

# Tackling race inequalities: community development, mental health and diversity

This paper describes some findings from an evaluation of the effectiveness of a community development project that aimed to overcome inequalities in mental health care experienced by members of the local black and minority ethnic (BME) communities. A participatory action research design was used involving people from BME communities who had experienced mental health problems, and external stakeholders. The study relied largely on qualitative methodology. Findings reported here indicate that participants in the project valued the culturally and spiritually relevant support they received, but felt that more opportunities were needed for training and employment, greater representation on the project's management committee, and greater awareness of the project in the community. External stakeholders felt that the project gained credibility from its community base and valued its ability to work across faith traditions and cultures. It was also seen as successful in acting as a bridge between the communities and statutory services, although there were concerns about the project's relationship with frontline services. The paper proposes two models of community development that primary care trusts may wish to adopt – radical or consensus, or a mixture of both – in order to address inequalities in mental health service provision.

It is widely accepted that people from black and minority ethnic (BME) communities are more likely than their white counterparts to have negative experiences when using mental health services (Walls & Sashidharan, 2003; Sainsbury Centre for Mental Health, 2002). The Department of Health (DH) is committed to rectifying this situation, and has published an action plan (DH, 2005) to appoint over 500 community development workers. This raises many questions. Can people from BME communities have a say in the sort of help they feel they need? Do they need help currently unavailable within mainstream provision? If so, can community development help commissioners understand and respond to these views? These questions are important, given that many commissioners have little experience of community development (CD): a way of working rooted in self-help and mutual aid. If DH policy is to be effective, then stakeholders must be clear about the role of CD in improving the mental health of

people from BME communities.

Although relatively little is known about the use of CD in mental health, some of its key features suggest it has the potential to be a useful tool in health and social services (Armstrong & Henderson, 1992; see table 1). It has been used to promote community participation in community care (Barr et al, 2001) and to develop the capacity of local communities to respond to their own support needs (Quilgars, 2002). This paper describes a participatory action research (PAR) study within a CD project working with Bradford's BME communities. Sharing Voices Bradford (SVB) was set up in 2002, funded by Bradford City teaching Primary Care Trust. Established on the principles of CD and a critical perspective on mental health theory (Bracken & Thomas, 2005), it works with statutory, voluntary and community sectors to tackle inequalities in mental health services for people from BME communities. People who have experienced mental health problems play a key role

## Key words

mental health services  
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**Table 1:** Key characteristics of community development

The characteristics of community development that make it a particularly useful tool for statutory health and social services have been identified as follows:

- knowing about community strengths
- mapping of needs and resources is an essential first step to working in partnership with local groups and organisations
- helping communities prepare for community care – informal teaching methods and dialogue with local people can reduce popular fears
- empowerment – peer groups, increased participation in decision making forums, facilitating community enterprise all enhance the scope for self-determination
- enhancing community support and networks – community development can facilitate positive networks and help tackle oppressive behaviour
- contracting – through capacity building on both sides, CD workers can increase opportunities for devolving services to small organisations
- training for statutory sector staff – this can promote understanding of local communities

in its activities, including peer support, public dialogue and participation in the design and delivery of services. Stimulating discussion and understanding the mental health needs of these communities forms the bedrock of the project's work. The main activities of SVB and the groups involved are shown in table 2, which also summarises the results of an audit of all those in contact with the project in October 2004 (Seebohm & Thomas, 2004), when the research commenced.

The nine-month PAR aimed to describe the CD process at SVB and evaluate it using a critical and developmental approach. This paper focuses on two questions addressed by the study: first, what kind of help do BME participants want, and second, what was the capacity of the CD process to help Bradford's statutory services to understand and respond to these views?

## Methods

We chose PAR because it mirrors the community development processes of goal setting, action and review. Those working together in a situation develop and improve their own practice (Winter & Munn-Giddings, 2001). PAR has been used to describe and evaluate complex interventions in health that are dependent on the collaboration of groups from different backgrounds (Greenhalgh et

al, 2005), and to maximise the involvement of disadvantaged communities in identifying and solving their own problems (Macaulay et al, 1999). It consists of a series of cycles: the identification of the problems to be addressed, establishing an action plan, implementing it, reflecting on progress, and then identifying what further action is necessary. At SVB a number of cycles ran concurrently to explore three different perspectives: those of the project participants (involved in peer groups and as volunteers), the staff team and the management group. The management group also wished to obtain the perspectives of external stakeholders so the research facilitator (PS) interviewed staff from statutory and voluntary sectors in Bradford. The stages of the study are summarised in table 3.

## Results

To answer the two questions identified above, we focus on the outcome of the action research process with project participants, before summarising the issues arising from the interviews with external stakeholders.

### *Peer groups and volunteers*

The three peer groups were gender specific, but involved people of different ethnicity. Each had a different focus: fitness activities (The Fitness Group), arts based activities (Creative Expressions) and a combination of spiritual and practical activities (Hamdard). Hamdard had the most robust participation in the PAR study, so it is selected here to illustrate how the groups functioned.

Hamdard is a group of Muslim women who met weekly, inspired and set up by a woman who had experienced mental health problems, with the help and support of a female Muslim community development worker at SVB. The group had its own constitution and funds, which were used to purchase sewing equipment, produce a leaflet, and fund other small-scale activities. It was attended by about ten women a week. Most were married with young children, and several brought their children to group meetings. All were Muslim, but drawn from diverse communities, including Pataan, Punjabi, Kashmiri and Mirpuri, as well as a white British Muslim. The results from this group are described in detail in table 4. Hamdard enabled Muslim women to think more positively about their future, develop coping strategies, and take an active, confident part in society. Similar results were reported by the other two peer groups.

Seven volunteers became involved in the study as researchers (see contributors). Four were of

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**Table 2:** Summary of SVB activities and participants 2004-2005

<p><b>Peer group activity</b></p> <p>Seven peer groups were attended by 67 people. The groups consisted of:</p> <ul style="list-style-type: none"> <li>● five women-only groups (one for Muslim women, two for South Asian women of any faith, two for women of any faith or ethnicity)</li> <li>● one group for men and women of any faith or ethnicity</li> <li>● one group for men of any faith or ethnicity</li> </ul> <p>Group activities included music, creative expression, fitness activities</p> <p>Use of mental health services varied. Overall, 45% used specialist mental health services, rising to 71% of fitness group members. Contact with GP for mental health problems also varied: overall, 65% had such contact, rising to 80% for the Muslim women's group</p> <hr/> <p><b>Individual support</b></p> <p>There were 18 supported volunteers (eight regularly active). An additional 18 people (neither volunteers nor peer group members) received one to one support, of whom 12 used mental health services and three had GP contact only for mental health reasons.</p> <p>Individual support included outreach sessions, one-to-one meetings and supported access to resources. up activities included music, creative expression, fitness activities</p> <p>Personal and career development support included Three Es Employment Project, which supported 15 participants into employment, nine into education/ training, and six into other daytime activities over an 18 month period</p> <hr/> <p><b>Audit of participants November 2004</b></p> <p>125 participants responded to the audit questionnaire, including volunteers, group members, supported individuals and others engaged in training/consultation. Of these:</p> <ul style="list-style-type: none"> <li>● 60% (80) were female</li> <li>● 50% (62) were young adults (age 25-34 years)</li> <li>● 30% (37) were aged under 25 years (10% under 18 years)</li> </ul>	<ul style="list-style-type: none"> <li>● 60% came from three Pakistani communities (Mirpuri, Punjabi, Pataan); others included Bangladeshi, Indian (Sikh and Hindu), African, African-Caribbean, Black (other), shared heritage and white Irish</li> <li>● 42% (52) participants had used specialist mental health services</li> <li>● 68% (84) had consulted their GP because of mental health problems</li> </ul> <p>Over 75% participants reported that they were 'more able to do the things that are important to me' since first making contact with SVB</p> <hr/> <p><b>Partnerships and networks</b></p> <p>Two year agreement with Bradford City tPCT to deliver community development (DRE)</p> <p>One year agreement with NIMHE North East to deliver community engagement pilot (DRE)</p> <p>Involvement in 'Minorities in Minorities' research projects in partnership with University of Bradford</p> <p>Participation in many local networks (eg. African Network, Black Health Forum)</p> <p>Men's' Health seminars with Health of Men (PCT-funded)</p> <hr/> <p><b>Increase participation</b></p> <p>Individuals encouraged and supported to participate in their own care plan reviews.</p> <p>'Participation: Why Bother?' seminars for local people and senior health managers, jointly with University of Bradford</p> <p>Focus groups and consultation for Bradford District Care Trust on citizenship and mental health</p> <hr/> <p><b>Signposting and information resource</b></p> <p>Telephone advice to enquiries from community, families, carers and individuals, statutory and voluntary agencies</p> <hr/> <p><b>Dialogue and debate</b></p> <p>Stalls at local events, presentations at national and international events (eg. Black Mental Health Forum, BME Mental Health Network, Royal College of Psychiatrists annual meeting)</p> <p>Spirituality seminars, local radio shows, two newspaper articles (one local, one national)</p>
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Pakistani heritage, and three were African-Caribbean. Four had used mental health services for between five and eleven years, two were carers, and one had personal difficulties but had not used mainstream services. They contributed to the study as group leaders, researchers and writers. Their activities at SVB included public speaking,

singing/music making, participating in events, workshops and seminars, as well as a wide range of activities to support the organisation.

The priorities of the participants in the three peer groups and volunteers were remarkably similar, and included the need for training, employment, social activities, greater representation of the

**Table 3:** Participatory action research stages

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<b>STAGE 1</b>	<p>Permission gained from all those to be involved (participants, staff team and management group)</p> <p><b>Selection of peer groups</b> Three of the seven groups involved with SVB were selected on the following grounds:</p> <ul style="list-style-type: none"><li>● participants in the groups expressed an interest to participate</li><li>● it was felt the PAR cycles would mirror and support the way they operated</li><li>● each group was set up because of the energy and inspiration of a participant</li><li>● they had a history of stability over several months</li></ul>
<b>STAGE 2</b>	<p><b>Selection of peer groups</b> Seven participants were selected on the following grounds:</p> <ul style="list-style-type: none"><li>● they were interested and enthusiastic</li><li>● they were trusted by the groups they represented</li><li>● they shared an in-depth understanding of how mental distress affects people in their communities.</li></ul> <p><b>Training of community researchers</b> All researchers underwent training delivered by the research facilitator (PS), and were supported by a research steering group</p> <p><b>Data collection</b> Data collection included semi-structured interviews using a schedule drawn up by the external facilitator with those to be interviewed, taped and fully transcribed, participant observation field notes made by the facilitator, and written reflections by volunteers and project workers. Textual materials were analysed using thematic analysis that included the identification of dilemmas and difference</p>
<b>STAGE 3</b>	<p><b>The research cycle</b> Identification and description of the current situation (initially through interviews) Identifying and agreeing immediate problems and priorities for action (through interviews and workshops) Drawing up an action plan (workshops) Carrying out the action plan (activities included training, social activities and workshops) Review of progress on action (workshops) Drawing up a revised action plan (workshop for the staff group)</p>
<b>STAGE 4</b>	<p><b>Integrating findings and final review</b> Towards the end of the research programme the different perspectives on SVB's work were brought together, to review the organisation as a whole, and to suggest a framework for future evaluation and strategic planning</p>

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volunteers on SVB's management group and greater local awareness so that more could benefit from the project. The action plans to deal with these priorities included training for participants, staff and management, free publicity material for local people in the form of three books written by the participants, and social activities. Participants were asked what they did not like about SVB. There was no negative feedback, but there was concern expressed by SVB staff about the sustainability of the Creative Expressions and Fitness groups.

### **External agencies**

Eleven staff from other organisations were interviewed and asked their views about SVB, and its impact. Interviewees included senior managers and practitioners from Bradford District Care Trust, Bradford City tPCT, a locality community mental health team, the assertive outreach team and the local authority. Interviewees welcomed the use of CD because it supported individuals and communities to bring about changes that they wanted. Interviewees (including those from the

**Table 4:** Hamdard: detailed findings

Hamdard is an Urdu word meaning 'companion' or 'one who gives support'. The group promoted a holistic approach to mental health, taking into account its members' experiences. The group aimed to avoid hospitalisation and crisis by providing a safe space in which the women could discuss their experiences. All the women experienced difficulties in family relationships, often with their husbands' families. A few were going through divorce, and consequently faced great isolation. Most had had GP contact on account of their problems, a few had self-harmed, and a growing number had been admitted to psychiatric hospital. (All quotes from interviews with Hamdard members)

*'I felt weaker and weaker and lonelier than ever... There were times I felt so low and dirty I would harm myself or make myself ill, just so that I could go back to my family for a while and get away from my husband and in-laws.'*

#### Joining the group

Most of the women heard about Hamdard by word of mouth, settled quickly and attended for nearly a year. SVB was seen by group members as a comfortable welcoming venue that was not identifiable as a mental health project:

*'It's not labelled outside so you don't have to worry about other people knowing where you've been.'*

*'It's relaxed. It's friendly. It's cosy.'*

#### Coming together as Muslim women

Most members valued the fact that they were all Muslim and shared an interest in their faith. During Ramadan the women decided to continue meeting to read the Qur'an to explore their Muslim identity together. But they also came from different Muslim communities, so they also discovered new perspectives on what it means to be a Muslim, and differences between Islam and regional culture. Women living in patriarchal traditions discovered female roles within other cultures that were acceptable within Islam. Their writing indicated that their Muslim faith

was an important source of strength at time of difficulty:

*'Other women [in the group] understand your feelings because they are going through the same thing.'*

#### Sharing problems in confidence

Group members painted a picture of loneliness, sadness and oppression before attending Hamdard. Confidentiality and trust were essential as the women felt unable to discuss their problems with anyone else:

*'I did go to the GP... and they put me on antidepressants but I found that didn't really help me... the problem wasn't going away. I couldn't get it off my chest.'*

#### Finding strength to be active in society

Through sharing experiences women gained the confidence to think more positively about their futures. After speaking initially of not wanting to go anywhere or do anything, they started to enjoy a more active social life, getting a job or starting college:

*'Hamdard's made me speak up – it's built my confidence... Now I'm thinking about the future... I'd like to get a job.'*

#### Gaining new friendships

Group members spoke warmly about each other and having fun together. It felt natural to share problems, and also share meals and outings together:

*'I feel like I belong somewhere because the group's helped me... We've all got quite a strong bond in the group... We've gone on trips as well; that was really enjoyable.'*

#### Helping others is as important as receiving help

All the women wanted more people to benefit from the support in the group. They had a strong ethos of mutual aid:

*'I would like to help them the way I've been helped out with Hamdard... I would like to see all the women out there who haven't got any confidence in themselves build themselves up by coming along.'*

tPCT) felt that the project gained credibility because it was based in the community. It was seen as sensitive to differences within South Asian communities and thus well placed to develop relationships and initiatives with them.

Interviewees stressed the importance of SVB's ability to work across cultures and faith traditions, and there was welcome for the way it placed spiritual, social and economic contexts in the foreground in response to their participants' expressed concerns. It was valued for drawing in

non-mental health workers who, it was said, make an important contribution to mental health. SVB was seen as a bridge between statutory services and local communities. Two interviewees (trust and PCT) spoke of the project's 'invaluable' success in creating a dialogue between statutory services and local communities; others valued its ability to inspire participants with the confidence to take part in this dialogue.

Challenges were identified. One interviewee expressed reservations that the bridge-building role

**Table 5:** Examples of consensus and radical models of community development

Function	Consensus	Radical
<b>Change agent</b>	Worker presents report on the needs of a new community after consulting community leaders with influence/ understanding. PCT appoints a specialist worker; outreach service, awareness training or similar	Worker works with leaders with influence and people at grassroots level to identify problems and draw up solutions. Solutions are delivered by community with the support of statutory services
<b>Service developer</b>	Worker organises training for NHS workforce, delivered by him/herself or local spokespeople for the community (likely to lack easy access to BME services users)	Worker organises training for NHS workforce, delivered together with BME service users. May be able to facilitate development of BME service training enterprise
<b>Capacity builder</b>	Worker links BME groups with training organisations. (time constraints prevent in-depth development support)	Worker may link BME groups with training organisations, also providing continuing development support for sustainability
<b>Access facilitator</b>	Worker may increase information resources, such as leaflets and videos (time constraints prevent in-depth development support)	Worker may increase information resources but also develop many opportunities for dialogue between BME service users and local people. Word of mouth communication, and safe spaces where people can discuss difficult issues (such as spiritual healers) may be encouraged.

had not been as effective in the past as it might have been, although the situation had improved. There was concern about ‘dissociation from frontline services’ that did little to improve the work of statutory services. The responsibility for this shortcoming was placed ‘50:50’ with both sides. It was said that some workers in statutory services chose not to know about the project because it was ‘outside our comfort zone’. These difficulties were blamed largely on past tensions between different service components in Bradford. In contrast, a statutory worker from another part of the service saw relationships between SVB and statutory services as very good. Three interviewees wanted greater transparency (communication) about SVB’s work.

When asked to comment on the impact of the project, there was general agreement that it had a positive impact on individual participants, and was well known within the voluntary sector, but the impact on local communities was less clear. It was said that many people from BME groups did not know about the project. One person expressed the view that the project had made a contribution to changing attitudes, but some felt that more liaison with mental health professionals was required.

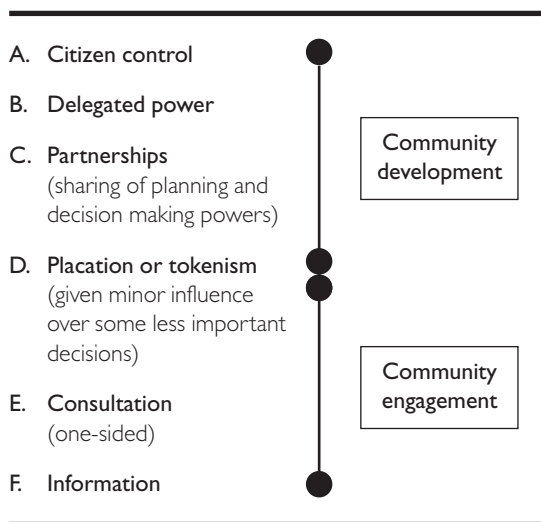
## Discussion

SVB participants wished to solve their problems in ways that are rarely available within mainstream services: shared spiritual, creative, fitness, social and learning activities, help to get work and a wish to help and be helped by their peers. They took a lead role in developing these options and were not dependent recipients: this was an important and arguably essential feature of what they wanted. The interviews suggested that SVB was facilitating a dialogue between local communities and statutory services, and enabled local people to deliver what they want. In the past ‘dissociation’ between SVB and statutory services mirrored what many commissioners must fear in relation to community development projects. This was being addressed, but the project’s challenge was to do more to attract the ear and trust of statutory services.

CD must be distinguished from community engagement (CE): CE is a reactive process that includes user involvement, consultation and service improvement, but with an agenda set by statutory authorities. With little exchange of power or influence, it lies low on the ‘ladder of participation’ (figure 1; Arnstein, 1971). CD, as defined by its own

professional bodies (Community Development Exchange, 2001), implies that local people identify the problems to be addressed and help to shape the solutions. Effective CD requires statutory authorities to give credence and priority to local concerns. It is an empowering process that brings about a redistribution of power and resources, and helps build social capital in socially excluded communities.

**Figure 1:** The Ladder of Participation  
(after Arnstein, 1971)



This brings us back to the policy context. Delivering Race Equality (DRE), the Department of Health policy agenda for addressing race inequality in NHS mental health services (DH, 2005) sets out an ambitious vision: reducing the fear of services in BME communities, increasing their satisfaction, and offering a more balanced range of therapies and a more active role for BME service users in service development and delivery. In contrast, the interim guidance issued by the DH (2004) emphasises the role of workers in the statutory sector and places less emphasis on working with local communities. Drawing on research (Gilchrist, 2004) within the CD field, we suggest that PCTs can choose between two models of CD: the ‘consensus’ and ‘radical’ models (table 5; Seebohm et al, 2005). The former might apply where commissioners want to improve the delivery of services to marginalised groups but seek no fundamental changes in the way services operate. Managers who opt for this model may feel that services are improving and simply want to speed this up. The latter applies where commissioners feel that whatever they do to improve services will be insufficient for those who share non-western understandings of the world and may want to

commission alternative approaches to sit alongside therapies and counselling. In reality, it may be that many commissioners and workers will either develop a combination of the two models, or take a position between them.

Most PCTs will find it a challenge to fit CD into their tight framework of accountability and performance. Enabling people to design and deliver their own services is not how they normally conduct their business. SVB and Bradford City tPCT show that this radical approach is possible and effective, but by no means easy. 🌐

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