

## Research paper

# Community development approaches to working with groups of people with mental health problems to promote race equality in mental health

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### What is known on this subject

- Many people with a black, Asian or minority ethnic background experience fear or alienation in UK mental health services.
- Community development takes different forms in different contexts, and the roles of community development workers differ accordingly.
- The role of the community development worker within the UK mental health services programme, *Delivering Race Equality*, is complex and challenging.

### What this paper adds

- It brings descriptions of the different professional approaches within the community development field together with different perspectives on social inequality and race inequality in mental health.
- It shows how these different perspectives have been merged by a sample of community development workers, funded through the UK *Delivering Race Equality* programme, to underpin their practice with groups of people with mental health problems, although conclusions can only be tentative with such a small sample.
- Despite the small sample size, the study identifies three distinct approaches adopted by these community development workers, namely a bold approach to tackle an imbalance of power within mental health services, a focus on promoting social inclusion and well-being within diverse communities, and finally a concern to deliver the required policy outputs.

## ABSTRACT

Community development is a process whereby people come together to address shared concerns. Community development workers (CDWs) support these processes, promoting justice and equality. In the UK, CDWs have had a long history of adapting to different contexts, but when in 2005 they were introduced within mental health services to promote race equality, expectations were said to be too high. This study explores the role of CDWs by focusing on how they worked with peer-led groups of people with mental health problems to increase race equality in terms of well-being and mental healthcare.

Employing a two-step process, the study began with a survey to find out which CDWs worked with people with mental health problems, what this involved and how they felt about working with peer-led groups. A diverse sample of those who

prioritised work with peer-led groups of people with common or severe mental health problems was selected for semi-structured interviews to explore their purpose, activities and perspectives, using thematic analysis.

A total of 46 CDWs responded to the survey, representing approximately 11% of the workforce. Most of them worked with people with mental health problems to promote inclusion, well-being and engagement, and four of them sought to help groups to pursue their own goals. Nine CDWs were selected for interviewing and, despite the small sample, three distinct approaches to their work were identified. The first approach supported service user-led groups to address the power imbalance in services, the second approach supported community-led groups to promote social inclusion, and the third approach focused on policy implementation

and outputs. Differences were associated with CDWs' previous experiences of mental health and workplace context.

Conclusions can only be tentative due to the small sample size, but the findings suggest that CDWs can promote race equality in mental health

services, using diverse approaches to community development. However, few of them appear to help service user-led groups to pursue radical change.

**Keywords:** community development, mental health, race equality, well-being

## Introduction

Community development is often described as a process whereby people within a situation come together to improve that situation, with a strong tradition of addressing inequality and exclusion (Community Development Foundation, 2006). Community development workers (CDWs) are catalysts who support these processes. In practice, community development takes different forms across different countries and contexts, ranging from social movements associated with less developed countries to professionally led interventions funded by public authorities (Henderson and Vercseg, 2010). Across Northern Europe, and particularly in the UK, where it has more than a 100-year history, community development is associated with traditions of mutual aid, partnership working and economic or social development (Henderson and Vercseg, 2010). The goals, philosophies and strategies of CDWs shift within the broad parameters of their field.

There has been long-standing concern in the UK about the high numbers and harsh experiences of people from black, Asian and minority ethnic (BAME) groups in mental health services (Bhui and Bhugra, 2002). In 2002, a primary healthcare trust in the north of England funded a voluntary sector organisation, Sharing Voices Bradford, to address race inequality in mental health using an innovative model based on the principles of community development and a critical perspective of psychiatry (Bracken and Thomas, 2005). A valued part of the community development in this context was the support provided for peer-led groups of people with mental health problems (Thomas *et al*, 2006). Then, in 2005, the UK Department of Health funded 500 CDWs to address race inequality in mental health within its *Delivering Race Equality (DRE)* action plan (Department of Health, 2005). Many people struggled to comprehend what contribution CDWs could make in this setting. Not for the first time, community development was considered to be 'vague and pretentious ... claiming too much' (Henderson and Vercseg, 2010, p. 25).

To learn how CDWs might contribute to the mental health field, and inspired by Sharing Voices Bradford, this study focused specifically on work with peer-led

groups. It aimed to describe how a sample of CDWs on the DRE programme worked with peer-led groups of people with mental health problems to increase race equality in terms of well-being or mental health services. The study explored how these CDWs described their goals, perspectives and workplace strategies. The understanding that was gained showed how the conceptual frameworks and traditions of community development, mental health and race equality can be merged to underpin useful interventions. Although the DRE programme has ended, many CDWs remain in their posts, and this study aims to inform the debate about their work.

## Literature review

The literature review sets the context by briefly outlining perspectives on race inequality in terms of well-being and mental health problems before describing the different approaches taken by CDWs in the UK.

### Social inequality and well-being

In the UK, social inequality abounds in complex ways across and within different communities, and it particularly affects BAME groups. Within the critical sphere of employment, inequality begins at school, where unintentional racism is one of the factors thought to explain black Caribbean boys' underachievement (Strand, 2007). The recession has taken unemployment levels among young black people to 48%, over twice that of their white peers (Institute for Public Policy Research, 2010). Members of BAME groups are less likely to be employed than white people, with rates being around 32% lower for Bangladeshi people and 6% lower for Indian people (Office for National Statistics, 2007). Unemployment, the social exclusion associated with it and the experience of living in a discriminatory or racist society all contribute to common and severe mental health problems (Karlsen and Nazroo, 2002; Janssen *et al*, 2003; Social Exclusion Unit, 2004). Across the world, relative deprivation and social injustice are said to 'erode the

emotional, spiritual and intellectual resources essential to psychological wellbeing.’ The solution lies not in individual pathology but in addressing inequalities and creating cooperative connections within communities (Friedli, 2009, p. iii).

Social inequalities are often explained by structural differentials in power and access to resources (Williams and Keating, 2005). Other suggestions include lack of understanding of the system, the notion of a deficit within certain groups, and blaming cultural barriers for some groups’ limited participation in society and a cultural preference for non-Western ways of healing (Community Cohesion Review Team, 2001; Fernando, 2003).

### Race inequality within mental healthcare

Race inequality is well documented within England’s mental health services. Africans, Caribbeans, people of mixed heritage, and others who identify themselves as black persistently experience disproportionately high rates of admission and detention (Care Quality Commission, 2010). The values and perspectives of the majority population dominate in public services, leaving people who are from a visible minority, who have a different view of the world or who speak a different language at risk of fear, alienation and discrimination in mental health services (National Institute for Mental Health in England, 2003; Keating and Robertson, 2004). If we want to improve this situation, it has been argued by Fernando (2009, p. 42), we must pay attention to ‘rights and justice, alienation and inclusion, power and privilege.’ Others have a more medical perspective, but some consensus is emerging that social disadvantage and discrimination create acute distress among black people, and a public health strategy to reduce this distress is long overdue (McKenzie, 2010).

Many argue that racism is deeply embedded in English institutional processes and practices (e.g. Blofeld, 2003). The Department of Health sidesteps this issue by referring instead to *discrimination* and *cultural difference*. In this context, training and increasing workforce diversity are seen as the way forward. However, training is insufficient, often fundamentally flawed (Bennett and Keating, 2008), and cannot be guaranteed to deliver the respectful, individually tailored and caring approach that most individuals want (Gunaratnam, 2008). Although hospital services increasingly cater for dietary, faith and language needs, the psychiatric model prevails over the spiritual, social and economic explanations that many BAME groups give for their distress (McCabe and Priebe, 2004; Sewell, 2009). The fear and stigma of mental health problems within BAME communities and their lack of

a voice within mental health services are addressed within DRE by community engagement initiatives, mainly workshops, events and research bringing communities and services closer together. However, engagement has no impact on the structures of our society (Seebohm *et al*, 2005). Indeed some research and other activities that are described as participatory mask a reassertion of power and social control by dominant groups and discourses (Ledwith and Springett, 2010).

BAME groups and organisations are greatly valued by people who attend them (Jones, 2009; Stanley, 2009), but secure funding enabling them to deliver their own approaches to healing or to pursue their own goals is rare. Mutual aid groups offer the alternative approaches to managing mental health problems that are preferred by many people, especially those from BAME backgrounds (Branfield and Beresford, 2006; Sewell, 2009). Participants are free from the provider–user or white–black differential in power and status. As they share experiences with their peers, individuals gain a broader understanding of their situation, re-interpret past experiences and gain strategies to address their problems (Munn-Giddings and Borkman, 2005). At Sharing Voices Bradford, group members gained confidence and aspirations with regard to work (Seebohm *et al*, 2005). By fostering members’ belief in their ability to succeed, peer-led groups can help people to achieve these aspirations (Grove and Membrey, 2005).

### The introduction of CDWs in mental health

In 2003, the death of a black musician, David ‘Rocky’ Bennett, within a secure mental health unit brought the problems facing BAME groups into the political arena in the UK. Based on a public consultation, new proposals suggested that CDWs were part of the solution to help BAME communities to build on their strengths (National Institute for Mental Health in England, 2003). However, when DRE was implemented in 2005, CDWs were given a strategic role, closely aligned to statutory services. *Capacity building* within communities became only one of four functions, alongside those of *change agent*, *service developer* and *access facilitator*. Many questioned the role, fearing that it was too ambitious (Greater London Authority, 2005). In 2009, a survey of the DRE CDW workforce identified valuable achievements, but found that many CDWs lacked understanding of their role and gave a low priority to their community capacity-building function, creating a risk that their CDW title was a misnomer (Walker and Craig, 2009, p. 86). The debate about CDWs continued.

## Overview of the CDW role in the UK

CDWs support people coming together within their community, which is defined by locality, shared interest, purpose or identity, and help them to identify shared concerns and increase control over decisions that matter to them. They also help public authorities to understand and engage with the communities that they serve (Community Development Foundation, 2006). A substantial body of international literature and occupational standards in the UK give CDWs a remit to promote social justice, equality and self-determination (Budapest Declaration, 2004; Lifelong Learning UK, 2009), but there is wide variation in practice.

Community development in the UK dates back to the university settlements in London at the start of the 20th century (Gilchrist, 2004). In the 1970s, CDWs were incorporated into social work teams, providing the 'preventative branch of social work' that encouraged involvement in social activities to protect people against mental health problems (Gilchrist, 2004, p. 14). This consensus approach addressed deficits that were perceived to lie within the population, and presented no challenge to the structures of society (Gilchrist, 2004, p. 24). In 1969, the UK government funded the Community Development Project (CDP), a national programme to address individual and family breakdown, but some CDP workers came to blame the imbalance of power across society, rather than personal deficiencies (Lees and Smith, 1975). At this time, CDWs were deeply influenced by the Brazilian, Paulo Freire. Although Freire (1972) wrote within a context of extreme poverty and violence, many found his teaching to have immediate and lasting relevance in the West (Ledwith, 2005; Pearce *et al*, 2010). He described how oppressed and marginalised people can overcome their internalised sense of inferiority by sharing their stories and how, with catalytic support, they can gain a critical understanding of the oppressive forces that confine them (Freire, 1972). As people realise that their oppression is neither their fault nor inevitable, they can self-organise and take a lead role in their own enlightenment and emancipation. These ideas underpin the radical model of community development which aims for a redistribution of resources and changes in policy to address inequalities of race, gender and class (Gilchrist, 2004, p. 25). The ideas of Freire (1972) resonate both with the peer-led groups mentioned earlier and with the mental health service users' concept of recovery which respects their lived experience and expertise in managing their own healthcare (Wallcraft, 2005).

Some CDWs adopt a pluralist approach, uniting people within a community of interest such as a disability or ethnic group, to obtain an equal, but not necessarily the same, response from public services

and develop their own resources (Gilchrist, 2004, p. 24). The future role of single-ethnicity organisations is increasingly questioned in the UK. Funders fear that they encourage community fragmentation (Commission on Integration and Cohesion, 2007), while others note the super-diversity of urban populations, where growing numbers of individuals have a mixed heritage (Vertovec, 2007). The Single Equality Act, 2010 integrates communities of interest, including race and gender, within a pan-equalities approach, and there is greater awareness of each person's multiple identities (Sen, 2006).

Since the 1990s, CDWs in the UK have become closely aligned with services such as housing, regeneration and public health, with a functional role characterised by short-term funding and targeted outputs to achieve policy objectives (Butcher *et al*, 2007). Like community engagement, this approach does not threaten existing structures and fits well with the monitoring culture and limited tolerance of bottom-up processes found within health authorities (Community Development Exchange, 2008). Its focus on engagement rather than empowerment creates concern within the profession, and some suggest that its impact is less sustainable (Henderson, 2005).

## The potential of community development in mental health

Where CDWs support group processes, they increase well-being as participants develop the skills, relationships and networks described as social capital (McKenzie, 2006). They draw the socially excluded into community activities (Henderson, 2005), and may support peer-led, non-medical responses to distress (Seebohm and Gilchrist, 2008). Some facilitate democratic processes in which providers and BAME service users work together (Seebohm and Gilchrist, 2008). By bringing service users and others together as equals on a regular basis, CDWs help to shift discriminatory attitudes (Crepaz-Keay *et al*, 2004).

## Aims and objectives

The aim of this study was to describe how a sample of CDWs worked with peer-led groups of people with mental health problems to increase race equality in terms of well-being and mental healthcare. The term '*people with mental health problems*' included those with common mental health problems who used primary care health services, those with severe mental health problems who used specialist mental health services, and others who were distressed but used no services. *Peer-led groups* included both those where

decisions about purpose and activities were made by group members (member led), and those in which decisions were made within the same community (community led). The study adopted a two-step process, beginning with a survey which identified a sample for follow-up interviews. Data collection took place between May and October 2008. Ethical approval was granted by Hertfordshire Research Ethics Committee in March 2008.

### Step 1: Survey

The aim of the questionnaire survey was to find out, from a workforce of approximately 400, which CDWs on the DRE programme worked with people with mental health problems, what this involved, and how they felt about working with peer-led groups. The objectives were to find out:

- which CDWs worked with individuals or groups of people with mental health problems, and whether those people accessed primary, specialist or no mental health services
- the activities involved and who made the decisions about what to do
- whether CDWs felt that working with peer-led groups of people with mental health problems was feasible within DRE, and if so, how important they rated this compared with other aspects of their job.

Access was facilitated by the national DRE leadership, enabling the researcher to explain the background and purpose of the study through presentations at five CDW network meetings in different strategic health authority areas and via email databases. CDWs were invited to complete a questionnaire combining open and closed questions to cover the three objectives listed above, adding at the end any comments on working together with people with mental health problems to promote race equality in mental health. Statistical data were analysed using Excel software. Qualitative data were coded manually using thematic analysis.

### Step 2: Interviews

Seven CDW respondents were selected and invited for interviewing using the following criteria:

- Their questionnaire responses suggested that they worked with groups of people with mental health problems.
- They came from a range of geographical and organisational settings.
- They attached high importance to supporting peer-led groups.

The aims of these interviews were as follows:

- to explore the purpose of the peer-led groups of people with mental health problems, their activities, and how CDWs supported them
- to explore the CDWs' purpose and perspective which influenced the way in which they worked with the groups
- to share the learning with all of the participants in the study.

Semi-structured interviews were conducted face to face, and most of them took just over an hour. With written consent and anonymity assured, interviews were taped, transcribed verbatim, and transcripts agreed with interviewees. The interview schedule asked about the following:

- the nature of the peer-led groups with whom the interviewees worked, including activities, membership and decision-making processes
- the interviewees' role in bringing together, developing and/or sustaining the groups
- their past experience of working with mental health service users
- the difference they sought to make in terms of race equality through this work
- their views on how well the work fitted within their broader CDW role.

Data analysis used a thematic approach, beginning with a broad inductive sweep of all the data (Braun and Clarke, 2006) within a social constructionist framework, which holds that knowledge is not neutral, but rather that different social groups united by culture and situation have diverse worldviews or understandings of the world (Schwandt, 2003). A coding framework was based on patterns of similarity and difference in the way interviewees spoke about their work and its context, focusing on themes relating to role, mental health and race equality, and how different perspectives might be explained. Data that could not contribute to the coding framework were excluded. The draft report was checked with the interviewees, who considered it to be a fair reflection of their views.

## Findings

### Step 1: Survey

A total of 46 questionnaires were completed, representing approximately 11% of the current workforce, and of these, five CDWs did not work with people with mental health problems. About a third ( $n = 15$ ) worked with individual service users, just over half ( $n = 29$ ) worked with groups in the community whose members might be using primary care services, and half ( $n =$

23) worked with groups of mental health service users. Some worked with all three, that is, individuals, community groups and service user groups. All except five questionnaires were completed at the network meetings, and the rest were returned by email. Although the CDWs were supportive at the meetings, few of them felt that the study was relevant to them, as they rarely worked with peer-led groups of people with mental health problems. Comments included the following:

I used to be a CPN [community psychiatric nurse] but I don't work closely with service users now that I'm a CDW.

My role is mainly strategic.

(Fieldnotes, 8 July 2008)

Most of the groups aimed to increase well-being, social inclusion and community engagement through a range of sports, leisure and workshop activities. Two CDWs supported BAME groups to identify and pursue their own goals, and a further two aspired to do so. Five CDWs ( $n = 5$ ) made decisions regarding group activities themselves, while nearly half of the respondents ( $n = 19$ ) reported that it varied, so that sometimes they made the decisions alone and sometimes with group members.

Half of the respondents ( $n = 23$ ) felt that it is possible to support group activities within their CDW role, just over a third ( $n = 17$ ) were not sure, and five did not think it was possible. Just under a third ( $n = 14$ ) felt that this was a very important part of their job. Comments suggested that most respondents were referring to groups promoting health, including occupational therapy, social inclusion or community engagement, and only four respondents were interested in supporting groups to pursue their own goals.

Most of the respondents ( $n = 32$ ) made comments at the end of the questionnaire, mainly about the barriers to community engagement caused by language, culture or stigma. Two respondents mentioned the difficulties of engaging commissioners and senior managers. Several spoke about the CDW role itself. One respondent considered it to be 'intense and demanding', while three others wanted more support to address their own needs. One respondent felt that the expectations placed on them were too high, and another felt that the grassroots and strategic strands of their role were incompatible.

## Step 2: Interviews

### *The interviewees and workplace context*

Seven CDWs agreed to take part, one opting to be interviewed together with two colleagues. In total, therefore, nine CDWs participated in semi-structured interviews, from seven sites across four strategic health authority regions. The participants were aged in their

20s (1), 30s (2), 40s (4) and 50s (2). There were five female and four male participants. They described their ethnic origin as African, African Caribbean and African/white ( $n = 4$ ), Pakistani, Bangladeshi, and Asian/white mixed ( $n = 3$ ) and third-generation Irish ( $n = 2$ ).

In three sites, CDWs were employed by statutory services, two mental health trusts and one PCT, but two of these had a base within the community as well. Four CDWs were employed by voluntary-sector agencies, but one of these planned to spend 60% of her week working from primary care trust offices. The agencies included regeneration, housing, mental health and BAME community organisations. Three of the CDW sites were in major cities, two were in large towns and two were in more rural or suburban settings. CDWs had been in post for different lengths of time, ranging from less than 6 months to over 2 years (see Table 1).

### *Goals, perspectives and strategies*

All of the CDWs were keen to comply with DRE guidance and shared a similar understanding of the community development process, beginning with gaining trust, mapping local needs, engaging people in mental health-related discussions or activities, and bringing communities and providers closer together to improve access and services. However, the DRE guidance was interpreted differently and, as they spoke about their roles, the CDWs revealed differences in their goals, values, perspectives and strategies. They all supported groups of people who lacked well-being or who had mental health problems, but three different approaches were identified. These were termed bands A, B and C, with two CDWs in each band. In the fourth site, three relatively new CDW colleagues did not yet have a defined, settled approach, and these formed band D. In the following description of the three bands the ethnicity of the CDWs is not disclosed, in order to maintain their anonymity. Ethnicity appeared to have some impact on the approach adopted, but other factors such as previous experience seemed equally or more important.

#### *Band A: The structural approach*

Two CDWs supported service user-led groups, helping them to improve the experiences of their BAME peers. The CDWs valued service user expertise and promoted user-led initiatives. They also supported community-led groups addressing race inequality and mental distress through enterprise, the arts and women's activities. This hands-on capacity building included development support, training, making connections and helping with funding applications. Their relationships appeared to be collaborative and friendly.

Both of the CDWs wanted providers and commissioners to hear from and be accountable to their

**Table 1** Community development workers' employer, office base, length of time in post at interview and allocated band (see Figure 1)

Employer	Office base	Time in post at interview	Band
Mental health trust	Voluntary sector	8 months	A (structural)
Mental health trust	Mental health trust and voluntary sector	18 months	A (structural)
Voluntary sector	Voluntary sector	5 months	B (social inclusion)
Voluntary sector	Voluntary sector	10 months	B (social inclusion)
Voluntary sector	Voluntary sector and primary care trust	Over 2 years (part-time)	C (managerial)
Voluntary sector	Voluntary sector	18 months	C (managerial)
Primary care trust	Primary care trust	9 months	D

service users, and they worked to make this happen. One CDW expressed frustration that, despite policy rhetoric promoting service user involvement, power rarely shifted in their favour. However, he was involved in drawing people from BAME communities on to the board of the NHS Foundation Trust and, together with others, sought to sustain them in these roles in order to create a lasting change in the balance of power. The other CDW sought to embed the community voice at a strategic level within planning processes to gain greater weight. They explained that:

Change will only happen if you work with communities collectively and support them and empower them. And from that process here, together, collectively, they can do what they think is necessary to meet their needs.

In terms of the town, getting money, the Local Area Agreements, it is just about getting everybody included in that picture so what is rolled out is more appropriate. Not trying to come in way down the line when everything has already been set ... I think that is the best way to try and make change.

(CDWs Band A)

Both of the CDWs in Band A worked in urban environments and were partly based within community network agencies, although both of them had permanent contracts of employment with the statutory mental health trust. Both were familiar with mental health services prior to this job, and their previous experience included working with people from BAME groups in the voluntary sector and supporting people with mental health problems. In their personal lives, both were involved in community action to address mental health, social or economic issues for black groups.

Both of the CDWs felt that social pressures caused mental health problems and, unlike the other interviewees, they never used the term *mental illness*. They spoke briefly but confidently about racism, discrimination and a lack of equality. Their language suggested that they understood the problems faced by BAME communities in terms of structural inequalities, because they alone spoke of wanting to change the balance of power within institutional settings:

The future of mental health services ideally should be really led by service users.

(CDW Band A)

### **Band B: The social inclusion approach**

Although they had been in post for less than a year, these two CDWs had supportive relationships with many community-led groups, offering empathy and encouragement to them and their leaders while also learning from them. Both of the CDWs wanted to increase social inclusion and inclusive practices, but they differed in their approach. One helped to set up community-led social activities for people from specific BAME groups who were isolated or distressed, so that they could join in activities of their choice within their own community. The other CDW prioritised integration and helped to make existing groups more inclusive. For example:

I think there needs to be more awareness of individual cultures and what their beliefs are ... there is too much of a 'one size fits all' approach.

I don't believe in fragmentation, I don't believe in creating islands of people. I believe in integration and that is the main purpose.

(CDWs Band B)

They had limited contact with mental health service user groups, and made no mention of promoting service user involvement processes, but they wanted to increase understanding of different cultures within services and society.

Both of these CDWs were employed by voluntary-sector organisations, one within a city housing project and the other in a suburban mental health project. Their previous experience included counselling, which they continued to deliver, helping troubled individuals to thrive, but they had no prior contact with mental health services. They valued the strengths of community groups which they felt had much to offer in terms of promoting well-being. They did not speak of racism or discrimination, but they recognised difference and disadvantage across cultural groups. Social inclusion was important to all of the CDWs in the study, but to those in band B it had a particularly high priority.

### *Band C: The managerial approach*

These two CDWs had been in post longer than the others, and described their work as a process which began with community engagement, that is, gaining the trust of people from BAME communities and raising their awareness of the DRE agenda. Now both of the CDWs felt well connected with local communities and they turned towards mental health services to improve cultural competency among the workforce. One was moving into primary care trust offices for 60% of her time. Their work with groups was primarily with community group leaders and rarely with group members. One of them had arm's-length contact with a wide variety of community groups after acquiring temporary funding for a worker to set them up.

Both of the CDWs tried to engage BAME representatives in formal planning processes, but encountered a lack of interest, skills or funding. Instead, they organised community engagement events, workshops and, in one case, research to gather community views and provide information about local services. They organised celebrations of culture, food and music, with positive written and verbal feedback from many participants.

These CDWs were employed on 3-year contracts within BAME voluntary-sector organisations, and had been in post for 18 and 25 months, respectively. Their midway positions on short-term contracts made it both easier and more pressing for them to see their work as a staged process with different activities and outputs recorded and measured. They perceived the CDW's role as primarily to increase awareness and understanding between providers and communities because:

We have to try to ensure ... that [public services] have cultural competence in serving these people, so they take their culture, their faith, their backgrounds into consideration when providing the service.

We wanted people to get a better understanding of services.

(CDWs band C)

They appeared to adopt a largely medical model of mental health problems, although one had seen the impact of economic and social pressures on BAME people in an earlier welfare rights role. The other CDW in band C had no prior understanding of mental health issues, and learned from mental health staff. Both of the CDWs felt that BAME communities lacked understanding of mental health problems:

We find with community groups a lot of the people have difficulties understanding mental illnesses. ... There is a lack of understanding in terms of medications ... and about mental health in general.

(CDW Band C)

Neither of the CDWs mentioned racism, discrimination or equality, but in different ways they spoke about the poor service and lack of interpreters available to people from BAME communities. Their approach had similarities to that of the CDWs in bands A and B, but differed in the way that they described their work as a process, implementing the DRE programme. They are described as *managerial* because of this focus on policy implementation and because they seemed to be removed from the grassroots population, identifying more with community leaders. In organising community activities they were more likely to take a lead role and they had a less collaborative style than the CDWs in bands A and B.

### *Band D*

Overall, the aim of these three CDWs was to empower local groups, by trying to give people more control over their group activities, linking others with the Scrutiny Panel which reviews local authority decisions and the NHS Foundation Trust board because:

[Professionals] assume that people just want to be passive recipients of services rather than actually getting involved in the decision-making process, which is what our role is about.

(CDW Band D)

However, compared with the other CDWs, it was taking those in Band D longer to gain the trust of BAME groups, who associated them with the primary care trust. They were keen to facilitate dialogue between commissioners and local people, but progress was slow. They felt more supported by the health authorities than did the other CDWs, and one member of the team emphasised that 'it's not a battle.' All three had permanent contracts with the primary care trust where they were based. Their previous experience included community development and mental health social work, and they shifted between community and medical perspectives of mental health,



which may have impeded some of their relationships with BAME groups.

## Discussion

Despite the small size of the sample, three distinctly different ways of working with groups of people with mental health problems were identified, underpinned by different goals and perspectives. Figure 1 illustrates the three approaches. The inner circle portrays the approach of the *structural* CDWs in Band A. These CDWs adopted a collaborative style in their support for service user-led groups, valuing their expertise and helping them to develop their resources, influenced perhaps by their personal involvement with mental health issues. They spoke of racism and inequality, and pursued greater accountability and a power shift from providers to users. Although they were employed by the mental health trust, their base in the community gave them the necessary connections and credibility, while their permanent contracts may have increased their confidence. These CDWs adopted a bold radical approach to community development, enabling oppressed and marginalised people to come together and create change on their own terms. With echoes of Freire (1972) and Fernando (2009), they tackled power differentials to promote race equality and well-being.

The second circle portrays the approach of the *social inclusion* CDWs in Band B. These CDWs supported community leaders to bring together their isolated and excluded peers, believing in the capacity of community-led groups to promote well-being. They tried to make society and services more inclusive and

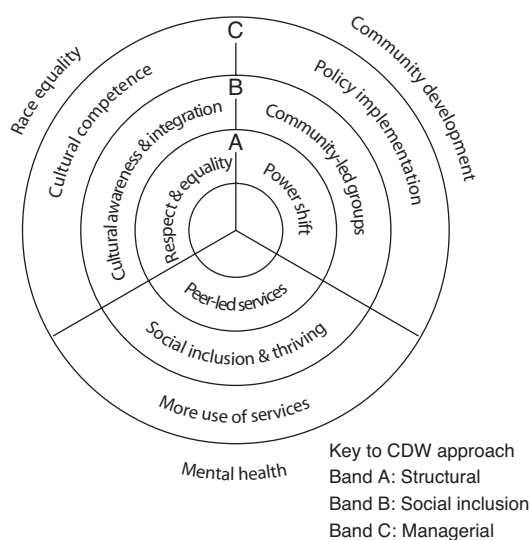
understanding. The approach taken by one CDW is reminiscent of the pluralist model of community development supporting culturally specific activities, while the other CDW shared government concern about fragmentation. As in the consensus model described above, neither of these approaches threaten social structures, as the question of who held the power seemed less important than how power was used by those who had it. Their voluntary-sector employer and personal background made it natural for them to focus on the community, increasing the connections and cooperation that build well-being (Friedli, 2009).

The third circle refers to the *managerial* CDWs in Band C. Despite being the only CDWs who were based within BAME community projects, these were most removed from the grassroots and clearly focused on policy implementation. Finding service users uninterested in planning processes, they successfully engaged large numbers of people in workshops and events, achieving significant outputs but being unlikely to create the type of contact necessary to shift attitudes or the balance of power. Overall, their approach most closely reflected the language and style of the DRE programme as, with short-term contracts, they sought to increase use of services and deliver cultural competence training. Their approach reflects the functional model of community development, associated with incremental but less sustainable change.

The team of CDWs in Band D, not illustrated in the diagram, spanned bands A to C. Permanent contracts and a background in community development may explain their readiness to use the mechanisms that shift the balance of power, but their effectiveness was limited because BAME groups identified them as part of the primary care trust. However, the team were still new and felt that the tide was beginning to turn in their favour.

This study helps to clarify the potential contribution of CDWs within DRE by showing that some of them can and do work with peer-led groups of people with mental health problems to promote race equality in terms of well-being and healthcare. Research referred to earlier in this paper suggests that peer-led groups enable individuals to replace their pathological and discriminatory self-images with more positive interpretations of their situation, helping them to manage their distress, challenge discrimination or move into employment. Some DRE CDWs help to bring about a sustainable shift in the balance of power towards service users and others from BAME groups.

However, the study also suggests that few CDWs do work in this way. The final comments from the survey indicate that, as anticipated, the DRE role may ask for too much. Time-consuming community capacity-building work and bottom-up processes with service user-led groups may not be compatible with a strategic



**Figure 1** Community development workers' goals and perspectives.

role within statutory services. CDWs who fail to respect community perceptions of mental health problems may struggle to make sustainable change in relationships between the medical profession, service users and BAME groups.

## Limitations

The 11% response rate to the survey does not provide a robust evidence base upon which to draw conclusions about the findings. However, there is a correspondence between the feedback at the network presentations, the low response rate and the findings, which all tentatively suggest that few CDWs work with member-led groups of people with severe mental health problems, although more of them appear to work with community-led groups of people who may have common mental health problems.

Despite the small sample in step 2, it is still possible to discern three different approaches to working with groups in the qualitative data. The analysis shows how the purposes and conceptual frameworks of community development, race equality and mental health can merge in different ways to shape practice on the ground. Further research would be required to confirm and develop these findings.

## Conclusions

This study shows how a sample of CDWs bring synergy to their different perspectives on race equality, mental health and community development, giving constructive coherence to their practice, with varying results. Within the small sample, it identifies three distinct approaches to working with groups, including a bold approach to tackling fundamental inequalities of power within UK mental health services, a focus on greater social inclusion within diverse communities, and finally a concern to comply with policy requirements. Together these illustrate the broad spectrum of approaches to community development found within the UK, but influenced by others as far afield as Latin America.

Due to the limited numbers involved, this study cannot claim that these findings reflect ways of working with groups across the wider DRE CDW workforce. Conclusions can only be tentative, but as a consensus emerges on the need for a public health strategy to reduce mental distress among black people, the findings offer hope that further research on the most effective approach to community development in this context might help to tackle mental distress among people with a BAME background.

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#### CONFLICTS OF INTEREST

None.

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