DUNDEE HEALTHY LIVING INITIATIVE RESEARCH REPORT

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Supported by

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FOREWORD

The Dundee Healthy Living Initiative Research Report was produced by Dr. Susan Lewis (PhD Social Anthropology) over a 2 and a half year period from the beginning of the project in March 2003 until September 2005. The research was an explicit element of the original stage 2 application to the Big Lottery Fund in 2002 and was agreed by a multi-agency Steering Group, which developed the bid over a 2 year period. The research element of the project was supervised and overseen by the *Nexus Programme*, a collaboration between St. Andrews and Dundee Universities, which researches the links between the clinical and social in terms of health.

The overarching aim of the research was to study the effects of the Dundee Healthy Living Initiative on community defined objectives and goals through:

- Studying users' attitudes, priorities and understanding
- Encouraging participant questions
- Exploring common experiences and analyses of these
- Encouraging communication from users
- Identifying norms and cultural values
- Providing insight into social processes
- Facilitating the expression of further ideas and experiences

In addition, it was proposed that the research process and findings would develop a broader theoretical framework to help facilitate the introduction of further social interventions aimed at improving the health of people in Dundee.

The DHLI Researcher gathered extensive fieldwork data recordings over a 2 year period and almost 70 project users took part in the *Conversations Project*, comprising 1 to 1 in-depth interviews and focus group sessions.

The final Research Report includes numerous academic references and incorporated a significant literature search to provide comparative and supporting evidence to further demonstrate the benefits and outcomes of a community development to health improvement. For the purposes of this edit many of the academic references available in the full report have been removed. It should be recognised that the

statements made and concepts discussed in the report have been substantiated through other sources of evidence.

The report is broken into 8 main sections and sections 1 to 5 can be read individually and on their own merits. Section 6 - CHP links - refers to other sections in the report but summarises the key points from these and thus can be read without a full knowledge of the rest of the document. Sections 1 to 6 are provided with a short summary at the end of the chapter.

It is hoped that the report will be used as a tool by policy makers, planners, service providers and community health projects alike to help develop and maintain interventions that promote positive health and help tackle health inequalities issues.

Copies of this edit, the full report and associated materials and documents are available from:

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ADDITIONAL REPORTS

The DHLI Researcher carried out "mini research projects" during the 2 and a half year research period, which ran alongside the longitudinal study. These shorter studies looked in-depth at particular pieces of work, generally from the planning stage through to implementation and evaluation. The fieldwork based ethnographic approach was used whereby the Researcher worked closely with both DHLI team members and participants employing many of the techniques and methods used in the main research project. In addition, the Researcher presented on her work at a number of conferences and seminars, and produced reports for the benefit of the DHLI team, Management Group and others. A number of articles and abstracts were produced with a view to publishing elements of the DHLI research.

The case studies, presentations and papers shown below are available from the DHLI office on request.

CASE STUDIES AND OTHER MATERIALS

Section 1	Ardler Health Issues in the Community: *The Day that Lasted Seven Months*
Section 2	Jumpin' - overweight children's group
Section 3	Out & About - summer walks and picnics for families
Section 4	Food and Mood
Section 5	SelfMade Arts Group
Section 6	Whitfield Young Parents Drama Group
Section 7	Hilltown Health Information Point

Section 8 Shop for Health in the Wellgate

Section 9 DHLI Stakeholder Event - February 2005

Section 10 Tayside Health Inequalities Strategy Document:
DHLI Contribution to the Public Consultation
Oct/ Nov 2003

Section 11 Other 'Write-Ups'

Section 12 Presentations and Publications

a. Scottish Public Health Conference, Nov.2003

b. SCOFF Conference, Nov.2004

c. Mental Health Promotion Conference, Apr.2005

d. SCOFF Conference, Jun.2005

e. Abstracts (various)

f. Health Inequalities Strategy Consultation, article for *Journal of Community Work & Development,* with S. McMahon

g. Chapter on applied research for book, *Working with Others*, with S. McMahon (forthcoming)

h. Paper prepared for *bmj*. In preparation.

i. Stakeholder Event presentation

EXECUTIVE SUMMARY

Research Remit: The purpose of the research was not to duplicate evaluation routines already in place. The Lottery bid gave the following remit: to **'provide action research** […] **researching the effect of the Healthy Living Initiative on community defined objectives and goals.** The overarching research theme is to answer the question: what is it about the programme which makes it work?

Action Research: Aims "to generate knowledge and, on the basis of this, to adapt or change the project on an ongoing basis." It is, therefore, a formative approach, requiring the researcher to offer immediate, and often verbal, feedback.

Summative Report: This Final Report has several sections. A summary of findings is attached, along with an analysis of the DHLI's performance qualitatively measured against the original stated aims of the Project.

Key Points:

- **The DHLI has a 'pedigree'** of more than ten years, beginning with the Whitfield Health Information Project (WHIP). This experience adds weight to claims that a community health and development approach is effective, particularly if that approach is given the time to become established.
- **How the approach works**. In brief, engaging people in groups and activities opens new social networks and ends social isolation. The resulting supportive learning environment enables the participants to build self-confidence, or what Bandura terms 'self-efficacy' (2000, 2004): a general belief that one does have the ability to make changes. People are 'empowered' to make changes. Health benefits arise either from the group activity itself (for example, 'exercise to music'), or from putting into (often tacit) practice the information received. They also have a 'ripple-effect', impacting also on families. Some participants then express a desire to engage others – a move from self- to collective-efficacy. Of this latter group, some express a desire to 'work with' the Project.
- **Key to the effectiveness:** Engagement is continuous, egalitarian, and dialogic. Local beliefs and experiences are valued and change is negotiated rather than dictated. Participants are given space to incorporate lifestyle change into their own socio-cultural milieux, at their own pace and through activities that suit them. Any change is therefore charged with personally relevant meaning

(rather than a meaning ascribed by an 'other'), and is 'owned'. The health-promoting function of the Project is evidence-based. Participants trust the health advice given, as it is presented by health care professionals and offered in such as way as to be relevant to their lives.

- **Engagement is based on 'reciprocity'**, which in turn promotes trust. Community – social life – is not a given. It requires constant 'work'. The DHLI team works with the community, becomes part of its 'social systems', which is effective but demanding. The effect is a grounded sense of involvement with the Project, a sense of empowerment, and of 'ownership' of change (or mechanisms of change).
- **Health benefits are individual and for the family,** including weight loss, smoking cessation, increased capacity for physical activity, fewer visits to GP, reduced reliance on medication (anti-depressants, inhalers). Other indicators are increased social networks, reduced isolation, increased self-esteem.
- **Alternative health services**: Opportunistic contact for health advice (different 'gatekeeper'), more 'time' for supportive listening, clarification of medical advice, facilitating contact between specialist services and community. Referrals. Opportunity for 'social prescribing'. Foundations laid for 'lay health workers'.
- **Challenges:** Resolving 'partnership-working' issues at team level, especially for new staff. Move toward 'culture of complementarity' required. Whilst the situation has improved in recent months, the team does not, at present, have the same sense of ownership of the Project as the community members/representatives. These issues need to be resolved before further expansion, but have not impacted on delivery. Maintaining momentum. Opening up opportunities to community members.

Summary: The DHLI has been very successful in implementing a challenging, complex project. It has faced this with an ambition to go beyond simply fulfilling its pre-defined targets (as symbolised by this accompanying research and its proposals to expand its operations). This is characteristic of the team also, but significant challenges exist at that level.

SECTION 1 - DETAILED SUMMARY

1.1 RESEARCH AIMS

The purpose of the research was not to duplicate other project evaluation systems. Whilst this evidence contributes to the overall evaluation of the DHLI, it extends beyond the usual question of 'is it working or not?' to ask a 'how?' which accounts for the programme's operational context.

1.2 RESEARCH SETTING

The research setting is a matrix of three relational elements:

***Geographical*:** DHLI target areas; designated, disadvantaged communities in Dundee

***Operational*:** delivery contexts e.g. group work, health talks, exercise classes etc.

Structural and systemic: management systems within which the DHLI and its partners operate, where these impact directly on project practice

1.3 COMMUNITY DEVELOPMENT APPROACHES TO HEALTH PROMOTION AND TACKLING HEALTH INEQUALITIES

1.3.1 The DHLI Process

Studying the process of health-related community development provides valuable evidence of ***how*** the approach works. Engaging people in groups and activities opens new social networks and helps end social isolation. A supportive learning environment enables participants to build self-confidence, or 'self-efficacy': a general belief that one does have the ability to make changes. Health benefits arise either from the group activity itself or from putting into practice the information received. There is also a 'ripple-effect' impacting on families and the wider community.

In addition, many participants express a desire to engage others – a move from self- to collective-efficacy - and some express a desire to 'work with' the Project.

Key to this effectiveness is the way in which the DHLI approaches the task: engagement with the public is continuous, egalitarian, and dialogic. Local beliefs and experiences are valued,

"you can show your life experiences, it's seen as being valuable",

and change is negotiated rather than dictated. Participants are given the space to incorporate lifestyle change into their own socio-cultural environment, at their own pace and through activities that suit them. Any change has personally relevant meaning rather than a meaning ascribed by an 'other', and is therefore 'owned'. The

project's health-promoting function is evidence-based, appropriate and relevant, and participants trust the health advice given:

"somebody actually explaining it to us in a language we understand. Not dictating, helping you to do it."

These concepts are fundamental to community development work and respondents have commented that the DHLI team:

"do their bit and they hang around, because it's like they care about what's going to happen and what you're thinking, whereas other groups kind of don't."

If the model is to be successfully translated to other contexts, the basic ethos of community development work combined with the over-arching purpose of promoting healthy lifestyles must be ***explicitly*** central to the task. It is strongly proposed that the relative autonomy of the team, which allows it to work responsively and keep its 'single focus' of better community health, is fundamental to this process.

1.3.2 Reciprocal relationships

DHLI activities are developed as a result of local requests, interactions between staff and local people, and community health needs investigations. Social exchanges such as these rely on reciprocal demonstrations of trustworthiness and create an obligation on the part of the managing partners. In the short term, this obligation is fulfilled by the continued presence of the DHLI and its programme but withdrawal of that provision, or inaction in terms of enabling participants to fulfil their desire to 'do more', may be interpreted as a cancellation of the trust relationship.

1.3.3 DHLI progress: the contribution of the qualitative perspective

The two Big Lottery Fund Annual Monitoring Reports submitted to date (2003-4, 2004-5), demonstrate that the Project has exceeded its agreed annual targets in the vast majority of activities. Where differences between estimated and actual targets exist this reflects the Project's facility to constantly reassess its relationship with its communities and respond flexibly to developing and emerging needs.

Whilst some qualitative information is collected and recorded by the DHLI team, the contact facilitated by the researcher enabled the Project to further reach the opinions, perceptions and beliefs of participants. For the respondents interviewed as part of the ***Conversations*** project, the following were reported as clear priorities:

a) Increase in social networks and the reduction in social isolation

"sat in the house, picked these [the children] ***up, brought these home, sat in the house…I had no-one."***

b) Increased self-confidence and improved communication abilities

"without [the groups], ***I'd still be a doormat for him. I'd still be a doormat for anybody else."***

c) Health benefits

All respondents reported health benefits and/or lifestyle changes, both for themselves, and for their immediate and often extended families:

"I stopped taking medication – inhalers, anti-depressants," or ***"I've lost five stone"***, and ***"Yeah, I've lost weight. My husband's doing it as well. Another couple of pounds, and he's three stone…in three months."***

d) Better relationships with children and family

"I'm finding I can speak to my mum easier now. I'm not getting in so many arguments with her. So even my mum's seen the change in me."

This in-depth data confirms other research data collected during focus groups, participant observation, informal interactions with participants and workers, and from DHLI monitoring and evaluation materials.

1.4 THE FUTURE: SUSTAINABILITY

Sustainability remains a concern for all involved in the DHLI. Its reach, in terms of the numbers and types of contacts it makes, the strength of its local relationships and its strategic impact, makes its potential absence damaging to local communities:

"it would be totally worse without it, because I'd be stuck back in the house again."

As far as respondents are concerned, given that the Project has made a significant impact on their lives, they state that they would fight to maintain it:

"We'd get a petition up. We'd be putting our views across, and I'd be wanting to know why, why? Why pull away now when it's only just getting heard?"

Both participants and staff have commented that the DHLI is filling certain gaps in local health service provision. These reflections are included under sustainability, on the assumption that continued resource may depend partly on assessing the type of contribution the Project makes in this area. These are:

a) Someone to listen

Respondents commented that GPs often give the impression of not having time to listen to them unless a specific medical condition is apparent.

"The doctor will say 'come to me for advice,' but if you go to the doctor just for advice they're going to sit there and go, 'well have you got a problem or not? 'What's your illness?' Doctors don't have time. I feel they don't have time for you."

In contrast, the DHLI offers the time and environment to air concerns. One interviewee with complex and multiple health problems, who is a regular user of a DHLI Health Information Point, reported that her GP seemed to ***"just want to get me out the door. And that's how it felt."***

b) Building a new life

One respondent spoke in detail about how the DHLI helped her recover after a breakdown. Whilst acknowledging the benefits of psychiatric services during the initial stages of her illness, she feels that the 'everyday' quality of the DHLI groups has accelerated and enhanced her recovery over the longer term:

"you don't want to be seen as 'we're all under one umbrella; let's all just sit down and talk about our problems, our mental health problems,' which can totally bog you down. In our DHLI group, it's everyday chat. It covers life, you know, not just one section of life. You become unwell, you want to get back into society. You want to be seen as getting on with life."

c) Opportunistic advice

Opportunistic health consultations via the Health Information Points offer general advice and information rather than addressing perceived medical need but can act as an early warning system. One contact, who was found to have very high blood pressure and referred to mainstream services, acknowledged that,

"If it wasn't for this stall I'd never have known."

d) Reassurance

People report that they lack written information from their GP to help them in their health decisions and compliance, and appear to need support to negotiate personal health issues. Facilities like 'Shop for Health' offer help by clarifying GP advice, and offering supplementary post-diagnosis support.

1.5 DISCUSSION

Monitoring information and performance indicators demonstrate that the DHLI is succeeding in its core aims. Qualitative analyses confirm the statistical picture and offer insight into participants' processes of engagement and change. They specify how individual change has a 'ripple effect', impacting on both the family and community. The evidence shows how the Project is laying foundation stones for building community capacity and for new ways of approaching health service delivery. It is this question of ***how*** the Project has achieved this that is central to the main contribution of the research, which has attempted to analyse the process by which these changes have happened and recommend how these might inform the development of a framework for the roll-out of similar programmes.

During the research period the DHLI has made a significant impact on improving health in target areas, creating social networks and building social capital:

"there's a freedom, sort of…instead of being enclosed in the house, you've got the freedom to go out and meet other people and not feel uncomfortable about having to go out and not know anyone,

However, the DHLI also faces a number of challenges. Some staff-related factors require attention to address ongoing concerns related to 'cultural differences' between disciplines and to foster a 'culture of complementarity'. In addition, the challenge remains to maintain momentum and increase further the Project's reach.

a) Cultural differences:

The community development approach promotes the 'coming back' of participants and the DHLI provides new activities which sometimes attract regular project users. This is in contrast to the ethos of 'moving people on' that characterises the health professionals' approach. Routes need to be found to allow staff to reinterpret these as complementary approaches. The community development approach is vital to the

'development' of those participants who will support community-level sustainability. The short course approach is valuable for those not wishing deeper involvement.

b) Practical difficulties

A partnership approach, broad remit, disparate team and innovative methods mean that the DHLI meets with practical difficulties. The operational context is highly challenging and the search for innovative ways to engage the public, work with other agencies and constantly reflect and learn (a feature of the community development approach) is also challenging. The geographical bases mean that day-to-day communication between colleagues can be difficult and many work-related stresses have no immediate outlet. Some consideration as to a practical solution for access to this kind of peer support would be beneficial.

c) Maintaining momentum

This report has based a proportion of its analysis on the processes of established, long-term groups, some of which are currently showing signs of coming to an end. This is not a negative development and signals a natural moving on for participants. However, the Project, if it is to increase its reach and engage more local people in activities, needs to 'employ' those participants who have moved on themselves.

d) Framework for future application

The key factors outlined in this report demonstrate that the DHLI model could be translated to other settings. Its success is due to:

- Focused application of established community development methods
- A skilled team committed to the approach
- Sufficient resources
- Enough autonomy to operate responsively to community need
- The single-issue focus of community health

The complex engagement required to achieve positive community health must be acknowledged and further work undertaken with strategic and operational partners to ensure that community health is not perceived solely as the responsibility of the DHLI.

SECTION 1 - DETAILED SUMMARY
KEY ISSUES, RECOMMENDATIONS AND LESSONS LEARNED

- Engaging local people in health-related activities increases social networks and ends isolation
- A supportive learning environment increases the self-confidence required to put health messages into practice
- Individual change has a positive "ripple effect" on the family and wider community
- Engagement is continuous, egalitarian and dialogic, and change is negotiated rather than imposed
- The relative autonomy of the team and single focus of "community health" is fundamental to this process
- The DHLI programme and relationship with local people is built on trust and "reciprocity"
- Key elements of the approach involve the DHLI team listening, supporting, advising and reassuring
- Cultural differences exist between the different disciplines in the DHLI team and a move towards "complementarity of approach" is recommended
- Practical difficulties arise in operating this kind of outreach project
- Further consideration needs to be given on how to best to "use" skilled-up project participants

SECTION 2 – METHODOLOGY

2.1 INTRODUCTION

The DHLI researcher is an applied social anthropologist and associated techniques are particularly useful when the research questions are not well defined, or the research context has many complex and overlapping features, as is the case with the DHLI. This project adopts a model of community development to deliver interventions aimed at addressing health inequalities issues in several distinct disadvantaged areas, using a multi-disciplinary, partnership approach.

2.2 DEFINITIONS

- **Qualitative research** focuses not on what has worked, but rather on ***how***. It is grounded in its research context and concerns itself with how that world is socially and culturally interpreted, understood and experienced.
- **Action research** aims to generate knowledge and from this adapt the project on an ongoing basis. It is a formative approach with collaborative and participatory methods and is suited to a community development setting.
- **The anthropological approach** takes a holistic view, where the research focus is considered in relation to the wider context. It is also comparative so that explanations arise from comparing data with results generated elsewhere.

2.3 THEORY-DRIVEN EVALUATION

The research and evaluation is theory driven in that it approaches the research setting with the 'why' question as its focus. The key message is that evaluation often allows a program to be labelled a success without attention paid to the fundamental question of ***what is it about a programme which makes it work***. This report and the research which informs it aim to address that question.

2.4 RESEARCH METHODS

From the outset of the project, the researcher has been embedded in the team and this has provided the kind of immersion into activities and relationships that are fundamental to the anthropological (ethnographic) approach to gathering research data. The following timeline offers a brief outline of the research activity:

- **March – December 2003**

The researcher and other new team members participated in an intense induction programme, which included networking and relationship-building with other agencies operating in localities. The researcher undertook several months of participant observation, which included joining in activities and talking with local participants, accompanying staff to inter-agency meetings, observing staff as they worked, attending team meetings, etc. This allowed for a thorough experientially-based understanding of the Project's activities and of its operational systems.

- **January 2004, ongoing**

Research activity was refocused to allow for consideration of specific programmes of work, from planning to final evaluation. A number of these programmes inform the 'case study' reports in the following section.

- **November 2004 – August 2005**

Fieldwork provided invaluable understanding of the research context and associated informal conversations helped identify emergent themes. In a dispersed environment such as a community development project, it was necessary to 'test' the emergent themes using in-depth qualitative interviews and focus groups. Almost 70 DHLI users were involved, and interviews and focus groups were audio-recorded and transcribed. Transcriptions were analysed using NVivo software, a research tool designed specifically for the analysis of qualitative data.

- **June 2005 – September 2005**

Supporting literature searches have been ongoing (specifically to support various conference papers and publications), and a certain amount of involvement with Project activity has continued. However, the final four months have been more closely focused on analysing the data in relation to theoretical and comparative material. That work informs the frameworks and conclusions presented within this report.

SECTION 3 - EVALUATION

"The Dundee Healthy Living Initiative is making a difference to us."

This section analyses the results in relation to the original aims of the Project as stated in the Stage 2 Lottery application. As indicated in the introductory section, the strategic aims outlined in the Business Plan fall outside the purview of the research and therefore outside any evaluation presented here.

3.1 TACKLING DISADVANTAGED LIFE CIRCUMSTANCES

To promote and improve the health of the people of Dundee by tackling disadvantaged life circumstances, encouraging healthy lifestyles and promoting physical and mental wellbeing, to reduce ill-health and prevent premature death.

The DHLI cannot directly tackle many of the factors that contribute to disadvantaged life circumstances such as inadequate housing or anti-social behaviour. Instead, efforts have been focused on taking local priorities to service providers at all levels and encouraging them to place community health and wellbeing at the centre of activity. More directly, the DHLI removes the cost, access, perceptual or cultural barriers to health, by providing accessible activities for target communities.

3.2 BREAKING DOWN BARRIERS TO PARTICIPATION

a) Cost barriers

Provision of free crèche and the nominal charge for exercise sessions removes the financial barrier for participants. Crèche provision was regularly cited by respondents as *the* most important factor in allowing access. No special clothing is required (beyond suitable footwear) meaning that further financial (and psychological) burden is removed. Participants are not refused access to classes if they do not have the money to pay. Informal feedback has demonstrated that understanding cost implications has assisted groups in taking responsibility for their own management.

b) Access barriers

Having activities in familiar, local premises is cited by respondents as significant. Timing is important and parents need to fit activities around school hours. Older attendees also prefer day-time activities: ***"Waiting for bus at night is worrying. Buses are only every 40 minutes at night. It's a long wait."***

Also important was being personally encouraged to join in with activities, especially for those people who socially isolated: ***"Coming into this group, that is really scary. Really really scary...I mean, I was lucky because my friend, she kind of brought me into it and it was fine. She would tell me what was going on, and then I came along. If they had something like that, someone to speak to, to meet first, then that…brings them into a group."***

c) Perceptual barriers

Cheap, simple activities, like the walking groups and 'Out & About' (which provides family activities over the summer), have encouraged people to re-evaluate perceptual barriers about exercise. Non-threatening physical activities have demonstrated that keeping active is easily accessible and achievable:

"You don't have to use all these machines and that to keep fit. You can walk down the road…"

Similarly, healthy eating sessions help tackle perceptions that making dietary changes is expensive, time-consuming and difficult, and participants are now taking ownership over the recipes:

"We had all the recipes and that, that we got from the groups, and we'd all try them out and 'oh, I changed this, and I changed that,' you know, just to make them a bit better."

Ingredients for cooking sessions and weight management activities are readily available, 'value' options. 'Taste and try' addresses further cost-related barriers, allowing people to try new foods without risking limited funds:

"I think that's the other thing, the great thing about taster sessions, you know, where you can come along and try something. I mean, we say about the kids not wanting to try things but we're almost as bad. I don't want to waste the money on buying that because I might not like it, whereas if you've got taster sessions where you can come and try things at other people's expense."

Other barriers, such as literacy issues, have been addressed by working alongside local literacy workers on reading and understanding food labels.

d) **Cultural barriers**

Support from other group members is important in changing habits from those of a local culture:

"The support of knowing that everybody else is trying it out and we're all trying to do it all together and it's easier that everyone's doing it."

People are more likely to make beneficial changes if they require adaptation, rather than a culture shift. If change is founded on local traditions and people choose to absorb, or 'domesticate' that change, it is more likely to be permanent than if it is dictated from above.

Cultural barriers also exist for ethnic minorities and DHLI groups have been established in collaboration with the translation service. In the Asian Women's Health Group, for example, the lack of dietary knowledge among Type II diabetics is being addressed. Participants report that this information is also benefiting husbands and members of the extended family.

e) Barriers remaining

Removing cost and other barriers has been successful but there remain specific factors for some sectors of the community. For example:

- **Specialist programmes -** The obese or very obese are unlikely to attend a standard exercise classes and other activities such as swimming are prohibitive due to their public nature. Consideration needs to be given to targeting programmes specifically at this client group.
- **Hard-to-reach individuals -** New ways of making contact, such as through GP surgeries, may offer one solution to targeting those people who are difficult to engage by the usual DHLI means. Lay health workers (or equivalent) may offer new opportunities to widen access to the community. A recent Cochrane review on lay health workers concluded that, while there was as yet insufficient evidence to confirm the effectiveness of lay health workers, they were *'most likely to be useful as a cadre of health care providers when they have an effective healthcare intervention to deliver.'* It is possible that extending the Project resource to include lay health workers may assist in extending participation.

3.3 PROMOTING PHYSICAL AND MENTAL WELL-BEING

DHLI participants prioritised social inclusion as the most important benefit from their involvement, and the contribution of this to physical and mental wellbeing, and to community capacity and social capital, should not be overlooked.

A strong evidence base exists to demonstrate that factors such as social support strengthen individual and community health, and studies show that existence of some minimal level of social contact is critical factor for health. The Conversations Project demonstrates that DHLI participants, particularly those with medium to long-term contact, feel less isolated and more empowered. They have a belief in their personal efficacy which, in the DHLI context, has a concomitant impact on perceived collective agency and social capital.

a) Encouraging healthy lifestyles

Although social inclusion is the main reported benefit, it is clear that the DHLI has had significant impact on supporting people to make changes in their lifestyle behaviours. The following quotes offer examples of (i) changes in eating habits, (ii) changes in physical activity, and (iii) other changes likely to have an impact on health.

i. Changes in eating habits

"I used to buy packets of hand-cooked crisps and eat them all in one go, and I've not bought them for about a year. I would do that every week. [Now] ***I pick stuff up and put it back. I come home and all I've got is fruit and veg!"***

"I even read packets of food now. I never used to do that. I've cut down the sugar, cut down the salt…"

"Before, I would eat a bar of chocolate if I was pissed off with somebody or had an argument. I would grab a bar of chocolate, bags of chocolate and crisps and sweeties, all the junk of the day would go in my mouth. And cans of coke. Not any more. I'm thinking, well, that's not doing me any good. I haven't been on a diet, but I've lost weight."

ii Changes in physical activity

"When I started, I couldn't even do the warm-up without coughing and spluttering. Now I'm training to be an instructor! I've got more personality, energy. Got so much energy."

"Well, I find that the exercise is fine. Whereas at first I used to get out of breath, just walking a wee distance, I find that I can walk for quite a bit now...but you're socialising as you go along and I find that that helps."

"My wee boy knows aerobics now. He likes joining in with me in the living room."

iii Other changes

"I've stopped smoking since you did that [carbon monoxide] ***test!"***

"I've got problems with my joints as well. I've got a type of rheumatoid arthritis. So losing weight like I have will help that as well."

"I've got Crohn's disease, and I've had it for a long time, and I was saying to [the DHLI worker] ***that the doctors advised me to try exercise. And me being me, I was very scared to go along to any of the classes or anything or to join in. She was like, oh no, just go in and go along. So I started to go on a Monday morning. I absolutely loved it."***

"That's why the groups have helped me, because it's given me that information and the recipes and that. And the stress group is helping me because I'm not so stressed. It's given me ways to cope."

3.4 REDUCING ILL-HEALTH AND PREVENTING PREMATURE DEATH

Progress against this initial aim can be assessed against proxy indicators and self-reported change only. Whilst Health Information Points provide written advice that clients visit their GP there are currently no objective mechanisms through which to check patient progress. However, Patient Satisfaction Questionnaires and feedback from clients is a good indication of their effectiveness. Similarly, self-reported changes in lifestyle behaviours by DHLI group members provide further evidence.

Exceeding agreed targets is a proxy indication that the project is meeting its stated aim to impact on ill-health and premature death. The following case studies and quotes from the Conversations project offer qualitative support for the monitoring data:

i) HIP Case Study 1

A regular user of one of the Health Information Points suffers poor health, is extremely nervous, functionally illiterate and has difficulty in communicating her needs to her GP. ***"I've been telling him for months and months my hands are sore. He wasn't touching them, he wasn't looking, or…everything will be OK, we'll wait 'til next time I see you, and it was going on, and on, and on. But, I don't think he was helping me. He was just wanting to get me out the door. And that's***

how it felt.” With support from the DHLI nurse, the user received appropriate treatment and an operation for another more serious health problem. Links were set up with other support agencies to improve her quality of life. This demonstrates the DHLI's role in meeting a complementary need for 1 to 1 advocacy for the multiply disadvantaged. Dedicated agencies exist (the client was theoretically in touch with the advocacy team), but access to them is by referral through the GP, who may not always be the most appropriate gatekeeper. Furthermore, these agencies may not have the same community presence as the DHLI team. Project nurses are trusted by the clients and have a network of clinical supports, which they can mobilise on the client's behalf.

ii) HIP Case Study 2

Feedback from a return user demonstrated that, as a result of a blood pressure check and subsequent advice, he visited his GP and was found also to have high cholesterol. He had since been referred to the hospital.

“If it wasn't for this stall I'd never have known.”

The 1998 SIP Health Audits confirmed that people in deprived areas consider their GP as the first, and often only, point of contact for health services and information. The Shop for Health offers an easy-to-access opportunity to have a health check and in both these case studies, the DHLI nurse opened access mainstream medical intervention.

iii) Self-reported health indicators and outcomes

“Up until 2 years ago, my chip pan was on constantly. Now my chip pan's never on. Things go in the oven.”

“I've stopped taking medication: inhalers, anti-depressants.”

“I've not been to the doctors for 8 months.”

“People have totally transformed themselves.”

“I stopped smoking, started thinking more seriously about my health. Felt guilty, wanted to act as a role model.”

“I started with healthy eating. It's not just dieting, it changes the way you eat.”

“Yeah, I've lost weight. My husband's doing it as well, another couple of pounds and he's three stone…in three months.”

“I've cut down the sugar, cut down the salt…”

“If it wasn't for this project, I'd be dead by now.”

3.5 TO SUPPORT, RESOURCE AND DEVELOP PROJECTS THAT TACKLE HEALTH INEQUALITIES AND SOCIAL EXCLUSION

In supporting and developing a wide range of activities in consultation with local people, the DHLI makes considerable progress towards addressing these two complex issues. However, informing people of healthy messages is not enough to prompt permanent change. Evidence on the benefits of community development shows that people need to:

(a) to become critically conscious of the causes and implications of their, and their community's, situation
(b) reach a point where they feel able to effect that situation.

(a) Critical consciousness

The ***Health Issues in the Community*** (HIIC) resource pack, an accredited course developed by NHS Health Scotland and supported by CHEX (Community Health Exchange), has been used extensively by the DHLI to raise awareness of the causes and consequences of health inequalities, and to prompt local people to reflect on how they can influence their situation. One local group has completed part 1 of the accredited course and presented a self-scripted play in early 2004 as the 'critical' culmination. Members have since gone on to become members of the Community Sub Group, to qualify as exercise instructors, or to request to ***'work for the DHLI'***. There is clear evidence here, for the lay health worker programme, as currently being advocated by the DHLI.

(b) Efficacy

Raising people's awareness of their situation has been coupled with raising sense esteem and collective efficacy, that is, fostering belief that changes can be made. The Project has helped people achieve this at a personal and collective level, and participants are aware that they are making a difference within their communities and that a local perspective is helping to influence decisions. The Community Sub Group is the most obvious example of how this has been achieved, where local representatives are involved in DHLI management processes and decisions.

In addition, the Stakeholder Event in February 2005, where local people led Story Dialogue sessions telling of their involvement with, and benefits of, the DHLI, and subsequent invitations to speak at various forums, helped affirm that their stories have a direct impact on decision-makers.

It is proposed that the Management Group remains conscious of maintaining progress in furthering their relationship with community representatives, and that proactive DHLI approaches, such as supporting local input at strategic committees, is acknowledged as a positive route to stakeholder involvement.

(c) Challenges

Critical consciousness and efficacy contribute to the achievement of a ***salutogenic,*** or health-generating, community. The DHLI has been successful in beginning this process and such progress carries with it a significant responsibility on the part of the managing partners. Once critical consciousness has been achieved, there is no going back for the individual. Some may respond by 'moving on', and the DHLI has acted as a springboard for some participants to find jobs. However, retaining these community resources will help further the Project's aims, especially where participants have already voiced a desire to do so. The short-term funding streams associated with these long-term, developmental interventions is the greatest barrier to achieving sustainability. New proposals to extend the Project's activities (and the possibility of employing participants) go some way to addressing this but again the funding is short-term.

"If the DHLI was withdrawn now, it'd be worse than if it'd never started."

Offering people the opportunity to experience things differently and then removing these opportunities can be seen as damaging to their mental (and psychosocial, physical) wellbeing. The recently released HLC Evaluation for Scotland (RUHBC 2005) confirms the message that ***'many poorer urban areas in the UK have now considerable experience of the rollout of short-term area-based projects, where early apparent success is followed by cessation of funding and withdrawal of the same initiatives. Consideration should be given by funding bodies to providing continuation funding for successful projects where unmet need remains.'***

On a short-term basis and evaluated against their own indicators, community health projects are successful but a broader view must prompt the question of the long-term cost-effectiveness of such short-term activity. DHLI participants are aware of the investment required if behavioural change is to be maintained:

> ***"It's not like maybe it's an instant thing. It's not like you go to a motivational class, and you suddenly get a better life and whatever. It's like when you***

study. I mean, you study for the job you're going to do, but you have to be in the job a while before you feel comfortable with it and everything else.

3.6 TO FACILITATE THE COLLECTIVE INPUT OF MEMBER ORGANISATIONS, INCLUDING THE VOLUNTARY AND COMMUNITY SECTORS, INTO STRATEGIC PLANNING PROCESSES SUCH AS TAYSIDE NHS BOARD'S HEALTH IMPROVEMENT PROGRAMME

Assessment of progress under this heading falls largely outside the scope of the research. However, one relevant observation can be made. The role of the Community Sub Group and its links with managing partners are contributory steps to achieving such collective input.

3.7 TO FACILITATE COLLABORATIVE WORKING, IMPROVE COMMUNICATION AND CO-ORDINATE THE ACTIVITIES OF MEMBER ORGANISATIONS, IN ORDER TO MAXIMISE THE USE OF RESOURCES, AVOID DUPLICATION AND IMPROVE THE HEALTH OF THE CITIZENS OF DUNDEE.

Collaborative working is fundamental to the DHLI. This section focuses on the effectiveness and impact of inter-agency collaboration at local level.

3.7.1 Successful collaboration

Local health fairs and events are subject to detailed joint planning between the DHLI, other agencies and local community groups, and result in successful collaborations. Key contributory factors include:

- Clear and shared objectives
- Consultation with all parties involved
- Clear role specification
- Commitment and follow-through
- Good communication.

However, even with successful events challenges have arisen in terms of co-ordinating timing with other local events and obtaining input from some agencies at weekends. The Ardler Health Fair, for example, did not receive the NHS input it had originally hoped for.

In terms of the Health Information Points, the Wellgate stall has included input from other health agencies and specialists. Agencies are briefed on arrival, and supported

throughout by DHLI staff. Feedback from the health care professionals involved has been positive:

"we need to have more opportunity to meet with the public in their environment"
"this has been a good time to learn more about engaging with the public." l

3.7.2 Less successful collaboration

Some partnerships have not been as successful, such as the *Jumpin'* group for overweight children (full report available from the DHLI). The programme experienced a number of barriers that impacted negatively on the commitment of partners, such as difficulty in accessing funding, limited evidence-base for community-based weight management programmes for children in deprived areas, few NHS resources made available to the programme, an overly protracted planning process and lack of clarity over who was the lead agency. In addition, the programme fell somewhat outside the normal parameters of DHLI involvement. Despite this, the programme went well and self-reporting from the children indicated that the programme was beginning to have some effect.

3.7.3 Partnership challenges

The DHLI is named as a key organisation for health improvement and tackling health inequalities in strategic documents such as the local Joint Health Improvement Plan and Community Plan. Whilst this is evidence of the Project's strategic impact, it raises another consideration. There is a danger that community health is seen as a DHLI responsibility rather than a shared one. However, the project's management, staff, and Community Sub Group, have been active in ways that counter such assumptions, for example, through the Stakeholder Event. Despite a strategic commitment to shared responsibility and partnership working on the ground some challenges remain in changing professional cultures at operational and middle management levels. *Health Issues in the Community* training for staff at that level would go some considerable way to opening up inter-agency dialogue on this.

Data on output and outcome targets are widely accepted as proxy indicators for health intervention programmes, and qualitative outcomes, particularly in the field of mental wellbeing, are increasingly being accepted. A recent NHS Health Scotland guide states, where outcome measures have been developed in conjunction with the community (which is the case with the DHLI), then ***'studies which address feelings,***

attitudes and experiences are important as reviews of effectiveness'. However, many funders demand evidence of an apparently objective nature and this presents an on-going evidence dilemma for DHLI stakeholders. However, the establishment of Community Health Partnerships may show signs of moving beyond a medical model.

It can be difficult to measure progress in community development interventions, where monitoring must be non-intrusive. The DHLI ethos and value based approach means that overt 'surveillance' will work against the process. Much of the evidence is qualitative and there is limited published material on health-related community development work on which to build a comparable evidence base. However, recent national collaborations and even medical journals such as the BMJ are placing more emphasis on qualitative evidence. These are signals that the atmosphere may be changing. Currently, however, the balance remains on the side of the medical model.

Further, in terms of sustainability, the Project needs to demonstrate cost-effectiveness. Questioning participants has demonstrated that they have made health-related changes that have a measurable cost benefit. Gathering such information is a delicate issue but there are indications that small focus groups of long term participants may be successful in gathering useful data.

3.7.4 Internal partnerships

Partnership working is symbolised by the DHLI's multi-disciplinary team. At the inception 5 'locality teams' were envisaged, comprising 1 nurse and 1 community development worker in each designated community cluster. This model, based on the former Community Development and Health Project, presents a complementary approach utilising the skills of each discipline, and joint working was implied rather than stipulated. However, during the early months of the DHLI and perhaps prompted by the 'locality team' concept, this model transformed into a concept of 'co-working' and, for a few team members, had the effect of stifling their own professional skills. The question of what joint working actually means is still a subject of internal debate. It is proposed that in place of the multi-disciplinary framework (which can foster 'difference' and is tied to the Project's historical issues), focus is redirected to allow staff to reinterpret the internal diversity as 'complementary' approaches (which are, therefore, affirmed as equally valued).

SECTION 3 - EVALUATION

KEY ISSUES, RECOMMENDATIONS AND LESSONS LEARNED

- The DHLI has largely succeeded in achieving the key aims as set out in the original Lottery application
- It has succeeded in breaking down financial, access, perceptual and cultural barriers to participation in health-related activities and services
- Barriers remain in providing appropriate services for people with specific condition and for "hard to reach" individuals
- Lifestyle changes for participants include improved diet, increased physical activity, weight loss and smoking cessation
- Health Information Points have been successful in attracting non-users of mainstream services
- The DHLI's community development approach has raised "critical consciousness" and promoted positive health changes on an individual and collective basis
- Challenges remain in relation to fully utilising a critically conscious community and addressing the issue of long-term change with short-term funded interventions
- Collaborative working with other local organisations has been innovative and largely successful
- Further consideration on rolling out the DHLI model needs to be given by partners at an operational and middle management level
- The DHLI programme would benefit from a cost effectiveness exercise

SECTION 4 - THE DHLI APPROACH

The Section 1 summary indicated that a key aim of the research was to address the fundamental question of ***what is it about this programme which makes it work***. Data presented in previous sections demonstrates that participants have responded positively to the DHLI approach, and case studies evidence further that the approach engages and encourages participants to go beyond their own expectations. It is proposed that an analysis of that approach goes a considerable way to answering the overarching research question.

The following discussion highlights the key contributory factors in the process, but should not be read as a sequential model. Many of these factors are either in place continuously throughout delivery, or are part of a feedback cycle that aims always to improve practice. The guiding principle of 'consultative, needs-led' delivery is an aspect of the team's ethos and is therefore constant.

4.1 Consultative, needs-led delivery

The DHLI draws a mandate from the Health Audits led by the Community Development and Health Project in 1998/99. Through focus groups, indepth interviews and questionnaires, residents of the SIP1 areas were consulted on four basic questions:

- What affects your health?
- What affects the health of your community?
- What could be done to improve your health?
- What could be done to improve the health of your community?

The following issues were common across all areas:

- Social exclusion
- Lack of mental well-being
- High incidence of smoking and support needed for cessation
- Lack of affordable, appropriate opportunities for physical activity
- Poverty and diet
- GP seen as first and/or only point of contact for health advice and information
- Life circumstances

These concerns and issues were strongly influential in the development of the DHLI and informed the local approach during the early months of operation. Ongoing investigations are carried out at health fairs and other local events, and within local groups and activities, to provide an opportunity for local people to suggest or request particular initiatives and to validate further the Health Audit findings.

4.2 Local presence and knowledge

It has been a key feature of the Project's operational structure from the planning stages that staff should be based within local communities. Whilst the administrative and management functions are centrally located, the locality teams have bases in, or close to, their locality. This has resulted in some challenges, but the response from participants supports the local base concept.

> ***"It's like a back up because they're always there."***
>
> ***"They're dead approachable, and if you've got an idea or anything like that, you can go and speak to them, it's very easy."***

Local presence allows team members to build and maintain an intimate knowledge of their locality. Health inequalities are not static or stable contexts and, consequently, an intimate knowledge of local circumstances is crucial to effective delivery. Similarly, knowledge of, and relationships with, other local agencies is important to streamline provision and avoid duplication. Finally, an effective knowledge of the community facilitates the 'bringing on' of key individuals who are most likely to be facilitators for future growth.

4.3 Planning, research, response and reflection

Before delivery: When planning a new piece of work DHLI staff are required to complete a Monitoring and Evaluation Pack containing the following:

- ***Proposal form***: This details aims and objectives, inputs, outputs and outcomes. It requests financial information, funding details and 'in kind' costs.
- ***Monitoring forms****:* These include 'pre- and post- questionnaires' or forms to measure, for example, mental well-being.
- ***Comments***: This form prompts the practitioner to request evaluative comments from the participants.
- ***Reflection***: Where the practitioner reflects on the activity after its completion, so that lessons learned can be fed back into future practice.

During delivery: The friendly atmosphere generated within DHLI groups was a strong theme that emerged from early, informal conversations with participants:

"the group is really nice, because what you say in that group gets kept there…I've told them things that not even my closest friends knows, and that's how confident and how safe and secure I feel there."

The cycle of research, response and reflection is also present *during* delivery. In community education terms, this contributes to the creation of a '*conducive learning environment*': that is, one which sets clear objectives for sessions, keeps the content appropriate to the objectives, monitors and controls progress, identifies and encourages 'stragglers', and acknowledges achievement.

Although aims and outcomes of activities are vitally important, the project approach requires the practitioner to be flexible enough to 'let go' of the planned format, if required. It is a highly sensitive, empathic approach, which proceeds only when participants are ready and is a key element in assessing the success of the approach.

> ***"You're not forced to do it."***
>
> ***"You feel more in control because you're not being instructed, you're being encouraged."***

When combined with other observed elements, and themes emerging from participant interviews (such as the egalitarian approach), this is a very powerful medium of communication.

4.4 Enabling, egalitarian approach

The Project team are termed 'practitioners' or 'facilitators', but the comments above would seem to indicate that 'enablers' is most appropriate. Community development aims to enable. It is not a new approach; its origins lie in socio-economic and environmental inequities worldwide and, despite the scepticism of medical and scientific disciplines, it is a well-evidenced and effective model of working with disadvantaged and marginalised groups. It is a value-based approach with the following key principles:

- Participation
- Partnership working
- Equity
- Empowerment

- Collective action

It is based on forming trust-generated learning relationships, which seek to unearth the origins and ideas behind the community culture and develop mutually acceptable and beneficial changes to, not only lifestyle behaviours, but to attitudes, beliefs and values.

Participants were asked in interviews, focus groups and other feedback situations if they felt that the DHLI 'did anything differently' and, if so, what that might be. The following extracted quotes offer a flavour of their responses:

> ***"See you as a human being, an individual. There's no power struggle."***
>
> ***"You can show your life experiences, it's seen as being valuable."***
>
> ***"They're not just workers, they become friends and they look at you as friends."***
>
> ***"People in authority sometimes treat you like 2 year olds"*** [the implication being that, in comparison, the DHLI staff do not].

Community development is not an approach that can be feigned or contrived and the following participant comment appears to confirm that the DHLI are succeeding in establishing a very open and honest connection with participants:

> ***"I know the people that have the purse strings, need to have the facts and figures, need to have the statistics. Statistics can be shown in a way depending on the questions, right. The way you're doing it here, is you're getting people who have lived it, that are sitting being honest with you and telling you the benefits, being honest with their lives as well."***

The basic principles of community development are rooted in Paulo Freire's theories of adult education. Freire developed his dialogical methods of education using "culture circles" in slum areas. Here, the role of the adult education worker was to immerse himself in the culture of these oppressed communities, observing, questioning, talking, listening and most importantly, being accepted by the residents. The workers encouraged the locals to recognise themselves as valid and valuable individuals who, by working together, could influence their surroundings and future.

4.5 Reciprocity: Entering the social

At the core of this approach lies trust. The DHLI, places itself *within* the community and its social system, and therefore *within* the mechanisms of social exchange and reciprocity. Community exists in the interactions between its members; 'Reciprocity'

arises from the relationships between those members, and describes the resulting obligations they feel toward one another. The DHLI trusts that when it trains local people in health skills they will volunteer within their own community, and local people trust that the DHLI will fulfil its promise and continue its activities. Instead of a negotiated contract, this form of social exchange relies on reciprocal demonstrations of trustworthiness, each of which serves to enhance the levels of trust existing between the individuals. However, these social exchanges create an obligation and, in the short term, this is fulfilled by the continued presence of the DHLI and provision of activities. Withdrawal of that provision or support for participants to fulfil their desire to 'do more' may be interpreted as a cancellation of the trust relationship.

4.6 Commitment: Continuity of input

Also in response to the question of what, if anything, the DHLI does differently, several interviewees offered a variation on the following quote:

> ***"You seem to care more. That other group, when we had workers coming in and things, they sort of came and did their thing and go and that was it, whereas Dundee Health come in, do their bit and they hang around, because it's like they care about what's going to happen and what you're thinking, whereas other groups kind of don't. They just come and do their thing and away you go. So yeah, I think that, and the Healthy Living Initiative also seems to make an impression, like, they come in and do this thing and it does get you."***

The continued community presence only partly explains this comment. What is revealed is an overt commitment by the DHLI to its communities and to its declared ethos. The continued presence is combined with a sense of working *together* and a commitment to the listening, dialogic approach to working *with* people. By its active engagement, the DHLI is seen to make an explicit commitment to the community and its members. This is demanding and must acknowledge local, strategic and financial accountability. In addition, the DHLI team are also pioneering new ways of delivering health improvement and promotion.

4.7 Looking forward, not standing still

The annual milestones detailed in the DHLI Business Plan evidence a developmental vision, which requires a sustained effort to build individual and community capacity. Annual workplans dovetail into the key Business Plan milestones for the coming year.

This planning process has a beneficial impact on community groups and several have become constituted and largely responsible for their own activities. However, it is important to recognise that this is a delicate and long-term process. The following responses were given in answer to a question about why, if the group was now largely 'independent', they still needed DHLI staff:

> ***"We enjoy having her in the group as well, and she's absolutely, in her chairperson's way, kind of bringing the group together. See, when there's three little groups, and they're all off on their own wee tangent, I find it very difficult to sort of clap my hands and say, right, listen, whereas she just goes, right, "can we bring you back" and they all kind of listen to her. So, I've got to work on that a wee bit."***

> ***"Well, she has the contacts. She's aware. She has contacts with different areas of Dundee, people that are doing the same job as her. So they have those contacts, which allow a local network to tap in to."***

Participants, despite taking on the responsibility for running their own groups, are aware that they have much to learn and require continued support. Both responses above demonstrate not *dependence*, but rather a developing *interdependence* that could be considered another form of collaborative working.

4.8 Community involvement in Project direction

Community involvement was at the heart of the Project's intended structure and although the format of community representation has developed differently than originally planned, the result has been highly successful. The Community Sub Group (CSG) was formed at the start of the Project's second year and draws its membership from a wide range of DHLI activities. The CSG is 'open access' and people can put themselves forward or 'cancel' their membership as and when they wish. It has, therefore, a relaxed and informal feel, which is conducive to learning about operational and strategic issues affecting the DHLI, and to feeling comfortable in offering opinions on issues brought to them. The CSG meets monthly, and ensures that a meeting takes place before the DHLI's Management Group meeting in order to comment on relevant agenda items.

4.9 Discussion

The philosophy of approach has been explicit during project planning and implementation and was based on the experience of former projects. Adherence to the approach is assisted by the Project's relative autonomy and commitment of its staff. The benefits of the approach were apparent only six months of operation;
"staff have got to know us and built up relationships…they want to hear our voice, and will feed upwards to those who need to know…we're feeling our voice is heard."
Evidence that the approach has been maintained is provided by recent responses:
"They talk to you, don't talk down to you;" "Don't use big words that you don't know what they mean."

This section has focused on the way of working in and with the community. Excluded are funding issues and other practical matters. These issues, and others as they arise, clearly impact on the team's ability to respond to local need, but do not impact on the maintenance of the overarching philosophy. This is summed up in the following comment from a respondent who is both a member of a women's health group, and attendee on a DHLI smoking cessation course:

> ***This method*** [of stopping smoking] ***has been tried and tested by a Healthy Living Initiative employee. Right, so, she's living proof and she's not like sort of, "I'm an employee from the government to give you a smoking cessation group, and I might not believe in it, I might be sneakily having a fag right, or I'll just get the salary at the end of the month," and the way it's put over is you're all the bad people, and I'm the good person and this is how you've got to live. Now, most people that watch the news or whatever know that there are problems with smoking, there's problems with child obesity, there's problems with adult obesity right. We all know about that, but the way that the Healthy Living Initiative does the job, to me, is that they get the message across. It's not like it's a wishy-washy way that they're doing it. She's actually running this course, she's tried and tested this method, she's still off the cigarettes, she knows what it's like to be a smoker and she's lived it, right."***

As stated previously, the elements in this section should not be read as a sequential model. However, the commitment to the egalitarian and dialogic approach and the willingness to 'immerse' oneself in the social context, are fundamental to the Project's success to date. On the assumption that those factors are in place, the process model is readily transferable to other contexts.

SECTION 4 - THE DHLI APPROACH
KEY ISSUES AND LESSONS LEARNED

- The key guiding principle to the DHLI's work is consultative needs-led delivery as epitomised by the community health needs investigations and previous project experiences upon which the project was built
- The local presence and knowledge of DHLI staff is crucial to effective delivery
- The flexible process of developing, delivering and evaluating work helps foster a "conducive learning environment" for all concerned
- The community development approach adopted by the DHLI creates "an enabling, egalitarian" environment built on trust and an understanding of, and "immersion" in, the local cultural context by staff
- This environment fosters "reciprocity" between staff and local people meaning that a healthy commitment to the programme exists on both parts
- The project works "with" local people and has an overt commitment to the community development approach, philosophy and value base
- The developmental aspect of the project helps build individual and community capacity to help sustain elements of the programme
- The Community Sub Group has been highly successful in involving participants in the running of the project and other decision-making processes in a meaningful and sensitive manner
- Funding issues and practical matters impact on the project's work but not its philosophy of approach
- On the assumption that the above factors are in place the process model is transferable to other contexts

SECTION 5 - EMPOWERMENT
"THERE'S NOTHING STOPPING US NOW"

This section draws on the Conversations project; a series of in-depth, semi-structured interviews conducted with participants from across the target areas. Analysis of the prime data confirmed local priorities when describing the benefits of engagement with the DHLI, that is:

(a) The creation of social networks and related reduction in social isolation
(b) Increased self-confidence and increased ability to communicate effectively

In *Developing Healthier Communities* (HDA 2004: 13), a guide to using community development approaches to tackling health inequalities, links are shown between building social capital and the existence of social networks/ mutual trust. The following table is adapted from the guide, and provides a link to the analysis that follows. The aim is to assess how the DHLI approach is contributing to building collective (social) capacity to articulate and address communities' own health concerns. The main foci of the analysis are 'social networks' and 'empowerment criteria'. These are linked to the 'networking', or 'enabling', function of the team. Finally, and rooted in a theoretical discussion, consideration will be given to the potential contribution to the promotion of a 'salutogenic', or health-generating, community.

Table 1. Links between Social Capital, Capacity Building, Social Inclusion and Reduction in Health Inequalities. Adapted from Developing Healthier Communities (HDA 2004).

Key Concept	Link to Community Development	Link to Reduction in Health Inequalities
Social capital: refers to the networks and trust between people, significant in combating social exclusion and providing a base for long-term economic development	Social capital is of fundamental significance for community development. It pinpoints key ideas that touch the essence of community development – above all, the need to listen.	Social capital builds links within communities that strengthen their ability to identify and realise their health potential.
Capacity building: development work that strengthens the community's ability to build structures, systems, people and skills so they are better able to define and achieve objectives	Links to the process of change and learning (akin to link with adult education). Capacity building and education are a vital part of sustainable regeneration.	It develops the skills and uses the assets of marginalised communities. It helps them articulate their concerns and find practical ways of addressing health concerns.
Social inclusion: Concerned with countering assumptions of dependency. It is rooted in an understanding of citizenship that sees people as having the right to influence and participate in decisions that affect them and to have views and experiences listened to.	Some of community development's potential to contribute [here] is to be found in its methods, skills and knowledge base – the process of building confidence and mutual trust, the skills of working with alienated people, knowing the community.	Links here are expressed in terms of indicators, such as infant mortality and life expectancy. For the DHLI, this links directly to the GM02 indicators (BLF annual workplan) .

5.1 SOCIAL NETWORKS

Existing evidence links informal networks, social activities, and participation in organisations with better health chances. These networks can provide social support, self-esteem, identity and perceptions of control. Renewed social connections are the most apparent benefit of respondents' involvement with the DHLI:

"you're part of the community…you interact more…you're less isolated…it's bringing back community spirit in a way."

There is a high level of awareness from participants that the DHLI is a health project but during interviews and focus groups the majority prioritised the biggest impact as no longer feeling isolated:

"When you go through what I've been through, you find out who your real friends are. So it has given me a new community, I suppose. I mean, that I could walk down the street and if I see somebody in the group, I've somebody to chat with."

Many also reported that they now meet fellow participants and their families at times and places outside the groups:

"Now we're actually socialising in the evening, you know with the group, we have a night out every so often."

5.2 NETWORKING

Developing and supporting social networks is a skilled and strategic aspect of community practice with identifiable skills in taking it forward. The following table lists many of the practices which go to facilitate and maintain networks, all of which are employed by the DHLI team. At one level the list might be read sequentially but all of the practices are, to some extent, constantly in use.

Table 2: Actions that facilitate and maintain networks. Taken from Gilchrist 2003

Mapping	Finding out who else might have an interest in a particular issue; gathering information about them, including existing connections.
Making contacts	Introducing oneself and organisation; making referrals.
Maintaining connections	Organising meetings; sending out information bulletins; keeping up-to-date records of names and contact details for key individuals
Managing the web	Servicing networks; making sure that power and inclusion issues are addressed.
Monitoring changes	Introducing and inducting new 'players'; adjusting to shifts on

	the policy agenda or concerns arising in the community
Mending	Identifying ruptures in the networks and addressing gaps that emerge through people leaving
Merging	Helping separate groups to recognise their common or overlapping interests; setting up joint organisational arrangements
Mediating	Dealing with conflicts and misunderstandings; challenging prejudices and apprehensions
Motivating	Persuading and encouraging people to link up with others; encouraging people to take on responsibilities and new roles
Mobilizing	Using the network to form alliances and get involved with collective action
Moving on	Making sure that network members have the confidence, information and support they need to sustain their own connections with one another

Accepting the significant role that social networks play the next step is to analyse if and how the DHLI has utilised these to empower participants to fulfil their own capacity to make change.

5.3 EMPOWERMENT

Empowerment refers to processes which enable people to enhance their individual and collective skills, and develop the capacity to control their lives. DHLI data is here analysed with 'empowerment criteria' (Tsey; 2003), to explore the links between the social determinants of health and the DHLI programme. Existing evidence suggests that such measurements demonstrate empowering and therefore health-promoting [improved] perceptions of self-worth and a belief in the mutability of harmful situations. The 6 criteria, or indicators of 'control', are:

(i) Self-reflection and growth
(ii) Greater assertiveness and improved communication abilities
(iii) Confidence that one is able to change one's situation
(iv) Empathy and the ability to help others
(v) Greater understanding of the root causes of problems
(vi) Greater understanding of the challenges and frustrations

Such measurements have relevance both to the community development and education model of intervention operated by the DHLI.

i. Self-reflection and growth

Respondents are keen to make clear that they do not consider the project as simply an opportunity to 'get out of the house'. Many have participated in a range of activities and have become involved in training opportunities. One respondent said, ***"before, I would say to myself 'I can't do that',"*** but is now chairperson of her local DHLI Women's Health Group.

Respondents are readily able to reflect on change, as evidenced by their regular use of the word 'before' in their responses.

"if I feel good inside me, I can feel good on the outside. Before, I wasn't feeling good inside. I've got my self-confidence, I've got me, I'm happy."

For others, this 'before' reflection has an added 'future' dimension:

"there's nothing stopping us now. We're doing things we'd never have thought of doing before."

One respondent trained as an Exercise To Music instructor through the DHLI and reported that she had previously found it difficult to get dressed in the morning or leave the house, whereas she now teaches exercise classes in her own community.

ii. Greater assertiveness and improved communication abilities

Respondents have reported increased ability to communicate effectively with others. Several mothers reflected on improved family relationships:

"I'm not screaming at them every ten seconds now. I felt I was ruining the kids' childhood, I wasn't getting the best of their lives. Because you only get, they're only young for a wee while, and even when they're teenagers, you want to enjoy them. Now, we laugh and we joke."

Some groups have communicated their messages by performing self-scripted dramas in front of an invited audience. One member expressed her own reaction:

"And then to do the presentation at the end, you know. After all that preparation, and you had to stand up in front of all these people and do it. It was just so nerve wracking but because I was quite confident by then, I thought, I can do this and I did."

Communication is also improving between different communities. Walking groups have joined forces to organise trips away, and the 'Out & About' groups have visited each other's areas:

"So it is a network in a sense, because you're then meeting people in different areas of the town that you wouldn't. But then there's the common denominator…[of the DHLI]***"..***

This increased ability to communicate was evidenced most publicly at the Stakeholder Event in February 2005. Based on the story dialogue method (Labonte et. al. 1999), the opportunity to have participants tell their 'before and after' stories proved a powerful medium through which to demonstrate both the impact of the Project and the effects of health inequalities.

iii. Confidence that one is able to change one's situation

Demonstrating sufficient confidence in the DHLI process, a member of a health group, whose life, she insists, has been 'saved' by the project – suggested that project users:

"could go to other places. Start off a wee group, and they'll maybe continue it themselves. We can pass on what we've learned."

Participants also recognised the 'ripple effect' of their engagement with the project:

"I think it's good for the kids, because they're getting out and about, and they're not stuck in the house with me moaning or snapping because I'm frustrated with them."

Another had felt alienated from her children because of her former behaviour:

"I felt I was ruining the kids' childhood. [Now] ***we laugh and we joke."***

Some participants already have a certain ownership over this change, and demonstrate a responsibility for it. Two newly qualified Exercise To Music instructors insisted they would teach community classes:

"but not for money…just to get people feeling good."

More recently, young parents who were originally reluctant to become involved with groups, and who were suspicious of 'authorities', wrote and performed a play in front of an audience of 'suits', as well as friends and family. The play depicted their gradual involvement in the DHLI and included scenes that encouraged others to follow their example.

iv. Empathy and the ability to help others

Participants demonstrate a desire to see others benefit from the DHLI, and by reflecting on how difficult the first step was for them, acknowledge that recruiting

new participants can be a challenge. Suggestions include peer befriending to ease the transition into groups, attendance at GP surgeries to advertise activities, and following up with 'meet and greet' facilities at local venues. Many project participants have been willing to tell personal stories in order to widen participation: ***"telling my story's just mainly to try and help other people. There might be somebody like me that can't read and write, that's had a beating from their husband, that's had mental abuse. If they see I've coped, they might see they can too."***

Respondents acknowledge the importance of the evaluation of activities for sustainability: ***"if it is going to be able to be kept on they are going to need like views of people that are checking it out so that is quite important for other people coming into the group in later times. If we don't help out with that then it's not going to be there for somebody else that might need it."***

Project engagement has also had an impact on attitudes and opinions, often increasing empathy for those people in different circumstances. ***"I like listening to these young girls, because it gives you sort of a different slant on their lives. Because you often look at single mothers, and you think, you've got yourself into that state. But not always, because if their husbands leave them, they're left holding the baby. They are isolated."***

v. Greater understanding of the root causes of problems

A key tool in the process of involving local people in decision-making processes has been the Health Issues in the Community (HIIC) training pack, a national training resource to help equip local people to develop community responses to health issues and become more active citizens. The DHLI team (who are registered HIIC tutors) have used exercises from the pack as introductory sessions, 'ice breakers', and as short and full courses. Participants have reported gaining, both personally and collectively, from their involvement. The course content has prompted wide-ranging discussion, experiential learning and the development of critical consciousness amongst members, some of whom have gone on to join the DHLI Community Sub Group.

Opportunity to do the latter has been largely facilitated by the work of the DHLI Team Leader. Using a community development approach with the CSG, key management and policy information has been summarised to help community

representatives absorb information more readily, and be in a position to offer opinions and suggestions. Effectively, the information has been 'translated' to enable discussion and community influence. Until now, discourse between the Project's management and community representatives has been mainly indirect but is now moving into a new, supported phase of more direct contact.

Critical analysis and understanding is also developed with the wider body of project participants. Interviews and focus groups demonstrated local knowledge of wider issues such as food quality, obesity and the importance of exercise. This awareness helps participants engage effectively with local decision-making partners, either directly through the DHLI, or through public consultation exercises. The DHLI's involvement with NHS Tayside's Health Inequalities Strategy consultation is an example of the latter, where previously excluded groups were provided with the preparatory support that gave them the confidence to offer their views.

vi. Challenges and frustrations

Critical consciousness extends to some of the challenges and frustrations. During interviews, however, there was often a sense that these were common concerns or were consequences of the world we live in: ***"It was on the radio the other day that Tesco had made millions. They can take a couple of pennies off something to let somebody that's not as well off as other people benefit."***

Such balanced awareness demonstrates a comprehensive understanding of the structures that impact on local conditions. However, as this report reflects throughout, this is considered not as an insurmountable barrier, but as one which can be positively addressed by focusing on the changes that can be made locally.

As stated earlier, many expressed frustration at not being able to get more of their community involved. Other concerns include discomfort with the surrounding socio-cultural environment within which the DHLI operates. One respondent commented: ***"Even in groups, I listen to them saying 'I'm going to batter her after.' Not people in the groups, but they're maybe talking about someone they know from outside the groups. People talk like that and I think 'oh god, I'm not used to that.' That's how they survive and that but it's not my way of living."*** It is part of the community development approach to challenge aspects of behaviour such as this and to encourage group members to take ownership and raise issues with one another.

Whilst most respondents did not perceive it as a problem, there is also a need for the Project to take care that participants do not take on too much. Comments such as the following should perhaps be taken as an indicator: ***"because I'm doing all the classes at night time, they're not getting their tea until sometimes, half past sixish, which I don't like because it's always been something like half four, five o'clock, they've had it."***

Perhaps the biggest challenge is in the elements of the Project programme where some participants appear dependent, especially the static Health Information Points: ***"She does phone calls for me, she reads my mail for me, she keeps me right…she reads my letters, she explains things and then if I don't understand she puts it in an easier way, and…everything, everything. Honestly, if it wasn't for*** [the DHLI Community Health Nurse]***, I don't know what, where I'd be, or what…Y'know, to be honest, I don't."*** This particular respondent also draws on other local services but significantly complex health and social issues mean that she is reliant on the DHLI one-to-one support and referral systems. This does, however, highlight some gaps in health (and more broadly social) services.

DISCUSSION

Empowerment is a key concept guiding the Ottawa Charter and health promotion, but one which sits uncomfortably with the concept of social capital. The latter assumes a well-balance social system, where social capital is the product of cooperation between social organisations and institutions, and where all players have equal roles. The community development approach to tackling health inequalities recognises that all members of society do not have equal access to the resources required to make beneficial changes to life circumstances. In addition, health partnerships (of which the DHLI is one) can sometimes be negatively analysed as systems that are a means of avoiding tackling the real issues.

The research findings reflected in this report argue that a more subtle analysis of projects like the DHLI offer a different and more hopeful perspective. The concept of Social Capital applied to the local context can help demonstrate if and how communities are building levels of cooperation and trust. Even within small groups, developing social interaction, support networks and mutual trust, provides a stepping-stone to wider engagement. In parallel, the developing interaction with local

and regional political structures aids the development of communication and the increase of trust between sectors.

Each stage of empowerment, from initial involvement in Project activity, to presentations at strategic committees, requires an initial level of confidence, and then the explicit and implicit affirmation that the involvement has, or will, make a difference. Each of these steps contributes to the realisation of individual and collective skills, that is to community capacity, and in turn feeds the sense of empowerment. Accompanying this is the provision of information on social dimensions of health, and the dialogic exploration of those issues, to help people become involved in decision-making processes. As the Stakeholder Event most clearly demonstrated, the greatest impact was local people having their voices heard.

This research has offered a unique opportunity to observe and experience the potential that lies within community development work in all its complexity. It is proposed that further, in-depth ethnographic and anthropological research would add immeasurably to understandings of interventions such as this. Through such subtle analyses we get beyond the kind of analytical dichotomisation that opposes top-down/bottom-up, or macro/micro, and see that both are valid and can be in action at all levels and at all times within a successful project. However, both the research and the community development work on which it is based are long-term investments. It is argued that one of the major reasons why health inequalities remain a problem is because insufficient investment and commitment, both financially and temporally, has been made. Knowledge of 'what works' will not emerge from short-term, unresearched interventions. Change such as this will be slow, but as the next Section aims to show, that change might include new ways of delivering 'health' and a shift from pathogenic to salutogenic environments.

SECTION 5 - EMPOWERMENT
KEY ISUES AND LESSONS LEARNED

- Existing evidence demonstrates the links between the existence of social networks/ mutual trust and the building of Social Capital
- The concept of Social Capital applied to the local context can help demonstrate if and how communities are building levels of co-operation and trust
- Linked to this is the notion of empowerment and how, through building individual and community capacity, and developing and supporting social networks, the DHLI has contributed to building Social Capital
- Developing and supporting these social networks which improve health, build confidence and capacity, and lead to the empowerment of participants is an integral and highly skilled element of the DHLI staff role
- Empowerment refers to the processes which enable people to enhance their individual and collective capacity to control their lives. The DHLI contributes to the development of "empowerment criteria" through facilitating with participants:
    - Self reflection and growth e.g. through the provision of learning and training opportunities
    - Greater assertiveness and improved communication skills leading to better family and community relationships
    - Confidence that one is able to change one's situation; through supporting people to take responsibility for, and control of, their lives
    - Empathy and the ability to help others e.g. by developing cross-generational/ cultural networks and involving participants in running activities
    - Greater understanding of the root causes of problems; for example, through the development of the Community Sub Group and offering learning programmes such as the Health Issues in the Community course
    - Greater understanding of the challenges and frustrations; the development of "critical consciousness" helps participants appreciate and explore the wider context for tackling health inequalities

SECTION 6: CHP LINKS
FROM PATHOGENIC TO SALUTOGENIC APPROACHES TO HEALTH

The DHLI has been recognised as having an important role to play in the local Community Health Partnership (CHP). The Project Management Group agreed at its meeting in September 2005 that the DHLI has the skills and experience to contribute to the CHP's aim to make a ***'significant shift'*** in approaches to health improvement and health inequalities. This section draws on the data and analysis presented throughout this report, in order to demonstrate how, through its philosophy and processes of delivery, the DHLI might make this contribution.

6.1 WHAT ARE COMMUNITY HEALTH PARTNERSHIPS?

The following is taken from the Scottish Executive website and outlines the key duties of the recently instituted Community Health Partnerships.

> Community Health Partnerships (CHPs) are being established by Health Boards under section 2 of the National Health Service Reform (Scotland) Act 2004. CHP's are key building blocks in the modernisation of the NHS and joint services, with a vital role in partnership, integration and service design. CHPs aim, amongst other things, to:
>
> 1. deliver more innovative services more effectively
> 2. shape services to meet local need
> 3. integrate health services
> 4. improve the health of local communities
> 5. be the main NHS agent through which the Joint Future Agenda is delivered
> 6. be the main NHS agent through which children's services will be progressed
> 7. promote involvement of, and partnership with, staff
> 8. secure effective public, patient and carer involvement

The DHLI has considerable experience in delivering innovative health-promoting programmes in disadvantaged areas of Dundee. It is proposed that its experience can contribute toward the achievement of objectives 1, 2, 4, 7 and 8 above. The following discussion is not exhaustive, and points are made as examples. The CHP objectives are used as headings to help collate the information as usefully as possible. The section concludes with a discussion on an alternative framework for thinking about community health: that is, the *salutogenic* approach (as opposed to the more traditional pathogenic approach). Although here it acts as the 'end point', it is suggested that this theoretical discussion might be a 'starting point' – a means of

introduction to a new working context – for those who will be delivering this 'significant shift' in community health services.

6.2 SELECTED CHP OBJECTIVES: THE DHLI CONNECTION

Each of the sub-headings below is numbered according to the Scottish Executive/CHP objectives above. Under each heading, a box indicates where relevant discussion on the topic can be found in the other sections of this report. Consideration is then given on how these contributory elements may be combined to shed light on the CHP objectives.

1. Deliver more innovative services more effectively

Section 4.2: Local presence and knowledge Section 4.3: Planning, research, response and reflection Section 4.5: Reciprocity: Entering the social

Reference has been made throughout this report to the innovative and creative ways in which the DHLI delivers its services. Of prime importance is local presence, knowledge of local need and the social (and therefore trust) relationships that this facilitates. The response is not only to provide activities that address immediate needs on topics such as healthy eating and general health information – many in new and sometimes challenging ways – but also to address 'bigger issues' whilst doing so. The following examples demonstrate how the CHP can learn from the DHLI to deliver services more innovatively:

- **The opening of dialogue with the community** on sensitive issues such as mental health and wellbeing, and supporting greater community involvement in decisions on health service provision. Examples here would include the *Food and Mood* programme which helped tackle the stigma surrounding mental health, the various public consultations that the Project has undertaken, the application of the *Health Issues in the Community* pack, and the creation and development of the Community Sub Group. Unless a community is aware of the issues that affect it, and are assisted in debating those issues, they are unlikely to be able to envisage making, and taking some responsibility for, changes.

- **Finding ways of engaging groups/individuals that may not come forward readily** by going *to them*. This practice is implicit in basing the team within the targeted communities, by inviting specialist agencies to give talks and run short courses, and by taking activities and services into the community in places such as shopping centres and public houses. Examples include the roving Health Information Points which operate in a variety of local, non-clinical venues, and the Shop for Health in the Wellgate. Reactive practice alone would risk confining participation to those who come some of the way forward. Proactive practice is more likely to widen participation and open doors for the more reticent members of the community.

- **Thinking outside of the box** is also a feature of DHLI delivery. For example, the summer months are traditionally quiet ones for community activity, partly because community centres are engaged in offering activities for local schoolchildren. From the outset the DHLI has offered *Out & About*. Building on existing groups, this brings together parents and children on walks or visits to parks, complete with a healthy picnic and games involving physical activity. This has proved extremely popular, and has encouraged joint, cross-community excursions that are facilitating extended networks.

  One group used arts and crafts to explore the theme of 'Self' in relation relationships; the finished product was included in an exhibition in Dundee's McManus Galleries. Another group of young parents were encouraged to explore their own lives and involvement with the DHLI by writing and performing a play, which has been recognised by a national charity.

Innovation has been shown to be beneficial but the CHP objective above also refers to delivering services more *effectively*. Good planning, adequate resources and effective monitoring are assumed. The additional dimension, perhaps prompted by innovation and the concomitant requirement to monitor progress, has been categorised in a team presentation as *'research, reflection and response'*. As outlined in Section 4.3, the facilitators will conduct 'research', both in terms of pre-delivery planning, and in terms of qualitatively assessing, during delivery, the reaction of the participants. This leads to reflection and assessment of what is working and what is not, and why. A subsequent, relevant response aims to ensure that:

(a) the individual session evolves to meet the needs of participants and/or

(b) the programme as a whole is adjusted to increase its effectiveness

It can never be assumed that programmes constructed in response to identified need will either be immediately effective, or have the same impact across different groups and communities. Practitioners must be constantly aware of the need to be flexible in session content and delivery, in order to maintain effectiveness with participants.

An innovative approach does not preclude work being evidence-based. Medical advice offered by DHLI nurses is given in accordance with relevant protocols, and community development and/or education approaches are theoretically grounded. What differs is the combination of the two approaches, in differing proportions, according to need.

2. Shape services to meet local need

Section 1.3.1:	The DHLI process
Section 4.1:	Consultative, ‘needs-led’ delivery
Section 4.2:	Local presence and knowledge
Case Study – Health Inequalities Strategy Consultations	

The DHLI and its antecedents have built up detailed knowledge of the needs of its communities, which has been supplemented on occasion by local health surveys/audits. Knowledge about service gaps develops through interaction and joint-working with other community services. However, an understanding of local health priorities and how services can respond effectively is most significantly gathered through the relationships and trust built between DHLI staff and local people.

Surveys provide a broad picture of, for example, services and service gaps, but if these are to be developed to meet local need, investment has to be made in discovering ‘the thinking behind the ticks’: that is, by asking why people responded the way they did, and by listening to the factors that informed choices. Discussing issues from within already established relationships allows a fuller picture to emerge and a more appropriate response developed. Project experience has shown that small group consultations using action research methods are useful not only for gathering information on the problems but also for exploring possible solutions. Further, if solutions are developed from within ‘social’ relationships, where a sense

of ownership of both the problem and potential solution is present, it is more likely that any constraints on delivery will be accepted or open to negotiation.

Social relationships are also the foundation of the Community Sub Group, which has brought local people more formally into formative dialogue with the operation and future direction of the Project, and therefore with the delivery of those health-related services that fall within the DHLI's remit. This is a different, and therefore usefully complementary, dialogic space to those offered within patient/community panels, and therefore increases the depth and breadth of knowledge about the areas within which the Project and its partner agencies operate.

Local knowledge is useful where a multi-agency approach is required, allowing for the most beneficial allocation of responsibility, placing the most appropriate agency as the 'lead', and avoiding duplication of effort. Shared local delivery has been a feature of the DHLI's work and numerous case study examples are available from the project demonstrating the benefits and challenges of partnership working.

4. Improve the health of local communities

Section 3.1.1: Tackling disadvantaged life circumstances Section 3.3 a): Encouraging healthy lifestyles Section 3.4: Reducing ill-health and preventing premature death Section 5: Empowerment

Participants report that the most important benefit has been the establishment of social networks and evidence shows that social networks impact positively on health. These networks were established by removing or making manageable barriers to access and involvement, whether financial, perceptual or cultural.

Also key is the manner in which information is presented. The Project avoids didactic methods of presentation, opting instead for an enjoyable and enabling approach that encourages participants to absorb information at their own pace. Health related advice is delivered with acknowledgement of local cultural acceptability and the aim is to encourage participants to take ownership of change. Evidence demonstrates that this approach is effective. Research on the processes that people go through when considering accessing health services demonstrates

that friends and family are the first to be consulted. Whilst participants acknowledge and trust the skills and expertise of the DHLI workers, it appears that the relationships established between them and local people is closer to receiving advice from friends rather than a health professional.

As discussed in Section 3.4, traditional methods of accessing health services are more likely to conform to an individually focused illness model, than to the desired community health model that informs CHP aims and objectives. In contrast, the DHLI has shown that the provision of alternative forms of access such as the roving Health Information Points have given people an alternative to the GP practice as 'gatekeeper' to health services. Further, these alternatives have facilitated the opportunistic health check, which has resulted in earlier detection of health problems for some participants than might normally have been the case. In addition, all DHLI activities from the briefest contact to longer term involvement, bring the healthy lifestyle message *to* the community in their places and in their language.

Bringing the message *to* the community also supports the aim of working *with* the community to improve health. Much of the literature on community focused health promoting interventions stresses, by recourse to one concept or another, that empowerment (involvement in decisions and belief in the ability to enact change) is a key factor in encouraging people to make beneficial alterations to lifestyle behaviours. In order for those changes to become permanent they must be 'owned' by participants. The community development approach adopted by the DHLI has encouraged the community to look at itself and its own behaviours, and to begin a grounded process of change. Supported by the DHLI team, local people have already made significant moves toward such changes, whether this is at family or peer group level. Initiatives such as the Community Sub Group further affirm for local people that they can 'make a difference', and community health improvement is more readily understood by participants as a 'partnership' issue.

6. Promote involvement of, and partnership with, staff

Section 1.5:	Discussion
Section 3.4.1:	Successful collaboration
Section 3.7.3:	Partnership challenges

DHLI staff have gained an indepth knowledge of the effectiveness of different ways of working, which is vital to operational and strategic planning, and internal systems are in place to ensure that this knowledge is captured. Annual work plans are drawn up by locality staff and managing officers, and are coordinated to contribute to yearly Project 'milestones'. A range of regular meetings allow for discussion on issues arising in the communities and the lessons being learned, which in turn allows the Manager and the Team Leader to 'feed up' relevant information to operational and strategic settings . In addition, the presence of the researcher has allowed staff to discuss their work and experiences in a less formal way and to inform the qualitative reporting that has accompanied the Project.

Staff are encouraged to represent the DHLI on a number of committees, and are actively involved in local Community Planning to ensure that the Project is accurately represented to other local agencies. In addition, the team has been encouraged to present on its work, locally and internationally, and it is clear that the majority of staff have a sense of ownership of the DHLI as a result.

Internal partnership working has been, and to an extent remains, a challenge. This report has demonstrated that a conceptual shift is required, from 'multi-disciplinary' to 'inter-disciplinary' working – or, as it is described herein, to develop a working 'culture of complementarity'. Different professional backgrounds will have different approaches to delivery, but historically within the Project this was interpreted by some as being required to alter their professional practice to 'do community development'. In contrast, the existence of a multiplicity of approaches increases the depth and breadth of the Project's reach. The longer term, community development approach is not necessarily applicable to all situations. Combined with the shorter term groups and opportunistic access to health information offered by the DHLI nurses and mental health nurse, this demonstrates the value of having a diverse range of skills within the team.

That said, achieving full appreciation of each other's contribution in the face of issues such as 'evidence-based practice', protocols and differing attitudes to dependency, is a difficult hurdle. In the early stages staff may need frequent support (beyond standard levels of support and supervision) in making the transition into an inter-

disciplinary environment, and specific training sessions may need to be developed to facilitate this culture change.

The DHLI has gained significant experience working in partnership with other agencies. The Shop for Health provides an opportunity for specialist nurses to make contact with local people in non-threatening settings, allowing for a shift in the power-relationship to prompt interest and questions. This has been effective in promoting health and informing people of the range of specialist services available. This kind of collaborative work has been effective in breaking down professional barriers, whether between hospital and community, or between different community-based services. Joint-working has been useful in helping to identify gaps in the provision of health services, has assisted in feeding community health and health inequalities issues into strategic planning, and has facilitated the sharing of knowledge between agencies. This experience paves the way for forms of 'social prescribing' or referral of clients to other suitable (internal or external) activities. The DHLI has already implemented forms of internal referral with contacts at the Shop for Health being sign-posted to relevant DHLI activities in their own community.

7. Secure effective public, patient and carer involvement

Section 3.5: To support, resource and develop projects that tackle health inequalities and social exclusion.
Section 3.7.3: Partnership challenges
Section 4.8: Community involvement in Project direction

Mention has already been made of public consultations involving the DHLI and its consistent engagement with the community, which allow for more in-depth consultations than would otherwise have been possible. Whilst it is not the role of the DHLI to constantly conduct consultations, where these sit comfortably with the project's remit, it is an effective way of broadening public and patient consultation.

Most apparent in terms of public involvement is the Community Sub Group (CSG), and the broader network of community groups that it represents. Whilst still relatively new, the CSG has already demonstrated that this method, which is rooted in the community development approach, is a meaningful way of engaging local people in decisions that affect them. It is resource-intensive but represents a

significant advance in community representation. It is an important source of local responses to health strategy and may be a vital adjunct to other, more 'formal' approaches to community and patient consultation.

4.1 Pathogenic to Salutogenic Approaches

In the discussion that closed the previous chapter it was argued that, despite various criticisms, the concepts that have been used in community development can be useful in understanding how communities and their members are responding to health development programmes. However, when applied, analytical tools such as 'social capital' and 'empowerment' still risk excluding those contributing disciplines that see themselves as having a more explicit health role, albeit a promotional or preventative one. Introducing yet another such tool might therefore appear counter-productive, but the following offers, at the very least, an opportunity to consider the benefits of an umbrella concept.

The word salutogenic derives from "salus" meaning health, and "genesis" meaning to give birth. Salutogenesis literally means "that which gives birth to health." In traditional public health and community medicine approaches, a pathogenic perspective, in which the focus is on disease or illness and its prevention or treatment, most often dominates interventions. Adoption of a salutogenic perspective highlights the importance of considering how health is created and maintained through community-based health promotion. Not only does this definition acknowledge the need to move away from individual illness models to community health models of intervention, it also introduces an explicitly health-focused concept which might serve to encompass the work of the various disciplines involved in projects such as the DHLI. It closely resembles the notions of social capital and community capacity building in that it prioritises a grounded approach to health which is sensitive to the context and recognises the need to maintain contact with the community concerned. It also acknowledges the need to take a more ecological approach to health and health improvement – the 'significant shift'.

4.2 Complementarity:

Whilst the community development approach is fundamental to DHLI practice it is apparent from the range of activities offered by the Project, and from the monitoring data, that other mechanisms and approaches are working to ensure that it impacts

further on the health of Dundee than longer-term groups alone might. These approaches, whilst also community based and focused, offer a complementary alternative to the more intensive and longer-term engagement seen, for example, in Women's Health Groups. This is achieved by:

(a) offering short focused courses on health-related topics

(b) providing people with opportunistic health consultations.

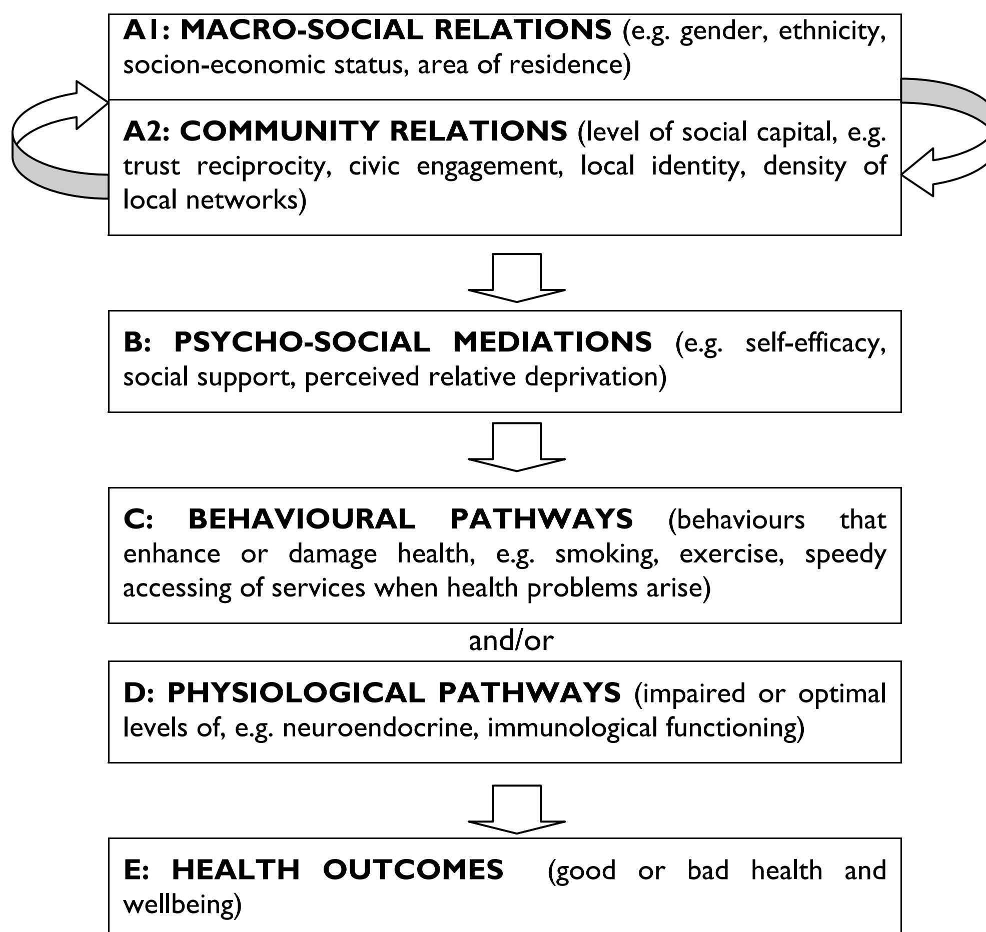
Both offer a DHLI-led route into longer-term engagement with the Project.

The above are offered by the nursing arm of the DHLI team and include Health Information Points, health checks in public houses and shopping centres and health talks. This has developed as a grounded response to community need, and as an efficient deployment of resources. It should be seen as an effective use of skills and a fulfilment of community needs using a diverse, appropriate and readily available range of programmes. Working in this manner serves to extend the programme available to the public, with the effect of being more inclusive. As a result, a 'culture of complementarity' should be encouraged.

4.3 Closing Remarks

This section has attempted to draw together lessons learned from the DHLI experience that might contribute to the development and maintenance of Community Health Partnerships. If there is to be a 'significant shift' in approaches to health improvement and health inequalities, the experience of projects like the DHLI will be significant to the successful implementation of new ways of working in mainstream services. The following diagram (Campbell et.al.1999) aims to respond to the key question of *'if health-related behaviours are influenced by the extent to which people are located within health-enabling[1] environments, how can such environments best be conceptualised/promoted?'*

Fig. 1: Pathways between social capital and health



Conclusions drawn from the qualitative research conducted on the DHLI concur with conclusions drawn from similar health projects elsewhere: that they operate in complex and multi-levelled contexts and that by breaking down local health inequalities into issues such as access, delivery, local presence and trust, projects can make inroads into these inequalities. The DHLI experience has shown how, by engaging *with* its client communities and being *in* those communities, the DHLI is in some way mediating macro and community (micro) relations. It has also demonstrated that beneficial intervention in the psycho-social mediations (self-efficacy) has opened pathways to beneficial behavioural and physiological change. Self-reported, positive health outcomes for individuals and families have resulted. It is proposed, having proved itself in several communities across Dundee, the DHLI model and evaluation of the Project's activities to date provide vital data for reshaped future of community healthcare delivery.

SECTION 6 - CHP LINKS

KEY ISSUES AND LESSONS LEARNED

- The DHLI has a multitude of skills and experience in new ways of working to assist the CHP in making a "significant shift" in approaches to health improvement and health inequalities
- The DHLI experience is relevant to achieving 5 of the 8 core CHP aims as specified by the Scottish Executive
- It can help the CHP to:
  - ***Deliver more innovative services more effectively*** by opening dialogue with the community via its local presence and the trust relationship that exists with local people; by facilitating the input of mainstream and specialist services in a community setting; by drawing upon its experience in offering innovative, health improvement interventions; by building the capacity of mainstream staff to adopt the flexible, action research, community-centred approach of the DHLI
  - ***Shape services to meet local need*** by facilitating methods of community engagement to identify local needs and solutions in relation to health inequalities issues; by working in partnership with others to deliver health improvement interventions based around the DHLI approach
  - ***Improve the health of local communities*** by developing and supporting social networks to help build Social Capital; by delivering health improvement interventions which recognise the cultural context and provide immersion in these by facilitators; by working alongside local people to sustain behaviour changes and interventions
  - ***Promote involvement of, and partnership with, staff*** by sharing the DHLI experience of collaborative working, especially within the locally based, inter-disciplinary, team context; by assisting mainstream staff to foster a "culture of complementarity" and helping build their capacity to work with different disciplines
  - ***Secure effective public, patient and carer involvement*** by engaging with disadvantaged communities and assisting the CHP to extend its reach in relation to hard-to-reach groups and individuals; by linking

the DHLI Community Sub Group and health network of groups formally into public involvement strategies

- Consideration should be given to adopting the concept of *salutogenic* rather than *pathogenic* approaches i.e. moving away from an illness model to a recognition of how health is created and maintained through community based, culturally sensitive interventions
- Offering a range of interventions and activities is fundamental in tackling health inequalities issues through utilising the different and complementary skills of health and community development professionals
- The DHLI operates in a complex and multi-levelled context and is providing valuable data from which the CHP can draw in terms of reshaping services to address health inequalities issues

SECTION SEVEN: RECOMMENDATIONS

Recommendations have been made throughout this report as part of the overall discussion. This final Section aims to summarise key recommendations for ease of reference. The list is therefore not exhaustive and other recommendations will hopefully arise out of discussion generated by or informed by the rest of the report.

1. The DHLI approach

The DHLI experience has demonstrated that local presence and accessibility of DHLI staff has been fundamental to building the local knowledge and trust between practitioners and clients, which is fundamental to the success of community development projects such as the DHLI. Some of this success is also due to a 'continuity' of presence from the DHLI's forerunners, which may be taken as evidence for longer-term projects or, preferably, mainstreaming.

Recommendations:

- Action to address health inequalities has tended to be focused on short-term projects. Health inequalities continue to be a major problem but the Dundee experience – focused on the DHLI and its forerunners – demonstrates that a longer-term project focus provides both the foundations for effective community development work and the local managerial expertise necessary to guide such a complex project. Consequently, the primary recommendation arising from this qualitative evaluation is that ways be found to establish the DHLI as part of mainstream community healthcare provision in Dundee/Tayside.
- However, much of the DHLI's success is down to its relative autonomy. This should be maintained and consideration given to enhancing operations by removing some of the administration barriers (for example, in financial management).
- The DHLI's experience should be discussed and disseminated more widely to inform the development of similar projects in the Tayside area and beyond.
- The experience of the DHLI and its forerunners, and the benefits arising from a lengthy and continuing involvement in areas (as opposed to short-term projects) should be used to lobby for such health development

(salutogenic) projects to be represented in mainstream provision.

2. **Enhancement of the role of the Community Sub Group and key clients**

The Community Sub Group has been a highly successful initiative, which has engaged local people in health-related decision-making processes and demonstrated that their actions can make a difference. The initiative has been sensitively applied, ensuring that the commitment has been at a level and pace acceptable to the individuals involved, but the process has reached a point where new challenges can be proposed. Further, certain key clients are expressing the view that they would like to become more involved with the Project's work, opening up the possibility of 'lay health workers'. Many of these have been trained by the DHLI in, for example, 'exercise to music'. There is a possibility that if opportunities to satisfy their ambitions is not forthcoming with, or within, the DHLI, they may find other ways to fulfill these ambitions.

Recommendations*:*

- That the possibility of enhancing the role of key individuals be discussed, and potential barriers overcome (in relation to employment, etc.), whether or not the 'lay health worker' option is progressed. This would either prepare the ground for 'lay health workers', or offer some local version of the scheme.
- Consideration should be given to the likely impact on the Project if, in order to satisfy their ambitions, these key individuals were to take their expertise to other organizations.

3. **New staff**

The challenges created in encountering what for some is a new working environment have been discussed throughout this report. The DHLI's experience has shown that the project's ways of working – being locally based, always accessible to local people, having a multi-disciplinary approach to development and delivery of activities – has led to a longer settling-in period for some staff. Even staff with significant levels of experience of working in the community have found the DHLI approach to be a considerable personal challenge. The DHLI response has been to increase levels of support and

supervision during the initial few months of service, and to ensure new staff are aware that senior staff can be approached at any time for further mentoring and support. However, each new team member on projects such as this are likely to have differing levels of need in this area.

Recommendations:

- That the DHLI continue to be explicit about the working environment when advertising posts, and ensure that new staff are fully aware of support and supervision opportunities, and that 'buddying' with established members of the project team be encouraged where requested or felt to be advantageous.
- That the team management ensure that systems continue to be responsive to individual needs.

4. Internal communication and team building

The benefits of a dispersed team do mean that communication between members of that team is intermittent. This can have a disruptive effect, especially in terms of building or maintaining a sense of team identity. Further, there have been challenges relating to fully appreciating others' roles and professional responsibilities and approaches. This has improved with time and familiarity, but the fundamental issue of appreciating what multi-disciplinary, inter-disciplinary or partnership working really means could still benefit from further internal debate. Also, the stresses and challenges that have a particular impact on new staff, do also impact to some extent on established staff members, and 'time out' is necessary. The DHLI has countered the effects of these issues by guarding time for 'team building' days which focus on group activities which may not be directly related to practice, but which have benefits for practice. Team members also meet socially, but informally.

Recommendations:

- That regular 'team building' days, involving group activity, be maintained and encouraged.
- That these be acknowledged as necessary to project identity, and that resource provision for such activity be included in any planning for extension or enhancement to the DHLI structure, and for similar

dispersed projects.

- That more explicit moves be made to move toward creating a 'culture of complementarity', by debating multi- or interdisciplinary working, and partnership working, and to reporting those discussions to the Management Group and beyond.

5. Staff development

The DHLI is staffed by highly trained, experienced and reflective individuals, each of whom is a valuable source of information on effective delivery of project initiatives and resources, and on gaps in local health service provision. However, team members have occasionally expressed a level of frustration at not being able to share this knowledge to the benefit of decision-making and development of community healthcare provision. This may be a matter of perception, as the Project's experiences are disseminated at decision-making level by its Manager and Team Leader. Steps have been taken to increase the direct communication between the team and the Management Group. However, the project is likely to benefit further if moves are made to alter team perceptions.

Recommendations:

- That when and the manner by which team experiences and resulting recommendations are fed up to decision-making level are made explicit.
- That, in combination, the Management Group continue to develop its more direct approach to the team (moving from presentations by team members at Management Group meetings, to a more 'workshop'-like approach to discussing key issues).
- That team members be encouraged to continue to present their work outwith the immediate context, at professional conferences etc.
- That methods of 'community development' be applied to the team, so as to ensure that members are explicitly aware of their contribution to the furtherance of community health development locally and more broadly.

6. The role of action research

The research enabled through this project has offered an unusual opportunity to observe and experience the potential that lies within community development work in all its complexity, and has provided valuable data that goes beyond standard project 'evaluation'. Additional, in-depth qualitative research would add immeasurably to understandings of intervention projects such as this. In addition, the team has benefited from having an 'insider/outsider' working alongside the team, as a resource to assist in evaluating new initiatives and as a 'sounding board' in what are sometimes challenging work contexts. The DHLI has also provided a somewhat pioneering 'case study' in the still-exploratory realms of interdisciplinary research and collaboration between academic and non-academic bodies. However, although the level of involvement may have been more intense, the DHLI is not the only Tayside-focused project to have included assessment by academic researchers in its evaluation. It remains the case, though, that little opportunity exists for findings to be shared or compared.

Recommendations:

- That the opportunity to include qualitative research in plans to expand or enhance the DHLI's future activities be seriously considered.
- That ways be found to bring academics together to share and compare findings and conclusions, to the overall benefit of health-related projects in the Dundee/Tayside area.

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