COMMUNITY DEVELOPMENT IN HEALTH – A SCOTTISH PERSPECTIVE

A recurring theme in both Consultative and Policy papers from the Scottish Executive has been the aspiration to "***place patients and communities at the heart of its policies***"(1) and a consequent demand that those involved in policy planning, development and service delivery find ways to engage more effectively with individuals and the wider community. Although the spectrum of that engagement may range from formal consultation to devolution of decision making there can be little doubt that this insistence can and does place considerable challenges for those involved – challenges to professional attitude and value base, skill base, understanding of methodologies and resourcing necessary to support and sustain such engagement.

The NHS and wider health sector in Scotland has not been exempt from these demands and faces similar difficulties in responding to this new agenda. This article seeks to demonstrate that the understanding of and application of community development practice should be an essential approach for those charged with driving forward the modernising agenda. Examples of current good practice and the clear and measurable benefits brought by the use of community development will be identified as will some of the tensions and issues raised by the use of that methodology.

Policy Context.

The White Paper, ***'Designed to Care'*** (Dec. 1997) was the first White Paper containing the Labour Government's proposals for re-structuring the Health Service. Introduced prior to the introduction of the Scottish Parliament, '***Designed to Care***' set out the first steps towards involving patients and communities* in the delivery of NHS services in the primary and acute sectors. Together with a raft of measures on restructuring the NHS, it introduced the local Health Improvement Programmes and Local Health Care Co-ops. Although, there was no pretence about partnership working with communities, there were initiatives for opening up decision-making on NHS services to the wider community. Health Improvement Programmes were given the key role and status to become the principle mechanisms at the local level for creating major and sustained impact on health problems. Along with community planning and social inclusion partnerships, they are the key mechanisms for community and voluntary organisations to influence local decision making on health priorities.

*Communities are referred to in this article as local residents or individuals with a common interest that does not include, public sector services, council members or officers or the business sector.

(1) A Plan for action, a plan for change Scottish Executive 2000 This Plan is not just another Government policy document. It is a plan for action and plan for change. And it is addressed directly to communities and patients: the people who value health and healthcare services and the people whose views count most. The views and opinions of the public are at the heart of this Plan.

Decision making was also devolved through Local Health Care Co-operatives (LHCCs) with their responsibility for "***breaking down the boundaries between health professionals, promoting greater structural integration across the while range of primary care services involving patients and the public effectively in NHS services***". Although, primarily in the hands of G.P.s' and other clinical staff, LHCC's provided the potential for community and voluntary organisations to affect decision-making on the development of local primary care services and prescribing budgets.

This was followed by the White Paper aimed at tackling health inequalities - **Working Towards a Healthier Scotland** (1998). The White Paper did not specifically promote community development, but instead took a more generalist approach:

'Strong, healthy and safe communities – a key objective for this Government – are most likely to flourish where goals are shared, views are respects and people are part of new initiatives. Every part of the community has a contribution to make to better health. The challenge is to foster a healthy climate and ensure that local programmes are effectively co-ordinated'.

Most importantly, within the political agenda, it did signal a departure from the historical concept of the NHS existing only to treat illness and acknowledged the links between ill health and poverty. It addressed the physical, mental and social dimension of good health and targeted three action levels - Life Circumstances, Lifestyles and Priority Health Topics. Allied to this was the recognition that tackling health inequalities should underpin every policy and programme affecting health and that the NHS must work in effective partnership with all those who have an interest or a responsibility for good health. However, the limited acknowledgement of new ways of working and the resources required to bring about culture change in partnership working with communities, resulted in community health initiatives remaining on the periphery of mainstream services and community development approaches generally being used only by those already committed to the practice.

In 1999, the Scottish Executive Social Justice Minister published "***Social Justice…. A Scotland where everyone matters."*** Promoted as the over-arching strategy for health, economic development and education, it laid down specific targets and milestones on each area of responsibility. It advocated an integrated, partnership approach to the promotion of social inclusion in all areas of health and social policy. Significantly, community and voluntary organisations would be recognised as having a key role in bringing this about. Commitment was given to involving the most excluded groups

"Above all, the involvement of the excluded was seen as critical, not only their input, but also their ownership and sense of responsibility for the process."

Clear commitments were beginning to emerge that would create significant opportunities for community development to provide a pivotal role in working across sectors on health

improvement, particularly in building on the five principles of integration, prevention, understanding, inclusiveness and empowerment outlined in the strategy document.

But, to what extent was the Social Justice Ministry talking the same language as the NHS and Scottish Executive Health Division? Despite reassurances on '***joined up'*** thinking and working, it seemed to the lay person that commitments, approaches and priorities were operating in non convergent streams. The use of language in the Social Justice Strategy seemed quite different from ***Working Towards a Healthier Scotland***. It stressed ***"working in partnership with communities on health inequalities",*** while policies from the Health Division talked about ***"patient focus and public involvement in health care"***. The challenge for community development workers was to identify the common themes and test out commitment to principles of community empowerment, partnership working and inclusive ways of working.

Patient Focus and Public Involvement in health care continued to be prioritised in ***'Our National Health: A plan for Action, A Plan for Change'*** *(Dec. 2000)*. The Plan moved beyond ***'Towards a Healthier Scotland'*** by specifying ways in which action would tackle health inequalities. While the Plan recognised that ***"community development and community action are essential elements in this process"*** and declares that ***"we will encourage the local initiatives and projects that drive forward that approach",*** the key section on ***'Involving People'*** however, opted to focus on patient and public involvement. Despite a rather fragmented collection of different initiatives and approaches on building capacity and communications, patient information, involvement and responsiveness, there was an opportunity for community development to be utilised as a recognised and credible approach to involving people in NHS services.

'A Review of the Contribution of Nurses, Midwives and Health Visitors to Improving the Public's Health in Scotland' (Jan. 2001) promoted some of the clearest and most specific proposals for involving NHS staff in community health work. It recommended that while nurses should not be working as community development workers they should be using community development approaches and finding new ways to work alongside existing community development projects.

It also recommended a new staffing resource for LHCC's, which has had significant implications for community development. 'Public Health Practitioners', were given a key role in developing work with local communities and on reducing inequalities.

Similar to Local Strategic Partnerships in England and Wales, Community Planning is the local mechanism in Scotland for streamlining, integrating and improving services delivery on all cross cutting responsibilities such as health. Community Planning is given the pivotal role for decision-making on priorities by public sector and community and voluntary sectors. The responsibility of local authorities, the process is now maturing to provide the platform for principle stakeholders including community and voluntary organisations to influence the delivery of services.

Much emphasis is being placed on public sector agencies developing partnership working with communities. Whereas, other health and social policies have tended to characterise working with communities in terms of community consultation, or community involvement, community engagement is now being promoted as the preferred option of the key agencies. There is recognition to move past the stages of merely consulting on proposals to negotiating and decision-making on mutually agreed priorities between service providers and communities. The message from the Scottish Executive and Convention of Scottish Local Authorities (CoSLA) is that communities should be directly involved in decision-making processes, with appropriate mechanisms and resources to ensure participation.

Engagement must be genuine. Community Planning partners need to demonstrate real commitment to engaging communities – with an acknowledgement that one-off consultations with the 'usual suspects' is likely to do very little bring about community ownership of shared vision of well being. They will want to work widely and in depth with their communities, making best possible use of the different methods techniques now available for facilitating effective participation. (Local Government Bill: Guidance Effective Community Engagement (revised draft, 28.2.02)

In Spring 2003, the Scottish Executive launched a White Paper on health – ***'Partnership in Care'***, quickly followed by ***'Improving Health in Scotland – the Challenge'*** and it was hoped by community development workers that they would give far greater recognition to the strategic implementation of community development practice across all health improvement activities. Since previous NHS policies had paved the way for community development, expectations were high that these new policies would consolidate commitment to methods and values and recognise the additional health benefits for individuals and community groups in participating on collective approaches to health.

Both documents did prioritise public and community involvement and the 'Challenge' document in particular promotes 'community-led' health in 'supporting and developing healthy communities. However, in the implementation of policies, the *development agenda* both in terms of working with community groups on their health priorities and actively supporting groups in local decision-making in conspicuous by its absence! While there is acknowledgement and support for methods and approaches which enhance capacity building for community involvement in NHS structures, there is limited recognition of community development's role in assisting community organisations and their partners in turning 'involvement' into robust partnership working across different structures including local authority and voluntary and community sectors. Also missing is the recognition that community development practice has the potential to influence processes and structures that enable decision-making and resource allocation, which give equal weight to community priorities.

Comment

This policy synopsis reflects a number of mixed messages from the Scottish Executive on the nature and extent of community involvement in health. On the one hand we have policies that actively encourage partnership working with communities, while on the other there is a leaning towards involving people in agendas that are set by national and local policy makers. Therefore, the question remains as to what extent community development practice will be readily embraced by all agencies and organisations with a responsibility for delivering the health agenda. Despite an increasingly supportive policy environment, different interpretations and values placed on community development present significant challenges in ensuring consistent strategic implementation across the wider health sector, along with adequate resources to support the development of good practice.

CHALLENGES

The experience and evidence of many meetings that the Community Health Exchange (CHEX) Network has participated in with service providers point to misunderstandings of the community development process and what it can achieve. To deride such misunderstandings brings no advance and it must also be accepted that some practice described as operating to community development principles has been both weak in the articulation of those principles, the evidence of their application and the evaluation of their outcomes. Recurring evidence of this especially relates to image, use of language, power sharing, perception of political motivation, and professionalisation of community development located within particular public sector services. For example:

- *"what we're interested in is capacity building and social capital. Community development is old hat, it reminds you of well-meaning students with Jesus sandals or donkey jackets"!* **Health Practitioner at 'Tales from the Field' event 2001.** The image, use of new language and application of new concepts have gone some way to undermine the understanding and acceptance of community development. The assumption that capacity building is not part of community development and that enhancement of social capital is not a positive outcome from community development interventions is an anathema to most community development workers.

- "*community development can encourage local people to make new demands on services, and create expectations that we probably couldn't meet*" **G.P. at Action/Research Seminar, 2001** The fear that patients and community groups will make new and unrealistic demands on resources is a common experience by many service providers.

- *'community development is too radical, it embraces politics and we just want to involve people in and help them to participate in health services"* **Health Policy Maker, Health Inequalities Seminar, 2002** The fear that community development propels community members into radical political activisms appears to be derived from the historical myth of community activisms. While there are examples of local people becoming active in left wing politics, the evidence shows that for the majority of people as they do become more politicised and skilled at negotiating within decision-making structures, this is a positive asset both to service providers and the wider community.

- *"we don't have a history of community development, we are more geared towards providing services for patients and ensuring that they get the best attention and advice.* **Health Practitioners at Community Development Health Seminar, 2002** Community development practice, although more commonly associated with the voluntary sector became 'professionalised' within the public sector mainly through Social Work and Community Education in the 1970s. In recent years, while there has been a shift in some strategic and operational support through health, housing and regeneration, this comment reflects a perception that community development is associated only with specific services and not understood as an approach which to tackle crosscutting issues such health inequalities.

Although these comments are from individuals they are indicative of more widely held beliefs and perceptions and as such present real and significant barriers to the adoption of community development practice. The challenge for those advocating community development is to more clearly demonstrate the tangible and unique benefits that are brought by its use in working with communities. Evidencing these benefits, particularly to those in health services and for who research and evaluation is a prerequisite for changing policy and practice, must become a priority.

Traditionally, the health sector has been more closely associated with using quantitative rather than qualitative methods for researching and evidencing health outcomes, whereas the opposite is true in evidencing community development impact. The last six years has seen a range of qualitative research on health outcomes from community development programmes and initiatives. Documented evidence of experiences in ***Pilton Community Health Project (2000), Community Health Work in the Western Isles (2000) Healthy Herbidean Islands – Promoting health and sustainable development on Islay and Jura, Argyle and Clyde Health Board (2000)*** and ***Addiewell Research Project (2000)*** illuminate both strengths and weakness of adopting community development approaches in health. The Rowntree Foundation ***'Towards Caring Communities'*** (1997) highlights valuable learning and insights into community development approaches to community care.

More recent case studies ***'Insights' – community development in health'*** (2003) carried out in different communities across Scotland (HEBS, CHEX and Glasgow Healthy Cities Partnership) identify the benefits and struggles by small independent community health

initiatives undertaking community development methods in assisting communities to take sustained action on their health priorities including:

- **Assisting young people to access training, employment and secure accommodation.** - young people from the Aberdeen Foyer highlighted healthier diet, increased confidence and assertiveness, greater awareness of sexual health, ability to manage money, achieve access to employment and training, capacity to move on and live independently.

- **Establishing new services such as a Stress Centre and Home Safety Project in the East end of Glasgow**. – the East End Health Action Community Health Project reported an increase in health awareness, integration of community development approaches into mainstream services and more locally relevant policies and practice.

- **Initiating opportunities for people with mental health problems to earn 'local currency' in a Local Exchange Trading Scheme in Stirling** - LETS MAKE IT BETTER reported improved self-esteem, opportunities to participate on equal terms within the local community, opportunity to access services, control over level of participation and developing more productive ways of working with health professionals.

- **Challenging inequalities in mental health and wellbeing** – the CHANGES Community Mental Health Project highlighted increased self esteem and confidence, increased access to health services, greater recognition from health professionals, enhanced ability to influence policy and practice, provision of additional services to parents.

- **Supporting community development in health approaches in Dundee** – the Dundee Community Development and Health Project reported increased community capacity, more joined-up working with agencies, effective input into statutory planning and policies, more support for community development approaches into mainstream health services and fewer barriers to healthy choices like nicotine replacement programme.

- **Supporting South Asian women in Edinburgh to undertake participatory research into their health needs**. Nari Kallyan Shangho (NKS) Community Health Project reported reduced reliance on anti-depressants, reduced isolation enhanced social networks, access to appropriate child-care facilities and improved communication between service providers and South Asian women.

- **Initiating services for older people, children and families in Balintore, East Highland. –** the Seaboard Community Development Trust reported

better access to health services, improved communication with statutory agencies and increased community capacity to negotiate health priorities.

COMMUNITY ENAGEMENT – UNDERSTANDING & IMPLICATIONS

Although the perceived lack of 'hard' evidence has been an obstacle in the adoption of community development practice, I would suggest that a more significant barrier has been the commitment at the strategic level to move from the ***involvement with individuals*** to the ***engagement and participation with community organisations*** – and this is in particular the case within the NHS. In exploring the implications of applying community approaches it is useful to draw on the model **"Building Involvement – Effective Participation**

'Building Involvement – Effective Participation'

Approach	**Strategic level – setting priorities**	**Delivery – decisions on implementation**	**Community control over resources**
Passive, one way People are informed about what has been decided: information shared between professionals only	Community and user groups, newsletters	Community and user groups, newsletters	Information made available to community on opportunities for resource control (e.g. grant or awards schemes)
Reactive 'community consultation' People are consulted or answer questions – the process does not concede any share in decision-making. Professionals under no obligation to take on board peoples' views	Questionnaires, surveys, focus groups, panels and juries	Community groups and forums respond to service proposals. Users in the minority on management committees	Meetings with groups and community interests to explore opportunities for resource transfer
Proactive 'community participation' Communities influence priorities, resource use and service provision to be provided through the Community Planning Partnership	Joint planning groups and forums. Some co-options to statutory committees	Joint management arrangements over specific projects and activities	Local service development on a franchise basis: terms and conditions set by the 'purchaser'
Interactive or Partnership working People participate in joint analysis, development of action plans and the strengthening of local groups and institutions. Learning methodologies are used to seek multiple perspectives, and groups decide how resources are	Support is provided for community to have equivalent access to expertise, advice and training	Users/community has management control of specified services	Local service provision with joint community/public sector control, or negotiated contracts

used			
Community mobilisation/empowerment People participate by taking initiatives independently to change systems. They develop contacts with external institutions for the resources and technical advice they need, but retain control over how those resources are used	Pressure group and campaign activity to influence policy	Complete community authority for management of services	Service provision independently funded and managed by the community
Entrusted community control As above, but community also influences prioritisation and control of service provision or associated budgets	Community has leading voice in determining priorities in policy	Community has leading voice in delivery of public services	Community making decisions over public budget allocation

Source: Models of Community Engagement, S. Hashagen, Scottish Community Development Centre

Currently, one of the major problems for health professionals is in seeking to work with communities beyond the first two approaches. While there is confidence about informing people and encouraging people to become involved in work on the pre-determined priorities of the health board, or primary care service, there is limited awareness and experience, of the *development work* necessary to sustain people in the next stages of becoming proactive, involved in joint planning, and ultimately influencing local services. There is need for greater strategic commitment to capacity building, which assists service providers in understanding the significance of working through the whole developmental process. Crucially, it is when people are supported throughout the whole process that the full impact and benefit of community development is experienced. For example:

- Community members participating in the development of health initiatives in the Eastend of Glasgow subsequently became involved in influencing the public involvement agenda within the Local Health Care Co-op, **Eastend Action on Health, Glasgow**

- Community members in Greenock becoming involved in drug work through the local community health project and subsequently chaired the cross-sector Drugs Forum in Inverclyde, **Phoenix Community Health Project.**

- Community members in Broomhouse, Edinburgh became active in a local food group and subsequently become influential in city-wide and national strategies on food and health. **Broomhouse Health Strategy Group.**

On the Margins

Although there is effective community development practice in health on the ground, much is ad hoc with limited strategic support from health boards, primary care trusts and local authorities. Despite some optimism with the creation of new posts such as Public Health Practitioners, and Health Improvement Officers, the lack of formal infrastructure has resulted in many health practitioners looking towards community and voluntary sector networks for information, advice, training and support in community development.

These demands further aggravate the issue of lack of long-term resourcing to independent community health initiatives. In the previously mentioned case studies, all the community health initiatives reported on their continual struggle with short term/time limited funding and the disproportionate amount of management and staff time being spent on securing financial resource. Some have succeeded in negotiating Service Level Agreements with public sector funders, explore a mixture of resources including 'in kind' and consortium bids with a range of range of partners from the public and voluntary sectors. But, others continue to fight for survival on short term funding arrangements, which restricts their ability to plan for any long term developments.

SECTION THREE

Practice Development

Despite these challenges, the last three years have seen significant movement in practice development. The recognition that substantial health benefits can be achieved by community involvement, and that this demands a practice base informed by values and methods aimed at community empowerment, has pressed policy makers and practitioners to become more pro-active in developing good practice. National organisations and community initiatives have sought to inform and improve community development practice in a number of ways. For Example**:**

- **Leadership from national organisations**

  The two national agencies – **Health Education Board for Scotland** (HEBS) and **Public Health Institute of Scotland** (PHIS) that provide leadership for the Scotland's health improvement work have merged to form **NHS Health Scotland** and are resourcing work on good practice in community development. It funds CHEX to facilitate a network and provide a community development resource to community health initiatives and the wider health work force. The new health agency is also actively supporting a number of Learning Networks on Heart Health, Sexual Health and Early Years Intervention. Focussed on policy, practice and research, there is scope for sharing learning on community development approaches to tackling the specific topic areas of health.

- **New Community Health Initiatives**

The New Opportunities Fund has contributed £34.5m to developing Health Living Centres (HLCs) aimed at tackling health inequalities and providing easily accessible health facilities. Although working with community development principles and methods is not made explicit in funding guidelines, many of the 46 HLCs in Scotland are carrying out community development approaches to health. A recent audit of development support and training needs highlighted that the HLCs were concerned to ensure that participation and engagement with communities was a priority for practice development.

- **Monitoring and Evaluation**

Significant progress has been made in the monitoring and evaluation of community development over the past four years. The promotion of '**Achieving Better Community Development**' and '**Learning, Evaluation and Planning' (LEAP)** has provided frameworks to measure both quantitative and qualitative outcomes. Although LEAP has its roots in community and adult learning, it has now been adapted to the needs of the wider health sector ('LEAP for Health' 2003) In providing a framework for measuring community development's impact on health, the model set out systems for measuring change that has taken place in individuals, organisations and the wider community.

Although monitoring and evaluation is relevant to all community health work it has a particular importance for those community health organisations on fixed term funding and facing the ongoing challenges of sustainability. The use of such models can better equip the organisation to demonstrate its ability to meet stated objectives. Quality monitoring and evaluation systems require to be embedded within the overall planning and delivery mechanisms. Encouragingly, national organisations such as ASH Scotland have produced useful, practical tools to assist community groups monitor and evaluate their work. While guidance such as the '**Evaluation Journey'** does not focus on community development, its methods and value base are implicit in the description of how groups should gather, analyse and produce their findings.

- **Training and Capacity Building**

Training and development has been given a substantial boost through funding support from NHS Health Scotland. In addition to the training modules within their Programmes, funding has been allocated for the strategic development of 'Health Issues in the Community' initiative.

A mapping exercise is currently underway to identify training on community development in health aimed at assisting those in the wider health work force to focus on:

- new ways of thinking about health improvement
- new ways of working with individuals and group of people
- different implications for planning and resource allocation
- new structures and processes for decision-making
- different way so undertaken research
- new ways of monitoring and evaluating health impact
- use of Health Impact Assessments

- **Participatory Research**

The Scottish Executive has recently funded the Scottish Community Action Research Fund and co-ordinated by SCDC which assists community and voluntary groups to plan and carry out research projects in their own neighbourhood. Although organisations like the Poverty Alliance have supported communities in carrying out their own research and producing Community Profiles, this is first national initiative to directly resource community organisations for research purposes.

- **Action Research and Shared Lessons from Action on the Ground**

Action Research and dissemination of case studies through local and national networks has helped to share experiences and lessons with the wider health sector. For example: Volunteer Development Scotland, in collaboration with Scottish Council Foundation, have undertaken research into health gain derived from volunteering. The research does not primarily focus on community development. however, several of the nine case studies are operating with community development approaches and the findings highlight between community development, health improvement and social capital. The Scottish Development Centre for Mental Health, Scottish Council Foundation and Office for Public Management research project on capacity building for mental health improvement and community well-being reflects the importance of community development in tackling health inequalities and developing social capital.

- **Partnership Working**

The demand for and constant struggle to achieve effective partnership working is a recurring theme for those involved in the strategic planning and delivery of services. For some the experience has been immensely frustrating with little evidence that the added value to be brought from partnership work has been realised. Yet no one would deny that tackling health inequalities, poverty and social exclusion demands cross sector responses, common goals, the bending of resources and the sharing of experience and expertise. The evidence does suggest that where the effort is made in setting common goals yet also accepting and

understanding the different histories, cultures and priorities of potential partners that real gains can be made – and in a way that no one agency could achieve on its own. All seven of the 'Insight - Community Development in Health' case studies highlighted the need for effective partnership working between the public sector and community and voluntary sectors.

Central Government's recognition to build the capacity of public sector agencies and community and voluntary organisations to work with communities was reflected in their funding of **Working Together: Learning Together** (WTLT) in 2000. The two-year programme brought together stakeholders from Social Inclusion Partnerships and Pathfinder areas to develop new ideas and exchange good practice in partnership working with communities. Although a structured programme focusing on concepts and policies in social inclusion, principles of partnership planning and evaluation and engaging community participation flexibility enabled participants to identify themed days, and consequently 'Working Towards Healthier Communities' was organised on effective partnerships for tackling health issues.

- **Networks and Networking**

Many different community health agencies and organisations have found networking to be effective in meeting diverse needs, whether in relation to practice development needs or in providing mutual support for collective action on policy development. Networking has assisted cross organisational, cultural and geographical working with practical exchange of information, contacts and ideas and has helped members to address the more complex arrangement of governance and accountability. A major benefit reported by the projects in the case studies was being able to access national and local networks such as West of Scotland Community Health Network and Lothian Community Health Projects' Forum to share their practice, exchange ideas and take forward their practice-based learning and priorities into the policy arena. The networking of contacts and activities through the Scottish Directory on Community Health Projects. (HEBS, CHEX and Glasgow Healthy Cities Partnership), highlights the range of community health initiatives promoting community development. While these initiatives reflect different starting points, and diversity in governance, resources and work priorities, there are common denominators in practicing community development.

- **New Personnel**

The new posts of Public Health Practitioners (located in Local Health Care Coops) and Health Improvement Officers (located in Local Authorities) are in a key position to support community development across the health boards, local authorities and other public sector agencies. Both posts have a catalyst role in assisting health boards, primary care trusts and local authorities in working with the community and voluntary sector on health issues. In addition, the Involving

People Team within the NHS are charged with developing the capacity NHS policy makers and practitioners on taking forward the 'Patient Focus: Public Involvement' agenda.

CONCLUSIONS

Seldom has the political and policy environment been as supportive to the promotion of community development practice within the health field. Additional resources have been made available, good practice identified, strong networks established to share that practice and increasing demands for training from those wishing to adopt community development methods. However, evidence suggest that this in itself is insufficient to ensure that anywhere near the full potential of community development will be brought into play.

We have seen some of the major challenges around image, use of language and perception, but probably the biggest challenge is securing commitment to a value base and method that takes health services beyond working with individuals to collective approaches to health improvement. Somewhere along the continuum of involvement and participation, policy makers and practitioners have to make clear choices about how they view working with communities, abandoning paternalistic top down approaches and being prepared to genuinely engage with communities in addressing their health needs and priorities. It requires further action on such challenges as:

- there being a consistent, strong message from all divisions within the Scottish Executive that community development has a significant contribution to make in bringing about healthy communities and is a recommended method of working.

- substantial investment in capacity building and training with policy makers and practitioners to ensure community development underpins the shaping and delivery of health services and is not tacked on an optional extra.

- building participatory, democratic structures, which facilitate more honest dialogue and effective decision making between politicians, policy makers and communities.

As the previous section highlights, developments in practice are providing the building blocks to meet these challenges. However, to successfully translate the Scottish Executive's vision of **'placing patients and communities at the heart of its policies',** into reality on the ground, we require greater attention to the structural and cultural shift towards the role of community development within the social model of health. In conjunction with national strategies which are truly 'joined up'; mechanisms, which demonstrate the health, impact from community development and recognition of the professional status of community development in health improvement. To further this agenda, community development workers should press for action on:

Social Model of Health
Health practitioners within all health improvement services should have guidance on recommended models of monitoring and evaluation e.g. 'Leap for Health' which has been designed to fully evidence the health outcomes from community development within a social of model of health.

Joined-Up Strategies
National policy makers across all Ministries should take forward an agreed agenda on community involvement. We have seen from the policy arena that each Ministry places different emphases on the nature and extent of community involvement. The most recent health improvement policy '**Improving Health In Scotland: The Challenge'** gives priority to 'community-led' health, but it is not clear where on the continuum of involvement it expects the wider health sector to work with communities. There is a need, for community development workers to advocate, based on good practice, experience and evidence for clear direction on how community led health can be taken forward both strategically and operationally to ensure maximum impact on health improvement.

Sustainability
There is a need for national and local government to find real solutions to dealing with short term funding and project work. Sustainability is a recurring theme, attracting much debate, but little direction. Fixed term funding creates constant pressure to deliver outputs, and often meet unrealistic outcomes. The case studies highlighted in this article have sought to find innovatory approaches to incremental development leading to long term sustainability and lessons can be learned from these approaches. There is a need for funders and projects to work together in managing change, which enables the projects themselves to secure futures in chosen options such as established organisations or their work taken forward into mainstream services.

Indicators for Standards for Community Involvement & Community Well-Being
Current initiatives on 'Standards of Participation' (funded by Communities Scotland and researched by SCDC) and 'Measuring Community WellBeing (NHS Health Scotland) should be built on to establish common indicators on community involvement and community wellbeing across all health related policies. Fundamental to establishing these indicators is the process of joint negotiation between communities and service providers.

Consultative Processes and Ongoing Dialogue
Community development workers should prioritise awareness raising with MSPs, civil servants, council members and officers the role of community development in developing ongoing dialogue in shaping and delivering national health and social policies.

Further Education & Professional Qualifications
Health Improvement practitioners come from a range of backgrounds across health, local authority and community and voluntary sectors. While principles and methods of community development underpins much of the Community Education Degree, there is a

case for community development to be also embedded in Public Health Master Degrees such as Masters in Public Health (MPG) and Masters in Health Promotion/Education.

References:

Understanding the Policy Maze: Social and Health Policies in Scotland (2002) – HEBS, CHEX and Glasgow Healthy City Partnership
Directory of Community Health Projects (2002) – HEBS, CHEX, Glasgow Healthy City Partnership
Our National Health A plan for action, a plan for change – Scottish Executive (2000)
Involving Local People in Community Planning in Scotland (2002) Community Development Foundation
'A Review of the Contribution of Nurses, Midwives and Health Visitors to Improving the Public's Health in Scotland' (2001) – Scottish Executive
Insights – Case Studies of Community Development and Health Projects in Scotland, NHS Health Scotland, CHEX and Glasgow Healthy Cities Partnership (2003)
Improving Health in Scotland: the Challenge (2003), Scottish Executive
Partnership in Care (2003), Scottish Executive
Health Improvement in Scotland - Health Promotion in North Ireland (2002)
Towards Caring Communities – Joseph Rowntree Foundation (1997)
Health Gain Through Volunteering, Volunteer Development Scotland and Scottish Council Foundation (2003)
Community Wellbeing - Capacity Building in Mental Health – Scottish Executive (2003)
Personal Ills and Private Issues – Community Learning Scotland (2002)
Healthy Herbidean Islands – Promoting health and sustainable development on Islay and Jura, Argyle and Clyde Health Board (200)
Community Health Work in the Western Isles – Overview of the three years of the SONAS project – Health Education Board for Scotland (2000)
Health Issues in the Community (2002) HEBS, CHEX and Edinburgh University
Achieving Better Community Development: Community Development Foundation
Learning, Planning and Evaluation (2001) – Scottish Centre for Community Development
Community Development and Networking (2000) Community Development Foundation and Standing Conference for Community Development
Healthy Living Centres in Scotland – A Study of development support and training needs – Stuart Hashagen, Jane Jones (2003)
Models of Community Engagement (2002) Scottish Community Development Centre.
Evaluation Journey, ASH Scotland (2001)