



**Community-level public health approaches and community partnerships to promote  
sustainable health equity in mental health service design and delivery**

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## Word Count

<b>Thesis section</b>	<b>Text (incl. tables)</b>	<b>References</b>	<b>Total</b>
Scoping Review	10035	2529	12564
Empirical Research	11857	2186	14043
Appendices	2338	-	2338
<b>Total</b>	<b>24230</b>	-	-



## Overview

This thesis explored community-level interventions and community partnerships to support psychological wellbeing and moving towards health equity through the design and delivery of mental health services. Two papers have been prepared for submission to the journal *Administration and Policy in Mental Health and Mental Health Services Research*, though the word count has been exceeded due to the requirements of the thesis (Appendix A).

**Chapter One** is a scoping review that explores the application of public health approaches at a community-level, through consideration of the population groups that have been the focus of community-level service developments in the UK. Twenty papers were included in the scoping review. The main themes identified were: overcoming structural barriers to accessing support; social connectedness and social networks; holistic and flexible services; and facilitating links to complementary and additional support. Key concepts, such as prevention, were explored, as well as ethical issues that can arise in their application and evaluation.

**Chapter Two** consists of a piece of original empirical research to explore the barriers and facilitators to engaging in community partnerships in the design and delivery of mental health services. The study utilised constructivist grounded theory methodology (Charmaz, 2014) and data collected through semi-structured interviews were analysed and a theoretical model was developed. Nine conceptual categories emerged, each containing multiple focused codes. A model and description of these are presented. Implications for practice and possibilities for future research are discussed.

## Chapter One: Scoping Review

**What is the evidence for, and where are the knowledge gaps in, the application of public health approaches at a community-level focussing on improving the mental health of population groups in the UK? A scoping review**

This review has been provisionally prepared for submission to the journal Administration and Policy in Mental Health and Mental Health Services Research. Author guidelines can be found in Appendix A.

## **Abstract**

This review addresses an under-explored area by consolidating interventions and service developments undertaken by mental health organisations for the implementation of public mental health approaches in the United Kingdom. A scoping review was chosen to facilitate the synthesis of this information. Searches were conducted in PsychInfo, CINAHL and MEDLINE and further articles were identified through hand searching of included studies. A total of 1285 articles were screened and twenty were included. Data relating to population characteristics, intervention descriptions and results were extracted, followed by a thematic analysis of the included studies. Four themes emerged from the data: overcoming structural barriers to accessing support; social connectedness and social networks; holistic and flexible service offers; and facilitating links to complementary and additional services. The reviewed studies described interventions and service developments with a view to address health and social inequalities for various population groups in the UK. Findings should be considered with an understanding that the nature of this review contained publication bias, excluding grey literature. There is a need for further research pertaining to the understanding and application of primary prevention approaches, and the ethical issues that can arise, including consideration for how these approaches are viewed, applied and evaluated.

**Key words:** Public mental health; Organisation; Scoping review.

# **What is the evidence for, and where are the knowledge gaps in, the application of public health approaches at community-level focussing on improving the mental health of population groups in the UK? A scoping review**

## **Introduction**

In the UK, inequalities in health exist between groups and across health conditions (Marmot 2010; Marmot 2020; The Health Foundation, 2022). Life expectancy for men living in the most deprived parts of England is almost 10 years less than those in the least deprived, and amongst women the gap is 7.9 years (Office for National Statistics, 2022). People living in the most deprived parts of the country are twice as likely to be diagnosed with lung cancer (Hastert et al., 2015), with similar findings across other health conditions.

Contemporary health movements envision a public health system that distributes good health, more justly, to the people who need it (Thomas, 2022). A holistic approach to health builds upon a range of factors such as access to stable employment, housing, education and individual and collective wellbeing. Under the Equality Act 2010, public bodies have a statutory duty to ensure that the needs of all people are considered when shaping policy and delivering services (2010). Public health approaches can support in fulfilling this duty, moving towards sustainable health equity, whereby all people are supported to live dignified lives (Marmot, 2020).

## **Language of public mental health**

The language of public health within the health sector often uses terms such as ‘health inequality’, ‘inequity’, or ‘the social determinants of health’. Less commonly used, ‘health justice’ examines how power operates in the distribution of health (Thomas, 2022). In this way, definitions of ‘public health’ can vary and are contested (Verweij and Dawson, 2007; World

Health Organisation, 2011). The World Health Organisation (WHO) defines public health as ‘all organised measures (whether public or private) to prevent disease, promote health, and prolong life among the population as a whole’ (WHO, 2011). In broad terms, public health can refer to everything that contributes to the aggregate health of a population and distribution of health stock (Thomas, 2022).

‘Public mental health’ has been used to describe population-level approaches to the prevention of mental health problems and promotion of wellbeing (Walker et al., 2019). Whilst ‘prevention’ is also a disputed term (Cowen, 1998; Radden, 2018), the idea remains central to discussions about the application of public health strategies to mental health, as well as the ethical issues that can arise (Cowen, 1998; Radden, 2018). Prevention has been described as ‘*a*, or perhaps *the*, central public health principle’ (Radden, 2018; Childress and Bernheim, 2008). However, the term has also become synonymous with ‘early intervention’, rather than ‘upstream’ approaches that address governance, policy or norms shaping access to health promoting resources (Crear-Perry et al., 2021). Heterogeneity in the understanding and use of this idea is bound with ethical implications, constraints and demands (Radden, 2018).

### **Present day context**

The social determinants of health, the conditions in which people are born, grow, work and live (WHO, 2008), offer an understanding of population health and health inequalities. Dynamic socio-political contexts inevitably impact health distribution (WHO, 2011), with a role for psychosocial, material, behavioural and structural processes (Benzeval et al., 2014; Macintyre, 1997; Whitehead et al., 2016). Over the last decade, changes to social security systems in the UK have exacerbated psychological distress and place-based health and social inequalities (Cooper and Whyte, 2017; Friedli and Stearne, 2015). Throughout the course of

the COVID-19 pandemic, disparities in access to healthcare and health outcomes in the UK have also been clear, supported by data published by Public Health England (2020).

The ideology of austerity, pursued by the 2010 coalition and successive UK governments following the 2007/2008 financial crisis, deflected responsibility of the financial deficit away from the businesses and private sector, towards the public (Cooper and Whyte, 2017). Public sector cuts were implemented in an attempt to recoup the money from the general population. In the UK, this commitment to the advancement of neoliberal policies has served the dominance of corporate and political elites, and worsened health and social inequalities (Cooper and Whyte, 2017). In a review of the depth of the impact of austerity measures and the housing crisis in the UK, the United Nations (UN) Housing Envoy in 2013 appealed to the government to ‘assess and evaluate the impact of the welfare reform in relation to the right to adequate housing of the most vulnerable individuals and groups, in light of existing data and evidence’ (UN Human Rights Council, 2013, p.20). Whilst understanding the multiple and intersecting effects, groups affected disproportionately have included working class households and communities, people with disabilities (Barr et al., 2015; O’Hara, 2015), women living in poorer areas and people from Black and Asian communities (Hall et al., 2017). For example, reforms such as Work Capability Assessments have created significant physical and psychological stress for those affected, including people experiencing mental health problems and disabilities (Gentleman, 2013). Levels of child poverty remain high, with many families having lower control over physical aspects of their home environment, or experiencing housing poverty, and struggling to afford basic material items, such as food and warm clothing (Wickham et al., 2016). These contexts can put people at risk of developing or exacerbating mental health difficulties (Davidson, Sewel and Tse, 2009), influencing both physical and mental health outcomes. Specific links have been made between poverty and psychological distress (Psychologists Against Austerity, 2015), described by Psychologists Against Austerity

as ‘austerity ailments’, which include experiences of humiliation and shame, fear and distrust, instability and insecurity, isolation and loneliness and being trapped and powerless. From 2011, Sane and the Depression Alliance reported concerns about links between financial struggles, austerity policies and rising stress and depression (Triggle, 2011). In 2016, Mind reported that 46% of people experiencing mental health problems had considered or attempted suicide due to social factors such as debt and welfare difficulties (Mind, 2016; Cooper and Whyte, 2017).

Bronfenbrenner’s Ecological Systems Theory (1979) framework contextualises complexities of environmental interactions across the five nested levels (micro-; meso-; exo-; macro- and chrono-systems). Bronfenbrenner’s model has been likened with Dahlgren and Whitehead’s Social Model of Health or Rainbow Model (1991), which provides a basis for public health planning and understanding, where the unequal distribution of the social determinants of health lead to health inequities. Maslow’s Hierarchy of Inequity (Moore, 2019) explicitly outlines the uneven distribution of access to basic rights, such as air, water, food, housing, income and safety from violence. Caplan (1964) and Gordon (1987) also offer classifications frameworks for the application of prevention approaches, which include primary, secondary and tertiary (Caplan, 1964) and universal, selected and indicated approaches (Gordon’s, 1987) to prevent psychological distress. Models such as these can be used to conceptualise how different settings can provide contexts for social and preventive interventions (Nelson and Prilleltensky, 2020; Orford, 2008), whilst also suggesting that change at distal levels can promote the wellbeing of individuals, families and groups at a micro-level (Browne et al., 2020).

### **The role of mental health services**

The health and wellbeing of a population can be improved through the development and innovation of health services, with consideration for planning, efficiency, audit and evaluation

(Walker et al., 2019). Moving beyond individualised and reactive interventions to address psychological distress generated by social and economic problems (Cromby, Harper and Reavey, 2013; Friedli, 2009; Marmot, 2010; Marmot, 2020; Mirowsky and Ross, 2003; Wilkinson and Pickett, 2009; Psychologists Against Austerity, 2015) and community-centred interventions, such as those tailored to specific population groups, have the potential to improve health and social outcomes, narrowing the observed mental health gap (Baskin et al., 2021; Marmot, 2020).

The Marmot Review, 'Fair Society Healthy Lives' (2010) outlines six main health strategy objectives to address inequalities across the life course: giving every child the best start in life; enabling all to maximise capabilities and have control over life; creating fair and good employment; ensuring a healthy standard of living; supporting healthy and sustainable communities; and strengthening ill health prevention. Within the NHS, The Public Health Outcomes Framework (NHS, 2017a) was launched in response to The Marmot Review, with annual Health Equity Reports (Public Health England, 2017) detailing eighteen key indicators of the distribution of health-promoting resources. However, these reports have been criticised for their absence of socio-political analysis needed to consider inequalities (Chouhan and Nazroo, 2020). Delivering Race Equality: A Framework for Action (Department of Health, 2005), the NHS Equality Delivery System (NHS, 2013) and the Workforce Race Equality Standard (NHS, 2016), also make specific requirements for commissioners and healthcare providers, including independent organisations under NHS contract, to implement these standards to ensure equitable and fair services, 'reducing the inequality challenge for their population' (NHS, 2017b).

Historically overlooked, the area of public mental health has recently become a priority area for Public Health England (Campion, 2019; Walker et al., 2019), with a growing consensus for more population-level and preventative approaches to mental health



(Department of Health, 2020; NHS, 2019). However, there remains a ‘public mental health implementation gap’ (Campion, 2019, p.1). Severe, imposed financial restraints and limited support to local areas to deliver national public mental health and wellbeing policy has also led to implications for practice (Cylus et al., 2015). This scoping review aims to summarise the evidence and identify knowledge gaps for the application of public health approaches at a community-level, focused on improving the mental health of groups in the UK. This includes people who experience mental health problems that are reflected in high prevalence in the general population, such as anxiety and depression, which may be more amenable to interventions focused on prevention and the promotion of positive mental health (Baskin et al., 2021). The review will begin by understanding which population groups have been the focus of community-level service developments in the UK to address mental health inequalities and the methods of evaluation used, before considering themes that are present in included studies.

## **Methods**

An inclusive search of the literature was conducted to gain a broad understanding of the scope and impact of mental health service interventions and innovation in response to public mental health priorities in the UK. A systematic review was considered unsuitable for this review due to the large, heterogeneous nature of the literature and the requirement for a specific clinical research question. Scoping reviews are a relatively recent approach to the synthesis of literature (Arksey and O’Malley, 2005). A scoping review was chosen for its approach to summarising evidence present in a given field, mapping primary research that could be representative of a breadth of published work, identifying knowledge gaps in emerging fields and clarifying key concepts or definitions within the literature (Munn et al., 2018; Peters et al., 2015; Tricco et al., 2016). Systematic scoping reviews can be an efficient way to collect, evaluate and present

the range of available knowledge and research evidence (Arksey and O'Malley, 2005). By gathering data in this way, this scoping review may help to guide future reviews to define their research questions and determine inclusion or exclusion criteria to support the identification of studies that may be synthesised, such as within a systematic review.

At the time of conducting this review, scoping reviews were not eligible for prospective registration with PROSPERO, the international prospective register for systematic reviews.

### **Study identification**

Scoping review methodology, outlined by Levac et al. (2010) and further developed by Peters et al. (2015), was employed as the methodological basis for this review. This framework ensures that the methods implemented are completed in a rigorous and transparent way (Centre for Reviews and Dissemination, 2008).

An iterative approach was taken with regards to the selection of search terms (Peters et al., 2015). Searches were conducted in April 2022 on PsychInfo, CINAHL and MEDLINE with the initial search terms “public mental health” AND “service development” to ascertain appropriate terms required to search for the data. Following this initial search, a comprehensive list of useful search terms identified were developed (Table 1) with the support of a medical librarian. A broad range of public mental health and organisational change related terms were used to optimise capture of all relevant results. Each line within a concept was combined using the Boolean operator “OR”. The results of the concepts (public health, service development, mental health, geography) were then combined using the operator “AND”. The following search strategy was therefore used: *(public health terms) AND (service development terms) AND (mental health terms) AND (geography terms)*. Public health terms, service development terms and mental health terms were searched in the titles and abstracts, and geography terms were searched in the full text of articles. Databases were searched for papers published between

the years 2010 and 2022, written in the English language and published in academic journals. Relevant papers were also identified from reference lists of included papers.

**Table 1.** *Summary of final search terms and search strategy*

<b>Concept 1: Public health (title, abstract)</b>
Public n3 health Prevent* n3 (primary OR approach* OR intervention*) Population n3 (level OR approach* OR need* OR health) Community n3 (level OR centred OR centered OR based) ("health inequal*" OR "health disparit*" OR "social inequal*" OR "social determinant*") Upstream n3 (approach* OR intervention*)
<b>Concept 2: Service development (title, abstract)</b>
(Organi?ation* OR service) n3 (change OR innovation OR development OR strategy OR policy OR intervention OR initiative)
<b>Concept 3: Mental health (title, abstract)</b>
("Mental health" OR "psychological well-being" OR "psychological wellbeing" OR "psychological well being")
<b>Concept 4: Geography (full text)</b>
(UK OR "United Kingdom" OR "Great Britain" OR Britain OR England OR Scotland OR Wales OR "North* Ireland" OR British OR Scottish OR Welsh OR "North* Irish" OR English)

### **Eligibility criteria**

Table 2 outlines the inclusion and exclusion criteria used to determine eligibility for this scoping review. Searches were limited to studies published from 2010 onwards to ensure the

studies reflected the most current UK policy and practice related to public services. The review included community-level mental health service development aimed at addressing public or population mental health in the UK. Studies that focused on physical health populations were excluded. Studies with populations described as experiencing serious mental illness, suicidality, self-harm, dementia and secondary, tertiary care and perinatal care, were excluded due to a need for specialist mental health support for those groups.

**Table 2.** *Eligibility criteria*

<b>Inclusion</b>	<b>Exclusion</b>
Concerns mental health orientated services in the UK	Solely measured physical health
Any non-clinical community-level interventions or developments that explicitly sought to promote the mental health and wellbeing of a population	Interventions that provided clinical care only for individuals (e.g. pharmaceutical interventions or psychotherapy), secondary care, acute, crisis, forensic, perinatal or early intervention services  Service development or intervention mentioned as part of recommendations only
Based on primary research or case studies	Abstracts, posters, books/chapters, editorials, letters and dissertations
Based in/on the UK	Study concerns/conducted outside the UK
Published from 2010 onwards	Published before 2010
Full-text article available	No full-text research article available
English Language	Non English language

## **Results**

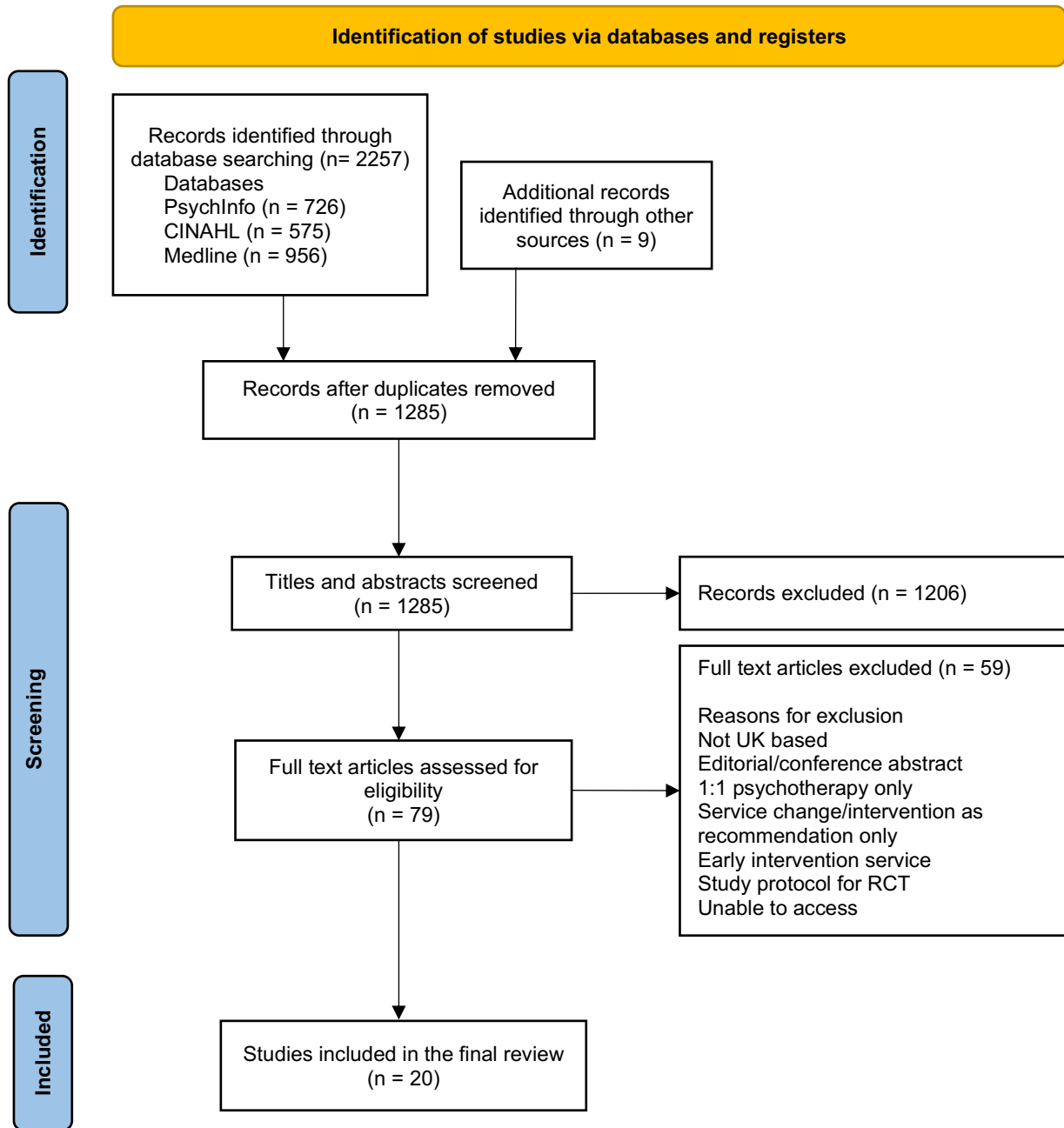
### **Study selection**

Using the above search strategy, a total of 1285 studies were screened. A PRISMA diagram (Page et al., 2021) details the search and selection process applied during the screening of articles (Figure 1). The primary researcher screened non-duplicate titles and abstracts against the eligibility criteria. Rayyan systematic review software (Ouzzani et al., 2016) was used to remove duplicates and screen titles and abstracts. Screening of titles and abstracts resulted in the exclusion of 1206 studies. Full text screening of the remaining 79 studies led to the exclusion of 59 further studies. In cases where abstracts and titles appeared to meet the eligibility criteria and the full text papers could not be retrieved, the authors were contacted. Additional articles were identified by examining references and citation searching of included articles. Utilising these steps, 20 studies were selected to be included in this review.

### **Data analysis and summary**

Data charting can be viewed as a narrative review of the data found (Arksey and O'Malley, 2005; Pawson, 2002). Data were extracted by the primary researcher. A charting table was used to capture key study characteristics: author(s), year of publication, title, study design, setting and population characteristics, intervention description, outcomes and results (Table 3).

Qualitative analysis techniques were also used to provide a further descriptive summary of the review findings (Levac et al., 2010). A thematic analysis was chosen to identify common themes within included studies (Nowell et al., 2017). Similar articles were grouped based on the intervention description and approaches to evaluation taken, these groups were read closely and in comparison to summarise themes featured.



**Figure 1.** Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow chart of search strategy (Page et al., 2021)

### **Quality of reviewed studies**

The heterogeneity of the reviewed studies meant that formal quality appraisal was not performed, consistent with other scoping reviews (Pham et al., 2014). However, efforts were made to highlight methodological and clinical implications where possible.

**Table 3. Charting table**

<b>Author(s) (year of publication)</b>	<b>Title</b>	<b>Study design</b>	<b>Setting; population characteristics</b>	<b>Intervention description</b>	<b>Outcomes</b>	<b>Results</b>
Afuwape et al.; 2010	The cares of life project (CoLP): an exploratory randomised controlled trial of a community-based intervention for black people with common mental disorder	Randomised Control Trial (RCT)	London; black minority ethnic groups with common mental health problems	Participants (n=40) received individual therapy and group sessions on advice on services, health education and mentoring; improve psychosocial functioning and feelings of hope through a culturally acceptable care package. Self-referrals and those from statutory and non-statutory organisations were accepted.	At 3-month follow up, individuals showed significant improvement in levels of depression (GHQ-28 adjusted $p > 0.05$ ), no difference in general functioning (GAF, $p = 0.87$ ).	Access to a needs level package of care, including brief psychological intervention, advocacy and health education improved mental health amongst black individuals with depression and anxiety, intervention found to be culturally appropriate and acceptable amongst users, no significant increased costs.
Chauhan et al.; 2022	"It's a big family here." Becoming and belonging in a service providing employment-related support for people with mental health problems: an interpretative phenomenological analysis	Qualitative interviews; Interpretative phenomenological analysis	England; people with mental health problems	Participants (n=11) in a social enterprise providing work experience, training and skills development for those with mental health problems.	Participants valued a sense of belonging and authentic relationships within the service, enabling a preferred identity to remerge. Some also feared the 'real world' outside of the service and were unsure whether they would be met with the same support.	Importance of a nurturing working environment is highlighted and the value of a range of meaningful employment.
Chiumento et al.; 2011	School-based mental health service for refugee and asylum seeking children: multi-agency	Service review; mixed methods; semi-structured interviews and outcome measures	Liverpool; refugee children and young people identified by schools as requiring additional support.	Groups passed on psycho-education, psychodrama, art psychotherapy, horticulture, local community arts organisations, film making,	Improvement in children's mental health, social connections and training and support for schools to support children and young people, who reported being more likely to access school based	Involving schools and CAMHS can mean multiple agencies working together to support children and young people, maximising resources in doing so and



	working, lessons for good practice			poetry writing and making a book.	mental health service than a CAMH clinic.	providing support in an environment they were already in.
Dickens et al.; 2011	An evaluation of the effectiveness of a community mentoring service for socially isolated older people: a controlled trial	Pilot RCT	South West England; socially isolated older people	Participants in intervention group (n=195) received a community-based mentoring service for improving mental health, social engagement and physical health for socially isolated older people.	No statistically significant between group differences for participant receiving the community mentorships and control group at 6 month follow up in the primary outcome (Short Form Health Survey v2 (SF-12) mental health component score (MCS) ( p = 0.48) and most secondary outcomes (SF-12 physical health component score (PCS), health status (EuroQol; EQ-5D), Geriatric Depression Score (GDS-10), social activity, social support and morbidities).	No evidence here to support the use of community mentoring to alleviate social isolation for older people. Further research needed to understand key components that may be effective.
Fieldhouse; 2012	Community participation and recovery for mental health service users: an action research inquiry	Action research including eight qualitative interviews, thematic analysis	Bristol; people with mental health problems experiencing occupational deprivation and social isolation	Two year action research project exploring assertive outreach use for people experiencing social exclusion and occupational deprivation to participation in their local community. Occupation was used as a basis to build relationships with assertive outreach practitioners and people using services, leading to participation in mainstream community.	Participants reported reconnecting with cherished roles, feelings of self-efficacy, belonging and wellbeing. Feedback based on qualitative interviews with learning informing local service development and critical reflection on its use.	Occupation can be basis for building relationships building relationships between mental health practitioners and people using services, promoting community participation, social inclusion and improvement in wellbeing. Accessing community opportunities was viewed as non-stigmatising. Feedback based on qualitative interviews with learning informing local service development and critical reflection on its use.
Fieldhouse et al.; 2014	Vocational rehabilitation in mental health	Action inquiry	Bristol; people with mental health problems	Partnership between mental health orientated Community Interest	Positive employment outcomes. Trainees gained paid employment, voluntary work, and	Horticulture is discussed as an effective work preparation medium. Work

	services: evaluating the work of a social and therapeutic horticulture community interest company			Company (CIC) and statutory service providing training and work preparation for adults with mental health problems.	joined the CIC team, qualifications and accessed higher education. Improvements in confidence, stamina, attendance and interpersonal skills. The inquiry would inform future service development.	readiness instilled a sense of hope for people engaging in the service, developing their skills and creating routes for them into employment and/or training.
Fulton et al.; 2019	Transition from service to civvy street: the needs of armed forces veterans and their families in the UK	Cross sectional mixed methods approach; three phase exploratory study	Warwickshire; veterans and their families	Veterans (n=8), their families (n=2) and public service and healthcare staff (n=17) co-developed an intervention: booklets and online digital versions for veterans, friends and family members of veterans and staff and stakeholders working with them.	Provided information about what services do, how and when to access them and what to expect. Confusion over when to seek help for mental health difficulties was highlighted.	More support for families was identified, alongside a need for health and social care to understand the needs for this group. Interventions to address stigma and veterans' reluctance to seek help were needed. Scope for co-created interventions.
Gosling et al.; 2022	Community support groups for men living with depression: barriers and facilitators in access and engagement with services	Qualitative interviews; thematic analysis	Greater Manchester; men experiencing depression	Community support groups for men living with depression. Service providers (n=9) involved were interviewed to understand the barriers and facilitators. Seven groups operated on a drop-in basis, two required attendance.	Four key themes were identified: 'Mental health as a weakness', 'Empowering practice', 'Trust and security' and 'Group support as a gateway to treatment'.	Gender specific community support groups were suggested to facilitate access and engagement with mental health interventions by providing safe spaces to address internal conflict reported.
Hammad et al.; 2020	The hand of hope: a coproduced culturally appropriate therapeutic intervention for Muslim communities affected by the Grenfell Tower fire	Mixed methods service evaluation; focus group interviews, thematic analysis and outcome measures.	London; Muslim Middle Eastern and North African (MENA) communities affected by the Grenfell Tower fire	Trauma-informed culturally appropriate faith-informed therapeutic group intervention, the Hand of Hope, coproduced with the community. Two group interventions piloted 10 months and 22 months after the fire, consisting of eight once-weekly two-hour sessions. Integrative approach – community	Identified barriers to mental health support, improved access and service experience for Grenfell-affected Muslim MENA communities who were not engaging with services. The group's engagement and retention of people who previously held negative views of therapy, challenged stigma of help seeking and increased uptake	Informal, coproduced, culturally appropriate, and faith informed therapeutic group intervention led to multiple positive outcomes.

				psychology, cognitive behavioural aspects,	of therapy for participants and their children.	
Hatchett et al.; 2015	Provision of mental health interventions in women's centres: an exploratory study	Online survey; descriptive analysis	Across England and Wales, Women's centres; vulnerable females, including offenders and those at risk of offending	Interventions across twenty-six women's centres were evaluated. Within twelve centres, peer support was offered. In eleven centres, 'other' mental health interventions included holistic therapies and mentoring, indicating a co-production approach to emotional resilience and wellbeing groups.	Of the 26 services providing mental health interventions, 13 indicated that they undertake evaluations, using validated tools and more general descriptions given – 'reviews, evaluation forms and in-house monitoring', not a uniform approach.	Specific interventions not detailed and no evaluation given for particular interventions.
Hodgson et al.; 2019	A qualitative study of an employment scheme for mentors with lived experience of offending within a multi-agency mental health project for excluded young people	Participatory research approach; qualitative interviews; thematic analysis	London; peer mentors	Full time staff (n=4) and peer mentors (n=2). Two tier employment scheme: one-off or short-term employment offered to young people (first tier), longer-term part-time or sessional employment as a 'peer mentor' (second tier). The paper explored experiences of peer mentors.	Thematic analysis revealed three themes of 'Opportunity and Empowerment', 'Supportive Processes' and 'Role Definition and Structure'.	Results suggest that meaningful employment opportunities, with holistic support and processes for reflection and mentalisation of self and others, contribute to the personal and professional development of ex-offenders in peer mentoring roles.
Hughes; 2014	Finding a voice through 'the Tree of Life': a strength-based approach to mental health for refugee children and families in schools	Case study, with qualitative participant feedback	London; refugee children and their families	'Tree of Life' groups for both parents and children in schools.	Groups enabled parents and children to develop empowering stories about their lives and develop shared, culturally congruent solutions to challenges they faced. Groups were of benefit to children, parents and schools, and their relationships. Teachers also reported more positive behaviour in children who participated in the groups.	Importance of taking support out of the clinic, school was somewhere people were familiar with and did not carry the stigma of mental health settings. Support from community members and link workers and strengths based, collective interventions, enabled families to reconnect with

						empowering stories and resources within the groups.
Lovell et al.; 2014	Development and evaluation of culturally sensitive psychosocial interventions for under-served people in primary care	Pilot RCT	Northwest England; Older people and people from ethnic minority groups across four socioeconomically deprived localities.	Culturally sensitive wellbeing intervention with individual, group and sign-posting elements.	The group receiving the wellbeing interventions improved compared to the group receiving usual care (for older people, largest effects on CORE-OM and PHQ-9, for ethnic minority people, largest effect was on PHQ-9), however no statistically significant changes were recorded. Qualitative data suggested that patients found the intervention acceptable, both in terms of content and delivery.	Some evidence of acceptability, although challenges in recruitment and engagement limited ability to generalise findings.
O'Shaughnessy et al.; 2012	Sweet Mother: evaluation of a pilot mental health service for asylum-seeking mothers and babies	Mixed methods based Participatory Action Research (PAR) framework, session by session evaluation, reflective focus groups analysed using thematic analysis and the CARE-index.	Liverpool; asylum seeking mothers and their babies in their first year of life	Social and practical support alongside a therapeutic mother-infant group. Cross-culturally trained volunteers offered emotional and befriending support, two psychologists delivered the therapeutic group.	Four to twelve mothers attended a significant number of/all group sessions. Six mothers attended 1-4 sessions. Reasons for drop out included immigration detention, obtaining refugee status, sufficient local family support and fear of gossip in the community. Results from the CARE-Index analysis and women's narratives indicated a positive shift, positive feedback included themes of being together, feeling safe, learning about motherhood and parenting, valued talking about their babies and relationships with them and unstoried narratives.	Adds to evidence for the need to develop relationship-entered interventions that take into account the contextual challenges for asylum seeking and refugee populations.
Pardi et al.; 2018	How young adults in London experience the Clubhouse model of mental health	Qualitative interviews; thematic analysis	London; young adults aged 16–25 with mental health diagnoses	Non-clinical working communities where members work side by side with staff, including Transitional Employment	Benefits of getting involved in the work of the clubhouse, a mostly positive perception of the clubhouse compared with other mental health services, sense of	Clubhouse model seems to be beneficial to its members, owing to collaborative and consultative processes between staff and members,

	recovery: a thematic analysis			Placements, and educational support through member-led classes, classes run by outside agencies and mentoring.	personal change and social improvement experienced through becoming members of the clubhouse.	lack of rigid or inflexible time limits, reciprocal relationships, where members are expected to both provide and receive support.
Perry et al.; 2018	Improving mental health knowledge of the Charedi Orthodox Jewish Community in North London: a partnership project	Mixed-method design; group pre- or post-test and descriptive approach from qualitative feedback	London; Charedi Orthodox Jewish Community (OJC)	Brief culturally tailored psychoeducational group focusing on mental health promotion and prevention, in which 34 carers in the Charedi OJC were provided with general information on mental health, the availability of support services and self-care.	34 participants attended the course, including informal caregivers (e.g. service users, family, friends, neighbours and volunteers) and formal care providers (e.g. healthcare professionals, mental health support workers, family workers, Rabbis/Rebbetsens, teachers, trustees, welfare officers). Improvements in well-being, increased intentions to access services, particularly talking therapies, and qualitative feedback indicated that the group was very well received.	Project endorses the value of culturally relevant psychoeducation and culturally appropriate service development.
Ross et al.; 2011	Tackling inequalities in primary care mental health	Case study	Glasgow; place based	STEPS Team established as a primary mental health team in Glasgow. Level 4 and 5 offer non-face-to-face and population-level activities.	Opportunity to expand services beyond one-to-one care, considering a more holistic approach to mental health and wellbeing in the population. Improvement in clinical services. Difficulty accessing some groups who would not typically engage with mental health services. Waiting lists for the services offered by the team were short and manageable.	Baseline for longer term action, wider organisational support, staff training, and further collaboration. Further attempts needed to ensure services are accessible to people.
Smith et al.; 2011	The Lambeth wellbeing and happiness programme:	Case study	London; place based	Approach to public mental health in Lambeth included an individual, community and policy focus. Some	Emphasised a focus on wellbeing and use of wellbeing measures including in community settings. Contributed to application of	Importance of taking a long view, senior leadership, capacity for cross sector coordination, evaluation,

	a strategic approach to public mental health			interventions included training and awareness raising for staff and community organisations, promotional materials, annual arts and cultural festival on the theme of wellbeing.	evidence- based approaches with individuals and contributing to policy and strategy.	persistence, vision and opportunism.
Thirlwall et al.; 2020	Utilising community engagement approaches to influence public mental health policy in a rural setting	Participatory appraisal approach	Dumfries and Galloway; place based	43 people took part in three-day “Training of Trainers” exercise with a focus on area (community mapping and community walks), time (activity calendars and time lines) and prioritising choices (ranking and nominal voting) to understand perspectives of community, which led to a forum with 20 key stakeholders to consider this information.	A working group formed to agree a plan/actions to enhance population health. NHS Health Scotland mental health outcomes framework was adapted to align with local need, including increased social support and social networks for all, improved access to interventions to improve confidence and mental health, promoting positive mental health behaviours, increased participation in decision making processes.	Community engagement processes can help to ensure information gathered is more holistic and reflective of the population within the context of the region. Resilience, support of families and friends, social inclusion, access to social and leisure opportunities important. Structural issues: fear of judgement, lack of transport, discrimination, financial support. Individual factors: sleep, meaningful hobbies and health.
Zlotowitz et al.; 2016	Service users as the key to service change? The development of an innovative intervention for excluded young people	Qualitative; focused ethnography largely from field notes analysed using thematic analysis	London; excluded young people	Coproduced project activities, contemporary music skills (DJ-ing and lyric writing) as a vehicle to build relationships and address young people’s multiple needs.	The intervention appeared to be valued by young people, leading to the development of a model of a replicable intervention labelled the ‘Integrate model’, being implemented by three pilot projects involving multiple agency partnerships.	Key principles of the intervention identified need for consistent relationships with trusted staff, mental health support to be wrapped around youth-led activities, local service delivery in safe territories.

## **Descriptive summary**

### ***Study design***

The twenty studies included in this review were published between 2010 (Afuwape et al.) and 2022 (Chauhan et al.; Gosling et al.). Studies were highly heterogenous in their design and interventions described. Three involved randomised controlled trials (RCTs) including two pilots (Afuwape et al., 2010; Dickens et al., 2011; Lovell et al., 2014), with one including qualitative feedback from participants (Lovell et al., 2014). Some studies employed qualitative analysis using interpretative phenomenological analysis (IPA) (Chauhan et al., 2022) and thematic analysis (Fieldhouse, 2012; Gosling et al., 2022; Hammad et al., 2020; Hodgson et al., 2019; O'Shaughnessy et al., 2012; Pardi et al., 2018; Zlotowitz et al., 2016), mixed methods (Chiumento et al., 2011; Fulton et al., 2019; O'Shaughnessy et al., 2012; Perry et al., 2018), case studies (Ross et al., 2011; Smith et al., 2012), and studies informed by Participatory Action Research (PAR) orientated approaches (Fieldhouse, 2012; Hodgson et al., 2019; O'Shaughnessy et al., 2012; Thirlwall et al., 2020).

Some evidence for effectiveness was reported within the RCTs included (Afuwape et al., 2010; Dickens et al., 2011; Lovell et al., 2014), supported by qualitative feedback indicating the benefits of culturally adapted interventions. Several studies utilised qualitative approaches to evaluation. Hughes (2014) discussed the unsuitability of quantitative evaluation methods and standardised outcome measures due to the contextual challenges women in this study faced, related to circumstances in pre-migratory countries, the asylum process and changes in social relationships. Hughes also made reference to the focus on symptom reduction in standardised outcome measures, at odds with strengths-based approaches, inferring implicit Western assumptions of what constitutes a successful intervention. Verbal feedback was

reported to overcome written language barriers and support women to describe how they had experienced the groups.

Six studies utilised participatory approaches with a view to ensure local people are central in planning processes (Fieldhouse, 2012; Fieldhouse et al., 2014; Hodgson et al., 2019; O'Shaughnessy et al., 2012; Zlotowitz et al., 2016; Thirlwall et al., 2018). Thirlwall et al (2018) utilised a participatory appraisal approach within a rural setting, engaging with local communities to explore understandings of mental health, the main influences on the local population's wellbeing, and to identify areas for action and change. This complemented information drawn from local statistical profiles compared with national mental health indicators at individual, community and structural levels (Parkinson, 2007). Fieldhouse (2012) described an action research study which involved semi-structured qualitative interviews to understand the impact of assertive outreach on community participation and recovery, feeding into an interagency consortium to inform local service development. The consortium's experiences were evaluated over time using cooperative inquiry (Heron and Reason, 2001) and appreciative inquiry (Cooperrider and Whitey, 2005). Fieldhouse and Donskoy (2013) appraised the methodology of this study, detailing that mental health service user researchers shared the interviewer role with a view to redress interviewer-interviewee power imbalances, a benefit also cited in the participatory approach used by Hodgson et al (2019). Zlotowitz et al (2016) describe a focused ethnography approach to evaluation, where data consisted of field notes, interviews and conversations with young people, stakeholders and staff. Similarly, young people participated in 'research consultant' roles alongside the authors. Qualitative data were analysed thematically to identify themes that led to the development of the 'Integrate model', a replicable intervention framework used to inform multiple subsequent pilot projects.



### ***Setting***

The studies included in this scoping review took place in England, Scotland and Wales. Eight of the studies took place in London (Afuwape et al., 2010; Hammad et al., 2020; Hodgson et al., 2019; Hughes, 2014; Pardi et al., 2018; Perry et al., 2018; Smith et al., 2012; Zlotowitz et al., 2016). Further studies were set across four disadvantaged localities in the North West of England (Lovell et al., 2014), Liverpool (Chiumento et al., 2011; O'Shaughnessy et al., 2012), Greater Manchester (Gosling et al., 2022), Warwickshire (Fulton et al., 2019), a rural county in the South West of England (Dickens et al., 2011), Bristol (Fieldhouse, 2012; Fieldhouse et al., 2014), Glasgow (Ross et al., 2011) and Dumfries and Galloway (Thirlwall et al., 2020). Some studied evaluated regional service interventions, such as those across England (Chauhan et al., 2022), and England and Wales (Hatchett et al., 2015).

### ***Population***

The interventions reported in the included studies were tailored to population specific groups, such as people with ethnic minority backgrounds and older people across four socioeconomically deprived localities (Lovell et al., 2014), black minority ethnic groups (Afuwape et al., 2010), Middle Eastern and North African Muslim communities affected by the Grenfell Tower fire (Hammad et al., 2020), a Charedi Orthodox Jewish community (Perry et al., 2018), asylum seeking or refugee children, mothers and families (Chiumento et al., 2011; Hughes, 2014; O'Shaughnessy et al., 2012), socially isolated older people (Dickens et al., 2011), veterans and their families (Fulton et al., 2019), people who have experienced offending (Hatchett et al., 2015), people experiencing mental health problems or in contact with mental health services (Chauhan et al., 2022; Gosling et al., 2022; Pardi et al., 2018) including those experiencing social isolation, occupational deprivation (Fieldhouse, 2012; Fieldhouse et al., 2014) and excluded young people (Zlotowitz et al., 2016). Interventions were also place

specific, such as those described in Glasgow (Ross et al., 2011), Dumfries and Galloway (Thirlwall et al., 2020) and Lambeth (Smith et al., 2012).

## **Thematic analysis**

Four themes were identified within the included studies, informing public mental health provision for population groups in the UK: overcoming structural barriers to accessing support; social connectedness and social networks; holistic and flexible services; and facilitating links to complementary and additional support.

### ***Overcoming structural barriers to accessing support***

Several of the included studies highlighted an imperative for designing responsive services able to adapt to the realities and cultural nuances of people's lives. Interventions included those within local community settings, which incorporated people's explanatory models of psychological distress and preferences of intervention design, such as where these were co-produced or collective in nature, and met specific group needs. Co-production and strengths-based approaches were described as ways to do this.

Three studies described interventions for people experiencing various stages of the asylum process (Chiumento et al., 2011; Hughes, 2014; O'Shaughnessy et al., 2012). Two of these included school-based interventions for refugee and asylum-seeking children (Chiumento et al., 2011; Hughes, 2014), overcoming barriers to seeking traditional mental health support in a clinic setting. Chiumento et al (2011) describe the Haven service, providing mental health support in seven core schools; four primary and three secondary. School settings were favoured for being an environment intended to support not only education, but also social and emotional development, whilst acting as a link between young people and parents and the local

community. In two studies, referrals were made by teachers (Chiumento et al., 2011; Hughes, 2014), as well as GPs and other statutory and voluntary services (Chiumento et al., 2011). Hughes (2014) described using the ‘Tree of Life’ (Ncube, 2006; 2007) as the primary intervention. Chiumento et al (2011) wrote of groups based on psychodrama, horticulture and art psychotherapy, with a view to bridge cultural and linguistic barriers. Both studies described the interventions as leading to parents and schools coming into contact in positive ways, rather than only in response to difficulties (Chiumento et al., 2011; Hughes, 2014). In these studies, generalisability of the findings are limited due to the small numbers presented.

Group based psychoeducation was described in two of the included studies (Afuwape et al., 2010; Perry et al., 2018). Perry et al (2018) describe a partnership between a community-based organisation, Bikur Cholim, a Rabbi and a Charedi Orthodox Jewish psychotherapist and City and Hackney NHS BME Access Service. They identified a need to increase local community knowledge of mental health, understanding the clinical issues affecting the Charedi Orthodox community and inclusion of culturally relevant material. A culturally informed psychoeducation-based group was developed as a strategy for health promotion. This improved awareness of mental health and facilitated positive attitudes towards accessing support or talking therapies from statutory and third sector services and improved social connectedness amongst group members. The mixed method design with a group pre- and post-test was used to examine the effectiveness of the course, however, the sample size and adapted evaluation questionnaire limit the wider generalisability of the findings.

Afuwape et al (2010) reported an RCT with an intervention group that followed a ‘stepped care approach’ (Department of Health, 2003), delivered by six community health workers, therapists and a psychiatrist. A rapid-access intervention included a needs-led care package consisting of practical advice and assistance, advocacy for social needs and health education and monitoring, alongside psychological therapies. At the 3 month follow up,

individuals in the intervention group showed significant improvement in levels of depression (General Health Questionnaire; Goldberg and Hillier, 1979; GHQ-28 adjusted  $p < 0.05$ ) and no evidence for difference in general functioning (Global Assessment of Functioning; Endicott et al., 1976; GAF,  $p = 0.87$ ). The small number of participants, imbalance at baseline between groups and difficulties maintain blindness among the researchers at follow-up may constitute to methodological weaknesses in this study.

Lovell et al (2014) describe interventions focused on psychosocial support for people from ethnic minority backgrounds which aimed to work with people's explanatory models to alleviate depression and reduce social isolation. In several studies, effective and culturally acceptable strategies for community engagement were reported to include preferences for the term 'wellbeing' rather than 'mental health' (Lovell et al., 2014), decisions not to label the intervention as a mental health intervention due to stigma and shame associated with accessing mental health care (Hammad et al., 2020), and the delivery of informal seminars comprising a 'course', rather than a mental health intervention (Perry et al., 2018).

Multiple studies described coproduced interventions to develop tailored support for specific populations (Fulton et al., 2019; Hammad et al., 2020; Zlotowitz et al., 2016), informed by community psychology principles (Hammad et al., 2020; Zlotowitz et al., 2016). Hammad et al (2020) evaluated two therapeutic groups coproduced at different time periods to reflect the various stages and difficulties people encountered post-Grenfell. This study demonstrated the value of coproduction in responding to contextual change and meeting the needs of cultural and faith groups following collective trauma and loss. Likewise, Zlotowitz et al (2016) describe a co-produced intervention that provided an alternative to traditional mental health services for excluded young people, highlighting the importance of meeting people out of the clinic in places people already met. This study was short term and the researchers took participant-observer roles, accruing potential bias. However, the applied ethnographic approach aligned

with the study's purpose, incorporating elements of PAR, a preferred methodology for community psychology interventions (Kagan et al., 2019).

Providing services in places that were familiar and local to community groups were noted in several of the included studies in this scoping review (Chiumento et al., 2011; Hughes, 2014; Perry et al., 2018; Zlotowitz et al., 2016). Fieldhouse (2012) describes affirming environments that can be used to promote wellbeing associated with participation in one's local community, such as in further education colleges and leisure centres. Nurturing environments were also said to develop as a result of supporting and accepting relationships, for example those reported by Chauhan et al (2022) in an employment service within a social enterprise. Similarly, Pardi et al (2018) discuss a 'Clubhouse' model of mental health recovery in London where members and staff worked alongside each other, developing reciprocal relationships, through which members reported experiencing personal change and social improvement.

Gosling et al (2022) evaluated a group support intervention for men experiencing depression from the perspective of service providers, describing the groups as a 'gateway to formal services' for people who may be less likely to access professional mental health support owing to gender role conflicts and stigma (Mansfield, Addis and Mahalik, 2003; Wester, 2008). The authors suggest that mental health campaigns ought to target distinct, age specific groups to address health inequalities. Hatchett et al (2015) appraised interventions provided in twenty-six women's centres across England and Wales, of which, twelve centres indicated that peer support was offered and in eleven centres, 'other' mental health interventions included holistic therapies and mentoring, implying a co-production approach was taken to promote emotional resilience and wellbeing groups. No further discussion or evaluation for these interventions were provided, with the study detailing a need for a more consistent means of evaluation across centres.

### ***Social connectedness and social networks***

Multiple papers described preferences for offering collective interventions, valuing social connectedness and support, and its appropriateness across cultural groups.

Social support was a positive feature reported across studies (Afuwape et al., 2010; Chiumento et al., 2011; Hammad et al., 2020; Hughes et al., 2014; O'Shaughnessy et al., 2012; Thirlwall et al., 2020). Hammad et al. (2020) describe the significance of social connectedness as a source of resilience in response to trauma and loss, where activating and strengthening social support networks is recommended post-disaster (Inter-Agency Standing Committee, 2007). The intervention involved the sharing of food, where feeding others is a deeply symbolic gesture of care and love following grief and bereavement in Middle Eastern and North African cultures; and 'hikayat' (Atallah, 2017; Zarifi, 2015), oral storytelling, in which people bear witness to each other's stories of sorrow, joy, life and memories (Zarifi, 2015). O'Shaughnessy et al (2012) describe the 'Sweet Mother' project, a pilot service designed to meet the needs of asylum-seeking women and their infants in the first year of life. The main strength of the intervention was said to be mothers' and babies' experience of being together, regularly sharing food, ideas, preoccupying or distressing thoughts, especially those in relation to asylum. In this study, maintaining a safe space included steps to ensure consistency of the weekly group, contact between sessions to sustain relationships and regular reminders of confidentiality in the context of the 'host' country, notably with regards to information sharing with specific institutions.

Thirlwall et al (2020) noted the social disconnectedness that can lead to, and cause, poor mental health. The focus of this study involved people living in rural areas, where there was a potential for increased visibility whilst accessing mental health support, or requiring longer travel distances to access services (Scottish Association for Mental Health, 2012). Participatory appraisal approaches identified community perspectives in relation to public

mental health priorities, with resilience, support of families and friends, social inclusion, access to social and leisure opportunities taking the forefront. This went on to inform NHS Health Scotland's mental health outcomes framework, aligning with local need, with priorities including increased social support and social networks for all, and increased participation in decision making processes.

Dickens et al (2011) describe a community-based mentoring service for older people experiencing social isolation, to improve mental health, social engagement and physical health for this population. Participants in the intervention group were assigned a mentor who worked closely with them for 12 weeks. The aim was for this to build self-confidence and engagement in personally meaningful social activities in the local community, developing necessary skills and abilities to ensure sustainable changes following the intervention. No statistically significant between-group differences were observed at six-month follow-up in most outcomes; exceptions were health status (EQ-5D) and one social activity item ('getting along with others'), where the intervention group participants reported significantly less improvement than those in the control group (mean difference -0.1; 95% CI -0.1 to -0.03;  $p < 0.01$ ), and the degree to which people in the intervention group reported getting on with other people (odds ratio 0.6; 95% CI 0.4 to 0.9;  $p < 0.01$ ) had also deteriorated compared with control participants. These effects could relate to methodological challenges, lack of consistency in the implementation, broad eligibility criteria and heterogeneity within the participant groups. However, methodological strengths include the participant recruitment, which exceeded the sample size target required to demonstrate potentially important between-group differences on the primary outcome measure, and participant retention at follow-up.

Similarly, Fieldhouse (2012) report the use of assertive outreach to support people become more confident exploring new social and occupational roles in their local community. Group based work was seen to fuel a sense of competence and acceptance by enabling self-

perceptions to be reappraised and recalibrated through the perception of peers (Moghaddam, 2019) and addressed social isolation embedded in the ‘doing’, which led to improvement in wellbeing for participants and their families. The appreciative inquiry, qualitative approach may construe a positive bias to the study’s findings, however the involvement of service user researchers as co-interviewers and data co-analysts, as well as involvement of a service user steering group aimed to mitigate this bias and elicit an authentic service user voice in the research.

The value of peer support and mentoring was repeated across studies (Chauhan et al., 2022; Hodgson et al., 2019; Pardi et al., 2018; Smith et al., 2012). Gosling et al (2022) highlighted the therapeutic potential of informal peer support groups as a precursor to accessing statutory services, from the perspective of service providers. Group support was identified as a means to addressing long waiting lists, yet highlighted the organisational and contextual challenges that may obstruct this, such as a lack of financial support. Relationships held by trusted community members and link workers helped people to address concerns before they met with mental health professionals and worked to ensure the appropriability of interventions offered (Hughes, 2014). Peer support was also reported to be beneficial between group facilitators who offered each other peer-supervision (Hammad et al., 2020).

### ***Holistic and flexible service offers***

Multiagency teams were noted in some of the studies included in this scoping review as a means to maximising available resources to deliver tailored services more broadly (Chiumento et al., 2011; Fieldhouse, 2012; Fieldhouse et al., 2014; Fulton et al., 2019; Perry et al., 2018; Smith et al., 2012).

Strategic partnerships amongst agencies included those within the Voluntary Charity and Social Enterprise (VCSE) sector (Fieldhouse et al., 2014; Chauhan et al., 2022), third



sector (Perry et al., 2018), local authority, NHS and police (Smith et al., 2012). Many of the included studies described roles for community organisations, an early point of contact for community members, holding valuable knowledge of the physical and mental health needs of a community and occupying a role that could traverse both statutory and third sector organisations (Hammad et al., 2020; Perry et al., 2018).

Within several of the studies, people were supported to access employment roles and skills, leading to positive impacts on wellbeing, social relationships, confidence and hopes for the future (Chauhan et al., 2022; Fieldhouse et al., 2014; Hodgson et al., 2019; Pardi et al., 2018; Zlotowitz et al., 2016). Fieldhouse et al (2014) explained that employing people who formerly accessed mental health services as staff provided meaningful opportunities for people, whilst modelling inclusive employment to other businesses. Training and work preparation was offered. Positive outcomes for people were reported with regards to paid employment, voluntary work, qualifications gained and access to higher education. Similarly, Chauhan et al (2022) describe an employment service that formed part of a wider social enterprise. Whether this work was valued was said to depend on the cultural meaning of paid work for people, as well as their material circumstances (Chauhan et al., 2022). Hodgson et al (2019) include an exploration of staff and peer experiences of an employment scheme for peer mentors within a project for young people. The results suggest that meaningful employment opportunities can provide roles in which employees feel valued and respected, conferring a sense of value for self and hope for the future for mentors. Once again, adequate training and support to perform the role, flexibility in responding to individual development needs and being explicit in communication helped to navigate some tensions that arose.

Finally, Chiumento et al (2011) discuss the value of a stable yet flexible service, where longer term contact could be maintained on an infrequent and informal basis, which proved to

be valuable for many of the young people and supported them to develop social connections in new environments. Similar findings were reported by Zlotowitz et al (2016).

### ***Facilitating links to complementary and additional services***

The importance of community-based public health interventions facilitating links to complementary and additional services was another key theme for the included studies. For example, Fulton et al (2019) describe an exploratory study that has three consecutive phases, culminating in a tailored co-developed intervention for veterans and their families. Questionnaires to explore the needs of veterans and their families, and health and public services staff knowledge of veterans' needs and the UK Armed Forces Covenant requirements (2011) (Phase 1) was followed by focus groups for further in depth exploration of issues raised (Phase 2), from which an intervention was co-developed (Phase 3). Prominent themes included confusion reported amongst this population regarding when to seek help, what services do, how and when to access them and what to expect. Booklets and online versions were developed for veterans, friends and family members of veterans and staff working with them. These included information about healthcare, finances, housing and jobs, to be distributed in job centres, children's centres, barracks, healthcare services and third sector organisations.

Finally, Lovell et al (2014) present an intervention involving person-centered health and social care orientated goals. They emphasised the importance of people as an 'agent of change', actioned through engagement with a wellbeing facilitator, culturally appropriate group sessions with other participants or direction ('signposting') to appropriate local public or voluntary services. No statistically significant changes were recorded. Qualitative data supported the acceptability and appropriateness of content for participants. The intervention complexity, time constraints and low recruitment rates impacted accurate identification of effective elements, limiting the transferability of findings to wider populations.

## **Discussion**

Twenty studies included in this scoping review described the application of public health approaches at a community-level, focused on improving the mental health of groups in the UK. The studies varied in their design, the population needs they addressed and intervention characteristics.

Several of the included studies described interventions that sought to overcome structural barriers to accessing support, addressing unmet mental health needs of specific populations who may not routinely access mental health services. This included where there were requests for tailored cultural and faith orientated support, and where clinic-based interventions could create barriers to engagement.

Many of the studies reported interventions that sought to address social network size and isolation through group interventions promoting social connectedness and peer support. The interventions took a holistic view of what may be helpful in supporting the wellbeing of a population group. This included support through employment, vocational opportunities and assertive outreach to facilitate community participation. Some service offers were flexible, where contact could be maintained on a longer term, infrequent basis. Finally, some interventions also placed an emphasis on signposting to complementary or additional health and social care services.

The concept of 'health' constitutes a number of ideas that operate differently for people at different times as they consider how health can be promoted and maintained (Cowley, 2018; Nutbeam, 2019). Health beyond healthcare remains something fundamentally dominated by a frame of individuals, individualism and personal responsibility (Thomas, 2022). Despite policy level commitments in the UK, public mental health has received far less attention and

expenditure compared with physical health (Naylor, 2017) and there remains a gap between policy aspirations and their implementation at local levels. A number of ideas for implementation have been identified in this review, however, studies remained heterogenous in their design, methods of change and evaluation.

### **Implications for mental health services and policymakers**

Distinctions between process and outcome measurement may influence judgments about the quality of an intervention. Outcome measurement remains the dominant paradigm in relation to service quality in the UK. However, a key focus of public health work can be understood to be preventative, a concept that is difficult to measure (Campbell, Cowley and Buttigieg, 1995; Macleod Clark et al., 1997). Public health interventions are often multi-faceted, multi-disciplinary and multi-sectoral, frequently influencing behaviour change over a long period of time (Tones and Tilford, 1994). The use of outcomes as a measure to assess service quality raises issues regarding longitudinality, validity of outcome measures and attribution (Cowley, 2008). Several of the reviewed studies predominantly used qualitative or mixed methods approaches to understanding the impact of the reported interventions. As such, it has been argued that the application of public health strategies to mental health requires systematic, sustained and informed ethical scrutiny, which has yet to occur (Radden, 2018).

As demonstrated by the studies included in this review, there are examples of services going to people in the places they live, supporting people to access community resources to support wellness. They often took a holistic view of people, not limited to singular aspects of a person or a mental health condition. Whilst some examples are offered, it would seem that these do not represent a fundamental change in mainstream, publicly funded service offers. There is also a disparity between the scale of community centred intervention provisions and the published evidence. This may be mediated by bias in scientific priorities and appropriate

allocation of resources, such as funding. The expertise that can be shared and created through interdisciplinary and multiagency working, including partnerships with community organisations and communities themselves, offers a way to establish mutually respectful and supportive relationships to further change on agreed priorities.

The contexts of interventions described in the reviewed studies varied between sector and location. All interventions described population and community level approaches. Beyond this, there was great heterogeneity in the application of interventions and a lack of consensus regarding definitions and boundaries among key components within public mental health (Davies, 2014). The included studies demonstrate the limitations of applying theoretical classification models without flexible and pragmatic approaches in certain contexts according to constraints and possibilities. Attention to public health approaches within formal training and mainstream service practices, including relevant socio-political and economic analysis, may be used as a basis to expand values and support application of relevant frameworks and policy objectives. Several studies detailed a need to change contexts, rather than individuals more explicitly; a theory of change that can align with ecological systems frameworks to create environments that are conducive to maintaining a level of wellbeing by addressing structural, social and economic determinants of distress, such as poverty and oppression.

Finally, homogenising the needs of groups through the use of terms such as ‘ethnic minority’ or ‘BAME’ people can obfuscate inequalities between groups. It has been suggested, in the first instance, that consistent use of national census categories across all sectors may support understanding of population need and epidemiology.

### **Future research**

The language of public health in relation to mental health provision also remains contested and unclear; there is a lack of agreement in the way public mental health constructs are viewed, their use and meaning across contexts. Some studies may describe relevant interventions by

detailing specific needs, such as those related to housing, income, food, warmth, fuel. Further research to explore and synthesise this evidence would be beneficial, as well as their relevance across specific population groups. Engaging with stakeholders to increase clarity of terms may be beneficial, alongside further enquiry into this under-researched area. Allocation of resources towards population-level mental health interventions and their evaluation, particularly those in the third sector where these interventions are typically provided, may help in understanding the mechanisms by which the mental health of population can be improved.

### **Strengths and limitations**

This scoping review sought to address a large evidence gap pertaining to public mental health approaches used by mental health services in the UK. A scoping review framework was used to summarise evidence relating to statutory and third sector organisations that described community based mental health interventions and services. A scoping review was chosen to take into account the vastly heterogeneous nature of the literature.

The included studies were limited to those published in peer reviewed journals and those identified through citation tracking of included studies. This will have omitted relevant studies within the grey literature, which may convey publication bias (Arksey and O'Malley, 2005). The reviewed studies also varied considerably in quality. In some cases the number of studies relative to a geographical area was small and multiple studies reported small sample sizes (Chauhan et al., 2022; O'Shaughnessy et al., 2012).

### **Conclusions**

Psychosocial interventions for communities impacted by adversity worldwide is a priority agenda item for the World Health Organisation (WHO) (Saxena et al., 2007), who advocate for an approach that is sensitive to local need and human rights (WHO, 2021). Over decades,

healthcare delivery in the UK has been transformed by means of neoliberal policy reforms, marked by a ‘motivated shift away from public-collective values to private-individualistic ones’ (Barnett, 2005, p. 7), an ethos of New Public Management (NPM) and the ‘do more with less’ politics of austerity (Thomas, 2022). This review presented evidence relating to initiatives that have targeted the needs of population groups in seeking to address widening health and social inequalities. Without understanding the unique experiences of such groups, health gaps are likely to persist. Public health approaches offer ways to address population-level mental health inequalities in the UK, including transformation of the contexts in which they exist.

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## **Chapter Two: Empirical Paper**

### **Community partnerships in the design and delivery of mental health and wellbeing services: a grounded theory study**

This paper has been provisionally prepared for submission to the journal Administration and Policy in Mental Health and Mental Health Services Research. Author guidelines can be found in Appendix A.

## Abstract

**Background:** Community partnerships have been suggested as a means of addressing health inequalities and ensuring health services are effective. Whilst this is an emerging field of research, little is written about the factors that enable or hinder meaningful partnerships with communities in the context of mental health services.

**Aims:** This study aimed to develop a comprehensive contextualised understanding of the processes involved in partnership working with communities in the design and delivery of mental health and wellbeing services, from the perspectives of a range of stakeholders.

**Methods:** Twenty-one people were interviewed about their experience of community partnerships in mental health and wellbeing service design and delivery. In accordance with social constructivist grounded theory methodology, data collected through semi-structured interviews were analysed and a theoretical model was developed, capturing the barriers and facilitators of this way of working.

**Results:** Nine conceptual categories emerged, each containing multiple focused codes. A model and description of these are presented.

**Conclusions:** Participants described a large variety of interactions that extended well beyond those with formal mental health organisations. An appreciation of peoples' context and experiences of services formed the basis of reflections. Attention to resources available and meanings of community partnerships and their implications were given. Time was said to be needed to build and honour relationships, supporting mutuality in partnerships, before action

could occur. The nature of change varied between groups according to need, priority and respect for existing community strengths. Some difficulties related to persistent inequalities and the decontextualisation of organisational practices and distress. Participants also reflected on transient relationships, exploitation and surveillance, and the impact of systemic barriers on the wellbeing of those involved. Hopes for the future included enthusiasm for more community working, with attention to professional reflexivity. Implications for practice and possibilities for future research are discussed.

**Keywords:** Mental health services; Community partnerships; Health inequalities.

# **Community partnerships in the design and delivery of mental health and wellbeing services: a grounded theory study**

## **Introduction**

Health inequalities continue to widen between and within countries, social groups and geographical regions (Marmot, 2010; Marmot et al., 2020; World Health Organisation; WHO, 2008). They are avoidable by reasonable means, but are not avoided (Marmot et al., 2020, p13). The COVID-19 pandemic has further amplified inequalities across groups, entrenching poverty and poor health outcomes among those already disadvantaged (Public Health England; PHE, 2020; Marmot et al., 2020; Women's Budget Group, 2021). The consequences in the UK are that many people continue to face largely unmet needs related to their physical and mental health, housing, employment, income, access to community resources, discrimination and exclusion (Zlotowitz et al., 2016). Marmot (2010) advocates that socioeconomic inequalities can be addressed through social action across all the determinants by ‘creating the conditions for people to take control of their own lives’, with a note that ‘for some communities, this will mean removing structural barriers to participation, for others facilitating and developing capacity and capability through personal and community development’ (Marmot, 2010, p.12).

There is evidence that inequalities exist in relation to access to, and the delivery of, mental health services in the UK. Conventional mental health provision is mainly predicated on an individualised view of self and individualism (Boyle, 2014; Brown and Baker, 2013), with an absence of equal commitment to the collective (Darlaston-Jones, 2015). Individualising approaches can lead people to believe that psychological distress is a consequence of personal failure, without recognising the contribution of social, material, economic and historical factors (Boyle, 2014; Afuape and Hughes, 2015). People are often referred for a mental health service



appointment to meet with an unfamiliar and unchosen therapist within a clinic setting, paying little reference to the potential barriers to engagement this creates (Zlotowitz et al., 2016). Current mental health provision is also said to be limited by a Western view of health, narrowed by rigid adherence to existing clinical models, assessment tools and research methods (Fernando, 2010; Fernando, 2014; Wessley, 2018; Wood and Patel, 2017; Patel and Fatimilehin, 2005). Adding to this picture are language barriers (Memon et al., 2016), a lack of culturally appropriate services (Arday, 2018; Mind, 2013) and some coercive routes into mental health services (Daley, Costa and Beresford, 2019). This can contribute to a fear and distrust of professionals and institutions, reflected in the underrepresentation and high attrition rates amongst some groups within mental health services (Mir et al., 2019; Naz, Gregory and Bahu, 2019).

Grassroots community-led organisations in the UK have often developed their own approaches, strengthening local social, economic, environmental and cultural circumstances of the communities they are a part of, also reflected in improved health and wellbeing for those groups (Marmot et al., 2020, p13). Community organisations provide vital services (Department of Health, 2009; Lane and Tribe, 2010), yet often rely on insecure funding (Zetter, Griffiths and Sigona, 2005). Cuts to local authority budgets and national spending in England have eroded resources for local communities and public services, often with a disproportionate effect geographically so that deprived areas experience greater funding cuts than more affluent areas (Marmot et al., 2020). Organisational pressures to maintain continuity of services can also lead to restrictions to core activities, limiting innovation (Thompson, Tribe and Zlotowitz, 2018).

Within UK policy, the NHS is obliged to work alongside local communities to ensure services are more accessible, addressing need and improving health and wellbeing, whilst reducing discrimination and health inequalities (Department of Health, 2012; The Equality Act,

2010). The White Paper ‘Liberating the NHS’ declared that in the future, citizens would have far more influence and choice in the healthcare system and that services would be responsive to their needs (Department of Health, 2010), with particular emphasis on the way they are designed, commissioned and delivered (Putting People First; PPF, 2010). Meanwhile, a growing mismatch between NHS capacity and national need (NHS Confederation, 2018) and global neoliberal policy shifts toward competition and markets have reduced entitlement, increased use of eligibility criteria and weakened democratic accountability within the NHS (Carter and Martin, 2018).

The language and key concepts of participation are often contested, described as vague and poorly defined (Beresford, 2005). Distinctions have been made between democratic and consumerist approaches, with the former describing a transfer of power and control in the planning, management and review of services to people who may use them (Andrews, Manthorpe and Watson, 2004). Arnstein’s ‘Ladder of Participation’ (Arnstein, 1969) is a model of citizen involvement that uses rungs of a ladder to represent the degrees to which the public hold power in decision making, ranging from ‘manipulation’ to ‘citizen control’ (Arnstein, 1969, p. 216). Arnstein has been criticised for the deliberate juxta positioning of power holders (Tritter and McCallum, 2006), however, the ladder remains a touchstone for policy makers and practitioners today.

Community participation, such as partnerships between grassroots organisations and health services, has been suggested as a means of addressing health inequalities and ensuring health services are effective (Haldane et al., 2019; Johnstone and Whaley, 2015; NHS, 2019). Community partnerships can be viewed within an Ecological Systems Theory (Bronfenbrenner, 1979) framework. Organisational interventions, including those with community groups, can be represented by those at the exo- level and can include partnership structures that improve mental health, structural and social inequalities. This aligns with

vulnerability and resilience theories which propose that increasing a population's access to resources through empowerment can improve psychological wellbeing (Norris, Stevens, Pfefferbaum, Wyche and Pfefferbaum, 2008). Although it is a contested term, 'resilience' is said to describe the 'ability of an individual, a community, a neighbourhood, an institution or a system to cope positively with rapid-onset shocks or significant and protracted sources of stress' (Manyena, 2004). Vulnerability and resilience theories incorporate variables across system levels and the connections between them, from the policy level to the individual (Hoffpauir and Woodruff, 2008). Issues of the social and physical environment are commonly identified as causes of vulnerability (McEntire, 2004). Some sources of ecological stress include disasters, conflict, poverty, corruption or resource scarcity (Manyena, 2004). Vulnerability to these are not evenly spread across people or communities, owing to the unequal distribution of resources within their social and physical environments to support social-ecological resilience (Zakour and Harrell, 2003; Folke et al., 2010).

National Institute of Clinical Excellence's (NICE) Community Engagement guidelines (2016) reaffirm the benefits of greater community involvement on the health of the population. Partnership working is also a central ethos tenet of Psychologists for Social Change, a national activist network of UK psychologists, who aim to work collaboratively and in solidarity with people with different forms of expertise, learning from them and building mutually supportive relationships to further social and political campaigns and actions (Psychologists for Social Change, 2022).

Whilst this is an emerging area of research, little is written about the factors that enable or hinder meaningful partnerships with communities in the context of mental health services, which remains a gap in the research literature. In particular, the question that has yet to be answered is what enables the process to be one that values and responds to the voiced needs of community groups?

### ***The current study***

This study aimed to develop a comprehensive contextualised understanding of the processes involved in partnership working with communities in the design and delivery of mental health and wellbeing services, through the perspectives of a range of stakeholders. The main research question was: *what are the barriers and facilitators of working in partnership with communities to design and deliver mental health and wellbeing services?* From this, a theoretical model was developed to capture the factors that have enabled and challenged this way of working.

### **Method**

#### ***Design***

This study used a grounded theory methodology. Developed by Glaser and Strauss, grounded theory is used to build a theoretical understanding of social phenomena where these cannot be predetermined. More specifically, constructivist grounded theory (Charmaz, 2014) was felt to be appropriate to meet the study aims, as it understands reality as “multiple, processual and constructed” (Charmaz, 2014, p. 13).

#### ***Ethics***

Ethical approval for this study was granted by The University of Liverpool’s Health and Life Sciences Research Ethics Committee (Appendix B).

Participants provided informed consent to take part. All identifiable information was anonymised during the transcription process. Participants were informed that they could

terminate the interview at any point and withdraw their data within two weeks of participation. All were debriefed and given the opportunity to ask questions.

### ***Participants***

Twenty-one participants were interviewed between April 2021 and February 2022. Inclusion criteria were people with experience of mental health orientated service design or delivery in partnership with communities in the UK, aged 18 years or older, who were able to provide consent to take part. Demographic information of individual participants has been removed to protect anonymity.

There were 14 women and 7 men in the sample, ranging from 24-61 years old (median 39 years old). Participants self-identified their ethnicities as African, Anglo-Canadian, Arab (2), Bangladeshi, Black British (2), Black Caribbean, British Moroccan, British Pakistani, Sikh, Turkish, White (4), White British (3), White Jewish and White Welsh. Participants had been working in their roles for an average of nine years. Types of roles included Assistant Psychologist, Consultant Clinical Psychologist (2), Clinical Psychologist (7), Co-Director (2), Communications Lead, Counselling Psychologist, CEO/Director/Founder and Trustee (3), Systemic Practitioner/Family Therapist (2), Participation Lead, Project Lead/Project Manager (2), Researcher (2), Social Worker and Youth Consultant. Participants' locations were spread across England and Wales and partnerships were across statutory, Voluntary Community and Social Enterprise (VCSE) and private sectors.

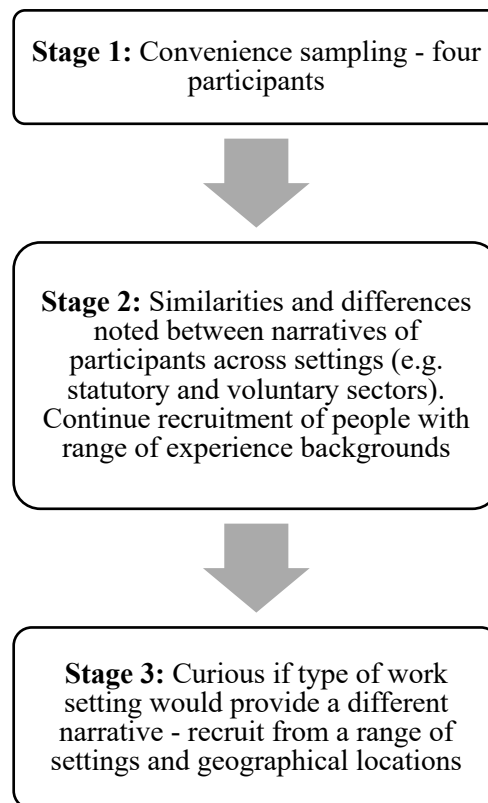
### ***Recruitment and sampling***

Participants were initially recruited via the social media platform 'Twitter' through the study advertisement (Appendix C). Emails were later distributed to community orientated mental health organisations and amongst community psychology networks. Participants who

expressed an interest via social media or email were emailed the participant information sheet (Appendix D).

The first four participants were selected using a convenience sampling strategy. Subsequent participants were recruited using theoretical sampling to facilitate the exploration of emerging relationships between participants' accounts, location and nature of the organisation and role. Figure 1 represents the operationalisation of the theoretical sampling process.

**Figure 1.** *Theoretical sampling process*



### ***Data collection and analysis***

All interviews were conducted and transcribed by the primary researcher. Participants were given the opportunity to read the information sheet and ask any questions prior to signing a

consent form (Appendix E). Interviews took place using Zoom video conferencing and were audio-recorded using an encrypted iPad. Each participant was interviewed once, using a semi-structured interview topic guide (Appendix F). This guide was developed as data collection and analysis progressed (Charmaz, 2014). Interviews lasted between 38 min (final interview) and 79 min. Participants were debriefed following completion of the interview. Each participant was offered a £15 voucher for their contribution. Memo-writing and reflective summaries were completed by the researcher following each interview (Charmaz, 2014).

Data were analysed using NVivo12 software. Following Charmaz's guidelines (2014), each transcript was analysed using line-by-line, focused and theoretical coding. Transcription and coding took place after each interview. First, the data were coded on a line-by-line basis when each transcript was fully read and then re-read. By reviewing the initial set of codes, those most significant and frequent were integrated and synthesised to form focused codes. These codes were considered for comparative focused codes across the interviews and were continually refined and developed during the process, remaining close to the data. Where needed, new initial codes were identified where new data emerged in later interviews. Codes were related to each other, creating the conceptual categories used to develop the emerging theory.

The research team met regularly to review the codes and developing model. Emerging findings were also used to adapt the interview guide and identify directions for theoretical sampling. Following interview sixteen, focused coding did not result in any new codes, considered to be evidence of theoretical saturation (Tay, 2014). Subsequent interviews supported the refinement of the developing theory. Following interview eighteen, a model was developed. Later interviews involved reviewing the draft model with participants, to explore the meaning and resonance for them.

### ***Participation and the development of materials***

At various stages of the project, people with different areas of knowledge and skills supported the development of the study and its dissemination.

Liverpool Expert by Experience group members were consulted during the planning stages of the research. These meetings informed the development of the interview topic guide and helped the researcher to develop her thoughts on the study.

The topic guide was drafted during a meeting between the primary researcher, study supervisor (RM) and a peer researcher with experience in the topic area. It was decided that participants would not be provided with existing definitions of ‘participation’, ‘partnership’, or ‘community’ to capture interpretations of these constructs and prevent leading the direction of data. The study’s supervisor (RM) took part in a pilot interview with the primary researcher to review the proposed questions. The supervisor reported to find the interview appropriate and no changes were made. The peer researcher chose the study advertisement from a selection and approved the Participant Information Sheet and Consent Form.

In the final stages of the project, an illustrator created visual resources to support dissemination of the study’s findings (Appendix G).

Those involved beyond the supervisory team were offered £15 per hour for their contributions.

### ***Study team and researcher perspective***

Reflexivity supported the researchers to consider their influences upon emerging data and to ensure the theory was grounded in participants’ accounts.

Throughout the research process, I reflected on my position as the primary researcher in relation to the focus of this study. I can be described as having multiple influences, related to being a British, Syrian, Muslim woman, born in Glasgow, undertaking this research as part



of a doctoral course in clinical psychology. From an early age and with family living across continents, I have been led to consider the ways people can be affected by their social, spiritual, cultural and material circumstances. Over time, I have been part of NHS and community organisations in the UK and abroad that have taken a systemic approach to support the wellbeing of population groups. The study team also comprised three supervisors with vast breadth and depth of complementary expertise in this topic and methodology. These experiences and interests will have influenced the research process. Reflexivity was managed through reflective discussions within supervision, memo-writing (Lempert, 2007), completing reflective summaries following each interview and keeping a reflective diary throughout the study (Charmaz, 2014). These reflections helped to make thoughts, feelings, and opinions visible and acknowledged throughout the study's design, data collection, and analysis processes (Ortlipp, 2008).

## **Results**

The main aim of this study was to develop a comprehensive contextualised understanding of the processes involved in partnership working with communities in the design and delivery of mental health and wellbeing services, through the perspectives of a range of stakeholders. Figure 2 shows the theoretical framework that emerged from this research that identified nine theoretical categories. Each category is based upon focused codes most salient to the model and is supported by participant quotes. A narrative summary of the model and its theoretical categories is provided here, followed by a visual representation of the model.

The foundation of the theoretical model is an **appreciation of context**, in which distress and wellbeing is understood in relation to conditions that impact communities from **local, national, global and historical contexts** and **experiences of services**, such as mental health services. The **meanings of 'community'** and **'partnership'** as a **"combination of expertise"**

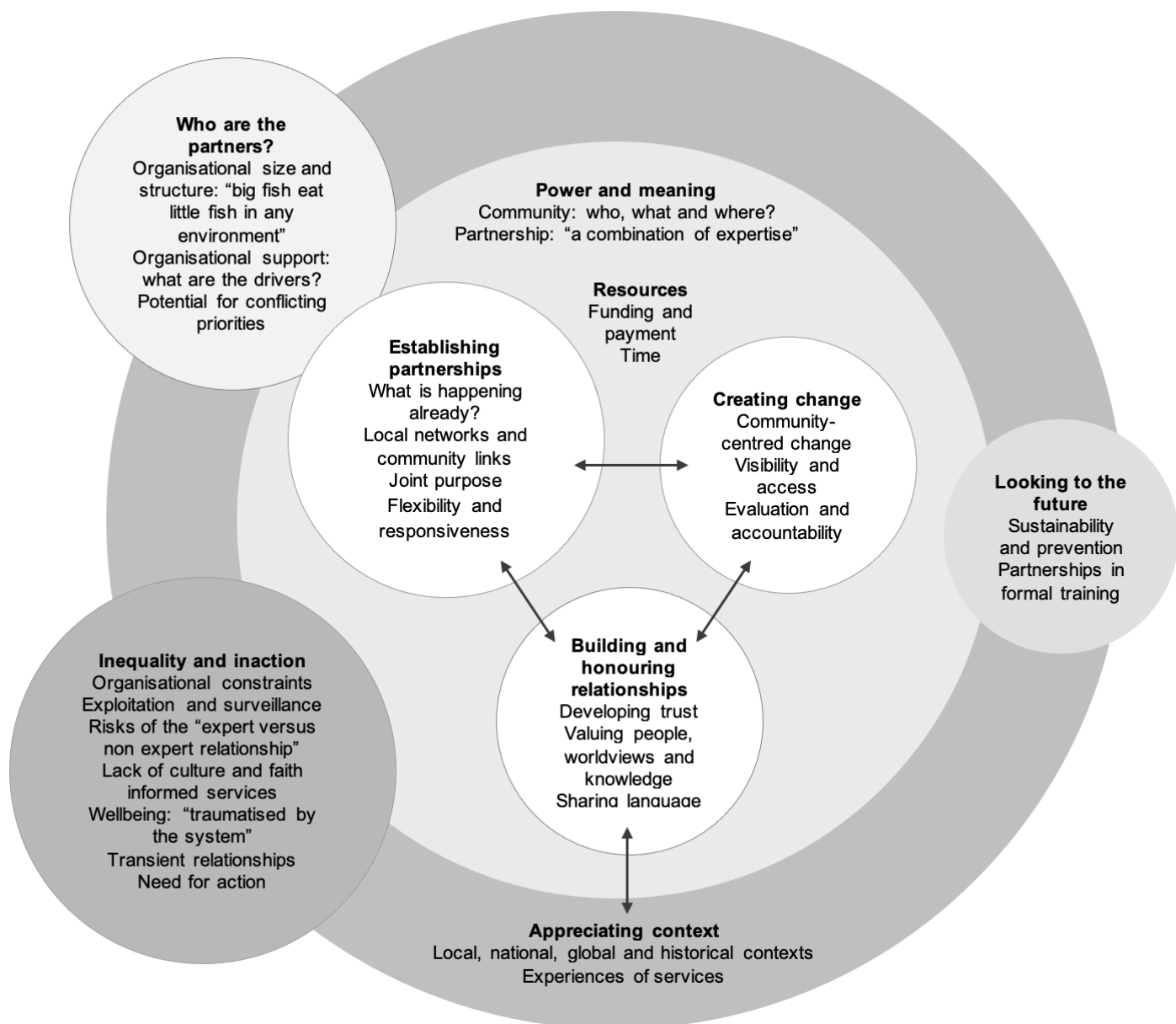
are also situated in and informed by the contexts in which they exist. **Resources** such as **time, funding and payment**, influenced the initiation and sustainability of partnerships.

Within the theoretical framework that emerged from this research, **building and honouring relationships** over time was central in enabling partnerships. **Developing trust** was important, where people and communities are valued for the many forms of expertise they bring to the process, as represented by the theoretical category **valuing people, worldviews and knowledge**. Ongoing negotiation enabled **shared language** and communication to emerge, with attention paid to facilitating the use of first language for people. From here, it became possible to establish partnerships with respect to **what is happening already**, entered into voluntarily by partners. In many cases, **local networks and community links** were already established. Where partnerships formed, organisational structures were required to be **flexible and responsive** to need and adaptive to ongoing change. The breadth of partnerships spanned well beyond formal mental health organisations. **Creating change** represented **community-centred change**, which varied in relation to priorities of community groups and included interventions at multiple levels. These were mainly asset-based and action-orientated, grounded in ideas of community, creativity, culture, faith, traditional therapeutic psychology, employment, income and housing. Organisations were **visible and accessible**, with some open to self-, peer- and community-referrals. **Accountability and evaluation** would determine what was working and areas for adjustment and change. Throughout this process, attention was given to relationships between partners and within organisations.

Periphery categories '**Who are the partners?**' and '**Inequality and inaction**' occurred within the wider context, but sat somewhat outside the contextual frames as they also had the potential to stagnate or decontextualise this work and the distress it sought to address. The **organisational size and structure** of partnering groups determined the ability to maintain priorities for both, where there was also **potential for conflicting priorities**. **Drivers for**

**partnerships** and availability of **organisational support** from senior managers influenced whether this work was facilitated or constrained. **'Inequality and inaction'** represents the challenges that may be faced working in partnership with communities to design and deliver mental health and wellbeing services. Challenges involved **organisational constraints, exploitation and surveillance, risks of the "expert versus non expert relationship", lack of cultural and faith informed services, transient relationships, ongoing need for action** and the impact on the **wellbeing** of those involved, who described being **"traumatised by the system"**.

**Looking to the future** included considerations of what was working already and building on this, with participants reflecting on the value of partnerships, **sustainability and prevention**. The problems with current formal training offers were discussed, as well as the potential to structurally embed **partnerships in formal training** courses and suggested areas for learning.



**Figure 2.** *A grounded theory model of barriers and facilitators of community partnerships in mental health and wellbeing services design and delivery*

### *Appreciating context*

Within this theoretical category, participants situated their accounts within local, national, global, and historical contexts and presented reflections on the relationship between communities and services.

#### *Local, national, global and historical contexts*

Participants' understandings of the context of their work were grounded in, and responsive to, shared experiences of the communities they identified with and worked alongside, where spending time with people and "really listening, genuinely listening" (Participant 19) was emphasised. Participant 5 explained that maintaining an appreciation of context worked towards ensuring organisations were not "blind" or "naïve" (Participant 5) to situated experiences of those they interacted with and provided "an understanding of how we ended up where we are today" (Participant 21).

Persistent gaps in support were highlighted and recognition of communities who continue to face social, cultural and economic marginalisation. Participant 5 explained that a lack of appropriate support represents an equity issue: "you just kind of have to know you're not working on a level playing field really". A wider context that has disadvantaged certain sectors of society was reflected upon, community groups who have been "really hit by A, austerity and B, lockdown", meaning that "a number of those smaller community groups, well they just aren't around in the way they used to be" (Participant 13). Discrimination and racism, their embeddedness within institutions, and ongoing injustice experienced by groups within society were reflected upon, a dynamic that also arose within the context of partnerships: "there was openness to working with some ethnic groups but not others (...) I kept getting very strong messages about not working with faith" (Participant 11).

Poverty was described as being “siloes into a different conversation, as though it doesn’t affect how people respond to services” (Participant 7), with professionals and services perceived as not understanding its impacts. The limitations of conventional mental health provision in addressing material insecurity and lack of basic resources were described:

“the biggest thing that’s underlain everything has been austerity, poverty and deprivation, it’s the biggest mental health issue that we have, I think that cannot be over emphasised (...) if someone really is on the bones of their arse, they don’t know where their next meal’s coming from, you can try to do all the self-actualisation work you want but you know you’re not gonna get anywhere because people are in survival mode” (Participant 8)

### *Experiences of services*

Participant 7 spoke of a “mistrust of authority, which has come about for various good reasons” and “a real disconnection from services and not knowing what’s available or even services actually being the answer”. This was echoed in Participant 13’s statement:

“I think about peoples attachment to society and that people form opinions about the organisations and services that kind of represent society and I mean the key ones are the blue light services, the police, fire service, the ambulance service, health service, but also social services would be a key one, education would be another, and if you’ve had bad experiences growing up and if you continue to have bad experiences in your life then you might feel like society is not looking out for you, it’s not offering you a secure and safe base” (Participant 13)

Narratives around stigma and taboo were also said to deter from engaging with communities, as Participant 1 explained: “the idea of stigma and taboo it’s just such a strong narrative and it has been for twenty plus years that it stops us from looking at what’s really going on”.

### ***Power and meaning***

The meanings of ‘community’ and ‘participation’ were informed by the contexts in which they existed. Participants reflected on their understandings of each, assumptions that can be made and issues that can arise in their implementation.

#### *Community: who, what and where?*

Participants used ‘community’ to describe groups based on shared commonalities, such as geographical area, identity, interest or need, explaining that people can belong to “multiple communities” (Participant 8). Participant 17 spoke about the problems of confining people to single identities:

“sometimes when we work in services we narrow people down to think about them just as that one identity which is the reason that gets them through the door, it’s their ticket to services, but they’re much more than that” (Participant 17)

Some participants spoke about their embeddedness within communities they worked alongside. There was a consensus amongst participants that, despite descriptors and acronyms, communities are not homogenous: “we understand that there’s a sensitivity that needs to be brought, you can’t just lump a whole bunch of people together, especially in the Black

community, because although the system might think it, we're not just one homogenous group" (Participant 3). It was clear that by failing to recognise specific communities, services could prolong the problem of not providing adequate, tailored support, addressing specific needs, as Participant 11 described:

"this was in part the problem because they didn't map the ethnicity of who we were working with, whenever we used to try and talk about who's actually impacted primarily you'd get shut down (...) the community were demanding things for a long time in terms of having culturally appropriate support, but that was not always taken on board" (Participant 11)

*Partnership: "a combination of expertise"*

Participants described partnerships as a response to under provision or inequity of access to mental health services, as a means of addressing public health issues and following crises that affect specific communities. A huge number of partnerships were identified; with communities themselves and across statutory and voluntary sectors, such as health, education, local authority, housing, sport and leisure, arts, faith, carer and user led networks. The scope of these extended well beyond formal mental health organisations.

Participants acknowledged that partnerships involved "a combination of expertise" (Participant 7) and "exchange of knowledge" (Participant 6), drawing on formal knowledge and training and knowledge and experience from living in a place, shared experiences or identities:

"until you engage with people in a genuine way and listen to them, as well as to ask them specific questions, you also give them a chance to ask you questions or make



suggestions, then you just don't know what's going to be either a bigger priority for somebody or a preference or a resource within the local community, some of the background, the traditions, the things that have gone before, unless you've grown up unless you know live in that community and have lived in it for a long time then there's always stuff that you don't know" (Participant 13)

It was considered that with partnership working, "there's a responsibility, but also a moral sensibility to it" (Participant 17). Participants explained that partnerships meant "doing more than just consulting" (Participant 5) and "ownership over these services" (Participant 3), yet returned that "it's a bit of a tick box, a bit of a buzz word and bit of like we need to show that we are including people" (Participant 19). It was also reflected that "to what degree they experience it as a partnership is always a question" (Participant 7).

### ***Building and honouring relationships***

All participants spoke of relationships as forming the basis of partnership working. Honouring relationships and dialogue meant valuing people, existing knowledge and different forms of expertise, building trust and negotiating a shared language.

### ***Valuing people, worldviews and knowledge***

Being part of a community was described as having "an insider perspective because I know we've had access to things that other people wouldn't" (Participant 1). Participant 8 described "a tendency to resent people who only see things in the abstract and they don't have that lived experience or that dimension of really knowing enough about the subject", explaining that for people of certain communities, "rather than seeing it in conceptual terms, they've got a more

visceral understanding of it” (Participant 8). This was central to the way some were able to build relationships with community members:

“community members reported that they felt that I could understand where they were coming from, I wasn’t a middle class white psychologist you know bringing these very Eurocentric ideas, I was someone who was speaking their language and inviting what felt helpful for them, which was something they said they hadn’t experienced before” (Participant 14)

Valuing expertise of those with knowledge of places and experiences raised the question of what knowledge is valued and not valued within professional spaces and “who doesn’t get to speak at the table” (Participant 11). It was also reflected that “the closer you are to it, the more painful and traumatic place to be” (Participant 6). Valuing people meant valuing their world views, such as culture and faith informed knowledge of wellbeing that often exists already:

“within clinical psychology we’d like to think of ourselves as you know very objective and very focused on the evidence base but we need to be mindful that we’re human beings first and foremost and we’ve all got a world view (...) it’s about working with those ideas and being curious about those ideas, but also respecting some of those ideas and not just imposing our own beliefs onto communities” (Participant 12)

This also meant reflecting on skills people would bring to the work and “building that into the systems, into the service” (Participant 21). Participants described a collective passion and sense of being a team within their organisations and partnerships: “it was always team wins, nobody

wins without everybody winning” (Participant 3). Participation would also “see a real blurring and sharing of peoples experiences” (Participant 10) beyond defined roles.

### *Developing trust*

Participants in this study described relationships as being at the heart of developing community partnerships: “it’s just the foundation for everything, it’s huge, absolutely massive” (Participant 21). Relationships in themselves were viewed as therapeutic:

“we think there’s an innate benefit and healing power in people forming their own social circles, connecting with each other and doing things which they enjoy doing, if you boil it down it doesn’t matter if you’ve got a mental health problem or you haven’t people really just want somewhere to go, something to do and some people to do it with and if you can generate the circumstances in which people get those three things then you know their mental health and their wellbeing will improve, they’ll flourish more as individuals you know just like old fashioned community development really” (Participant 8)

Participants explained that building relationships and dialogue over time needed to be “from a position of humility, open mindedness” (Participant 10): “I think it’s about being humble even if you’re from the same faith and culture there’s so much variation that you also can’t make assumptions about what someone might find helpful” (Participant 11). “Honesty and transparency” (Participant 17) and being human were emphasised: “I think it’s really important that we’re all fellow human beings and not setting ourselves up to be impervious or so resilient that we don’t feel things” (Participant 10).

The importance of relationships between local services or organisations and community members or gatekeepers was noted: “if you don’t have that you are just going to struggle so much, but those connections need to be authentic” (Participant 5). Relationships between decision makers were also said to be professional and informal, overt and covert:

“when people know and trust each other, whether they’re commissioners of the VCSE sector or NHS, once that relationship’s in place a lot can change around that, but it’s not explicit at all, it’s not minuted, it’s not recorded, if you’re in a system you become aware of it eventually and sometimes not even aware of it, it’s just by accident that you kind of trip over it and then suddenly certain decisions make sense” (Participant 21)

How to build trust was described as “the million dollar question really and truly because of the amount of damage that’s happened” (Participant 3), with trust being “so easily broken and so hard to create”. Time was said to be needed to build trusted, meaningful relationships, before other work could become possible: “the social action work tends to come a lot later because there’s a lot of building up relationships before (...) the biggest way of building trust is consistency and commitment” (Participant 7). Between some long standing, grassroots community organisations and community members, trust was said to have existed over time: “they’re like banging down the door to get in, it’s not like a new service” (Participant 6).

### *Sharing language*

Shared language and communication were essential in building relationships. Participants described this as a “nice ongoing negotiation” (Participant 6), one that “opens the door to a curious conversation” (Participant 7). Participants reflected on shortcomings of the term ‘mental health’, explaining that “it can narrow what you do” (Participant 8). More critical

approaches were said to “probably alienate some people, but actually we got past that and if anything we would say that the two approaches could coexist” (Participant 10). Professional language was said to help the work become accepted by systems, giving it a “gloss of professionalism” (Participant 10), but could also be limiting: “I remember being in training googling words under the table being like is anyone else googling words because my family do not talk like this (...) it’s amazing how many people learn to speak like they don’t speak” (Participant 6).

Participant 12 explained that “certain words and diagnostic terminology is just not recognised across cultures or translated easily into certain languages” (Participant 12). Building on this, Participant 21 reflected on the assumption of interpreters being gold standard in practice:

“we talk a lot about using interpreters you know as if that’s the best outcome, that’s the goal, and you know I’ve always said it’s not the goal, the goal is to have bilingual staff who can talk to the families in their first language, because otherwise they’re getting a second class service if they use an interpreter because they’re not getting the same service as a family for whom English is the first language” (Participant 21)

### ***Establishing partnerships***

As partnerships began to be considered, it was important to understand and not undermine what was happening already, including local networks and community links. Establishing mutual purposes through agreement on key issues and maintaining organisational flexibility in light of feedback enabled partnerships to remain responsive.

### *What's happening already?*

Some groups began by undertaking ecological systems mapping of an area, place or group, with opportunities to do this collaboratively as a participatory workshop. Attention was given not to replicate or undermine the work of smaller organisations and groups doing similar work. Power mapping was similarly suggested as a means of understanding distributions of power and interest:

“knowing who is it who really pulls the strings outside of the notional structures, who are the real movers and shakers, what's motivating them, where do their self-interest lie, working along those kinds of roots and looking at the nexus of people and their motivations as much as the actual formal structures” (Participant 8)

### *Local networks and community links*

Participant 10 described the initial stages of community working as “being very proactive in meeting people and keeping your ear to the ground in terms of local activity and then things sort of generate their own momentum”. Overall, participants centred the value of local knowledge and building collaborative relationships over time with people and organisations who placed similar value in taking a systems approach to addressing need.

### *Joint purpose*

Early agreement on key issues was facilitated through clarifying matters related to the scope, duration and collaborators within a partnership. At times, communities had taken the lead in designing services that were “very much in the heart of where they live” (Participant 7), with services born out of ideas of community groups themselves: “the way how this service started, it was our plans, the young people's ideas” (Participant 2).

Where relationships were already established, some participants were approached by community members looking to work together: “they approached me like ok we have this funding and we need to spend this for our community and we want to do some mental health project” (Participant 9). A “bottom up approach and going where the energy is with our community to work together on things” (Participant 4) also meant recognising that community organisations were often already working in ways that were beneficial to people they connected with.

### *Flexibility and responsiveness*

Some participants described the importance of organisational flexibility, with a view to remaining responsive to feedback, need or challenges as they arose. Centering relationships, learning could happen iteratively:

“people are faffing on endlessly almost trying to construct the perfect architecture, you can’t plan it perfectly you’ve just got to get out there and try stuff and work and learn iteratively (...) don’t pretend you’ve got all the answers, it’s gotta be about relationships not blueprints” (Participant 8)

### *Who are the partners?*

Experiences of partnerships and their drivers varied across different organisational contexts, with potential for conflicting interests.

### *Organisational size and structure: “big fish eat little fish in any environment”*

According to participants, community working in the NHS is becoming increasingly limited by strong governance that serves as “a great container and it also prevents more kind of flexible

agile ways of working” (Participant 7), leaving little room to respond in more in creative and responsive ways: “it comes down to creativity for me, I feel the NHS kind of blocks that” (Participant 12). This was said to have increased over the last 50 years:

“there was quite a lot of autonomy to do things in different ways in different areas and to connect with local need (...) now I think that would be incredibly hard to do, I can’t imagine doing it, it’s like a juggernaut isn’t it now, it’s just like this is what we do, we go down this pathway, we go down that pathway, it just become impossible for it to become innovative if all you’re doing is ticking the boxes that you’ve got all those pathways into care (Participant 21)

Participants explained that for smaller organisations, partnering with large ones may be “overwhelming” (Participant 21) or “intimidating” (Participant 11), as “big fish eat little fish in any environment, even in partnership working” (Participant 17). This was due in part to the complexity, cultures and processes within bigger organisations, such that “better structures in place” (Participant 1) were said to be needed.

#### *Organisational support: what are the drivers?*

The significance of support from managers, funders and commissioners was repeated amongst participants: “we had really strong support from some really senior people, they were really committed and kind of inspired really by the ethos” (Participant 10). Relating community-orientated practice to trust-level quality improvement agendas was said to help in protecting time for participants within some organisations. Understanding the motivating factors was important in shaping the work:



“what’s the driving factor for the person paying for it or the commissioner or the person who’s going to back it, is it a political driver? Is it a financial driver? Is it a genuine good will driver? That has a huge impact on how far you can take it sometimes, so who have you got buy in from and who’s gonna really to push this forward and hold onto it’s true meaning (...) you don’t really understand what someone’s drivers are, you’ve got to get to know them a little bit first” (Participant 20)

### *Potential for conflicting priorities*

In the process of establishing partnerships, some participants reflected on decisions to partner or not to partner with organisations where there was (or was potential for) a conflict of interests: “there are some organisations which we won’t work with (...) we said we’re not working with you, we just keep them at arm’s length” (Participant 8). For another participant, this process was said to involve “weighing up lots of things, but actually there have been quite a few occasions where we have influenced back (...) it’s sort of a relationship back I think” (Participant 6).

### *Creating change*

Participants reflected on the range of interventions and ways to create change through partnerships working, specific to each context. Visibility and access of services were discussed, as well as evaluation as a means to understand what was working well, ongoing negotiation and reorientation.

### *Community-centred change*

The nature of support and change varied between community groups and was characterised by an openness to what would be helpful. This process aimed to be responsive, involving change

at multiple levels (individual, community or organisational settings, or society and policy). Where this was possible, support intended to be asset-based and action-orientated, grounded in and informed by faith, culture, community, connection, creativity, traditional therapeutic psychology, or addressing access to housing, employment and education.

Consideration for what people were already good at meant “you build up from that, you can’t build from a deficit” (Participant 8). This meant being careful not to undermine what was already working well: “in terms of offering our tools and our techniques I always think that we need to be a bit careful about that because there’s already strengths and skills that exist within communities and it’s about exploring those first” (Participant 12).

#### *Visibility and access*

Participants described “being visible, if people actually see you or see your presence in and around places you gain trust through familiarity” (Participant 5). This included the use of social media platforms, another place people could engage.

Flexible and open organisational structures meant that people could decide what they wanted their relationship with the service to look like. Based in community venues or locations, people could come to a place close to them, or somewhere they would already gather. Participants provided reflections on the expectations placed on people to provide information in the first instance and how this is collected in mainstream services: “there’s a tension, there’s a constant tension between accessibility and governance, accessibility and governance” (Participant 4).

#### *Evaluation and accountability*

With evaluations came opportunities for learning and chances to review partnerships’ stated priorities and resources. The nature of evaluations varied between participants’ accounts: “in

terms of the demand for the service, the referrals, but also in terms of epidemiology and kind of anticipated needs at a population-level ” (Participant 13). Evaluation was driven by people’s priorities, as described:

“it’s about how connected people are you know, when we talk about connection it’s both the breadth of connection, how many contacts they have with people, but also the depth of that connection with other people, what’s their personal social support system look like, how safe people feel, and how good they are at taking responsibility for what’s going on around them, how optimistic they are, all these kind of dimensions that the statutory sector weren’t capturing and that did make the commissioners sit up and take notice a bit, we decided those things by getting a whole load of different people saying what is it you’d like to measure basically and from the conversation drawing those out” (Participant 8)

### ***Resources***

This category captured the considerations participants made about the nature and conditions attached to funding and payment, and time as a necessary resource.

#### *Funding and payment*

Participants in this study described how the source of funding played a role in the sustainability and nature of the support offered: “where the funding comes from and the conditions attached to it make a massive difference to the kind of services that are provided” (Participant 13). Longer term, secure funding was more likely to nurture initiatives, their adaptability and responsiveness to local area priorities and relationship building. Pressures to secure money and

asymmetry in distribution of resources fuelled competition between groups, leading to organisational siloes. The amount of funding could create additional pressures: “there are pots of funding that we as an organisation have kind of walked away from because the expectations and the resource provided just don’t match up” (Participant 13). Experience within teams of bid writing, funding applications and fundraising was noted, however this would demand significant resources: “it is hard to not get drawn into a constantly chasing funding situation” (Participant 7).

Participants spoke about employment and payment for people involved in partnerships. This would include people who faced underemployment, or who were not able to work in qualified professions due to national policy. Where relevant, attention was given to how this may affect social security: “we’ve got to dance around every individual’s personal circumstances (...) we have got a welfare advisor to try and help navigate that, there isn’t a hard and fast approach because it depends on a person’s individual situation” (Participant 8). Around this was said to be “all types of red tape” (Participant 3). Payment across organisations was also considered:

“we pay professionals the same amount as we pay people with lived experience and that will never ever change, so we have a standard rate that we pay people for their time (...) I think that level of equity is important” (Participant 17)

### *Time*

Time as an important resource was a theme that ran through participants’ accounts: “the approach is to spend time and do with, not storm in and do to” (Participant 6).

### *Inequality and inaction*

Participants reflected on various challenges they had faced in partnership working, which included organisational constraints, exploitation and surveillance of community groups, risks of taking an expert position over others, lack of culture and faith informed services, the impact of this work on wellbeing, transient relationships and need for action.

### *Organisational constraints*

Established and institutionalised ways of working were described by participants to have created physical and psychological barriers between people. Participant 10 reflected that mounting pressures made it difficult to engage meaningfully with people:

“I think that the service pressures are so great that there’s an emphasis on a very high threshold of need before people get into services and I don’t think that’s compatible with meaningful listening and the time people need to share their stories and really be heard” (Participant 10)

Participants echoed the challenges posed by current service arrangements:

“it was really striking me that you had to have some social mobility in order to get yourself to a clinic in the first place and on top of that you needed to have the capacity to be able to think your way out of your problems” (Participant 4)

“there is this kind of drive for efficiencies and business outcomes at the expensive of humans and you kind of go isn’t actually human flourishing essentially, shouldn’t that

be the goal of civilisation? Isn't that the foundation of a good life as opposed to unfettered profit?" (Participant 8)

Participant 11 described the reactions they received to this way of working from people within the service: "they were so adverse to us doing anything different like they belittled the work a lot (...) it was just not respected, there was a lack of openness to trying anything different" (Participant 11).

Security risks associated with actual and perceived risks of practicing in different ways were also deliberated:

"there's a conditioning that occurs to be a particular way and to play the game a particular way and if you step outside of that then it feels like there's a security risk there, you might lose your job or you might be disciplined or you know, if you do things in probably what most of us outside of clinical psychology would think of as a more humane way and a more normal way to do things, there are risks, and some of those are not necessarily risks, they're perceived risks" (Participant 17)

### *Exploitation and surveillance*

Participant 3 described instances where professionals have taken credit for the work of others: "what happens is that systems will use the volunteer, take them on a journey, use their ideas and then run off with their results and the accolades or whatever and then it leaves the community with nothing" (Participant 3).

Concerns over statutory policies within the NHS and the exploitation of relationships between community organisations and communities were described:

“if the NHS is going to use the reputation of community organisations to gain access to certain vulnerable groups they will contaminate the relationship with the community organisation who are usually the first point of access (...) I don’t think the NHS is designed to work in this way, they’re heading in that direction where they are creating services, but they’re not services that are safe for certain groups (...) we’re becoming increasingly like the mental health professionals are like an apparatus of the state” (Participant 11)

#### *Risks of the “expert versus non expert relationship”*

Participants in this study described how grassroots groups have longstanding experience in addressing relevant community matters and are, therefore, “much better at that kind of thinking than psychologists” (Participant 7). Participant 5 emphasised the danger of assuming an expert position over others: “creating a feeling of it’s us versus them, I know that’s something that I think keeps people away, ‘oh I’m the professional, I’m the expert, I know all the answers, I have all the power’, no that doesn’t work” (Participant 5).

#### *Lack of culture and faith informed services*

A lack of cultural and faith informed provision was reiterated in feedback from community members themselves: “the conversations I was having was they won’t understand my faith, they won’t understand my culture” (Participant 14).

“they kept telling me their husbands aren’t engaging, their mum’s not engaging, they’ve got friends that are suffering, they’re not engaging, I was having conversations with them about what do you think would help (...) it was a consensus, it wasn’t like it was ambiguous, it was very clear and different people in the community as well as

community organisations were saying, complaining as well, about the lack of culturally appropriate support” (Participant 11)

Participants strongly opposed rigidity in the ways that health and wellbeing can be understood:

“if we don’t have a flexible approach to what health and wellbeing means to different people then I mean basically we’re being racist aren’t we? I mean it’s almost getting to be kind of an issue about human rights for me” (Participant 13)

*Wellbeing: “traumatised by the system”*

With change came resistance. This would bear upon people, as described: “in the end it did actually impact on our wellbeing because me and my colleagues we would also get shamed about the work we were doing by some colleagues, they were very, very critical” (Participant 11). Participant 14 explained, “we became quite traumatised by the system”.

Participant 4 explained that for people working in the service, “they didn’t have any of that protection or that shielding psychological models, theories or frameworks or research in order to inform what they were doing, they were using themselves so burnout was incredibly high” (Participant 4). For organisations providing novel services, there was also a risk of taking on too much:

“we probably say yes to things to a lot more than other organisations would, but my perspective on that at the moment, it might change, is that I think other organisations have said no and niched themselves too much and then it just means who does the other stuff, but equally we may burn out because we are doing like a lot” (Participant 1)



### *Transient relationships*

Staff turnover and transient services were said to be noticeable, undermining relationships that were built or needed to be developed over time:

“there’s a lot of things that happen, initiatives that happen, where this initiative will come out specifically for Black women or Black men and then it’s kind of like done and then nothing really happens or like there’s no sort of follow up or anything like that, so sometimes it feels like things are being done just for the sake of them being done, but it’s actually do these people, do these organisations, do they really care about this demographic?” (Participant 5)

“that’s where fit becomes really important and people who have the trust in communities are people who have been there for ten years and they’re not coming in and out and deciding to come one year and then leave the next when it gets a bit harder and they get a better offer, so yeah I think that consistency and you’ve got to do work to convince people you’re in it for a while cos there’s a lot of people who don’t get that choice to just leave” (Participant 7)

### *Need for action*

Action was seen as a necessary part of building trust. Participant 2 stated that “everybody didn’t trust everybody first, everyone thought ah these people ain’t really here to help us”, explaining that when support began to materialise, trust started to develop; “everyone just had to see it happen first” (Participant 2). Talk over action was viewed as a longstanding issue: “you constantly give feedback about what the community are asking for and you’d have lots of

conversations about what we need to do but it never would actually materialise in any form of actual support” (Participant 11).

“if I hear that one more time about think about people’s diversity, not ourselves, just the client, oh they’re impacted by their socioeconomic status and their money, that’s probably affecting their mood, what are you going to do about it? Ok good to think about that isn’t it and I think a lot of people don’t think about that, but then what? The then what, I don’t think we get trained with the then what” (Participant 6)

### *Looking to the future*

With a future view, participants shared their hopes for partnership working, discussing sustainability, prevention and the potential to transform formal training structures.

#### *Sustainability and prevention*

Participants shared hopes of a cultural change that holds genuine collaborative partnership working at the centre of its values and attitudes. For example, Participant 5 wished for community working and development to become standard practice:

“at the moment it’s such a like specific thing, like this is a coproduction project, we are working with the community, it’s such a separate thing and for me it should just be the normal standard way of working, otherwise who are you working for? How’d you know what to do if you’re not working with the community?” (Participant 5)

For some participants, ambitions were linked to sustainability of funding and increasing capacity for statutory services to embed more community working. Addressing the root causes of economic and social adversity was seen as necessary to protect psychological health and wellbeing, which meant creating ecosystems around people that are truly preventative. Addressing material insecurity, “things like universal credit not being cut and peoples financial situations being more secure (...) not having to live with these terrible conditions put on money that’s not enough money to live on anyway” (Participant 10).

Next steps for some included sharing learning, maintaining scope and size, or growth. This raised questions around sustainability and safety: “we wanna get bigger, but the safety then goes out the window” (Participant 2), with reflections that as an organisation, “the challenge with growth, if that happens, is it can change who you are” (Participant 21).

### *Partnerships in formal training*

Some participants spoke of the lack of formal training in preparing them for their work: “certainly I never had training in a number of areas that I have to use in my role” (Participant 4). At times, this meant looking elsewhere for support: “it was something that I had to seek further supervision outside of my training institute” (Participant 12). Formal training also included discouraging messages for those looking to explore these ideas and practices:

“I had such a tie of ‘they have trained you, they have put their money into you’ that I felt shame for leaving the NHS, so not only does it not give you that experience it almost binds you to stop you from looking for that elsewhere” (Participant 19)

Some participants saw formal training as an appropriate time to support people to develop skills in community working. Co-production and partnership were suggested as

models by which to transform training courses, “so that when you’re learning about this work you can see it in action from the course and the ways it’s being facilitated” (Participant 19).

A theme across participants’ hopes was for participatory inclusiveness, “inclusion of different ways of knowing and bringing in it” (Participant 7). Participants shared hopes that “we can start to position ourselves slightly differently as professionals and work with some of those ideas that already exist” (Participant 12). Absence of this was particularly clear for participants speaking about faith and culture: “I just thought that it wasn’t really the remit of psychology” (Participant 1).

“maybe we can get to the point where we can just write something about indigenous forms of healing on its own and our own psychology (...) I think we need to stop being so scared and just try new things and write them up so people can learn from them” (Participant 11)

Participants’ wishes were underpinned by a call for more “collaborative, cooperative, genuinely participative work” (Participant 10). This was not separate from calls for more explicit conversations about the risks of psychologists being involved in this work:

“we should be having a dialogue as a profession about what benefits and what risks there are of clinicians and psychologists getting involved in a community and community partnerships, like what should we be wary of and what should we be proud of and what we can bring, and I don’t think we’ve probably had that conversation explicitly enough as a profession yet (...) people have been overcoming and resisting adversity way before we got involved so what does that mean because also I don’t

believe we should just carry on doing what we're doing as a profession so I think it's important for us to ask the profession to be having those conversations" (Participant 7)

## **Discussion**

Partnership working with communities and community engagement in the context of mental health services is an emerging field of research (Batalden et al., 2015). The purpose of this study was to provide an account of the barriers and facilitators that may be encountered in doing so, from the perspectives of a range of stakeholders. It was also to offer an account of the ways that collaborations have been possible across different settings, each with related considerations. Twenty-one people were interviewed about their experience of community partnerships in mental health and wellbeing service design and delivery. Data were collected and analysed, and a theoretical framework was developed in accordance with social constructivist grounded theory methodology (Charmaz, 2014).

Participants' accounts highlighted an appreciation of context and peoples' experiences of services, in particular mental health services. Partnerships were used to describe a huge variety of interactions between organisations and communities. Building trusting relationships over time enabled ideas to emerge through a shared language, with attention to flexibly of structures and funding to facilitate this. The nature of support and change varied between groups according to need, priority and respect for existing strengths. Challenges comprised organisational limits and rigidity, transient relationships, exploitation and surveillance, and the impact of these on the wellbeing of those involved. Hopes for the future varied between participants, from building on what is working already, addressing the content and delivery of formal training, to sustainability and prevention. Enthusiasm for more community working was shared amongst all participants, supported by professional reflexivity.

Partnership working can relate to community engagement, community development and community psychology approaches, with some distinctions between these. Community engagement describes ‘the direct or indirect process of involving communities in decision making and/or in the planning, design, governance and delivery of services, using methods of consultation, collaboration and/or community control’ (Bagnall et al., 2016; O’Mara-Eves et al. 2013), whilst community psychology is a field of psychology that emphasises injustices, inequalities and oppression in societal and community structure, with a focus on partnership working to generate transformational change (Thompson, Tribe and Zlotowitz, 2018). Partnership and building of alliances are also key concepts in community development processes (Cowley, 2008; Funnell, Oldfield and Speller, 1995).

An awareness of context formed the foundation of participants’ accounts. Bronfenbrenner’s Ecological Systems Theory (1979) and notion of human ecology (2005) describe nested social structures that interact with each other, influencing individual and collective wellbeing. In the context of mental health service provision, public health approaches offer ideas for population-level and preventative approaches by addressing the social determinants of health inequalities (Marmot, 2020). Coordinated Management of Meaning (CMM) (Cronen, Pearce and Tomm, 1985; Cronen, 1994) and narrative practices also suggest ways to deconstruct social narratives and illuminate contexts in which they were created (Persaud, 2019).

A psychology based on social justice and human rights ‘would remain vigilant self-reflexive, pedagogically innovative and dialogically responsive to the voices and lives of those who engage with the discourse’ (Dudgeon, Darlaston-Jones and Bray, 2018). Openness to listening and building mutually supportive relationships was a thread that ran through the participants’ accounts within this study. Involvement of community members in service design and provision can provide increased level of transparency, community ownership,

sustainability, relevance of service offers, and protection from harm (McNeish et al., 2019). Participation can also help people to feel a greater sense of control, with benefits for wellbeing and other health outcomes (Marmot, 2010). Issues of power also ought to be addressed openly to ensure meaningful and valid interactions (Chamberlin, 2005; Lane and Tribe, 2010).

Relationships between services and community groups were explored, including an awareness of how injustice is reproduced and contested (Dudgeon, Darlaston-Jones and Clark, 2011). For example, the Prevent policy may be seen to position people within ‘suspect’ communities (Medact, 2021; Shankley and Rhodes, 2020), disproportionately impacting people of Asian ethnicity and Muslim faith (Younis and Jadhav, 2020). This can cause direct and indirect harm to physical and mental health for the people concerned (Younis and Jadhav, 2020), as well as their families and communities, leading to disengagement and erosion of trust between people and public services (Medact, 2021; Shankley and Rhodes, 2020). This assault on the notion of universality of healthcare provision was repeated within the current study’s participants’ accounts.

Current mental health service provision can position people in dichotomous ways, ‘professionals’ and ‘service-users’, ‘providers’ and ‘consumers’, or ‘other’, with consequences for power relations and claims to ‘truth’ (Grosfoguel, 2010). In the British healthcare context, this was driven in part by the introduction of consumer models (Ilfie and Manthorpe, 2021; Bury and Taylor, 2008), which risk undermining trust between people in the context of health (Ilfie and Manthorpe, 2021). Said (2004, p. 871) describes ‘the dominance of crude power allied with simplistic contempt for dissenters and ‘others’’, generating ideological fictions used to control groups within society. Rather than widening the field of discussion, injustice and suffering become decontextualised from history, culture, and socio-economic realities (Said, 2004). Within relationships, genuinely engaging and shifting perspectives of deficit to ones of capacity, strength and mutual respect are suggested (Dudgeon, Darlaston-Jones and Clark,

2011). In the UK, Khadeejah, Founder of The Black Muslim Girl, reflected that “There’s more to being Black and Muslim than racism, but every time people want to work with us or they want to come into our community, that’s all they want to talk about” (The Muslim Council of Britain, 2021). Khadeejah clarified the difference between great partnering organisations and the ones that haven’t been great: “It’s actually very simple. The ones that are really good, they listen.”

### ***Service implications***

Latest in a long line of legislative changes in the UK is the White Paper, ‘Joining up care for people, places and populations’ (Department for Health and Social Care, 2022), which set out new plans to integrate health and social care in England. As part of the Health and Care bill and supported by the NHS Long Term Plan (2019), April 2022 saw most Clinical Commissioning Groups (CCGs) absorbed into Integrated Care Systems (ICSs), taking on the commissioning responsibilities and duties for strategic planning in regional areas and increasing focus on population health and local partnerships. The proposals encourage a movement away from competition towards collaboration, encouraging the NHS to work alongside local authorities and through partnerships to address social and economic determinants of health (The Kings Fund, 2021). Partnership and delivery structures under the proposed ICS frameworks would include partnerships at the place level, including Integrated Care Board (ICB) members, local authorities, VCSE organisations, NHS trusts, Healthwatch and primary care (NHS, 2021). This follows decades of competition propelled by a strong economic culture and internal market forces within the NHS, where bodies for health service commissioning separated from those responsible for health care provision and contracts were competitively tendered. The suggested replacement could allow contracts to be handed to providers, such as those in the private sector, and risks lacking transparency (BMA, 2022).



Examination of the nature of partnerships, the extent to which partners hold power in decision making and support through infrastructure and resource allocation, remain relevant here.

Alongside these changes, understandings of mental health remain limited by the way systems perceive and construct psychological help. Current mental health service offers could form part of a broader package of support to improve their effectiveness, such that issues of housing, employment, income, social connectedness, faith and spirituality are considered and valued as legitimate areas of exploration and action (Hammad et al., 2020; Patel and Fatimilehin, 1999). The Organisation for Economic Co-operation and Development (OECD) report, 'How's Life?' (2011), understands wellbeing to be determined by eleven essential dimensions: income and wealth; jobs and earnings; housing; health status; work-life balance; education and skills; social connection; civic engagement and governance; environmental quality; personal security; and subjective wellbeing. A balance between the individualism of current practices and the need for social interventions can be upheld through increased community and organisational investment (Rivest and Moreau, 2015), supported by resource allocation across all sectors, where funding decisions are made on the basis of need and level of deprivation to level up the social gradient in health and its social determinants (Marmot, 2020).

There remains an implicit assumption that partnership brings together partners as equals or with a degree of mutual dependency reflected in the power relations and distribution of resources (such as money and authority). However, this is not guaranteed. Participation has been described as a means of regulation rather than liberation (Beresford, 2002), resonating with warnings that 'partnership is a convenient smokescreen behind which to conduct business, as it always has been' (Popham, 1995). Community working can make it difficult to outline likely outcomes in advance (Bryne, 2020) and there is an 'evidence paradox' (Pollard, Studdert and Tiratelli, 2021) where local, community-driven change is expected to demonstrate its worth

according to measures that are not set up to recognise their value. Issues of ethnicity, faith, 'race', class and gender can also precipitate inequalities in partnership working (Thompson, Tribe and Zlotowitz, 2018). Pressures of continuous growth and the profit motive can further lead to underhand, exploitative or undesirable practices (Thomas, 2022). Within a context of diminishing resources, there may be pressures to avoid sharing resources or information, resulting in unequal or corporate advantage, risking partners becoming excluded from the process (Knifton and Goldie, 2010) or coercion into partnerships which do not reflect partners' concerns. For some, attention to negotiability, trust and co-operation are described as means of countering cultures of competition in partnerships, shifting away from transactional relations where competition is the dynamic, towards more relational ways of working, where trust and personal relations distinguish interactions (Srbljanin, 2000). Targeted resources and a commitment to openness and honesty, shared purpose, equal ownership and appropriate input from each partner can support partners to recognise each other's needs and concerns. Opportunities for partners to convey their version of how partnerships are operating and influence future development would be important, including critical reflections on the process.

Through engaging with community organisations, representatives and leaders, openness to knowledge and frameworks that may already exist and hold importance can become possible. This requires a reframing of whose knowledge 'counts' and ownership in the process. A richness of resources is available to support community working, many of which have been developed by community groups themselves, shedding light on the barriers and gaps in mental health service provision for UK communities with ideas for transformation. Guidance for psychologists on working with community organisations (Thompson, Tribe and Zlotowitz, 2018) offers a comprehensive set of ideas about how to work with community organisations, community representatives and diverse partners in a non-prescriptive way. The 'Integrate' approach, developed by MAC-UK, also emphasises the importance of developing and

delivering services with, rather than to young people, creating change across multiple levels (Zlotowitz et al., 2016; Music and Change UK, 2022). Another key paper, ‘Realising the value: Ten key actions to put people and communities at the heart of health and wellbeing’ centres citizens in these processes (Finnis et al., 2016).

### ***Methodological strengths and limitations***

This study had a number of methodological strengths and limitations. Using a snowballing procedure yielded a large, diverse group of participants in terms of demographics reported and nature of partnerships described. It was possible to integrate topics of social, economic, ethnic, faith and cultural importance due to participants’ reflections. The primary researcher was already familiar, or shared experiences of identity, with some participants, with feedback indicating that this helped people to connect and share their experiences during the interviews. All interviews were transcribed by the primary researcher, enabling consistency and close familiarisation with the data.

For the researcher, there was an unease between the size of the topic and the requirement to condense information for this research paper. Largely, there were commonalities between participants accounts. However, unique challenges and opportunities were also part of these accounts, highlighting the danger of only promoting ‘sameness’ between people, something the researcher sought to avoid (Happell, 2007). Some participants in this study shared concerns that they had not understood or answered the semi-structured questions ‘correctly’, perhaps influenced by the formality of the interview process. In this way, there was a tension between this research topic and design, contrasting with more participatory approaches (Kindon, Pain and Kesby, 2007).

### *Future directions*

Drawing on this study, there are several possibilities for future research. Informed by Global South theories of power (Cordeiro, Soares and Rittenmeyer, 2017), Participatory Action Research (PAR) methods can contribute to the pursuit of knowledge democratisation and emancipatory social change, dealing with real-life problems through collaboration, dialogue, mutual learning, producing tangible results (Denzin and Lincoln, 2008). Community-Based Participatory Research (CBPR) can also work to address public health priorities (D'Alonzo, 2010; Lazarus et al., 2015), where contextually focused interventions are developed through research processes that centrally involve communities in their planning, development, implementation and evaluation (Sandoval et al., 2012; Lazarus et al., 2015). Sufficiently detailing these processes can support knowledge sharing and replicability. Finally, critical examination of the relationship between conventional therapeutic psychology and participatory, contextual change may also be beneficial, supported by sustained calls from some of the participants in the current study. Engagement with critical and community psychologies may support this ongoing process.

The clinical and service implications of this research have been discussed in some detail. It has been proposed, by the study's supervisors and participants, that the theoretical model developed in this research may support the establishment of new and closer partnerships in the future to support the wellbeing of population groups. The model is intended for flexible use at various stages of partnership development and certain aspects may be more or less amplified in response to the contexts in which they are applied. Further research could evaluate the implementation and impact of the model in these endeavours.

## **Summary**

Participatory processes can generate new insights and strategies to overcome challenges of change (El Ansari and Weiss, 2005; NSUN, 2021). Partnerships rooted in local, unmet need are means by which public services can address inequalities and become more equitable. This has clear benefits for health services in relation to pooling information, knowledge, experience, skills and resources (Cowley, 2008). Partnership working can promote a whole system approach, building on the strengths of citizens and communities to co-produce solutions to inequalities, understood within the contexts they exist (Morgan, Davies and Ziglio, 2010). Structural and cultural change would be required for this to be perceived as core work, rather than marginal or an ‘add on’ to mainstream practices. Communities and community organisations could increasingly become active partners and share authority in health planning and delivery, requiring targeted emphasis on resources to address inequalities, reduction in surveillance and genuine accountability of health systems to the communities they serve.

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## Appendices

### Appendix A: Author guidelines



## **Administration and Policy in Mental Health and Mental Health Services Research**

### Submission guidelines

#### General Contents

The aim of *Administration and Policy in Mental Health and Mental Health Services* is to improve mental health services through research. This journal primarily publishes peer-reviewed, original empirical research articles. The journal also welcomes systematic reviews. Please contact the editor if you have suggestions for special issues or sections focusing on important contemporary issues. The journal usually does not publish articles on drug or alcohol addiction unless it focuses on persons who are dually diagnosed. Manuscripts on children and adults are equally welcome. Topics for articles may include, but need not be limited to, effectiveness of services, measure development, economics of mental health services, managed mental health care, implementation of services, staffing, leadership, organizational relations and policy, and the like. Please review previously published articles for fit with our journal before submitting your manuscript.

#### Editorial procedure

##### **Double-blind peer review**

This journal follows a double-blind reviewing procedure. This means that the author will remain anonymous to the reviewers throughout peer review. It is the responsibility of the author to anonymize the manuscript and any associated materials.

- Author names, affiliations and any other potentially identifying information should be removed from the manuscript text and any accompanying files (such as figures of supplementary material);
- A separate Title Page should be submitted, containing title, author names, affiliations, and the contact information of the corresponding author. Any acknowledgements, disclosures, or funding information should also be included on this page;
- Authors should avoid citing their own work in a way that could reveal their identity.

## **Style**

Authors should refer to the Publication Manual of the American Psychological Association (6th edition) as a style guide for the abstract, main body of the manuscript, tables, figures, and references.

The references should adhere strictly to the APA style. Authors are responsible for all information in a reference, since accurately prepared references help establish credibility as a careful researcher.

Tables and figures should be placed at the end of the article, one table or figure per page. Use short, descriptive titles and subheads.

## **Manuscript Preparation**

### Title Page

The title page should include:

- The name(s) of the author(s)
- A concise and informative title
- The affiliation(s) and address(es) of the author(s)
- The e-mail address, and telephone number(s) of the corresponding author
- If available, the 16-digit ORCID of the author(s)

### Abstract

Please provide a structured abstract of 150 to 250 words which should be divided into the following sections:

- Purpose (stating the main purposes and research question)
- Methods
- Results
- Conclusions

### Keywords

Please provide 4 to 6 keywords which can be used for indexing purposes.

## Appendix B: Ethical Approval Letter



Health and Life Sciences Research Ethics Committee (Psychology, Health and Society)

16 February 2021

Dear Dr Golding

I am pleased to inform you that your application for research ethics approval has been approved. Application details and conditions of approval can be found below. Appendix A contains a list of documents approved by the Committee.

### **Application Details**

Reference: 8330  
Project Title: Designing and delivering mental health and wellbeing services in partnership with communities  
Principal Investigator/Supervisor: Dr Laura Golding  
Co-Investigator(s): Miss Yasmine Olabi  
Lead Student Investigator: -  
Department: School of Psychology  
Approval Date: 16/02/2021  
Approval Expiry Date: Five years from the approval date listed above

The application was **APPROVED** subject to the following conditions:

### **Conditions of approval**

**Please note:** this approval is subject to the University's research restrictions during the pandemic, as laid out on the [research ethics webpages](#). Therefore, wherever possible, research should be conducted via remote means which avoid the need for face-to-face contact with human participants during the pandemic. The process for requesting an exemption to these restrictions is described on the [research ethics webpages](#).

- All serious adverse events must be reported to the Committee ([ethics@liverpool.ac.uk](mailto:ethics@liverpool.ac.uk)) in accordance with the procedure for reporting adverse events.
- If you wish to extend the duration of the study beyond the research ethics approval expiry date listed above, a new application should be submitted.
- If you wish to make an amendment to the study, please create and submit an amendment form using the research ethics system.
- If the named Principal Investigator or Supervisor changes, or leaves the employment of the University during the course of this approval, the approval will lapse. Therefore it will be necessary to create and submit an amendment form within the research ethics system.
- It is the responsibility of the Principal Investigator/Supervisor to inform all the investigators of the terms of the approval.

Kind regards,

Health and Life Sciences Research Ethics Committee (Psychology, Health and Society)

[iphsec@liverpool.ac.uk](mailto:iphsec@liverpool.ac.uk)

0151 795 5420

**Appendix - Approved Documents**

(Relevant only to amendments involving changes to the study documentation)

The final document set reviewed and approved by the committee is listed below:

Document Type	File Name	Date	Version
Interview Schedule	Interview Schedule	10/02/2021	1
Advertisement	Research Poster	10/02/2021	1
Advertisement	Recruitment email	10/02/2021	1
Participant Information Sheet	Participant Info Sheet	10/02/2021	1
Participant Consent Form	Participant Consent Form	10/02/2021	1
Advertisement	Email to interested participants	10/02/2021	1
Study Proposal/Protocol	Research Proposal YOlabi	15/02/2021	6
Research Tools	Yasmine Olabi Proposal Amendment Approval letter 15.02.2021	15/02/2021	1



# RESEARCH STUDY: COMMUNITY PARTICIPATION IN MENTAL HEALTH AND WELLBEING SERVICE DESIGN AND DELIVERY

We are looking to speak with anyone over the age of 18 with experience of being part of mental health and wellbeing services that are co-produced and delivered in partnership with the communities they serve.

We would like to speak with you about how these services are designed, how they work, what helps and what gets in the way.

This will involve a 60 minute interview with Yasmine Olabi (Trainee Clinical Psychologist, University of Liverpool).

All participants will receive a £15 voucher for taking part. If you would like to find out more, please email [Y.Olabi@liverpool.ac.uk](mailto:Y.Olabi@liverpool.ac.uk)

## Appendix D: Participant Information Sheet



10<sup>th</sup> February 2021  
Version Number: 1

### **Participant Information Sheet**

We would like to invite you to take part in a research study. The purpose of this document is to give you information that you need to consider in deciding whether to take part in the study. Take the time to read this carefully and discuss it with others if you want. Please ask us for any further information you would like to help you make your decision or if anything is unclear.

#### **Study Title: Community Participation in Mental Health and Wellbeing Service Design and Delivery**

##### **Who am I?**

My name is Yasmine Olabi and I am a Trainee Clinical Psychologist conducting this research as part of my Doctorate in Clinical Psychology at the University of Liverpool. I am being supervised by Dr Laura Golding (University of Liverpool), Dr Barbara Rishworth (Reframe Collective) and Ryan McGillivray (Youth and Community Worker).

##### **What is the purpose of the study?**

The aim of the project is to understand the facilitators and challenges to designing and delivering services to support wellbeing in partnership with communities, which are beneficial to the community when held in its context. I am interested in speaking with people who have experience of being part of these kinds of services and understanding from them what helps and gets in the way.

##### **What does the study involve?**

If you choose to take part, you will be asked to sign a consent form. You will be invited to take part in a remote interview, lasting approximately 1 hour with me (Yasmine) via Zoom or MS Teams. The interview will be audio recorded, so that we can transcribe it. I will ask you some questions such as your age, gender, ethnicity and job role. All of the results will be anonymous, so it will not be possible to identify you or link you to what we have written in any way.

I will write up the project as a doctoral thesis which I will submit in partial fulfilment of the Doctorate in Clinical Psychology programme at the University of Liverpool. I will also be interested to know how you and other people involved would like to publish this research and who we should share the findings with.

##### **Do I have to take part?**

No. Participation is completely voluntary and there are no requirements to take part in the study. If you do decide to take part, you will be asked to sign a consent form.

**Will other people know I am taking part?**

If you agree to take part in the study, we will store your information in a safe locked location. The only people who could see this would be members of the research team.

**What happens to the things I share? Will they be kept private?**

During the study, I will record our conversation on a University of Liverpool protected iPad and I may make some notes. The audio recording will be transcribed and this transcription will be kept in a secure password protected file. To protect the security and confidentiality of your responses, all data will be anonymised. I may need to use a transcribing service to transcribe the audio recording, but it will still remain anonymous. All audio recordings will be kept in a password encrypted file will be deleted after the study is complete.

Quotes and extracts from things you have shared may be used in the analysis of the research and write up (this is common in this sort of study). However, all information that might identify you, such as your name and location, will be removed from all aspects of the study.

In case we need to contact you (if you have indicated on the consent form that you would like to be part of the study's dissemination), we will keep your name and contact details in a secure password protected file which only the research team will have access to.

Only members of the supervisory team can access the data. The data will be stored for 10 years and destroyed after this, in line with University of Liverpool policy.

The University processes personal data as part of its research and teaching activities in accordance with the lawful basis of 'public task'. Under UK data protection legislation, the University acts as the Data Controller for personal data collected as part of the University's research. The Primary Supervisor, Dr Laura Golding, acts as the Data Processor for this study, and can be contacted [goldlau@liverpool.ac.uk](mailto:goldlau@liverpool.ac.uk) if you have any queries relating to the handling of your personal data.

**Are there any advantages to taking part?**

You will be contributing towards research that we hope will be important in understanding how services are designed and delivered in partnership with communities to support wellbeing.

We will be interested to know how you would like to publish this research and who you think should be invited to know about the research when we share it. We can do this collaboratively and hopefully make it fun by being creative. If you would like to be involved in disseminating the study, you can let the researcher know and indicate this on your consent form, for us to be able to contact you after you take part.

There will be a payment of a £15 gift voucher for your time during the interview.

**Are there any disadvantages to taking part?**



We do not expect there will be any risks to you in taking part in this project. You will be asked a range of questions during the interview, but there is no requirement to share any information beyond which you feel comfortable with sharing.

**What if I decide I don't want to be a part of the research anymore?**

You can change your mind before the interview, or end the interview at any point. Once the interview has taken place, then you have a right to withdraw your data for up to two weeks; you will not be required to provide any reasons if you choose to do so and there are no consequences. Two weeks after our interview, it will not be possible to withdraw your data as transcription and analysis will have already started. To withdraw, you can email me at [Y.Olabi@liverpool.ac.uk](mailto:Y.Olabi@liverpool.ac.uk).

If you have any questions or concerns about how the study has been carried out, please contact:

- Yasmine Olabi (Trainee Clinical Psychologist/student researcher): [Y.Olabi@liverpool.ac.uk](mailto:Y.Olabi@liverpool.ac.uk)
- or Dr Laura Golding (Primary Supervisor), [goldlau@liverpool.ac.uk](mailto:goldlau@liverpool.ac.uk).

**Thank you for considering taking part in this study.**

Yours sincerely,

Yasmine Olabi  
Trainee Clinical Psychologist

## Appendix E: Participant Consent Form

10<sup>th</sup> February 2021  
Version Number: 1



### Consent Form

**Title of Study:** *Community Participation in Mental Health and Wellbeing Service Design and Delivery*

Researcher: Yasmine Olabi, Trainee Clinical Psychologist

Supervisors: Dr Laura Golding, Dr Barbara Rishworth & Ryan McGillivray

*Please tick*

I have read and have understood the Participant Information Sheet dated 10<sup>th</sup> February 2021 for this study.

The researcher has explained to me why this research is being done and what it involves. I have had the chance to discuss the details and ask questions about this information.

I understand that my interview will be recorded and that the recordings will be stored securely and will be destroyed once the findings have been written up.

I understand that my involvement in this study, and any personal data from this research, will remain strictly confidential, which means other people will not have access to this information or be able to see my personal details.

I give permission for members of the research team to have access to my anonymised responses. I understand that my name will not be linked with these and that I will not be identifiable in the findings and reports that result from this study.

I understand that even once I have given this consent I have the right to withdraw from the study at any point before and up to two weeks after my participation without disadvantage to myself and without needing to give any reason. I have been made aware that two weeks after my interview, it will not be possible to withdraw my participation as analysis will have begun.

I understand that the information I provide will be held securely and in line with data protection requirements at the University of Liverpool and the Data Protection Act.

I give consent to be contacted to think with the researcher about dissemination of the study's findings.

I understand what it is I am being asked to take part in. I agree to take part in this study.

**Participant Name**

**Date**

**Signature**

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**Researcher Name**

**Date**

**Signature**

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**Contact Details**

If you have any further questions or concerns about this research, please feel free to contact myself or a research supervisor:

Yasmine Olabi, Trainee Clinical Psychologist: [Y.Olabi@liverpool.ac.uk](mailto:Y.Olabi@liverpool.ac.uk)

Primary Supervisor: Dr Laura Golding: [goldlau@liverpool.ac.uk](mailto:goldlau@liverpool.ac.uk)

## Appendix F: Semi-Structured Interview Topic Guide

10<sup>th</sup> February 2021

Version Number: 1



### Interview Schedule

#### **Title of Study: *Community Participation in Mental Health and Wellbeing Service Design and Delivery***

Thank you for agreeing to take part in this study. We aim to explore how organisations are designed and delivered in partnership with the communities they serve in order to support wellbeing for communities when held in context.

The interview will last approximately an hour. It begins by asking some demographics questions and then about the roles you have been involved in as part of services that have worked in this way. It will ask about the work you have done, the steps you took and some of the things that helped or got in the way. It will also ask about your hopes for the future of service design and delivery in partnership with communities.

[A reminder of confidentiality agreement in Participant Information Sheet and Consent Form and chance for questions]

#### **Demographic information:**

I would like to start by asking a few demographic questions. Could you tell me your:

Gender

Age

Ethnicity

Role

Length of time spend in role (or similar role)

#### **Guideline list of potential questions:**

[NOTE: Some of these questions may change over the course of the study, however the changes will be minor and the questions below demonstrate the overall thematic nature of the study]

**Can you tell me about your current and previous work that involved community led organisations or working in partnership to design and deliver organisations?**

#### **Prompts:**

Where was the partnership/service based?

How would you describe the community group involved?

How would you describe the service?

Is this in the statutory/voluntary/third sector/private?

**Could you tell me what establishing the partnership was like?**

**Prompts:**

How did the partnership/working relationship start?/Where did you start?

How did the organisation get to know the community (strengths, needs and history)?

How were the aims of the organisation established?

How do you build trust with people/communities?/How do you make the environment safe?

What do you think are the qualities or characteristics of an effective person working with the community?

Do you feel it's important that the team are already part of this community?

**Can you tell me what the social, political and economic context of this organisation doing this work?**

**Prompts:**

What factors are affecting this community? Social/political/economic/cultural/how does the organisation consider these?

Does the service consider prevention for the community in their context?

**What are the values of the service?**

**Prompts:**

How were these developed?

**How does the service operate?**

**Prompts:**

How did the organisations describe psychological wellbeing? E.g. mental health, wellbeing, spirituality based, faith based

How is local knowledge incorporated into the organisations design and delivery?

What are the interventions used?

How does someone access the service?

How does the service manage conflict or competing needs?

**How much is language considered in the organisation?**

**Prompts:**

How do the organisations feel about the word service?

**What do community partnerships look like in the service?**

**Prompts:**

What are the roles? What do these roles involve? Are they paid?

Do people need any relevant training or accreditation to do these roles?

What are the confidentiality and consent processes involved?

How did the service ensure the wellbeing of people working in the service?

How does the service ensure that the participation/partnership is meaningful?

**How is the service funded?**

**Prompts:**

What was needed to establish and maintain this?  
Who led on this?/Who developed the relationships with funders?  
Would training in this be helpful?

**What have the outcomes been for the service? (positive and negative)**

**Prompts:**

How were the outcomes evaluated?  
How does the service make sure that there was lasting change?

**How is the service evaluated?**

**Prompts:**

How is the evaluation developed?

**What factors do you think made it work?**

**Prompts:**

What knowledge does the service draw on in this kind of work?  
Who and what has helped you in this work?  
What personal or professional skills did you draw on?

**What factors made it more difficult?**

**Prompts:**

How did you overcome these?  
Are there any systemic/political/social/economic issues that make the service work more difficult?  
How did the service tackle or overcome these problems?  
What are the challenges to developing services in this way during COVID-19?

**Do you think training in this way of working would be helpful?**

**Prompts:**

What would that be?  
In what areas?

**What are the future goals for the service?**

**Prompts:**

How are you planning to move towards those goals in the future?  
What are your hopes for community projects around mental health and wellbeing?  
What would inform these?

**Closing section**

(That's all of my questions)  
Do you have any other thoughts about this topic?  
How did the interview feel for you?

Do you have any questions for me?

Would you like to be contacted to speak about dissemination of this project?

Thank you very much for taking part in this interview. You are welcome to contact me at any time in the future if you have any more thoughts about this study. I will send all interviewees a summary of the main findings of the study in the summer of 2022 when it is finished (if indicated - and will be in touch to talk about dissemination). Thanks again.

# Appendix G: Illustrations

