

**“Using my knowledge to support people”:
A qualitative study of an early intervention
adopting community wellbeing champions
to improve the mental health and wellbeing
of African and African Caribbean communities**

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South West London and St George's

Mental Health NHS Trust



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Executive Summary

The Coalition Government's strategy (2010) for public health in England highlighted the benefits of the community health champion role and indicated the contributions that lay public health workers can make in their local communities. There is growing evidence relating to the advantages of engaging community members in promoting health as positive impacts have been identified through a range of health and social outcomes. Involving community and faith leaders in supporting other people to make positive changes in their lives is based on a sound understanding of the value of life experience and the support systems that can exist within neighbourhoods (Woodall et al., 2012). The contribution that lay people can make to the public health agenda is being increasingly recognised in research and policy literature.

This report presents findings from an evaluation study of the role of lay workers - referred to as 'Community Wellbeing Champions' - involved in a community project *'From Surviving to Thriving': Improving Mental Health and Wellbeing in African and African Caribbean Communities* delivered by Hope Atrium. The aim of the report is to evaluate the community project and to describe key features of the Community Wellbeing Champion approach and to examine the evidence that this type of intervention can have an impact on wellbeing.

The study applied a participatory research approach whereby a researcher was recruited from within the African community who collaborated with the community project's organisers in facilitating some of the events comprising this culturally sensitive intervention. Our main method of gathering evidence was one-to-one semi-structured interviews (with Community Wellbeing Champions, faith leaders and community participants), and observations of selected training. The thematic interview areas were: understanding of the community project; engagement in the community project; recruitment to the project; the role of champion; improving the project.

The data was analysed thematically with NVivo10. The findings for this study suggest that becoming a Community Wellbeing Champion has health benefits such as increased self-esteem and confidence and improved well-being. For some champions, this was the start of a journey to other opportunities such as education or paid employment. There were

some examples of the influence of champions extending to the wider community of family, friends and neighbours, including helping to support people to take part in community life. Champions recognised the value of connecting people through social networks, group activities, and linking people into services and the impact that that had on health and well-being.

Recommendations

Community Wellbeing Champion programmes should be embedded in areas where there are good social networks in the community, so as to enable them to thrive. Community and faith leaders form network structures that are well placed to build bridges, engagement and advocacy for change in African and African Caribbean communities.

There are organisational challenges to establish Community Wellbeing Champion programmes in relation to the time taken to establish such programmes, and particularly the awareness raising and community engagement work underpinning the Community Wellbeing Champion programme. Awareness raising and community engagement work have the potential to create sustainable cycles of widening engagement, but they are slow processes. Indeed, the churches are viable structures for reaching large sections of black communities, but other community structures could be productively targeted to engage other parts of the community such as employment projects, residents associations and other community initiatives. Moreover, Community Wellbeing Champions prefer to work with people of the same gender and this needs to be taken into consideration when planning which part of the community the public services need to reach out to.

In addition, Community Wellbeing Champions need to be equipped with a high level of competence and practice-based training in conjunction with government support and adequate resources. The supervision and continuous support of community champions need to be carefully considered together with thorough and sustained programme management.

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1. BACKGROUND

In the last few decades significant changes have taken place in UK governmental policy which have shaped mental health services, increasingly focusing on service user participation, empowerment, and greater emphasis on a social model of mental health care. Currently, policies are shaped by the 'Big Society' agenda which emphasises enabling people to come together to improve their own lives. This is about putting more power in people's hands and a shift of power from Whitehall to local communities. There are three key parts to the 'Big Society' agenda: a) Community empowerment which entails giving local councils and neighbourhoods more power to take decisions and shape their area. Current planning reforms led by the Department for Communities and Local Government (DCLG), give real power for neighbourhoods to decide the future of their area; b) Opening up public services whereby charities, social enterprises and private companies will compete to offer people high quality services; and c) Social action where people are encouraged and enabled to play a more active part in society. National Citizen Service, Community Organisers and Community First will encourage people to get involved in their communities.

A recent initiative in the Yorkshire and Humber region 'Altogether Better' capitalising on these ideas, developed a Community Health Champion approach to build capacity to empower individuals and communities, to improve their own health and well-being. The Marmot Review 2010 'Fair Society, Healthy Lives' supported this approach stating that: 'Local Strategic Partnerships (LSPs) should engage the third sector in a systematic way to maximise the potential in engaging local communities, tapping into local communities and supporting and fostering individual and collective empowerment and capacity-building to contribute to the development of civic participation' (p. 160). Advocates of this approach call for creating the conditions where people can take control of their own lives, stating that national policies would not work without effective local delivery systems that empower individuals and local communities (Grady, 2010). Community engagement approaches include community champions, whose contribution to community health and well-being has become a growing component in the British public health system as they make an increasing contribution to community health and wellbeing (Warwick-Booth et al., 2013; South et al. 2010). National guidelines such as the National Institute for Clinical Excellence (NICE, 2008)

and the NHS Confederation and Altogether Better (2012) also stress the champions' important contribution to health.

In the Borough of Wandsworth, in South West London, a systematic engagement of communities in partnership has begun in recent years. This system of engagement operates within the 'Wandsworth Model' (WM), which was developed by Wandsworth Community Empowerment Network (WCEN) in association with the South West London and St George's Mental Health Trust. It entails canvassing partnerships with local faith-based/other community groups to co-produce responsive mental health services, while at the same time attempting to address issues such as access and effectiveness of service delivery (see Hatzidimitriadou et al., 2012). The initiatives operating under the WCEN umbrella are: Improving Access to Psychological Services (IAPT) clinicians delivering services in 10 community sites; Self-Management of Long Term Conditions Programmes being delivered with 3 community partners; Peer to Peer Carers Assessments being piloted with Adult Social Services and the BME Carers Network; a Black Church Pastors' Network being developed with Family Therapy Directorate; and Establishment of a Senior Managers' Group nurturing the co-production project within the Mental Health Trust.

The initiative which this evaluation study is focusing on, is linked with WCEN and part of this new way of thinking about the delivery of services, which aims to create community capacity building to improve mental health and well-being among black minority groups in the Tooting and Battersea area.

1.1 Context of the evaluation

The mental health needs of African and African Caribbean individuals, particularly men, have become a public concern. A considerable body of research indicates that these groups are disproportionately represented in mental health statistics (Keating, 2007). African and African Caribbean groups are currently more likely than other groups to enter mental health services through the criminal justice system, rather than being referred from primary care (Healthcare Commission, 2007). This situation persists despite the fact that the needs, issues and concerns of black and minority ethnic people with mental health problems are at the fore of the policy agenda (DH, 2003; DH, 2005). It has been acknowledged that achieving

good mental health care for individuals from these communities is one of the biggest challenges for mental health services in England and Wales (Commission for Healthcare Audit and Inspection, 2005) because the disparities in rates of mental illness, treatment, care and outcomes remain. Evidence illustrates that individuals from African and African Caribbean communities do not receive equal care (Rabiee and Smith, 2007).

In an attempt to break this seemingly unchanging situation Wandsworth Public Health (WPH) is working in partnership with faith community groups to introduce a number of ground breaking innovations to co-produce the design and delivery of services to address the mental health needs of African, African Caribbean and other black communities. This study will be looking at the community outreach work that was commissioned to New Testament Assembly in Tooting and developed and delivered by The Hope Atrium (Health, Opportunity, Participation and Empowerment). It was funded by Wandsworth Public Health, with gifts in kind from South London and St George's Mental Health Trust, Wandsworth Community Empowerment Network, Lynwood Fellowship, and the Redeemed Christian Church of God (RCCG).

The overarching aim of *Surviving to Thriving- Improving Mental Health and Wellbeing in African and African Caribbean Communities*, was to raise awareness about mental health and mental illness among African and African Caribbean communities. The basic idea underpinning this early intervention initiative was to educate these communities about the issues surrounding mental health and mental illness, so as to 'open up' culturally sensitive pathways to accessing mental health services. Through sustained cycles of community engagement, education and empowerment, alongside the building of capacity for active leadership for mental health issues within African and African Caribbean communities, this early intervention sought to facilitate transformation in the mental health and wellbeing of African and African Caribbean people; to see a significant increase of mentally healthy individuals among these groups.

The evaluation study commenced six months after the community initiative had begun. The Section of Mental Health at St George's University of London was commissioned to

undertake an evaluative research, which was funded by South West London Mental Health Trust and St George's University of London.

2. THE EVALUATION

A participatory action approach was used to undertake this evaluation. Participatory approaches have been identified as suitable to execute and enable intervention pathways towards addressing disparities in health outcomes involving ethnic minority groups (Savage et al., 2006; Wong et al., 2011). Participatory approaches are aimed at empowerment and capacity building within communities in order to narrow the gap in inequalities. This often entails joint collaboration in planning, design and implementation of culturally sensitive interventions by research units and community organisations as active partners in the endeavour.

The aims of the evaluation were:

- 1) to describe the collection of related, structured activities that comprised the community wellbeing champions project;
- 2) to evaluate the success of the project in fulfilling its stated objectives of building bridges into communities, raising awareness and building community capacity;
- 3) to reflect on capacity within African and African Caribbean communities – including community structures such as faith-based organisations – to support future, large scale cycles of community engagement in mental health and wellbeing.

2.1 Evaluation strategy

The participative approach enabled a collaborative style of working between the researchers at SGUL and the Hope Atrium's organisers. To this end, periodic research meetings were held either at SGUL or NTA where the planning and the design of the evaluation were discussed. The organisers were involved in the various phases of the research process.

SGUL researchers had expertise in service user involvement in mental health research, and mental and sexual health in migrant communities. A researcher with a background in mental

health nursing was recruited from within the African community and employed by SGUL. The researcher attended a number of community empowerment, mental health and faith events through the lifetime of the evaluation to ensure that the community focus of the evaluation was retained. Some informal interviews were conducted with community members attending an awareness workshop run by Hope Atrium in order to help define the interview schedule.

2.2 Evaluation methods

With the assistance of Hope Atrium we selected evaluation participants to enable detailed exploration of the community engagement process, including the role of churches as structures of engagement and the recruitment of Community Wellbeing Champions. We conducted 27 interviews in total (15 men and 12 women) which included Community Wellbeing Champions, faith leaders and people from the community attending awareness programmes as table 1 illustrates.

Table 1 Participants by gender

	Male	Female	Total No.
Community Wellbeing Champions (Ch)	7	6	13(*)
Faith Leader (FL)	6	1	7
Community Participants (CP)	2	5	7
Total	15	12	27

(*) The community project recruited 14 champions; the researchers interviewed 13 of them.

The collection of the data was undertaken adopting a number of complementary approaches. We conducted retrospective, in-depth interviews with the two project coordinators (Hope Atrium) which aimed at describing the process of setting up the community programme. We undertook semi-structured, face-to-face interviews with the Community Wellbeing Champions and church leaders, and focus groups interviews with people from the local community attending awareness events. These were aimed at assessing the participants' experiences of engagement and participation with the community project. The interviews were shared between NM (1-1 interviews with seven

women) and SJ (the remaining twenty). Five participatory observations of some of the champions' training were carried out: *induction training*, *action learning circles*, and *thriving despite stress (IAPT)*. The observations aimed at assessing the level of the champions' engagement with the training material presented/discussed. A semi-structured checklist was used to guide the researchers' observation. The observation was recorded qualitatively. It is important to note that the researcher played an active role in supporting activities across the champions' project. As such, data collection was informed by the participatory, 'insider' insight (Ramji, 2008) that the researcher SJ brought to the programme.

A narrative description of early implementation of the Community Empowerment project was produced from the retrospective interviews with project coordinators (see section 3.1). At the early stages of the data collection SJ organised the initial data into themes that reflected the experiences and views of stakeholders as they engaged with the project. These preliminary themes were presented at a workshop where participants represented a wider group of stakeholders, which included public health officers, academics, project coordinators, co-production practitioners and Community Wellbeing Champions. The thematic structure was refined following this discussion in an attempt to ensure that a range of community perspectives were represented in the analysis.

2.3 Data analysis

For the purpose of this report, a pragmatic, thematic approach to the analysis of qualitative data was adopted. Data analysis was conducted over a number of stages. Interview and focus group recordings were transcribed verbatim. Transcripts along with observation reports were read a number of times by researcher MP to familiarise herself with the data, following which a coding framework was developed which was refined and agreed among the research team and applied to the original transcripts to extract major themes. Following open coding MP adopted an iterative process looking for patterns, similarities and differences. Through the iterative process an analytical framework (i.e. a comprehensive set of themes) was developed and applied to all semi-structured interviews. Themes that comprised the framework were created as 'nodes' in the NVivo10 qualitative analysis software package and all transcripts were coded to those nodes; that is, sections of text were assigned, using the software, to the themes to which they were relevant. The

resulting, coded NVivo database was used to facilitate the management of the large qualitative dataset. In undertaking the process evaluation 'query' functions within NVivo were used.

3. FINDINGS

3.1 Describing the Community Wellbeing Champions project

The Community Wellbeing Champions project was developed using a modified version of the Logic Model approach proposed by Medcalf (2008). Logic models aim to clearly describe a change process, while at the same time making visible the programme's goals, activities and outcomes (expected and unexpected). The programme development aimed at maximising the community engagement; its underlying belief is that, when people are engaged in a programme of community development, an empowered community is the product of enhancing their mutual support and their collective action to mobilise resources of their own and from elsewhere to make changes within the community.

The community project progressed over a period of fifteen months from January 2012 to March 2013. Below we describe the three overlapping phases of the programme development.

Phase 1: 'Bridging links to gain buy-in'

This first phase aimed to initiate conversations and build relationships with the leadership of local faith communities and community organisations in order to gain their "buy-in" to the programme. Programme coordinators began by identifying structures within the African and African Caribbean communities in order to initiate dialogue. Leadership of faith groups (churches) and community organisations in Wandsworth were identified as the first point of contact to bridge links with the African and African Caribbean community. This strategy was adopted because of the access to a substantial community of people that these groupings offered; churches represented the largest community organisations in African and African Caribbean communities locally. In addition, the role of faith and spirituality in mental health and wellbeing was recognised to be an important aspect in the lives of African and African

Caribbean communities. Faith and community organisations that also had some awareness of the mental health challenges facing African Diaspora communities were approached as it was identified that individuals within these organisations were willing to make personal commitments to the programme.

Phase 2: 'Community engagement'

Building on phase 1, this work aimed at engaging and sensitising a broad cross-section of the community in thinking about mental health and wellbeing in their communities. A range of strategies were adopted, including holding mental health and wellbeing workshops at local churches, delivering presentations about mental health issues to students at South Thames College and to single mothers' groups in the area; showcasing at relevant local conferences (e.g. STORM; Support Trust Opportunity Rebuilding Motivation), and through meetings with pastoral teams at local churches. Over 700 people attended a total of 40 events organised by the project coordinators, resulting in 10 organizations (8 churches, 2 community organisations) becoming active partners in the following stage. These activities, as well as beginning the awareness raising process, enabled the programme coordinators to identify and plan subsequent work. Potential champions were recruited through these activities, and a shared vision was harnessed among partners to build mentally healthy African and African Caribbean communities in their locality.

Phase 3: 'Building community leadership capacity'

This phase comprised the Community Wellbeing Champions training programme and aimed to build community leadership capacity in mental health and wellbeing. Participants volunteered to take on the role of 'spearheading' mental health awareness in their community. Training aimed to equip the champions with the knowledge and skills to inform African and African Caribbean community members about what mental health is (or isn't), to extend community members' ability to identify signs of emotional distress, to share strategies on how to cope with the pressures and stresses of everyday life, and to signpost people to appropriate help. The training consisted of four full-day and four half-day sessions over a four month period. The training was delivered by the programme coordinators and by qualified staff from SWLSTG Mental Health Trust. The training applied an *action learning*

approach whereby participants worked and learned together by tackling real issues and reflecting on their actions. The training included a Mental Health First Aid Training session.

3.2 Faith communities as structures of engagement

Faith communities in England carry out activities designed to support their own faith group members and many also support people from the wider community, either in local areas or for specific interest groups. Usually, this work is conducted either through the faith organisation itself or through charities set up to deliver specific services. In this section we illustrate the faith communities’ participatory practices in local governance which faith leaders themselves articulated in relation to their engagement with the Community Wellbeing Champion project.

Faith communities engaged in the community project had a pivotal role in finding solutions to address the health inequalities among African and African Caribbean groups residing in their geographical community. Table 2 highlights the participating faith communities by church denomination. Because of their pre-existing support networks as well as strong ties and deep roots in the community which help to reach more vulnerable groups, churches are in a position to provide the community project with a broad geographical base for engagement. In addition to this, at a material level faith communities possess buildings that are used for wider community purposes (e.g. integration activities, or loss and bereavement assistance), or utilised for other therapeutic purposes of which the IAPT drop-in centre is an example (located within the Testament Assembly Church). Faith communities have also a high amount of social capital (e.g. events, group activities, volunteers, staff, campaigning) generated within them which can be harnessed and built upon to ensure good, comprehensive local provision of services.

Table 2 Participating churches by denomination

Community Church	Pentecostal
Holy Trinity and St. Augustine	Anglican
Junction Community Church and Testament Assembly	Pentecostal
Lynwood Christian Fellowship	Pentecostal
New Testament Assembly	Pentecostal
Redeemed Christian Church of God	Pentecostal

Faith leaders commented that, as a structure of engagement, faith communities were in an advantageous position to reach out to a large portion of the local population. They saw community engagement and their participation in developing local interventions as incremental; their congregation could receive both spiritual advice and obtain information about mental health and therefore enhance the faith communities' wider social contribution:

It will serve a very large constituency. When you think, really, that the church in the community is a place where so many people come and I think when people know that they can access resources and information from a church basis, I think the church will expand into the community more because people will not just see it as a place where you come and get a message on spirituality, but it's by far more than that, I think. (FL3)

Faith leaders spoke of the social capital generated within their churches. Some named the numerous activities that were precursors of the Community Wellbeing Champion project, which the organisers of Hope Atrium were able to tap into, which ensured them access to and engagement with a future pool of Community Wellbeing Champions. The social capital and material resources brought by the participating churches to the community project are illustrated in the extracts below:

Even before Hope Atrium came we had training here on – what's it called – on Mental Health First Aid [...] and we tried to call on people in the community to attend the training. It was free training and three days training [...] we have a training on the understanding of addiction here [...] We try as much as possible to work collaboratively with any agencies that it's community focused and so it's our drive. Anything that has to do with the community we, as a church, we feel that our aim, the main reason why we are here is to add value to the life of people. (FL5)

I do provide a space where one could come and see me if they needed counselling or needed to talk [...] But it would be nice to have a nice little clinic, although that sounds a bit clinical, where we can just talk to help one. (FL4)

Faith leaders stressed the importance of faith communities' direct involvement in decision-making and action in community development and engagement. They pronounced the public agencies' delegation of power as a vital step to achieve collaborative partnership with them. Having a two-way communication with public services was regarded as another important step on the 'ladder¹ of participation':

If we all sit down and everybody brings suggestions and we brain storm on it and we agree on it and then the other forum people are delegated to do this ownership – so giving people more responsibilities, allowing people to share their ideas and there's more that can be gained from sharing ideas. (FL5)

Linking up with public services ensured that faith communities did not work in isolation. Faith leaders argued that their engagement in the community project reinforced their position as partners of public agencies; they acquired knowledge and understanding of the ways in which public agencies and faith communities are working with one another collaboratively. They stressed that collaborative working had opened up channels of communications between faith communities and other professionals where cross-fertilisation of ideas and practices took place, thereby enhancing their learning:

We've not seen it necessary, in the past, to be involved with other services. But [...] the whole strengthening situations where we're finding ourselves being strengthened, in this programme as champions, that it is really kind of helping us to understand the reality, what it means to support and to collaborate – to be all –

¹ Arnstein, S. (1969) "A Ladder of Citizen Participation," *Journal of the American Institute of Planners* Vol. 35 (4): 216-224.

really I think we see that more co-working together we are able to do what many, many years ago the church used to do. The church used to work with Social Services, the church used to work with teachers, psychologists and various departments. And I'm very interested in a multi-disciplinary way of working [...] It has helped us to have dialogue with other people. And the conferences we've had with the NHS and also with the mental health forums has opened doors for us to be able to communicate with other practitioners in services. (FL7)

Partnering with public services also brought about concerns regarding accountability. Introducing the role of champions to raise awareness among communities of interest within their churches, added a dimension of complexity in their working partnership with public services. Some of the faith leaders voiced this concern about making champions accountable for the work they did with the people from their congregation, and suggested that faith leaders ought to take up a supervisory role:

I think the pastors and community leaders, responsible leaders in the communities in which the champions are working, need to have an active role. Perhaps, like a supervisory kind of role, maybe a touch base [...] we could help the Community Wellbeing Champion to clarify their thoughts or maybe redefine their context that they're coming from and maybe develop themselves more. (FL2)

If they're working with churches, part of it will be from the leadership. But I think part of it, there would have to be some inbuilt supervision system for them to be able to do this well. I think that's essential. Somebody – or there has to be a system of being able to say, some accountability has to be built in with what they do. (FL6)

Working in partnership with public services also raised other concerns. Some faith leaders voiced their disquiet on how to integrate the perspective of the church and that of public services when assisting black people affected by mental health problems. They wondered

whether there was a common ground on which theology and the values underpinning mental health could tread upon and practise in unison:

How do you enter into the discourse that goes on within the black Christian community, particularly the discourse around health, around healing, around miracle... You get a – I mean, dementia's the thing we know most about. You know, what actually happens when someone says, 'I'm going to pray for your healing,' when healing isn't what the person with advanced dementia needs. You know, so how do you understand health and then obviously sort of probably as you go out on the concentric circles, how do you understand extreme mental health conditions, things like schizophrenia, stuff like that, within a theological discourse around miracles, around the supernatural, around healing? (FL1)

3.3 Recruiting champions to the community project

This section reports the champions' accounts of their engagement with the community project. It briefly describes the reasons why they got involved and the personal skills and qualities they brought to the role.

Most of the champions had strong links with the church. This became the route through which most champions were recruited to the community project, either because they attended the 'awareness events' conducted by the Hope Atrium organisers (No 7), or because they were practising pastors in one of the participating churches (No 2). By contrast, four champions were referred to the community project by friends or family who had attended or heard of the aforementioned events.

The process of recruiting champions was a lengthy one. Potential champions had a number of contacts with the organisers of the community project before they decided they wanted to become champions. In some cases, the champions attended a number of 'awareness events' before they committed to the role. In the case below the champion's commitment

coincided with her decision to have a career change. The champion's role provided an opportunity to make that change:

No, I hadn't decided at that stage to becoming a champion. I thought about it and at that time I had been thinking of a career change and it gave me an idea that that could be a path I could take to implement that career change. However, what transpired from that was I attended a number of other sessions and was then invited or encouraged, had I thought about it, and I left the second session that I'd attended thinking that it was a possibility. And then I became even more interested when I arranged one of the sessions to be held at my church because I thought this was something our community could be involved in and get to know more about it. (Ch09, female, 58, African Caribbean)

3.3.1 Champions' reasons to engage in the project

Champions gave a number of reasons for becoming involved in the community project, which we have grouped as altruistic and biographical.

Wanting to help other people was the main reason champions gave to embrace the community project. They wanted to help their own communities – the African and African Caribbean communities. On attending the awareness programme champions became aware of a number of issues surrounding the mental health of their communities such as the high representation of African and African Caribbean communities in mental institutions who are referred by the police, or the high level of mental health problems among people from African and African Caribbean backgrounds. Altruistic reasons mobilised them to do something about it:

I noticed particularly in the African and Caribbean community there's a lot more stress and a lot more of those sorts of issues than some of the other sort of affluent communities. (Ch02, male, 24, African)

I wanted to do some pro-active work in terms of being able to address the situation. (Ch13, male, 57, African Caribbean)

Champions cited their biographical experiences as a reason why they got involved in the community project. Five spoke of their experience of coming into close contact with people with mental health problems who were either close friends, or close members of their family, which had deeply affected them. A champion spoke about his teaching experience where he had witnessed several cases of mental ill health amongst young males.

As a secondary school teacher I've actually come across several people, several young men, black men especially, who suffered mental health problems when they got to between the ages of 15 and above. And also in church there were a few people who went off to university, top universities, and then have problems. (Ch01, male, 68, African Caribbean)

It has affected me directly and indirectly because of, you know, other families and friends that you've seen and can identify with. (Ch11, female, 33, African Caribbean)

3.4 Resources brought to the champions' role

Champions brought human capital to the role they were about to undertake. Champions had skills they had acquired through a life-time's work experience - skills they attained in an academic context or educational system which they practised in a professional framework. They also brought to the role interpersonal and person-based skills.

Interview data indicates that most participants believed that the skills acquired through their life experiences, life events, and the learning from life's lessons were important qualities that made them suitable for the role of champions:

I brought the skill of exploring, yeah, exploring things; digging deep [...] As somebody who has looked after, yeah, okay – as somebody

who has looked after a sick wife for a long time I have understanding of what it takes to be ill and to not be able to do something for yourself and mental health would not be a different experience of dealing with caring. (Ch03, male, 53, African Caribbean)

Being flexible [...] I did have the ability to nurture or the ability to – I was always, I guess, thankful and sensitive to people's needs, caring, I guess. Always willing, yeah, just willing to do whatever. (Ch08, female, 36, African Caribbean)

Champions also highlighted their interpersonal skills such as communication and listening, empathy and/or their sense of humour, which in their view allowed them to develop trusting relationships with other people. These were essential qualities that enriched their practices when undertaking their role:

I'm good with people ... I've got a heart for people ... and I don't judge. I'm not a judge to judge and say what someone is, so, you know, I accept people for what they are so I think that mainly and I'm a good listener ... I'm quite sociable ... I socialise with a lot of different people. (Ch02, male, 24, African)

Six of the participants saw their educational background as a source of capital. The knowledge they acquired through their education enabled them to become practitioners in the health care profession, which in turn equipped them with professional skills such as therapeutic or nursing skills, the capacity to assist people with psychiatric conditions (alcohol or drug addictions), which they regarded as enriching them as champions.

I'm a therapeutic counsellor and I'm also a workplace mediator so obviously mediation, counselling, you're working in interpersonal ways, you think about how best to engage and relate to people as well as the general specialist information related to counselling them. (Ch04, male, 38, African)

I brought my skills from my past job, which was nursing, so I brought that knowledge and skills from that. (Ch06, female, 70, African Caribbean)

3.5 Building capacity through training

The purpose of capacity building in the champion project was to strengthen its organisational capabilities to enable the project to be sustainable in the future, in order to play a fuller part in community participation and cohesion, and engage more effectively with public services. In the context of building the capacity of champions, this involved development work to strengthen their ability to build their network structures and skills, so that they were better able to define and achieve their objectives to deliver early intervention, and thereby take part in partnerships and community enterprise. This included training, organisational and personal development, and resource building.

The champions who committed to the role were offered preparatory training. As mentioned earlier, the training consisted of a series of eight training days (4 full days and 4 half-days) which took place between the end of November 2012 and the end of March 2013. These were delivered by the organisers of Hope Atrium in collaboration with health professionals from St George's South West London Mental Health Trust.

On the whole, champions responded favourably to the training received, and described the content discussed in the training as 'extremely stimulating', 'very rich', 'very helpful', 'very valuable', 'quite useful, broad, and effective'. Mostly, champions said the training had equipped them with basic notions about mental health, and gave them the necessary tools to establish supportive relationships with people. They felt adequately equipped with the necessary knowledge to talk to people about mental health, to identify signs of mental ill health, to support others to improve their mental wellbeing, and to recommend pathways to mental health care services:

Yes, because for me it gives me the confidence of talking to people outside of my remit because I would not do that before because that

was interfering in somebody else's business. (Ch07, female, 75, African Caribbean)

I feel very equipped in terms of being able to engage with people, being able to have conversations that help people to, hopefully, broaden their understanding and their perspective on things. Also, in terms of kind of signposting people, making use of the availability of however good or bad people may think that the services are, there are a lot of services available that a lot of times we don't think to use or we don't realise are there for us to use. So part of the process as well is saying, 'Actually, if you want help and you need help, these are your points of call.' And it's like you've got your GP, your local hospitals, you have so many Social Services available. (Ch04, male, 38, African)

Three respondents did not consider themselves fully prepared to act as champions, which they imputed to their inconsistent attendance to training:

I think it's because the fact that I didn't get involved fully for that training. So it has an impact on me as well, saying that I'm not well prepared for that but as well I think because it's about confidence I have to fight as well to be just bold and, yeah, in approaching the community. But just, yeah, I'm needing more equipment in case the community start asking more questions to find out more and if I don't have any answers you won't be a great idea to just go and engage, or to the community. (Ch05, male, 27, African)

To be equipped means you have gone to the training but I haven't gone through all the training so I could not be fully equipped. I had no skill about mental health until I joined the training, so I could not say that I am fully equipped. I am not fully equipped yet. (Ch03, male, 53, African Caribbean)

Some champions were critical of the content of the training which in their view needed to be more substantial and in-depth. The champion below also comments on the reflective practices adopted in the training, which he felt lacked focus and was not embedded in a clear schema:

Perhaps in the initial sessions things could be a bit more fine-tuned and have a lot more content. Yeah, a lot of focus was on group reflecting and more or less that the impetus actually came from the group, you know, their experiences. That was all good, excellent, but sometimes I think having kind of an agenda. You know this, this, this and this, some hard content. (Ch01, male, 68, African Caribbean)

Only three participants attended all the training sessions, all the others missed one or more training sessions. These absences were mainly due to work commitments and personal reasons. Observational data highlighted the lack of punctuality of the participants attending the five training sessions that were observed.

Observational data of the training indicated that these sessions were structured and comprised of individual sessions, rotational speaking, listening and observer sessions. These different methods enabled the facilitators to engage with the participants effectively and to maintain their attention throughout the sessions. It was observed that contributing to the liveliness of discussions was the adoption of 'journaling' and 'self-reflection' exercises which culminated in the sharing of personal experiences, which was when participants were noted to be highly engaged. Facilitators delivered the training sessions aided by PowerPoint presentations, journaling, writing, group discussions and feedback points on flipcharts, ice breaker activities and other strategies which prevented monotony and maintained high levels of interest throughout the sessions. The facilitators (CD and DB) were also involved and moderated, and gave feedback to their respective groups and to the class in general. This strategy enabled the trainees to take ownership of their discussions while at the same time contributing to the observed lively atmosphere.

3.5.1 Resource building – acquiring knowledge

Champions acquired a broad view of what impacted on the mental health of African and African Caribbean communities as a result of the training and the ‘awareness events’ they attended. Champions had differing views about the determinants of mental health in these communities. Some imputed it to environmental factors, citing migrations and the migrants’ broken expectations and lack of future prospects to return to their country of origin, as important factors affecting the mental health of black communities. Others, believed that mental health was the result of life-style choices that individuals in the communities made:

And about expectations too because many came with the height of expectations to the UK and their expectations were never met so it brings about some form of depression. They don't know where they are. They want to go back home. They can't even go back home so they are stuck and things are not really moving the way it's supposed to, so they get depressed. So many easily get angry, agitated, and so you just need to – so it's not a problem you probably find amongst the white, so that area of problem is peculiar to the blacks. (Ch12, male, 50, African)

If people smoke marijuana and there aren't positive things and there aren't productive things, their minds work differently. So I think if you engage – because it's such a broad area and it's, like, no-one can pinpoint exactly what is causing people to go crazy, I think that will gather a large conversation where people can hear both maybe some of the aspects of marijuana that do contribute to making people mentally ill but also, you know, the fact of self and some of the aspects within yourself and the way you deal with yourself which will cause mental illness. (Ch02, male, 24, African)

Nevertheless, the majority of the champions (n. 10) were very well aware of an important phenomenon occurring among the people from their own African and African Caribbean communities, which, as we will see later, became a hurdle to negotiate when undertaking

their role. Champions spoke of the cultural taboo surrounding mental health in their own communities, and their subsequent 'denial' contributing to their misunderstanding and resistance to seeking help from services. This knowledge enabled champions to think about how to work in order to undo these knots:

It will become easier and easier when the black community becomes a bit more honest and a bit more up-front about accepting that it's part of – it's nothing to feel sorry about, to feel upset about, to feel shame about, it's nothing. So in a sense you've got to get them to unlearn – once they start to unlearn certain types of learning, the education which they've had, you know, that people who show the slightest incidence of behaviour that was not considered normal were either mad or might even be bad, you know, or might even be something to do with magic or strange beliefs or voodoo, or crazy.
(Ch01, male, 68, African Caribbean)

3.6 Community in action – champions' practices

This section describes the practices the champions had undertaken by the time we interviewed them. The interviews with champions were undertaken between mid-April and mid- July 2013; just a few months away from their last training day (first week in March 2013). This may have had an impact on the level of activities reported. Table 3 below illustrates that four champions approached several people (one of whom said he had engaged with as many as 30 people), seven champions talked to few people and two approached only one person.

Table 3 Volume of people engaged with since completing training

Several	Ch01, Ch02, Ch04, Ch06
Few people	Ch05, Ch07, Ch08, Ch09, Ch11, Ch12, Ch13
One person	Ch03, Ch10

In terms of time commitment, the role of champion still had a marginal role in their day-to-day lives. Champions cited lack of time and their current employment as a reason for this. At the time of the interview only a couple of champions had undertaken champions' activities in a full capacity. Champions mostly engaged with people they knew, such as people in their immediate circle -family/friends- or work colleagues. Those who had already an active role within the church used their existing networks such as WIFFA (Welcome Indian Families and Friends) to access people to raise awareness about their mental health. Some others used the church's congregation as a route to accessing and approaching people. Only one champion engaged with someone outside their close social circle. Cross analysis indicates that champions spoke to the people of the same gender and that, generally, they did not engage with people whom they did not know:

We have – and I mean – I'm going to be honest, I have – I wouldn't say I've necessarily approached a stranger, to be honest, but within my own family and my own community, as in the church, and own friends, but not even just them, even at work, you know, we talk about it and stuff like that so, you know, so I think, as I said, I'm from the community so I'm more or less going to my friends, my family. The majority of them will be from that community. (Ch11, female, 33, African Caribbean)

I wouldn't say specifically this is what I have done, to reach out to the black and the Caribbean community. Just in this immediate neighbourhood we have more whites and Asians, actually. I have very few blacks. The blacks and Caribbeans that I have interacted with, those are members of my church. (Ch12, male, 50, African)

Champions favoured group settings or one-to-one setting to raise awareness about mental health and well-being. In one case, a champion inventively used technology as a means to reach out to a bigger audience. He used mail-out and facebook to send people information about mental health, articles, or addresses of useful websites:

Now I'm more pro-active into sending things, informing my friendship circles, particularly via e-mail. If there is an article, there is a website, which I think is very useful – which I did that recently – I will e-mail it to people. The recent one I sent via e-mail to a lot of people was a guide about how to engage people in mental health conversations. A lot of people sometimes find it difficult on how to approach a subject, so this guide that I found was very useful in terms of how you have that conversation with people. Again, I sent it round as a resource so that if the issue does come up people can feel more confident in how to talk about it. So, for me, a lot of it is disseminating information, engaging in conversations and just making it present in people's lives.

(Ch04, male, 38, African)

Champions described the range of activities they engaged in with the people they had made contact with. Broadly, their roles covered three areas: talking to people informally as part of their daily lives; providing more intensive support to individuals; partaking in or managing/leading activities, groups or events. These are highlighted below:

I've set up and facilitated a number of sessions in my own church
(Ch09, female, 58, African Caribbean)

So I mean since having done the workshops and so on, again, I've been able to engage on various levels with various individuals both in terms of helping people to be aware of their own sort of mental wellbeing and, really, just to look at the whole issue of the thriving and surviving stage and recognising the fact that most of us are in that survival mode and to be able to both recognise that and be aware of their own, as I said, wellbeing in that situation. But equally, as it were, helping others to help because engage with others who themselves might be concerned about either friends or family members in that situation as well [...] I've tried, really, to bring some

of that learning to bear on being able to assist people. (Ch13, male, 57, African Caribbean)

3.7 Difficulties encountered in undertaking the role of champion

Champions articulated the difficulties they encountered in undertaking their role. They cited the cultural taboo associated with mental health, their feeling of inadequacy associated with being insufficiently prepared to undertake their role, their lack of confidence in approaching people resulting from their nature, and interfacing with mental health services.

Many champions spoke of the challenges they experienced in attempting to break the taboo about mental health when approaching people from their own African and African Caribbean communities. The taboo was viewed as a reason why people did not participate in community events that had been purposely designed to open a dialogue with them:

At the beginning people are difficult. As they hear 'mental health' for them it is madness and they don't want to know. So you could put what you like on there and they're not coming because they think – some people say they haven't got mental health in their family [...] I've put on a mental health conference here and nobody came. (Ch07, female, 75, African Caribbean)

As a group the responses are different. The responses are, 'I don't need this,' or, 'What is this all about? I'm not mad.' 'What is talking going to do?' (Ch09, female, 58, African Caribbean)

Yeah, I've done this, talk about mental health. People don't – people don't seriously believe that they have a mental health problem even if they appear to have the signs. They don't want to talk about it. They think it's other things and not mental health. So you have a block there when you want to talk about it. (Ch03, male, 53, African Caribbean)

3.7.1 Lacking adequate skills for the role

Although in the earlier sections champions reported the training had fully equipped to undertake their role and felt prepared to do so, when it came to practising they noted a number of personal shortcomings. Some felt unable to divert a general conversation with people about mental health, to a more personal experience of it. This needed particular sensitivities:

It is very tough trying to get people to focus on themselves in terms of their mental health side. Because they have a picture of it, 'Mad people, oh, belong to Springfield.' So they see mad people, 'Oh, Springfield. What are you talking to me about it?' And if you ask them what is the meaning to mental health, they give you all the schizophrenic because that's what they see and hear. But they don't look at themselves and say, 'Well, I've got physical good health if I eat a well-balanced diet,' this thing and the next thing. You know, keep the GP away, all that sort of thing. (Ch06, female, 70, African Caribbean)

Three male champions found it difficult 'to break through' people. They found people's lack of response difficult to manage which suggests lacking skills (e.g. counselling skills) that are necessary to open up people and gain their trust.

One of those challenges, sometimes people don't respond much. They sort of listen but don't say much after. That was one of the challenges. (Ch02, male, 24, African)

Actually just because you've been to Mental Health First Aid doesn't mean you have all the... the knowledge about mental health (and how to deal with it). (Ch03, male, 53, African Caribbean)

3.7.2 Lacking confidence

Champions spoke about their initial reluctance to start practising their role. Some champions described the internal dialogue they had with themselves about ‘how to proactively engage people in mental health conversations’. They found it difficult to just walk up to people and ‘talk very explicitly how to deal with mental health’. A champion mentioned her personal nature as a barrier to engage with people on this sensitive topic:

The challenge was most about me, myself, because, first of all, I’m not a talking person so...and, secondly, it's a challenge to me. And, thirdly, because I don't have enough knowledge [...] I think going through different stages, having a lot of responsibility, that became a challenge to me that I couldn't, like, fully express even the little training I did have. I couldn't fully, like, put it in practice because I didn't take part at all for that information due to my time (commitments) I didn't take involvement at all... (Ch05, male, 27, African)

3.7.3 Interfacing with mental health services

A champion cited the difficulties he encountered in referring someone to IAPT services. The account below indicates that IAPT, after an initial consultation with the person referred by the champion, thought to re-route this person to a more appropriate service. The process of doing so was long and had an impact on the person referred, according to the champion’s account:

So, yes, in terms of challenges what I would say is that being able to – I mean I've had the opportunity to signpost someone on to the IAPT service or I should say, attempt to do that. But initially, after they had their initial interview, there was some delay in terms of getting back to them so they did feel a bit sort of left high and dry and eventually when they did get back, after they weren’t accepted for the service itself – they weren’t accepted on to the programme, but they were able to signpost them on to another service which has been fairly

successful, so it did work out in the end. (Ch13, male, 57, African Caribbean)

3.8 Impact of the champions project

This section examines the impact of the Community Wellbeing Champion project as articulated by the champions themselves. The champions discussed this impact in terms of subjective impact (e.g. wellbeing, empowerment, and increased opportunities), and in terms of their assessment on how effectively they engaged with people they had approached while undertaking their role.

3.8.1 Positive impact on self

Champions spoke about the impact that undertaking the role of champion had on their wellbeing and other aspects of their lifestyle. Most champions reported that taking part in the project had been an opportunity to make changes in their lifestyle such as exercising more, eating a more balanced diet, and carving a space to take stock and reflect about things that mattered to them. Mastering the capacity to handle difficult and stressful situations that affected them was also cited as a positive impact of becoming a champion:

The main thing is it's made me more conscious about how I nurture my own wellbeing and my own mental health. I mean, if I was being active, if I was being mindful of it but I think as a result of this programme I've actually almost like even stepped it up and say, 'You know what, I need to actually devote time, I need to pro-actively engage with nurturing my own wellbeing,' whether it's taking time out, whether it's exercising, whether it's talking, whether it's engaging with the challenges I'm facing rather than trying to avoid it. But I think fundamentally it's about actually, you need to build in looking after your own wellbeing rather than quite often. (Ch04, male, 38, African)

Some champions said that the knowledge and tools they acquired in undertaking their role, had helped them to understand people better. They felt better equipped to deal with people displaying aggression toward them. Having a better understanding of mental health and the reasons underpinning said behaviour, enabled some champions to understand how to respond in such situations:

It's helped me deal with people in conflict and it's also – I think sometimes where maybe in the past I would get angry or maybe I would get really frustrated, sometimes it makes me stop and think, 'Is this person okay? How can I help this person? Could I maybe start a conversation to find out if there's any area of someone's life that needs to be resolved?' So it's changed my perception sometimes. If someone is really negative to me, sometimes, it's not my issue, maybe they have an issue and maybe I can help them. So it's stopped me from angering as well, so it's been good on both accounts. (Ch02, male, 24, African)

A number of champions got personal satisfaction out of being able to exercise their role and put into practice the knowledge and the techniques learned during their training. One respondent highlighted that as the project progressed her spiritual faith strengthened, while another felt that he had gained social recognition within his community:

I feel I've got a *raison d'être* to go to the black community and say, 'I am trained as a champion. I'm still being trained as a champion to bring the issue of mental health and mental wellbeing in our community and to you to help us help ourselves', because no-one's going to come to help us. No-one's going to wait for us. There's no-one who's championing black people's – they'll tell us what's wrong when there is a crisis, how much it's costing the Health Service. (Ch01, male, 68, African Caribbean)

The champions derived their empowerment from the knowledge and skills they had acquired. Through their actions and activities they were able to influence and make a difference in people's mental health and wellbeing. They felt empowered with resources they could employ in other life circumstances; now they knew how to 'deal with difficulties' and this gave them 'self-confidence'. Through the community project they had the opportunity to correct personal weaknesses such as self-doubt and shyness:

I'm more informed and I'm more knowledgeable. I've got more knowledge of how to cope and how to approach and how to deal and how to resolve and how to empower others. (Ch08, female, 36, African Caribbean)

I was brought up when you talk about yourself you're boasting, you know. And I've come to learn, more so on this course, that it's good to talk about yourself because you're acknowledging things that you know about yourself and things that you might want to change or adjust or, you know, or say, 'Oh, that's not so good. Or this is good.' At one time I would never do that. I would know that I have this shyness to answer questions regarding myself. (Ch09, female, 58, African Caribbean)

The champions' mental health also benefited from their participation in the project. A couple of champions explicitly mentioned that taking part in the champion project enabled them to look after their mental health better:

I realise that I also have, you know, I have issues I also need to resolve. So, as I said, it's made me a better person because it's allowed me to deal with what I need to deal with, be it daily or whenever it's presented itself. I guess, yes, so that's been, as I said, it's woken up my awareness to my mental state. (Ch08, female, 36, African Caribbean)

Participating in the community project had broadened the horizons of a number of champions who felt they had now become much more involved and engaged with community activities, or that their participation had opened up the door of future prospective employment.

I find myself now attending courses and seminars and volunteering and do things that I'm pretty certain I wouldn't have done before, I'd probably stick to my narrow thing of mathematics and statistics, that sort of stuff. But I'm seeing myself getting involved in all sorts of things and all sorts of situations in that respect. (Ch01, male, 68, African Caribbean)

Certainly it has enhanced it in the sense of should we get our qualification I think it will be a step into going for the next level maybe or to be employed in that field, if necessary, or offer freelance work or voluntary; you know, to tap into the community. (Ch09, female, 58, African Caribbean)

3.8.2. Impact on the local communities – the champions' view

Community Wellbeing Champions talked about the perceived changes that took place in other people. As a result of undertaking their role, champions felt that the people they had contact with had improved their understanding of mental health, which is illustrated in the excerpt below:

So for me, personally, it's been quite positive because a lot of people are – I would say a lot of people, I would say the majority of people that I've spoken to, they are aware of mental health in terms of stress, depression, but they don't necessarily understand it to a deep level, but they recognise that it's there and it's happening and it just gives them an opportunity to ask a few questions to clarify their understanding and what it means for them. And with other people

it's actually linking the fact that do you think these things are happening and these could be the causes? (Ch04, male, 38, African)

Moreover, five champions reported that the people they had engaged with were now more informed about the local service provisions. They had informed them of self-referral options such as IAPT services or their local GPs, that were available to them in their geographical community:

Because what I've found certainly by speaking with someone about, say, for example signposting to IAPT and so on, they seemed quite willing to run with that but, as I said, even where they were referred on to that again they came back quite positive and said, 'I did find that very useful and I'll definitely continue with it.' (Ch13, male, 57, African Caribbean)

But I think the good thing is I was able to, in one conversation – well, not one conversation, several conversations I've had with one particular person – I was able to see that the person was deteriorating and then we spoke about it and, you know, the person went to actually see their GP. So that was a good thing. (Ch11, female, 33, African Caribbean)

Four respondents reported that as a result of their intervention some people said they were willing to change some of their ingrained habits:

There are active steps of having to start looking at things from a different perspective. Not necessarily active steps in the area of having to visit a professional, but active steps, a personal active step, of having to do things, to change things, the way they look at things ... people in their workplaces and things like that, getting a more positive attitude and not allowing what people say to affect your personal self-esteem. (Ch12, male, 50, African)

And by the time we finished talking she said to me, 'You know what, you're right, you know.' That was a good thing and by the end of that she was addressing me by name. We'd never met before. It was the first time we'd met and we were at a conference actually and she said to me, 'You are so right. You've given me a lot to think about. Things that I hadn't dealt with,' she said, especially from her childhood. (Ch09, female, 58, African Caribbean)

Becoming a point of reference to some people they had approached was mentioned by two champions. This may be indicative that the champions were able to develop a trusting relationship with some of the people they had approached and maintain a supportive relationship:

Another person said that they'll contact me when they need sort of guidance, when they need sort of support. And, yeah, I think the main thing was for me was if they wasn't sure or if they felt a bit frustrated they would talk to me to find out what I have got to say about the situation. (Ch02, male, 24, African)

4. PARTICIPANTS' RECOMMENDATIONS

We asked all participants (faith leaders, champions, and people from the wider community attending awareness events) to reflect on their experience of engaging in the community project in order to offer recommendations to further its development. We grouped the participants' recommendations in relation to: development of the community project (increasing participation and improving information, recruitment and selection, training and support, and dissemination of information); bridging and linking in with other faith communities; and connecting with mental health services.

4.1 Development of the community project

Participants made several recommendations in relation to the development and/or management of the community project. These suggestions were geared at addressing some

of the issues participants themselves had experienced or had observed while taking part in the community project.

Advertising the community project more widely was suggested as a means to increase people's participation and engagement in the project. Faith leaders suggested going the extra mile to advertise the community project through 'putting up posters in the church' (FL1), or writing 'a little A4-size paper' and handing it out to people (FL3). Community participants said they would have favoured written information about both the project and the role of champion:

I would have liked to have had a leaflet saying da, da da, whether it's five, eight, ten champions are expected, simple things. At least I could have read it and maybe have answered more questions but, you know, we're going blind here because I don't know exactly what champions are and what they're supposed to do. (CP1, female)

More information about what the role entails because I don't know that much about it [...] About the kind of – more about what being a champion entails. Because I have, obviously an idea, an overview, but I don't know on a week to week or whatever basis it is that they do. (CP5, female)

Some participants suggested that having a job description describing the role of champion would have helped them in deciding as to whether to engage with the project or not. This would have informed them fully about what the role entailed and what the expectations were:

You need some sort of – something like a job description of what it's like [...] you need to define some sort of job description of what they're expected to do on the job itself, every day from day to day. What are they supposed to do? And what are the boundaries? What are their limitations? What can they do and what can't they do?

What are they supposed to do and what they cannot definitely do.

(CP2, female)

Disseminating more widely information about this new role in their geographical community was suggested as a way to raise the champion's profile so that people – including professional people – would be aware of this new initiative and what a champion could offer:

I know that within church, or certain communities that you're frequent in, people would know who you are so they would know what your role is and then they would know they can approach you for that assistance. But be it just anyone, you'd have to approach that person yourself or it depends on the connection you have. If it's just through conversation you can identify yourself to say, 'Okay, I've been doing this programme and I have these resources and I could suggest this might help,' and assist in that situation. So I think, yes, there is a bit of grey area in that respect. [...] I can reach out to somebody but I don't know if somebody can reach out to me. Do you understand what I mean? (Ch08, female, 36, African Caribbean)

Maintaining contact with people who attended the awareness events who had expressed an initial interest with the community project, was also voiced as a way to improve participation in the project. We can see the disappointment felt by these participants who were not updated about the progress of the project:

As someone who came to the first workshop and I was promised, 'I will send you A, B, C, D,' and there was no follow up and I was very much surprised, shocked, disappointed at that and I wrote to my vicar and said, 'I thought you'd tell me,' blah, blah, blah' about this thing?' And he says, 'I haven't heard from them either! I'll ring them.' And I said, 'It might be a waste of time but it's quite interesting, I'd like to hear more about it.' (CP4, female)

I've been to all these meetings and I didn't even know if we already had champions so there's a breakdown of communication there!
(CP2, female)

Training and the provision of support was also discussed in relation to strengthening the project. Participants argued that more flexibility in the provision of training would be helpful in improving attendance. Employment status being difficult to reconcile with the training schedules was cited as a reason. Other participants made observations regarding the structure of the training and the group activities shared within the training:

I think for the most part there was always a kind of plan... but I think sometimes that the time could have been better spent if it was more rigid, more tight, you could have got a lot more done. That's right, the training aspects, yes. (Ch01, male, 68, African Caribbean)

Be a little bit more firm, the facilitators could be a bit more firm on capping each person's responses, [...] you will always get one or two that are dominant in a group but to curb it so that, you know, timing. One of the rules for each session could be that we each be mindful that other people need to take their turn and that we have a limited time in which to do it. (Ch09, female, 58, African Caribbean)

Support for the champions and support for the people participating in the events organised by the champions was suggested as a way to improve their practices. Some participants voiced their sense of isolation and discouragement at not being able to share their experiences with peers. Other recognised the project did not offer support to those individuals participating to the community events:

When the training is all done we have to bring it on a wider basis. Let's talk about the issues and so you can – because some of us get really frustrated with some of the issues we find and, you know, can't

get people to understand that they've got to look at this. It can get frustrating. (Ch06, female, 70, African Caribbean)

When we have projects like this we need to ensure we have counsellors available so that people can talk to them after the main training or the main session, you know. Yes, definitely, and with hindsight that's one thing we overlooked for the two sessions that I had facilitated at my church but at the same time, even though people felt that that was lacking. (Ch09, female, 58, African Caribbean)

Sharing 'good practice' among champions was viewed as a way to support each other and share learning from each other:

People may appear very, very laid back from a distance but by the time you get them engaging, you'd be surprised at the level of their input [...] So you share that and that may help people to be more involved, more to see it as their own project because they buy into. (FL5)

4.2 Bridging and linking-in with other faith communities

Linking the community project in with other faith groups was suggested as a way to widen participation. In order to reach out to African and African Caribbeans from other faiths it was suggested that new links should be forged, and new partnerships developed with other faith communities, not only Christian:

I think by its very nature if we're talking about the black community, the black community consists of obviously genders, ages, backgrounds, occupations, faiths, so an element of it is it's relatively church based. So if you're thinking of the black community there's going to be a lot of black community who are Muslims. Would they come into the church to do some of the courses that we're doing?

Even though it's not a religious programme, it's based in a setting which is associated with Christianity. (Ch04, male, 38, African)

4.3 A connecting focal point within mental health services

Having a point of contact within the mental health services, a coordinating figure to link with, was seen as a means to give a sense of continuity to the project and the champions operating within it. A coordinator figure could provide champions with new opportunities such as any training offered by mental health services:

I think in terms of how we sort of move this forward into other areas then I think we would want to probably kind of maintain some kind of link I suppose with the services and to really – obviously it's useful, in terms of how we move forward because, of course, once the programme is completed you kind of obviously don't want to just feel as if you're kind of left to get on with it, sort of thing. So I guess you probably want that sort of contact to be maintained and to explore other avenues and ways of being able to use the training, really.
(Ch13, male, 57, African Caribbean)

5. REFLECTIONS

It is important to take into consideration the dimension of gender when public services plan, implement or sustain projects such as the Community Wellbeing Champions projects. This is because of the existing gender differences in mental health problems among African and African Caribbean groups, and the noted champions' tendency to approach people from the same gender.

It might be worth considering that in the future the newly recruited champions would be provided with examples and methods that experienced champions used while operating in their geographical community. Champions could be invited to share their good practice with champions from other areas.

Community Wellbeing Champion programmes ought to be embedded in areas where there are good social networks in the community, so as to enable them to thrive. Therefore, community and faith leaders' network structures are well placed to build bridges for engagement and advocacy for change in African and African Caribbean communities to take place. To date, most faith-based interventions have focused on providing sound health education (Dodani et al., 2011).

There are organisational challenges to establish Community Wellbeing Champion programmes in relation to the time taken to establish such programmes, and particularly the awareness raising and community engagement work underpinning the Community Wellbeing Champion programme, which indeed have the potential to create sustainable cycles of widening engagement, but they are slow processes. Certainly, the churches are viable structures for reaching large sections of black communities, but awareness raising events ought to expand toward other community structures so as to reach out to a broader section of the local African and African Caribbean population. Employment projects, residents associations and other community initiatives could be productively targeted to engage other parts of the community.

Whether Community Wellbeing Champions have the potential to build and sustain mental health and wellbeing capacity in the community should be assessed with a further look at the community project a year on from the training. This would establish whether the project has been self-reliant; how many of the 13 champions have continued practising their role in their geographical community after we interviewed them, and in what form.

In addition, Community Wellbeing Champions need to be equipped with a high level of competence and practice-based training in conjunction with government support and adequate resources. The availability of supervision and support of community champions needs to be carefully considered together with a thorough and sustained programme management.

Engaging members of the public as Community Wellbeing Champions to support the delivery of early intervention programmes has a number of potential benefits for both

services and individuals; it provides a 'bridge' between services and communities thereby increasing access and appropriate use of services. It also may reduce communication barriers – 'peers' can find it easier to reach and be understood by the public than professionals, and may provide peer support. For example, someone who can empathise with people because they have been in a similar situation to themselves (e.g. experience of mental health problems). Involving champions may increase service capacity – complementing but not replacing paid staff, and can offer opportunities for volunteers to benefit through developing their skills and confidence, social contacts and employability. Employing Community Wellbeing Champions to raise awareness about mental health in the African and African community may develop a network through which health information can be cascaded out and community intelligence fed back into service planning (for evidence base see White and Woodward, 2013).

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