Community and Mental Health

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Commissioned by the
National Economic and Social Forum
Project Team on Mental Health and Social Inclusion²

March 2007

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² The final report of the Project Team, Mental Health and Social Inclusion, is available from the National Economic and Social Forum. See the NESF website www.nesf.ie.
Introduction

This report explores how the inclusion of those experiencing mental ill health might be attained through social supports and strengthening communities with particular reference to community development approaches. It begins by considering how the community or area in which one lives can influence overall health and well being generally and more specifically mental health. It then considers the impact of social exclusion on those experiencing mental illness and how strengthening social capital is regarded as a means of promoting the social inclusion within communities. The main focus of the paper is on community development as an approach to promoting social capital and social inclusion by considering what community development is, the role of community development in health in a wider sense, community development projects which aim to improve mental health and the potential of community development in Ireland to promote the social inclusion of those with mental illness. The paper concludes that a community development approach to fostering the social inclusion of those with mental illness while challenging can be achieved if there is a strong policy and organisational commitment to doing so.

How Community Impacts on Health

Today the research and policy focus in Ireland as in many other developed countries are as much on deprived areas as deprived people. This concern with place stems form a growing acknowledgement of spatial policy within wider social policies and allied to this a perception that where a person lives might be a considerable factor in structuring social and economic inequality (Buck, 2001). Within this concept there is “implicated a belief that where people live affects their chances to participate in an ‘inclusive society’ over and above non-spatial explanatory social categories” (Atkinson and Kintrea, 2001; 2277). Yet as Propper et al (2005) highlight there are few systematic investigations of whether individuals living in disadvantaged areas experience more ill health because they are predominantly of lower socio economic status “or because there is something unhealthy about living in such communities” (2005; 2066).

The effect of community on health is an area of growing interest for those concerned with understanding the causes of health inequalities (for example, Macintyre, Maciver & Sooman, 1993; Sooman & Macintyre, 1995; Cattell, 2001; Popay et. al, 2003). It is
generally accepted that inequalities in mortality and morbidity stem from differences in location, ethnicity, occupation, income, social class, unemployment, educational achievement and gender. Graham (2001) argues that there are three main explanations for causation of health inequalities: material, behavioural and psychosocial. Material factors include living conditions, the physical environment, employment conditions and standards of living. Behavioural explanations focus on the individual and their health related behaviours such as diet, smoking alcohol consumption and exercise. Psychosocial factors involve the psychological effects of living in an “unequal society. For example, perceiving oneself to be worse off relative to others may carry a health penalty, in terms of increased stress and risk-taking behaviour” (Graham, 2001; 15). In reality, it is the combination of these factors that or the sum of all parts that result in health inequalities as “the distinction between behavioural and materialist explanations is seen as increasingly artificial” (O’Shea and Kelleher, 2001; 292).

The central question is whether or not social and economic inequalities are compositional that is; that an individual’s well-being is dependent on their or their families’ characteristics or contextual; that is “whether a concentration of (some or all) disadvantage groups in particular areas gives rise to externalities with an additional effect on the opportunities, behaviour and well-being of (some or all) of the local population” (Buck, 2001; 2252). The reality is that it is difficult to separate the compositional and contextual effects as Buck concludes “people are influenced by their context and, at the same time, influence that context” (Buck, 2001; 2256). For those such as Graham (2001) there is a belief that the area in which people live exerts an influence on their health, over and above the effects of their individual socio-economic circumstances. Popay et al (2003) highlighted that for some individuals their experience of a place at a particular time may in fact be the dominant influence on their quality of life. Sooman and Macintyre (1995) found evidence that how an individual perceives aspects of their local area such as housing and the quality of the neighbourhood might be important for health and well-being.

Ellaway, Macintyre and Kearns (2001) explain that from the ‘psychosocial environment perspective' health inequalities stem from perceived levels of relative income which can create emotions such as shame and distrust. Such negative emotions can then manifest in poor health through ‘psychoneuroendocrine mechanisms’ and behaviour damaging to
health as well as lead to low levels of civic participation and social cohesion. They argue that it is in this manner that “perceptions of social status have negative biological consequences for individuals and negative social consequences for how individuals interact, and serve as the conceptual link between individual and social pathology” (Ellaway, Macintyre and Kearns, 2001; 2300).

With regard to how the area an individual lives in impacts on their overall well-being, Atkinson and Kintrea explain that the exploration for an area effect is “the attempt to consider the outcome in life chances and opportunities that might vary if one lived or grew up in different types of areas” they also point to the difficulty in identifying such effects “as they are located among a number of social processes which are themselves circuitous and inter-related” (Atkinson and Kintrea, 2001; 2278). They point to concentration effects, location effects, milieu and socialization, physical and service effects as the main area effects. The authors note Power’s (2000) observation of the effect of long term disadvantage of an area:

“the larger and longer running the area problems, the stronger the cumulative impact becomes, leading to the flight of those most able to go and the gradual loss of control resulting from chronic instability … these clustering impacts on people’s life chances and on neighbourhood conditions have wider consequences [they] generate a gradual loss of confidence in the system” (Power cited in Atkinson and Kintrea, 2001; 2279-80).

Macintyre, Ellaway and Cummins (2002) proposed the utilisation of a framework of universal human needs as a basis for thinking about how places may influence health and proposed five broad categories of socio-environmental influences of place upon health in order to ascertain what constitutes a ‘healthy neighbourhood’:

- The physical environment;
- Availability of healthy & unhealthy environments;
- Services provided privately or publicly to support people in their daily lives;
- Socio-cultural features of a neighborhood; and
- Reputation of an area (MacIntyre, Ellaway and Cummins, 2002).
As those such as Propper et al (2005) observe there is limited evidence on the link between place and its effect on mental health. How place impacts on mental health can also be understood from the compositional and contextual predicament. Propper et al's large scale investigation in the UK found that composition was more important than context they concluded that:

“neighbourhood attributes are relatively unimportant in determining either levels or trajectories of common mental health disorders. What really matters for mental ill health are the characteristics of individuals and their households” (2005; 2081).

With regard to the impact of communities or neighbourhoods on people's mental health Cameron et al (2003) note that disadvantaged areas often contain large numbers of people with mental health problems and that complex cause and effect relationships create this situation. Cameron et al cite three main reasons for the tendency of people with mental health problems to be concentrated in disadvantaged areas:

- People with mental health problems may be placed in social housing in certain areas due to unemployment or challenging behaviour;
- The mental well being of individuals in disadvantaged areas may be detrimentally affected by poor quality services or a lack of employment opportunities; and
- Severe physical health problems are more prevalent in disadvantaged areas and are related to challenges to mental health (Cameron et al, 2003; 12).

**Mental Health and Social Exclusion**

“A socially inclusive society is defined as one where all people feel valued, their differences are respected, and their basic needs are met so they can live in dignity. Social exclusion is the process of being shut out from the social, economic, political and cultural systems which contribute to the integration of a person in the community” (Cappo 2002, cited in VicHealth, 2005; 1).

‘Social exclusion’ is a relatively well established concept in Irish public policy. It has been widely argued that individuals with mental illness are generally the most excluded in society (Huxley and Thornicroft, 2003). Indeed, Rankin (2005) argues that social exclusion and discrimination can lead to sustained poor mental health. She explains that
individuals do not experience mental illness in isolation “in particular severe mental illness is frequently linked to poverty, discrimination and other complex needs” (Rankin, 2005; 7). Cameron et al explain that “symptoms of mental distress also have a profound impact on life beyond the home. For example, depression and lack of confidence present invisible barriers to activities like accessing employment or training schemes, or taking part in community initiatives” (2003; 12). The social inclusion of individuals with poor mental health is a key policy challenge and one which requires a myriad of responses at the individual, community and wider societal level.

Key policy approaches to tackling social exclusion involve area regeneration and employment both of which are pertinent to those experiencing mental ill health. As Atkinson and Kintrea explain the policy focus on social exclusion indicates that “neighbourhood is an important location that profoundly affects such outcomes as education, employment and health. Nothing is more stark than the possibility that someone will did younger by virtue of where they live or that a person’s address affects their chances of getting a job” (2001; 2277-8).

Social inclusion is increasingly equated with integration in the labour market as Levitas discerns “social exclusion is principally construed as non-participation in the labour market” (2001; 451). Silver and Miller (2002) observe that most policies which promote social cohesion or inclusion emphasise participation of the socially excluded in their own inclusion into economic and social spheres (Millar, 2007). Huxley and Thornicroft (2003) in reference to the UK argue that the economic cost of excluding individuals with mental health problems for the workforce as vast. In Ireland, the ’What we Heard’ report commissioned by the Expert Group on Mental Health found that 68% of those surveyed are dependent on social security benefits, 30% are in employment and 2% have no direct income (cited in NESF, 2006). Currently, the Department of Social and Family Affairs’s agenda is of moving from a contingency structured social security regime to one that identifies claimants by reference to their relationship with the labour market; claimants are simply young, old or ‘working age’. The 2006 Social Welfare Bill relabelling of unemployment payments as ‘Jobseekers’ is consistent with this policy agenda (Murphy and Millar, 2007). This will undoubtedly have implications for those experiencing mental illness and claiming social security and represents a challenge in terms of how such inclusion in the labour market might take place.
Social Capital, Communities and Mental Health

Strengthening social capital within communities is regarded as key mechanism in promoting social inclusion. The work of Robert Putnam (1993, 2000) has drawn attention to the significance of ‘social capital’ as an important political resource that “makes us smarter, healthier, safer, richer, and better able to govern a just and stable democracy” (Putnam, 2000: 9). Whilst there are many advocates of the utility of social capital for civic society, the concept has just as many critics who point to its definitional diversity, over-versatility and measurement challenges (Schuller, Baron and Field, 2000). In Ireland, social capital has gained increased political currency and is endorsed by the current government in their Programme for Government. Taoiseach Bertie Ahern has described it as “a kind of glue that holds society together” and “the exact opposite of social exclusion” (2003).

Significant attention is being placed on the effects of social capital and health and well-being. Lochner, Kawachi and Kennedy (1999) argue that social capital as defined by its principal theorists “consists of those features of social organisation –such as networks of secondary associations, high levels of inter-personal trust and norms of mutual aid and reciprocity- which act as resources for individuals and facilitate collective action” (1999; 260). Hean et al 2003 explain that social capital is a multi-dimensional concept, “each dimension contributing to meaning of social capital although each alone is not able to capture fully the concept in its entirety” (2003; 1062). They add that the main dimensions of social capital are commonly seen as; trust, rules and norms governing social action, types of social interaction, network resources and other network resources. People living in communities where they feel connected and are high in social capital, may view their neighbourhood as healthy (Chappell and Funk, 2004). In addition, some have begun to consider the antithesis of social capital or social disorganisation which McCulloch defines as “the inability of residents of an area to regulate everyday public behaviours and physical conditions within the bounds of their community” (2002). Such disorganisation manifests itself in the form of trouble amongst neighbours, the presence of people lounging on streets and the overall appearance of the neighbourhood would be neglected or rundown.

In the context of health inequalities it is argued that social capital as a concept has “added potential for illuminating processes which link determining social structures-like income
distribution, policies, local resources- to individual outcomes, and structures to agency, or for clarifying our understanding of health inequalities and the role of place” (Cattell and Herring, 2002; 9). Cattell (2001) in her work explored the dynamics between poverty and exclusion; neighbourhood and health and well-being by considering the role of social networks and social capital in the processes involved. By focusing on specific communities in the East of London, Cattell (2001) deconstructed the complexities of social capital and found that neighbourhood characteristics and perceptions; poverty and social exclusion and social consciousness were the main factors in influencing social capital. Cattell’s research demonstrates that community context is a key feature in understanding the genesis of social capital. “Neighbourhood factors, including the area’s history, work opportunities, local resources and opportunities for participation, played a role” (2001; 1512).

McKenzie et al (2002) note that there has been an absence of research and theoretical development surrounding mental health and social capital. With regard to mental well-being two different but concurrent methods have been put forward to explain how social networks influence mental health. Kawachi and Berkman (2001) explain that social networks can be good for mental health notwithstanding whether or not an individual is experiencing stress, social networks can also improve the mental health of individuals under stress by performing a buffer role for such stress (cited in VicHealth, 2005). Sohlman (2004) in a Finnish study found that social support strengthened the mental health of all 2000 respondents. Berkman and Glass (2000) explain that:

“by providing emotional support, companionship, and opportunities for meaningful social engagement, social networks have an influence on self-esteem, coping effectiveness, depression, distress and sense of wellbeing” (VicHealth, 2005; 4)

However, social capital alone will not lead to better mental health in communities indeed it would be naive to assume that increased social capital alone can regenerate communities and lead to better health outcomes for all. As Ellaway, Macintyre and Kearns expound “social cohesion and social capital are often either found, advocated or assumed to exist in abundance in disadvantaged neighbourhoods as residents find endogenous means of ‘getting by’ in the context of poverty and social exclusion” (2001; 2301). Indeed, Pevan and Rose (2002) in a large scale UK study highlight how social capital cannot
overcome the negative effect of structural socio-economic factors on physical and mental health problems. As Kay asserts:

“there are limitations to what social capital can do. Social capital alone cannot build the social economy and develop communities. It has to be used in conjunction with the other forms of capital – financial, human, environmental and cultural. Adding to social capital and within a local area is not a substitute for other forms of capital” (2006; 168).

Moreover, social capital may actually exacerbate the social exclusion of those who are mentally ill in a community. Shaw (2006) drawing on the work of Clark (1992) who explains that “a sense of security, a sense of significance and a sense of solidarity” are often seen as ‘the essentials of community’ but that these ‘essentials’ may not always be compatible. Shaw explains that “security for some may be achieved only by the exclusion of others; the ‘belonginess’ associated with solidarity may be constituted through the not-belonging of others; significance may actually signify the reproduction of unequal roles and relations” (2006; 5). Indeed, activities engaged in promoting better mental well-being in communities can be hampered by the fact that mental illness can carry a stigma; “it tends to be seen as a frightening mystery, coming out of the blue, requiring special treatment, and bringing about a permanent separation between ‘the ill’ and ‘the not ill’” (Cameron, 2003; 8). As such at its worse social capital could contribute to the exclusion of those who suffer mental illness “social capital is not always ‘a Good Thing’ … it can actively exclude others and not allow new people and different people to become part of a network” (Kay, 2006; 170).

Increasingly, community development is regarded as a key strategy for building social capital particularly with regard to facilitating communities in a self-help approach to in providing solutions to collective problems such as ill health (Wakefield and Poland, 2005). O’Ferrall (cited in The Wheel, 2005) argues that the significance of the community and voluntary sector in health care in Ireland is situated more in the social capital it produces than the services it provides. Indeed some argue that “in most cases, social capital is just another way of talking about what already goes on in community development” (Wakefield and Poland; 2005, 2829).
Community Development

“Community development, like the camel, is easier to describe than define. It is a discourse of social action informed by communitarian values that aims to promote social inclusion and democratic participation” (Powell and Geoghegan, 2006; 130).

Despite a vast emerging literature around community development and health there seems to be little conformity in applying the concept. The Combat Poverty Agency has expressed concerns about the wide use of the term community development in general and the difficulty in establishing common core principles (CPA, 2006). As Shaw indicates “the contradictory provenance of community development with its roots in both benevolent welfare paternalism and autonomous working class struggle has created a curious hybrid practice, which has awkwardly (and sometimes unconvincingly) embodied both of these meanings simultaneously”(2006; 3).

In Ireland, the Combat Poverty Agency define community development as a “process whereby those who are marginalised and excluded are enabled to gain in self confidence, to join with others and to participate in actions to change their situation and to tackle the problems that face their community” (CPA, 2000). Community development involves collective action which aims to bring about social change with a strong importance placed on empowerment and participation as well as the need to focus on the process as well as outcomes (CPA, 2006). The recent White Paper on Framework for Supporting Voluntary Activity and for Developing the Relationship between the State and the Community and Voluntary Sector (2000) defines community development as “an interactive process of knowledge and action designed to change conditions which marginalise communities and groups and is underpinned by a vision of self-help and community self-reliance” (Government of Ireland, 2000; 49).

The benefits of utilising a community development approach to tackling social problems are seen as twofold; firstly it is seen as a means of addressing a deficit in access to democracy for marginalized groups and secondly, improved participation is also regarded as leading to improved social outcomes as local understanding is incorporated into an improved decision-making process (CPA, 2006). Proponents of community development argue that it has the “potential to effect changes that will combat poverty and social exclusion and address power imbalances in policy making. In other words at its best, community development is seen as a powerful force for social and political change” (Lee,
Lindsey et al argue that community development is viewed as a “philosophical orientation or process of engagement within the community, rather than as a method to which community members must adhere” (Lindsey et al, 2001; 829). Moreover as Lee (2006) explains central to all definitions of community development is the belief that it has the potential to ‘develop a voice for the voiceless’ (2006; 7). Community development is as such ‘political’ Curtin states that community development concerns “at least at a rhetorical level, some commitment to the redistribution of power” (1996; 265).

“The fundamental premise is that when people are given the opportunity to work out their own problems, they find solutions that have a more lasting effect than when they are not involved in such problem solving. Changes that take place within a community are considered peripheral to the changes that take place within people themselves” (Lindsey et al, 2001; 829).

The principle of participation, central to community development, is based on the premise that change is more likely to occur when the people it affects are involved in the change process. Participation by local people is posited as having the greatest and most sustainable impact in solving local problems and in setting local norms (Mahony, Millar and Barry, 2003). The process of participation and engagement is recognised as promoting a sense of ownership of the programme and enhancing overall community competence and capacity (Wallerstein, 1990; Robertson and Minkler, 1994). A number of related constructs also appear in the literature including community ‘involvement’, engagement ‘empowerment’, ‘ownership’, ‘competence’ and ‘capacity’ building (Wallerstein and Bernstein, 1994). Empowerment as a process involves:

- Development of new skills and competencies;
- Increased feelings of control in daily life;
- Informed choices from a range of options and access to information;
- Recognition of self worth and self esteem;
- Meaningful participation in decision-making;
- Effecting change within institutions and social groups;
- Ability to self advocate; and
The application of community development to health concerns “enhancing awareness of needs, promoting effective problem solving, and developing capacities for implementing solutions in high risk communities” (Wells et al. 2004, 955). Community participation in health can take many forms one of which is the community development model. Indeed, as Campbell and Jochelovitch (2000) ascertain that a lot community development work that is not formally aimed at improving health will have an indirect effect on health outcomes. As a public health practice community development has been defined as:

“the process of organising and/or supporting community groups in identifying their health issues, planning and acting upon their strategies for social action/change, and gaining increased self-reliance and decision-making power as a result of their activities” (Labonté, 1993, p.237).

As stated previously within the literature confusion has arisen “from overlapping meanings and the interchangeable use of terminology” (Robinson & Elliott, 2000; 221). In a health context Robinson and Elliott present the following definitions of community development and its variants:

- **Community development**: The process, by which a community identifies its needs, develops an agenda with goals and objectives, then builds the capacity to plan and tackle action to address these needs and enhance community well-being;
- **Community organisation**: the process of involving and mobilizing major agencies, institutions and groups in a community to work together to coordinate services and create programs for the united purpose of improving the health of a community; and
- **Community based**: the process of agency development of solutions for health problems which incorporate community consultation and input thus allowing adaptation of the implementation to suit local needs/ circumstances (Robinson & Elliott, 2000; 221).
Community participation in health care is regarded as an essential component of the wider strategy for primary health care which has gained global acceptance in the wake of the WHO ‘*Health for all by the year 2000*’ strategy. Zakus defines community participation in health as a process by which members of the community, either individually or collectively:

- Develop the capability to assume greater responsibility for determining and assessing their own health needs and problems;
- Plan and decide on solutions;
- Become actively engaged in implementing the solution; and
- Create and maintain organisations in support of these efforts; and evaluate the effects and bring about necessary adjustment in goals, targets and programmes on an ongoing basis (Zakus, 1998; 481).

Community development health projects employ a community development approach to improving the health and well-being of people within a defined community. These projects may be initiated by local people themselves or they may be stimulated through the activities of health-related professionals (Mahony, Millar and Barry, 2003). However, what differentiates a community development approach in health from others is the following:

- It is about a process – galvanising the community into action;
- It increases the community’s sense of identity and the capacity of individuals to act for themselves;
- The community contributes to defining and addressing the problem with appropriate help from professionals. This relationship between professionals and the community is sometimes described as ‘doing with, not doing for’;
- There is recognition and harnessing of individuals’ expertise regarding their own problems and how to resolve them;
- The root cause of the problem is identified and addressed, not just the symptoms; and
- It creates an ongoing process at community level which has its own momentum independent of organisational change (Kennedy, 2003; 4).
In terms of the role of community development in tackling wider health inequalities Burton and Harrison state that:

“the community development approach to health is positive and proactive and can enable people who do not normally access existing services to access them. As it seeks to redress the balance and to help communities help themselves it can begin to reduce inequalities in health and ensure that those with the greatest need have the best care” (1996; 31).

A community development approach recognises the socio-economic influences on health and also recognises that the context in which people live directly influences health status and affects the way decisions are made regarding health (Black, 1980, Whitehead, 1987).

**Utilising Community Development within the Health Services**

Fostering a community development approach to improve mental health will involve significant adjustments for those who are currently involved in delivering health services. As Cox and Findlay (1990) note “the process of involvement and participation which is fundamental to community development is itself health promoting, enhances self-confidence and helps people to feel more in control of their lives” (Cited in Burton and Harrision, 1996, p. 31). As such, a community development approach to health takes time it may take two to three years to foster trust, involvement as well as an appreciation of issues and concerns within the community (Department of Health and Children, 2004). Community development approaches to health therefore require a long term commitment to specific communities. Wells et al advise that strategies which can assist in bringing about meaningful change through community development include:

- Agreeing on goals and expectations at the beginning of the project;
- Maintaining a structured, equal partnership using an independent community facilitator;
- Sharing expertise and resources across community organisations;
- Educating the community about the goals of the project; and
- Developing financial support for community programmes (2004, 957-8).

Indeed, health professional advocates of community development such as Longest argue that many health service organisations under appreciate the myriad of benefits of such an approach and that they should “aggressively engage in community development” (Longest, 2006; 102). Longest (2006) contends that health service organisations can improve their primary health enhancing purpose within the community by effectively engaging in community development. However, he cautions that an organisation who wishes to engage in community development “must develop and prioritize the elements of its own community development agenda, beginning with making it part of the organisation’s vision for itself” (Longest, 2006; 92). As such he develops a continuum of levels of community development shown in Figure 1 he states that levels 1 and 5 are hypothetical:

**Figure 1: Longest’s Continuum of levels of community development commitment and activity**

**Illustrations**
When asked their views on their organisation’s community development commitment and activity leaders in organisations at different levels on the continuum might respond as follows:

**Level 1** – “We don’t know what community development has to do with an organisation like ours: we try to help people improve their health by providing health services. Community development is unrelated to our mission”.

**Level 2** – “We engage in community development by providing health services to our community. That is enough for our organisation to do in community development”.

**Level 3** – “We believe in and support community development, but we have to focus the resources we devote to it because they are limited. Community development is important to us, but we do not see it as a core element in our organisation’s success”.

**Level 4** – “We fulfill our community development responsibilities, although we could better coordinate and synergize our diverse activities in this area. We are committed to community development and are building substantial capability in this area, although we could obtain more of a contribution to our overall success if we managed these activities more carefully”.

**Level 5** – “We are strongly committed to community development and count community development among our key capabilities, and gain significant strategic advantage from the capability, including its contributions to fulfilling our organisation’s core health-enhancing mission” (Longest, 2006; 93).
Longest (2006), the Director of the Health Policy Institute at the University of Pittsburgh, utilizes the example of the University of Pittsburgh Medical Centre (UPMC) which states its commitment to community development in its mission statement as well as other organisations that have had success in community development projects. Longest argues that key to this success there are four steps which are essential in supporting health services in moving along the continuum:

1. “Explicitly incorporate a commitment to community development in the organisation’s purposes;
2. Organise to facilitate decisions and actions that further community development;
3. Develop and implement a broad-based strategy for community development; and
4. Audit community development performance, and act upon the results of the audits” (2006; 97).

The provision of services by voluntary and community groups funded by government typifies the new public management culture of purchaser/provider split coupled with the view that governance by partnership is more effective in assisting the vulnerable and disadvantaged. In the current climate of partnership approach we see the ‘enabling state’ in many areas of social policy- in local initiatives under the umbrella of community development which are in keeping the wider aspirations of social policy are provided by the voluntary and community sector on behalf of the state with an increased focus of social inclusion measures shifting to community regeneration and the building of social capital (Millar, 2006). The publication of Green and White Paper on the Community and Voluntary Sector and its Relationship with the State signalled the States recognition of the voluntary and community sector as having a significant role in the promotion of social cohesion and as active partners in this process (McCashin, O’Sullivan and Brennan 2002, 266). As such from a social policy perspective there is the potential to utilise a community development approach to improving mental health as part of a broader social inclusion strategy.

The Wheel is a support and representative body connecting Community and Voluntary organisations in Ireland. They explain that as the nature and density of services and supports provided by the community and voluntary expands so to does the difficulties associated with quantifying the number and nature of such organisations especially in
light of the absence of a national registration system. However, the Wheel estimates that community and voluntary organisations receive €1 billion of the approximate €10 billion annual health service budget (The Wheel; 2005, 15). The organisations online database which has information pertaining to 8,657 community and voluntary organisations who have registered with The Wheel shows that only 181 classify themselves as operating in the area of health but 1,735 classify themselves as operating within areas that influence the wider determinants of health. They provide services in a wide range of areas including advocacy and advice, disability services, mental health and economic and community development among others (The Wheel, 2005).

From a policy making perspective, charged with opportunity costs and limited resources one of the shortcomings of employing a community development approach within social policy is the lack of systematic evaluations of such interventions. There is a dearth of information on this phenomenon in Ireland and elsewhere indeed the Combat Poverty Agency notes that “measuring the poverty impacts of a community development initiative is extremely difficult. Impacts are often more related to ‘process’ themes such as empowerment and activation” (CPA, 2006; iv). However, the Combat Poverty Agency ‘Building Healthy Communities: tackling poverty and health inequalities through community development approaches’ programme has recently been evaluated. The mid-term evaluation found evidence of:

- The establishment of a range of procedures to facilitate working relationships involving community based groups, health and other service providers;
- The successful completion of community based courses;
- Greater participation in activities by more disadvantaged individuals as well an increase in voluntary involvement in a range of consultative mechanisms;
- An increase in the extent to which health issues have featured on various community development programme and project agendas;
- An increase in awareness about issues linking to health and poverty within and between projects participating in the programme; and
- The beginnings of a more productive working relationship between community groups and service providers (Nexus, 2004).
Community Development and Mental Health

In the UK community development has become a key element in the Governments policy to tackle discrimination and inequality in mental health services as laid out in Delivering Race Equality (Seebohm et al 2005). One of the primary reasons for employing a community development approach within mental health services in the UK has been due to the fact that “the fear and stigma associated with mental ill-health has been associated with the avoidance of services and a failure to get help ... community development is charged with facilitating earlier access to services” (Seebohm et al. 2005; 88). It is argued that when individuals with mental health problems play a significant role in identifying and managing their problems confidence skills and assertiveness increase (Seebohm et al. 2005; 87). Warner et al (1998) argue that the voluntary sector “has a reputation for being more innovative, creative and flexible than statutory services, providing an alternative model of services which can be more responsive to the needs and wishes of users” (1998; 8). As such community support services for people with mental health problems should not exist as substitute for statutory health services rather they should compliment them by providing services which would otherwise not exist. As Warner et al advocate “providing practical and emotional support to people with severe and enduring mental health problems may relieve the demand on other services for these types of activity, resulting in a more appropriate use of professional staffs time” (1998;8).

With regard to the nature of community development approaches to improving mental health Faulkner and Layzell (2000) argue that “non-medical interventions such as physical activity, spiritual nourishment, creative arts and voluntary work contribute significantly to recovery from mental ill health and many people from all ethnic groups prefer these to medication” (cited Seebohm et al. 2005; 22). However, many people with mental health problems are disinclined to avail of such activities labeled as being for those with mental health needs and as such lack access to other options to engage in such activities (Seebohm et al. 2005; 22). The challenge for community development then lies in the integration of individuals with mental health problems engaging in activities designed for everyone in the community. Huxley and Evans (2001) suggest that urban initiatives which aim to improve quality of life or mental health need to promote security, increase leisure opportunities, foster social capital and build up the image of the area (cited in Cameron et al 2003; 15). As such community development initiatives are most effective when they
involve strengthening communities in the wider sense as opposed to focusing on specific need such as mental health.

Kennedy (2003) utilized a case study approach to consider the work of some community development health projects operating in Scotland though quite diverse in their origin and operation she concluded that the participatory nature and flexibility in the process employed by the projects studied are vital to success. Underlying their work was the belief that:

“people need to feel that they are the authors of their own change if that change is to be sustainable … (with) a real emphasis on promoting an increased sense of autonomy for those taking steps to identify and address their own health needs, and on restoring connection, purpose and meaning within communities to facilitate the promotion of health” (Kennedy, 2003; 9).

The case studies in Kennedy’s collection that had a mental health orientation were diverse. CHANGES is one such project in the East Lothian area it aims to work in partnership with local individuals and professional services to promote the emotional well-being of people in the community by providing them with information and experiences that will facilitate them in managing and understanding their mental health needs. After a local needs assessment the need for interventions such as stress management and counseling were identified. The Scottish Association for Mental Health facilitated the establishment of the project and a number of social workers and community psychiatric nurses worked with members of the community to develop the project initially. Its functions and activities include:

- **Groups and Courses**- CHANGES supports self help groups for those experiencing panic attacks and depression and runs courses such as ‘Positive Thinking and Relaxation’ to help deal with stress;
- **Enquiry Service** – CHANGES has an enquiry service concerning sources of support for people experiencing stress this service is intended for the public and professionals;
- **Resource Provision** – Small resource library about parenting and common emotional and mental health problems; and
• **The Positive Parenting Forum (PPF)** – The PPF operates within CHANGES it leads parenting courses with professionals and parents working together as opposed to parents being told how to be a good parent (Kennedy, 2003; 33-41).

LETS Make It Better (LIMB) is another such project designed to involve people with mental health problems in the Stirling and Alloa area. LETS is a local exchange trading system where members of a group offer goods and services to each other for a number of units and then trade within the group for goods and services they require. LETS for people with mental health issues is expanding in the UK with over 25 systems in operation they are seen as a way of responding to their labour market needs and promoting social inclusion. LIMB is concerned with people disabled by or recovering from mental illness it focuses on rebuilding their confidence after an acute episode and supporting them in feeling they have something to contribute as well as building networks of support. Its activities include LETS trading, social support, publicity, café, arts and crafts, training, promoting health and well-being, and partnership. The café is seen as the cornerstone of the project by providing a drop in space for social contacts and a forum for trading their skills as well as being staffed by volunteers with mental health problems who are supported by paid staff. This has led to LIMB members acquiring new skills, enhanced their self-esteem as well as improving their employability, for others they have learned about health eating and food preparation. For all members “the project provides a structure to the day, a meeting place and a focus which is all too often absent for people recovering from mental health difficulties” (Kennedy, 2003; 90). LIMB has facilitated some members in moving to paid employment and further education. As with CHANGES the relationship between the project and health professionals is crucial to its success indeed many professionals have joined LETS and this has facilitated in breaking down barriers (Kennedy, 2003; 79-95).

**Community Development and Mental Health in Ireland: Issues and Challenges**

The use of community development to improving mental health in Ireland will involve challenges for individuals, communities, health professionals and health services as such there is a need to be aware of the issues before embarking on such an approach. One of the primary issues to be considered is the willingness of the community and voluntary sector to be involved in such an approach linked to this is the capacity of the sector to be
involved in such an initiative. Recent work by Meade (2005) highlights the level of dissatisfaction of many in the community/voluntary sector and questions their willingness to engage with government and new policy initiatives. The Wheel has identified the following as the key issues facing the sector:

- A general lack of information on the overall nature and size of the sector in Ireland;
- The need for a broadening and deepening of the relationship between the sector and the State (it is currently largely focused on funding from the State to the sector); and
- A lack of detailed information about the variety of different roles played by sector, particularly in terms of the promotion of the healthcare needs and relationship with the statutory sector (2005; 16).

Moreover, The Wheel believe that a number of issues have hindered the ability of the community and voluntary sector to stimulate a health agenda including a lack of recognition of the role of the community development in health, insufficient resources and capacity and a lack of cohesion within the sector itself (2005; 31). It could be argued therefore for the need for community development organisations involved in the delivery of health related services to mobilize and engage in the wider health policy community. Figure 2 lays out the key recommendations made by The Wheel concerning the future of the community and voluntary health care sector in Ireland (see Annex).

Overall these include the need to promote a greater understanding of the sector and the contribution it makes, quantify the number of organisations and the nature of the services they provide and advance the creation of improved linkages between the sector and the wider health policy network (The Wheel; 2005). In order to better promote the use of community development in health in Ireland there needs to be more rigorous evaluation of the approach particularly for those who individuals and communities that are socially excluded. As Wells et al advocate in the long run research must focus on:

“whether such approaches achieve either more enduring or far-reaching reductions in the individual and societal burden of mental illness for diverse communities, in which burden is defined at least partly in community terms” (Wells et al 2004, 960).
Lessons to be learned from current community development approaches to mental health include the need for health professionals and members of the community to work together on an equal basis. This is one of they key factors in the success of the CHANGES project in East Lothian who argue that ‘empowerment’ can only occur in such a context involving recognition amongst professionals and individuals of the benefits of listening to each others perspectives on tackling health issues in the community (Kennedy, 2003; 41). Indeed, the support of local professionals to the community development approach is crucial to the success of any such project it involves challenges and opportunities for health sector organisations. From the perspective of the project there is a requirement on them to work with existing health services. Kennedy (2003) describes this work as ‘building bridges across to the mainstream health sector’ which is crucial for the continued existence of projects. Indeed, in Kennedy’s review of projects in Scotland she notes that:

“some of the projects attributed their survival to having a mentor or a champion in a senior position within the health sector – someone who values the ability of community development to involve communities in addressing their health needs” (Kennedy, 2003; 130).

Fostering the social inclusion of those in our society with mental illness by increasing social capital and encouraging community development needs to be placed in the wider socio-economic, political and cultural context “whilst recognizing that social organisation – not just social connection – impacts on health” (Wakefield and Poland; 2005, 2828). Nor is it a strategy which will yield rapid results rather the use of a community development approach to supporting individuals with mental health problems should be viewed as a process which can bridge the gap between traditional services and the needs of service users.

Community development approaches to improved mental health are very often concerned with improving the overall well-being of individuals by engaging in activities as diverse as stress management to leisure activities to education and training for the workplace. The challenge for community development then lies in the integration of individuals with mental health problems engaging in activities designed for everyone in the community. Community development approaches are not about replacing existing
statutory services their added value is to complement services that are already provided or to link individuals in need of statutory services with existing service providers.

Moreover, on an individual level involvement in community development can enhance the social capital and promote the social inclusion of those experiencing mental illness. Such an approach would require a commitment from those working in the statutory services to a new way of working and as we have seen from abroad this works best when there is commitment from senior officials within the health services. However, as Longest (2006) advocates to be effective partners in community development health service organisations must have an explicit strategic commitment to the approach in their mission statement in Ireland this would be best suited to strategy statements and policy.
References


Zakus, J.D. (1998) ‘Resource dependency and community participation in Primary Health Care.’ *Social Science and Medicine, 46 (4-5) 475-94.*
Annex

Figure 2: Recommendations from The Wheel on the Future Needs of the Community and Voluntary Health Care Sector (2005; 45-46)

I. Promote a Greater Understanding of the Role of the Community and Voluntary Healthcare Sector
   1. Explore and promote a greater awareness and understanding of the social model of health among the Community and Voluntary Sector, and in particular to promote the unique role played by the Community and Voluntary Sector in this construct.
   2. Raise awareness of the concepts of active-citizenship, social capital and people centredness.
   3. Undertake research to identify examples of good practice that profile the value and nature of services provided by the Community and Voluntary Healthcare Sector.
   4. Promote greater communication and collaboration within the sector to identify and address common issues.
   5. Identify and develop capacity-building supports for community and voluntary healthcare organisations, for example, training.
   6. Shift the focus of media attention to include a focus on community care rather than just hospital care.

II. Quantify the Nature and Role of the Community and Voluntary Healthcare Sector
   7. Undertake research to quantify the size and value of the sector nationally using the social definition of health.
   8. Develop a comprehensive categorisation of all services and activities in which the Community and Voluntary Healthcare Sector is involved under a social model of health.

III. Promote the Development of Enhanced Linkages between the Community and Voluntary Sector and the Wider Health Sector
   9. Actively identify mechanisms through which the Statutory/Voluntary Sector Partnerships can be enhanced:
      o Promote the implementation of good practice as identified in the Health Service Executive’s Community Participation Guidelines (2002)
      o Identify positive action to be undertaken by Statutory agencies to ensure parity of representation in partnership structures.
      o Seek the establishment of multi-annual funding programmes thereby increasing both the autonomy of the Community and Voluntary Sector and improving the parity of the relationships between the Statutory and Community and Voluntary Sectors.
   10. Seek the establishment of a defined route and/or structures to feed into the Health Service Executive.
   11. Seek the establishment of a Voluntary Activity Unit in the Health Services Executive.
   12. Enhance the extent and nature of participation in the Health Policies/Programmes at national and local level.
   13. The Community and Voluntary Health Care Sector should seek to encourage the Health Service Executive to implement Section 43 of the recent 2004 Health Bill which allows the Executive to take such steps as it considers appropriate to consult with local communities or other groups about health and personal social services.
   14. Build structured linkages with political representatives at national and local level.
   15. Seek the development of more participatory mechanisms for the engagement of the community and voluntary health care sector to ensure a role at a practical level in the implementation of the National Health Strategies.