknowledged that mental health services were increasingly looking outwards, but felt that statutory sector staff did not always understand the community initiatives around them. For instance, STR workers in one site brought service users to community led groups, run by volunteers with past or continuing mental health issues. There was no discussion as to whether the service user wished to become a member of the group, and no financial support for the group.

“It is trying to get them to understand we are not a service; we are a community group.” (CDW)

The relationship could seem exploitative. One community initiative provided service user placements on financial terms unlikely to be acceptable elsewhere. A CD practitioner described how members of a service user-led training team were asked to travel long distances for only one hour of paid work. In two sites, public authorities ‘showcased’ initiatives which fit with emerging national policy, despite having given little or no support up to that point.

12. Improving public services

Supporting public sector staff

Sometimes CDWs worked with mental health providers to help them make their services and workforce more appropriate and responsive. In Leeds, some mental health teams approached Touchstone for advice because they were not attracting or retaining sufficient clients from Black and minority ethnic communities. Touchstone helped them to explore the reasons and solutions, looking at what the service offered, what it did well and how it might make the service relevant to different client groups. For instance, if talking to Muslim people about medication, staff could think about how to help them manage their drugs during the fasting of Ramadan.

“In terms of us being a bridge, we do get a lot of people who really, really want to make it work. Sometimes it is a question of saying, ‘Maybe you need to think about it a bit more, and we can help you with that process’.”
(CDW, DRE)

In Barnsley, the CDW team will be contributing to the design and delivery of the PCT training on cultural diversity for the workforce, adopting a positive, non-judgemental style in drawing out the implications of DRE for mental health staff. They are following this with shadowing mental health practitioners, both to improve and learn from statutory services.

CD practitioners worked with a wide range of public services to improve their capacity to serve people with mental ill-health, generally through awareness and anti-stigma training. Several spoke of giving mental health service users a central role in this training. Others spoke of the Mental Health First Aid programme (see glossary).

Developing public participation

Another way of improving public services was by developing structures, processes and skills for public participation in the planning and design of services. There was evidence of established but also creative approaches to this.

Some CDWs supported individuals to attend planning meetings, enabling new groups to be involved. For instance, one CDW enabled two carers from different community groups (one with an interpreter) to take part in the Carers’ Strategy Group, and as a direct result, different languages were included in an Information Guide.

“It may not seem like a lot ...but for Barnsley it was a huge first.”
(CDW, DRE)

Where new democratic structures were being developed (Supporting People, Torbay and Mental Health Guides, Hackney) commissioners and providers gave their full support for a two-way communication process with their local communities, confirming that the time and resources committed to developing this was worthwhile. It enabled them to improve their services and meet their targets.

“[Services] need to be delivered to meet the needs of the customer and the only way to ensure that is to involve the customer in how you actually specify and commission services.” *(Commissioner)*

In Torbay, 15 people attended a Service Users Group and others contributed on an individual basis. Group representatives passed on their views to commissioners, and fed back the response to the group. In Hackney, 13 African Caribbean service users, carers and other concerned people qualified as Guides to work in community and mental health settings, passed information up to the Local Implementation Team and other forums, then fed back the response to local people. The relationship of the CD practitioners involved (described in Chapter 8) played a central role in sustaining involvement. In both sites it was recognised, however, that the initiatives were evolving in flexible ways and there was much more to be done.

Payment for public participation was raised as a difficult issue. In Hackney a system for paying participants was in place, but the difficulties raised by the benefit system continued. In Torbay, an inter-departmental policy on payment for participation was to be developed in an attempt to provide a locally coherent approach to a complex situation.

In Bradford, homeless people were encouraged to contribute to housing practice by a less structured process which drew on community artists, music and food to engage people. It was said that there was an inevitable element of chaos and uncertainty in the process with this population, but the continuing role of Bradford's SpeakOut suggests that its CD practitioners maintained (sometimes on a voluntary basis) an underlying purpose and energy beyond the intermittent events.

In all the sites, CD skills and values were evident in the way they worked to promote democracy across all aspects of their work. Their relationship with local people naturally instilled confidence and enabled people to have a greater say about their services.

“The project is about going to a group of people who say they are not heard when they speak to their doctor or professionals. We give them an opportunity to be heard, with a process of feeding [their views] up to the decision makers. It gives an opportunity for democracy to be fully-fledged.”
(CD practitioner)

13. Developing community resources

Initiating social activities

Several CD practitioners brought people together in social activities, and even where there was no mental health remit, these activities helped to promote both individual and community well-being. CD practitioners helped to organise leaflets, videos and group activities like trips, celebrations, arts, football and other sports. In South Tyneside, 22 refugees and asylum seekers came together to form two multi-national football teams. Through these activities, people made relationships with others who may or may not have a shared identity. Many were not targeted at people with mental health problems but did include some service users.

“Now we have a relationship with each other we have been able to put in things like ‘cook and eat’ sessions, and exercise classes for older people, and [now there] is not just an improved knowledge of diet and exercise but networks of people who have fed back that it’s invaluable to get out of their house and mix with others.” *(CD practitioner)*

A small amount of funding was often needed to enable these activities to happen, and CDWs could sometimes, but not always, help to find this. Trips were increasingly difficult to fund, despite their value in bringing people together across social boundaries.

Facilitating community led resources

Several CDWs enabled people to develop their own initiatives, ranging from peer support and mutual aid groups to a ‘listening ear’ service. Beat the Blues in Stockport took nearly a year to be established as a support group run by and for women with post natal depression (PND), and has met once a month for nearly two years since then with a regular attendance of about 18 women and a few male partners. Some of the group members have received help from the GP or been referred to mental health services, but it was said women with PND rarely go to mental health services because of the stigma. The group provides a community alternative which they find more acceptable.

“My [post natal depression] was for 8 and a half years and the doctors didn’t know how to deal with it. It was six or seven months after I came to the group that I felt well enough to come off my medication.”
(Community participant)

Awakenings in Newcastle provides activities and company in the evenings and at weekends, run by and for people with experience of mental health difficulties. About 15 – 20 people attend their bowling evenings, 10 have enjoyed a Christmas day meal cooked by another member for each of the last 2 years, and their trips were also well attended.

“Some people had never been on a train in their lives and hadn’t been out of Newcastle. It was difficult to get them there on the day. We picked them up and got them to the station....They all without exception said that they would do it again.” (*Community participant*)

A Refugee Forum in Barnsley brings together women from across the globe twice a week to do whatever it is they want to do, including shared meals, complementary therapies and website training. One woman has used mental health services and receives support. Others have experienced trauma as asylum seekers. Some are born locally. All contribute to the decisions about what to do.

A CDW with a mental health remit in Stockport supported a number of social groups which were set up by and for people who had been isolated, anxious or depressed, offering a range of activities including Tai Chi and creative arts.

Typically, these mutual aid, peer support groups benefited both the helpers and the helped. They were by nature small, but their impact could be wide as it extended far beyond the inner core group members. They were felt to fill a gap in existing provision.

“I work closely with them when there are issues like funding. They decide their own direction. I am happy about that, because there was no refugee group.” (*CDW, DRE*)

“It has helped me to help someone else. It has given me the satisfaction of knowing that someone else won’t go through what I did.” (*Community participant*)

The role of the CD practitioner in all of these initiatives was to provide whatever help was needed to get set up, establish a clear purpose and structure and ensure a sustainable future embedded within the community. Where community groups involved people with long term mental health issues, transient lifestyles or lack of social skills, CDWs provided continuing encouragement and support. With other groups they had more scope to retreat until and unless called upon at times of instability.

One CD practitioner encouraged his two groups of mental health survivors to join the Council for Voluntary Service, because this could help to establish a sustainable future within the infrastructure of the local community sector.

“We get nice rooms quite cheap for the meetings, they tend to be quite central, its also given us access to free or very cheap educational programmes and training courses. It also gives us some links in with other community groups. We can share information - get things out on the mailing list for free. In terms of longevity and sustainability, that will give us very valuable support.” (*CD practitioner*)

Creating bridges in social life

Some CDWs initiated new networks, for instance bringing local people around the table for the first time in a deprived neighbourhood so they can identify shared interests and work together in a more cooperative way. Some people developed their own networks as the number of community groups they knew of and found welcoming increased.

“You find that people come to one [of these groups] and I know that they go on to other community groups within the area. There is a ‘People like Us’ group for gay and lesbians and so some of the members have gone on to that and things that Mind do.” (CDW)

People using mental health services moved across mental health specific and other groups. Members of community groups that included a number of mental health service users felt that they were accepted without prejudice. Several CD practitioners felt that the tendency of statutory sector services to protect and segregate service users was unnecessary and inappropriate when individuals moved into the community. It was only when a large number of people discharged from a long term psychiatric hospital joined a small community group that social mixing proved difficult, apparently because of the visible side effects of their long term drug treatment.

There were stories of divisions brought about by history, faith, disability, geography or ethnicity being broken down. One CDW spoke of supporting communities to invite other groups to their events, for instance to share their learning or a celebration. A few CDWs found that women of diverse faith and nationality enjoyed parties where they could bring and share their food. Another CDW was setting up a network around faith and mental health for Muslims, other faiths and NHS services. She hoped to get spiritual healers trained in counselling.

“At first I was thinking they might say, oh no, I don’t want to go there, but they were really happy, you wouldn’t think they were two different cultures or religions. Sometimes you need to give the opportunity to do that.” (CDW, DRE)

There were less positive experiences, but these were few. One CDW found it difficult to engage the mosques. Some individuals did not want to attend groups where they perceived a different faith was dominant. The CDWs had continuing challenges in this aspect of their work.

Generating learning opportunities

There was a huge amount of learning opportunities generated by CD activity, covering a wide range of topics. These were delivered in a style which was fun, and several people said that the learners set the goals and were helped to discover hidden or forgotten talents. Topics included culture, creative expression and sports such as dry stone walling, sign language, felt making, Tai Chi and swimming. There was a lot of learning around core CD, such as how to set up and run community groups, and in several places there was mention of the Mental

Health First Aid and ASIST training which increases confidence and skill in coping with people who have mental health problems or suicidal thoughts.

“CD is about saying, ‘Let’s have some Mental Health First Aid training for activists, community people, religious people, and why aren’t the Trust doing more of that?’” (CDW, DRE)

Promoting volunteering

There were many examples of people taking up voluntary roles as committee members or generally contributing to community activities. People who came to community groups often progressed to volunteering within the group or in other settings. Many spoke of a positive impact on their mental health when they took on a role they felt was worthwhile and rewarding. Some people changed their career, having found more satisfying work through their involvement in community activities.

“She has been coming for about three months and she is now a Back Marker for me, which is essential. I can’t lead a walk without a Back Marker. Just hearing her talk and seeing how she chats to me, ‘Oh I feel so much better!’” (CDW)

Supporting enterprise and work

Enterprise development was mentioned by about a third of the CD practitioners. Two enterprises were up and running, two more were being explored and others had been considered in the past. One was a cooperative of people with personal experience of distress and the other established as a limited company and charity, set up some time ago by a former occupational therapist. Sustaining the viability of the enterprises had required huge commitment, enthusiasm and drive but this appears to have been plentiful. Financial support from the NHS had been limited or absent. Both were generating paid work opportunities and participants were rewarded both financially and emotionally.

14. Creating positive change in mental health

Individual gain

There was a consensus among CD practitioners and people with mental health problems that CD had a beneficial impact on individual's mental health. The CD practitioners enabled individuals to establish new relationships and take part in social, purposeful and entertaining activities, making their own or group decisions about what to do.

“Feeling that they are in control just helps people's mental health and well-being without anything else. It helps them to make friends, it gives them hope.” (CDW)

“Getting involved can develop confidence and bring people together with others, so they can move outside of their particular comfort zone but still be in a secure environment.” (CDW)

In at least six of the eight sites visited, people felt that the CD initiative may have saved lives.

“Most probably I would still be drinking, most probably dead by now. It has made a big difference to my life. Even my family look at me differently.” (Community participant)

“This is a lifeline.” (Community participant)

“It saved me really.” (Community participant)

It was said that our mental health services tend to treat the individual in isolation from their family and community, leaving them alienated from the wider population.

“Sometimes mental health services have a tendency to [say] ‘When you have recovered, you shouldn't be reliant on anyone else, you shouldn't be dependent.’ But the stuff of life is being dependent on other people and CD can really show that inter-connectedness, and say it is not something to be shied away from or be ashamed of.” (CDW, DRE)

CD practitioners and community participants spoke of the importance of sharing personal difficulties to ease the pressure and find solutions. A ‘web’ of relationships with different people for different purposes is vital for recovery, as it is for all of us at all times. These networks need to be within the community and not, as often happens, solely within mental health services.

“It made me feel I wasn't isolated any more. It gave me the confidence to show someone else, *you* are not isolated any more. So it's worked very well.” (Community participant)

“We don’t live our life in bunkers or ghettos - we need to look at integration with other parts of the community and other community groups.”
(*CD practitioner*)

Community benefits

CD practitioners and community participants spoke about how the groups benefited a wide and often changing network of people. After regaining their health, group members got satisfaction and pride from helping others. Activities were sometimes said to be complementary to statutory services but could never be replicated by them. They evolved as their membership changed, and some became more secure than others. A CD initiative led to UTASS, a local resource which has received national recognition and praise, but it still lacks the financial security of a mainstream service. Other smaller, newer initiatives also offer unique alternative sources of help; their popularity is evidence of their value.

“I get a sense of achievement and satisfaction that it is a group that started from nothing, and now it is successful and helping the women. I’m just so proud of Beat the Blues.” (*Community participant*)

In addition to the groups, established and led by the community, CD practice led to an increase in social networks which made an important difference to the way people felt about their neighbourhood. There were new opportunities to meet socially or for specific purposes, which were taken up with enthusiasm, reducing stigma, fear and prejudice.

“It has created a sense of community that wasn’t there before, because they have done something together, their children have met, that has increased their sense of security and well-being. So it is minor stuff that actually impacts in quite a major way.” (*CD practitioner*)

“It is making these little filaments that hold people together in a very delicate way, it is very subtle.” (*CD practitioner*)

As previously hidden issues became opened up within these networks, it was said there were subtle changes which enabled people to talk about and share problems. Attitudes were changing and people were more likely to know about and seek the help they needed.

“Once you start discussing this within the community openly, it becomes acceptable to talk; it becomes acceptable to start talking about some of these feelings.” (*CD practitioner*)

“They don’t believe in mental health problems. It is only now that they are thinking maybe there is.” (*CDW, DRE*)

Changing mental health services

The collaboration between CD practitioners and statutory mental health services enabled mental health practitioners, managers and commissioners to see things differently, potentially making a positive impact at different levels. The CD practitioners did this from different positions, based within the mental health trust, primary care trust or the voluntary sector, sometimes but not always with targeted mental health funding.

Whatever their base, their skills and social perspective had something to offer but there were limitations partly due to their employment status, connections and time constraints. Those based within mental health services were familiar with and supported the current policy agenda.

“We try to promote recovery by trying to get people involved in community activities and to extend their social outlets and also to be involved in ‘citizen’ activities.” (*CD practitioner*)

Some felt CDWs could achieve more change in mental health when based in the community, and most DRE posts in this study were in the voluntary sector. As one commissioner put it, history has showed us that the NHS could not engage with Black and minority communities.

The three interviewees working at mental health practitioner or manager level were not representative of the workforce, identified as they have been through their interest in and support for CD practice. Their attitudes, approach and flexibility have much in common with the CD practitioners and testify to the fact that there are, within the NHS, people working in new ways. They took a developmental and creative approach to their work. All sought to create links with CD practitioners and other community based practitioners. They valued the CD approach as a useful tool or method which helped them to achieve their goals.

“In terms of making in-roads into the BME community and building capacity in the community, then empowering the community, it is a very useful method.” (*Commissioner*)

15. Sustaining change

Support and funding for CDWs

CD practitioners received variable levels of support and guidance. Some were based in teams of three or more, so they discussed their work, helped each other and shared information. Two CDWs were more isolated, lacking practical and emotional support.

“Every Friday we meet up for about 2 or 3 hours to discuss our work, any ideas we have. We also have, at the end of the meeting, a ‘creative space’ where we discuss, for example, if I have a workshop to do and I’m not sure how to do it, I bring it to the team and we discuss it as a group.”
(*CDW, DRE*)

Most CD practitioners had line managers available to provide support, but in both the voluntary and statutory sector several practitioners found that their managers had a limited understanding of or interest in their work. There was some disagreement over what work should be prioritised and how CD can be most effective, sometimes because the CDW reported to both the voluntary sector line manager and PCT management. This was an issue particularly but not only affecting CDWs recruited to support DRE.

“Everyone has the same aim, it is just the process to get there seems divergent. That sometimes makes me unhappy and a bit tense. It’s having two masters, how can I satisfy both? I can’t.” (*CDW, DRE*)

Most CDWs would have liked more opportunity to reflect with other CDWs, ideally through a local or regional network, an opportunity available to two CDWs.

There was little support or supervision on mental health. One CDW had access to clinical supervision, and a few received support from their colleagues. Two had Mental Health First Aid training, one had ASiST training. A couple disclosed personal experience of mental distress and a few had worked in the mental health field. Several had no previous experience in mental health, being recruited for their community connections. One CDW new to the field adopted a medical model of mental health, out of touch with much of current thinking. Most felt some training on mental health was very important.

“When you are talking on a one to one with people, they are disclosing things to you and you need to give an appropriate response. There is a need to know what you can say to reassure that person. We need to value what they are saying.” (*CD practitioner*)

About half of the CD practitioners had permanent posts, but four had job security for less than a year. People spoke of the difficulty in paying a mortgage, supporting a family and retaining workers. Short term funding (2 years or less) reduced the scope for CDWs to establish trusting relationships which need a long term commitment.

Bringing in the evidence

In several sites, there had been a recent instruction from the local authority or PCT to increase the level of monitoring. This was broadly welcomed, and some CDWs produced regular reports on all their work. One was putting in place an outcomes focussed approach to planning and evaluation. Most had statistical data (attendance figures at meetings, training etc) and some had feedback forms, minutes, and photographs. Several felt that this gave an incomplete record of their work, but lack of time, guidance and funds made it difficult to reflect the quality of their outcomes more accurately.

It was felt the nature of CD made it extremely hard to monitor or evaluate. Conventional approaches could appear intrusive and jeopardise the progress being made. Funders were sometimes felt to be unrealistic in their demands. One CD project refused to comply with demands perceived to be invasive, preferring to manage without a significant grant.

Broad but not unlimited scope

There was general agreement among the CD practitioners, their community participants and mental health practitioners that they have an important role in enabling people with mental ill-health to live equally respected lives alongside others without distinction. They sought to help staff across public services, voluntary sector and the private sector understand distress as something we all experience in some form, and as something we all can help to address. CD practice aims to create the kind of communities and services which promote well-being and reduce stress.

People also spoke of the limits to the effectiveness and impact of CD. One practitioner noted that strife in her area continues, because, however strong the CD practice, structural inequalities remain. Several participants and practitioners suggested that, for some people, peer support, supportive networks and other CD activities offered a useful and sustainable alternative to medication. However, it was also said that for people with severe mental health problems, CD alone cannot provide the solution and mental health services have an important, complementary role to play. The unique contribution and skill of the CD practitioner is to address mental health issues within the community, enabling people and groups to live healthier, more fulfilling lives.

“Often the setting in which people are placed is part of the problem, and so by working within that setting you are more likely to be able to help with that problem.” *(CD practitioner)*

“By connecting people together, which is what community development is about, you are putting in place an informal support system which is probably going to be more effective and long term than drugs.”
(CD practitioner)

PART FOUR: DISCUSSION & CONCLUSIONS



16. Discussion and conclusions

Introduction

This has been a broad, exploratory study, the unifying framework provided by an interest in mental health and a way of working characterised by CD values. This section considers the nature of the CD intervention and how commissioners and others can use a CD approach to promote recovery from mental ill-health and well-being within all our communities.

Trusting and empowering relationships

The CD practitioners developed mutually respectful, warm relationships with people from their communities and brought them together in activities and groups. Where there was a focus on mental health, the process of gaining trust could take a long time. CDWs had to work at a pace acceptable to the community. To do otherwise would have detracted from their purpose.

For people with mental health problems, 'self-efficacy' or a person's belief in their ability to achieve their goals can be fostered – or destroyed – by those around them (Renegold *et al*, 1999). The CD practitioners' style in this study instilled people with confidence, enabling them to take more control over the decisions that concerned them and take up new worthwhile opportunities.

Easing tensions, creating bonds

The CD intervention was described as both lubricant and glue, easing tensions and creating new bonds. It enabled people with mental ill-health to lead their own community groups, support each other into work and help others in greater need. They enabled local people to create solutions complementary to but distinct from statutory services, for instance those led by and for people in the hill farming community and women with post natal depression.

CD practitioners refused to be confined by social divisions, inhibitions or labels. South Asian women were encouraged to talk about hearing voices. Sikhs and Muslims were invited to meet up regularly. Service users needing support for alcohol abuse or their age or their disability were enabled to work together. Local agencies which competed for resources came to identify shared concerns. CDWs appeared to think the 'unthinkable' and as one of them said, it is about creating the opportunity to bridge social divisions.

The individual and community gain

The impact on some individuals was life-changing, averting serious harm or inspiring a new journey. Many acquired skills, confidence, voluntary or paid work and trusting relationships. They got huge satisfaction from helping others and had a strong sense of ownership of the community resources they created. If recovery from mental ill-health is about growth, taking control back over one's life, having people around who believe in you, and gaining a sense of worth by contributing to society, then CD clearly promotes recovery.

Benefits for the individual and the wider community were intertwined and inter-dependent. Close relationships (bonds) enabled people to mix with others from different groups (bridging). Two way communication was established through new structures across and within organisations, giving local people more influence at different levels (linking). Local people felt they were making a difference, with new skills and opportunities to help others. Groups took up opportunities to have their say, which those responsible for community empowerment and well-being would do well to note. In these ways, CD increased social capital and community well-being.

Collective action

The scope of collective action was usually small scale in the sites visited, partly because initiatives were in their first or second year. Where there had been continuity of CD support and values over many years, there were examples of resources developed and owned by the community.

In Stockport where one CDW has had a mental health focus for several years, a number of community groups were run by and for local people. Many of their members had long term mental health issues but they had a wide network of social contacts, different non-stigmatising things to do and places to go every day.

In Upper Teesdale, where the CD intervention began over 10 years ago, there is now a resource run by and for the local community. It has a staff of 8 part time workers, all local people, all sharing CD values. They provide vital support in times of agricultural crisis and facilitate networks of mutual aid in an isolating, harsh environment. Their connections range from the local GP, welfare services and police to central government departments.

Delivering Race Equality

It is not clear to what extent the CDWs with a DRE remit will be able to facilitate collective action on this scale. Those who took part in this study seemed committed to giving a lead role to local communities, but were also concerned to frame their work within the DRE guidance and action plan. Few had long term funding or managers with a good understanding of community development.

However, as one CDW said, there is so much to do, even small steps towards change make an important impact. It was clear that the DRE CDWs in this study had a challenging role due to the task ahead and the expectations placed upon them. Both community participants and mental health practitioners spoke highly of their commitment, skills and achievements.

Some of the CDWs with a DRE remit were new to CD or new to mental health, recruited primarily because of their community connections. It was said that these CDWs have to grasp the complexity of diverse perspectives on mental health, and the need for access to suitable training was clear, although availability was very variable. A critical perspective of psychiatry would make a valuable contribution to their understanding and awareness, helping them to bridge established and community perspectives. They need to recognise the value of solutions to distress found within non-western cultures and the kind of help that different groups of people find relevant and appropriate. They need to be aware of the mental harm that can be caused by racism and the importance of help to deal with this aspect of life. Their understanding of these issues can increase or reduce their capacity to empower local people.

The CDW skills and mental health

The CD practitioner working with mental health issues may need enhanced skills. One CDW spoke of needing more time when working with people who have mental health problems. Several felt they benefited from basic training, personal experience of distress or clinical supervision.

Beyond that, generic CDWs did not speak of working differently when involved with mental health issues; the process was said to be the same. Further, they felt that many people experienced stress and mental ill-health due to the oppressive nature of their lives, so skills around mental health and well-being were useful across all CD. Also, many had a commitment to addressing stigma in the community and supported initiatives which made public services and communities more tolerant of difference.

However, it was notable that only some generic CDWs engaged explicitly with mental health issues. They had an interest, confidence and awareness in relation to mental health issues that their colleagues lacked. It seemed that some CDWs still identify mental health as a separate arena where specialist workers are required.

CD activities and mental health

The CD activities described here do not seem distinctly different from those described in the textbooks of generic CD, but the literature, survey and fieldwork suggest they can be framed with a mental health focus (Box 8). The preliminary survey identified six strands within this framework, but the interview data gave a central role to 'establishing trusting relationships', so our final analysis includes this as the first strand to the CD role within a mental health context. Although some CDWs focus primarily in one or two of these areas, their value base of equality, participation and social justice pervades all their work.

Box 8 Activities and outcomes of CD in a mental health context

- *Establishing trusting relationships:* respectful relationships and constructive partnerships between people from diverse community groups, local organisations and statutory services. Creating connections within communities, community cohesion.
- *Facilitating social and economic inclusion:* access to local groups, activities, resources, networks and work opportunities (paid and unpaid).
- *Promoting participatory democracy:* structures, skills and processes for the participation of local people and mental health service users in the planning of public services.
- *Promoting mental health:* increased awareness of mental well-being and strategies to increase it, including events, opportunities to talk, Mental Health First Aid training.
- *Facilitating self determination, self-help, peer support and mutual aid:* collective action to create change, community groups, networks and community led resources, including peer support/mutual aid and social enterprise.
- *Increasing learning:* opportunities for learning and personal development, including creative expression and developing leadership and democracy within community groups.
- *Promoting equality and social justice:* equality increased in social, health, economic and political spheres, particularly:
 - Reducing the stigma of mental ill-health
 - Reducing race inequality in mental health
 - Reducing other inequalities, e.g. associated with gender, sexuality, faith.

Not a service

Some people may feel that the importance attached to one-to-one work here suggests that the CD described is perilously close to a service. In fact, in one site, community self-help groups were mistaken for a service. Some people may be concerned about professional boundaries when working closely with people who can be dependent and vulnerable. Supervision and reflection with peers, always important in CD, may be especially important in this context.

However, the findings suggest that during the process of bringing people together in collective activity, the shared values, purpose and friendships become more important to the individuals than their relationship with the CDW. The CDW only stepped in to mediate, or if members were unwell or out of their depth.

The 'In-Reach project' was a possible exception to this, largely because it was in its early days and is still taking shape.

Relations with statutory services

There appeared to be some scepticism and misunderstanding of CD from mental health services in at least 4 of the 8 sites visited, as anticipated by the literature review in Part One. In the other sites, there were better or good working relationships. The potential of the CD intervention often seemed to increase when

done in cooperation with statutory service workers, but the potential was threatened when that relationship was exploitative or indifferent.

Some CDWs actively supported service development and workforce training. In three CD initiatives, we know that commissioners gave their full support, and we may have found more if our study had been more extensive. The skills and values of the CD practitioners were central to the success of evolving, creative structures and processes for user involvement in service development, and this was recognised, funded and valued.

CDWs got on well with frontline mental health staff where these were able to think creatively and explore new ways of working. One CDW had difficulties where mental health practitioners remained aloof. Two innovative examples of joint working between mental health practitioners and CDWs (East Riding and Leeds) resulted in social and learning opportunities, one for service users and the other for people in the community.

Multi-agency forums seemed to work well, confirming that CD can support partnership working to meet mental health needs. Primary care and GP services were sometimes less easy to engage but were said to be central to the needs of people in all communities. The new shift in funding to benefit primary care, noted in the policy background, will be welcome.

Limitations of management and funding

The limitations upon CD practitioners stemmed from their management, supervision, training and funding rather than any lack of opportunities, which were plentiful. There was an emotional toll on the worker which needed to be acknowledged and addressed. Workers were dealing with sensitive, politically charged issues and, as mentioned above, reflection with others was required to help them think through their next steps. They needed to define the limits of their work, and be able to explain and justify this. About half of the CDWs lacked support in these areas.

Most DRE funded CDWs would have liked more support, particularly through contact with their peers within the region, recognising this as a valuable source of ideas, guidance and support. The constraints of short term funding inhibited the development process, especially in respect of building trusting relationships. Good workers left to find more secure employment. Small grants for trips and minor initiatives helped to ignite collective activity, but could be difficult to find.

Measuring the outcomes

A major challenge to the CD practitioners was the need to measure their effectiveness and demonstrate the outcome of their work. Most endeavoured to keep records, some giving it a higher priority than others. Many lacked a systematic approach to evaluating the impact of their work, more due to a lack of guidance, resources or time than lack of concern.

Local authority and NHS commissioners are now required to be outcome-focused, and one CDW had already adapted his evaluation to fit this approach. Most needed guidance, tools and resources so that they can measure their outcomes in ways that are not invasive or burdensome. Participatory approaches contrast with the statistical monitoring which left workers feeling that the most important aspects of their work were unrecorded. This is an area where CD organisations are beginning to share their learning more widely (e.g. Community Development Foundation and CDX: The Community Development Exchange, 2008).

Conclusion

This has been an exploratory study and should be regarded as preliminary to further research. As noted earlier, it illustrates what can be achieved rather than providing a representative sample of CD practice.

Nevertheless, it demonstrates that, at its best, CD has much to offer. There are commissioners, practitioners and local people who know, from their own experience, that a CD approach can contribute to individual recovery and community well-being through making connections between individuals, groups and organisations. People who are often excluded can be included as both participant and leader in their communities.

Many have a vision that it can succeed on a broader scale by helping to create the healthy and cohesive communities that government and local people want. We hope that this vision can be shared more widely by gathering the evidence, reducing the fear of giving local people (including those with mental health problems) more control, and resourcing the skills and continuity of the community development practitioners.

“Those of us who are mental health professionals need to ...hand over control to service users and communities by fostering service user leadership, integrating with other sectors and fostering community development and inclusion. Only by doing this do we stand a chance of reducing the exclusion that both increases the likelihood of serious mental health problems and decreases the likelihood of those with such difficulties living well and prospering.” (Perkins, 2008)

17. Recommendations

FOR POLICY MAKERS

(including Public Health, Mental Health, Community Cohesion, Welfare Benefits)

1. Identify connections between policies for community cohesion, community well-being, social inclusion and equality.
2. Promote CD as an effective tool for local implementation of these policies at a community level.
3. Ensure policy implementation through strong, visible leadership at a national level.
4. Improve sustainability by promoting continuity of funding (3 – 5 years or more) for community development.
5. Increase opportunities for people on incapacity based benefits to participate in these activities, by reducing the fear of being financially penalised by the benefits system.

FOR COMMISSIONERS AND STRATEGIC HEALTH AUTHORITIES

(including commissioners for Public Health and Mental Health)

6. Identify connections between strategies for community cohesion, community well-being, social inclusion and equality, and use CD as an effective tool for the implementation of these strategies.
7. Ensure strong, visible leadership at Strategic Health Authority and at a local level, to support effective development of the CD role.
8. Enable and equip all generic community development practitioners to have the confidence, sensitivity and knowledge to welcome and involve people with mental health difficulties from all local community groups.
9. Enable and encourage all community development workers to give local people a lead role in addressing their shared problems, by collective action to develop community led resources.
10. Promote sustainable change through community development by providing continuity of funding (3 – 5 years and more).
11. Increase the number of enterprise support workers who have the confidence, sensitivity and knowledge to support individuals and groups of people with experience of mental health problems.

FOR EMPLOYERS OF CDWS

(including Primary Care Trusts, Local Authorities and Voluntary Sector Organisations)

12. Train and support all CDWs to work with people with mental health difficulties, so they have a good understanding of:
 - the social model of mental health and how different communities understand mental health issues;
 - the source and nature of help from local mental health services; and
 - how to communicate effectively and sensitively on mental health issues to service providers and people from all local communities.
13. Train and support CDWs to reduce the tensions which arise within community groups because of mental health issues, such as fear, stigma and stereotyping.
14. Provide opportunities for support, reflection and professional development by:
 - regular support from colleagues, peers and manager;
 - networks (e.g. through CDX¹, FCDL² and where appropriate, DRE regionally and nationally); and
 - continuing professional development available through a variety of means and at different levels.
15. Where CDWs work alongside people with acute mental health needs, offer:
 - an opportunity to off-load emotional pressures (ideally the same day);
 - clinical supervision at regular (monthly) intervals.
16. Ensure CDWs with a mental health remit are managed by those committed to develop an expertise in both mental health and community development, and in particular, sensitive to the pressures of mental health and community development work:
 - support CDWs in maintaining role boundaries;
 - limit over-commitment and burn-out; and
 - plan a manageable work programme which balances the needs of both the funding body and targeted communities.
17. Train and support CDWs to facilitate self-help initiatives in such a way as to place control within the group, avoid dependency and promote inclusion of people with mental health problems.
18. Provide 'seedcorn' funding for the CDW to use at their discretion, to initiate and support community activities e.g. room hire, trips, publicity, refreshments, translations.
19. Promote sustainable change through community development by providing continuity of funding (3 – 5 years and more).

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¹ Community Development Exchange – www.cdx.org.uk

² Federation of Community Development Learning – www.fcld.org.uk

FOR COMMUNITY DEVELOPMENT AGENCIES

20. Support the development of rigorous, community sensitive, participatory approaches to evaluation and monitoring for community development with a range of guides and tools.
21. Adopt outcomes and indicators of progress which guide and measure work rather than confine CDWs to preconceived targets and outputs.
22. Within the community development profession, raise the profile of mental health problems as a major cause of social exclusion and inequality.
23. Increase understanding of how community development can tackle this social exclusion and inequality by promoting well-being, respect and inclusion within and across groups and services.
24. Within the community development profession, promote lay perspectives of mental health and increase understanding of how mental health services work in the statutory and voluntary sector.
25. Work with mental health service user groups, voluntary sector organisations, NHS agencies (secondary care, primary care and regional bodies) and universities to:
 - increase the confidence, sensitivity and knowledge of CDWs to work inclusively with local communities;
 - increase the understanding of community development within the mental health sector.

APPENDIX 1

List of organisations and groups participating in the interviews

Aberdeen City Council, Community Learning, Mental Health, Neighbourhood Services Central

Ground Floor, St. Nicholas House, Broad Street, Aberdeen. AB10 1AR
01224 522000

Active Faiths Communities Programme

Chantry House, Victoria Road, Kirkstall, Leeds. LS5 3JB
0845 658 0388
www.activefaiths.org.uk

Awakenings

(Formerly based at West City Community Project)
Queries to: Community Development Unit, Civic Centre, Barras Bridge, Newcastle upon Tyne. NE99 1RD
0191 2328520

Barnsley Black and Ethnic Minority Initiative (BBEMI)

Unit 4, Burleigh Court, Burleigh Street, Barnsley. S70 1XY
01226 284477
www.bbemi.org

Beat the Blues

Mind, Dove House, 65-67 Union St, Stockport. SK1 3NP.
07757 745 759

Bradford Speakout

c/o BACC Unit 37 Carlisle Business Centre, 60 Carlisle Road, Bradford. BD8 8BD
01274 481590
www.bradfordspeakout.org

Bradford Vision

(no longer operational)
Queries to: Senior Health Promotion Specialist/Community Development, Public Health Directorate, Bradford and Airedale teaching Primary Care Trust, Leeds Road Hospital, Maudsley Street, Bradford. BD3 9LH
07931 674 107

East Riding of Yorkshire, Sports Development Service

County Hall, Cross Street, Beverley. HU17 9BA
01482 392534
www.eastriding.gov.uk/leisure/sportsdev

Ffenics Ltd and Humunn Resources

17 Park Crescent, Abergavenny, Monmouthshire. NP7 5TH
0845 347 9316

www.humunn-resources.com

www.ffenics.coop

Leeds Partnerships NHS Foundation Trust, Carers Team

South Wing, St Marys House, St Marys Road, Leeds. LS7 3JX
0113 295 4445

Leeds NHS Primary Care Trust

North West House, West Park Ring Road, Leeds. LS16 6QG
0113 305 7370

Midweek

c/o Stockport PCT Community Development Team
St Luke's Parish Hall, Northumberland Road, Brinnington, Stockport. SK5
0161 419 4840

Newcastle City Council, West City Community Project

(no longer operational)

Queries to: Community Development Unit, Civic Centre, Barras Bridge, Newcastle upon Tyne. NE99 1RD
0191 2328520

**NHS South of Tyne and Wear (South Tyneside Primary Care Trust),
Community Development Team**

Clarendon, Windmill way, Hebburn, Tyne and Wear. NE 31 1AT
0191 283 1238

Open Up

Mental Health Media, 356 Holloway Road, London. N7 6PA
020 7700 8171

www.openuptoolkit.net

Orb Community Enterprise

Unit F9, The Warehouse, Harcourt Road, Harrogate. HG1 5NL
01423 500620

www.orbcommunityenterprise.org.uk

Roshni Ghar

13 Scott Street, Keighley, West Yorkshire, BD21 2JH
01535 691 758

www.roshnighar.org.uk

Social Action for Health, Mental Health Guides Project

62 Beechwood Road, Hackney, London. E8 3DY
0207 275 2730

www.safh.org.uk

Start the Week

c/o Stockport PCT Community Development Team
Tiviot Dale Methodist Church, Tiviot Dale, Stockport. SK1 1TA
0161 419 4840

Stockport Primary Care Trust, Community Development Team

The Gallery, Cherry Tree Hospital, Cherry Tree Lane, Stockport. SK2 7PZ
0161 419 4840

Stockport Metropolitan Borough Council, Stockport Adults and Communities Directorate

Town Hall, Edward Street, Stockport. SK1 3XE
0161 480 4949

Torbay Housing Services, Supporting People Team

Pearl Assurance House, 101-107 Union Street, Torquay, Devon. TQ1 3DW
01803 208424

www.torbay.gov.uk/supportingpeople

Touchstone Community Development Service

53-55 Harehills Avenue, Leeds. LS8 4EX
0113 219 2727

www.touchstone-leeds.co.uk

Upper Teesdale Agricultural Support Service (UTASS)

1-2 Horsemarket, Middleton-in-Teesdale, Co.Durham. DL12 0SH
01833 641010

www.utass.org

Warrington Council for Voluntary Service,

The Gateway, 89 Sankey Street, Warrington. WA1 1SR
01925 246880

www.warringtoncvs.org.uk

APPENDIX 2

Occupational Standards

Extract from:

A summary of Good Practice Standards for Community Development Work

- Available at www.fcdl.org.uk
- Note these standards are to be updated in 2008.

Role A:

Develop working relationships with communities and organisations

- Make relationships within communities.
- Build relationships within and with communities and organisations.
- Develop strategic relationships with communities, organisations and within partnerships.

Role B:

Encourage people to work with and learn from each other

- Contribute to the development of community groups/networks.
- Facilitate the development of community groups/networks.
- Facilitate ways of working collaboratively.
- Promote and support learning from practice and experience.
- Create opportunities for learning from practice and experience.
- Support individuals, community groups and communities to deal with conflict.
- Take action with individuals, community groups and communities to deal with conflict.

Role C:

Work with people in communities to plan for change and take collective action

- Work within communities to select options and make plans for collective action.
- Contribute to collective action within a community.
- Support communities to plan and take collective action.
- Ensure community participation in planning and taking collective action.
- Contribute to the review of needs, opportunities, rights and responsibilities within a community.
- Work with communities to identify needs, opportunities, rights and responsibilities.

Role D:

Work with people in communities to develop and use frameworks for evaluation

- Support communities to monitor and review action for change.
- Facilitate the development of evaluation networks.

Role E:**Develop community organisations**

- Encourage the best use of resources.
- Review and develop funding and resources.
- Develop and evaluate a funding/resourcing strategy.
- Develop people's skills and roles within community groups/networks.
- Facilitate the development of people and learning in communities.
- Develop and review community-based organisational structures.
- Develop and maintain organisational frameworks for community-based initiatives.

Role F:**Reflect on and develop own practice and role**

- Identify and reflect on own practice, knowledge and values.
- Review own practice, knowledge and values.
- Evaluate and develop own practice.
- Identify and take action to meet own learning and development needs.
- Review and meet own learning and development needs.

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GLOSSARY AND ABBREVIATIONS

ASIST training	ASIST is workshop based training that provides participants with the practical skills to identify when someone is at risk of suicide and know how to competently intervene.
CD	Community Development
CDW	Community Development Worker
CSIP	Care Services Improvement Partnership
CVS	Council for Voluntary Service
DRE	<i>Delivering Race Equality</i> Department of Health policy and action plan 2005
ESOL	English as a second language teaching
Mental Health First Aid Training	As with first-aid for physical health, mental health first aid is based on the idea that the earlier a person can get help the better. It teaches people how to recognise the signs and symptoms of mental health problems, how to help in a crisis, and to guide people towards getting assistance. (www.smhfa.com)
NIMHE	National Institute for Mental Health England
PCT	Primary Care Trust
Primary care	Primary care services are those delivered in the community to individuals and families, usually through the GP or local health centre.
Secondary care	Secondary care services include specialist mental health services delivered in hospitals and through specialist mental health services.
Mental health service user	A person who is using or has used mental health services
SHIFT	A programme funded by the Department of Health to reduce the stigma of mental ill-health
Survivor	A person who has used mental health services and chooses to describe him or herself this way
STR worker	Support, Time and Recovery Worker in mental health services

