

BRITISH PSYCHOLOGICAL SOCIETY GUIDELINES (2018)

Kate Thompson, Professor Rachel Tribe and Sally Zlotowitz were lead authors, and with multiple contributions from others including Aneta Tunariu, Shikainah Champion, Angela Byrne, Tom Gillespie, Rachel Liebert and Deanne Bell.

Guidance for psychologists on working with community organisations**Contents**

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Preface

There is widespread agreement on the need for community engagement to improve health outcomes^{1,2}. Despite this, it can be difficult for psychologists working in the diverse settings in which they are employed to bring a more community based or community driven stance to their work.

The recent economic downturn has led to restructuring in many statutory and voluntary sector organisations where psychologists work. There is a perception that services need to restrict themselves to core activities and avoid the additional costs that accrue to creative working practices. This is unfortunate, as innovation and evolution in the provision of services is as crucial as continuity. The impact of this change can be felt on a number of levels both amongst individual psychologists and the community representatives that they work with, and at organisational levels when strategies for engagement and joint working may become increasingly strained. All parties may feel overwhelmed by the challenges of exploring innovative practices and the lack of secure funding for community groups can create a shadow over any initiatives, even those that could bring additional funding or opportunities³. On the plus side, psychologists can often use their position to argue against this narrowing of focus and in favour of the opportunities that “thinking outside the box” can bring.

In addition, recent national health policy emphasises the importance of co-production and prevention in healthcare, as well as the importance of reducing stigma and discrimination and equitable access to services⁴. To achieve these aims and develop solutions, proactive engagement with communities and community groups is essential.

About this guidance and way of working:

This guidance may be used by all practitioner psychologists in a variety of settings including (but not limited to) health and social care, forensic, educational and research. This document is not a top-down set of rules to follow or 'manual'. It aims to provide some ideas about how to work well with community organisations, community representatives and diverse partners but in a non-prescriptive way. It also aims to encourage psychologists to be tolerant of uncertainty, giving permission not to know all the answers in advance and to take time to find out. What it does offer are clear case examples, and includes both large scale projects and smaller more routine ones in order to demonstrate the variety of ways in which psychologists can work with a community focus.

It also includes dilemmas and difficulties, and the ways in which these have been overcome as well as offering some pointers as to how to translate ideas from community psychology and working with a community focus for others who might be unfamiliar and suspicious of this approach to psychological work.

As with many professions, psychology can sometimes have difficulties working without fixed answers or so called "evidence based" interventions. This can make it challenging to work in truly open and collaborative ways with community organisations and representatives without bringing in too "expert" and "directive" a stance. This non-directive and collaborative stance may, however be, exactly what is needed if work is to be truly joint.

Similarly, the systems we work within may have their own automatic drivers to move towards recognisable models of intervention (for example "treatment" in psychological health settings or interventions in educational psychology settings) rather than leaving space to learn what else might be needed. This requires the ability to tolerate not knowing all the answers, waiting to discover new approaches and learning from all those involved. This can be hard to sell to managers but psychology also gives us the language to talk about the need for patience, the time to build trusted relationships and allow all parties to become actively involved, as well as the need for a range of skills and knowledge.

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Introduction

There is no universal definition for the term “community” and terms such as community engagement and community development are often used interchangeably without clarity of respective definitions.

For the purposes of this document, communities are defined as being groups with a commonality in at least one of the following areas:

- a. geographical area or setting
- b. interest
- c. health need
- d. disadvantage
- e. shared identity

There can be some uncertainty in what psychologists and others might mean by community approaches and the underlying philosophies, theories and motivations. Community focused work can be unfamiliar to psychologists and to the organisations that they work with, with such work being devalued as a “meet and greet” type intervention rather than being given priority and resources. Training courses may not include much of relevance, although there are a number of courses in community or community and clinical psychology now becoming available.

Working in partnership with community groups is not the same thing as practicing ‘community psychology’. Community psychology is a specific field of psychology that emphasises injustices, inequalities and oppression in societal and community structures and encourages working in partnership with communities to generate transformational change to those forces. It is notably explicitly political and value-based (see Kagan et al⁵ for further information). This may or may not overlap with the work of any given community group.

For example, some community groups support individuals with their specific needs in the way that mirrors conventional psychology but usually in community-adapted and culturally-appropriate ways (see for example case study 3). This is a good example of working in partnership with community groups to adapt, tailor and improve standard clinical approaches to fit specific groups, but is different to ‘community psychology’ approaches, although there may of course be areas of overlap. Similarly, working ‘in the community’ as a psychologist (such as being based in a GP office) does not necessarily involve working in partnership with community groups and is, on its own, unlikely to be ‘community psychology’ as defined above.

Some approaches are multi-level – working with individuals, wider organisations and services and at the policy-level (e.g. some community refugee groups support individuals but also campaign for better resources for refugees). Psychologists can work in partnership with community groups to support all the different components of the work.

There is general agreement that partnership working with communities, and community engagement, are good things, although it is often difficult to examine the evidence for

this as approaches are described too generally and only a few interventions have been effectively evaluated. As noted by Lane and Tribe⁶ “Although research suggests that group or community life in itself has a positive impact on individual wellbeing, the definitions of a community vary widely” (page 2). In addition to this, most sources agree on the need for both adequate resources and a longer term commitment for such work to be effective^{1,2}.

NICE¹ guidance on the use of community engagement to improve health notes “*community engagement approaches used to inform (or consult with) communities may have a marginal impact on their health. Nevertheless, these activities may have an impact on the appropriateness, accessibility and uptake of services...(and) on people’s health literacy*” (Page 6). This acknowledges the indirect benefits of greater community involvement on health. The same guidance document also points out beneficial corollaries of engagement like enhancing the sense of belonging of a particular group (social capital), empowerment (increasing confidence, self-esteem and self-efficacy) and a feeling of greater control over key decisions, increased trust in government or statutory bodies (democratic renewal) and so forth.

For Christens⁷ empowerment is the key change wrought by community development initiatives as he notes both the protective effects of empowerment on mental health and its capacity to bring about positive social change that is truly sustainable in the long term. In contrast to this, Lane & Tribe⁶ have noted the danger that community engagement is used as a form of pseudo-democracy where community consultations are provided to offer a remedy for a deficit which exists in representative democracy.

Key Practice Points

1. Community engagement through partnering with community groups requires resources (financial, time, equipment and people) and may have training implications for both psychologists and community based partners. There is a need for longer-term investment and for openness to organisational and cultural change (particularly a willingness to share power, recognise areas of systemic discrimination and develop trust and mutual respect between all partners). In cases in which this is present, there are multiple benefits that accrue from this way of working jointly.
2. There are key questions about power involved in any work in this area. It is important to identify how power is currently distributed as regards the area of work, and to negotiate and agree how power will be shared in the future, particularly in relation to any project. Questions about decision making, resource allocation and defining project objectives and outcomes need to be clarified preferably with all partners involved. It is important to recognise the way in which issues of race, ethnicity, class, gender and religion can shore up inequalities in power sharing and take steps to address this.
3. To maintain a critical reflection process, psychologists should consider why and for whom the community focused work is being done and who is leading the approach along with the wider socio-historical and economic context of the work. Consider who is gaining from the work financially, who is gaining employment, status, recognition or contacts and where does the power lie in decision-making.
4. There is a specific skill to asking individuals and communities about their priorities and needs, which goes beyond simple needs assessment or engagement. Psychologists may be well placed to develop this skill.
5. Psychologists working in public sector organisations or large agencies may need to identify the way in which their organisational culture (values and attitudes) supports or prevents community driven work and take steps to address this.
6. It is important to ensure diverse communities are represented in all their diversity so that no one individual member of a group or subgroup monopolises, and to avoid specific individuals becoming so key that if they leave or are no longer available, this does not lead to the collapse of the work. Further all parties need to remain mindful of the way in which processes could *“inadvertently (build) on current inequalities, as the more articulate, confident and powerful members of any community are the most likely to respond”* (Page 4) and other voices perhaps be lost⁶
7. It is also important that members of community groups can decide on how willing and able they are to contribute to decision-making, service provision and management (and to recognise that this may change over time). There needs to be clarity around the commitment required in terms of time and workload.

8. All those involved could agree in advance what will be needed to ensure the long-term sustainability of any activities associated with joint working.
9. Joint training for all partners, including community group members, can build trust and skills to improve engagement and other activities.
10. Communities with specific needs, specific access problems, living in disadvantaged areas should be encouraged to identify priorities and contribute to the commissioning, design and delivery of services.
11. Community groups should also be involved in the planning, design and where appropriate, the implementation of an evaluation framework. Such evaluations can then feed into ongoing monitoring and service adaptation.

Considerations and examples

1. Make sure everyone is ready for the challenge

Both the department or organisation and the local community or community group need to be ready for community driven work otherwise anything undertaken may just be a paper exercise or form of *pseudo-democracy*⁶ in action. It may be necessary to take some additional steps to find out whether all potential participants are ready.

Consider using the Community Involvement Checklist⁸ (see appendix) as a way to test out how far your team or organisation is already involved in the community and which areas could benefit from further development. There are also ways to assess 'community readiness' for change, some of which draw on more conventional psychological ideas, like the individual readiness for change model. See here for a guidance document on this approach: http://triethniccenter.colostate.edu/docs/CR_Handbook_8-3-15.pdf

It may also be important to involve people who have experience of working with community groups, or other organisations who provide support to individuals and teams, and who would like to develop more skills. Consultation with communities to explore needs before the start is often a crucial step:

Case Study 1: Consultation/Needs Assessment: The iNEAR Intervention. ⁹

The iNEAR intervention is a community positive psychology intervention developed to bring about transformative change in a school setting. It was piloted during 2016 at a school in South East England and involved a group of 350 young people aged 11 and 12.

Psychologists were invited to get involved with a needs assessment exercise to enhance the already robust provision of positive education in the school and better understand the role of resilience and emotional intelligence within it. Meetings were organised with senior management and with teachers who played a key role in developing and delivering the Personal, Social, Health and Economic syllabus. The meetings followed an appreciative enquiry approach converging on an asset rather than a deficit model, and engaged in asking different questions such as “What works well in spite of?”. Several important insights emerged out of the consultation process.

First, a number of examples of good practice stood out as important pillars to scaffold further intervention (e.g., the use of the token based system to reward kindness, sharing, resilience and initiative). Second, it became clear that the preferred teaching style used in the school was characterised by learning through experience and by the use of philosophical dialogues offering young people platforms to practice skills of moral reasoning and analytic thinking. Thirdly, the consultation process itself informed the content and purpose of the subsequent forum based activities involving the teachers. These activities included the teachers as stakeholders – the teachers’ expertise and views feeding into the development of further intervention. The teachers as scholars – the teachers’ commitment to ongoing scholarly development was expanded through their partaking in the train-the-trainer provision associated with the intervention. The teachers as practitioners – sections of the train-the-trainer provision were dedicated to recognizing the crucial importance of staff wellbeing. Prior to embarking on the next stage of the intervention (delivering 7 sessions to pupils as below), the authors provided bespoke personal and professional sessions with the aim of resourcing and replenishing. Fourthly, teachers’ views and experience of delivering the iNEAR intervention concluded the consultation process and formed part of a triangulated approach to data collection and evaluation.

iNEAR’s 7 session intervention consisted of activities to build positive identities, character strengths and resilience through learning skills for growth and flourishing¹⁰. The focus was on “I” as a social agent developing and (congruently) owning:

- N New knowledge about myself
- E Emotional resources and emotional intelligence
- A Awareness of values, of options, of choice
- R Responding with growth ‘in spite of ...’

iNEAR’s philosophy and intended outcomes grew out of the school’s positive and socially responsible education ethos and culture. Its 7-lessons structure and style of delivery complemented the pedagogical approach local to the school and were delivered as an integrated as part of the PSHE (Personal, Social, Health and Economic) National Curriculum activities scheduled for the academic year.

It is worth noting the way in which the iNEAR intervention can complement culturally sensitive approaches in other areas, notably clinical practice¹¹. Its positive-enquiry ethos can help ease the task of engaging community stakeholders and beneficiaries and deliver collaboratively established interventions to bring about change without re-problematizing groups that may be already disenfranchised or vulnerable in some way (e.g., Tunariu et al.¹².)

2. Learn to speak a “different” language...

As stated above, it can be difficult to get beyond entrenched positions of power and feelings of distrust to build genuine partnerships. Psychologists should train themselves to hear sensitively the anxieties that groups or organisations may have about joint working. For example, there are sometimes worries within organisations about whether there is sufficient cultural competence to offer effective support within partnerships with black and ethnic minority groups.

Psychologists also need to be sensitive to different communities’ beliefs around health, social issues, gender relationships and relationships between young people and older adults. Considering these issues may help psychologists understand how to speak with the right “language” for the context. There may also, of course be a need to consider the areas of linguistic difference and interpretation/translation in order to allow truly joint working. Do consider seeking help and advice from community groups and partners to try and get it right. Community partners and experts by experience often have much to teach psychologists, particularly because they may not be limited in the way they construct or perceive psychological help.

Case Study 2: Collaborative agenda development by a psychologist to help a project get started or get funded

This collaboration developed from the idea of an expert by experience (here called John, although that is not his real name), during a review meeting following many months work at a charity working for survivors of organised violence and torture., most of whom were asylum seekers or refugees. As part of this process, John was asked whether there was anything not offered to him that might have helped him regain his psychological and physical health.

John came up with what felt initially like a very radical suggestion: that the charity organize a team sport that could be played regardless of language or nationality and during which survivors would play alongside others who had shared similar experiences. John felt that this would enable him to regain a sense of his own physicality as well as his sense of self, identity and place in a community or group in this country of exile and that this would also benefit others in a similar position. After much discussion with John and colleagues, it was decided that a football team should be set up, as this is a sport played across the world and one that could be played across genders and ages.

Colleagues at the charity were initially skeptical about this form of intervention. Indeed it was necessary to combat some views that were almost hostile, seeing this as “not really therapy”, and it was noticed that posters in the reception area were sometimes removed. Over time, however, colleagues became curious and cautiously supportive of the initiative. This may have been helped by the fact that the charity was open to using creative forms of therapy which did not require fluent English and which had been found to be beneficial to users of the charity¹³.

After some time and effort, the charity agreed to sponsor a team kit, which felt like a significant achievement at the time. The first match was against a team from Amnesty International, which was won easily. The team joined a local league and due to having several players who had played at either national or top levels within their countries of origin, it came top of the league in its first season. The team obtained the services of a volunteer coach, interest from a professional team and after some time, attention from the media when German television made a film about the team.

Almost all of the service users were dealing with a range of issues related to physical and psychological well-being linked to their experiences of organized violence or torture. It seemed that being part of a welcoming, cohesive and supportive group and community, as well as enjoying their team win in a local league offered a range of therapeutic benefits. The team built up a fan base, who frequently took time to talk to John or clinical workers at matches or other activities organized around the team. In addition to weekly games, there was a regular meeting for the players, John, myself and a colleague attended this, during which players often reviewed issues relating to their former and current lives, as well as issues concerning the football team. This setting appeared to enable many of the players to talk about issues more freely than they might have done if the group had been labeled a therapy group^{11, 14}.

When reviewing the work of the team, it was found that 57% of players had gone on to take up courses at college and 19% had obtained employment. All reported that being part of the team had been a positive experience for their sense of well-being both physically and psychologically. John went onto obtain a degree and set up a successful enterprise in the UK, The collaboration shows the importance of being open and curious and learning from the people worked alongside.

It is also important to consider what the benefits of any suggested intervention are likely to be to those in the community. This is particularly relevant when projects are being suggested as a result of an organisational or governmental priority (rather than being asked for by communities).

Case Study 3: Merton & Sutton IAPT Project

The Merton & Sutton IAPT Project was able to use an IAPT (Improving Access to Psychological Therapies) framework to engage the local Tamil community, traditionally seen by the statutory sector as a 'hard to reach' group.

The ethos underpinning all IAPT services is to 'improve access' to psychological therapies and in doing this to increase referral rates from certain minority groups that have historically declined the use of psychological therapies. The first step was to establish a partnership between Tamil speaking IAPT staff and a local community hub: the Sri Ganapathy Temple in Wimbledon and to get a feel from our community partners of the needs and how best they could be met. Following this key documents were translated into Tamil including self-help material and the Mood Manager DVD etc. A rolling depression management group was then started exclusively in Tamil in the upstairs hall of the temple. The service-users came either via self-referral or through their GP, and following assessment for suitability were offered a 12 week group. Being seen in a non-clinical setting like the temple seemed to help people engage better and reduced the stigma often associated with mental health difficulties in this population. Over time, the therapy materials were adapted to the cultural context, for example incorporating mindfulness meditation keeping in mind its religious and cultural links with Hinduism. Referring to our groups as 'classes' rather than 'group therapy' seemed to resonate better with this population, showing the importance of small nuanced changes in language.

During the course of the work, it became clear that the clients accessing our service had multiple needs apart from their primary presentation of depression. Since many of the participants had fled from the conflict in Sri Lanka, and some had experienced torture, or seen relatives and friends killed in front of them, time needed to be allocated in initial sessions for psychoeducation about post-traumatic reactions to normalise symptoms. Safety planning was also built in around suicidal thinking and actions, something that often arose in relation to the stresses of seeking asylum in the UK. One or two whole sessions were set just to help people draw up their personal safety plans and the concept of an 'Emergency Box' anchoring them in the 5 senses was used to help calm and stabilize them during moments of hyperarousal, or despair. In cases of need, some individual therapy for post-traumatic stress disorder was also offered including narrative exposure therapy (NET).

Many of the participants were still seeking to have their asylum status formalised and had additional needs ranging from legal services to housing, having to learn English, monetary needs, and general needs to adapt to the culture of the UK. Most often, they were also unaware of what they could access in terms of help and where to access it. Therefore some of the time at the temple was also used to offer a kind of 'one stop shop', inviting people from outside to present on issues related to advice and support needs, and link service-users directly to them. On one occasion, a Merton Councillor was invited to speak about how to access housing services for asylum-seekers. The depression management group also made use of help seeking for advice as one of the behavioural activation goals which participants could follow-up outside the groups.

Overall, excellent feedback was received from service-users and the Tamil community more widely and the feedback from GPs was also very positive. The overall IAPT service also benefited from greater understanding of the issues pertinent to the Tamil community. The project was cited as an example of 'best practice' by the partner organisation leads who have now encouraged the service to present this model to Tamil communities in other boroughs of London, notably Lewisham. There are also plans to involve ex-service users as co-facilitators in future. The project was also shortlisted in 2014 as a finalist for the prestigious Trustwide quality awards under the categories of 'Promoting Partnership and 'Co-production' award.

3. Map the sphere of action

Consider:

- Who the local communities in are in your area of work (remaining mindful that communities may form around a health need (e.g. diabetes) or an issue such as 'being a young carer' rather than based on ethnicity, gender or heritage)
- How many people are represented by an organised community group
- What past initiatives have there been to engage them
- Did they work (build on success and analyse failures and missed opportunities).
- What questions been asked of the communities in the past and what was discovered

It is important not to repeat work that has already been done, and not undertake work that looks unlikely to be of benefit for a particular community at a specific time.

Case study 4: Co-producing mental health services with excluded young people in the community – the MAC-UK way

The charity MAC-UK aims to transform services for the UK's most excluded young people to address the vast health and social inequalities they experience. The vision is that excluded young people act as partners in designing and delivering multi-agency projects that work for them and which directly address their well-being and mental health in ways that are meaningful to them.

To enable a good understanding of the local community which a MAC-UK project intends to serve, they begin with a process of mapping. Ideally this is completed with local stakeholders, community members or community gatekeepers, however this may or may not be possible depending on the level of engagement from the outset. In all their work, MAC-UK have an awareness that they are 'guests' in any particular community and the expertise and knowledge is held with local people and institutions. Mapping involves assessing and understanding a community's resources and assets, as well as needs and issues. The process helps in identifying potential partners, resources and networks that a project can draw on.

Mapping Networks and Community Agencies

MAC-UK projects often have contact with local authority and local NHS services as they are funding partners. Through the relationships with people in these local services, MAC-UK will ask about locally valued community groups and resources as well as local community leaders and important gatekeepers. They can ask for introductions through these contacts to start building and joining local networks. They will attend local multi-agency panels, forums or tenants' association meetings, introducing themselves and their ideas and approach whilst also being curious and asking questions about people's experiences and current areas of work. They aim to join alongside these groups and people, aware that they have been in the community a long time and showing them all the respect and admiration that deserves. They are transparent about how the project will work with young people in the area and what their hopes are, including that the project is co-produced with young people and desires to draw on local assets and create partnerships. They actively ask for help from other agencies and sometimes this leads to introductions to other people or groups.

This kind of agency mapping helps to know how to find allies and partners in the work. Making personal contact with people then allows local relationships to flourish and to resist feeling in 'competition' with or threatened by others, something our economic culture often generates. It also helps with avoiding duplication and hearing directly what the gaps are in community provision and resources.

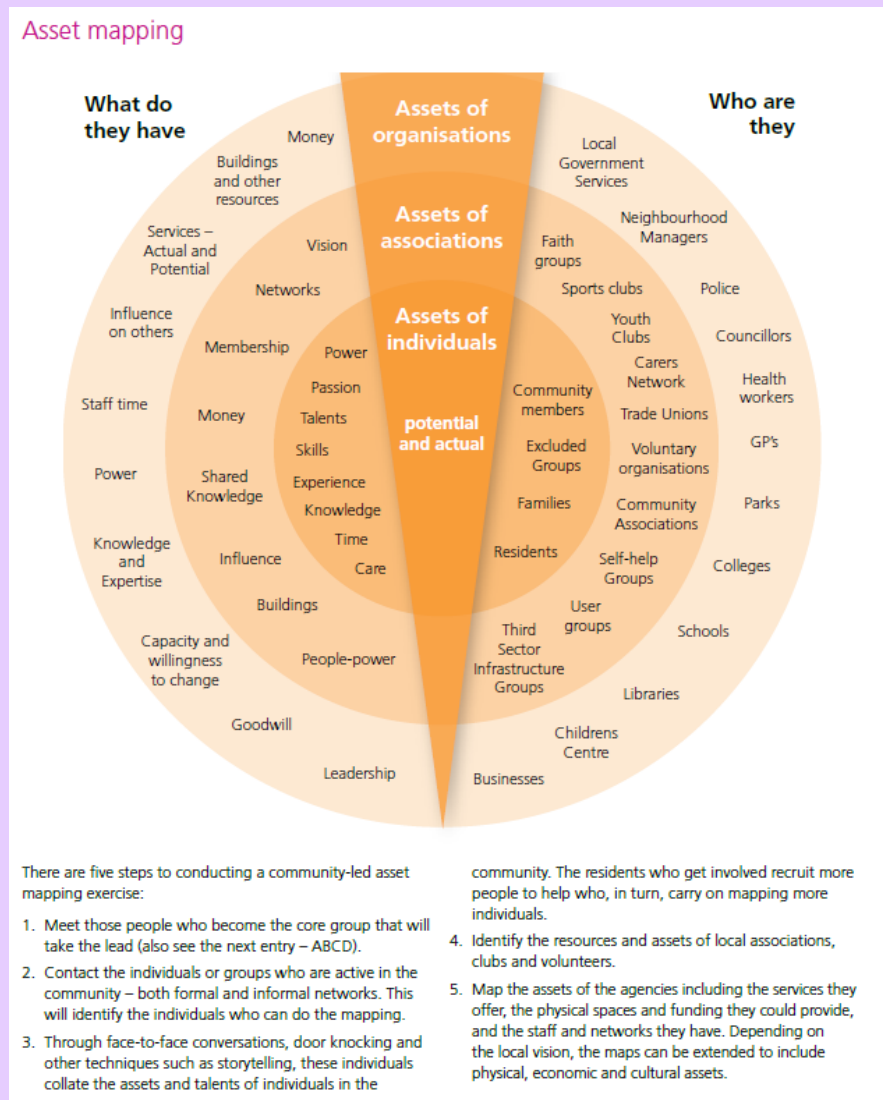
Sometimes it makes sense after mapping to work 'through' other partners, rather than doing specific types of work directly in MAC-UK projects (for example, if a local community group does sports development work, the charity would try and bridge young people into that group or encourage young people to work in partnership with them rather than set up a football group separately). This process of meeting other local agencies and services might also involve taking a walk through the local community and just talking to local people and stakeholders. These processes will often result in a 'directory' of local services and resources, which can be used later. Often there are already such directories, so mapping can involve tracking these down and making contact with agencies through their listing. However, it's always easier and more rewarding to be introduced through others.

Other sources can provide useful information, like the local authority's Joint Strategic Needs Assessment and other information from the local authority website, for example on what buildings, centres or community spaces are available. In addition, there are often community volunteering hubs or centres who often have an excellent record of local community organisations and active groups. Mapping and network building can continue in a dynamic way throughout the lifecycle of a community project.

Other Types of Asset Maps

MAC-UK also go through a multi-systemic asset-mapping exercise best illustrated in a report by Jane Foot called 'The Glass Half Full: how an asset approach can improve community health and well-being', available here: [http://www.assetbasedconsulting.net/uploads/publications/A glass half full.pdf](http://www.assetbasedconsulting.net/uploads/publications/A%20glass%20half%20full.pdf)

See Figure 1 below: This process allows for all types of assets to be considered and can help with formulating ideas for ways of harnessing these assets. As before, if this can be completed with community groups or gatekeepers, it will be a more accurate picture and can also be an 'intervention' in itself. Young people can be surprised by what is available to them in their communities.



4. Plan for intervention

Consider how best to involve communities in shaping projects as they move forward so that they remain community driven and relevant. Many of the case studies already listed above make clear some ways in which this can be done. In addition, it is worth considering the use of a mixed steering group to oversee the development of joint working.

Case Study 5: Re:Assure Women's Project at Positive East^{15 16}

Re:Assure Women's Project is a project for refugee, asylum-seeking and migrant women who are living with HIV and is one of the services provided by Positive East, an East London-based HIV charity. The project began in 2008, run by an African Communities worker and psychologist as well as volunteers and peer supporters from among the women participating in the project.

Prior to the start of the project, there were already good links between Positive East and the local NHS HIV clinics. These included joint projects, delivered by a psychologist from the local NHS service but based at Positive East. In 2005, a project to meet the needs of women living with HIV was started and a female psychologist began doing outreach sessions at Positive East. The women were often presenting with sex and relationship difficulties in the context of histories of abuse and trauma. These were compounded by current experiences of abuse. For many women, psychology or counselling was unfamiliar or seemingly irrelevant to their concerns and for others who did want this form of support, it had proved extremely difficult to access via mainstream services.

The project had to work in a way that took account of the social and political context of women's lives. The psychologist began to work closely with the African Communities Development Workers to provide an accessible and culturally relevant service. This service although based around a traditional, NHS-style model in which women were referred, assessed and offered individual psychological therapy, was well used and valued by the women who attended. When cuts to NHS funding led to the psychologist's post being cut, there were protests by the women attending the project, highlighting their desire to retain the service. This inspired Positive East to secure additional funding for a project dedicated to their needs. The psychologist moved to being employed directly by Positive East to develop and deliver the new project alongside an African Communities Worker.

Sue Holland's¹⁷ social action psychotherapy approach was key to this project, enabling women whose distress has generally been individualised and medicalised to engage in a series of steps moving 'through psychic space, into social space and so into political space'¹⁸ (p.141).

The personal level: building strengths

Women were not assessed, screened or required to fill forms in order to access the service. To facilitate access, travel was covered for those with no recourse to public funds. Joint sessions were also offered where language or cultural support was needed or where women felt unsure about seeing a psychologist and preferred to access support from a peer support worker. One to one peer support was an important part of the model, providing women with the opportunity to talk to someone also living with HIV, who might have had similar experiences to them.

The interpersonal level: making connections

A crucial aspect of the work involved women coming together in groups, where they could develop collective strategies to challenge the stigma and discrimination in their lives. There were courses such as 'Self-expression, sex and relationships', which grew out of discussions with women about common difficulties they faced. Access was supported by provision of a crèche. Women who attended the course played a significant role in its delivery; co-facilitating and sharing their experiences on issues such as surviving domestic violence, dating with HIV and having a baby. This aspect of the work was highly valued by participants. Several community events were organised and women contributed by writing and performing plays, giving testimonies, cooking and facilitating discussions. One of the most common themes in women's discussions of the project was the extent to which these groups facilitated the creation of a sense of family and community.

The political level: taking action

Positive East, as an organisation, is active in trying to influence policy around issues affecting the lives of people living with HIV. Women involved in the Re:Assure women's project have taken a significant role in this, addressing politicians and commissioners about issues that concern them such as the impact of welfare cuts and the immigration system. Women have become involved in volunteering, both for Re:Assure women's project and in other capacities, for example, as peer support volunteers and promoting HIV awareness. Some women have gone on to establish their own networks and projects.

Steering the project

It is always important to consider how to be accountable to participants and ensure their meaningful involvement in directing the projects in which they participate. In attempting to do so, it was decided to establish a steering group and this was done in a fairly traditional manner by explaining the purpose of the steering group in a presentation. Initially eight women signed up, however, there were challenges including the difficulty of ongoing attendance; representation of those voices that were absent and including those who experienced language barriers. Further, it was clear that the facilitators were often the ones setting the project agenda. It was acknowledged that the traditional steering group format needed to be changed.

The project began to have meetings alongside other group events at which crèche and food were available. While a core group of women consistently attended and got involved in thinking about the running of the project, this also allowed for flexibility, with more women being able to input without having to make an ongoing commitment. Core members were supported and encouraged to gather the views of their peers. One aspect that especially concerned participants was that of funding for the project. Women requested to meet the funders in person to share their views and their aims in terms of the future directions for the project and this happened on a number of occasions. In conclusion, ensuring meaningful involvement of project participants requires commitment to the principle of accountability. Even if the traditional structure of a steering group doesn't fit, it is important not to abandon this principle but to seek other ways of adhering to it.

One model that can be useful in thinking about intervention is that described by the Centre for Ethnicity and Health (2007). This describes some “key ingredients” for successful community engagement which include involving someone in the role of ‘facilitator’ (creating an environment where community organisations and agencies can work together), and in specific a host community organisation, with a meaningful time-limited and manageable task and support offered in the form of training, project support workers, funding and/or steering group involvement¹⁹.

5. Community groups as service providers

Psychologists should consider involving community groups in co-providing or co-producing services, bringing their own expertise in working with their community to supplement what the psychologist can provide

Case Study 6: co-facilitation (community groups as providers/co-providers of services)

The “Face-up” programme²⁰ was commissioned by the London Metropolitan Police and was designed and delivered in collaboration with a London based charity, the Youth Foundation.

The aim of this community intervention was to assist the Metropolitan Police in their work with a group of 20 disenfranchised young men aged between 12 and 18 of various ethnic and socio-economic backgrounds. The young men were known to the police service in relation to repetitive antisocial behaviour, often disengagement from school, and demonstrating a disruptive approach towards their neighbours and the neighbourhood in general. The brief required a positive psychology programme with a strong developmental and restorative justice type ethos. A training guide and resources were also developed with a view to re-running the programme in the future, potentially with programme ‘graduates’ as future facilitators.

The issue of person-activity fit: community agency staff as co-providers of service

Police officers and local youth workers, known to the group of young people who took part in this programme, were involved as co-providers of service in different ways. In order to destabilise these young people’s tendency to be sceptical and combative and secure their engagement with alternative narratives, the programme team needed to engineer conditions necessary for building a ‘new’ culture. On the first day, for instance, two police officers participated at introductory round table conversations. The officers’ skilled manner and openness generated opportunities for frank dialogues about the issues, doubts, needs and wishes these young people harboured. The officers suggested ways for mending bridges and endorsed the courage and commitment to ‘face up’ the young men displayed. Informed and energised by what was being said, the young men, in turn began to by-pass the ‘otherness’ that the police uniform symbolised to them and began to listen to themselves; to their own stories within the emergent communal space. Importantly, it became apparent how intense, shared lived-experiences paired with a non-judgemental witnessing by significant others began to crystallise a ‘new’ group with a culture underpinned by authentic communication and relational empathy.

The issue of person-activity fit: young people as co-providers of service

A collectively shared grievance amongst the young people was a strong sense of hurt and unfairness. As a result, it was felt that the ‘paper-man’ activity would resonate with participants. In a circle format, each participant was given a paper-man cutting and then instructed to tear it apart. The instruction was received as childish and pointless yet also gently began to build up a common voice of the (new) group as distinct from the facilitators. They each reluctantly completed the task. The second instruction required participants to put back the paper-man to its original shape using sticking tape. It too provoked a similar reaction. Chaos and collaboration emerged as these young men were looking for lost pieces of their paper-man on the floor, across the room. Laughter and industriousness to finish the task as promptly as possible strengthened the team spirit. Once each individual paper-man was restored as best as possible with the tape provided, the next instruction was delivered: “Tear it apart once more”. Every attempt to do so now failed. Surprised by the instruction yet trying to comply, the group cried: “We can’t. It won’t work”. The final instruction: “Now, in turn, tell the story of your paper-man”. As individual story telling progressed, the ‘it happened to it/this imaginary paper-man’ switch organically to ‘they cannot break me again; I am stronger; I am now made in my image’. They got the point: Face up was about resilience. Within this developmental contexts, later activities focused on emotional intelligence and emotional resourcing were usefully nourished, and exercises addressing skills for and value of positive relationships, responsible citizenship, and positive future-perspectives enabled.

Based on their feedback, the Face-up programme offered the young men an appreciation of the notion that Self-understanding informs Self-compassion; that compassion towards others informs Self-understanding and aids Self-control; and that together these are a very powerful resource

6. Joint research, evaluation and monitoring

Involving community groups in research and in evaluating the success of interventions is crucial, whether they have been involved in providing services or not. If possible, research priorities should emerge from community groups and their activism (see case study below). Similarly, Ideas around how to evaluate interventions and how to collect data based on the wide range of voices that there may be in any community are key. Ethical issues need to be considered around consent and data protection, and there may be issues to weigh up around translation for black and ethnic minority groups⁶

Case study 7: Conducting research in collaboration with communities: the Focus E15 participatory action research project

Between 2015 and 2016, academic researchers collaborated with the Focus E15 housing campaign to conduct participatory action research into the experiences of people facing homelessness and displacement in the East London borough of Newham. Activists from the Focus E15 campaign, some of whom were struggling with homelessness themselves, were trained as researchers and conducted 64 structured interviews with participants who had approached Newham Council with a housing need in the previous year.

Rather than the researchers taking a lead in designing the project and then recruiting the campaigners, the idea for the project emerged from a long-term engagement between them. The researchers were living in East London at the time and through their interest in housing became involved in the campaign as activists. The campaign organises a weekly stall on the high street in Stratford, Newham, and members of the public would often approach the campaign and share their experiences of housing poverty, homelessness and displacement. It became apparent that there was a need to develop a system for capturing these stories so that they could inform the campaign. As such, the research project emerged organically from the organising methodology of the campaign.

The researchers worked closely with the campaigners to design a questionnaire that could capture people's complex stories. The campaigners' own experience of homelessness and displacement enabled a fine-tuning of the questionnaire to capture the important information. The campaigners were then trained to administer and record the interviews. The campaigners drew on their intimate knowledge of the housing system to identify sites where they could approach potential participants, such as Newham Council's housing office and temporary accommodation in Hertfordshire. As a result, the project was able to access a transient population that is normally very difficult for researchers to access.

The research revealed that homeless people who approached Newham Council were being housed in poor quality, overcrowded and insecure accommodation for long periods of time and, in many cases, were being rehoused outside of the borough and even the city altogether. Amongst other findings, the research found that these conditions were having a negative impact on people's mental health, with 89% of respondents reporting worsening mental health as a result of their housing situation. The research was covered in the Guardian newspaper and provoked the formation of a national network of practitioners, researchers and activists concerned with the intersection of mental health and housing. The research also informed Focus E15's decision to launch their "Housing is a Mental Health Issue" campaign.

This case study demonstrates how collaboration between researchers and communities can generate new insights into the social and economic conditions that produce mental health problems. In addition, by involving campaigners in the research design from the beginning, and allowing campaign priorities (rather than academic research questions) to dictate the approach, it was possible to produce knowledge useful for communities campaigning around mental health issues.

7. Ongoing relationships

There needs to be openness about misperceptions on all sides and the potential for honest dialogue about past successes and failures, bearing in mind the propensity for differing agendas. It is important to recognise the need for trust to develop and for joint working to meet the needs of all participants. The case example below shares the ways in which misperceptions, difficulties in communication and mistrust may influence the development of a project, and the way in which the involvement of a psychologist may help in managing this.

Case Study 8: The Porn Project

In 2012, critical feminist psychologists from the University of Auckland received a large grant from the New Zealand government to create a space for public dialogue on pornography. *Pornography in the Public Eye (PPE)* was a response to a discursive context that cast people into rigid opposites: either 'pro' or 'anti' porn. The Porn Project was an attempt to not resolve but refuse binaries, seeking to enter their borderlands and look for transformative potential.

PPE included commissioning high-profile artists to respond to pornography for an exhibition at the University's gallery, however there was concern about only doing work within institutions: both from the point of view of the constraints posed by bureaucracy, but also the possibility of ending up with an exclusive space for dialogue. It was decided to co-curate a 'fringe art campaign' that would have the same aims as, but different tactics to, the main project – regarded, crucially, as both affiliated and autonomous. Keen to also make the campaign both radical and careful, a manifesto was drafted about what this kind of "intentional space" would look like before inviting people to shape our words into mixed media and editing this together as a call for more to join us. By now the campaign was already being referred to as "The Porn Project".

The campaign was opened to as many contributors as possible, and what came through would determine what shape it would take. It was clear that some values resonated with people from both 'sides' so with this in mind, with feedback from the University, Intentional Space, and street-artists, a call for participation was drafted that included, "walking a line that is collectively neither 'pro' nor 'anti' porn. Instead we're celebrating diverse desires, bodies, sex and erotica, while at the same time refusing misogyny and racism – whether the repetition of narrow ideas about 'normal' sexuality, or explicit gender- and race-based violence". In many ways this statement became a sort of manifesto for the campaign itself, putting out a shared commitment that we could return to when making decisions. The psychologist took advantage of as many media opportunities as possible, while also meeting face-to-face with potential contributors.

There were over 50 submissions, with a notable abundance of pieces that "celebrated diversity" and a notable scarcity of pieces that "refused misogyny and racism". Although disappointing, knowing the dominant culture of Aotearoa New Zealand, this pattern did not surprise us, and we knew the onus was on us to find alternative means to enact our antiracist and anticolonial commitments. 200 or so people that came to the campaign's opening night, held in the first gallery space, a collision of a wide range of pieces and bodies that always felt on the verge of erupting. The following night members of Intentional Space held an urgent meeting to debrief about the dominant heteronormativity, the lack of 'trigger warnings' and the 'missing' politics.

Following this, the psychologist created a zine, printed, folded and stapled 200 copies, and distributed them by hand in shared spaces throughout the central city. The closing night was held in a second gallery space, crafted with more attention to safety (including the debated decision to have security and a small cover charge) and framed more in terms of attracting people who were schooled in feminist and queer theory. And, in-between there were exhibitions in pop-up and corner stores, a "gender smash" street action and breast-feeding "sip-in", open-days at the New Zealand Prostitute Collective, a wildly attended poetry and open-mic night at a local cafe, two performance art pieces about 'cleanliness' and 'sex education', and talks, panels, and film-showings from librarians, academics, artists, and porn-stars.

This project of community and psychology, showed that 'misperceptions' and 'mistrust' are sources of expertise, of acute historical and social analyses, that offer the seeds for moving forward, not barriers to be overcome. Indeed, combining pro and anti, postfeminists and radicals, institutional art and outsider art, university and community, government and street, fueled the lively shape, making collective spaces for all sorts of expected and unexpected dialogue, engaging (not erasing) differences. The psychologist's role was one of guardianship, of protecting a space for these dialogues across difference.

Part of what may be important in continuing to support relationships of trust and joint working is timely feedback about the results of consultations, interventions or action research. This should demonstrate how the results of joint working have affected the outcome/planning of service delivery, particularly if community engagement activities are not ongoing.

8. Being in it for the long haul...

In keeping with the first point above, having established that all potential participants are ready to work in a community focused way, there is likely to be a pull to work in this way for the long term. This is in contrast to the many occasions when organisations appear to wish to run one consultation with communities (perhaps to confirm their pre-existing ideas and approaches) and then continue as usual. This guidance argues that what is necessary is a cultural change that holds open and genuine consultation and joint working at the centre of its values and attitudes.

Case Study 9: The importance of long-term involvement

This example describes the use of participatory action research as a tool for community healing. In this case the psychologist worked with people living in Tivoli Gardens, an inner city community in Kingston, Jamaica. It is also a 'garrison' community, a politically polarized neighbourhood controlled by the Member of Parliament and leaders of criminal enterprises. Rarely do people living outside of Tivoli Gardens enter the community as it is considered violent and potentially dangerous.

In 2012, the psychologist learnt that some residents of the community were experiencing symptoms of post-traumatic stress disorder in the aftermath of a state of emergency called in May 2010. The Jamaican government, in an attempt to arrest a known drug lord who lived in and ruled the neighbourhood, invaded the community. The violent confrontation between security forces and the community resulted in the death of at least 76 civilians in four days – the largest number of civilians killed by the state in Jamaica since the Morant Bay Rebellion in 1865. Despite pressure from local human rights groups the state did not immediately investigate charges of extrajudicial killings by the security forces nor did they provide all families the opportunity to identify bodies of the deceased. Even now, some do not know the circumstances of their loved one's deaths.

Social services responded to community members' distress by providing brief counselling and organizing beach excursions. Later on, when it became clear that these interventions were inadequate to meet community members' mental health needs the Ministry of Education created a hotline for school-aged children but the hotline was flooded by calls from the adults in the community.

The psychologist involved saw this response by the government as inadequate, and conceptualized a truth and memory project, a participatory, collaborative truth-seeking undertaking, linked to creating the conditions under which survivors can experience a sense of justice. As a framework for engaging with the Tivoli Gardens community, the aim was to facilitate the production of a historical record of survivor's experiences, provide an opportunity for family members to publicly honour their dead, with dignity, create a memorial for victims and promote civic dialogues about racism and classism (the ideologies that allow these atrocities to take place). These acts are known to contribute to community healing processes. Oral history was chosen as a qualitative interviewing method to ensure community members retained authority for their voice in the research and with a view to creating an archive from which their knowledge of what took place could be revealed to increase public understanding of the atrocity. Between 2013 and 2016 the stories of 26 members of the community who volunteered to talk with us about their experiences were video recorded. Some participants spoke on multiple occasions. These are being edited into *Four Days in May*, an experimental documentary and creating a multimedia arts installation titled *Tivoli Stories*, as a memorial to those killed.

Shawn Bowen (who asked that his name be used) described the daily re-traumatization the community experiences since a security post was established in Tivoli Gardens during the state of emergency. Given this and the ways in which people in Tivoli Gardens are socially excluded and socially alienated, Shawn believes that what is needed is a kind of social engagement in which the full measure of the oppressive conditions of community members' lives can be witnessed and addressed. In addition to the acute trauma of May 2010 and the daily re-traumatization the community is exposed to, Tivoli Gardens residents are also experiencing what Kai Erikson²¹ calls collective trauma. Erikson defines collective trauma not in the traditional sense (as shared traumatic experience), but as a long, slow process of social alienation and fragmentation. A "blow to the basic tissues of social life that damages the bonds attaching people together and impairs the prevailing sense of communality" (p. 154). Understood in this way a response to what Tivoli Gardens' residents have endured would be for the society to come together to bear witness to the multiple forms of trauma people are experiencing. Instead, they have been met with piecemeal reactivity from the fields of psychology, human rights and journalism. Behavioural reactions that affirm disconnection, fragmentation, and disintegration which characterize collective trauma.

A further example of the importance of longer term commitment is offered by the case of the Healthy African American Families (HAAF) Project in California, USA. This project, running for well over two decades shows the value of building long term relationships to involve community groups and activists, universities and health providers. In this case, the duration of a successful partnership founded in community-based participatory research, developed into an independent incorporated community organisation facilitating and brokering research and health promotion activities within the community²².

Psychologists working with communities can offer ways of being that help repair social bonds. Working with others, psychologists can reset what it means to be **in** community with people. Such radical psychological approaches – which are at once both psychological and cultural – take time and require that psychologists recalibrate and pivot shifting focus away from prescriptive, preventative, ameliorative and consultative work toward the harder but ultimately worthwhile project of co-creating an entirely new way of being, in community.

Conclusion

This guidance has sought to outline some key principles for psychologists involved in working in partnership with community organisations. It is in no way exhaustive, but rather seeks to stimulate ideas for creative practice by offering examples and directions. It is undoubtedly a work in progress, open to revision and changes in practice. However, its key message is that joint working with groups who may find conventional health and other services difficult to engage with (and risk themselves then being defined as “hard to reach”) is both possible and advisable for psychological work in all spheres.

Glossary

AGENTS OF CHANGE: Local individuals or groups responsible for encourage communities to engage in activities to improve their health and tackle the wider social determinants of health. They can gain commitment for change from the community and statutory organisations, identify barriers to change, promote and facilitate monitoring and evaluation activities and encourage the dissemination of learning

CITIZENS' JURIES: Usually involved 12-16 people to look at a particular issue and answer a pre-determined question after hearing evidence from a range of speakers

CITIZENS' PANELS: Comprise a cross section of 1000-2000 residents of a local population who complete three or four questionnaires a year on a range of local issues to help local authorities to clarify community priorities and provide a means of evaluating services

COMMUNITY CHAMPIONS: Community entrepreneurs, mentors or leaders (inspirational figures) who champion the priorities and needs of their communities and help them get involved by building on their existing skills, driving forward community activities and passing on their expertise to others.

EXPERT BY EXPERIENCE: People who have experience of using (or caring for someone who uses) health and/or social care services. They are often asked to take part in inspections of health and social care services and to accompany inspectors (for example the CQC) on visits to monitor the application of the Mental Health Act in health and social care settings. Experts by Experience can also become involved with services in other ways, including gathering intelligence from the public about services in local areas to inform regulatory practise or taking part in consultations and with delivering staff training.

FOCUS GROUPS: A focus group is a qualitative research tool in which a group of people are asked about their perceptions, opinions, beliefs, and attitudes towards a product, service, concept, advertisement, idea, or packaging. Questions are asked in an interactive group setting where participants are free to talk with other group members.

HEALTH CHAMPIONS: Individuals who possess the experience, enthusiasm and skills to encourage and support other individuals and communities to engage in health promotion activities and ensure that health issues facing communities remain high on the agenda of organisations that can effect change.

NEIGHBOURHOOD COMMITTEES: Usually made up of councillors representing relevant wards and up to five co-opted members (usually local residents elected to represent their community). They discuss council priorities and raise matters of concern within the local community and lead of neighbourhood development activities.

STEERING GROUP: Steering groups are made up of individuals with relevant experience or skills who oversee a project to ensure that it follows its guiding principles or protocols and provide advice where necessary. The steering group usually meets at key stages during the course of a project and influences strategic decisions. In the case of

community projects, the involvement of a steering group drawn from community members can help ensure that the project remains truly community driven.

References

1. NICE (2008) *Community Engagement to Improve Health*. Nice Public Health Guidance 9. February 2008.
2. NICE (2016) *Community Engagement: improving health and wellbeing and reducing health inequalities*. Nice guideline 4 March 2016.
3. Ware, P. (2013) "Very small, very quiet, a whisper – Black and minority ethnic groups: voice and influence". Third Sector Resource Centre, Briefing Paper **103**.
4. The Five Year Forward View for Mental Health (2016). The Mental Health Task Force: <https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf>.
5. Kagan, C., Burton, M., Duckett, P., Lawthom, R. and Siddiquee, A. (2011). *Critical Community Psychology*. West Sussex: Wiley Blackwell.
6. Lane, P. & Tribe, R. (2010) Following NICE 2008: a practical guide for health professionals on community engagement with local black and minority ethnic (BME) community groups. *Diversity, Health & Care* **7 (2): 105-14**.
7. Christens, B.D. (2012) "Targeting empowerment in community development: a community psychology approach to enhancing local power and wellbeing". *Community Development Journal* 2012: 538-554
8. Evelyn Oldfield Unit (2015). Checklist developed by Zibiah Alfred, Sarah Menzies and colleagues from the Evelyn Oldfield Unit. London: Evelyn Oldfield Unit.
9. Tunariu, A.D., Tribe, R., Frings, D. & Albery, I.P. (2017). The iNEAR programme: an existential positive psychology intervention for resilience and emotional wellbeing. *International Review of Psychiatry*, 29 (4): 362-372
10. Tunariu, A. D. (2015). *The iNEAR psychological intervention. A resilience curriculum programme for children and young people*. Teacher and Student Guides. University of East London. London, UK.
11. Tribe, R. & Tunariu, A.D. (2017). Psychological Interventions and Assessments. In D. Bhugra and K. Bhui (Eds). *Textbook of Cultural Psychiatry*. Cambridge: Cambridge University Press, 458-471.
12. Tunariu, A.D., Boniwell, I., Ruffion, A. & Clamy – Sebag, V. (2017). *The Philosophical Dialogues Program: An existential positive psychology intervention for resilience, wellbeing and affirmative mindset*. Towards sustainable prevention of youth radicalization. UNISMED, Nice, France.)
13. Freedom from Torture, London UK.
14. Tribe, R. (2002) Football for facilitating therapeutic interventions among a group of refugees. In I. Cockerill (Ed). *Solutions in Sport Psychology*. London:Thomson, 173-183.
15. Byrne, A., Tungana, J., Upenyu, Monika, Devota, Janet, Fay, Rose, Rukia, Wonderful, Patience, Becky, Mary, Hope, Lizzy, Linda, Barbie and Uwamaria of Re:Assure Women's Project at Positive East (2016). 'Women can build a nation. our disease, hiv, cannot stop us to be mothers because we are the mothers of the nations' : a liberation approach. In Afuape, T., and Hughes, G. (Eds) *Liberation Practices: Towards Emotional Wellbeing Through Dialogue*. London: Routledge.
16. Reassure Women's Project at Positive East available at <http://www.positiveeast.org.uk/index.php/our-services/> (accessed 02/11/2017)

17. Holland, S. (1992). From social abuse to social action: a neighborhood psychotherapy and social action project for women. In J. Ussher & P. Nicholson (eds), *Gender Issues in Clinical Psychology*. London: Routledge
18. Holland, S. (1995) 'Interaction in Women's mental health and neighbourhood development' In Fernando, S. (ed) *Mental health in a Multi-Ethnic Society: A Multidisciplinary Handbook*. London: Routledge.
19. Fountain, J., Patel, K. & Buffin, J. (2007). Community Engagement: The Centre for Ethnicity and Health Model. Amsterdam, Netherlands: Foundation RegenboogAMOC.
http://clock.uclan.ac.uk/2584/1/buffin_reader_community_engag1.pdf.
20. Boniwell, I. & Tunariu, A.D. (2010). Face Up: Emotional Resilience programme for young people. A Trainer's Guide and materials. Commissioned by London Metropolitan Police in association with The Young Foundation. London, UK.
21. Erikson, K (1976). *Everything in its path: Destruction of community in Buffalo Creek flood*. New York: Simon and Schuster.
22. Ferré, C.D., Jones, L., Norris, K.C. & Rowley, D.L. (2010). "The Healthy African American Families (HAAF) Project: From Community-Based Participatory Research to Community-Partnered Participatory Research". *Ethnicity & Disease*, 20 (Suppl2) 1-8.

Bibliography for the Checklist:

- Aslin, H.J. & Brown, V.A. (2004) Towards Whole of Community Engagement: A PRACTICAL TOOLKIT. Murray-Darling Basin Commission
- Herefordshire Council (2014). Best Practice Community Engagement Techniques, *Neighbourhood Planning Guidance Note 12*, January, (available from https://www.herefordshire.gov.uk/media/6312587/12_best_practice_community_engagement_techniques.pdf)
- Homes & Communities Agency (n.a.) What is Community Engagement? Available from: http://www.homesandcommunities.co.uk/sites/default/files/book/community-engagement/what_is_community_engagement_-_guide_v1_-_no_cover.pdf)
- National Institute for Health and Care Excellence (2008), Community Engagement, *NICE Public Health Guidance 9*, February (available from <http://www.nice.org.uk/guidance/ph9/chapter/introduction>)
- The Scottish Government (n.a.). National Standards for Community Engagement (available from: <http://www.scotland.gov.uk/Resource/Doc/94257/0084550.pdf>)

APPENDIX:

Community Involvement Toolkit

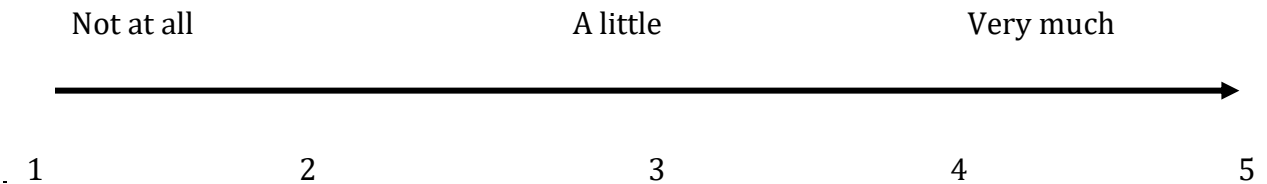
Network of Community Psychologists

*The checklist is composed of a series of questions where answers are given on scale from (1) “not much” to (5) “very much”. The questions are intended to provide guidance on the breadth and depth of your team’s community engagement. This toolkit was designed with the main aim of exploring the following broad question: **How effectively engaged are you and your team to your local community?***

*The toolkit is divided into **FIVE** areas which are the common stages of any community engagement process. Questions are asked to assess the engagement process by stage. The respondents are asked to answer the questions by entering **X** on a scale from 1 to 5 which is explained below. Please keep a score as you progress through the toolkit. Some of the questions are multiple choice. Please count your score on these also. Advice will be offered at the end of this checklist.*

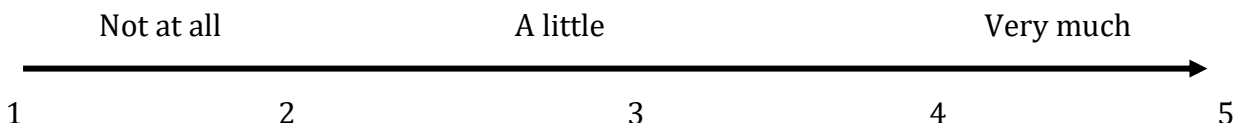
The ultimate goal is to support you to improve your engagement practice and to recognise the huge benefit that normalising engagement can have to your work.

The scale



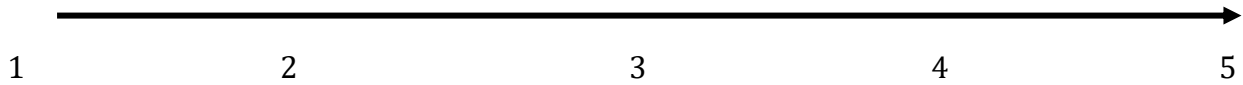
First stage: Inform
Providing information to the community to understand the opportunities, problems, alternatives and/or solutions

a. To what extent do you keep an updated database of your target community?



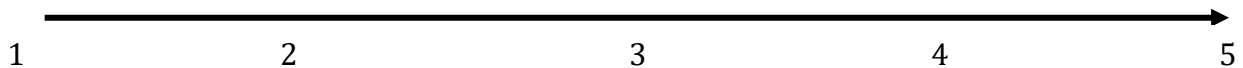
Please give details:

b. To what extent do you allow the community to set the priorities of your engagement work, particularly what the engagement will look like – how often, whom, to what degree will the community be involved?



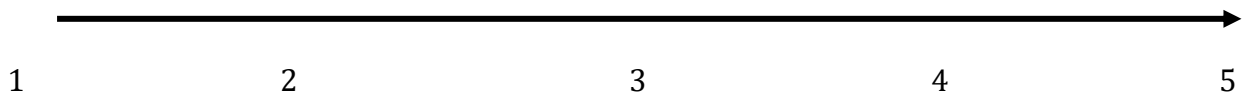
Please give details:

c. How knowledgeable are you about community organisations working in your target community?



Please give details:

d. To what extent do you inform your target audience in the community about your work priorities?



Please give details:

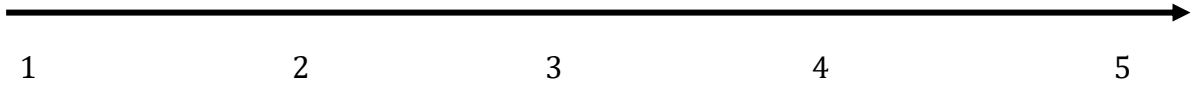
e. Which channels have you used to disseminate the information?:

- | | |
|---|--|
| <input type="checkbox"/> Newsletters/news releases | <input type="checkbox"/> Schools |
| <input type="checkbox"/> Posters/leaflets/brochures | <input type="checkbox"/> Websites |
| <input type="checkbox"/> Exhibitions | <input type="checkbox"/> Using the local CVS |

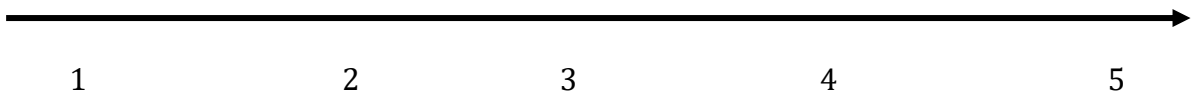
- Attending community events
- Through other specific networks
- Information via community groups
- Through doctor's surgeries
- Others, please specify

f. To what extent do you allocate the following resources for community engagement in terms of resources for your staff team?

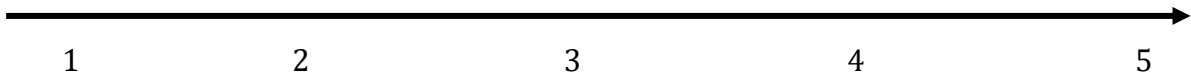
i. Funds



ii. Adequate time



iii. Sufficient other resources particularly staffing



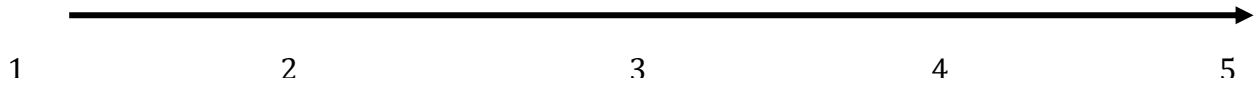
Please give details:

h. To what extent do you offer joint training for all partners on the engagement process, including community members?



Please give details:

i. To what extent do you investigate barriers for participation by some community groups/members?



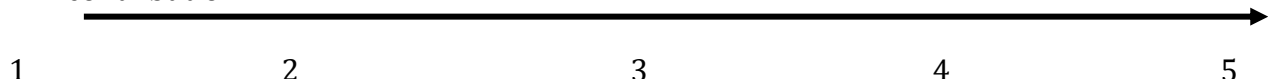
Please give details:

j. Do you have specific targets/ strategies to engage the following 'groups'?

- Older participants (over 50 years)
- Minority groups
- Women from minority groups
- Young people and children
- People with disabilities
- Others, please specify

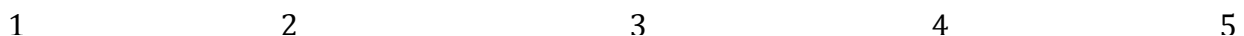
Please give details:

k. To what extent do you offer expenses for participants? i.e. An attendance contribution?



Please give details:

l. To what extent is your place of service provision accessible to the target community (i.e. spaces/areas for childcare; paths for mobility impaired people; sign language/interpreters; lifts)?



g. To what extent do you provide training to staff who will be interacting with community members?

1 2 3 4 5



Please give details:

h. To what extent do you offer joint training for all partners on the engagement process, including community members?

1 2 3 4 5



Please give details:

i. To what extent do you investigate barriers for participation by some community groups/members?

1 2 3 4 5



Please give details:

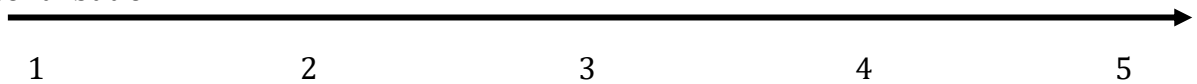
j. Do you have specific targets/ strategies to engage the following 'groups'?

- Older participants (over 50 years)
- Minority groups

- Women from minority groups
- Young people and children
- People with disabilities
- Others, please specify

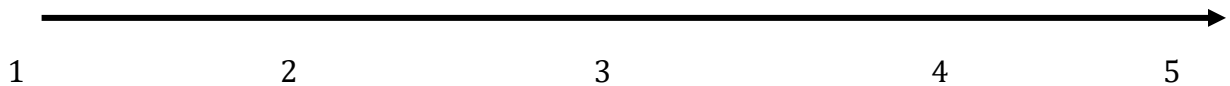
Please give details:

k. To what extent do you offer expenses for participants? i.e. An attendance contribution?



Please give details:

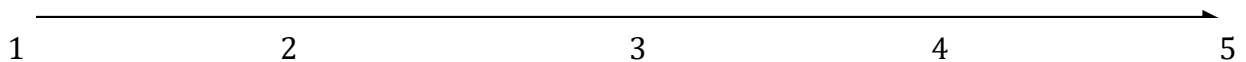
l. To what extent is your place of service provision accessible to the target community (i.e. spaces/areas for childcare; paths for mobility impaired people; sign language/interpreters; lifts)?



Please give details:

Representation and Inclusion:

m. To what extent do you involve community champions¹ in the consultation groups?



¹ Community champions are inspirational figures, community entrepreneurs, mentors or leaders who 'champion' the priorities and needs of their communities and help them get involved by building on their existing skills. They drive forward community activities and pass on their expertise to others. They also provide support, for example, through mentoring, helping people to get appropriate training or by helping to manage small projects.

n. If you do, please indicate which types of the champions do you often include:

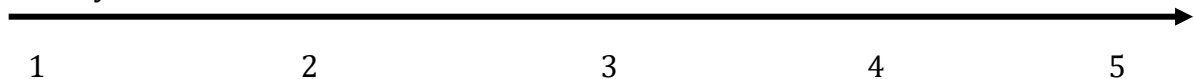
- Community entrepreneurs
- Community mentors/leaders
- Volunteers
- Those with experience of accessing your agency or organisation (service-users)
- Other inspirational figures; please specify

Please give details:

Second stage: Consult

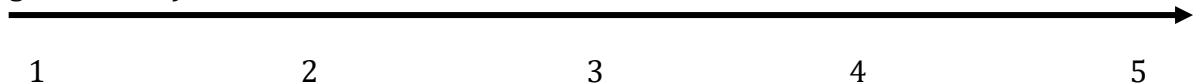
This means obtaining community feedback/responses to information provided in the first 'inform' stage

a. To what extent do you consider the time schedules of your target community when planning consultation, eg. school, timetables, prayer times, cultural festivals/holidays and others?



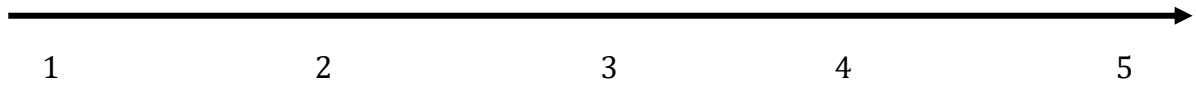
Please give details:

b. To what extent do you arrange communication support for community members during consultation events (i.e. having interpreters for non-English speakers, same-gender staff)?



Please give details:

c. Do you feel you have a good awareness of the diversity of the community? Do those who take part in your consultation reflect this?



Please give details:

d. Which consultation methods have you used previously?

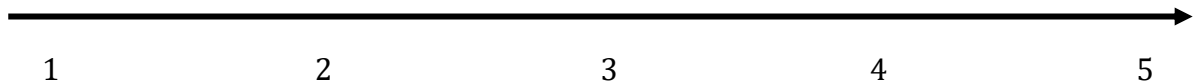
- | | |
|--|---|
| <input type="checkbox"/> Surveys | <input type="checkbox"/> Citizens juries |
| <input type="checkbox"/> Focus groups | <input type="checkbox"/> Panels |
| <input type="checkbox"/> Public meetings | <input type="checkbox"/> Neighbourhood committees |
| | <input type="checkbox"/> Other, please specify |

e. To what extent do you involve community members in choosing the engagement methods?



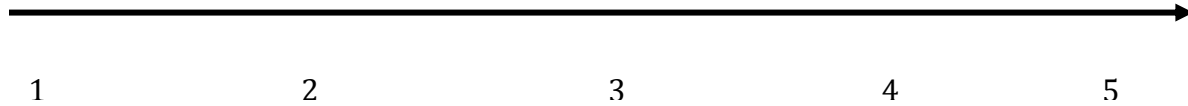
Please give details:

f. Do you take time to explore the mutual benefits of engagement?



Please give details:

g. To what extent do you take time to negotiate roles and responsibilities within the engagement process?

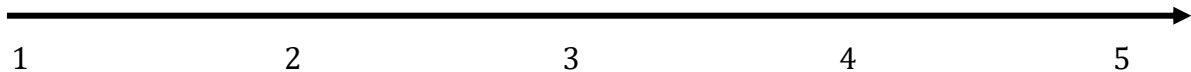


Please give details:

Third and Fourth stages: Involve and Collaborate

This means working directly with the community throughout the process to ensure their contribution to policies and strategies, working as partners with the target community on all aspects of decision making and problem solving

a. To what extent do you work directly with the target community to ensure that their aspirations and concerns are reflected in your service provision?

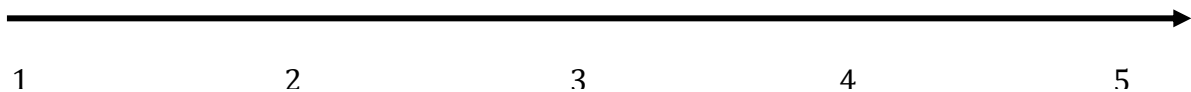


Please give details:

b. Which channels have you used to involve them in decision making:

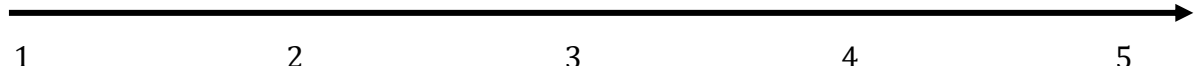
- Discussion groups
- Deliberative polling
- Agents of change
- Community workshops
- Other, please specify

c. To what extent do your staff *maintain* ongoing contact with community members?



Please give details:

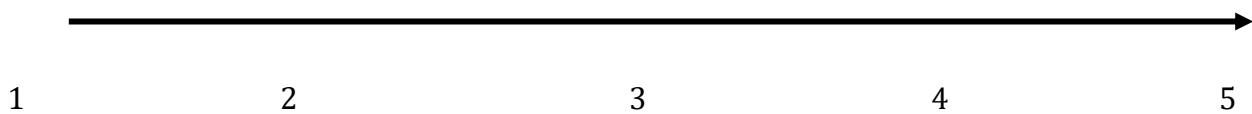
d. To what extent do you align your long-term activities with the local priorities of the community?



Please give details:

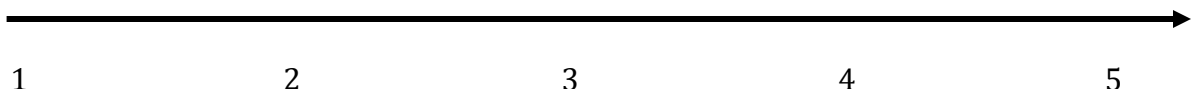
Accountability

e. To what extent do you allow the participants and community members to hold you accountable?



Please give details:

f. To what extent do you keep records and minutes of meetings with community members ensuring these are accessible and updated?



Please give details:

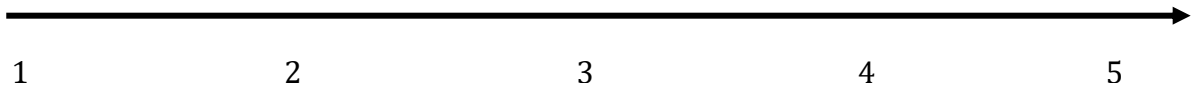
g. To what extent do you explore different means of dissemination, i.e. considering accessible formats, large font, using 'Plain English'?



d. Please specify the area with the most noticeable change/s in your experience:

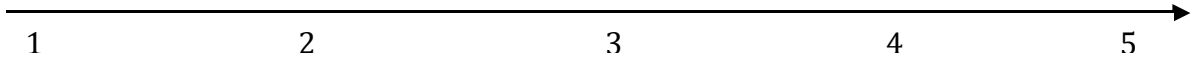
- | | |
|---|---|
| <input type="checkbox"/> Self-confidence | <input type="checkbox"/> Knowledge |
| <input type="checkbox"/> Skills | <input type="checkbox"/> New projects being developed |
| <input type="checkbox"/> Improved health in the area | <input type="checkbox"/> Other, please specify |
| <input type="checkbox"/> Improved health literacy | |
| <input type="checkbox"/> Increased uptake of services | |

e. If there is conflict, which can occur frequently on matters involving health and provision of services, do you address this actively, e.g. running sessions on conflict management or open discussions to address issues as they occur?



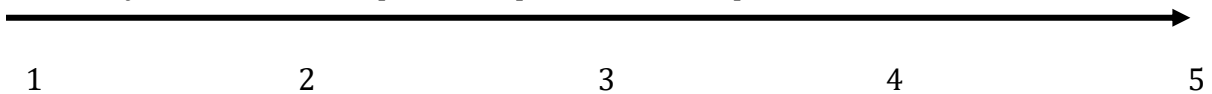
Please give details:

f. To what extent do you work with the community to devise an evaluation framework, supporting them to come up with indicators to assess how effective the process has been?



Please give details:

g. To what extent do you then share this with the community and then demonstrate actions you will take to improve the process based upon this?



Please give details:

Scoring & Reflection

Mainly 1 and 2s?

It seems like you could consider some new strategies to become better engaged with your community possibly through organising some training on community engagement. This is something the Evelyn Oldfield Unit could support your team with.

3s?

You are doing well but there is room for improvement. Look at the questions where you score low and consider whether practices could be changed to better engage with the community. Again you can get further training and support from Evelyn Oldfield Unit and for psychologists, from the Community Psychology Section of the British Psychological Society.

For those with mostly 1s,2s and 3s consider the following:

The term community engagement reflects the process of involving communities in decisions that affect them through establishing community champions, neighbourhood committees, citizens' panels, etc. The involvement of local communities in health-related activities has been proven to be vital in improving health and reducing inequalities, particularly for those experiencing disadvantage.

Considering the diverse approaches of community engagement, as reflected in the five areas of the toolkit, the direct and indirect influence on health and wellbeing is dependent on the approach used. For example, the approach of informing or consulting communities may have a minor impact on community's health and health literacy, but it will certainly improve the accessibility and uptake of services. Wellbeing benefits may be even stronger when the community is encouraged to work as an equal partner or when some power is delegated to them. This is achieved by improving people's sense of belonging to a community and empowering them to take a more active role in the running of services that they use.

4s and 5s?

You have exemplary practice and should be sharing this with others!