Social care in the community

Engaging communities to improve mental health in African and African Caribbean groups: a qualitative study evaluating the role of community well-being champions

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What is known about this topic

- Inequalities exist in (mental) healthcare experience among African and African Caribbean groups.
- Community engagement fits within a framework of action on the social determinants of health.
- Community health champion approaches are reported to improve individual health outcomes.

What this paper adds

- Insight into how community and well-being champions (CWBCs) can be instrumental in a cultural shift in African and African Caribbean communities towards healthier and more integrated living.
- CWBCs' own assessments of their training and support needs, and practices aimed at delivering community engagement interventions.
- It highlights resistance to engage in the community project which was imputed to the stigma associated with mental health.

Abstract

Over the last decade, Britain has undergone reforms to promote engagement in local structures of governance. These reforms have encouraged the promotion of active citizenship and have been central to the government's public service modernisation agenda. This article presents the findings from a study evaluating a pilot outreach intervention which adopted a community engagement model to address the mental health needs of African and African Caribbean groups, which entailed a partnership between faith-based organisations, local public services and community organisations to co-produce the pilot project. Lay people were trained to raise awareness about mental health among these communities in South London. Between 2012 and 2013, a qualitative participatory approach was used to evaluate the pilot project, which enabled a researcher to take part in the engagement phase of the pilot project, and the project co-ordinators to be involved in the research process. Semi-structured, one-to-one interviews were carried out with 13 community and well-being champions (CWBCs) recruited from African and African Caribbean communities (seven male and six female). This study examines the impact of the relationship between the intervention and community through the participants' engagement in the pilot outreach project and the action undertaken as champions. We found that although CWBCs used *circles of influence* to share ideas about mental health and well-being and to encourage change, they encountered resistance on the part of the people they engaged with, which resulted from a lack of knowledge about mental health, taboos and ascribed stigma. We argue that CWBCs acted as healthy examples to communicate mental health knowledge to those approached, but that they needed to be equipped with bespoke communication skills to be able to talk about such sensitive issues as mental health.

Keywords: community well-being champions, Black minority groups, empowerment, community engagement, evaluation, mental health

Introduction

Mental health is more than the absence of mental health problems; it is the foundation for well-being and effective functioning for an individual and for a community. The World Health Organization (WHO 2001) conceptualised mental health as:

…a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community. (p. 1)

Inequalities in mental health in African and African Caribbean groups

Social determinants such as poverty, inequality, lack of education and unemployment have an impact on mental health (Patel & Kleinman 2003, Lund *et al.* 2010), with research demonstrating a relationship between income inequality and prevalence of mental health problems in developed countries such as the US and UK (Picket *et al.* 2010).

A key finding in the UK literature on inequalities in health is the high admission rates of African Caribbean people to psychiatric hospitals with a diagnosis of first-episode psychosis (Bhui *et al.* 2003, Morgan *et al.* 2006). A recent survey demonstrated that the proportion of African Caribbean service users was double that of African service users (CQC 2011). The range of interpretations include: the ethnic differences in health explained in relation to the processes of migration; to genetic differences and culture; the socioeconomic inequalities and the impact of racism; the methodological flaws in the existing research; and the uptake and experience of disadvantaged ethnic minority service users (Nazroo & Iley 2011).

Keating and Robertson (2004) have argued that 'black people' are held back from seeking help by what they have identified as a vicious circle of 'fear of psychiatric treatment or services' (p. 439), which coupled with their belief that mainstream mental health services cannot offer 'positive help' (p. 446) conspires to make them estranged from services. African and African Caribbean communities favour mental health resource centres staffed with individuals from the same ethnic groups who look 'at the world from their clients' perspective' and share 'something of themselves' (Secker & Harding 2002a, p. 275), over traditional types of services such as inpatient services (Secker & Harding 2002b).

Experiencing mental health problems can have a long-term impact on a person's life. Even a single hospital admission, period of sickness or absence from work can lead to unemployment, homelessness, debt and social isolation, which, in turn, can trigger worsening mental health and a cycle of exclusion, with stigma and discrimination being an underlying cause for social exclusion (Social Exclusion Unit 2004).

Lay workers' roles in public health

There is a long history and growing evidence based on the involvement of lay people in public health settings which highlights a range of roles (e.g. health workers, health trainers, peer educators, health advocates), focusing on different areas of health (e.g. smoking, diet, sexual health, mental health) for a wide range of target groups (e.g. women, disadvantaged, prisoners, migrants) (South *et al.* 2010a, Stacciarini *et al.* 2012, Tran *et al.* 2014). In mental health settings, it is the peer worker figure that has played a central role in mental health services across the western world (Castelein *et al.* 2008, Daniels *et al.* 2010, Franke *et al.* 2010, Scott *et al.* 2011, Faulkner & Kalathil 2012). Peer workers are people who have personal experience of mental health problems to support others in recovery (Davidson *et al.* 2012), though like other lay figures, they are trained and employed to work in a formalised role (Wallace *et al.* 2013).

Community engagement initiatives to address inequalities

Community engagement approaches have become a growing component in the British public health system (NHS Confederation and Altogether Better 2012) with community health champions (CHCs) becoming a favoured method of engagement to address a variety of issues (Woodall *et al.* 2013). They are part of a wider public health workforce linked to networks embedded in the local community to provide support to public services, which brings a culturally sensitive perspective to the service they provide (NICE 2008, White *et al.* 2010). CHCs are lay people who have the experience and competence to engage and encourage others, both individually and at the level of the community in health promotion campaigns (Firth 2013). The act of being engaged is the intervention which is intended to bring about a change in people's behaviour. Tapping into local circles and networks as a starting point to improve health is a method to make an impact within the champions' own *circle of influence* of friends and family (Warwick-Booth *et al.* 2013). Primary qualitative research of a national

programme (Altogether Better) employing the CHCs' method of engagement reported the direct and indirect benefits of engagement (White *et al.* 2010, Attree *et al.* 2011, Woodall *et al.* 2013, South & Phillips 2014).

Description of the pilot intervention

The community and well-being champion (CWBC) project (a role equivalent to CHC) was part of a wider community development programme taking place in South London, which entailed cross-sector partnerships between primary, secondary and third sectors. The local public health commissioned the pilot project from faith-based organisations (FBOs) in the area, which was then developed and delivered by a newly set up community organisation. The pilot project espoused an empowerment model, whereby the local groups identified mental health needs, and mobilised themselves into action to address the recognised inequalities through employing and training CWBCs as a method of engagement and delivery of the intervention (Mantovani et al. 2014). Their objectives were to educate African and African Caribbean communities about mental health through local community capacity building.

The development of the pilot project progressed over a period of 15 months (January 2012 to March 2013) during which time relationships with the leadership of the local (FBOs) and other community organisations (COs) were built to gain their buy-in to the programme. FBOs were the primary route through which to access a broad cross-section of African and African Caribbean communities to mobilise/engage them. Awareness events were held in partnering FBOs and on one occasion in a local college and also a CO for single women. Other strategies included workshops, delivering presentations, showcasing at relevant local conferences and through meetings with pastoral teams at local FBOs. These activities were aimed at sensitising these communities to the current knowledge about mental health while at the same time identifying and recruiting potential CWBCs.

The 40 events undertaken resulted in partnering with 10 organisations (eight FBOs, two COs) and the recruitment of 13 champions (nine through FBOs, four via word-of-mouth). Volunteers were trained to build community leadership capacity, with training consisting of four full-day and four half-day sessions over a 4-month period which were delivered by staff from the local Mental Health Trust and the project co-ordinators. The curriculum consisted of: foundation skills (e.g. journaling, individual reflections,

effective communication and listening, and to help people); the role and function of CWBC's; mental health awareness in sub-communities; specialist skills (Mental Health First Aid); improving mental wealth and self-management; improving access to psychological therapies (IAPT); leadership building; and action learning enquiry circles.

Methods

This study seeks to build an understanding of whether and how lay contributions from CWBCs have impacted on the social determinants of mental health, including the system within and through which the intervention was delivered. The evaluation design reflected this conceptualisation by adopting a logic model (Baxter *et al.* 2010) to explain the non-linear, reciprocal relationship between community engagement processes and the social determinants of mental health. The participatory approach (Johnson 2006) adopted entailed recruiting a research assistant from within the African community living locally, participating in a number of community events to ensure a community focus in the evaluation, and partaking in periodic meetings with the project co-ordinators and their involvement in various phases of the research process. The researchers were not part of the project development team as the community project had commenced 6 months earlier than the evaluation study.

While the main study employed a variety of methods to collect qualitative data with a number of different stakeholders, the data presented here are based on semi-structured, face-to-face interviews. Convenience sampling strategy was adopted and all the CWBCs who subscribed to the community project were invited to take part in the study. Thirteen of 14 CWBCs agreed to be interviewed; interviews were conducted between mid-April and mid-July 2013. Participants were recruited via eight geographically adjacent FBOs of differing Christian denominations, which were the churches that had 'bought-into' the pilot programme. The recruitment process was facilitated by the pilot organisers who sent an invitation letter, together with an information sheet explaining the purpose of the study to the identified participants. Interviews sought to assess their experiences of engagement and participation in the community project. Project co-ordinators introduced the study to CWBCs by e-mailing them an information sheet about the study.

The female researcher conducted interviews with female CWBCs and the male researcher with males. Although matching ethnicity of researcher and partic-

ipant may increase comfort levels and disclosure (Whaley 2001, Sherman 2002), it does not guarantee quality of data or rapport (Daily & Claus 2001, Springman et al. 2006). Participants were interviewed in the FBO they were linked to, and in doing so added contextual and interpretive information to the interview (Hyden 1997). The topic guide included questions related to undertaking the role of champions, the reason(s) for engaging in the community project, the approach adopted in engaging with people, the challenges encountered, the benefits to themselves and those of the community they served.

Interviews were digitally recorded and transcribed in full. Analysis involved a detailed reading and re-reading of the transcripts to identify the main descriptive themes in NVivo software, and an initial coding framework was developed. Through an iterative process considering patterns, similarities and differences (Sim & Wright 2000), the coding framework was then refined, and an analytical explanatory framework was developed and applied to all semi-structured interviews.

Governance

The evaluation was designed to recruit only CWBCs who had consented to take part in it when they became involved in the programme. The evaluation was guided by the *Ethics in Qualitative Research* (Miller et al. 2012). The community organisers were involved in the design of the document intended to inform participants about the purpose of the study, what taking part would involve and what would happen to the information collected. Participants received this document prior to being asked to take part in the evaluation. Once they agreed, they were requested to sign a consent form to confirm that they understood the purpose and conduct of the evaluation. In accordance with the St George's University of London (2009) Research Code of Ethics, data were anonymised. All identifying information about the participants was kept separately from the evaluation data. The conduct of analysis and report writing were based on anonymised data.

Findings

The following sections report our analysis of the CWBCs' narrative accounts of their experiences of engagement in the community project. We begin by describing the participants of the study. We then highlight their motivations to engage, the practices undertaken and the resistance encountered, the

CWBCs' own assessment of the development of the project, and the impact they thought the project had on themselves and the community they lived in.

Participants' description

We recruited 13 participants (seven men and six women). The age ranged from 24 to 75 years (mean age 49). Nine participants were of African Caribbean background – of which five were British-born, and four were of African origin – of whom three were British-born.

Their employment status and type of jobs were heterogeneous: three participants were unemployed and doing voluntary work, seven were in employment (five part-time, two full-time) and three were retired. Six worked or had worked prior to retirement in the public sector (five in health, one in teaching), two worked in the private sector (e.g. retail) and two worked in the community as community leaders as they were practising pastors.

Participants were active members or affiliated to eight different Christian FBOs that were geographically adjacent: 10 participants practised Pentecostal faith, one was an active Anglican member, one practised both the Methodist and Baptist faiths and there was one Adventist. Six of those practising the Pentecostal faith belonged to the same FBO that received the funding for the pilot community project.

Motivation to engage in the pilot project

The enthusiasm of participants for their role as CWBCs came across strongly and many were passionate about it. Participants had become involved in the community project mainly for three reasons: they saw the potential for personal development, they wanted to help others, or for biographical reasons (given in combination or as single reason). Some had anticipated that their involvement could be a route for personal development in terms of gaining new skills, experience and ultimately getting a paid job. Others 'wanted to understand' mental health so as to make 'a positive change' in their communities. Those who cited biographical reasons (five) specified the deep impression that dealing with friends and family with mental health problems had made on them. A former teacher said that he had witnessed 'too many cases of mental ill-health among young males', which needed action. By contrast, a personal belief about bringing the service user perspective into the planning and development of public services was also mentioned. Altruism and personal belief can be gauged below:

I'm really interested and passionate about mental health and if I can make a difference even to one person, or be available for one person to talk to, in their time of stress or to give ideas or even to direct them to the right organisation or the right community support them. If I can educate somebody about it, I think I would have done my job. (Ch11, female, 33, African Caribbean)

The idea of becoming a champion rang true to me in the sense that I've always believed in continuing ... in terms of being able to champion the (service) users' perspective to the Health Services [...] I've been keen to sort of bring that about really, because the way to the Health Service tends to be kind of configured. (Ch13, male, 57, African Caribbean)

Community in action – champions' practices

This section examines the CWBCs' practices and the range of activities they undertook. Although at the time of the interview many participants had only recently begun to apply the training in practice, we found a wealth of evidence illustrating the type of actions they engaged in to fulfil their role. To combine work and other commitments with the role of champion was difficult for many.

The participants' accounts of practice highlight that they primarily operated within their *circle of influence* (Warwick-Booth *et al.* 2013). Those CWBCs who had an active role in their local FBO used its congregation as a route to access and approach people to talk about mental health. They also used existing networks linked to the FBO they were associated with to access and engage with people. Nevertheless, those who were 'not necessarily embedded in a church community' engaged with people they knew from their immediate circle such as family, friends, neighbours or work colleagues. Generally, CWBCs did not engage with people they did not know or people of the opposite sex; only a couple of CWBCs approached people outside their close social circle:

I'm going to be honest. I wouldn't say I've necessarily approached a stranger. But within my own family and my own community, as in the church, and own friends, but not even just them, even at work, we talk about it ... I'm from the community, so the majority of them ... will be from that community. (Ch11, female, 33, African Caribbean)

Different modes of communication to raise awareness about mental health and well-being were adopted by CWBCs. Strategies embraced were formal group work and informal one-to-one conversation. Primarily, CWBCs favoured group interactions to one-to-ones which may indicate the difficulty they encountered in engaging people in conversation about a sensitive health issue. The excerpt below illustrates how different modes of engagement produced different responses:

Often time when I've engaged, especially on a one-to-one, 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?' And then when the presentation takes place, they then realise that it's their preconceived idea and their first thought when they hear the phrase 'mental health and well-being' that they realise where we're coming from [...] So, the initial response changed by the time the presentation finished. On a one-to-one, I very rarely mention mental health. (Ch09, female, 58, African Caribbean)

Participants had different styles of intervention which can be divided into: (i) talking to people informally about mental health as part of their daily lives; (ii) providing more intensive support to individuals; (iii) imparting knowledge on how to take control over one's own health; and (iv) partaking in or managing/leading activities, groups or events in the associated FBO. Participants were 'able to engage on various levels with various individuals' to help them 'to be aware of their own mental well-being' and discuss 'thriving and surviving' strategies. Personalised and knowledge-based approaches can be seen here:

I feel sometimes that people want to talk about it – stressful familial relationships – especially in the one-to-ones, people want to talk about those things. It's like releasing. (Ch06, female, 70, African Caribbean)

I've been able to counsel someone in a friendly way. And it was approaches like: 'What do you want to achieve from this conversation? How would you know that your needs have been met?' [...] So, basically, allowing them to question themselves, giving themselves self-help. (Ch02, male, 24, African)

Resistance to talking about mental health

Narrative accounts of engagement and the activities undertaken reveal the negative responses that some CWBCs experienced. According to them, resistance to engage resulted from people's lack of knowledge about what mental health is, which fed their misconception(s) that linked all talk about mental health to the extreme end of the spectrum and conditions such as 'schizophrenia or insanity'. Others imputed the resistance they encountered to people's denial about having a mental health problem, which, as a result, led them to distance themselves from it. They did 'not want to talk about it', thereby creating 'a block' to engagement:

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 [...] I've put on a mental health conference here and nobody came. (Ch07, female, 75, African Caribbean)

Resistance to engage may be ascribed to the stigma associated with mental health (Clement *et al.* 2014). It has been shown that mental health can be considered a taboo subject within African and African Caribbean communities (Hopkins 2003, Gordon 2013), which may have had an impact on engagement. Evidence on health trainers intervening in matters of sexually transmitted infections (STIs) in local populations shows poor engagement which was imputed to the stigma associated with STIs (Cook & Wills 2012). The taboo surrounding mental health and feelings of shame are likely to have deterred some individuals from engaging with CWBCs:

They still cannot accept that – having someone in the family with mental health [...] Families want to keep their business, as they'll see it. You don't want to wash your linen in public. So it's stigma. Fear and stigma and a kind of self-loathing, I think. They are the three things that have bedevilled the black community. When I speak to people I am amazed how it comes across. It's almost like a release when they speak about it. (Ch01, male, 68, African Caribbean)

Lacking tools to address sensitive issues

Participants spoke openly about a feeling of inadequacy which they attributed to a range of factors. Six participants felt they did not have the tools to be able to confidently broach the subject of mental health; three of them specifically imputed this to the training which they felt did not prepare them sufficiently to converse about sensitive issues such as mental health, while another ascribed it to his personal nature and poor attendance at training. The self-doubt brought about by engagement can be witnessed here:

The challenge was mostly about me because, first of all, I'm not a talking person and it's a challenge to me. And because I don't have enough knowledge [...] it became a challenge to me that I couldn't fully express even the little training I did have and put it in practice [...] I didn't get involved fully in the training, so, it had an impact on me as well, saying that I'm not well prepared for that. But it's about confidence as well. I have to fight, to be bold to approach the community. But I just need more equipment (training) in case the community starts asking more questions to find out more and if I don't have any answers, it would not be a great idea to just go and engage. (Ch05, male, 27, African)

Feeling inadequate for the role – whether resulting from insufficient preparation or personal inhibitions – may be viewed as a negative aspect of becoming a CWBC. Research has reported that engagement may have negative consequences if champions are inadequately supported or if their expectations are not met (Popay & Finegan 2006, Dinham 2007).

Direct and indirect beneficiaries of community engagement

People can benefit from community engagement and/or public interventions. O'Mara-Eves *et al.* (2015) identified the *engagees* as the direct beneficiaries – those who take part in the community engagement – and the wider community towards which community engagement and/or public health interventions are targeted, as the indirect beneficiaries. Similarly, CWBCs reported personal benefits and wider benefits to communities.

As a result of their participation, 11 participants had acquired more knowledge of the conditions that contributed to maintaining and improving mental well-being, and had become better at 'spotting things sooner'. Knowledge informed the changes that six participants had made in their day-to-day lives, in relation to their own lifestyle choices and/or social relations; they 'had started re-educating' themselves. Participation was also a source of psychosocial benefits; 10 participants detailed how their active engagement had bolstered their self-confidence and self-esteem, with some feeling they had become better people. Beneficial changes are illustrated here:

I have more knowledge. I'm taking time out, I'm taking exercise, examining my own lifestyle, the way in which I do things ... because it really has impacted me doing this programme and it really has made me feel ... it certainly has built my self-esteem because before I was fairly shy but now. (Ch09, female, 58, African Caribbean)

Participation also acted as a catalyst for personal development. Five participants spoke of the potential opportunities that this role had opened to them, such as gaining future employment in 'jobs to help people'. Eight anticipated that they would improve their current professional and personal condition as they had acquired skills they foresaw as transferable to other contexts, or career enhancement. Furthermore, all the participants spoke of a sense of empowerment resulting from their participation. Not only could they now take control over their own health and mental health but also with the knowledge and techniques acquired, they could help others:

I feel I've got a raison d'être to go to the black community and say: 'I am trained as a champion ... to bring the issue of mental health and well-being in our community'. To help us to help ourselves, because no-one is going to come to

help us [...] There is no one who's championing black peoples. They'll tell us what's wrong when there is a crisis, how much it's costing the Health Service; directing us. So, I feel confident enough to say to people: 'I think we have to do it ourselves and we can do a lot of it ourselves'. (Ch01, male, 68, African Caribbean)

The indirect beneficiaries of the work the CWBCs had been trained to do were the African and African Caribbean communities. The 13 CWBCs who were embedded in existing formal and informal networks formed a network structure (a resource) through which well-being messages could be communicated. There was evidence that this web of networks and connections was supportive of the needs of the local community. Ten participants spoke of the relations of help they had established that went beyond the first encounter. Some acted as a 'bridge' with public services; five reported referral practices to primary care services (three to IAPT services and two to general practitioners). Others recounted that as a result of their intervention, people 'took on board' their advice, which had a beneficial effect as the person 'was not feeling as depressed as before'.

Through their practice, CWBCs formed new social networks and strengthened old ones. They did not speak of social capital per se but CWBCs recognised the significance of social networks, or group activities, or linking people into services to people's mental health. These networks also became hubs through which CWBCs exchanged practices, could meet people from different walks of life and professions and learn from each other's experiences:

It was an opportunity to build networks, to build understanding as well. It's given me a lot of insight from different points of view, because it's attracted a large mix of people who all have different specialisms and who all have a different flavour in terms of their own networks and their own communities, sub-communities of people. Whether it's because of being former teachers, being former nurses, being pastors [...] I think a lot of other people who are champions are very proactive in their own sub-communities and that, in itself, is a very inspiring and empowering experience to witness or to hear how people are engaging in their own groups with people around mental health. (Ch04, male, 38, African)

Discussion

This paper sets out to highlight the findings from a thematic evaluation of a community-based intervention focusing on mental health and well-being. This intervention involved lay people taking on the role of CWBCs and was accomplished in faith-based communities. The option to involve the black churches in the realisation of a project for the promotion of health among minority populations (Asomugha *et al.* 2011) and addressing health inequalities was due to their pre-existing support networks and high amount of social capital (Campbell & McLean 2002). The study intended to examine the key features of the CWBC approach to engagement, and to scrutinise the evidence of the impact that this type of intervention can have on individual health behaviour. It points to practice for future development of this type of outreach work. One strength of the design was the in-depth interviews with the participating CWBCs, which allowed a comprehensive view of the champion role and the mechanisms underlying the empowerment model.

This evaluation provides evidence of the emergence of a new body of practice in South London, where individuals take a more active part and engage more with service development and delivery (WHO 2010, Woodall *et al.* 2012). Community well-being champions were instrumental in bringing people together and initiating community change while contributing to social capital. They helped to form and strengthen existing social networks within communities, which have the potential to create a cultural shift in these communities towards a healthier and more integrated living (White *et al.* 2010). This is corroborated by empirical evidence from US outreach interventions adopting *promotoras* (lay health educators) to improve mental health in hard-to-reach groups (Tran *et al.* 2014).

The support for emerging practice highlights that CWBCs were resourceful as they formed self-supportive network structures to exchange practices. Nonetheless, by their own admission, some did not feel fully prepared to break the wall of silence surrounding mental health among their own communities. It is often difficult to gauge the level of training that is most effective in engagement programmes (South *et al.* 2010c), but where community champions receive support, research shows successful engagement (White *et al.* 2010) as training and support are critical to translating these approaches into practice (WHO 2010, Stacciarini *et al.* 2012, Woodall *et al.* 2013). In addition, the stigma ascribed to mental health impeded the CWBCs' engagement despite being recruited from within the communities the intervention was supposed to serve. Bottom-up approaches to engagement are supposed to provide culturally appropriate ways to communicate health messages (Andrews *et al.* 2004, Woodall *et al.* 2013). Nevertheless, considering that stigma can discourage people from early help-seeking (Link *et al.* 1997, Thornicroft *et al.* 2009), it may have acted as a mechanism

for social exclusion (Ritsher & Phelan 2004) and disengagement. Resistance was a barrier to these communities' engagement, which was imputed to a fear of being labelled insane and the consequent attribution of stigma. Powerful and pervasive, stigma mental illness makes it hard for a person to admit that s/he has a mental illness, to talk about it to others and to seek help (Clement et al. 2014).

The impact of community engagement was evidenced by the direct benefit to the CWBCs and indirect benefits to the community. Although the focus of the CWBCs' work was raising awareness about mental health issues in others, the CWBCs who were actively involved and utilised community engagement approaches experienced positive benefits in terms of psychosocial and emotional health, well-being and individual empowerment (defined as the feeling that they are being useful to others, feeling in control of events, being able to express ideas and having an awareness they were addressing inequalities among their community). These findings chime with the wider literature on lay involvement and the impact this has for participants (Andrews et al. 2004, Rhodes et al. 2007, Casiday et al. 2008, Stacciarini et al. 2012, Tran et al. 2014). In addition to this, the pattern of communication exhibited by CWBCs mirrored a circles of influence (Warwick-Booth et al. 2013) approach, as they tapped into existing social networks, circles or connections to deliver well-being messages, thereby building on and strengthening the existing networks and resources. Social support was a mechanism for supporting behaviour change through enhancing social relationships and promoting coping responses (Dennis 2003, Andrews et al. 2004, WHO 2010, Tran et al. 2014).

As a network, the CWBCs were a resource to the community and the communities they served. Through their grass-roots knowledge, they were able to provide people with appropriate support and to connect them to other community resources and sources of help. They linked people into primary care services, thereby improving access to services to a number of people. Bottom-up approaches are favoured by minority ethnic communities (Andrews et al. 2004, Thomas et al. 2006) as they reduce communication barriers; lay workers can find it easier to reach and be understood by their target group than professionals (Stacciarini et al. 2012, Warwick-Booth et al. 2013, Tran et al. 2014). Increased social networks might lie on a causal pathway that leads to better health (Nutbeam 1998). The benefits of champions in influencing the health of the wider community are also reported in Woodall et al. (2012, 2013) and South et al. (2010b).

Our findings should be interpreted with some caution. Although this qualitative approach provides an in-depth understanding of the CWBC's role in improving the health and well-being of African and African Caribbean communities, because of budget and time limitations, the longitudinal effects of the early intervention programme and the effects of the engagement strategies within this population could not be measured. It is often challenging to capture impact when mental health and well-being is being promoted both informally and using brief interventions. A policy move to invest in local communities' involvement in health-related activities for those experiencing disadvantage can be a promising way to reduce the social gradient (Marmot et al. 2010) of mental health among the disadvantaged, provided bespoke communication skills are offered. This may combat the overall resistance to talking about mental health in African and African Caribbean groups, and to break down the stereotypes that are detrimental to help-seeking behaviours.

Conclusion

Lay workers have a unique advantage in accessing hard-to-reach groups as they are embedded in local community networks (Tran et al. 2014) and can make a contribution to multidisciplinary public health (Taylor 2007) while overcoming barriers created by professional culture. However, the reality is more complex (Chiu & West 2007): there are unaccounted factors to be faced – that potentially constrain the reach and/or effectiveness of champions – such as the characteristics of the champion, community, training and the sensitive/stigmatising focus of the intervention. Our research illustrates that the project achieved its objectives to build community capacity through the creation of a network of trained champions to raise awareness about mental health problems in their communities. Further research is needed that adopts measures and designs that capture the transformative changes within community engagement approaches, irrespective of whether those changes take place at the individual or at the community level.

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